Community Clinic and Health Center Emergency Operations Plan

Template

June 2004

California Clinic Emergency Preparedness Project

California EMS Authority   **California Primary Care Association**

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Clinic Emergency Preparedness Project

Emergency Operations Plan Template

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PREFACE

How to Use This Template

The purpose of this template is to assist community clinics and health centers to develop and maintain an emergency management program to guide their response to all emergencies, regardless of cause. The template is in a "fill-in the blank" format and includes planning language, procedures, policies, and forms needed to create a comprehensive plan. For clinics initiating their disaster planning programs, these tools can provide a "jump-start". For clinics that have already developed an emergency management program, the template may provide useful resources to refine or extend their programs.

The template is intended to serve as a guide. This template is only a starting point. Template users will need to do more than "search and replace" their clinic name in the appropriate parts of the document. The template delineates mitigation and preparedness actions that must be completed in order for their emergency response to be as successful as it could be. The information and tools in the template should be adapted for each clinic to take into account:

- The hazards the clinic faces.

- Its emergency management system.

- The clinic's day-to-day health care resources and the availability of other health care resources in the community.

The plan may also require hazard and response information specific to each clinic site, including satellite and mobile clinics.

The elements of the template are intended to be adapted to clinic needs, environments, resources and existing plans. Clinics are encouraged to review, use and modify the tools, forms, and procedures included in the template over time. As experience is gained in exercises and responses, clinic adaptations of these tools will become increasingly sophisticated and relevant to their emergency response operations. Furthermore, clinics may need to develop additional emergency management tools. Users of the template should feel free to modify the order and content of template sections.

The template is responsive to regulatory and accreditation requirements. The developers of the template took into account the Environment of Care Standards of the Joint Commission on the Accreditation of Healthcare Organizations (**JCAHO**). However, use of this template does not guarantee that plans and programs based upon it will meet **JCAHO** or government regulatory requirements for clinic emergency preparedness. See **Appendix A – JCAHO EC 4.10 and 4.20** and **Appendix U - Appendix U: Clinic Emergency Management Regulatory References.**

The template emphasizes coordination with government emergency management agencies. Clinics will need to coordinate their emergency preparedness, response and recovery activities with the Medical Health Operational Area Coordinator (**MHOAC**). The **MHOAC** is responsible for the overall coordination of Operational Area's (**OA**) medical and health response and for coordinating the request for and application of medical and health

resources from outside the local area. Clinics must develop plans and procedures for contacting and exchanging information with local officials and response plans that are consistent with the overall medical response system in which they operate.

California has adopted the Standardized Emergency Management System (**SEMS**) that has helped to create consistency among government agencies in their approach to emergency management. This template incorporates **SEMS** concepts and recommends that clinics adopt the Incident Command System for emergency organization structure and management. However, each county system is somewhat unique in its approach to receiving requests and providing resources, interacting with health care providers and coordinating its medical response to disasters. Clinics should work with their consortia and local government agencies to obtain guidance, assistance or referral to sources of information on emergency preparedness.

The template takes an "all-hazards" approach and is organized according to the four phases of emergency management. The all-hazards approach ensures the template's applicability to the development of plans for natural and man-made disasters, including technological, hazardous material, and terrorist events. The template's organization around the four phases of emergency management – mitigation, preparedness, response, and recovery – provides a systematic approach to the development and implementation of the clinic's emergency management program.

The template requires an active implementation effort. We recommend that the leadership of clinics initiating the development of their emergency management program:

- Read this template.

- Appoint an emergency preparedness committee **(EPC)** to manage the development and maintenance of an emergency management program.

- Set priorities and create a work plan for developing plans and preparing staff and organization for emergency response. All provisions of the template do not have to be implemented simultaneously.

- Recognize the importance of training, drills, and keeping plan information up-to-date.

The template builds on the work, expertise and relationships of Clinic Consortia. Clinics should work with their consortia to develop their emergency management programs. Consortia can play a variety of important roles including facilitating coordination among clinics and with local authorities and providing access to technical assistance and training. In some counties, consortia may also play a role in coordinating the disaster response and recovery activities of clinics.

Terminology
Given the diversity of clinic community roles and organization and management structures, it was not possible to develop a single template that would apply in every respect to the organizational, operational and environment of every clinic. Some of the conventions used in the template include:

- The term "clinic" refers to the full range of non-profit community clinics, free clinics and health centers.

- Similarly the term "clinic consortia" refers to the county based or regional associations of clinics.

- The term "Executive Director" also refers to Chief Executive Officer or any other manager who has primary onsite responsibility for a clinic facility. Other staff titles may need to be translated for different organizational structures.

INTRODUCTION

Purpose

The purpose of the *<Name of Clinic>* Emergency Operations Plan (**EOP**) is to establish a basic emergency program to provide timely, integrated, and coordinated response to the wide range of natural and man made events that may disrupt normal operations and require preplanned response to internal and external disasters.

The objectives of the emergency management program include:

- To provide maximum safety and protection from injury for patients, visitors, and staff.

- To attend promptly and efficiently to all individuals requiring medical attention in an emergency situation.

- To provide a logical and flexible chain of command to enable maximum use of resources.

- To maintain and restore essential services as quickly as possible following an emergency incident or disaster.

- To protect clinic property, facilities, and equipment.

- To satisfy all applicable regulatory and accreditation requirements.

Policy

- *<Name of Clinic>* will be prepared to respond to a natural or man-made disaster, suspected case of bioterrorism or other emergency in a manner that protects the health and safety of its patients, visitors, and staff, and that is coordinated with a community-wide response to a large-scale disaster.

- All employees will know and be prepared to fulfill their duties and responsibilities as part of a team effort to provide the best possible emergency care in any situation. Each supervisor at each level of the organization will ensure that employees are aware of their responsibilities.

- The *<Name of Clinic>* will work in close coordination with the Medical Health Operational Area Coordinator **(MHOAC)** and other local emergency officials, agencies and health care providers to ensure a community-wide coordinated response to disasters.

Scope

- Within the context of this plan, a disaster is any emergency event which overwhelms or threatens to overwhelm the routine capabilities of the clinic.

- This all-hazards **EOP** describes an emergency management program designed to respond to natural and man-made disasters, including technological, hazardous material, and terrorist events.

- This plan describes the policies and procedures *<Name of Clinic>* will follow to mitigate, prepare for, respond to, and recover from the effects of emergencies.

- **CCR Title 22:** This disaster plan complies with California Code of Regulations, Title 22, Division 5, Section 75057 Disaster Plan.

- Development and implementation of this plan complies with relevant sections of **JCAHO** Environment of Care standards related to emergency preparedness. Refer to **Appendix A - JCAHO Standards EC 4.10 and 4.20** for additional information checklist on **JCAHO** requirements.

Key Terms

Refer to **Appendix B - Emergency Management Acronyms** and **Appendix C - Emergency Management Glossary** for a list of acronyms and more extensive glossary, respectively. The following terms are used frequently throughout this document.

ALTERNATE SITES/FACILITIES
Locations other than the primary facility where clinic operations will continue during an emergency.

CONTINUITY OF OPERATIONS (COOP)
Plans and actions necessary to continue essential business functions and services and ensure continuation of decision making even though primary facilities are unavailable due to emergencies.

EMERGENCY OPERATIONS CENTER (EOC)
The location at which management can coordinate clinic activities during an emergency. It is managed using the Incident Command System **(ICS)**. The **EOC** may be established in the primary clinic facility or at an alternate site.

EMERGENCY PREPAREDNESS COMMITTEE (EPC)
The Emergency Preparedness Committee guides the development and maintenance of the clinic's emergency management program and development of its emergency operations plan.

EMERGENCY RESPONSE TEAM (ERT)
The Emergency Response Team (**ERT**) consists of the clinic staff who will fill the core positions of the Emergency Operations Center (**EOC**) and manage the clinic's emergency response.

ESSENTIAL FUNCTIONS (EF)
Essential functions and services are those that implement the clinic's core mission and goals. The extended loss of these functions, following an emergency, would create a threat to life/safety, or irreversible damage to the clinic, its staff or its stakeholders.

HAZARD MITIGATION
Measures taken by a facility to lessen the severity or impact a potential disaster or emergency may have on its operation. Hazard mitigation can be divided into two categories.

- Structural Mitigation. Reinforcing, bracing, anchoring, bolting, strengthening or replacing any portion of a building that may become damaged and cause injury, including exterior walls, exterior doors, exterior windows, foundation, and roof.

- Nonstructural Mitigation: Reducing the threat to safety posed by the effects of earthquakes on nonstructural elements. Examples of nonstructural elements include: light fixtures, gas cylinders, HazMat containers, desktop equipment, unsecured bookcases and other furniture.

HAZARD VULNERABILITY ANALYSIS
Hazard vulnerability analysis identifies ways to minimize losses in a disaster considering emergencies that may occur within the facility as well as external to the facility in the surrounding community.

INCIDENT COMMAND SYSTEM (ICS)
A temporary management system used to manage and coordinate clinic activities during an emergency. **ICS** is designed facilitate decision-making in an emergency environment.

MEDICAL HEALTH OPERATIONAL AREA COORDINATOR (MHOAC)
The position in the Standardized Emergency Operations System **(SEMS)** responsible for all disaster medical and health operations in an operational area. The **MHOAC** is stationed in the County **EOC** and is frequently, but not always, the County Health Officer or designee. During the response to disasters, the **MHOAC** is the Operational Area contact point for requests for medical and health resources including personnel, supplies and equipment, pharmaceuticals, and medical transport.

MULTI-HAZARD APPROACH
A multi-hazard approach to disaster planning evaluates all threats including the impacts from all natural and man-made disasters, including technological threats, terrorism, and a state of war.

OPERATIONAL AREA (OA)
An intermediate level of the State emergency organization, consisting of a county and all political subdivisions within the county area. Clinics and other health facilities will coordinate their disaster response with the **Medical Health Operational Area Coordinator (MHOAC).**

PHASES OF EMERGENCY MANAGEMENT

Mitigation - Pre-event planning and actions which aim to lessen the effects of potential disaster.

Preparedness – Actions taken in advance of an emergency to prepare the organization for response.

Response - Activities to address the immediate and short-term effects of an emergency or disaster. Response includes immediate actions to save lives, protect property and meet basic human needs.

Recovery - Activities that occur following a response to a disaster that are designed to help an organization and community return to a pre-disaster level of function.

STANDARD OPERATING PROCEDURES (SOP)
Pre-established procedures that guide how an organization and its staff perform certain tasks. **SOPs** are used routinely for day to day operations and response to emergency situations. **SOPs** are often presented in the form of checklists or job action sheets.

STANDARDIZED EMERGENCY MANAGEMENT SYSTEM (SEMS)
SEMS is the mandatory system established by Government Code Section 8607(a) for managing the response of government agencies to multi-agency and multi-jurisdiction emergencies in California. **SEMS** incorporates the use of the Incident Command System.

1 MITIGATION

1.1 Introduction

<Name of Clinic> will undertake risk assessment and hazard mitigation activities to lessen the severity and impact of a potential emergency. Mitigation begins by identifying potential emergencies (hazards) that may affect the organization's operations or the demand for its services. This will be followed by development of a strategy to strengthen the perceived areas of vulnerability within the organization.

During the mitigation phase, the *<Name of Clinic>* Executive Director and staff will identify internal and external hazards and take steps to reduce the level of threat they pose by mitigating those hazards or reducing their potential impact on the clinic. The areas of vulnerability that cannot be strengthened sufficiently are then addressed in emergency plans.

Mitigation activities may occur both before and following a disaster.

1.2 Hazard Vulnerability Analysis

1.2.1   *<Name of Clinic>* will conduct a hazard vulnerability analysis to identify hazards and the direct and indirect effect these hazards may have on the clinic. This will provide information needed by the clinic to minimize losses in a disaster.

Appendix D.1 - Clinic Hazard and Vulnerability Analysis provides a tool for estimating and ranking the probability of occurrence and potential severity of various events. This assessment should be performed every three to five years.

1.2.2   As part of its risk management program, *<Name of Clinic>* will also conduct a Management of Environment safety survey of its facilities at least quarterly. **Appendix D.2 Hazard Surveillance / Assessment Form - Hazard Vulnerability Assessment Tool** provides a tool for conducting that survey, ranking problems and setting priorities for remediation. This ongoing remediation contributes to reducing the overall vulnerability of the clinic to various hazards. The tool provided in **Appendix D.2** should be modified, if necessary, to address problems associated with hazards identified through the hazard vulnerability assessment describe in **Section 1.2.1.**

1.3 Hazard Mitigation

<Name of Clinic> will undertake hazard mitigation or retrofitting measures to lessen the severity or impact a potential disaster may have on its operation. These measures are taken prior to disasters to minimize the damage to the facility.

Refer to **Appendix D.3 - Structural and Non-Structural Hazard Mitigation Checklists** for a checklist of **structural** and **non-structural** hazard mitigation recommendations for specific hazards.

1.4   Risk Assessment

<Name of Clinic> will assess the risks identified in its Hazard Vulnerability Assessment that could not be eliminated or satisfactorily mitigated through its hazard mitigation program and determine their likelihood of occurrence and the severity of their consequences. This assessment of remaining risks will help to define the emergency response role the clinic adopts for itself and the preparation required to meet that role. See **Section 1.6 below.**

1.5   Insurance Coverage

The Chief Financial Officer of *<Name of Clinic>* will meet with insurance carriers to review all insurance policies and assess the facility's coverage for relocation to another site, loss of supplies and equipment, and structural and nonstructural damage to the facility.

The CFO will assess clinic coverage for floods or earthquakes. If coverage is absent or inadequate, the clinic will evaluate if it is financially sound to acquire it. Clinics located in special flood hazard areas must have flood insurance to be eligible for disaster assistance.

1.6   Clinic Emergency Response Roles

1.6.1   *<Name of Clinic>* may play a variety of roles in responding to disasters including providing emergency medical care, providing temporary shelter and expanding primary care services to meet increased community needs created by damage to other health facilities. *<Name of Clinic>* may also provide mental health services to disaster victims and serve as a conduit for information dissemination to affected communities. However, clinics are not equipped to respond definitively to all disasters. Clinic roles may be constrained by limited resources and technical capability and by the impact of the disaster on the clinic facility. Refer to **Appendix E – Clinic Response Roles and Requirements** for a list of potential roles and the planning and preparedness requirements for meeting those roles.

1.6.2   As a part of its mitigation program, *<Name of Clinic>* will identify the response roles it will prepare to perform following a disaster. This decision will involve input from clinic management and staff, the clinic board of directors, the community and government emergency officials. Based on the findings of the risk assessment, *<Name of Clinic>* will take the following steps to define the disaster response roles for which it should prepare:

- Assess the pre-disaster medical care environment and the role the clinic performs in providing health services.

- Assess clinic resources including availability of staff to respond and ability of the clinic to survive intact.

- Discuss potential response roles and findings of risk assessment with Medical Health Operational Area Coordinator or Office of Emergency Services.

- Obtain community input.

- Obtain input from clinic staff especially medical and nursing directors, safety officer, and chief operating officer.

- Present recommendations to its board of directors for ratification.

2 PREPAREDNESS

2.1 Introduction

Preparedness activities build organization capacity to manage the effects of emergencies should one occur. During this phase, the *<Name of Clinic>* Executive Director, Emergency Preparedness Committee (**EPC**) and staff will develop plans and operational capabilities to improve the effectiveness of the clinic's response to emergencies. Specifically, the clinic will:

- Develop / update emergency plans and procedures, including the Emergency Operations Plan.

- Develop and update agreements with other community health care providers and with civil authorities.

- Train emergency response personnel.

- Conduct drills and exercises.

2.2 Emergency Operations Plan

The *<Name of Clinic>* Emergency Operations Plan is an "all-hazards" plan that will guide *<Name of Clinic>* response to any type of a disaster or emergency.

2.3 Standardized Emergency Management System (SEMS)

2.3.1   *<Name of Clinic>* has incorporated the principles of SEMS into its **Emergency Operations Plan** to ensure maximum compatibility with local government response plans and procedures.

2.3.2   According to California Government Code Section 8607 SEMS shall be used by all State Agencies responding to any of the following emergency operations:

- Single jurisdictional/agency involvement

- Single jurisdictional responsibility with multiple agency involvement

- Multiple jurisdictional responsibility with multiple agency involvement

2.3.3   **SEMS** incorporates the Incident Command System (**ICS**) which provides an efficient tool for the management of emergency operations. SEMS/ICS is designed to be adaptable to any emergency or incident. The system expands in a rapid and logical manner from an initial response to a major incident call-out. When organizational needs dictate, the system also contracts just as rapidly.

2.3.4   These components of SEMS / ICS are incorporated or referenced in this **EOP.**

- Common terminology

- Modular organization

- Unified Command
- Action Plannning
- Manageable Span-of-Control
- Multi-Agency and Inter-Agency Coordination

2.3.5　　**SEMS** operates at the following levels of government:

- State - Statewide resource coordination integrated with federal agencies.
- Regional - Manages and coordinates information and resources among operational areas.
- Operational Area – Manages and coordinates all local governments within the geographic boundary of a county.
- Local - County, city or special district.
- Field - On-scene responders.
- Clinic Relationship to SEMS
- *<Name of Clinic>* interfaces with SEMS through the Medical Health Operational Area Coordinator **(MHOAC)** who is usually the county health officer.

2.4　Integration with Community-wide Response

<Name of Clinic> will notify the **MHOAC** of any emergency impacting clinic operations and will coordinate its response to community-wide disasters with the overall medical and health response of the Operational Area. See **Appendix J.3 – Disaster Contacts** for list of agencies and individuals, including the **MHOAC**, who should be contacted in emergencies.

2.4.1　　Coordination with Government Response Agencies

To the extent possible, the *<Name of Clinic>* will ensure that its response is coordinated with the decisions and actions of the **MHOAC** and other health care agencies involved in the response. To ensure coordination, clinic staff will:

a. In coordination with the clinic Consortium meet with the **MHOAC** to define the clinic's role in the emergency response system. Determine which response roles are expected by officials and which are beyond the system's response needs or the clinic's response capabilities. See **Appendix E – Clinic Response Roles and Requirements** for a list of potential clinic roles.

b. Participate in planning, training and exercises sponsored by medical and health agencies.

c. Develop reporting and communications procedures to ensure integration with Operational Area response.

    d. Define procedures for requesting and obtaining medical resources and for evacuating / transporting patients.

    e. During a response, report the status and resource needs of the clinic and obtain or provide assistance in support of the community-wide response.

Note that in some areas, the clinic consortium will coordinate the completion of these tasks while in others, clinics will be responsible for taking the initiative in completing these tasks.

2.4.2 Coordination with Emergency Responders

2.4.2.1 Emergency services availability

During an area-wide disaster, fire, EMS and law emergency services may not be able to respond to emergencies at the clinic.

2.4.2.2 Response authority

Clinic personnel will cooperate fully with EMS and law enforcement personnel when they respond to emergencies at the clinic. This may include providing information about the location of hazardous materials or following instructions to evacuate and close the clinic.

2.4.2.3 Command post

The *<Name of Clinic>* has identified a recommended location for an emergency responder command post for coordinating the response to an emergency at the clinic. The location of the primary command post and an alternate are listed in **Appendix L.2 – Health Care Alternate and Referral Facility Locations**.

2.4.3 Coordination with other Medical Facilities

<Name of Clinic> recognizes that it may need to rely on other health care facilities, especially those nearby, in responding to a disaster to augment its capacity to meet patient care needs. *<Name of Clinic>* will review existing formal and informal arrangements with health facilities to explore expanding their provisions to cover disaster response conditions. The clinic will also seek to establish agreements with relevant facilities where no agreement currently exists. *<Name of Clinic>* views these agreements as reciprocal and will also explore opportunities to provide support to these facilities if conditions allow.

2.4.3.1 Examples of potential disaster related arrangements with nearby hospitals include:

- Referral / diversion of patients to nearby hospitals, especially patients that require a higher level of care than *<Name of Clinic>* can provide.

- Acceptance of diverted patients from hospitals to increase their capacity to care for seriously ill and injured.

2.4.3.2   Limitations

During an area-wide disaster in which the Operational Area has opened its **EOC**, patient transfers and access to ambulances may need to be coordinated through the **MHOAC**, overriding other agreements.

Developing arrangements for receipt or diversion / referral of disaster victims requires careful and detailed planning including:

- Alert and notification

- Sharing of medical information

- Patient tracking

- Contingencies that impact ability of either party to meet the terms of the agreement.

2.4.4   Relationship to Clinic Consortium

The clinic and its clinic consortium will define their emergency response relationship in accordance with the role established by the clinic consortium.

a. In the preparedness phase, the consortium role could include:

- Strengthening the relationship and coordination between the **MHOAC** and clinics in the county.

- Resource acquisition including grant funding, group purchasing and shared equipment.

- Training and technical assistance.

- Coordinated planning.

- Exercise coordination.

b. In the response and recovery phases, the consortium role could include:

- Consortium coordinated clinic assistance to clinics.

- Information gathering and dissemination to other clinics or Operational Area.

- Resource acquisition.

- Public information.

- Technical assistance.

c. In the recovery phase, assisting with obtaining financial recovery assistance.

d. As soon as practicable following a disaster, the *<Name of Clinic>* Incident Manager will report the following to the clinic consortium. See **Appendix J.3 – Disaster Contacts** for call list:

- Nature of the emergency.

- Impact of the emergency on clinic operations.

- Current operational status of the clinic.

- When the clinic expects to become fully operational.

- Clinic resource needs.

  e. Clinic reporting to the clinic consortium does not take the place of reporting to the **MHOAC**, unless operational area plans call for clinic – **MHOAC** coordination to be mediated by the clinic consortium.
  f. Clinic reporting to the clinic consortium does not necessarily constitute a request for resources or other assistance.

2.4.5   Coordination with Corporate Headquarters

The *<Name of Clinic>* Executive Director will notify the corporate headquarters of the clinic in the event of any emergency that requires clinic evacuation, 9-1-1 response of emergency medical or law enforcement personnel, or the opening of the clinic **EOC**.

Corporate headquarters emergency management staff, in coordination with the clinic Emergency Preparedness Committee and the clinic's Operational Area officials should determine the respective roles of corporate headquarters and the clinic in managing the clinic's response, coordinating with the Operational Area and requesting response resources.

2.4.6   Acquiring Resources

2.4.6.1   *<Name of Clinic>* will develop procedures for augmenting supplies, equipment and personnel from a variety of sources. Assistance may be coordinated through the following channels:

- Prior agreements with vendors for emergency re-supply.

- Stockpiles of medical supplies and pharmaceuticals anticipated to be required in an emergency response.

- Medical Health Operational Area Coordinator (**MHOAC**) assistance to clinics.

- From other clinics, hospitals or health care providers.

2.5 Roles / Responsibilities

2.5.1   The *<Name of Clinic>* Executive Director is responsible, directly or through delegation, for the development of the **EOP** and for directing the response to emergencies. Specific responsibilities include:

  a. Execute (oversee) the development and implementation of the disaster plan.

  b. Appoint an Emergency Preparedness Committee (**EPC**) to coordinates the development and maintenance of the *<Name of Clinic>* Emergency Operations Plan; ensure the clinic's emergency preparedness program meets all JCAHO standards or government regulations; and, provide for

ongoing training for clinic staff. See **Appendix A – JCAHO EC 4.10 and 4.20** and **Appendix U - Appendix U: Clinic Emergency Management Regulatory References.**

The **EPC** should include the safety manager, facility manager and senior representatives from administration and health care staff. The **EPC** role may be assigned to an existing committee of the clinic, such as the Infection Control or Safety Committee.

c. Assign staff emergency management duties and responsibilities. Appoint the Emergency Response Team **(ERT).** See **Appendix F.1 – Day-To-Day Org Chart / ERT Assignment)** based on Job Action Sheets and **Appendix F.2 – Emergency Management Organization Chart**.

d. Ensure staff is trained to perform emergency roles. See **Appendix G - Training And Exercises.**

e. Ensure that drills and exercises are conducted semi-annually and records are maintained. See **Appendix G - Training and Exercises.**

f. Evaluate the disaster program annually and update as needed including a description of how, when and who will perform the activity.

g. Activate the clinic's emergency response.

h. Direct the overall response to the disaster/emergency.

i. Develop the criteria for and direct the evacuation of staff, patients and visitors when indicated.

j. Ensure the clinic takes necessary steps to avoid interruption of essential functions and services or to restore them as rapidly as possible. See **Section 2.5.**

k. Ensure a hazard vulnerability assessment is performed periodically.

2.5.2   Medical Director

The Medical Director, directly or through delegation, will:

a. Serve as leader, co-leader, or member of the emergency response team (**ERT**).

b. Identify alternates and successors if unavailable or if response requires 24 hour operation.

c. Contact local health department to determine local system for bioterrorism updates. Monitors **<name of local system >** for updates. Provide clinicians with updates from the CDC and **<name of county>** Health Department on standards for the detection, diagnosis, and treatment of chemical and bioterrorism agents.

d. Ensure the continuity of care and maintenance of medical management of all patients in the care of the clinic during a disaster.

   e. Assign clinical staff to medical response roles (triage, treatment, decontamination, etc.)

   f. Determine disaster response clinical staffing needs in cooperation with the Nursing Director.

2.5.3 Nursing Director

The Nursing Director may fill the following roles:

   a. Serve as a member of the **ERT.**

   b. Monitor <name of local system> for bioterrorism updates.

   c. Provide clinicians with updates from the CDC and NHD of standards or the detection, diagnosis, and treatment of chemical and bioterrorism agents.

   d. Determine the disaster response clinical staffing needs in cooperation with the Medical Director.

   e. Perform other duties delegated by the *<Name of Clinic>* Medical Director, Executive Director or Incident Manager consistent with training and scope of practice.

2.5.4 Safety Officer

The Safety Officer will appoint teams and develop procedures for the following response tasks:

   a. Light search and rescue

   Appoint and train a light search and rescue team to ensure all rooms are empty and all staff, patients, and visitors leave the premises when the clinic is evacuated. If required and safe, this team will perform additional search and rescue tasks that do not entail using equipment or disturbing collapsed structures.

   b. Damage Assessment

   Appoint and train a damage assessment team on each shift to evaluate items on the Damage Assessment Checklist**. See Appendix D.1 - Disaster Assistance Forms.**

   Supply the teams with hard hats, work gloves, flashlights, clipboards, tape, cameras, film and videotape, if possible.

2.5.5 All Clinic Staff

- All clinic staff have emergency and disaster response responsibilities. The duty statements of all clinic staff will include the following language:

   "Participates in all safety programs which may include assignment to an emergency response team."

- Additional specific response duties may also be included for staff with appropriate skills and responsibilities.

In addition, all staff are required to:

a. Familiarize themselves with evacuation procedures and routes for their areas. See **Appendix H.1 - Emergency Procedures (Flip Chart)** and **Appendix H.3 – Clinic Floor Plan.**

b. Become familiar with basic emergency response procedures for fire, HAZMAT and other emergencies. See **Appendix H.1** and **Section 3.14.**

c. Understand their roles and responsibilities in *<Name of Clinic>* plans for response to and recovery from disasters. See **Appendix F.3 – EOC Job Action Sheets.**

d. Participate in Clinic training and exercises. These exercises are intended to practice emergency response activities and improve readiness. See **Appendix G - Training And Exercises.**

All staff will also be encouraged to:

a. Make suggestions to their supervisor or the Emergency Preparedness Committee on how to improve clinic preparedness.

b. Prepare family and home for consequences of disasters. See **Appendix I – Home Preparedness Guidelines** for guidelines.

2.6 Initial Communications and Notifications

2.6.1 *<Name of Clinic>* Staff Call List

The clinic will compile and maintain an internal contact list that will include the following information for all staff: name, position title, home phone, cell phone, pager numbers, and preferred method of contact during off hours. See **Appendix J.1 – Staff Call Back List.**

The Staff Call List contains sensitive contact information and will be treated confidentially.

The list of staff phone numbers will be kept offsite as well as onsite by key employees and at key locations. The phone list should be provided to the clinic's answering service.

<Name of Clinic> will also develop an email group and a paging group for employees to facilitate rapid staff contact. The clinic should also distribute laminated wallet-sized cards with emergency contact information for key staff to keep information readily accessible. See **Appendix J.4 – Wallet Card.**

    2.6.2   External Notification

The clinic will compile and maintain an external contact list of phone numbers of emergency response agencies, key vendors, stakeholders, and resources.

a. **Appendix J.2 – Basic Clinic Support** lists routine and emergency contact numbers for basic support services for clinic operations (e.g., utilities, repair services, etc.)

b. **Appendix J.3 – Disaster Contacts** lists contact information for use in response to disasters (e.g., government response entities, nearby hospitals and clinics, media, etc.)

    2.6.3   Primary Communications Methods

Refer to **Appendix K.1 – Communications Equipment Inventory** for a list of communications resources available to *<Name of Clinic>*. The primary means of emergency communication is the local telephone system. If telephones fail, clinic staff will notify the telephone provider by any means available including: telephones in another area of the clinic, cell phones, messenger, e-mail, or pay phones.

The clinic will keep change for pay phones in its disaster supplies.

<Name of Clinic> has installed standard telephone jacks that bypass the electronic phone system. These jacks are used for fax machines and for telephones that do not require electricity to operate. Refer to **Appendix K.1** for the location where these devices are located or stored.

    2.6.4   Alternate Communications Methods

In addition to its telephone system, the clinic maintains the following radio communications equipment:

- A *<county specific radio / communications system>* (e.g., HEAR, Reddinet©> for communications with the Operational Area medical/health response. Refer to **Appendix K.2 – County Communications Procedures** for procedures for operating the *<county specific radio / communications system>*. The radio is located in *<area in clinic>* area and is to be used only by trained staff.

- An Amateur Radio System or alternate communication system that is located in *<area in clinic>* and an agreement with a local Amateur Radio group to respond to the clinic when requested.

Other alternate communications tools include:

a. FAX, Cell Phone, Internet/Email, Public Pay Phones, and Voice Messaging. See Appendix K.1 – Communications Equipment Inventory for Communication Resource List.

b. Handheld Radios (Walkie-Talkies) – The clinic uses handheld radios for internal communications in both routine and emergency situations.

c. If telephone and radio communications are unavailable, runners will be employed to take messages to and from the clinic and appropriate agencies rendering assistance.

d. The clinic EOC has a radio, television with an antenna or cable connection and a VCR to monitor television and radio broadcasts to remain up-to-date on official government announcements and other information during a disaster.

e. Refer to **Appendix P.4 – Communications Procedures.**

2.6.5   Communications Equipment Testing and Maintenance

a. *<Name of Clinic>* will appoint a communications coordinator to maintain and test communications equipment.

b. All communications equipment will be tested twice per year. Defective equipment will be repaired or replaced. Batteries will be replaced per manufacturer's recommendation or as required. Spare batteries will be stored with equipment.

c. The communications coordinator will ensure copies of operating instructions, warranties and service agreements for communications equipment are retained both at the clinic and at an offsite location.

d. The communications coordinator will review communications requirements and equipment annually as a part of the review of this overall plan and will make recommendations for equipment upgrades or replacement.

2.7   Continuity of Operations

2.7.1   Policy

It is the policy of *<Name of Clinic>* to maintain service delivery or restore services as rapidly as possible following an emergency that disrupts those services. As soon as the safety of patients, visitors, and staff has been assured, the clinic will give priority to providing or ensuring patient access to health care.

2.7.2   Continuity of Operations Goals and Planning Elements

The clinic will take the following actions to increase its ability to maintain or rapidly restore essential services following a disaster to ensure:

a. Patient, visitor and personnel safety

Develop, train on and practice a plan for responding to internal emergencies and evacuating clinic staff, patients and visitors when the facility is threatened. See **Appendices H.1 – Emergency Procedures (Flip Chart)** and **H.5 – Clinic Evacuation Template.**

b. Continuous performance or rapid restoration of the clinic's essential services during an emergency

Develop plans to obtain needed medical supplies, equipment and personnel. See **Appendix J.3 – Disaster Contacts.** Identify a backup site or make provisions to transfer services to a nearby provider. See **Appendix L.1 – Health Care Alternate and Referral Facilities.**

c. Protection of medical records.

To the extent possible, protect medical records from fire, damage, theft and public exposure. If the clinic is evacuated, provide security to ensure privacy and safety of medical records.

d. Protection of vital records, data and sensitive information

- Ensure offsite back-up of financial and other data.

- Store copies of critical legal and financial documents in an offsite location.

- Protect financial records, passwords, credit cards, provider numbers and other sensitive financial information.

- Update plans for addressing interruption of computer processing capability.

- Maintain a contact list of vendors who can supply replacement equipment. See **Appendix J.2 – Basic Clinic Support.**

- Protect information technology assets from theft, virus attacks and unauthorized intrusion.

e. Protect medical and business equipment

- Compile a complete list of equipment serial numbers, dates of purchase and costs. Provide list to the CFO and store a copy offsite.

- Protect computer equipment against theft through use of security devices.

- Use surge protectors to protect equipment against electrical spikes.

- Secure equipment to floors and walls to prevent movement during earthquakes.

- Place fire extinguishers near critical equipment, train staff in their use, and inspect according to manufacturer's recommendations.

f. Relocation of services
<Name of Clinic> will take the following steps, as feasible and appropriate, to prepare for an event that makes the primary clinic facility unusable. *<Name of Clinic>* will:

- Identify a back-up facility for continuation of clinic health services, if possible. See **Appendix L.1 – Health Care Alternate and Referral Facility Locations** for location of back-up facility.

- Establish agreements with nearby health facilities to accept referrals of clinic patients.

- Establish agreements with nearby health facilities to allow clinic staff to see clinic patients at these alternate facilities.

- Identify a back-up site for continuation of clinic business functions and emergency management activities. See **Appendix L.1** for location.

g. Restoration of utilities

   <Name of Clinic> will:

- Maintain contact list of utility emergency numbers. See **Appendix J.2 – Basic Clinic Support.**

- Ensure availability of phone and phone line that do not rely on functioning electricity service.

- Request priority status for maintenance and restoration of telephone service from local telephone service provider.

2.7.3   *<Name of Clinic>* will obtain and install an emergency generator to ensure its ability to continue operations in the event of an emergency that creates power outages. *<Name of Clinic>* will obtain assistance from local utilities or vendors.

Specific steps include:

- Inventory essential equipment and systems that will need continuous power.

- Determine the maximum length of time the clinic will operate on emergency power (i.e., is emergency power primarily for short term outages or for extended operations)

- Determine power output needs.

- Select fuel preference: propane or diesel.

- Determine location of nearest supplies of selected fuels that can be accessed in an emergency.

- Select, purchase and install generator.

- Perform recommended periodic maintenance.

- Run monthly generator start-up tests.

2.8 Clinic Patient Surge Preparedness

2.8.1   Surge capacity encompasses clinic resources required to deliver health care under situations which exceed normal capacity including potential available space in which patients may be triaged, managed, vaccinated, decontaminated, or simply located; available personnel of all types;

necessary medications, supplies and equipment; and even the legal capacity to exceed authorized care capacity.

2.8.2   Normal clinic capacity could be exceeded during any type of emergency for reasons that include the following:

- Random spikes in numbers of presenting patients.

- Seasonal or other cyclical spikes (e.g., school required immunizations, flu epidemics, etc.).

- Convergence of ill or injured resulting from disasters.

- Psychogenic convergence that results from emergencies.

- A combination of any of the above.

Events that create patient surge may also reduce clinic resources through exhaustion of supplies and pharmaceuticals and reduced staff availability. Staff may be directly impacted by the emergency, unable to reach the clinic or required to meet commitments at other health facilities.

2.8.3   The *<Name of Clinic>* Medical Director, Nursing Director, and other staff with responsibility for emergency preparedness will review provisions of Operational Area emergency plans that describe:

- How the surge capacity of the health system will be increased.

- Patient transportation policies and procedures for bioterrorism and other major disasters.

- Procedures for augmenting medical care resources at sites of medical care including Operational Area plans for accessing and distributing the contents of the National Pharmaceutical Stockpile.

2.8.4   The Medical Director and Nursing Director will develop a surveillance process to provide early indications of potential for patient surge that may result from an infectious disease outbreak, bioterrorist attack, or release of a hazardous material. *<Name of Clinic>* clinical staff will monitor:

- Appointment patterns.

- Walk-in clinic utilization patterns.

- News reports about flu and other pandemics.

- Signs of bioterrorism attacks. See **Section 3.15.4.1.**

Clinical staff will also review past utilization experience to identify cyclical variations in clinic utilization.

2.8.5   Patient flow and site planning

<Name of Clinic> clinical staff will:

a. Periodically review patient flow and identify areas on clinic grounds that can be converted to triage sites and patient isolation areas.

b. Evaluate the appropriateness of the use of cafeteria, break rooms and other spaces for patient holding, decontamination or treatment areas.

c. Designate sites available for isolating victims of a chemical or bioterrorist attack. Sites should be selected in coordination with the facility manager based on patterns of airflow and ventilation, availability of adequate plumbing and waste disposal, and patient holding capacity.

d. Ensure triage and isolation areas are accessible to emergency vehicles and to patients.

e. Triage, decontamination and isolation sites should have controlled access.

2.8.6   *<Name of Clinic>* will also take the following actions to increase surge capacity:

a. Store cots, blankets and other items required for holding and sheltering patients while they await transfer.

b. Establish reciprocal referral agreements with nearby clinics and hospitals.

c. Survey staff to develop estimates of the likely number of clinical and non-clinical staff able to respond during clinic operating hours and off hours for each day of the week. The estimates will take into account distance, potential barriers and competing responsibilities (hospital practice, other clinics, etc.).

2.8.7   Clinics may be also be able to refer / divert patients to nearby clinics if *<Name of Clinic>* is damaged or overwhelmed, or obtain space and support from other health care providers.

2.9 Disaster Medical Resources

2.9.1   Personnel

2.9.1.1 *<Name of Clinic>* will rely primarily on its existing staff for response to emergencies and will, therefore, take the following measures to estimate staff availability for emergency response:

- Identify clinical staff with conflicting practice commitments.

- Identify staff with distance and other barriers that limit their ability to report to the clinic.

- Identify staff who are likely to be able to respond rapidly to the clinic.

2.9.1.2   *<Name of Clinic>* will also develop a roster of bi-lingual staff by language.

2.9.1.3   *<Name of Clinic>* will take the following steps to facilitate response to clinic emergencies by its staff when their homes and families may be impacted:

- Promote staff home emergency preparedness. See **Appendix I.**

- Identify childcare resources that are likely to remain open following a disaster.

2.9.2   Pharmaceuticals / Medical Supplies / Medical Equipment

2.9.2.1   *<Name of Clinic>* will work with the clinic consortium to determine the level of medical supplies and pharmaceuticals it is prudent and possible to stockpile. Given limited resources, the clinic will stockpile only those items it is highly likely to need immediately in a response or in its day-to-day operations. All stored items will be rotated to the extent possible.

2.9.2.2   The *<Name of Clinic>* will identify primary and secondary sources of essential medical supplies and pharmaceuticals and develop estimates of the expected time required for resupply in a disaster environment.

2.9.2.3   National Pharmaceutical Stockpile

In a bioterrorist event, if mass quantities of pharmaceuticals are needed then the county will request mobilization and delivery of the National Pharmaceutical Stockpile through the State of California. The CDC has established the National Pharmaceutical Stockpile (NPS) program as a repository of antibiotics, chemical antidotes, life support medications, IV administration sets, airway maintenance supplies including ventilators, and other medical/surgical supplies. The California Department of Health Services and the Governor's Office of Emergency Services are the lead state agencies for obtaining access to the NPS. *(In Los Angeles, county agencies have lead responsibility for access to the NPS).* The NPS is designed to supplement and re-supply state and local public health and medical response teams in the event of a biological and/or chemical terrorism incident anywhere in the U.S.

It is not anticipated that healthcare facilities will be directly involved with the distribution of NPS assets. However, clinic leadership should be informed of local level plans and what role, if any, they might be expected to play in the distribution of assets to the community.

2.9.2.4   Personal Protective Equipment (**PPE**):

a.   *<Name of Clinic>* will take measures to protect its staff from exposure to infectious agents and hazardous materials. Clinic health care workers will have access to and be trained on the use of personal protective equipment. *<Name of Clinic>* will obtain and maintain a minimum of *<insert number>* complete sets of PPE.

    b.   The recommended PPE for clinic personnel is: N95 HEPA mask, TYVEK Coverall with hood and booties, with TYVEK booties, face shield, and Nitrile Gloves. This set does not provide full level C protection without a canister equipped respirator. See Appendix N – Personal Protective Equipment for information on the limitations of PPE and the requirements to achieve higher levels of protection.

    c.   The Nursing Director and designee will receive training to provide just-in-time training in the event use of PPE is required. Training Records will reflect the nature of training each employee receives in the proper use of PPE.

    d.   The Medical Director and Nursing Director will designate clinical staff who are to receive PPE when a patient with a suspected infectious agent is present. Licensed medical personnel and support personnel assigned to respond to care for victims of weapons of mass destruction will be assigned PPE.

    e.   Protective equipment is located in *<location in clinic>,* and will be accessed by *<position of person>* or *<position of person>* when a patient with a suspected infectious disease presents.

2.10 Disaster Mental Health

2.10.1   Following a bioterrorism event, or other major disaster, anxiety and alarm can be expected from infected patients, their families, healthcare workers, and the worried well. Psychological responses may include anger, fear, panic, unrealistic concerns about infection, fear of contagion, paranoia, and social isolation. When available, mental health workers (psychiatrists, psychologists, social workers, and clergy) can be deployed to help manage the mental health needs of patients and families.

2.10.2   Responsibilities

The *<Name of Clinic>* Medical Director will establish a disaster mental health program and appoint a clinic Disaster Mental Health Coordinator who will be the Director of Behavioral Health or other licensed mental health professional. *(If the clinic has no behavioral health professionals available, the Clinic Medical Director may choose a staff person to identify and coordinate with external mental health resources.)* See **Appendix M – Mental Health Coordinator Checklist** for a list of actions for the Mental Health Coordinator.

The scope of mental health services *<Name of Clinic>* can perform depends in large part on the availability of licensed mental health providers at the clinic during the response to disasters.

2.10.3   Mental Health Preparedness

The clinic Medical Director, Nursing Director, Disaster Mental Health Coordinator, other clinicians and mental health team members, in coordination with Emergency Preparedness Committee, will develop and exercise plans and procedures for implementing the disaster mental health

program during an emergency. Specific preparedness tasks for the Mental Health Coordinator or designee may include:

a. Develop an internal clinic mental health disaster response plan.

b. Serve as a member of the Emergency Preparedness Committee and the Emergency Response Team.

c. Promote clinic mental health preparedness through clinician and staff training and exercises to test mental health response. Promote training of clinicians in the basics of disaster mental health intervention, especially if the clinic employs no licensed mental health professionals.

d. Establish a mental health response team. Develop mental health team member callback lists and alert and notification procedures for off-hour activation.

e. Coordinate with local jurisdiction and Operational Area (county) to identify community resources and define procedures for accessing those resources in an emergency.

f. Develop and maintain a resource list of community mental health resources (County Mental Health Agency, American Red Cross, clergy, community mental health providers, etc.) that could augment the response of the clinic's mental team. Establish MOUs when possible.

g. Identify mental health disaster communications needs.

h. Work with the clinic **PIO** to develop information (brochures, PSAs, etc.) that could be used in a response.

i. Acquire and maintain the following resources that will be stored with other disaster supplies in a container labeled "Mental Health Supplies":

- Contact information for clinic disaster mental health team and other mental health resources updated annually.

- A master copy of one or more brochures providing information about typical survivor responses to a disaster or critical incident with clinic or mental health agency contact phone numbers.

- A supply of brochure copies available for immediate use.

- Culturally appropriate brochures in the languages of the clinic's service populations. These languages are *<language1>, <language2>, and <language3>*.

- A basic office supply "go-box" with pens, paper clips, tape, note pads, etc. available to go with staff to work sites.

- Paper, crayons and other items for children.

- Cell phone or calling cards available for staff to use.

- Disaster forms to document contacts.

- Copies of a local resource directory and an agency directory to facilitate referrals.

2.11 Public Information / Risk Communications

2.11.1   The Incident Manager will appoint a Public Information Officer (**PIO**) to coordinate the release of clinic information internally and externally to media and community. The **PIO** will develop a Disaster Public Information Plan to guide clinic information dissemination and response to media and community inquiries following the disaster.

2.11.1.1 This plan will include provisions for coordination with the Operational Area Public Information Officer during an emergency to ensure availability of up-to-date information and consistency of released information. It will address the information needs of the clinic's various "publics" that need to be considered when providing information. These stakeholders include community, patients, staff, volunteers and other interested parties.

2.11.1.2 The plan will define how the following information is gathered, verified, coordinated with the **OA PIO**, and communicated to communities served by the clinic and other stakeholders:

- The nature and status of the emergency.

- Appropriate actions for protection, seeking health care services, and obtaining needed information.

- The status of the clinic and its ability to deliver services.

    Refer to **Appendix P.5 – Information and Intelligence** for guidance.

2.11.1.3 It will also include provisions for employee meetings, internal informational publications, press releases and other programs intended to disseminate accurate information regarding the event and its impact as well as deal with misinformation.

2.11.2   *<Name of Clinic>* will incorporate disaster preparedness information into its normal communications and education programs for staff and patients including:

- Home and family preparedness. See **Appendix I** for guidelines.

- Information on clinic emergency preparedness activities.

Information dissemination channels for these activities include newsletters, pamphlets, health education and in-service education classes, and internet postings.

2.12 **Training, Exercises and Plan Maintenance**

2.12.1   Training (Seee **Appendix G - Training and Exercises** for general guidelines.)

2.12.1.1 Employee Orientation

All employees will learn the following information from their new employee orientation or subsequent safety training. This checklist will also be used to design facility-wide drills to test clinic emergency response capabilities. Employee essential knowledge and skills include:

- The location and operation of fire extinguishers.

- The location of fire alarm stations and how to shut off fire alarms.

- How to page a fire.

- How to dial 911 in the event of a fire.

- How to assist patients and staff in the evacuation of the premises.

- Location and use of oxygen (licensed staff).

- Location and use of medical emergency equipment (medical staff and staff trained on **AED**).

- How emergency codes are called in the clinic and appropriate initial actions. See **Appendix H.2 – Emergency Code Examples.**

- Actions to be taken during fire and other emergency drills.

All employees must attend annual training and updates on emergency preparedness, including elements of this plan.

2.12.1.2 Clinician Bioterrorism Training

a. All physician and nursing staff will receive documented training on procedures to treat and respond to patients infected with a bioterrorism agent. Training will include:

- Recognition of potential epidemic or bioterrorism events.

- Information about most likely agents, including possible behavioral responses of patients.

- Infection control practices.

- Use of Personal Protective Equipment.

- Reporting requirements.

- Patient management.

- Behavioral responses of patients to biological and chemical agents.

b. General staff training will include:

- Roles and responsibilities in a bioterrorism event.

- Information and skills required to perform their assigned duties during the event.

- Awareness of the backup communications systems used in a bioterrorism event.

- The location of and how to obtain supplies, including Personal Protective Equipment **(PPE)** during a bioterrorism event.

c. Clinicians and other staff will receive periodic updates as new information becomes available.

2.12.1.3 Mental Health Team Training

<Name of Clinic> Mental health team members will receive training that promotes understanding of the normal human response to disasters. The training for the Mental Health Coordinator and other mental health professional team members will include delineating the difference between traditional mental health therapy and crisis counseling. Training will also address cultural considerations of the service population and how they are affected by disasters.

2.12.2   Drills and Exercises

2.12.2.1 *<Name of Clinic>* will rehearse this disaster plan at least twice a year. All drills shall include an after-action debriefing and report evaluating the drill or exercise. **JCAHO** Environment of Care Standard 4.20 also requires health care organizations to regularly test the emergency management plan through planned drills and exercises. The plan must be executed twice a year, either in response to an actual emergency or in planned drills. See **Appendix G - Training and Exercises** for further guidance.

2.12.2.2 Exercises should include one or more of the following response issues in their scenarios:

- Clinic evacuation

- Bioterrorism

- Mental Health response

- Coordination with government emergency responders

- Continuity of operations

- Expanding clinic surge capacity

See **Appendix G - Training and Exercises** for a variety of scenarios to test internal and external disasters and disasters that require extensive community cooperation.

2.12.2.3 *<Name of Clinic>* will participate in community drills that assess communication, coordination, and the effectiveness of the clinic's and the community's command structures.

2.12.3   Evaluation

2.12.3.1 The effectiveness of the administration of this plan will be evaluated following plan activation during actual emergencies or exercises. Staff knowledge and responsibilities will be critiqued by the Emergency Preparedness Committee (**EPC**) and reported to the clinic Executive Director.

2.12.3.2 Based on the after-action evaluation, the clinic Emergency Preparedness Committee will develop a Corrective Action Plan that includes recommendations for:

- Additional training and exercises.

- Changes in disaster policies and procedures.

- Plan updates and revisions.

- Acquisition of additional resources.

- Enhanced coordination with response agencies.

2.12.4   **Plan Development and Maintenance**

2.12.4.1 The Emergency Preparedness Committee (**EPC**) is responsible for coordinating the development and implementation of a comprehensive emergency preparedness program and this plan.

The **EPC** will review and update this plan at least annually. The plan will also be reviewed following its activation in response to any emergency, following exercises and other tests, as new threats arise, or as changes in clinic and government policies and procedures require.

2.12.4.2 A copy of this plan will be provided to the Medical Health Operational Area Coordinator (**MHOAC**).

2.12.4.3 The *<Name of Clinic>* environment undergoes constant change including remodeling, construction, installation of new equipment, and changes in key personnel. When these events occur, the Emergency Preparedness Committee will review and update the *<Name of Clinic>* **EOP** to ensure:

- Evacuation routes are reviewed and updated. See **Appendix H.1 – Emergency Procedures (Flip Chart).**

- Emergency response duties are assigned to new personnel, if needed**.**

- The locations of key supplies, hazardous materials, etc. are updated. See **Appendix H.2 – Emergency Codes.**

- Vendors, repair services and other key information for newly installed equipment are incorporated into the plan. See **Appendix J.2 – Basic Clinic Support Call List.**

3 RESPONSE

3.1 Introduction

During this phase, *<Name of Clinic>* will mobilize the resources and take actions required to manage its response to disasters.

3.2 Response Priorities

<Name of Clinic> has established the following disaster response priorities:

- Ensure life safety – protect of life and provide care for injured patients, staff, and visitors.

- Contain hazards to facilitate the protection of life.

- Protect critical infrastructure, facilities, vital records and other data.

- Resume the delivery of patient care.

- Support the overall community response.

- Restore essential services/utilities.

- Provide crisis public information.

3.3 Alert, Warning and Notification

Upon receipt of an alert from the **MHOAC** or other credible sources the *<Name of Clinic>* Executive Director will notify key managers, order the updating of phone lists, and the inspection of protective equipment and supply and pharmaceutical caches. See **Section 3.14.5.2** for procedures for determining if the clinic remains open, closes, or re-opens.

3.4 Response Activation and Initial Actions

This plan may be activated in response to events occurring within the clinic or external to it. Any employee or staff member who observes an incident or condition which could result in a emergency condition should report it immediately to the Safety Officer or his/her supervisor. Fires, serious injuries, threats of violence and other serious emergencies should be reported to fire or police by calling 9-1-1. All staff should initiate emergency response actions consistent with the emergency response procedures outlined in **Appendix H.1 - Emergency Procedures (Flip Chart)**: Emergency Response Procedures (in color coded flipchart format).

If the emergency significantly impacts clinic patient care capacity or the community served by the clinic, the Executive Director or Incident Manager will notify the **MHOAC**.

This plan may also be activated by the Executive Director, or designee, at the request of the **MHOAC**.

3.5   Emergency Management Organization

**<Name of Clinic> Emergency Management
Organization Structure**

```
                      ┌─────────────────┐
                      │ <Name of Clinic>│
                      │ Incident Manager│
                      └────────┬────────┘
        ┌──────────────┐       │      ┌──────────────┐
        │     PIO      │───────┼──────│Safety Officer│
        └──────────────┘       │      └──────────────┘
        ┌──────────────┐       │      ┌───────────────┐
        │   Liaisons   │───────┼──────│Security Officer│
        └──────────────┘       │      └───────────────┘
   ┌────────────┬──────────────┴────────┬────────────────┐
┌──────────────┐┌──────────────┐┌──────────────┐┌──────────────┐
│  Operations  ││   Planning   ││  Logistics   ││   Finance    │
│   Section    ││   Section    ││   Section    ││   Section    │
└──────────────┘└──────────────┘└──────────────┘└──────────────┘
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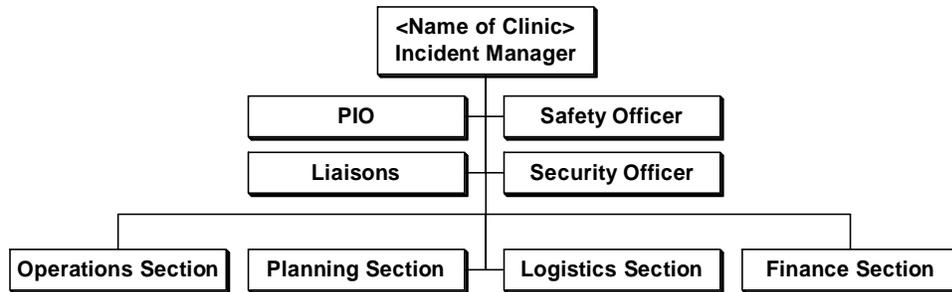
<Name of Clinic> will organize its emergency response structure to clearly define roles and responsibilities and quickly mobilize response resources. The *<Name of Clinic>* will use the **Incident Command System (ICS)** to manage its response to disasters. **ICS** is a standardized management system used by government agencies and hospitals in emergencies. Under **ICS**, the clinic's overall response is directed by an Incident Manager. The Executive Director may serve in that role or may appoint another senior clinic manager or clinician to the position.

See **Appendix F.2 – Emergency Management Organization Chart** for an expanded organization chart and example of staff assignment to Emergency Response Team positions.

3.5.1   The Incident Manager overseas the **command/management** function (command at the field level and management at all other levels) is the function that provides overall emergency response policy direction, oversight of emergency response planning and operations, and coordination of responding clinic staff and organizational units.

The management staff supporting the Incident Manager consists of a public information officer, safety officer and security officer. Liaison officers, who are responsible for coordination with other agencies, and legal counsel may also be added to the management staff. (Management staff is sometimes referred to as the Management or Command Section).

3.5.2   **ICS** employs four functional sections (operations, planning, logistics, and finance) in its organizational structure. A detailed description of staff roles and functions is included in **Appendix F.3 – EOC Job Action Sheets**.

Operations Section — Coordinates all operations in support of the emergency response and implements the incident action plan for a defined operational period. Medical care and mental health services are managed through the Operations Section.

Planning and Intelligence Section — Collects, evaluates and disseminates information, including damage assessments; develops the incident action plan in coordination with other functions; performs advanced planning; and,

documents the status of the clinic and its response to the disaster. See **Appendix O.1 – Situation Status Report Form** and **Appendix O.2 – Action Planning** for Action Planning Guidance and Forms. See **Appendix P.5 – Information and Intelligence** for guidance on gathering and managing information.

Logistics Section — Provides facilities, services, personnel, equipment and materials to support response operations. The Logistics Section also manages volunteers and the receipt of donations.

Finance and Administration Section — Tracks personnel and other resource costs associated with response and recovery, and provides administrative support to response operations. See **Appendix O.4 – Financial Tracking Forms** for forms for tracking expenditures. See **Section 4.4** for information about recovering costs and losses.

3.5.3   The Incident Command System has the following additional characteristics:

a. Organization Flexibility - Modular Organization

The specific functions that are activated and their relationship to one another will depend upon the size and nature of the incident. Only those functional elements that are required to meet current objectives will be activated. A single individual may perform multiple functional elements, e.g., safety and security or finance and logistics.

b. Management of Personnel - Hierarchy of Command and Span-of-Control

Each activated function will have a person in charge of it, but a supervisor may be in charge of more than one functional element. Every individual will have a supervisor, except the Incident Manager.

c. **EOC** Action Plans

Action Plans provide **EOC** and other response personnel with knowledge of the objectives to be achieved and the steps required for their achievement. They also provide a basis for measuring achievement of objectives and overall response performance. The action planning process should involve the **EOC** Incident Manager, management staff and other **EOC** sections.

Action plans are developed for a specified operational period which may range from a few hours to 24 hours. The operational period is determined by first establishing a set of priority actions that need to be performed. A reasonable time frame is then established for accomplishing those actions. The action plans need not be complex, but should be sufficiently detailed to guide **EOC** elements in implementing the priority actions. See **Appendix O.2** for Action Plan development forms and guidance.

3.5.4   **EOC** Staff Assignments

The organization chart, located above, displays the response management organization structure.   See **Appendix F.3 - EOC Job Action Sheets** for position duties and responsibilities during an emergency. Positions will be filled only as needed to meet the needs of the response. Some overlap will occur to account for limited personnel resources during an emergency, however all significant decisions within the five primary functions of the Incident Command System (**ICS**) will be made or delegated by the Incident Manager.

ICS positions should be assigned to the most qualified available and trained staff. Under emergency conditions, however, it may not always be possible to appoint the most appropriate staff. In that case the Incident Manager will be required to use best judgment in making position appointments and specifying the range of duties and authority those positions can exercise.

Following are examples of potential position assignments of clinic staff to **ICS** position.   See **Appendix F.2 – Emergency Management Organization Chart** for example of how assignments can be made.

- Incident Manager – Executive Director, Chief Operating Officer (COO) or Deputy Director, Medical Director, Nursing Director

- Operations Section Chief – Medical Director, Nursing Director

- Planning / Intelligence Section Chief - COO

- Logistics Section Chief – Facilities manager, Purchasing manager, Human Resources manager

- Finance / Administration Section Chief – Chief Financial Officer (CFO) or Finance Director, COO

3.6   Emergency Operations Center (EOC) Operations

3.6.1   The Emergency Operations Center will be located at ***<location of primary EOC>*.** See **Appendices P.2 - EOC Activation and Setup** and **P.3 - Command and Control.**

3.6.2   In the event this site is obstructed or inoperable, a new location will be chosen by the Incident Manager and **ERT** based on environmental conditions. If the primary **EOC** site is not usable, the **EOC** will be set up at *<alternate EOC site>*. See **Appendix L.2 – Primary and Alternate EOC and Command Post Sites.**   See **Appendix P.7 – EOC Relocation** for **EOC** relocation procedures.

3.6.3   The **EOC** will be activated by the Executive Director, Medical Director, other designated staff or most senior staff available under the following circumstances:

- The *<Name of Clinic>* will be inoperable for more than 24 hours during its normal work week.

- Coordination is required with the **MHOAC** or local medical responders over an extended period of time.

- *<Name of Clinic>* requires augmentations of medical supplies, pharmaceuticals or personnel.

- *<Name of Clinic>* needs to coordinate movement of patients to other facilities through the Operational Area **EOC**.

- Damage to the clinic or clinic operations is sufficient to require clinic management to set priorities for restoring clinic services and manage the full restoration of clinic services over an extended period of time.

- Potential evacuation of the clinic.

- Locally declared disaster with potential for illness or injury in clinic service area.

3.6.4   Required supplies include copies of this disaster plan, forms for recording and managing information in **Appendix O – EOC Forms**, frequently used telephone numbers, marking pens, floor plans, and alternative communications equipment. See **Appendix F.3 - EOC Job Action Sheets** for **EOC** Position Checklists.

3.6.5   The **EOC** will be deactivated by the Incident Manager when the threat subsides, the response phase ends and recovery activities can be performed at normal work stations. See **Appendix P.8 – Deactivation of ERT** for **ERT** and **EOC** deactivation procedures.

3.7 Medical Care

It is the policy of *<Name of Clinic>* that:

a. The confidentiality of patient information remains important even during emergency conditions. Clinic staff will take feasible and appropriate steps to ensure confidential information is protected.

b. Due to legal liabilities, staff will never transport patients in private vehicles under any circumstance. In a widespread emergency, the Operational Area will determine how and where to transport victims through already established channels selected by the county.

c. Patients will be permitted to leave with family or friends ONLY after they have signed a release form with the Medical Director or designated clinic staff.

d. Children will be allowed to leave only with parents, family members or other adults who accompanied them to the clinic and who provide confirming identification (e.g., driver's license of other government identification). If no appropriate adult is available, clinic staff will:

- Provide a safe supervised site for children away from adults.

- Attempt to contact each child's family.

- If contact is not possible, contact Child Protective Services to provide temporary custodial supervision until a parent or family member is located.

3.7.1 Medical Management

To the extent possible, patients injured during an internal disaster will be given first aid by the clinic staff. If the circumstances do not permit treating patients at the clinic, they will be referred to the local emergency room at *<Name of Hospital>* unless their injuries require immediate attention. **Appendix L.1 – Health Care Alternate and Referral Facility Locations** lists the alternate clinic site and hospital and clinic referral facilities.

If immediate medical attention is required and it is not safe or appropriate to refer the patient to the emergency room, 911 will be called and the patient will be sent by ambulance to the nearest emergency room. If 911 services are not available, a request for medical transport will be conveyed to Medical Health Operational Area Coordinator **(MHOAC)**.

Visitors or volunteers who require medical evaluation or minor treatment will be treated and referred to their physician or sent to the hospital. Employees who need medical evaluation or minor treatment will be treated and referred to their physician or sent to the hospital.

As directed by the Medical Director or designee, clinic staff will take the following actions:

a. **Triage/First Aid:** The clinic Medical Director or Nursing Director will establish a site for triage and first aid under the direction of a physician or registered nurse. Triage decisions will be based on the patient condition, clinic status, availability of staff and supplies and the availability of community resources. The most likely location may be either the patient or the staff parking lot. A Registered Nurse or physician will be assigned to triage.

b. **Assessing and administering medical attention:** A physician or Registered Nurse will assess victims for the need for medical treatment. The medical care team will provide medical services within the clinic's capabilities and resources.

c. Additional medical care resources can be requested through procedures outlined in **Section 3.8.**

3.7.2 Increase Surge Capacity

3.7.2.1   The Executive Director, Medical Director, or Nursing Director of the clinic will activate the clinic's procedures for increasing surge capacity when (1) civil authorities declare a bioterrorist emergency or other disaster that affects the community or (2) clinic utilization or anticipated utilization substantially exceeds clinic day-to-day capacity with or without the occurrence of a disaster. *<Name of Clinic>* will take the following actions to increase clinic surge capacity:

- Establish a communication link with **MHOAC** at the County **EOC**

- Periodically report clinic status, numbers of ill/injured, types of presenting conditions and resource needs and other information requested by the **(MHOAC)** in a format defined by the Operational Area **(OA)**.

- Reduce patient demand by postponing / rescheduling non-essential visits. Cancel and reschedule non-essential appointments.

- Report status to facilities with which clinic has patient referral reciprocity or to which patients may be referred. Inform them of types of conditions that presenting patients have. See **Appendix J.3 – Disaster Contacts** for contact information.

- Refer patients to alternative facilities. Patients with symptoms that indicate exposure to infectious, nerve, or other toxic agents will be referred to the following facilities:

    1. **<Name of Hospital>**
    2. **<Name of Hospital>**

3.7.2.2   Triage procedures

a. The *<Name of Clinic>* will establish a triage area in the *<location of triage area>* of the clinic that is clearly delineated, secured and with controlled access and exit.

b. If bioterrorism is suspected, all staff in the triage area will wear Personal Protective Equipment (**PPE)**.

c. All patients entering the triage area will be tagged and registered. See **Appendix T.1 - California Fire Chiefs Triage Tag**.

d. Triage converging patients to immediate and delayed treatment categories.

e. In response to suspected or verified bioterrorist attack, isolate infected patients from other patients, especially if suspected agent is human-to-human contagious or is unknown. Use standard infection control standards at a minimum. Refer to *<Name of Clinic>* Policies and Procedures for more information.

f. Implement decontamination procedures as appropriate.

g. Arrange for transport of patients requiring higher levels of care as rapidly as possible through 9-1-1 or **MHOAC**. See **Appendix T.2 – Patient Tracking Form.**

h. Direct uninjured yet anxious patients to the area designated for counseling and information. Recognize that some chemical and biological agents create symptoms that manifest themselves behaviorally.

       i.   Provide written instructions for non-contagious patients seen and discharged.

3.8   Acquiring Response Resources

The Logistics Section should carefully monitor medical supplies and pharmaceuticals and request augmentation of resources from **MHOAC** at the earliest sign that stocks may become depleted. The clinic will maximize use of available hospitals, other clinics and other external resource suppliers as is feasible.

3.8.1   **EOC** Request Process

3.8.1.1   In the response to a disaster, clinic staff may require additional personnel, supplies, or equipment or an executive decision concerning the acquisition or disposition of a resource, or the expenditure of funds. Requests for assistance will be transmitted from the various areas of the clinic via existing lines of communications to the **EOC**. The **EOC** will acknowledge the receipt of the request and, immediately address the need from current resources or incorporate the request into planning and priority setting processes.

3.8.1.2   The Logistics Section staff in the **EOC** may turn to external vendors for the resources or the **MHOAC.**

3.8.1.3   The **MHOAC** will seek resources to fill the request from within the **OA.** If resources cannot be found and the request is high priority, it will be submitted to Regional, State, and Federal response levels until the requested resource can be obtained.

3.8.2   Vendors

As information develops about current and future resource needs, clinics should consider contacting vendors of critical supplies and equipment to alert them of pending needs and to ascertain vendor capacity to meet those needs. *<Name of Clinic>* recognizes that in a major disaster, medical supply vendors may face competing demands that exceed their capacity. In that case, request for assistance will be submitted to the **MHOAC,** who will set resource allocation priorities.

3.8.3   Other Clinics / Consortia

<Name of Clinic> will notify clinics with which it has mutual assistance arrangements. It will also notify the clinic consortium and request assistance if the consortium has a resource acquisition role.

3.9   Communications

3.9.1   The Incident Manager will appoint a Communications Officer, who may be the Communications Coordinator, who will work under the Logistics Section and will use the clinic's communications resources to communicate with:

- The Medical Health Operational Area Coordinator (**MHOAC).**

- Emergency response agencies.

- Outside relief agencies.

- Clinic consortium.

- Other clinics.

Contact Lists:

- Telephone service providers and maintenance for the clinic's internal telephone system, along with utilities are listed in **Appendix J.2 – Basic Clinic Support.**

- Staff contact telephone numbers are listed in **Appendix J.1 – Staff Call Back**.

- Disaster response agency contact telephone numbers are listed in **Appendix J.3 – Disaster Contacts.**

3.9.2   Communication Procedures

- See **Appendix P.4 – Communications** for communications procedures.

- All external communications will be authorized by the Incident Manager or designee unless emergency conditions require immediate communications.

- All outgoing and incoming messages will be recorded on message forms shown in **Appendix O.3 – Basic EOC Forms** or in notebooks.

- All incoming messages will be shared with the **EOC** Planning Section.

3.10 Public Information / Crisis Communications

3.10.1   During a disaster response, all public information activities must be coordinated with the Operational Area **PIO.**

3.10.2   The *<Name of Clinic>* may perform the following public information / crisis communications tasks coordinated by the clinic's Public Information Officer (**PIO**). See **Appendix F.3 - EOC Job Action Sheets:**

- Conducting interviews with print and broadcast news media.

- Coordinating the dissemination of information to clinic staff, community members, patients and other stakeholders.

- Managing visits by VIPs.

- Providing information to the *<name of clinic consortium>* and, where appropriate, coordinating media relations with the consortium.

3.10.3   Media Relations

In an emergency, the Public Information Officer is designated as the media contact and will receive approval from the Incident Manager or Executive Director prior to any interviews or media releases.

Most media inquiries regarding a disaster will be managed by the County. Media requests and responses regarding a disaster should be coordinated through the Operational Area Public Information Officer in the County **EOC**. It is critical that information disseminated by the clinic be consistent with information disseminated through the Operational Area **PIO**. See **Appendix P.6 – Public Information** for additional procedures for managing Public Information activities and for a form for documenting media contacts.

If the clinic receives a media inquiry, the clinic's media relations policy will be put into place. If the clinic is part of a larger organization the media relations may be handled by the headquarters **PIO**. See **Appendix P.4 - Communications** for information disseminations procedures.

3.10.4   Community Relations

- The **PIO** will coordinate clinic release of information to the community on the status of staff, family and friends. Briefings will be held at a safe location away from the designated assembly area to prevent further interruptions with evacuation and treatment efforts.

- The **PIO** will participate in media interviews and develop communications strategies to keep patients and community members informed of the situation at the clinic, its operating status, and alternatives for receiving services.

- The **PIO** should establish relationships with community media, especially outlets that are preferred by communities served by the clinic including non-English language broadcast media, where appropriate.

- In coordination with the Operational Area, the **PIO** can provide information to the community that includes recommended actions, protective measures, and locations of various services and resources. Under some circumstances, the **PIO** can request broadcast media to broadcast a message specifically for the staff of the clinic to inform them of clinic operational status and expected actions. Information should be disseminated in the languages spoken in the communities served by the clinic.

3.10.5   Communication with Staff

The **PIO** will coordinate the delivery of information to staff through flyers, meetings, and conference calls. Information provided can include clinic

status, impact of the disaster on the community, status of the overall response, and clinic management decisions.

The **PIO** will also be alert for the spread of rumors among staff and will apply rumor control procedures to curtail the spread of false information.

3.10.6   Communications with Patients and Family Members

Refer to **Section 3.12** of the Emergency Operations Plan (**EOP**) for Mental Health guidance.

3.10.7   The **PIO** will ensure that all public releases of information protect patient confidentiality.

3.11 Security

The purpose of security will be to ensure unimpeded patient care, staff safety, and continued operations.   The Incident Manager will appoint a Security Officer (see **Appendix F.3 - EOC Job Action Sheets)** who will be responsible for ensuring the following security measures are implemented:

- Security will be provided initially by existing security services or by personnel under the direction of the Security Officer.   Existing security may be augmented by contract security personnel, law enforcement, clinic staff or, if necessary, by volunteers.

- Checkpoints at building and parking lot entrances will be established as needed to control traffic flow and ensure unimpeded patient care, staff safety, and continued operations.

- Supervisors will ensure that all clinic staff wears their ID badges at all times. Security will issue temporary badges if needed.

- Security staff will use yellow tape and a bullhorn to assist in crowd control, if needed.

- The Security Officer will ensure that the clinic site is and remains secured following an evacuation.

3.12 Mental Health Response

The Mental Health Coordinator will report to the Medical Care Leader (e.g., Medical Director or Nursing Director) position in the Operations Section of the clinic's emergency organization. Refer to **Appendix M - Mental Health Coordinator Checklist**. When directed by the Incident Manager to activate the clinic mental health response, the Mental Health Coordinator will:

a. Assess the immediate and potential mental health needs of clinic patients and staff, considering:

- The presence of casualties.

- Magnitude and type of disaster.

- Use or threat of weapons of mass destruction.

- Level of uncertainty and rumors.

- Employee anxiety levels.

- Level of effectiveness of **EOC** operations.

- Convergence of community members.

- Patient levels of stress and anxiety.

- Presence of children.

- Cultural manifestations.

b. Request the **EOC** to notify the Operational Area of the mental health response.

c. Communicate community mental health assessments to Operational Area (county) and local jurisdiction contacts.

d. Determine need to: recall mental health staff to the clinic, request the response of contract mental health clinicians, or request mental health assistance from the **MHOAC** or other clinics. Establish communications and alert contract and other mental health providers who may need to support clinic's mental health response. Coordinate with other mental health service responders.

e. Establish site for mental health team operations.

f. Conduct ongoing monitoring of the mental health status of employees and patients.

g. Establish procedures to refer employees or patients to required mental health services beyond the scope that can be delivered by the mental health team.

h. Document all mental health encounters with staff and patients. Include information required for follow-up on referrals. Maintain records of events, personnel time and resource expenditures.

i. Coordinate any issuance of mental health information with the Incident Manager or **PIO**.

j. Provide reports on the mental health status of clinic employees and patients. Report mental health team actions and resource needs to the clinic **EOC**.

k. Activate procedures to receive and integrate incoming mental health assistance.

l. Initiate recovery activities.

3.12.1.1 Response to psychological aspects of emergencies including bioterrorism events.

The following are some steps that can be taken by clinicians and licensed mental health personnel to mitigate and respond to the psychological impact of the disaster:

a. Communicate clear, concise information about the infection, how it is transmitted, what treatment and preventive options are currently available, when prophylactic antibiotics, antitoxin serum or vaccines will be available, and how prophylaxis or vaccination will be distributed.

b. Provide counseling to the worried well and victims' family members.

c. Give important tips to parents and caregivers such as:

- It is normal to experience anxiety and fear during a disaster.

- Take care of yourself first. A parent who is calm in an emergency will be able to take better care of a child.

- Watch for unusual behavior that may suggest your child is having difficulty dealing with disturbing events.

- Limit television viewing of terrorist events or other disasters and dispel any misconceptions or misinformation.

- Talk about the event with your child.

3.13 Volunteer / Donation Management

3.13.1   Volunteers

In a widespread emergency, physicians and nurses may seek to volunteer at the clinic. The Logistics Section will establish a Volunteer and Donations Reception Center. The center's location will be set-up in a safe location based on existing disaster conditions away from the clinic treatment center. See **Appendix Q.1 – Volunteer Management Policies and Procedures, Appendix Q.2 – Volunteer Roster Form** and **Appendix Q.3 – Donation Management Form** for tools for managing volunteers and donations.

All volunteers who arrive at the clinic will be sent to the Center for verification of identity and credentials and to complete volunteer registration forms. This center will provide for organization of the intake process.

The Center will also coordinate the receipt of donations. The Logistics Section Chief will delegate the appropriate staff on site to handle this task:

- All donations will be documented and accounted for by the CFO or delegated staff.

- The Medical Director and clinic Nurse Manager will supervise distribution and disposal of donated medical supplies, equipment and pharmaceuticals.

- All donations will be documented and acknowledged by the CFO or designated staff prior to being handed over to the Medical Care Director for disbursement.

3.14 Response to Internal Emergencies

3.14.1   An Internal Emergency is an event that causes or threatens to cause physical damage and injury to the clinic, personnel or patients. Examples are fire, explosion, hazardous materials releases, violence or bomb threat. External events may also create internal disasters. See **Appendix H.1 – Emergency Procedures (Flip Chart).**

The following procedures provide guidance for initial actions for internal emergencies (refer to *<Name of Clinic>* Fire Emergency Plan for complete information:

a. If the event is a fire within the clinic, institute **RACE:**

R = **Remove patients** and others from fire or smoke areas.

A = **Announce CODE RED** (3 times) and **Call 9-1-1**

C = **Contain** the smoke/fire by closing all doors to rooms and corridors.

E = **Extinguish** the fire if it is safe to do so.
Evacuate the facility if the fire cannot be extinguished.

b. If the internal emergency is other than a fire, the person in charge will determine if assistance from outside agencies is necessary. Such notification will be done by calling 911.

c. Notification of on-duty employees of an emergency event will be made by calling the appropriate code shown in **Appendix H.2 – Emergency Code Examples,** telling them of the situation or calling for help, as appropriate. During the early stages of an emergency, information about the event may be limited. If the emergency is internal to the clinic, it is important to communicate with staff as soon as possible.

d. If the event requires outside assistance and the telephones are not working, a person may be sent to the nearest working telephone, fire station or police department for assistance.

3.14.2   Damage Assessment

<Name of Clinic> will conduct an assessment of damage caused by the disaster to determine if an area, room, or building can continue to be used safely or is safe to re-enter following an evacuation. Systematic damage assessments are indicated following an earthquake, flood, explosion,

hazardous material spill, fire or utility failure. The facility may require three levels of evaluation.

Level 1: A rapid evaluation to determine if the building is safe to occupy.

Level 2: A detailed evaluation that will address structural damage and utilities.

Level 3: A structural/geological assessment.

Depending on the event and the level of damage, fire or law services may conduct a Level 1 or 2 assessment. If damage is major, a consulting engineering evaluation, assessment by a county engineer, and/or an inspection by the licensing agency may be required before the clinic can reopen for operations.

Following each level of evaluation, inspectors will classify and post each building as: 1) Apparently OK for Occupancy; 2) Questionable: Limited Entry; 3) Unsafe for any Occupancy. In some cases, immediate repairs or interim measures may be implemented to upgrade the level of safety and allow occupancy.

Refer to **Appendix S.1 – Damage Assessment Form** for a damage assessment site survey tool that may be used if the clinic facility is completely safe.

3.14.3   Hazardous Materials Management

<Name of Clinic> will maintain a list of all hazardous materials and their MSDSs, locations, and procedures for safe handling, containing and neutralizing them. This list should be kept with the clinic's Policies and Procedures or other central and accessible location. The list should also be kept in an offsite location.

All materials will have their contents clearly marked on the outside of their containers. The location of the storage areas will be indicated on the facility floor plan. See **Appendix H.3.**

In the event of a hazardous material release inside the clinic, clinic staff should:

- Avoid attempting to handle spills or leaks themselves unless they have been trained, have appropriate equipment as shown in **Appendix N – Personal Protective Equipment)** and can safely and completely respond. **NOTE: Level C protection, or below, is not acceptable for chemical emergency response.**

- Immediately report all spills or leaks to the Safety Officer or designee.

- Isolate area of spill and deny entry to building or area. Initiate fire or hazmat cleanup notifications, as appropriate.

- Obtain further instructions from the clinic Executive Director or Safety Officer or refer to management guidance maintained at *<location within clinic>.*

3.14.4 Evacuation Procedures

The clinic may be evacuated due to a fire or other occurrence, threat, or order of the clinic Executive Director or designee. Refer to *<Name of Clinic>* Facility Evacuation Plan for complete information. See **Appendix H.5 – Clinic Evacuation Plan Template.**

3.14.4.1 *<Name of Clinic>* will ensure the following instructions are communicated to staff:

a. All available staff members and other able-bodied persons should do everything possible to assist personnel at the location of the fire or emergency in the removal of patients.

b. Close all doors and windows.

c. Turn off all unnecessary electrical equipment, but leave the lights on.

d. Evacuate the area/building and congregate at the predetermined site. Evacuation routes are posted throughout the clinic.

e. Patients, staff, and visitors should not be readmitted to the clinic until cleared to do so by fire, police, other emergency responders, or upon permission of the Incident Manager.

3.14.4.2 Procedures for evacuation of patients

a. Patients will be evacuated according to the following priority order:

- Persons in imminent danger.

- Wheelchair patients.

- Walking patients.

b. Staff should escort ambulatory patients to the nearest exit and direct them to the congregation point. Wheelchairs will be utilized to relocate wheelchair-bound patients to a safe place.

c. During an evacuation, a responsible person will be placed with evacuees for reassurance and to prevent patients from re-entering the dangerous area.

d. If safety permits, all rooms will be thoroughly searched by the Search and Rescue Team upon completion of evacuation to ensure that all patients, visitors, and employees have been evacuated.

e. Lists of patients evacuated will be prepared by the Nursing Director or designee and compared to the patient sign-in log. This list, including the names and disposition of patients, will be sent to the Medical Director, Incident Manager and Executive Director.

f. The Nursing Director or designee will report the numbers of patients and staff evacuated, as well as any injuries or fatalities, to the clinic Executive Director, Incident Manager, Safety Officer or designee.

g. When patients are removed from the clinic, staff will remain with them until they are able to safely leave or have been transported to appropriate facility for their continued care and safety. If patients evacuated from the clinic are unable to return home without assistance, the relatives of patients evacuated from the clinic will be notified of the patient's location and general condition by the clinic staff as soon as possible.

3.14.4.3 Evacuation information

In case a partial or full facility evacuation is required, see **Appendix H.1 – Emergency Procedures (Flip Chart)** for general clinic evacuation procedures. The following information should be used to facilitate the evacuation:

- Floor plan and map of exits with the building, location of emergency equipment including fire extinguishers, phones, fire route out of the building, and first aid supplies. See **Appendix H.3 – Clinic Floor Plan.**

- Where and How to shut-off the utilities, including emergency equipment, gas, electrical timers, water, computers, heating, AC, compressor, and telephones are listed in **Appendix H.4 – Utility Shutoff.**

3.14.5 Decision on clinic operational status

Following the occurrence of an internal or external disaster or the receipt of a credible warning the Executive Director will decide the operating status for the *<Name of Clinic>.* The decision will be based on the results of the damage assessment, the nature and severity of the disaster and other information supplied by staff, emergency responders or inspectors. The decision to evacuate the clinic, return to the facility and/or re-open the facility for partial or full operation depends on an assessment of the following:

- Extent of facility damage / operational status.

- Status of utilities (e.g. water, sewer lines, gas and electricity).

- Presence and status of hazardous materials.

- Condition of equipment and other resources.

- Environmental hazards near the clinic.

See **Appendix S.2 – Clinic Open/Close Decision Tool** for a tool to assist making the operating status decision for the clinic.

3.14.5.1   Extended clinic closure

If the *<Name of Clinic>* experiences major damage, loss of staffing, a dangerous response environment or other problems that severely limit its ability to meet patient needs, the Incident Manager, in consultation with the Executive Director, may suspend clinic operations until conditions change. If that decision is made, the clinic staff will:

a. If possible, ensure clinic site is secure.

b. Notify staff of clinic status and require that they remain available for return to work unless permission is provided.

c. Notify the Medical Health Operational Area Coordinator **(MHOAC)** of its change in status. Request location of nearest source of medical services.

d. Notify the California Department of Health Services Licensing and Certification Division, local field office or other appropriate licensing agency (e.g., Los Angeles County Department of Health Services).

e. Notify the nearest hospital(s) and clinic(s) of the change in clinic operating status and intent to refer patients to alternate sources of care.

f. Notify corporate headquarters and the clinic consortium, if applicable.

g. Place a sign on the clinic in appropriate languages that explains the circumstances, indicates when the clinic intends to reopen (if known), and location of nearest source of medical services. See **Appendix L.1 – Health Care Alternate and Referral Facility Locations.**

h. If the environment is safe, station staff at clinic entrance to answer patient questions and make referrals.

i. Implement business recovery operations. Refer to **Section 2.5,** above**.**

3.14.5.2   *<Name of Clinic>* Response to Disaster Alert, Warning or Notification

Disasters can occur both with and without warning. Upon receipt of an alert from the **MHOAC** or other credible sources the *<Name of Clinic>* Executive Director will notify key managers, order the updating of phone lists, and the inspection of protective equipment and supply and pharmaceutical caches.

Depending upon the nature of the warning and the potential impact of the emergency on *<Name of Clinic>,* the Executive Director and Medical Director may decide to evacuate the facility; suspend or curtail clinic operations; take actions to protect equipment, supplies and records; move equipment and supplies to secondary sites; backup and secure computer files; or other measures he/she may find appropriate to reduce clinic, staff and patient risk.

The *<Name of Clinic>* Executive Director will consider the following options, depending on the nature, severity and immediacy of the expected emergency:

a. Close and secure the clinic until after the disaster has occurred. Ensure patients and visitors can return home safely.

- Review plans and procedures. Update contact information.

- Check inventory of supplies and pharmaceuticals. Augment as needed.

- Ensure essential equipment is secured, computer files backed-up and essential records stored offsite.

- Notify the Operational Area, community members and staff. Cancel scheduled appointments.

- If time permits, encourage staff to return to their homes.

- If staff remains in the clinic, take shelter as appropriate for the expected disaster.

- Ensure staff is informed of call-back procedures and actions they should take if communications are not available.

- Take protective action appropriate for the emergency.

- Communicate status to the **MHOAC.**

b. Allow clinic to remain fully or partially operational.

- Review plans and procedures. Update contact information.

- Check inventory of supplies and pharmaceuticals. Augment as needed.

- Reduce clinic operations to essential services.

- Cancel non-essential appointments.

- Ensure safety of patients and staff.

- Communicate status to **MHOAC**.

3.14.5.3 Determining *<Name of Clinic>* Response Role (See **Appendix E – Clinic Response Roles and Requirements**)

If *<Name of Clinic>* remains fully or partially operational following a disaster, the Executive Director, Medical Director, and other members of the **ERT** will define the response role the clinic will play. The appropriate response role for *<Name of Clinic>* will depend on the following factors:

- The impact of the disaster on *<Name of Clinic>.*

- The level of personnel and other resources available for response.

- The pre-event medical care and other service capacity of *<Name of Clinic>.*

- The medical care environment of the community both before and after a disaster occurs as assessed by the **MHOAC** (e.g., medical care demands may be reduced if the 9-1-1 system and nearby hospitals are operational and not overwhelmed).

- The needs and response actions of residents of the community served by *<Name of Clinic>* (e.g., convergence to the clinic following disasters).

- The priorities established by the *<Name of Clinic>* Executive Director and Board of Directors (e.g., to remain open if at all possible following a disaster).

- The degree of planning and preparedness of *<Name of Clinic>* and its staff.

3.15 Response to External Emergencies

An External Disaster is an event that occurs in the community. Examples include earthquakes, floods, fires, hazardous materials releases or terrorist events. An external disaster may directly impact the clinic facility and its ability to operate.

3.15.1 Local vs. Widespread Emergencies

Local emergencies are disasters with effects limited to a relatively small area. In local emergencies, other health facilities and resources will be relatively unaffected and remain viable options for sending assistance or receiving patients from the disaster area.

In widespread emergencies, nearby medical resources are likely to be impacted and therefore less likely to be able to offer assistance to the clinic. Hospitals may also have a higher response priority than clinics for resupply and other response assistance.

3.15.2 Weapons of Mass Destruction (**WMD**)

Preparations for an event involving weapons of mass destruction - chemical, biological, nuclear, radiological, or explosives (CBRNE) - should be based on existing programs for handling hazardous materials. See **Appendix R – Bioterrorism Agents** for a matrix of biological weapons agent characteristics.

If staff suspects an event involving CBRNE weapons has occurred, they should:

- Remain calm and isolate the victims to prevent further contamination within the facility.

- Contact the Medical Director, Nursing Director, or other appropriate clinician.

- Secure personal protective equipment and wait for instructions.

- Comfort the victims.

- Contact appropriate Operational Area authorities. See **Appendix J.3 – Disaster Contacts.**

3.15.2.1 Shelter-In-Place

Terrorist use of Weapons of Mass Destruction may result in the release of radiation, hazardous materials and biological agents in proximity to the clinic. Shelter-In-Place may be the best strategy to minimize risk of exposure to these agents. See **Appendix H.6 - Shelter-In-Place Guidelines.**

3.15.3 Bioterrorism Response

3.15.3.1 Reporting

Emergency amendments to the California Code of Regulations (Title 17, Section 2500) require that health care providers immediately report to the local health department those diseases that pose a significant public health threat, such as agents of biological terrorism.

<Name of Clinic> will report diseases resulting from bioterrorist agents, like other communicable and infectious diseases, to the County Health Department Epidemiologist at *<telephone number of epidemiologist>.*

3.15.3.2 *<Name of Clinic>* response to a bioterrorism incident may be initiated by the Executive Director or Medical Director due to:

- The request of local civil authorities.

- Government official notification of an outbreak within or near the clinic's community.

- Presentation of a patient with a suspected exposure to a bioterrorist agent. In case of presentation by a patient with suspected exposure to a bioterrorist agent, *<Name of Clinic>* will follow current CDC response guidelines.

3.15.3.3 Potential indicators of a bioterrorism attack are:

- Groups of people becoming ill around the same time.

- Sudden increase of illness in previously healthy individuals.

- Sudden increase in the following non-specific illnesses:
  o Pneumonia, flu-like illness, or fever with atypical features.
  o Bleeding disorders.
  o Unexplained rashes, and mucosal or skin irritation, particularly in adults.
  o Neuromuscular illness, like muscle weakness and paralysis.
  o Diarrhea.

- Simultaneous disease outbreaks in human and animal or bird populations.

- Unusual temporal or geographic clustering of illness (for example, patients who attended the same public event, live in the same part of town, etc.).

   Appendix R – Bioterrorism Agents provides a summary table of potential biological warfare agents, including signs, symptoms, transmission, precautions, and treatment.

3.15.3.4   Infection Control Practices for Patient Management

<Name of Clinic> will use Standard Precautions to manage all patients, including symptomatic patients with suspected or confirmed bioterrorism-related illnesses.

For certain diseases or syndromes (e.g., smallpox and pneumonic plague), additional precautions may be needed to reduce the likelihood for transmission. See **Appendix R** and **Reference 7**: Los Angeles Department of Health Services, *Zebra Pack* for specific diseases and requirements for additional isolation precautions.

In general, the transport and movement of patients with bioterrorism-related infections, as with patients with any epidemiologically important infections (e.g., pulmonary tuberculosis, chickenpox, measles), should be limited to movement that is essential to provide patient care, thus reducing the opportunities for transmission of microorganisms within healthcare facilities.

- <Name of Clinic> has in place adequate procedures for the routine care, cleaning, and disinfection of environmental surfaces, and other frequently touched surfaces and equipment, and ensures that these procedures are being followed.

- Facility-approved germicidal cleaning agents are available in patient care areas to use for cleaning spills of contaminated material and disinfecting non-critical equipment.

- Used patient-care equipment soiled or potentially contaminated with blood, body fluids, secretions, or excretions is handled in a manner that prevents exposures to skin and mucous membranes, avoids contamination of clothing, and minimizes the likelihood of transfer of microbes to other patients and environments.

- <Name of Clinic> has policies in place to ensure that reusable equipment is not used for the care of another patient until it has been appropriately cleaned and reprocessed, and to ensure that single-use patient items are appropriately discarded.

- Sterilization is required for all instruments or equipment that enter normally sterile tissues or through which blood flows.

- Contaminated waste is sorted and discarded in accordance with federal, state and local regulations.

- Policies for the prevention of occupational injury and exposure to blood borne pathogens in accordance with Standard Precautions and Universal Precautions are in place.

If exposed skin comes in contact with an unknown substance/powder, recommend washing with soap and water only. If contamination is beyond the clinics capability, call 911. Local government, fire departments and hospitals normally conduct decontamination of patients and facilities exposed to chemical agents.

3.15.3.5 Patient placement

In small-scale events, routine clinic patient placement and infection control practices should be followed. However, when the number of patients presenting to a healthcare facility is too large to allow routine triage and isolation strategies (if required), it will be necessary to apply practical alternatives. These may include cohorting patients who present with similar syndromes, i.e., grouping affected patients into a designated section of a clinic or emergency department, or a designated ward or floor of a facility, or even setting up a response center at a separate building.

3.15.3.6 Evidence collection
a. *<Name of Clinic>* will establish procedures for collecting and preserving evidence in any suspected terrorist attack. In the event of a suspected or actual terrorist attack involving weapons of mass destruction, a variety of responders, ranging from health care providers to law enforcement and federal authorities, will play a role in the coordinated response. The identification of victims as well as the collection of evidence will be a critical step in these efforts.

- The health care provider's first duty is to the patient; however interoperability with other response agencies is strongly encouraged.

- The performance of evidence collection while providing required patient decontamination, triage and treatment should be reasonable for the situation.

- Information gathered from the victims and first responders may aid in the epidemiological investigation and ongoing surveillance.

  It is imperative that individual healthcare providers work with the local law enforcement agencies and prosecutors in the development and customization of these policies.

b. Evidence to be collected could include clothing, suspicious packages, or other items that could contain evidence of contamination. At a minimum:

- *<Name of Clinic>* has a supply of plastic bags, marking pens, and ties to secure the bags.

- Each individual evidence bag will be labeled with the patient's name, date of birth, medical record number, date of collection and site of collection.

- An inventory of valuables and articles will be created that lists each item that is collected. The list will be kept by the clinic and a copy given to the patient.

- The person responsible for the valuables and articles will be identified and documented. If possessions are to be transported to the FBI or local law enforcement agency, the facility will document who received them, where they were taken, and how they will be returned to the owner.

3.15.3.7 Mass prophylaxis

<Name of Clinic> encourages its clinicians to participate in a mass prophylaxis program, if the disruption to clinic operations would not negatively affect the health of the community the clinic serves.

Health care providers from clinics throughout the county could be called to volunteer to distribute medication or provide vaccines in response to a large-scale attack. Under this scenario, *<Name of County>* would establish mass prophylaxis sites throughout the County. These sites would be large facilities such as school gymnasiums or warehouses that can accommodate large groups of people. These sites would require a large number of healthcare providers to administer medications. Since the county does not employ enough practitioners to staff the sites, they will look to the private sector, including clinics, to adequately staff mass prophylaxis sites.

4 RECOVERY

4.1 Introduction

Recovery actions begin almost concurrently with response activities and are directed at restoring essential services and resuming normal operations. Depending on the emergency's impact on the organization, this phase may require a large amount of resources and time to complete.

This phase includes activities taken to assess, manage and coordinate the recovery from an event as the situation returns to normal. These activities include:

a. Deactivation of emergency response. The *\<Name of Clinic\>* Executive Director or designee will call for deactivation of the emergency when the clinic can return to normal or near normal services, procedures, and staffing. See **Appendix P.8 – Deactivation of the ERT and EOC.** Post-event assessment of the emergency response will be conducted to determine the need for improvements.

b. Establishment of an employee support system. Human resources will coordinate referrals to employee assistance programs as needed.

c. Accounting for disaster-related expenses. The Finance Section Chief will account for disaster related expenses. Documentation will include: direct operating cost; costs from increased use; all damage or destroyed equipment; replacement of capital equipment; and construction related expenses.

d. Return to normal clinic operations as rapidly as possible.

4.2 Documentation

To continue providing the same efficient service as was provided prior to the incident, *\<Name of Clinic\>* will immediately begin gathering complete documentation including photographs. Depending on the event, it may be necessary to expedite resumption of health care services to address unmet community medical needs.

4.3 Inventory Damage and Loss

\<Name of Clinic\> will document damage and losses of equipment using a current and complete list of equipment serial numbers, costs, and dates of inventory. One copy will be filed with the CFO and another copy in a secure offsite location.

Refer to **Appendix O.4 – Financial Tracking Forms** for forms for tracking costs and losses.

4.4 Lost Revenue through Disruption of Services

The CFO will work with the Finance Section to document all expenses incurred from the disaster. An audit trail will be developed to assist with

qualifying for any Federal reimbursement or assistance available for costs and losses incurred by the clinic as a result of the disaster.

4.5 Cost / Loss Recovery Sources

Depending on the conditions and the scale of the incident, *<Name of Clinic>* will seek financial recovery resources in accordance with the following:

4.5.1   The eligibility of clinics for federal reimbursement for response costs and losses remains ambiguous. It may be possible to gain reimbursement through county channels under certain (largely untested) circumstances.

4.5.2   Public Assistance (**FEMA**/**OES**) - After a disaster occurs and the President has issued a Federal Disaster Declaration, assistance is available to applicants through **FEMA** and the **OES**. The Small Business Administration (**SBA)** provides physical disaster loans to businesses for repairing or replacing disaster damages to property owned by the business. Businesses and Non-profit organizations of any size are eligible.

Federal Grant - Following a presidential disaster declaration, the Hazard Mitigation Grant Program (**HMGP**) is activated.

4.5.1   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

4.5.2   Insurance Carriers - *<Name of Clinic>* will file claims with its insurance companies for damage to the clinic. The clinic will not receive federal reimbursement for costs or losses that are reimbursed by the insurance carrier. Eligible costs not covered by the insurance carrier such as the insurance deductible may be reimbursable.

4.6 Psychological Needs of Staff and Patients

Mental health needs of patients and staff are likely to continue during the recovery phase. The Mental Health Coordinator will continue to monitor for and respond to the mental health needs of clinic staff and patients.

4.7 Restoration of Services

<Name of Clinic> will take the following steps to restore services as rapidly as possible:

a. If necessary, repair clinic facility or relocate services to a new or temporary facility.

b. Replace or repair damaged medical equipment.

c. Expedite structural and licensing inspections required to re-open.

d. Facilitate the return of medical care and other clinic staff to work.

e. Replenish expended supplies and pharmaceuticals.

f. Decontaminate equipment and facilities.

g. Attend to the psychological needs of staff and community.

h. Follow-up on rescheduled appointments.

4.8 After-Action Report

<Name of Clinic> will conduct after-action debriefings with staff and participate in consortium and Operational Area after-action debriefings. The clinic will also produce an after-action report describing its activities and corrective action plans including recommendations for modifying the surge capacity expansion procedures, additional training and improved coordination. See **Appendix P.9 After Action Report.**

4.9 Staff Support

The clinic recognizes that clinic staff and their families are impacted by community-wide disasters. The clinic will assist staff in their recovery efforts to the extent possible.

5   REFERENCES

1. American Red Cross. *Home Preparedness Guidelines: What You Can Do to Prepare.* 2004. http://www.redcross.org/static/file_cont36_lang0_23.pdf.

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4. Council of Community Clinics. *Emergency Procedures Flip Chart.* San Diego, 2003.

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