



Disaster Healthcare Volunteers

Principles of Operations

Version 1.5 – March 13, 2008

A summary of policies, procedures and guidance for local governments, state agencies, care delivery sites, and volunteer health professionals on the use of the Disaster Healthcare Volunteers System in California

Effective July 2007, EMSA established the Disaster Healthcare Volunteers Program,

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Steve DeMello, CA OES
John Eaglesham, Santa Barbara County EMS Agency
Susan Fanelli, CDPH
Keith Harrison, LA County, OEM
Cheri Hummell, CA Hospital Association
Nancy Lapolla, Santa Barbara County EMS Agency
Patrick Lynch, RDMHS, Reg. IV
Karen Mandell, CA OHS
Sheila Martin, CA EMSA
Bill Norris, 2-1-1 San Diego
Jan Ogar, San Mateo County EMS Agency
Pamela Perdue, California Service Corps
Roger Richter, CA Hospital Association
Kevin Rose, San Mateo County EMS Agency
Jeff Rubin, CA EMSA
Mitch Saruwatari, Kaiser Permanente
Lisa Schoenthal, CA EMSA
Sandra Shields, LA County EMS Agency
Cheryl Starling, Kaiser Permanente
Adam Sutkus, CSUS/CCP
Paul Tassone, Sacramento County Sheriff's Office
Cindy Teague, CCP/CSUS
David Zocchetti, CA OES*

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Introduction

System Establishment

The Disaster Healthcare Volunteers Program is designed to ensure that, in the event of a disaster, pre-credentialed volunteer medical and health staff will be deployed to assist in response and recovery efforts. The Emergency Medical Services Authority (EMSA), together with their stakeholders, has worked collaboratively to establish this program in the state.

In July 2007, EMSA established the Disaster Healthcare Volunteers program as the overarching program for medical volunteers in California. As such, the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) has been folded into the Disaster Healthcare Volunteers System. In addition to registration of health professionals, Disaster Healthcare Volunteers also has operational, training, and exercise components not only for the health professionals, but for governmental entities and health care organizations.

Purpose of Document

The purpose of the “Disaster Healthcare Volunteers Principles of Operations” document is to capture policies that underlie how the system will be used by local government, state agencies, and care delivery sites. As such, this document serves as the baseline from which users can begin to integrate medical volunteers into their own protocols for responding to a disaster. It is anticipated that the policies in this document will continue to be updated as use of the Disaster Healthcare Volunteers System proceeds in California. More detailed, stand-alone Disaster Healthcare Volunteer procedures are currently under development, including Standard Operating Procedures (SOPs) and a Volunteer Manual.

This document reflects the efforts of a robust consensus-based policy process, a tabletop exercise, and related stakeholder-based activities. While this document predates the current program name (Disaster Healthcare Volunteers) and the current software used for the system, the principles remain valid. The program name has been updated in this document, and in a few cases, slight changes have been made to policies. These changes are identified explicitly as post-implementation addenda.

Addressing Pending Issues

As work has progressed with key stakeholders, issues have arisen that need to be further explored as development of Disaster Healthcare Volunteer System precedes. The issues below, listed in alphabetical order, emerged during the development of the first version of the Principles of Operations and in the March 2007 Tabletop Exercise.

EMSA continues to work with key stakeholders to address these topics. Currently under development are Standard Operating Procedures for Operational Areas, Region, and State, and a Volunteer Manual. As these documents are developed, EMSA anticipates resolving several of these issues.

Registry

- **Cost and payment process for system users** – There are costs associated with use of the Disaster Healthcare Volunteers System which may need to be shared with counties if federal funding decreases in the future.
- **Eligibility for reimbursement** – Eligibility for reimbursement of registry usage costs should be considered. For example, costs associated with disaster response may be reimbursable from the state or federal government. Costs associated with training and exercises may also be eligible under certain grants.

Disaster Service Workers (DSW)

- **Impact of additional DSWs on annual allocation for workers compensation** – OES and the State Compensation Insurance Fund coordinate workers' compensation claims for DSWs. Funds are allocated on an annual basis as part of OES' budget to pay for DSW claims. As more healthcare professionals register as Disaster Healthcare Volunteers/DSW volunteers, OES and EMSA should monitor the potential impact to the annual allocation.

Health Care Facilities and Employers

- **Liability protection** – While Government Code Section 8659 may be interpreted to provide immunity for hospitals, it is clear that liability protection for health care facilities and employers is an area that requires further analysis and discussion.
- **Privileging** – The Disaster Healthcare Volunteers Principles of Operations document recognizes hospitals may grant disaster privileges to volunteers. This issue needs further analysis and discussion for registered volunteers to work most effectively.
- **Access process** – Large healthcare employers may have many employees registered as Disaster Healthcare Volunteers. In order to ensure their workforce is managed properly, statutory and regulatory requirements are met,

and their workforce is not unduly depleted in an emergency, these employers may wish to establish internal protocols for volunteer deployment. EMSA recognizes this issue and will work collaboratively to meet the needs of our partners.

Operations

- **Terminology** – Terminology used in all Disaster Healthcare Volunteers documents must be standardized, defined, and consistent with accepted policy documents.
- **Role of the region and state** – Under California’s Standardized Emergency Management System (SEMS), the regional level coordinates resource requests within the region and between their Operational Areas (county) and the state. The medical/health function at the regional level may or may not be robust enough to effectively coordinate the volume of anticipated requests for registered volunteers through the system. EMSA recognizes this issue by allowing state activation of the Disaster Healthcare Volunteers Notification System while still providing deployment coordination through the Region and Operational Areas. In the coming months, as the roll out of the Disaster Healthcare Volunteers System progresses to all 58 counties, EMSA will be working closely with the county MHOACs or their designees to frame policies and procedures for the activation of the system at a local, regional and state level.
- **Role of Local Government & Operational Area** – The MHOAC or his/her designee will function as the Disaster Healthcare Volunteers System Administrator for their county. This role includes notification and activation of the county’s volunteer medical professionals through the Disaster Healthcare Volunteer System. The system will allow the management of the volunteers for the duration of the emergency. How this functions within local governments will require further planning and analysis.
- **Logistics** – Of critical importance is clarification of the roles and responsibilities for the OA, region, and state for all aspects of logistics, i.e., deployment, staging, housing, transportation, and tracking and monitoring of registered volunteers during a response.
- **Deployment priority and coordination of resources** – The Disaster Healthcare Volunteers Principles of Operations states that deployment of medical assets is determined by the specific situation and resource need. Locally, the MHOAC or his/her designee will be notified by local EOC that they are requesting medical volunteers. Once this request comes from the local emergency managers, the MHOAC as the System Administrator will notify the medical volunteers in his/her county through the Disaster Healthcare Volunteers System to determine who in the community is available to respond. The MHOAC or his/her designee will determine through the replies of the volunteers who is available for response and if they can fill the volunteer request from the Operational Area EOC. If locally this MHOAC is unable to fill the request, he/she notifies the Operational Area EOC which will move the

request to the Regional EOC. This request will then move to the Medical/Health Branch at the Regional EOC who will contact surrounding county MHOACs that more medical volunteers are needed in the affected operational area. These surrounding county MHOACs will also contact their medical volunteers through the Disaster Healthcare Volunteer System and report back to the Regional EOC that they have xx number and xx type of medical volunteers who are available to respond. This overall approach needs to be tested in exercises.

- **Factors in determining who to deploy** – Registered volunteers will be deployed into a wide range of situations. Disaster response is always stressful but can be compounded, for example, by austere living conditions, long deployments, and insufficient numbers of responders to address disaster needs. Minimal On-line Training Standards will be required to prepare the Disaster Healthcare Volunteer for these situations and what to expect while responding.
- **Out-of-state deployment** – Registered volunteers can be deployed out of state only if the volunteer has indicated that they wish to be included in an out-of-state response under the Emergency Management Assistance Compact (EMAC) and the Interstate Civil Defense and Disaster Compact (ICDDC). The Disaster Healthcare Volunteers Principles of Operations document describes these compacts in general, including workers' compensation coverage and limited liability protection for deployed volunteers. However, specific deployment policies and procedures require development.

Standardized Emergency Management System (SEMS)/National Incident Management System (NIMS)

It is understood that the Disaster Healthcare Volunteers System will operate under SEMS/NIMS. On-line self-paced training of SEMS/NIMS will be available to the volunteers to fully understand how requests for assets work within SEMS/NIMS.

- **Guidance** – Health professional volunteers come from a variety of backgrounds and experiences. Guidance needs to be provided so that the individual volunteer understands his/her role, responsibilities, and parameters of his/her actions relative to the Disaster Healthcare Volunteers System and SEMS/NIMS. In addition to the roles and responsibilities of government and health care, specific expectations of the registered volunteer when deployed must be included in the guidance.
- **SUVs** – The goal of the Disaster Healthcare Volunteers System is to have pre-registered volunteers. However, it is recognized that there will be spontaneous unaffiliated volunteers (SUV) during an emergency/disaster. How SUVs are handled requires further analysis.
- **Training** – What type of training that will be required for all volunteers or for various subgroups; requires analysis, assessment and planning.

Section I: Background

ESAR-VHP Nationwide

As recent disasters demonstrate, in an emergency, many health and medical providers are eager and willing to volunteer professional health services. To meet the extraordinary demands of a large-scale emergency, hospitals and other providers of healthcare will depend upon the services that health volunteers can provide. However, in a time of emergency, utilizing the capabilities of the health volunteers presents a major challenge to hospital, public health, and emergency authorities.

Immediately after the attacks on September 11, 2001, tens of thousands of people spontaneously showed up at ground zero in New York City to volunteer their assistance. A large number of these volunteers arrived to provide medical assistance to the victims of the attacks. In most cases, authorities were unable to distinguish those that were qualified from those that were not qualified, though well intentioned. Because the response was unsolicited and there was no mechanism of coordination, those that presented themselves reduced the effectiveness of the overall response effort rather than helping. In addition to the experiences in New York City on 9/11, similar difficulties have occurred when the nation has had to respond to hurricanes, earthquakes, and other mass casualty events.

The goal of the ESAR-VHP program is to eliminate a number of the significant problems encountered when seeking to utilize medical and healthcare volunteers in a complex emergency response situation. The federal government's intent is to provide states with options and flexibility to develop an ESAR-VHP system which best meets the states' needs while enabling a national system of mutual aid.

The ESAR-VHP program is a state-based approach to establishing a national system. Each state is being tasked under the HRSA Hospital Bioterrorism Program to independently develop, maintain, operate, and manage an ESAR-VHP system. However, it is important that all members of the volunteer health community work together to ensure maximum surge capacity by establishing a system that facilitates the exchange of health care workers between jurisdictions. Such a system for mutual assistance will be a state, as well as national, asset.

The ESAR-VHP system will be supported by an electronic registry of health care personnel who volunteer to provide aid in an emergency. An ESAR-VHP system must (1) register health volunteers, (2) apply emergency credentialing standards to registered volunteers, (3) allow for the verification of the identity, credentials, and qualifications of registered volunteers in an emergency, and (4) supported by the emergency management system, be used to deploy health volunteers.

Disaster Healthcare Volunteers Program

California is in the process of developing the Disaster Healthcare Volunteers Program (which includes the ESAR-VHP component) and is reaching out to critical stakeholders with a goal of building a clear and supported program (see Attachments 1 and 2.) As is the case nationally, many complex policy and implementation issues serve as the challenge to scope, design, implement, and evaluate Disaster Healthcare Volunteers System — as well as utilize the registry tool in its most useful and efficient manner. This “*Principles of Operations*” document will serve as the focal point for developing and implementing collaborative operational guidelines, policies, and procedures governing the California system.

California’s Disaster Healthcare Volunteers System will be supported by a robust registry where individuals will register and their data will be maintained for potential disaster use. At this time, medical volunteers are the primary entity being registered within this statewide system. The Disaster Healthcare Volunteers Program is being designed as a statewide system, which operates in coordination with the state’s Operational Area emergency medical services and public health officials, to recruit, register, credential, track, identify, deploy, and maintain currently licensed volunteer healthcare professionals for response to emergencies, disasters and terrorist incidents in California and throughout the nation.

Section II: Key Operational Policies

A. Emergency Management System

#1. California's Standardized Emergency Management System (SEMS) is the primary response framework for Disaster Healthcare Volunteers.

At all times, consistency with the Standardized Emergency Management System will serve as the key reference point for all response constructs, including the state's emergency medical infrastructure (see Attachment 3 for emergency response system overview). Under SEMS, all resource requests move through the designated response levels until the request is filled. A request initiated at the field or incident site moves to local government, to the operational area, to the region, and then to the state and, if necessary, from the state to the federal government.

#2. In accordance with mutual aid principles, no Disaster Healthcare Volunteer will be assigned, tasked, or otherwise deployed without being coordinated through standard SEMS channels.

California Medical Volunteers will be viewed as another of many skilled personnel types potentially available to assist in any disaster. In addition to being pre-qualified and pre-credentialed through the Disaster Healthcare Volunteers System, volunteers may also join California's cadre of Disaster Service Workers (see Section II.D.18).

#3. Notwithstanding #2 above, state-directed activation of Disaster Healthcare Volunteers Notification System may occur when the impacted operational area(s) is no longer functional and/or the event is of such magnitude that the need for medical volunteers from throughout the state is immediately determined.

Simultaneous with this activation, the state will ensure that all levels of SEMS (local government, operational areas, and regions) are notified and that deployment of Disaster Healthcare Volunteers follows SEMS as outlined in #1 and 2 above.

#4. Requests from another state or from the federal government for Disaster Healthcare Volunteers will be directed to OES.

Requests for California's Disaster Healthcare Volunteers by another state or by the federal government will be directed to OES' 24-hour California State Warning Center. The resource request will be processed in coordination with the Emergency Medical Services Authority and the Department of Health Services using established duty officer procedures and SEMS channels.

#5. Consistent with the principles of SEMS, the Incident Command System (ICS), and the Hospital Incident Command System (HICS), once a registered volunteer has been identified and deployed into a response incident, that volunteer comes under the operational command of the Incident Commander.

Whether at an EOC level, in a field response under ICS structure, or at a hospital, Disaster Healthcare Volunteers fall under the control of the EOC manager or Incident Commander, until such time as the resource is released from the incident response.

#6. A Disaster Healthcare Volunteer is a pre-registered, pre-credentialed skilled volunteer resource that can be utilized at any point in a disaster. In an emergency, resources are requested based upon specific local, regional, or statewide situations that need to be addressed. The decision of which medical volunteer resource to deploy will be based upon the specific requirements of the mission to be accomplished.

Volunteers registered through Disaster Healthcare Volunteers are specific resources that will be used on an infrequent basis during a declared disaster, at a point where more readily available resources have been exhausted. Further, Disaster Healthcare Volunteers are not envisioned to be “first responders” but will typically serve as backfill support to local resources and response to surge needs.

#7. Support of deployed registered volunteers will be accomplished using standard emergency management resource request protocols.

Prior to emergency personnel being deployed to an incident, the requestor and provider must agree upon who will provide logistical support, including transportation, lodging, feeding, and specialized equipment and materials.

#8. In California, consistency with the National Incident Management System (NIMS) is achieved through using SEMS for operations and planning—when local and state agencies include volunteer resources, including Disaster Healthcare Volunteers, in their activities, NIMS consistency has been achieved.

The current Federal Fiscal Year 2006 NIMS requirements for local, tribal, and state governments are general in nature and address interacting with volunteers and voluntary organizations overall. By using SEMS in California, NIMS consistency is achieved with regards to volunteer organizations when resources such as the Disaster Healthcare Volunteers (MRC, CalMATs, etc.) are included in advance planning for preparedness and response.

#9. In California, management of medical and health disaster response planning is carried out by the local health officer and emergency medical services agency at the county (Operational Area) level.

Medical and health issues in disasters are seen within the boundaries of cities and counties. However, planning for the medical and health response in a disaster is carried out at the county (Operational Area) level.

B. Mutual Aid

#10. Standard California mutual aid concepts will apply to the Disaster Healthcare Volunteers System

When an event surpasses a local government's ability to respond, registered volunteers may be requested through standard SEMS mutual aid channels (Local to OA to Region to State.).

#11. Consistent with standard mutual aid principles in California, no jurisdiction will be required to deplete its registered medical volunteers if it feels doing so would leave it unacceptably vulnerable.

California's Master Mutual Aid Agreement has been signed by the state, all counties and virtually every city. The agreement is built upon the principle that aid is not mandatory if it unduly exposes a jurisdiction to risk; this concept applies to registered volunteers within the Disaster Healthcare Volunteers System as it does to any other resource during disaster.

#12. Based upon California's mutual aid principles, no private entity or organization is expected to expose itself to undue risk when releasing employees or members who are in the Disaster Healthcare Volunteers System.

It is anticipated that the vast majority of registered volunteers will be private sector employees. It is understood that their employers must attend to the needs of their organization and the laws that govern them. The conditions under which an employee will be released to volunteer in an emergency remain between the employer and employee.

C. Registries

#13. The Disaster Healthcare Volunteers System is intended for use during declared emergencies and disasters. Use of the system and its registered volunteers is not appropriate for day-to-day use.

It is anticipated that the use of the Disaster Healthcare Volunteers System will be needed in situations where a local government has declared an emergency or the Governor has declared a state of emergency. Day-to-day medical situations that may arise should be addressed without the use of this system. Use of the registered volunteers, therefore, is also intended for declared emergency and disaster situations.

#14. The Disaster Healthcare Volunteers System will be managed, accessed, and maintained consistent with the operational principles outlined in this document. All resources will be clearly marked and categorized for ease of use by operational area and state system administrators, consistent with SEMS.

The Disaster Healthcare Volunteers System will be designed and maintained in a manner that will make every effort to allow user-friendly local oversight and statewide quality control, consistent with SEMS deployment and operations concepts. Strict access rights will be limited to local government and state administrators using procedures consistent with SEMS. Operational areas and state agencies will designate the organizations and individuals tasked with system oversight.

#15. As currently constructed, only medical resources will be entered into the Disaster Healthcare Volunteers System. It is anticipated that the system will potentially house other volunteer medical support resources.

As a useful tool for use locally and statewide, consideration will be given to tracking volunteer support personnel of various types necessary for providing a medical response during a declared disaster.

Post-implementation addenda: The system acquired by California is now registering non-clinical volunteers able to help during a disaster medical operation (e.g., logistics personnel).

#16. It is understood that there are numerous pre-existing emergency response resource tracking registries. The system will be operated in a manner to provide the continued autonomy of other registries while maximizing the ability to coordinate information, whether technologically or through procedures.

Many local volunteer programs—such as Community Emergency Response Teams (CERT), Citizen Corps, or other local volunteer management system-- have developed registries and programs to manage names and resources for planning and response. Further, CA OES manages the Response Information Management System (RIMS), which is the primary resource and information tracking tool in use statewide during all emergencies and is used routinely by local and state entities. The statewide Disaster Healthcare Volunteer System will integrate as needed with these systems and work towards procedural integration.

D. Volunteers

#17. It is understood that registered volunteers are individuals that are volunteering their time and expertise; therefore, the flexible nature of this resource must be built into expectations for use by the program.

All use of registered volunteers should be guided by the understanding that individual volunteers may or may not choose to respond to a given request for service. As volunteers, they need to be respected for the balancing act they must perform between their routine jobs, home life, and decision/commitment to volunteering.

#18. In order to receive workers' compensation benefits, Disaster Healthcare Volunteers will be registered under the state's Disaster Service Worker (DSW) Volunteer Program. Registration may occur at the time of a disaster or in advance. Registered DSWs are covered for workers' compensation and have limited immunity from liability. Registration as a DSW is required before a volunteer can be deployed.

Under California statute, accredited disaster councils at the city or county level, the State Office of Emergency Services, and other state agencies delegated authority by OES may register volunteers as Disaster Service Workers. All California counties and virtually every city currently have this authority. There are a variety of DSW classifications established by regulation, including Medical & Environmental Health. (See Attachment #4 for information on the DSW Volunteer Program.)

Workers' Compensation: *When duly tasked by the registering entity (city, county, state agency) to respond to an actual incident or to participate in approved training, Disaster Healthcare Volunteers in their status as DSWs are covered for workers' compensation. The California Legislature budgets funds annually for DSW workers' compensation insurance. Claims are coordinated through the State Office of Emergency Services and the State Compensation Insurance Fund.*

Liability. The California Emergency Services Act (Government Code Section 8657) provides DSW volunteers with limited immunity from liability while providing disaster service as it is defined in Sections 2570.2 and 2572.2 of the Disaster Service Worker Volunteer Program Regulations (Cal. Code of Regulations., Title 19.) Additionally, U.S. Public Law 105-19, Volunteer Protection Act of 1997, provides limited protection. Immunity from liability protects the political subdivision or political entity and the DSW volunteer in any civil litigation resulting from acts of good faith made by the political subdivision or political entity, or the DSW volunteer, while providing disaster service (e.g., damage or destruction of property; injury or death of an individual). Immunity from liability does not apply in cases of willful intent, unreasonable acts beyond the scope of DSW training, or if a criminal act is committed.

#19. Overall, California law appears to afford ample protections for volunteer health care providers against civil liability (e.g., defense, indemnification and immunity.) Despite the varying types of conduct that do not qualify for immunity (gross negligence, willful conduct), it is clear that all of the statutes immunize acts that represent ordinary negligence.

Protections against civil liability for volunteer health care providers are addressed in several areas of California law.

Government Code Section 8657(a) – Emergency Services Act (ESA) – *provides that duly enrolled or registered volunteers (e.g., Disaster Service Workers) shall have the same degree of responsibility for their actions and enjoy the same immunities as officers and employees of the state and its political subdivisions performing similar work for their respective entities. In effect, Section 8657(a) places volunteers in the same position as public employees for purposes of civil liability.*

California case law strongly suggests that a public employee engaged in providing health care services would not be immune from civil liability under Government Code Section 820.2. It also appears that a private volunteer under Section 8657(a) would similarly not be immune from civil liability under Section 820.2. However, it appears that a volunteer who falls under Section 8657(a) would be entitled to the significant protections available to a public employee – notably the right to a defense under Government Code Section 995 and indemnification under Government Code Section 825 with regard to acts and omissions committed within the volunteer’s scope of “employment.”

Civil Code Section 1714.5 – *appears to provide somewhat greater immunity, stating:*

No disaster service worker who is performing disaster services ordered by lawful authority during a state of war emergency, a state of emergency, or a local emergency, as such emergencies are

defined in Section 8558 of the Government Code, shall be liable for civil damages on account of personal injury to or death of any person or damage to property resulting from any act or omission in the line of duty, except one that is willful.

Government Code Section 8659 – *appears to provide substantially the same level of immunity as Section 1714.5, but only for a defined class of health care providers, stating:*

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

Business and Professions Code Section 2395 – *provides with regard to physicians that:*

No licensee, who in good faith renders emergency care at the scene of an emergency, shall be liable for any civil damages as a result of any acts or omissions by such person in rendering the emergency care. “The scene of an emergency” as used in this section shall include, but not be limited to, the emergency rooms of hospitals in the event of a medical disaster. “Medical disaster” means a duly proclaimed state of emergency or local emergency declared pursuant to the California Emergency Services Act (Chapter 7 (commencing with Section 8550) of Division 1 of Title 2 of the Government Code). Acts or omissions exempted from liability pursuant to this section shall include those acts or omissions which occur after the declaration of a medical disaster and those which occurred prior to such declaration but after the commencement of such medical disaster. The immunity granted in this section does not apply in the event of a willful act or omission.

Business and Professions Code 1627.5 – *states with respect to dentists that:*

No person licensed under this chapter, who in good faith renders emergency care at the scene of an emergency occurring outside the place of that person’s practice, or who, upon the request of another person so licensed, renders emergency care to a person

for a complication arising from prior care of another person so licensed, shall be liable for any civil damages as a result of any acts or omissions by that person in rendering the emergency care.

Business and Professions Code Section 2727.5 – states with regard to registered nurses:

A person licensed under this chapter who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of that person’s employment shall not be liable for any civil damages as the result of acts or omissions by that person in rendering the emergency care. This section shall not grant immunity from civil damages when the person is grossly negligent.

Business and Professions Code Section 3503.5 – states with regard to physicians’ assistants:

- a) *A person licensed under this chapter who in good faith renders emergency care at the scene of an emergency that occurs outside both the place and course of that person’s employment shall not be liable for any civil damage as a result of any acts or omissions by that person in rendering the emergency care.*
- b) *This section shall not be construed to grant immunity from civil damages to any person whose conduct in rendering emergency care is grossly negligent.*
- c) *In addition to the immunity specified in subdivision (a), the provisions of Article 17 (commencing with Section 2395) of Chapter 5 shall apply to a person licensed under this chapter when acting pursuant to delegated authority from an approved supervising physician.*

Health and Safety Code Section 1799.106 – provides that an emergency medical technician “who renders emergency medical services at the scene of an emergency shall only be liable in civil damages for acts or omissions performed in a grossly negligent manner or acts or omissions not performed in good faith.”

Government Code Section 1660 – provides that health care practitioners who are not licensed in California, but who are licensed in another state and provide health care services in California in the event of a state of emergency under Government Code Section 8558(b) are immune from liability under Section 8659.

#20. Disaster Healthcare Volunteers who are registered DSWs may be deployed out-of-state under California statute. California statute addresses licenses, workers’ compensation, and limited liability protection for out-of-state deployment.

California has adopted by statute the [Interstate Civil Defense and Disaster Compact](#) (ICDDC), Government Code Sections 179-179.9, effective December 10, 1951, and the [Emergency Management Assistance Compact](#) (EMAC), Government Code Sections 177-178.5, effective September 13, 2005. Both compacts provide for the sharing of resources between requesting states (those asking for assistance) and assisting states (those sending assistance). It is anticipated that most DISASTER HEALTHCARE VOLUNTEERS deployments will be under EMAC.

The compacts share many similar provisions. Of relevance to registered volunteers, both compacts provide for recognition by the requesting state of licenses and certificates of the assisting state. Compensation for injuries and death benefits are paid at the rate of the assisting state.

One key difference between the compacts is in the area of liability. Under EMAC, assisting state personnel are considered agents of the requesting state for tort liability and immunity purposes. Under the ICDDC, requesting states must extend the same immunities as the assisting state. Because of this difference, California's EMAC statute contains provisions that (1) ensure personnel deployed under EMAC are indemnified by the state as if the acts occurred in California and (2) require the state to provide legal defense for deployed personnel of local governments as they would for state employees. (For purposes of EMAC or ICCDC, Disaster Healthcare Volunteers registered as DSWs are considered personnel of the entity registering the DSW.)

It should be noted that California's EMAC statute will become inoperative on March 1, 2007 and will be repealed as of January 1, 2008 unless extended by legislation.

Excerpts From EMAC:

Government Code Section 179.5

Article 5. Licenses and Permits

Whenever any person holds a license, certificate, or other permit issued by any state party to the compact evidencing the meeting of qualifications for professional, mechanical, or other skills, and when such assistance is requested by the receiving party state, such person shall be deemed licensed, certified, or permitted by the state requesting assistance to render aid involving such skill to meet a declared emergency or disaster, subject to such limitations and conditions as the governor of the requesting state may prescribe by executive order or otherwise.

Article 6. Liability

Officers or employees of a party state rendering aid in another state pursuant to this compact shall be considered agents of the requesting state for tort liability and immunity purposes. No party state or its officers or employees rendering aid in another state pursuant to this compact shall be liable on account of any act or omission in good faith on the part of such forces while so engaged or on account of the maintenance or use of any equipment or supplies in connection therewith. Good faith in this article shall not include willful misconduct, gross negligence, or recklessness.

Article 8. Compensation

Each party state shall provide for the payment of compensation and death benefits to injured members of the emergency forces of that state and representatives of deceased members of such forces in case such members sustain injuries or are killed while rendering aid pursuant to this compact, in the same manner and on the same terms as if the injury or death were sustained within their own state.

Government Code Section 179.7

- a) *Notwithstanding Article 6 of the Emergency Management Assistance Compact, as set forth in Section 179.5, the state shall indemnify and make whole any officer or employee who is a resident of California, or his or her heirs, if the officer or employee is injured or killed in another state when rendering aid pursuant to the compact, as if the act or acts occurred in*

California, less any recovery obtained under the provisions of Article 6 of the Emergency Management Assistance Compact.

- b) *Local government or special district personnel who are officially deployed under the provisions of the Emergency Management Assistance Compact pursuant to an assignment of the Office of Emergency Services shall be defended by the Attorney General or other legal counsel provided by the state, and shall be indemnified subject to the same conditions and limitations applicable to state employees.*

Government Code Section 179.9

This article shall become inoperative on March 1, 2007, and, as of January 1, 2008, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2008, deletes or extends the dates on which it becomes inoperative and is repealed.

Excerpts From ICCDC:

Government Code Section 178

Article 3. Each party state shall extend to the civil defense forces of any other party state, while operating within its state limits under the terms and conditions of this compact, the same powers (except that of arrest unless specifically authorized by the receiving state), duties, rights, privileges and immunities as if they were performing their duties in the state in which normally employed or rendering services. . .

Article 4. Whenever any person holds a license, certificate or other permit issued by any state evidencing the meeting of qualifications for professional, mechanical or other skills, such person may render aid involving such skill in any party state to meet an emergency or disaster and such state shall give due recognition to such license, certificate or other permit as if issued in the state in which aid is rendered.

Article 5. No party state or its officers or employees rendering aid in another state pursuant to this compact shall be liable on account of any act or omission in good faith on the part of such forces while so engaged, or on account of the maintenance or use of any equipment or supplies in connection therewith.

Article 7. Each party state shall provide for the payment of compensation and death benefits to injured members of the civil defense forces of that state and the representatives of deceased

members of such forces in case such members sustain injuries or are killed while rendering aid pursuant to this compact, in the same manner and on the same terms as if the injury or death were sustained within such state.

#21. A hospital may grant disaster privileges to volunteers eligible to be licensed independent practitioners, including Disaster Healthcare Volunteer registrants.

Hospitals are required to conduct a process for credentialing and granting clinical privileges to medical staff members. Under the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) Comprehensive Accreditation Manual for Hospitals (CAMH), Standard MSM.4.110 provides that a hospital "may grant disaster privileges to volunteers eligible to be licensed independent practitioners." The CAMH states, in part, that when the hospital's disaster plan has been implemented and the immediate needs of the patients cannot be met, the organization may implement a modified credentialing and privileging process.

#22. Disaster Healthcare Volunteers are *pre-registered* as volunteers and are not considered spontaneous, unaffiliated volunteers (SUVs); as such, they can be referenced and exercised in pre-planning for events and can be included in key after-action reviews.

It is anticipated that Disaster Healthcare Volunteers and other skilled volunteer resources will be used increasingly in California. It will be important to identify them as specific resource types to allow for proper pre-planning and after action reviews for system effectiveness.

Many registered volunteers may not ever become affiliated with a formal team or other response structure. These independent/non-assigned registrants are valuable resources that will be addressed on a case-by-case basis for emergency involvement and will be inserted into an EOC or ICS structure as individuals.

Section III: Procedures/Job Aids

This section is designed to be a more detailed companion to the Principles of Operations in Section II, offering specific situational procedures that further outlines the use of the Disaster Healthcare Volunteers System in California under specific circumstances. These “thematic” groupings are intended to allow guidance in real-world circumstances that will allow local, state and private agencies to integrate their own procedures with this statewide program.

Situation A: Notification and Deployment of Disaster Healthcare Volunteers (who, when, under what circumstances)

The notification and deployment procedures below follow the SEMS structure from the field, to local government, to operational area, to region, and to state. In the vast majority of cases requiring the use of Disaster Healthcare Volunteers, EOCs at all levels will be activated.

- 1. An incident occurs that requires the activation of Disaster Healthcare Volunteers and other medical assets.*
- 2. The MHOAC in the affected area, in coordination with the OA EOC, will activate the local Disaster Healthcare Volunteers. The MHOAC also advises the Regional Disaster Medical Health Coordinator/Specialist (RDMHC/S) and ensures that the EMSA Duty Officer has been notified. The MHOAC, RDMHC/S and EMSA Duty Officer will then coordinate response efforts.*
- 3. Based on the scale of the incident and level of state activation, resources will then be coordinated through the appropriate local or state emergency operations center.*
- 4. If the event exceeds local volunteer resources, the EMSA Duty Officer and Disaster Healthcare Volunteers staff will contact the nearby unaffected MHOACs to attempt to fill the requests within the region. Close communication will be maintained with the RDMHC/S in the affected region throughout the incident.*
- 5. If the medical volunteer request cannot be filled by nearby MHOACs then the RDMHC/S outside the affected area will be notified. EMSA will then forward the requests to unaffected MHOACs outside the region who will contact their Disaster Healthcare Volunteers.*
- 6. After receiving and reviewing the Disaster Healthcare Volunteers availability information, EMSA will coordinate with the responding MHOACs the assignment and deployment of the volunteers through the SEMS channels.*

Situation B: Interface between spontaneous, unaffiliated volunteers (SUV) and registered Disaster Healthcare Volunteers during response

In most large-scale emergencies, local governments call on their cadre of registered, trained volunteers for assistance. They also find themselves managing spontaneous,

unaffiliated volunteers, including those who may be eligible to register as a Disaster Healthcare Volunteer.

- 1. SUVs arriving at an incident or emergency facility should be directed to the local government's designated emergency volunteer center.*
- 2. The volunteer center should screen the SUV to determine if their skills can be used in the emergency.*
- 3. The SUV may be referred to the Office of the Governor's California Volunteers "Volunteer Match" website.*
- 4. If the SUV is a healthcare professional, the SUV should also be referred to the Disaster Healthcare Volunteers website.*

Situation C: Integration and use overlay with DMAT, CALMAT, and MRC resources

Disaster Medical Assistance Teams (DMAT) are activated by the federal government. California Medical Assistance Teams (CalMAT), when formed, will be activated by the state under the authority of EMSA. Medical Reserve Corps members are activated at the local level.

- 1. Disaster Healthcare Volunteers may be used to support DMAT or CalMAT operations, or in conjunction with MRC assignments.*
- 2. The determination to deploy registered volunteers in the above capacity will be driven by the response needs for a specific event.*
- 3. Registered volunteers will be requested and deployed as outlined in Situation A.*
- 4. Once deployed, the registered volunteers will come under the general operational command of the Incident Commander. For DMAT or CalMAT assignments, tactical command will default to the Team Leader.*

Situation D: California's Disaster Healthcare Volunteers are requested by another state

California is signatory to the Emergency Management Assistance Compact (EMAC) and the Interstate Civil Defense and Disaster Compact (ICCDC). These compacts are the vehicles for state-to-state requests for resources.

- 1. The California State Warning Center receives a request from another state for Disaster Healthcare Volunteers assets EMAC or ICCDC.*
- 2. The Warning Center contacts the OES Executive Duty Officer (EDO).*
- 3. The EDO contacts the EMSA and CDPH Duty Officers with the resource request.*
- 4. The EMSA Duty Officer through EMSA Staff, activates the Disaster Healthcare Volunteers Notification System requesting registered volunteers' availability for deployment. The EMSA Duty Officer notifies the RDMHCs of the activation; the EDO notifies the OES Regional Duty Officers; and the RDMHCs notify their MHOACs.*

5. *After receiving and reviewing Disaster Healthcare Volunteers availability information, the EMSA Duty Officers, coordinating through the SEMS channels, determine which Disaster Healthcare Volunteers will be made available for deployment. (Standard resource deployment protocols will be followed as described in Section II. A.)*
6. *The EDO contacts the requesting state with information about registered volunteer assets available for deployment.*
7. *Once the requesting state has accepted California's resource offer, the registered volunteers can be deployed to the requesting state. The EDO advises the EMSA Duty Officer that the assets can be deployed. The EDO also advises the OES Regional Duty Officers of which assets will be deployed; the Regional Duty Officers advise their OAs. The EMSA Duty Officer advises their RDMHC(s) of the registered volunteers to be deployed; the RDMHC(s) advise their MHOACs.*
8. *When the assets are released, the requesting state notifies the California State Warning Center. Notifications of release follows from the EDO to the EMSA Duty Officer and OES Regional Duty Officers, from the EMSA Duty Officer to the RDMHCs, from the RDMHCs to the MHOACs, and from the Regional Duty Officers to the OAs.*

Section IV: Scenarios with FAQs

To test this system for realistic use, four scenarios will be utilized on a regular basis to examine the policies and procedures governing the Disaster Healthcare Volunteers System in California to outline and refine situational procedures and job aids (see Section III) and frequently asked questions. These scenarios are based on information in “Planning Scenarios – Executive Summaries – Created for use in National, Federal, State, and Local Homeland Security Preparedness Activities” (Version 2, July 2004.)

1. Major earthquake in a large urban area
 - *Catastrophic event, with immediate state declaration*
2. Statewide pandemic
 - *Local emergency that evolves gradually*
3. Bio-terrorism attack originating in a rural setting
 - *Deliberate event with regional/statewide/national implications*
4. Series of strong hurricanes in the Southeast U.S.
 - *Event requires massive aid from throughout the nation*

Scenario #1 – Major Earthquake

A magnitude 7.2 earthquake has occurred in the Los Angeles Basin. More than 100,000 people are injured. Approximately 18,000 of the injured require hospitalization. Functioning hospitals are limited. Emergency medical service vehicles have been damaged. More than 300,000 households have been displaced. The massive number of injured and displaced persons require the activation of task forces for the delivery of mass care and health and medical services. Bridges and major highways are down or blocked and damaged runways have caused flight cancellations. There are widespread power outages and ruptures to underground fuel, oil, and natural gas lines. Water mains are broken. Wastewater primary receptors have broken, closing down systems and leaking raw sewage into the streets. Sizable aftershocks are continuing.

Response: Los Angeles, Orange, Ventura, San Bernardino, and Riverside Counties have declared emergencies and activated their Operational Area EOCs. The EMSA/CDPH JEOC, the Southern REOC, and the SOC are activated. The federal government has also activated the Region IX Regional Response Coordination Center (RRCC) and the Homeland Security Operations Center. The RRCC is sending a representative to the SOC. The MHOACs at the five affected OA EOCs are working to determine what type of medical assets are available in their OA's, what additional assets need to be requested, and where medical assets need to be deployed. Based on the severity of the situation, EMSA has activated Disaster Healthcare Volunteers notification statewide; the SOC, Southern REOC, and all RDMHCs have been alerted.

Using risk assessment software to estimate damage from the earthquake and information received from the OA EOCs, the Southern REOC, JEOC, and SOC are assessing the methods of transportation and locations for staging of medical assets.

FAQ's

1. Isn't it a violation of SEMS for EMSA, rather than the city or county, to contact their registered volunteers?

No. In a disaster of catastrophic proportions, determining registered volunteers' status must be done quickly. The other SEMS levels, i.e., regional – Southern REOC and RDMHCs, and state—SOC, were notified of the decision. Each organization has a responsibility to notify its members, i.e., RDMHCs to alert all MHOACs in their respective regions, Southern REOC to notify all of their OAs, and the SOC to notify the unaffected regions. Remember, EMSA is notifying Disaster Healthcare Volunteers personnel of the situation and asking for their availability for deployment. Actual deployment of registered volunteers will be coordinated using SEMS as described in Section II. A.

Scenario #2 – Statewide Pandemic

At least twenty-five cases of influenza caused by a novel virus occur first in a small village in China. Over the next 2 months, outbreaks begin to appear in Hong Kong, Singapore, South Korea, and Japan. Although cases are reported in all age groups, young adults appear to be the most severely affected and case-fatality rates approach 5%. Several weeks later the virus appears in four major U.S. cities, including San Francisco. At this point, the World Health Organization (WHO) has classified this outbreak as Phase 5 (large-clusters, still localized, virus becoming better adapted to humans), but is assessing whether Phase 6 (increased and sustained transmission in the general population) has been reached. As outlined in the CDPH Pandemic Influenza Preparedness and Response Plan (Draft - 1/18/06), the operational priorities for Phase 5 (pandemic alert period) are to maximize efforts to contain or delay spread, to possibly avert a pandemic, and to gain time to implement pandemic response measures. In Phase 6 (pandemic period), the operational priorities are to minimize the impact of the pandemic, while striving to maintain routine provision of public health and healthcare delivery.

Response: With a laboratory-confirmed novel influenza virus human infection in California, the CDPH has activated the JEOC in coordination with EMSA. The OES Warning Center has been notified of the activation. The OES Director has activated the SOC and REOCs at minimum staffing levels to monitor the situation and has sent a representative to the JEOC. The JEOC Director convenes an internal conference call to assess the current situation and determine the appropriate public health actions and priorities. Within one day of receiving the laboratory confirmation, the CDPH Division of Communicable Disease Control has convened a conference call with all local health officers, key state agencies, and other local contacts. San Francisco has declared a

local emergency and opened their OA EOC. Because of their proximity to San Francisco, Marin, Alameda, Contra Costa, Solano, Napa, Sonoma, and San Mateo are considering EOC activation. Due to late onset of symptoms and the rapid rate at which the disease spreads, evacuation and quarantine are not recommended. In addition to emergency public information, actions currently under consideration are administering vaccines and antiviral drugs to key responders and residents of the San Francisco area and, potentially, social distancing measures such as wearing masks and canceling school and public events in the affected area.

FAQ's

1. I am registered as a Disaster Healthcare Volunteer System volunteer, but am concerned about being deployed to an area affected by novel influenza virus. Am I required to go?

As a volunteer, you can decline to be deployed

2. If I am deployed to an affected area as a medical volunteer, will I receive a vaccine and/or antiviral drugs before I go?

CDPH is in the process of finalizing strategies for pandemic influenza vaccine and antiviral prioritization.

3. If I am deployed to an affected area, who would be responsible for my logistical needs, e.g., transportation, housing, and feeding?

Decisions on logistics are determined pre-deployment as part of the resource request process. Discussions occur between the requesting and providing jurisdictions and potentially other involved parties. For example, an Operational Area has received a request for twenty-five registered volunteers to work at a hospital. Because these volunteers are not available within the Operational Area, the OA contacts the Region requesting those volunteers. The Region locates available volunteers in another county. A decision is reached jointly by the hospital, the requesting OA, and the Region that air transportation will be provided by the National Guard; ground transportation to the hospital is provided by the OA; and lodging and feeding will be provided by the hospital. The State Management Support Team (MST) may be called upon to provide on-site logistics and management support.

SCENARIO #3—BIO-TERRORISM ATTACK ORIGINATING IN A RURAL SETTING

Sutter County was home to 79,000 people in 2000 and has a growing population (estimated to be 96,000 by 2010). Many newcomers live in Sutter County, but work in the Sacramento area. A single aerosol anthrax attack occurred in Yuba City, the county's largest city with a population of approximately 37,000. The first cases of

anthrax began to present to emergency rooms approximately 36 hours after the attack with rapid progression of symptoms and fatalities in untreated or inappropriately treated patients. The release occurred at the beginning of an unusually early influenza season and the early symptoms of inhalation anthrax are relatively non-specific. Physician uncertainty resulted in low thresholds for admission and administration of available antibiotics, producing severe strains on commercially available supplies of such medications as ciprofloxacin and doxycycline, and exacerbating the surge capacity problem. The public wants to know if it is safe to stay in the affected area. Residents of surrounding communities, including Sacramento, are concerned that they may have been infected despite public health guidance to the contrary. The “worried well” are putting an additional strain on Sutter and surrounding counties’ hospitals and clinics. Other areas of the state are concerned that they may be the next target of an attack.

Response: Based on the confirmed anthrax attack, the Homeland Security Alert Level for California has been raised to red. Sutter County has declared a local emergency and requested and received a gubernatorial proclamation. The SOC REOCs, and JEOC have been staffed to monitor the situation and provide resources as requested. The Medical/Health Branches of the REOCs are staffed and are working in coordination with RDMHCs. Sutter County MHOAC, in coordination with the OA EOC, has requested additional medical personnel.

FAQs

1. I’m a MHOAC and I have been contacted by the Region requesting Disaster Healthcare Volunteers personnel who are registered with our county. I’m concerned that our Operational Area may be a target for the next anthrax attack. Am I required to make my registered volunteers available for deployment?

Disaster Healthcare Volunteers, as registered volunteers of the county, fall under the auspices of the Master Mutual Aid Agreement (MMAA). Therefore, the county (as signatory to the MMAA) is not required to unreasonably deplete its resources in furnishing mutual aid. The county should; however, consider whether they can deploy a portion of their registered volunteers personnel without unreasonably depleting their resources. (Please note that as a unique resource, unlike other medical resources that can be easily counted, county operations staff may not know exactly how many registered volunteers are available for deployment. Thus it may be difficult to deploy a portion of registered volunteers. It is likely that more will be learned as the system gets used. Determining the number of available resources may require multiple notification calls to volunteers.)

2. I’m a private-sector employer of a Disaster Healthcare Volunteers registrant who has agreed to be deployed to an area that suffered an anthrax attack. I have agreed to let my employee use vacation time to respond.

- a) If my employee, in the course of volunteer duty, is exposed to anthrax and becomes ill, will I be held legally responsible?

Your employee has been deployed as a volunteer, as a Disaster Healthcare Volunteer registrant and for this purpose is not considered your employee.

- b) What recourse will my employee have for compensation?

Disaster Healthcare Volunteers who have been registered as Disaster Service Workers and are injured during duly authorized disaster service or training will submit a Workers Compensation Claim to the registering jurisdiction. Claims are coordinated through the State Office of Emergency Services and the State Compensation Insurance Fund.

SCENARIO #4 – SERIES OF OUT-OF-STATE HURRICANES

A series of strong hurricanes have again battered the Gulf Coast. One million people have been evacuated and 100,000 homes are seriously damaged. There have been more than 1,000 fatalities and 5,000 people have sustained injuries requiring professional treatment. Many hospitals have sustained severe damage and those that are open are overwhelmed. First responders have been requested from throughout the nation. Shelters throughout the region are filled to capacity. The impacted states have declared emergencies and have requested and received a Presidential Declaration of a Major Disaster.

Response: Based the magnitude of this event, California has begun to receive requests for resources through the Emergency Management Assistance Compact (EMAC). The SOC and REOCs are activated at minimum staffing levels. State agencies and Operational Areas have been notified that they may be contacted to provide resources for deployment out of state. The federal government has also activated the Region IX Regional Response Coordination Center and the Homeland Security Operations Center.

FAQS:

1. A hospital administrator in Mississippi calls his friend in California—a county Public Health Officer--asking her to send Disaster Healthcare Volunteers to his hospital. The Public Health Officer refuses. Disaster Healthcare Volunteers aren't employees of the Public Health Officer. Why can't the Mississippi hospital's request be passed on to the Disaster Healthcare Volunteers who can decide for themselves if they want to deploy?

To be eligible for deployment out-of-state, Disaster Healthcare Volunteers register as Disaster Service Workers. As such, the request for their assistance must come through official channels. Under EMAC or the ICCDC, the request would come from the State of Mississippi to the State of California. California would use its existing SEMS system (from the state to the regions to the OAs) to ask if the requested resource was available. Each operational area must determine, based on their current circumstance, whether they want to deploy these volunteers.

Attachment 1: Summary – Disaster Healthcare Volunteers in California

(As developed by stakeholders, 2005/06)

What is it?

Disaster Healthcare Volunteers System is the new name for the federally sponsored Hospital Preparedness Program (HPP) [formerly HRSA] for the **E**mergency **S**ystem for **A**dvanced **R**egistration of **V**olunteer **H**ealth **P**rofessionals. It is a national effort to develop a system that allows for the advanced credentialing of clinicians needed to augment a hospital or other medical facility to meet increased patient/victim care needs during a declared emergency. States are expected to develop their own system but follow national guidelines in order to allow for potential future integration. The national guidelines address standards and definitions, terminology, registry standards, resource (i.e. personnel) “typing” and “levels”, as well as some legal and regulatory issues, etc. California was instrumental in development of the guidelines.

Why is it necessary?

Following any large-scale disaster or mass casualty event, numerous healthcare volunteers arrive spontaneously offering their time and clinical expertise. If not pre-qualified generally these volunteers cannot be used. There is currently no statewide method by which to immediately check the suitability of these volunteers to fill these professional roles. A statewide registry of pre-screened and pre-qualified clinicians would allow volunteers to be put to work right away. *The idea behind the Disaster Healthcare Volunteers System is to register and credential the large stream of healthcare volunteers PRIOR to the need for such volunteers.*

History & Funding

States received funds for bioterrorism (BT) preparedness efforts starting in 2003 with a multi-year grant from the Health Resources and Services Administration (HRSA). One of the mandates of the HRSA Bioterrorism Grant is for each state to develop a system for pre-registering and pre-credentialing healthcare volunteers as one way to help address the need for increased personnel (surge personnel) in a disaster or terrorist event. When it was discovered how large a task this was, states were allowed to apply for additional funding; this process continues today.

California’s Disaster Healthcare Volunteers System

The Emergency Medical Services Authority (EMSA) is charged with the development of a state-based Disaster Healthcare Volunteers through an interagency agreement with the California Department of Health Services (CDHS) which is the recipient of the Hospital Preparedness Program (formerly HRSA BT) grant.

The Disaster Healthcare Volunteers mission is to be a “statewide” system, which will operate in coordination with County Operational Areas, to recruit, register, credential, track, identify, deploy, and maintain currently licensed volunteer healthcare professionals for response to emergencies, disasters and terrorist incidents in California & throughout the nation.”

Attachment 2: Summary – Mission and Scope of Disaster Healthcare Volunteers

(As developed by stakeholders, 2005/06)

MISSION

The Disaster Healthcare Volunteers System is a statewide system, which operates in coordination with County Operational Areas, to recruit, register, credential, track, identify, deploy, and maintain currently licensed volunteer healthcare professionals for response to emergencies, disasters and terrorist incidents in California and throughout the nation.

TYPES OF PROFESSIONALS ACCEPTED

Currently, the Disaster Healthcare Volunteers System is expanding to include over 35 medical professions. Retirees without active licenses will be considered for the Disaster Healthcare Volunteers System, but may not be utilized in their medical profession without an active license.

Summary Scope of the Disaster Healthcare Volunteers Program:

1. Disaster Healthcare Volunteers Program will be the leadership group for organizing healthcare volunteers used by government agencies in California.
2. Disaster Healthcare Volunteers Program is the system for the advanced registration of healthcare professionals and not for the management of spontaneous, convergent volunteers at time of disaster.
3. Disaster Healthcare Volunteers Program will develop and recommend all policies, procedures, and guidance for the State in coordination with federal guidelines.
4. Disaster Healthcare Volunteers Program will research statutory and regulatory impediments.
5. Disaster Healthcare Volunteers Program will identify and resolve liability and malpractice issues on behalf of the state of California
6. Disaster Healthcare Volunteers Program will recommend the proper state agency to sustain the System.
7. Disaster Healthcare Volunteers Program will identify potential stakeholders and promote best practices.
8. Disaster Healthcare Volunteers Program will develop state-level Memoranda of Understanding with stakeholders in order to facilitate the establishment of partnerships at the Operational Area level that will support the Disaster Healthcare Volunteers System.
9. Disaster Healthcare Volunteers Program will work with the Operational Areas to develop and implement a unified credentialing and identification system for Disaster Healthcare Volunteers System in California.
10. Disaster Healthcare Volunteers Program will design a system to recruit, screen, and register volunteers in coordination with the Operational Areas in the State.
11. Disaster Healthcare Volunteers Program will design a system to develop and maintain a coordinated volunteer registry system with the Operational Areas in the State and according to federal guidelines.
12. Disaster Healthcare Volunteers Program will determine “resource-typing” and “levels” of volunteers.

13. Disaster Healthcare Volunteers Program will work with local Operational Areas to develop standard operating procedures to deploy eligible volunteers to disasters in California or other states.
14. Disaster Healthcare Volunteers Program will provide guidance to integrate the Disaster Healthcare Volunteers Program with related volunteer and emergency response systems.
15. Disaster Healthcare Volunteers Program will not assume responsibility for the recruitment or management of healthcare volunteers for non-profit organizations such as the American Red Cross.

Summary Parameters: What the Disaster Healthcare Volunteers Program Will and Won't Do:

1. The Disaster Healthcare Volunteers Program Committee of the Whole will seek to identify, include and collaborate with all stakeholders as much as possible.
2. Building on lessons learned and input from other agencies and volunteer management groups, the Disaster Healthcare Volunteers Program will create statewide parameters for groups to build on at the local level. This will result in the ability for data interchange between the local, regional and state levels.
3. Disaster Healthcare Volunteers System is intended to be a statewide registry system charged with pre-screening and pre-credentialing healthcare volunteers.
4. Disaster Healthcare Volunteers System will be a mutual aid personnel registry system that will be accessed similar to other mutual aid resources, i.e. using California's Standardized Emergency Management System (SEMS) or the National Incident Management System (NIMS) if/when Disaster Healthcare Volunteers is integrated nationally.
5. Disaster Healthcare Volunteers System will not take over the recruiting for or the management of healthcare volunteers for non-profit organizations or manage convergent volunteers at time of disaster.
6. Disaster Healthcare Volunteers System will not replace the Medical Reserve Corps or any other volunteer group in the state. The Disaster Healthcare Volunteers System will be offered to the Medical Reserve Corps statewide to enhance their current systems. The National MRC Office in the Office of the Surgeon General is welcoming and collaborating with nation-wide state ESAR-VHP efforts. See the National Medical Reserve Corps website (www.medicalreservecorps.gov) for more information on their involvement in ESAR-VHP.
7. Disaster Healthcare Volunteers System will not replace or attempt to manage local emergency management systems or first responders.

Attachment 3: Overview of Emergency Response in California

Standardized Emergency Management System (SEMS)

The October 1991 Oakland-East Bay Hills Fire highlighted the need for a standardized approach to handling emergencies throughout the state. Senate Bill 1841 (Petris), Section 8607 of the California Government Code, required the development of a standardized emergency management system, known as SEMS.

SEMS is a uniform method for managing emergencies based on the Incident Command System (ICS). The ICS has been used by the fire services in responding to all types of incidents. SEMS standardizes the organizational structure and terminology used by every response agency in California.

SEMS is critical to California's emergency management organization. It is the system required by law for managing responses to multi-and multi-jurisdiction emergencies in California. SEMS facilitates coordination among all responding agencies and expedites the flow of resources and communication within all organizational levels.

SEMS is used to:

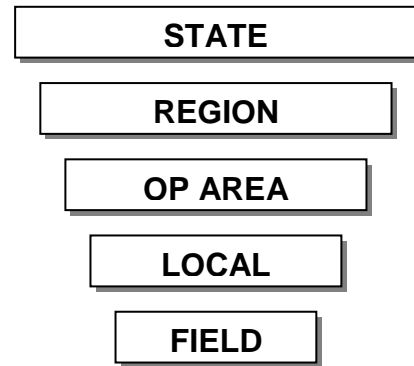
- Establish an organizational structure
- Facilitate decision-making
- Establish response operations
- Staff emergency operations centers
- Coordinate the emergency response
- Request assistance
- Communicate with other levels of government

Since December 1, 1996 SEMS has been required:

- To manage response to multi-agency and multi-jurisdictional emergencies in California.
- To be used by all state agencies.
- For local government agencies to be eligible for state reimbursement of eligible response related personnel costs resulting from a disaster.

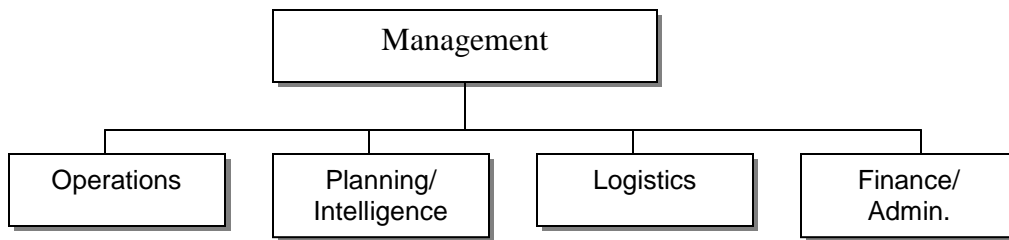
SEMS can be used by all levels of government, including special districts and by the private sector to organize their response structure.

SEMS incorporates the use of five organizational response levels. Requests for assistance move from the level closest to the disaster--field--up to the next higher governmental level until the request is filled. SEMS is the foundation by which resources from all levels of government can be deployed rapidly to support emergency operations.



	LEVELS	DESCRIPTION
1	STATE	Responsible for statewide resource allocation integrated with federal agencies.
2	REGIONAL	Manages and coordinates information and resources among Operational Areas.
	MUTUAL AID REGIONS	Because of its size and geography, the State has been divided into six mutual aid regions. They provide for the effective application and coordination of mutual aid and other emergency related activities.
	OES ADMINISTRATIVE REGIONS	OES provides administrative oversight over the mutual aid regions through three administrative regional offices. The OES regions maintain day-to-day contact with emergency services organizations at local, county, and private sector levels; manage and coordinate information and resources among OAs within mutual aid regions, and between OAs and state agencies.
3	OPERATIONAL AREA	Encompasses the county and all political subdivisions within the county. The OA serves as a focal point for all local emergency management information and the provision of mutual aid. It manages information, resources, and priorities among local governments within the OA. The OA also serves as the coordination and communication link between the local government level and the regional level.
4	LOCAL	Includes counties, cities, and special districts. Local governments manage and coordinate the overall emergency response and recovery activities within their jurisdiction.
5	FIELD	Many emergency response organizations have direct control of resources and response functions at the site of a disaster. These organizations command law enforcement, fire, public works, and other response personnel and resources to carry out tactical decisions and activities within their jurisdiction.

SEMS uses the same basic organizational response structure from the field through state levels.



- Management: Responsible for overall emergency policy and coordination through the joint efforts of governmental agencies and private organizations.
- Operations: Coordinates all jurisdictional operations in support of response to the emergency through implementation of the organizational level's action plan.
- Planning/Intelligence: Responsible for collecting, evaluating, and disseminating information; developing the organizational level's action plan in coordination with the other functions and maintaining documentation.
- Logistics: Responsible for providing facilities, services, personnel, equipment and materials to meet the needs of affected jurisdictions, and supports the EOC and incident operations.
- Finance/Administration: Responsible for all financial and administrative aspects of the incident.

MUTUAL AID SYSTEM: Neighbor Helping Neighbor

California's mutual aid system represents an integral part of SEMS by using the "neighbor helping neighbor" concept. Whenever a jurisdiction's own resources may be inadequate to cope with a given situation, local governments and the state provide mutual aid.

Mutual aid is provided between and among local jurisdictions and the state under the terms of the California Disaster and Civil Defense Master Mutual Aid Agreement (MMAA). California's counties, the state, and most cities signed this Agreement in the early 1950s.

Several formalized discipline-specific mutual aid systems function within the California Mutual Aid regional framework including, but not limited to, fire and rescue, law enforcement, coroner's services, and emergency management. Mutual aid may be obtained from local governments and the state for needed equipment and personnel. No jurisdiction, however, is required to unreasonably deplete its own resources in furnishing mutual aid. It is important to note that the local official receiving mutual aid remains in charge at the incident, including the direction of personnel and equipment provided through mutual aid.

Mutual aid also may be obtained from other states. The state is a signatory to the Emergency Management Assistance Compact (EMAC) whereby California can provide or receive assistance to or from other signatory states when requested. Inter-state mutual aid may be obtained through direct state-to-state contacts, pursuant to inter-state agreements and compacts, or may be coordinated through federal agencies.

The state is divided into six mutual aid regions for the most effective application, administration, and coordination of mutual aid and other emergency-related activities. Each mutual aid region consists of designated counties. OES has established three Administrative Regions to coordinate emergency management in the six mutual aid regions. The Coastal Region in Oakland coordinates activities in mutual aid region II; the Inland Region in Sacramento coordinates activities in mutual aid regions III, IV, and V and the Southern Region in Los Alamitos, coordinates activities in mutual aid regions I and VI.



STATE EMERGENCY OPERATIONS IN CALIFORNIA

State Operations Center

When activated, the responsibility of the SOC, located in Rancho Cordova, is to identify and designate scarce or potentially scarce resources and ensure for the proper prioritization and effective use of such resources during an emergency or disaster. The SOC coordinates with the federal government for the procurement of federal response assets and acts as the coordination point for interaction with the Governor's Office.

The following defines scarce resources for the purposes of disaster response:

- A resource that is in great demand for many diverse tasks but is in short supply.
- A resource that requires prioritization and assignment for statewide use.
- A scarce resource that is not available in great supply but needed or requested by multiple agencies for multiple uses in the mitigation of an emergency situation.

Regional Operations Centers

The REOCs are the primary state response coordination points for state and federal resource assistance to local government during a disaster. Operations Centers in the OES' three regional headquarters – Southern (Los Alamitos), Coastal (Oakland), and Inland (Rancho Cordova) – are staffed during an activation to provide this function for

their respective operational areas (OAs). When activated, the REOCs are staffed by regional OES and state agency personnel and volunteer organizations, supplemented when needed by staff from headquarters offices or other region/field offices.

The primary mission of the Regional Emergency Operation Centers (REOCs) is to ensure that the state provides for or coordinates the necessary resources to assist operational areas and local governments in the protection of life, property, and the environment during times of natural or man-made disaster.

Activation

Activation and deactivation of the State Operations Center and Regional Emergency Operations Center are accomplished at the direction of the Director or Chief Deputy Director of OES and the Regional Administrator respectively. Activation and deactivation may be accomplished in phases, allowing for buildup and demobilization of SOC and REOC staffing.

The SOC and REOC will be activated in response to any event which endangers public health and well being, private and public property, and which disrupts vital public services.

Department Operations Center (DOC) Coordination

SEMS defines a DOC as a facility used by a distinct discipline or agency where centralized management of that discipline's or agency's emergency response is performed. Departmental Operations Centers are structured similar to an Emergency Operations Center and must provide for the five primary SEMS functions. DOCs typically coordinate an agency's response actions statewide and therefore should coordinate with the SOC when activated. A DOC can coordinate response, perform action planning, and track resources across geographic and regional boundaries. Communication between state agency DOCs and the SOC is most effectively accomplished by sending an agency representative to the SOC; this ensures the SOC has current information on resource availability and mitigation strategies underway.

California Disaster Medical Management System

The California Disaster Medical Management System operates within the SEMS structure described above. The Disaster Medical Management System represents all disaster medical resources available within the state which may be applied in disaster response and recovery phases. Disaster Medical Management System organizations, at all levels of government and the private sector, operate from established Emergency Operations Centers (EOC). (The system for resource flow is depicted in the "Mutual Aid System Concept – General Flow of Requests and Resources" on page 39.)

Field (Private Sector)

Coordination with private sector medical resources and facilities may depend on pre-existing agreements and relationships. State-level private sector coordination for disaster medical response and recovery should occur through the Joint Emergency Operations Center (JEOC). In large-scale emergencies, EMSA and the California Department of Public Health co-locate their Department Operations Centers to form the JEOC in order to ensure coordinated and efficient emergency response and recovery activities. Private sector representatives with authority over regional operations should work directly with the RDMHC/RDMHS and the REOC. Local disaster medical resources in the private sector should coordinate through the OA EOC.

Local Government

Local governments (county, city, and special district) disaster medical management may be assisted by the efforts of the Local Health Officer (LHO) and the Local Emergency Medical Services Authority (LEMSA). Requests for disaster medical assistance beyond the resources of a jurisdiction would be sent to the OA EOC.

Emergency mutual aid response and recovery activities are generally conducted at the request and under the direction of the affected local government. In some cases there may be joint responses, requiring management by a Unified Command between state and local jurisdictions.

Operational Area

Resource requests for response and recovery originate at the lowest level of government and are progressively forwarded to the next level until filled. If an Operational Area (OA) is unable to provide the necessary requested assistance from within the OA, it may contact the RDMHC and RDMHS at the regional level to obtain mutual aid support. These requests are managed from the OA by the Medical/Health Operational Area Coordinator (MHOAC) and/or the Local Health Officer (LHO).

Region

Disaster medical mutual aid requests that arrive at the mutual aid regional level are managed by the Regional Disaster Medical Health Coordinator (RDMHC) and the Regional Disaster Medical Health Specialist (RDMHS) in coordination with the Regional Emergency Operations Center (REOC). If the regional mutual aid system does not have the resources needed, requests will be made for State level resources through EMSA at the JEOC.

State Government

The California Health and Human Services Agency's role in disaster medical response is to:

- Assist in providing direction for and approval of response policy decisions.
- Participate in the Joint Information Center (JIC) and the JEOC.

EMSA, a department of the CHHSA, coordinates medical resource requests based on the emergency needs of the other levels of government. EMSA works with the Regional Disaster Medical Health Coordinators (RDMHC) to manage medical mutual aid from the State among the mutual aid regions, and between the regional level and State level. EMSA also serves as a coordination and communication link with the federal medical and health resources. EMSA has the authority for coordinating state-level medical resource requests. This is done at the Joint Emergency Operations Center (JEOC). EMSA carries this out with the disaster health authority of the California Department of Public Health.

When disaster medical resource needs cannot be met within California, the State, through its State Operations Center (SOC), may request assistance from federal agencies having statutory authority to provide assistance in the absence of Presidential Declarations. The Governor may also request a Presidential Declaration of an Emergency or Major Disaster. A federal declaration allows access to federal disaster medical assets and for federal disaster recovery funding for disaster medical response activities. California may also request assistance directly from other states under the authority of the Emergency Management Assistance Compact (EMAC),

Attachment 4: Overview of Disaster Service Worker (DSW) Volunteer Program

(Condensed from OES Disaster Worker Volunteer Program Guidance, dated April 6, 2001 and available on line at <http://www.oes.ca.gov>, under Plans and Publications)

Program History

The Disaster Service Worker (DSW) Volunteer Program had its beginnings in World War II. The California War Council (predecessor to the current California Emergency Council) recognized that, because of the war effort, human resources in California were inadequate to address the problems of mass attack or natural disasters. Men and women who were willing to train for and be called upon to perform hazardous jobs were subject to possible safety risks. Recognizing that failure to compensate volunteers for injuries was not conducive to recruitment, legislation was passed that provided for benefits for injured volunteers. Volunteers had to register with accredited local war councils (now called local disaster councils) to be eligible for workers' compensation. State law now also provides limited immunity from liability to DSWs in the course of their duties.

Administrative Regulations

Administrative regulations governing the DSW program can be found in California Code of Regulations, Title 19, Sections 2570 – 2573.3 (approved October 26, 1999). The regulations are included in OES' DSW guidance document and at <http://www.oal.ca.gov> under Cal. Code of Regulations.

Accredited Disaster Councils

California law requires DSWs to register with an accredited city or county disaster council, the Governor's Office of Emergency Services, or an authorized state agency. Virtually all cities and every county in California have established disaster councils that are accredited by the California Emergency Council. Accreditation must be received before a jurisdiction can register DSWs.

Eligibility for accreditation requires a certified copy of an ordinance addressing the four items below be submitted to the Governor's Office of Emergency Services:

1. The ordinance must provide for the existence of a disaster council.
2. A chairperson or director of the disaster council must be specified.
3. The emergency management organization must be recognized.
4. Compliance with the Emergency Services Act must be stated.

Disaster Service Workers

Registered DSWs have chosen to volunteer their time to assist a disaster or emergency services agency in carrying out the responsibilities of that agency. The DSW must:

1. Be officially registered with the accredited Disaster Council, Governor's Office of Emergency Services, or an authorized state agency, and
2. Not receive any pay, monetary or otherwise, for the service being provided.

Disaster service, as defined for DSWs, is designed primarily to aid in disaster events, not day-to-day emergency response activities typically associated with, for example, law enforcement, fire services or emergency medical services.

Reimbursement of Expenses

Although DSWs volunteer their time without pay or other consideration, personal expenses incurred while performing disaster service may be reimbursed. Reimbursement policies are determined by the accredited disaster council or designated authority.

DSW Classifications

DSW volunteer classifications are approved by the California Emergency Council and contained in the DSW regulations. Currently approved classifications are:

<i>Animal Rescue, Care & Shelter</i>	<i>Laborer</i>
<i>Communications</i>	<i>Law Enforcement</i>
<i>Community Emergency Response</i>	<i>Logistics</i>
<i>Team Member</i>	<i>Medical & Environmental Health</i>
<i>Finance & Administrative Staff</i>	<i>Safety Assessment Inspector</i>
<i>Human Services</i>	<i>Search & Rescue</i>
<i>Fire</i>	<i>Utilities</i>

The regulations outline the following general duties for the "Medical & Environmental Health" classification:

"Staff casualty stations, establish and operate medical and public health field units; assist in hospitals, out-patient clinics, and other medical and public installations; maintain or restore environmental sanitation; assist in preserving the safety of food, milk, and water and preventing the spread of disease; perform laboratory analysis to detect the presence and minimize the effects of nuclear, chemical, biological, radiological or other hazardous agents."

Registration of DSWs

DSWs must be duly registered before participating in training or being activated in a disaster in order to receive the benefits and protections of the program. DSWs must complete a registration form which includes a “loyalty or affirmation oath.” This portion of the form must be signed by an official authorized to administer the oath. The registration form is kept on file with the registering jurisdiction.

Training

Registered DSWs are provided workers compensation insurance coverage and limited liability protection while participating in training activities that are pre-approved and documented by the supervising authority. All training should be supervised by the accredited disaster council or its designee. Documentation of pre-approved training will help substantiate any workers compensation insurance claims.

Activation

All registered DSWs should wait for official activation from their supervising authority before carrying out volunteer work. Official activation ensures the DSW will enjoy the benefits and protections of the DSW program. Activation of DSW volunteers should be documented by the authorizing agency or organization.

Workers Compensation

Registered DSWs may file a claim for injuries sustained while engaged in the following activities:

1. Performing disaster service, including travel to and from the incident site, when called to duty during an emergency or disaster, or while participating in a search and rescue operation.
2. Participating in an authorized and documented, planned disaster training activity or disaster exercise. Coverage for these activities does not include travel to and from the training site.

The supervising agency is responsible for briefing registered DSW volunteers on injury reporting procedures. The supervising agency is responsible for submitting required workers' compensation documentation to the Governor's Office of Emergency Services and the State Compensation Insurance Fund.

Immunity from Liability

The California Emergency Services Act (Government Code Section 8657) provides DSW volunteers with limited immunity from liability while providing disaster service as it is defined in Sections 2570.2 and 2572.2 of the Disaster Service Worker Volunteer Program Regulations (Cal. Code of Regulations., Title 19). Additionally, U.S. Public Law 105-19, Volunteer Protection Act of 1997, provides limited protection. Immunity

from liability protects the political subdivision or political entity and the DSW volunteer in any civil litigation resulting from acts of good faith made by the political subdivision or political entity, or the DSW volunteer, while providing disaster service (e.g., damage or destruction of property; injury or death of an individual). Immunity from liability does not apply in cases of willful intent, unreasonable acts beyond the scope of DSW training, or if a criminal act is committed.

Attachment 5: Acronyms

BT – Bioterrorism

CalMAT – California Medical Assistance Teams

CAMH – Comprehensive Accreditation Manual for Hospitals

CDC – Center for Disease Control

CDPH – California Department of Public Health

CERT – Community Emergency Response Teams

DISASTER HEALTHCARE VOLUNTEERS – Disaster Healthcare Volunteers

DMAT – Disaster Medical Assistance Teams

DOC – Department Operations Center

DSW – Disaster Service Worker

EMAC – Emergency Management Assistance Compact

EMSA – Emergency Medical Services Authority

EOC – Emergency Operations Center

ESA – Emergency Services Act

ESAR-VHP – California Emergency System for Advance Registration of Volunteer Health Professionals

HICS – Hospital Incident Command System

HRSA – Health Resources and Services Administration

ICDDC – Interstate Civil Defense and Disaster Compact

ICS – Incident Command System

JCAHO – Joint Commission on Accreditation of Healthcare Organizations

JEOC – Joint Emergency Operations Center

JIC – Joint Information Center

LEMSA – Local Emergency Medical Services Authority

LHO – Local Health Officer

MHOAC – Medical/Health Operational Area Coordinator

MMAA – Master Mutual Aid Agreement

MRC – Medical Reserve Corps

MST – Management Support Team

NIMS – National Incident Management System

OA – Operational Area
OES – Office of Emergency Services
RDMHC – Regional Disaster Medical Health Specialist
REOC – Regional Emergency Operation Center
RIMS – Response Information Management System
RSS – Receiving and Storage Site
SEMS – Standardized Emergency Management System
SNS – Strategic National Stockpile
SOC – State Operations Center
SUV – Spontaneous Unaffiliated Volunteer
WHO – World Health Organization