OCHCA EMERGENCY OPERATIONS PLAN (EOP): ANNEX

Orange County Health Care Agency (OCHCA)

Medical Surge Plan

Last Revised: January 2021

This page intentionally left blank.

Disclaimer Notice

This plan cannot anticipate all possible emergency events or situations and therefore should not be used without competent review, training, and exercising of the plan by qualified emergency management professionals to test, revise, and/or validate its contents. Conditions may develop in actual operations where standard methods will not suffice. Users of this plan should always use the foundation of the Incident Command System (ICS) and Standardized Emergency Management System (SEMS) combined with their experience and knowledge to overcome situations or conditions this manual cannot anticipate. Users of this plan assume all liability arising from such use.

The OCHCA Medical Surge Plan sits as an Annex to the OCHCA EOP.

Confidentiality Notice

The information gathered in this plan is classified as For Official Use Only (FOUO) and should be handled as sensitive information not to be disclosed. This document should be safeguarded, handled, transmitted, and stored in accordance with appropriate security directives. Reproduction of this document, in whole or in part, without prior approval from the OCHCA is prohibited.

This page intentionally left blank.

Record of Changes

Date of Change	Revision Made	Approved By
06/29/2015	Original Release	
01/04/2021	Activation Section Updated	

This page intentionally left blank.

Table of Contents

This page intentionally left blank.

Section 1: Plan Purpose, Scope, and Assumptions

Introduction

The OCHCA Medical Surge Plan is a support document to the OCHCA EOP.

This plan outlines the anticipated timeline for planning, response, and recovery to an event, with roles, responsibilities, and response actions. The Medical Surge Plan provides the foundation to mobilize medical/health resources in response to a medical surge event that exceeds the day-to-day capacity of the Orange County Public Health and Medical System. The Orange County Public Health and Medical System, including all of its partners and support agencies, collaborates under this plan to prepare for, respond to, and recover from any situation that will significantly challenge that system.

Purpose of the Plan

The OCHCA Medical Surge Plan provides procedural guidance to coordinate resources in response to any medical surge event. The underlying priority of this plan is to identify vulnerable populations, including those most at risk during an event, and ensure equal access to resources.

This plan:

- Identifies the authorities, responsibilities, functions, and operations of the Health Emergency Operations Center (HEOC) related to medical surge.
- Describe the available resources within Orange County relating to a medical surge response.
- Guides the coordination of mutual aid with the Medical Health Operational Area Coordinator (MHOAC), Orange County Health Care Agency, and medical facilities and agencies within the county.

Plan Priorities

The surge plan is intended to assist stakeholders in managing a disaster that creates a surge of patients beyond community capabilities:

- To augment existing health care services that have been overwhelmed with a surge of patients, including pediatrics, burn, trauma, and other specialty care.
- To assist overburdened Emergency Receiving Center (ERC) hospital infrastructure with facilitating solutions for the delivery of health care.
- To assist ERC hospitals in maximizing care for more critically ill patients with potentially survivable conditions.

- To facilitate establishment of surge alternative sites until the healthcare system recovers from a surge event.

These priorities may be modified when required by strategic and/or tactical issues faced in the response to an emergency.

Incident Command System (ICS)

The ICS is the standardized emergency management concept specifically designed to allow its user(s) to adopt an integrated organizational structure equal to the complexity and demands of single or multiple incidents without being hindered by jurisdictional boundaries. The organizational charts used by Orange County reflect these ICS principles.

Standardized Emergency Management System (SEMS)

The SEMS is required by California Government Code, Section 8607 (a) for managing responses to multi-agency and multi-jurisdiction emergencies in California. SEMS provides a multiple-level emergency response organization, which is intended to structure and facilitate the flow of emergency information and resources within and between the organizational levels. SEMS is based on the Incident Command System. SEMS is consistent with the federal National Incident Management System (NIMS) and the National Response Framework (NRF). This plan is consistent with both state and federal level management systems.

Public Health and Medical Emergency Operations Manual (EOM)

The California Public Health and Medical EOM is designed to strengthen coordination within the Public Health and Medical System during unusual events and emergencies that have public health or medical impact. The EOM describes basic roles and activities within the Public Health and Medical System and coordination with the emergency management structure at all levels of SEMS. The EOM supports California's ability to provide assistance to local governments or Operational Areas when disasters overwhelm available medical/health resources. This plan is consistent with the EOM.

The California Public Health and Medical EOM identifies the Public Health and Medical System as composed of the following functional entities:

SEMS LEVEL	ENTITY WITH PUBLIC HEALTH AND MEDICAL ROLE
State	State agencies with a public health and medical role, including but not limited to: • California Department of Public Health (CDPH), including Duty Officer Program and/or Joint Emergency Operations Center (JEOC) if activated • Emergency Medical Services Authority (EMSA), including Duty Officer Program and/or JEOC if activated • California Department of Health Care Services (DHCS) • California Governor's Office of Emergency Services (Cal OES) Executive Duty Officer and/or State Operations Center (SOC) if activated • California State Warning Center (CSWC) operated by Cal OES
Region	• Regional Disaster Medical and Health Coordination (RDMHC) Program • Cal OES Regional Duty Officer or Regional Emergency Operations Center (REOC) if activated
Operational Area	• MHOAC Program • Operational Area Emergency Operations Center (EOC) if activated
Local (City/County/ Special District)	• Local Health Department (LHD) • Local Environmental Health Department (EHD) • Local Emergency Medical Services Agency (LEMSA) • Local Emergency Management Agencies • Department/Agency Departmental Operations Centers (DOCs) • Local Government EOCs
Field	• Numerous organizations/entities including but not limited to hospitals, EMS providers, community clinics, skilled nursing facilities, laboratories, public water systems and dispatch centers

Plan Activation

This plan may be activated as a result of any medical surge event requiring coordination and/or resources from OCHCA.

This plan can be activated by:

- MHOAC or designee
- OCHCA EMS Duty Officer

Plan Assumptions

The following assumptions guide this plan:

- This plan is applicable to all ages that may be affected by a medical surge event.
- Orange County's medical surge response may need to embrace tourists as well as residents, not captured in standard census measures of the county's population.
- The initial medical response system in most incidents may be comprised almost exclusively of local and neighboring jurisdiction assets, and in some situations, outside assistance may be severely limited throughout the incident.
- The response to medical surge incidents is rarely isolated to the health and medical sectors. As such, the management of health and medical response efforts must integrate with other response disciplines through defined processes and plans.
- Community planning requires participation from public and private entities as well as healthcare service entities to establish surge solutions based on an all-hazards approach.
- Lifesaving response may be performed by local emergency responders and residents in the impacted area regardless of the efficiency of state and federal response systems.
- A local emergency may be declared by the Health Officer (HO).
- The jurisdiction may have limited availability for additional supplies to support a surge event and limited capability for treatment of patients (e.g., severe burn cases, severe trauma).
- Medical material and medical professionals may be scarce when the health care system is stressed.
- Some resources may be requested and available through the SEMS/NIMS mutual aid process to help support surge plan consistent with the California Public Health and Medical EOM.
- County officials may activate this plan as well as plan annexes based on the level of response required or anticipated within the healthcare community.
- Activation of healthcare provider surge plans does not require activation of the OCHCA medical surge plan.

Supporting Plans and Agreements

The following plans may be referenced during the prevention, preparedness, response, and recovery phases of an incident:

- OCHCA EOP and other department plans
- OCHCA Disease Outbreak Response Annex
- OCHCA COVID-19 and Flu Surge Annex
- OCHCA Medical Surge Plan Annex: COVID-19/Flu Surge
- California Public Health and Medical EOM, July 2011
- Orange County Operational Area EOP, August 2014
- Orange County Hospitals Mutual Aid Memorandum of Understanding (MOU)
- Relevant county Memoranda of Agreement (MOA)/Memoranda of Understanding

Section 2: Stakeholder Roles

The purpose of this section is to provide an overview of key identified roles within the response to a medical surge event in Orange County.

A. Federal

Federal agencies will follow the NIMS and integrate into SEMS during emergencies that affect California.

B. Region/State

- Each Mutual Aid Region will have an RDMHC Program that will provide support and coordination to affected Operational Areas during emergencies.
- CDPH and EMSA will maintain Duty Officer Programs.
- CDPH and EMSA will jointly operate the JEOC to coordinate CDPH, EMSA and California DHCS response and support the REOCs and SOC during emergencies.
- State agencies with regulatory or statutory responsibilities will continue to fulfill those responsibilities during emergencies, including the provision of essential services.
- State agencies will provide support to mitigate the effects of an emergency in accordance with the California Emergency Services Act (ESA) and the State Emergency Plan (SEP).

C. Orange County Operational Area (OA)

The Orange County Operational Area (OA) will be responsible for supporting the MHOAC Program and related reporting requirements, activation of the OA EOC as needed, and coordination of mutual aid.

D. Orange County Health Care Agency (OCHA)

OCHCA will be responsible for communication and coordination with healthcare system partners, patient distribution and tracking, and determining levels for unmet need of medical resources including ambulances, beds, and healthcare personnel.

E. Healthcare Entities

Healthcare entities will be responsible for communication and coordination with healthcare system partners, patient management, and determining levels of unmet need for medical resources. Identified healthcare entities within the Orange County Public Health and Medical System include:

- Disaster Resource Centers (DRC)

- ERC Hospitals
- Clinics
- Long Term Care (LTC)
- Dialysis
- Skilled Nursing Facilities (SNFs)

The DRCs, identified above, will be responsible for supporting pre-identified healthcare entities from a primary, well-resourced facility. This “hub and spoke” design allows for a more centralized, coordinated effort for managing surge incidents in coordination with the County. The primary responsibilities of the DRCs is to prepare, plan and mitigate with spoke hospitals who are responding to the surge situation, and maintain a robust network of communication and coordination that ensures smooth transfer of patients within the community, as needed, for delivery of care.

F. Other Stakeholders and Response Partners

Other identified stakeholders and response partners that may fill roles during a medical surge event include the following. Some of these partners also maintain seats at the OA EOC.

- Ambulance Providers
- Fire Departments
- Local Government
- EMS Providers
- Schools
- Orange County Transportation Agency (OCTA)
- American Red Cross
- Hospital Disaster Support Communications System (HDSCS)
- Medical Volunteers
- State and Federal Disaster Response Teams

Section 3: Planning and Mitigation

A. Medical Surge Definitions

The Center for Disease Control (CDC) Public Health Emergency Preparedness Capabilities define Medical Surge, Capability 10, as: the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the healthcare system to survive a hazard impact and maintain or rapidly recover operations that were compromised. The capability consists of the ability to perform the following functions:

- Function 1: Assess the nature and scope of the incident
- Function 2: Support activation of medical surge
- Function 3: Support jurisdictional medical surge operations
- Function 4: Support demobilization of medical surge operations

B. OCHCA Response Hazards

Based on the HCA Hazard Vulnerability Analysis, the top hazards most likely to lead to a medical surge in Orange County are:

1. Wildfire
2. Earthquake
3. Pandemic

Additional planning assumptions and anticipated event impact for each of these identified hazards can be found in Section 4.

C. Vulnerable Populations

OCHCA has taken into consideration specific vulnerable populations, or populations that may be at a higher risk during a medical surge event. Orange County's definition of disabilities and access and functional needs (as described in the OA EOP, dated 2014) is as follows: *Populations whose members may have additional needs before, during, and after an incident in functional areas, including but not limited to: maintaining independence and the ability to perform the activities of daily living, communication, transportation, supervision, and medical care. Individuals in need of additional response assistance may include those who have disabilities; who live in institutionalized settings; who are elderly; who are children; who are from diverse cultures; who have limited English proficiency or are non-English speaking; or who are transportation disadvantaged.*

For the purposes of this plan, OCHCA has identified the following vulnerable populations in a medical surge event:

- Children in schools
- Unaccompanied minors
- Frail and elderly
- Homebound population
- Persons with chronic disease, including dialysis
- Psychiatric patients
- Persons rendered homeless
- Geographically isolated citizens

D. Government Alternate Care Sites (ACS)

A Government-Authorized ACS is a location that is not currently providing healthcare services and will be converted to enable the provision of healthcare services to support, at a minimum, inpatient and/or outpatient care required after a declared catastrophic emergency. These specific sites are not part of the expansion of an existing healthcare facility (i.e., extensions of general acute care hospitals, clinics, or long-term care facilities), but rather are designated under the authority of the local government (CDPH Standards and Guidelines for Healthcare Surge During Emergencies).

The objective for establishing an ACS is to absorb the patient load until the local healthcare system (e.g., hospitals, clinics, and long-term care facilities) can manage the demands of patients. An ACS will be established only when it is anticipated that all other healthcare resources are exhausted.

- ACS may include mobile field hospitals, schools, shuttered hospitals, stadiums, arenas, churches, and other facilities not currently licensed to provide healthcare services that, under the authority of local government, are designated as an ACS to help absorb the patient load after all other healthcare resources are exhausted.
- ACS do not include sites that are established as part of an expansion of existing healthcare facilities, such as tents set up for patient care in the parking lot of a hospital, or sites set up for patient triage by Emergency Medical Services (EMS), such as field treatment sites.

If any of the ACS or shelters in a medical surge event are not capable of providing adequate medical care for any of the identified at risk populations, they will be transported to a healthcare facility.

E. Medical Surge Bed Categories

The Agency for Healthcare Research and Quality (AHRQ) released the following standardized hospital bed definitions:

- **Licensed Beds:** The maximum number of beds for which a hospital holds a license to operate. Many hospitals do not operate all of the beds for which they are licensed.
- **Physically Available Beds:** Beds that are licensed, physically set up, and available for use. These are beds regularly maintained in the hospital for the use of patients, which furnish accommodations with supporting services (such as food, laundry, and housekeeping). These beds may or may not be staffed but are physically available.
- **Staffed Beds:** Beds that are licensed and physically available for which staff is on hand to attend to the patient who occupies the bed. Staffed beds include those that are occupied and those that are vacant.
- **Unstaffed Beds:** Beds that are licensed and physically available and have no current staff on hand to attend to a patient who would occupy the bed.
- **Occupied Beds:** Beds that are licensed, physically available, staffed, and occupied by a patient.
- **Vacant/Available Beds:** Beds that are vacant and to which patients can be transported immediately. These must include supporting space, equipment, medical material, ancillary and support services, and staff to operate under normal circumstances. These beds are licensed, physically available, and have staff on hand to attend to the patient who occupies the bed.

Beds also can be categorized according to the type of patient they serve:

- **Adult Intensive Care Unit (ICU):** Can support critically ill/injured patients, including ventilator support.
- **Medical/Surgical:** Also thought of as "Ward" beds.
- **Burn or Burn ICU:** Either approved by the American Burn Association or self-designated. (These beds should not be included in other ICU bed counts.)
- **Pediatric ICU:** The same as adult ICU, but for patients 17 years and younger.
- **Pediatrics:** Ward medical/surgical beds for patients 17 and younger.
- **Psychiatric:** Ward beds on a closed/locked psychiatric unit or ward beds where a patient will be attended by a sitter.
- **Negative Pressure/Isolation:** Beds provided with negative airflow, providing respiratory isolation. Note: This value may represent available beds included in the counts of other types.
- **Operating Rooms:** An operating room that is equipped and staffed and could be made available for patient care in a short period.

For purposes of estimating institutional surge capability in dealing with patient disposition during a large mass casualty incident, the following bed availability estimates also may be reported:

- **24-hour Beds Available:** An informed estimate of how many staffed, vacant beds for each category above could be made available above the current number within 24 hours. This would include created institutional surge beds as well as beds made available by discharging/transferring patients.
- **72-hour Beds Available:** An informed estimate of how many staffed, vacant beds for each category above could be made available above the current number within 72 hours. This would include created institutional surge beds as well as beds made available by discharging/transferring patients.

F. OCHCA Emergency Receiving Center (ERC) Capabilities

For information on type and quantity of beds within Orange County Hospitals, refer to Appendix C: Designated ERCs Capability List.

G. Transportation Resources

OCHCA has identified several options for transportation resources during a medical surge event:

- Routine Emergency Medical Response
- OCTA buses
- Non-acute medical transportation (i.e. gurney/wheelchair vans)

Section 4: Planning Scenarios

A. Wildfire

Orange County has a significant wildfire history. As is the case with all wildfires, the greatest risk lies in the interface between wild land and urban interface. The greatest concern regarding medical surge and wildfire in Orange County is the resulting need to evacuate a healthcare facility.

Assumptions

Pertinent assumptions related to wildfire in Orange County include:

- A wildfire that would require evacuation of a healthcare facility may present with little warning and a short time for preparation.
- The duration of a wildfire event in Orange County requiring medical surge response is unlikely to be long.
- Wildfire may have impact on the respiratory health of people throughout the county, including areas not immediately threatened by the fire itself.
- Wildfire is likely to produce a significant number of “worried well” until the period of containment.

Impact

As with other scenarios, the impact of wildfire depends on many factors. In general, the most likely impact involves:

- The need for a short-term evacuation of patients from a large healthcare facility or from long term care facilities of various sizes.
- An increased need for short-term treatment of exacerbation of respiratory illnesses of both inpatients and outpatients.

B. Earthquake

Orange County has a number of seismic faults, and earthquakes are a significant threat identified through hazard vulnerability analyses. A moderate to severe seismic incident could result in extensive property damage (especially to older buildings), significant numbers of fatalities and injuries, damage to water and sewer systems, disruptions in communications, broken gas mains resulting in fires, and disruption of transportation routes.

Assumptions

Several assumptions can be made about earthquakes and any impact they may have on the healthcare infrastructure. These include:

- In sudden impact situations, like earthquake, the earliest that *outside* assistance can reach an impacted area is approximately 24 hours (but potentially as long as 72 hours). This suggests that any area directly impacted by earthquake must be prepared to sustain its own healthcare services for at least 24 hours before being able to count on regional, state, or federal support.
- The principal demand for healthcare following a sudden impact event like an earthquake is for conditions that often could be managed on an ambulatory basis. The injuries and conditions for which there will be increased demand include the following:
    - Soft-tissue injuries or lacerations
    - Fractures
    - Eye conditions
    - Respiratory conditions (including exacerbation of pre-existing conditions)
    - Acute medical illnesses
    - Acute exacerbation of chronic conditions and diseases (e.g., CHF, COPD)
    - Psychological/behavioral health emergencies
- The peak time for demand in surge capacity following such an event is 24 hours.
- Emergency departments of local hospitals will be the primary access points for people seeking the kind of care required in this type of event.
- Should evacuation of any healthcare facility be required following an earthquake, it will probably need to occur in the first 24 hours following the incident.
- Earthquakes can have a generally disruptive impact on a community. This impact includes the potential for significant disruption of services, including transportation, communication, power, shelter, and sanitation.

Impact

- The impact that an earthquake can have on the healthcare delivery system is dependent on the extent of the disruption generally occurring in a location as well as specific consequence experienced by healthcare facilities.
- To properly assess the impact of an earthquake on the healthcare delivery system, the following factors must be taken into consideration:
    - Damage to any healthcare facility. The extent of damage to existing facilities will be a key issue in determining the proper response to an earthquake. The following issues must be determined: Is there any damage

to the facility that will require partial or total evacuation? Are there earthquake-related injuries to patients or staff at any healthcare facility? Has the earthquake impacted access to the facility?

- Damage to the communications infrastructure. Again, normal modes of communication may well be impacted by an earthquake. The ability of the HO to respond appropriately to a surge situation is dependent on the two-way exchange of important information. Thus, it must be determined immediately the extent to which normal communications are affected and backup communication systems must be put into operation.
- Damage to transportation channels. A significant risk associated with earthquake is a disruption in transportation. Staff may not be able to reach their usual place of employment. Pre-hospital care may not be able to deliver patients to acute care facilities. Patients may not be able to reach hospitals. Evacuation plans may be disrupted. And the usual vendors of materials and supplies may not be able to reach the facilities to maintain needed supplies.

C. Pandemic

Pandemic influenza presents significantly different challenges than the other risks discussed in this plan. In contrast to the other scenarios, pandemic does not have a single or identifiable point of impact. Also, the impact of the pandemic is likely global, and Orange County will be one of many communities trying to meet the medical surge associated with this crisis. National and State plans for dealing with pandemic influenza have been developed and will be operative. This plan attempts to look at the issues that are specific to planning for medical surge resulting from a pandemic in the county. Additional planning and response considerations for pandemic and other outbreaks are captured in the OCHCA Disease Outbreak Response Annex.

Assumptions

Pertinent assumptions about Pandemic Influenza and medical surge in Orange County include:

- It is probable that Orange County will have significant warning of the impending arrival of pandemic influenza in the County. While it is not considered probable that the pandemic will emerge from California, it is anticipated that pandemic influenza will spread to Orange County during the course of an outbreak.

- The emergence of pandemic influenza will be tracked closely by international organizations (e.g., World Health Organization [WHO]), federal government agencies such as the CDC, and the State of California. These agencies and the national press will be alerting local authorities and the local populace about the risks of influenza.
- Due to the fact that influenza is a serious respiratory illness, it is assumed that there will be a need for ventilators and medical supplies and capacities to support large numbers of seriously ill patients.
- It is assumed that large numbers of health care providers and other staff will be impacted by the illness—either ill themselves or caring for seriously ill family members.
- In contrast to other risks, there is little if any risk to the physical infrastructure. Buildings will remain intact and the transportation and communication channels should remain unaffected. Thus, the greatest impact on the system will come from staffing needs, supplies, and the need for space presented by large numbers of ill patients and need to cohort care.
- It is assumed that a pandemic influenza situation will be such that home care is encouraged and, unless absolutely necessary; many patients will be discouraged from seeking care at a healthcare facility so as to retard the spread of the illness in the community.
- Pandemic influenza may require the use of isolation and quarantine as tools to protect citizens from exposure to the virus.
- Due to the global nature of a pandemic, the ability to rely on outside assistance and resources will be limited as other communities will be similarly affected.

Impact

The impact of pandemic influenza will be enormous on all aspects of the healthcare delivery system:

- Staffing at all levels of healthcare delivery - outpatient clinics, long term care facilities, and hospitals will be significantly impacted. Many employees, of all professional levels, will be unwilling or unable to come to work as scheduled. The usual sources of augmenting the workforce will be similarly impacted and will not be able to fully meet the needs.
- Cohorting of patients (i.e., grouping patients and caregivers known to be infected with influenza) in order to contain the infection will have to be implemented at most, if not all, healthcare facilities. This will require significant demand on space within an existing facility.

- Impact of pandemic influenza is likely to be so overwhelming, in terms of patients ill and decreased resources of staff that broad measures will need to be taken to decrease workload across healthcare facilities. This may include the discharge of patients early, cancellation of scheduled elective or non-emergency surgeries.
- Increased reliance on home care nursing, altered standard of care for hospitalized patients (e.g., decrease in required paperwork and other charting), and other measures.

Section 5: Medical Surge Incident Life Cycle

Introduction

The OCHCA Medical Surge Plan separates the life cycle of a medical surge event into the following phases: the initial response (estimated from 0-72 hours), and the ongoing response (for events lasting over 72 hours). This 72-hour mark is the estimated time for state and/or federal resource support to OCHCA response operations.

A. Initial Response (0-72 hours)

During the initial response to an event, OCHCA should conduct an Impact Analysis to:

- Evaluate number of new and existing patients in the healthcare system
- Assess the status of existing infrastructure, including:
    - Ambulance providers
    - ERC
    - Existing resources
- Determine level of unmet need for medical resources and patients
- Determine the capacity of known ERC hospitals, and their ability to receive the expected number of patients
- Determine the situational status of the health and medical system

Specific OCHCA response actions include:

1. Activate the Orange County Health Care Agency Operations Center (HAOC) and/or EMS DOC
    a. Notify internal and external stakeholders and response partners of activation and provide relevant contact information
    b. Request Hospital Available Beds for Emergencies and Disasters (HAvBED) Poll and Service Level Update from ERC hospital partners using ReddiNet
        i. HAvBED information will provide general information regarding status of facility, but will not be considered a wholly accurate view of the system status
        ii. HAvBED survey will be sent out through ReddiNet
    c. Request a Situational Status Report from ERC hospitals within 2 hours
        i. Identify which ERC hospitals are impacted and how
        ii. Coordinate EMS traffic based on ERC hospital impact
    d. Activate a Mass Casualty Incident (MCI) event in ReddiNet as needed

e. Activate the Ambulance Resource Coordinator
    i. Use of MED-9
    ii. ReddiNet
    iii. Monitor Ambulance Resources
f. Evaluate ERC hospital resource levels and facilitate resource requests as received
g. Evaluate other healthcare system entities
    i. Capture dialysis medical surge
h. Evaluate schools and the potential need to close, as appropriate
i. Assess vulnerable populations related to the event
j. Assess need for alternate care sites

2. Activate this medical surge plan
    a. Activation may take place in anticipation of a medical surge within the community
    b. A decision to activate may take place based on the requests received from community healthcare providers
    c. Based on incident parameters such as incident severity, location(s), and type of surge, OCHCA may elect to activate the DRC(s) in advance of activating this plan
    d. The EMS Duty Officer will be the primary contact for members of the Health Care Coalition of Orange County (HCCOC)
        i. HCCOC members are not required to contact the EMS Duty Officer when surge plans are activated at their organization (that is an organizational decision where county input and notification is not necessary)
        ii. If the County is being notified of an incident, this process should be followed:
            1. HCCOC members will notify the EMS Duty Officer of support needed
            2. HCCOC members will need to submit a Situation Status (SitStat) report
    e. Reasons for HCCOC members to contact the EMS Duty Officer may include:
        i. Surge is related directly to COVID-19

ii. Resources necessary for response cannot be obtained from within the organization or from other HCCOC members, such as the Disaster Resource Center (DRC)

B. Ongoing Response (72+ hours)

1. Continue to support ongoing incident response operations.
2. Continually update and reassess impact analysis.
3. Conduct operational communications and information sharing with internal and external stakeholders and response partners.
4. Incorporate federal support as needed.

C. Demobilization

The HAOC Emergency Response Manager and/or the EMS DOC Director has the authority to demobilize medical surge response operations. The decision to demobilize should be based on the need for incident coordination and resources. Resources should be demobilized as soon as they are no longer needed for emergency response. Staff may be directed to return to day-to-day operations as their roles are no longer needed. Response operations may be scaled down as objectives are met.

D. Recovery

Once response operations have ended, all entities within the Public Health and Medical System will need to conduct recovery operations. Some specific OCHCA recovery actions include:

- Return OCHCA facilities to safe, normal, or “new” normal operating conditions
- Assess resource status, including:
    - Tracking and inventory
    - Resupply and restocking
    - Returning loaned or shared resources
- Recuperate costs and/or seek reimbursement if applicable
- Determine the needs for critical incident stress debriefing
- Develop an After-Action Report/Improvement Plan (AAR/IP)

E. Long-Term Recovery

After the dust has settled, there are long term recovery actions that may be needed to prepare OCHCA for potential future events. Consider the following:

- Plan revision
- Training and exercise
- Equipment procurement
- Addressing damaged or destroyed infrastructure within the Orange County Public Health and Medical System

Appendix A: Contact Information

HEALTH CARE AGENCY
Disaster Response
Call Down Directory

This list is utilized for staffing of the OCHCA HAOC and the OA EOC. It reflects the principal individuals of each office, program, or division. *Due to security reasons, call down lists are not included in this plan.*

Begin the notification process by calling the first name in each section. Advance to the next name only if unable to contact the previous name. The first person contacted in each section becomes the responsible party in ensuring that the remaining individuals in their section are notified.

Each program is responsible for developing a method for calling the various individuals, what the tiers of notifications are, and who must be notified in each service area.

Updating of the information within this document is the responsibility of each service area. The changes to this document are coordinated through OCHCA/HCCOC. All corrections being submitted must have been approved by the respective Executive Team Member.

FOR OFFICIAL USE ONLY (FOUO)

REGION I DISASTER MEDICAL HEALTH COORDINATION PROGRAM

CONTACT LIST

Updated: January 2021

OES MUTUAL AID REGION I – MEDICAL AND HEALTH COORDINATION		
Region I RDMHC **(24 Hour POC)** **LACo EMS: 866-940-4401** **or 562-941-1037** *Request EMS Administrator on Duty or RDMHC Staff*	**RDMHC1: Cathy Chidester** Main: 562-378-1500 Office Direct: 562-378-1604 Cell: 562-321-0126 cchidester@dhs.lacounty.gov RDMHC Alternate: **Kay Fruhwirth** Office Direct: 562-378-1596 Cell: 562-666-5502 kfruhwirth@dhs.lacounty.gov	
RDMHS-1 CONTACT INFORMATION **LA EMS Agency** **10100 Pioneer Blvd., Ste # 200** **Santa Fe Springs, CA 90670**	RDMHS1: **Mike Noone** Office: 562-378-1510 Work Cell: 213-587-3034 Personal Cell: 310-435-3666 mnoone@dhs.lacounty.gov RDMHS1 Alternate #1: **Jeremy Fahey** Work Cell: 213-298-5748 Personal Cell: 626-533-0474 jfahey@dhs.lacounty.gov RDMHS1 Alternate: **Jim Eads** Cell: 805-559-4044 DSF: 562-378-2445 jeads@dhs.lacounty.gov	
REGION I MEDICAL AMBULANCE TRANSPORTATION COORDINATORS	Ken Liebman AMR Ambulance Office: 626-633-4612 Cell: 661-810-7635 Dispatch: 877-808-2100 Ken.liebman@amr-ems.com	Bill Weston CARE Ambulance Office: 714- 288-3823 Mobile: 714-713-5708 Dispatch:714-288-3888 bill.weston@falck.com

MUTUAL AID – MEDICAL AND HEALTH COORDINATION PARTNERS	
Region VI RDMHC Program 951-358-7122 Office County of Riverside EMD 550 E. Alessandro Blvd Riverside, CA 92508	**Region VI RDMHS: Ralph Serrano** Office: 951-358-7122 Cell: 951-237-9079 Main: 951-358-7100 24-hr.: 951-830-8117 raserrano@rivco.org **RDMHS Alternate: MHOAC Duty Officer** rdmhs6@rivco.org (emergency/activation email) 951-830-8041 primary 951-712-3342 secondary
California Dept. of Public Health	**CDPH Duty Officer**: 916-328-3605 Fax: 916-445-5460 cdphdutyofficer@cdph.ca.gov
EMS Authority	**EMSA Duty Officer: 916-431-0475** EMSAdutyofficer@emsa.ca.gov
MHCC– EMSA/CDPH DOC	MAIN: 916-650-6400 FAX: 916-341-3987
CA OES State Warning Center 24 hour/day	916-845-8911
CA OES Southern Regional Office 11200 Lexington Dr, Los Alamitos Ca.	**Acting Regional Administrator** Jim Acosta Office: (562) 795-2939 Cell: (714) 458-1271 Jim.Acosta@caloes.ca.gov Southern REOC Office: 562-795-2900 Fax: 562-795-2877
Southern REOC Medical Health Branch Desk (Only active when REOC staffed)	M&H Branch Desk 562-795-2977 REOC Main 562-795-2900 MedicalandHealthBranchCoor-SouthernREOC@oes.ca.gov

OES MUTUAL AID REGION 1 MHOAC & PHER PROGRAMS	
MHOAC Program **Los Angeles Co.** 10100 Pioneer Blvd., Ste # 200 Santa Fe Springs, CA 90670 **24 HOUR MAC: 562-941-1037, Request AOD** laemsadutyofficer@dhs.lacounty.gov	***Cathy Chidester, RDMHC/MHOAC/EMS Administrator*** Email: cchidester@dhs.lacounty.gov **John Opalski,** **MHOAC Designee/Disaster Preparedness Coordinator** Office: 562-378-1503 Cell: 323-376-1790 Fax: 562-944-6931 Email: jopalski@dhs.lacounty.gov DHS/EMS DOC Main: 562-378-1550 Email: laemsadutyofficer@dhs.lacounty.gov **Department of Mental Health Duty Officer** 800-854-7771
Emergency Preparedness and Response Division (EPRD) **Los Angeles Co.** 600 Commonwealth Ave. Ste #700 Los Angeles, CA 90005 **Public Health 24 Hour Duty Officer: 213-989-7140** phemergdesk@ph.lacounty.gov	**Stella Fogleman, EPRD Director** Email: sfogleman@ph.lacounty.gov **Pablo Valadez, MPA, CEM** **Acting Director, Emergency Operations Program** **Los Angeles County Department of Public Health** Office: 213-351-7823 Email: pvaladez@ph.lacounty.gov **Public Health 24 Hour Duty Officer: 213-989-7140** Email: phemergdesk@ph.lacounty.gov **Health Officer: Muntu Davis, MD MPH** LHO Tele (213) 288-8769 Email: mudavis@ph.lacounty.gov

OES MUTUAL AID REGION 1 MHOAC & PHER PROGRAMS	
	MHOAC/EMS 24-Hour Duty Officer Phone: 714-415-8980 Email: emsdutyofficer@ochca.com
MHOAC & PHEP **Orange Co.** 405 West Fifth Street, Suite 301A Santa Ana, CA 92701 **MHOAC/EMS 24 Hour Duty Officer** 714-415-8980 emsdutyofficer@ochca.com	**Tammi McConnell, MHOAC/EMS Director** Office: 714-834-2791 Cell: 714-720-1514 Email: tmcconnell@ochca.com **Jesse Allured, Asst EMS Director** Office: 714-834-5032 Cell: 714-917-9387 Email: jallured@ochca.com **Health Officer: Clayton Chau** Phone: 714-834-2830
MHOAC & PHER **San Luis Obispo** San Luis Obispo EMS Agency 2180 Johnson Ave San Luis Obispo, CA 93401 **24 HOUR: EMS Duty Officer** Phone: 805-380-3411 publichealth.mhoac@co.slo.ca.us	***Vince Pierucci, MHOAC/****EMS Division Director* **Vince Pierucci** Email: vpierucci@co.slo.ca.us Office: 805-788-2512 Cell: 805-904-3555 **Denise Yi** Email: dyi@co.slo.ca.us Office: 805-781-2067 Cell: 805-266-0987 SLO PH DOC: 805-781-5531 SLO OAEOC: 805-781-1268 **Penny Borenstein, County Health Officer** Office: 805-781-5519 Cell: 805-602-6268 Email: pborenstein@co.slo.ca.us

OES MUTUAL AID REGION 1 MHOAC & PHER PROGRAMS	
MHOAC & PHER **Santa Barbara** 300 North San Antonio Road Santa Barbara, CA 93110-1316 **24 HOUR:SB Sheriff Dispatch** **805-692-5744** Request EMS Duty Chief MHOAC.SantaBarbara@sbcphd.org	***Nicholas Clay MHOAC/EMS Administrator*** Nicholas.clay@sbcphd.org 805-319-0099 (cell) 805-681-5394 (office) **Jan Koegler, PHEP Manager** **Office: 805-681-4913** **Cell: 805-331-8360/448-8053** **Email: Jan.Koegler@sbcphd.org** **EMS Office Fax : 805-681-5142** PH DOC 805-696-1106 EOC M&H: 805-696-1154 Sat:8816-224-13824 OR 8816-224-13872 Health Officer: Dr. Henning Ansorg, M.D. LHO Tele: 805-681-5105 henning.ansorg@sbcphd.org
MHOAC & PHER **Ventura** 2220 East Gonzales Road, Ste. 130 Oxnard, CA 93036 **24 HOUR:** **805-981-5339** **EMS Duty Officer or VCFD** **805-388-4279, Ask for EMS Agency Duty Officer or** **EMSagencyDutyofficer@ventura.org**	**Steve Carroll, *MHOAC/EMS Administrator*** Office: 805-981-5305 Cell: 805-207-9325 Email: steve.carroll@ventura.org **Chris Rosa, Back-Up MHOAC/Deputy EMS Administrator** Office: 805-981-5308 Cell: 805-617-5365 Email: chris.rosa@ventura.org EMS Office Fax: 805-981-5300 M&H EOC: 805-654-2551 Health Officer: Dr. Robert Levin LHO Tele: 805-981-5101 Email: robert.levin@ventura.org

REGION I CITY PHER PROGRAMS	
City of Long Beach 3205 N Lakewood Blvd Long Beach, CA 90806 **24 HOUR**: (562) 965-4934 HE-PHEM@longbeach.gov	**Sandy Wedgeworth, PH Emergency Management Director** Office (562) 570-4376 Cell: (949) 307-0384 Sandy.Wedgeworth@longbeach.gov **Gabriela (Gaby) Hurtado, MCM Coordinator** Office: 562-570-4115 Cell: 805-416-4372 Gabriela.hurtado@longbeach.gov **Anissa Davis, MD, MPH, City Health Officer** Phone: (562) 570-4047 Cell: 562-688-5866 Anissa.davis@longbeach.gov **24 HOUR Duty Officer**: (562) 965-4934 HE-PHEM@longbeach.gov
City of Pasadena 1848 N. Fair Oaks Ave. Pasadena, CA 91103	**Adrienne Kim, PHEP Coordinator** Office: (626) 744-6151 Cell: (626) 695-6068 Email: akung@cityofpasadena.net Fax: (626) 744-6113 **Ying-Ying Goh, M.D., M.S.H.S., Health Officer** Office: 626-744-6103 Cell: (310) 801-9284 Email: ygoh@cityofpasadena.net **24 HOUR**: (626) 744-6043 PPHDdutyofficer@cityofpasadena.net

ADDITIONAL PARTNERS: EM EOCS	
M&H DOCs/EOCs	LACo EOC Duty Officer 323-459-3779 LACo EOC 323-980-2260 LA City EOC Duty Officer 213-200-6414 LA City EOC 213-484-4831 LACo EMS DOC: 562-347-1550 or 1545 Riverside County: 951-358-7100/ RDMHS-VI Duty officer: 951-830-8041 San Bernardino: Inyo County: 760-878-0383 Mono County: 760-932-7549 Imperial County: 760-791-7521 Clark County: 702-229-3810 Kern County: 661-321-3000 OAEOC: 805-861-3200 REGION II Duty Officer: 925-260-8226 REGION III: SJCo EMS Office:209-468-6818; DO Pager:209-234-5032 24 Hour:209-236-8339 REGION IV: 209-468-0252 REGION V: 661-363-3862; Pager: 661-307-1154 24 Hour: 661-868-4055 REDDINET Tech Support: 800.440.7808
Dialysis Centers ESRD–Network 18. 6255 Sunset Boulevard, Suite 2211 Los Angeles, CA 90028	Eileen Boyte Southern California Renal Disease Council, Inc MAIN: 888—268-1539 FAX: 888-280-8669 EBOYTE@nw18.esrd.net www.esrdnetwork18.org
CHA Hospital Preparedness Coordinator	Mary Massey 714-315-0572
SITREP AND/OR RESOURCE REQUEST SUBMISSION	
Send simultaneously to M&H BRANCH/EMSA & CDPH Duty Officers via email: medicalandhealthbranchcoor-southernreoc@oes.ca.gov cdphdutyofficer@cdph.ca.gov emsadutyofficer@emsa.ca.gov emsa.soc@emsa.ca.gov	

This page intentionally left blank.

Appendix B: Legal Authority

- California Government Code, section 8550 et seq.
    - This section of statutes, the California Emergency Services Act, is the source of broad HO authority in responding to a declared State emergency. This section allows the HO to:
        - Carry out orders of the governor pursuant to this section, including, if necessary, commandeering of personal or real property.
        - Seek mutual aid in the case of a local declared emergency
- California Health and Safety Code sections 1797.204, 1797.220, 1798.2, 1798.6(c), and 1798.170
    - 1797.204. (EMS System Responsibilities) The local EMS agency shall plan, implement, and evaluate an emergency medical services system, in accordance with the provisions of this part, consisting of an organized pattern of readiness and response services based on public and private agreements and operational procedures. (Added by Stats. 1980, Ch. 1260.)
    - 1797.220. (Local Medical Control Policies, Procedures) The local EMS agency, using state minimum standards, shall establish policies and procedures approved by the medical director of the local EMS agency to assure medical control of the EMS system. The policies and procedures approved by the medical director may require basic life support emergency medical transportation services to meet any medical control requirements including dispatch, patient destination policies, patient care guidelines, and quality assurance requirements. (Amended by Stats. 1988, Ch. 1390, Sec. 5.)
    - 1798.2. (Base Hospital Direction of Prehospital Personnel) The base hospital shall implement the policies and procedures established by the local EMS agency and approved by the medical director of the local EMS agency for medical direction of prehospital emergency medical care personnel. (Amended by Stats. 1988, Ch. 1390, Sec. 7.)
    - 1798.6. (Medical Control in an Emergency)
        - (c) Notwithstanding subdivision (a), authority for the management of the scene of an emergency shall be vested in the appropriate public safety agency having primary investigative authority. The scene of an emergency shall be managed in a manner designed to minimize the risk of death or health impairment to the patient and to other persons who may be exposed to the risks as a result of the emergency condition, and priority shall be placed upon the interests of those persons exposed to the more serious and immediate risks to life and health. Public safety officials shall consult emergency

medical services personnel or other authoritative health care professionals at the scene in the determination of relevant risks. (Added by Stats. 1983, Ch. 206, Sec. 2.)

- 1798.170. (Development of Triage & Transfer Protocols) A local EMS agency may develop triage and transfer protocols to facilitate prompt delivery of patients to appropriate designated facilities within and without its area of jurisdiction. Considerations in designating a facility shall include, but shall not be limited to, the following:
  - (a) A general acute care hospital's consistent ability to provide on-call physicians and services for all emergency patients regardless of ability to pay.
  - (b) The sufficiency of hospital procedures to ensure that all patients who come to the emergency department are examined and evaluated to determine whether an emergency condition exists.
  - (c) The hospital's compliance with local EMS protocols, guidelines, and transfer agreement requirements. (Amended by Stats. 1987, Ch. 1240, Sec. 16.)

- California Health and Safety Code, Section 101000 et. seq:
  - This section of the California Statutes outlines the powers and duties of the local HO. These provisions state that:
    - Each county Board of Supervisors shall appoint a health officer
    - That the HO may, upon consent by ordinance or resolution, orders, regulations, and statutes related to public health within incorporated cities.
    - The HO shall enforce all rules, orders, and statutes related to public health in unincorporated areas.
    - The HO may, in response to particular threats or if granted specific authority by the Board of Supervisors, declare a local emergency. Such a declaration allows for other political subdivisions to provide mutual aid and may confer some immunity on persons providing care.
- California Health and Safety Code, Section 120100, et seq.
  - This section of Statutes provides the HO with broad powers as relates to the spread or threat of spread of communicable disease. Among the authorities granted are:
    - Action to “take measures as may be necessary” to prevent spread of disease,
    - Authority to require isolation or quarantine,
    - Authority to take actions to enforce rules or orders from the Department of Health Services

    - Authority to require healthcare facilities to disclose inventories of critical supplies, equipment, drugs, vaccines, and other products.
    - Authority to carry out directives of the Department of Health Services to provide places for isolation or quarantine.
- California Code of Regulations, Title 22, Section 70809 (b)
    - Patient Accommodations
        - (a) No hospital shall have more patients or beds set up for overnight use by patients than the approved licensed bed capacity except in the case of justified emergency when temporary permission may be granted by the Director or his designee. Beds not used for overnight stay such as labor room beds, recovery beds, beds used for admission screening or beds used for diagnostic purposes in X-ray or laboratory departments are not included in the approved licensed bed capacity.
        - (b) Five percent of a facility's total licensed bed capacity may be used for a classification other than that designated on the license. Upon application to the Director and a showing that seasonal fluctuations justify, the Director may grant the use of an additional five percent of the beds for other than the classified use.
        - (c) Patients shall not be housed in areas which have not been approved by the Department for patient housing and which have not been granted a fire clearance by the State Fire Marshal, except as provided in paragraph (a) above.
        - (d) The number of licensed beds shown on a license shall not exceed the number of beds for which the facility meets applicable construction and operational requirements.
- California Penal Code, Section 409.5.
    - This statute allows the HO to order evacuation for the protection of public health and safety.

Appendix C: Pediatric Surge Considerations

OCEMS requires Orange County ERC hospitals to have equipment and capability to handle pediatric patients, including staff trained in Pediatric Advanced Life Support (PALS).

In Orange County, ERC hospitals could increase pediatric bed capacity under the California Code of Regulations, Title 22, Section 70809, which states “Five percent of a facility's total licensed bed capacity may be used for a classification other than that designated on the license.”

- Hospitals are allowed by CDPH to use 5% of their total licensed beds (known as Flex Beds) to accommodate patients of all types without special permissions, provided Title 22 standards of care are met for competency, equipment and staffing for the patients involved is met.
- If the number of patients cannot be managed using 5% flex, altered standards of care may be required, generating the need for additional permissions, interruptions in normal hospital operations (e.g. elective surgeries cancelled) and approval from CDPH Licensing and Accreditation prior to implementation. Hospitals who do not adhere to these strict requirements may be subject to fines and penalties.

Appendix D: Emergency Receiving Centers (ERC) Capability List

	Designated Emergency Receiving Centers Capability List																	
Facility Name ***(2020 updated)***	**ERC**	**Base**	**PTRC**	**CCERC**	**CCS PICU**	**C VRC**	**SNRC**	**Pediatrics**	**NICU**	**Perinatal**	**ICU**	**Coronary Care**	**Burn**	**Unspecified General Acute Care**	**Acute Psych**	**Rehab Or SNF**	**Chemical Recovery**	**Licensed Capacity**
COUNTY TOTALS								*218*	*324*	*635*	*580*	*101*	*15*	*3339*	*387*	*227*	*71*	*5967*
Anaheim Regional Medical Center	**X**					**X (2 CV's)**			11	27	22	10		153				223
Chapman Global Medical Center	**X**										12			35	12	27	28	114
Children's Hospital at Mission					**Tertiary**				22		8			24				54
Children's Hospital of Orange County	**X**		**II**	**X**	**Tertiary**			158	104		54				18			334
South Coast Global Medical Center	**X**							9		12	9			79	23	46		178
Foothill Regional Medical Center	**X**										15			98		42	22	177
Fountain Valley Regional Hospital & Medical Center	**X**				**Ped Comm**	**X**	**X**	13	23	38	36			183				293
Garden Grove Hospital and Medical Center	**X**								12	35	12			108				167
Hoag Memorial Hospital Presbyterian	**X**	**X**			**Standard**	**X**	**X (2 NIR's)**		21	70	19	12		273		18	21	434

Designated Emergency Receiving Centers Capability List																		
Facility Name *(2020 updated)*	**ERC**	**Base**	**PTRC**	**CCERC**	**CCS PICU**	**C VRC**	**SNRC**	**Pediatrics**	**NICU**	**Perinatal**	**ICU**	**Coronary Care**	**Burn**	**Unspecified General Acute Care**	**Acute Psych**	**Rehab Or SNF**	**Chemical Recovery**	**Licensed Capacity**
Hoag Hospital Irvine	X					X					12			72				84
Huntington Beach Hospital	X	X									6	6		70	49			131
Kaiser Foundation Hospital, Anaheim	X				Ped Comm			12	20	34	40			156				262
Kaiser Foundation Hospital Irvine	X								15	37	20			144				216
La Palma Intercommunity Hospital	X									11	4	4		105	16			140
Los Alamitos Medical Center	X					X	X			12	9	8		133				162
Mission Hospital Regional Medical Center	X	X	II	X		X	X			43	36	27		217		22		345
Mission Hospital Laguna Beach	X									19	10			75	36			178
Orange Coast Memorial Medical Center	X					X			12	25	21			164				222
Placentia Linda Hospital	X										4	4		106				114

Designated Emergency Receiving Centers Capability List

Facility Name *(2020 updated)*	ERC	Base	PTRC	CCERC	CCS PICU	C VRC	SNRC	Pediatrics	NICU	Perinatal	ICU	Coronary Care	Burn	Unspecified General Acute Care	Acute Psych	Rehab Or SNF	Chemical Recovery	Licensed Capacity
Saddleback Memorial Medical Center, LH	X					X (3 CV's)	X (3 NIR's)		19	39	22			168				248
St. Joseph Hospital, Orange	X				Gen Comm	X	X			89	32	20		379	37	6 (renal tran)		463
St. Jude Medical Center	X	X			Standard	X	X		14	33	51			192		30		320
University of California, Irvine Medical Center	X	X	I		Gen Comm	X	X		30	22	60		8	236	48	14		418
West Anaheim Medical Center	X					X					10	10		147	30	22		219
Anaheim Global Medical Center	X					X			5	37	22			35	90			189
Orange County Global Medical Center	Yes	X	II		Special	X	X	26	16	52	42		7	111	28			282

Appendix E: Acronyms and Definitions

Acronym	Term
AAR	After Action Report
AHRQ	Agency for Healthcare Research and Quality
ARC	American Red Cross
Cal OES	California Governor's Office of Emergency Services
CDC	Center for Disease Control
CDPH	California Department of Public Health
CHF	Congestive Heart Failure
COPD	Chronic Obstructive Pulmonary Disease
CSWC	California State Warning Center
DHCS	(California) Department of Health Care Services
DOC	Department Operations Center
DRC	Disaster Resource Center
EHD	(Local) Environmental Health Department
EMS	Emergency Medical Services
EMSA	California Emergency Medical Services Agency
EOC	Emergency Operations Center
EOM	(California Public Health and Medical) Emergency Operations Manual
EOP	Emergency Operations Plan
ERC	Emergency Receiving Center
ESA	(California) Emergency Services Act
FOUO	For Official Use Only
HCA	(Orange County) Health Care Agency
HAvBED	The Hospital Available Beds for Emergencies and Disasters (HAvBED) System is a real-time electronic system that tracks the numbers of beds available at hospitals in California. HAvBED information will be utilized in a medical surge event to assist in determining availability of suitable beds for patients.
HAOC	Health Care Agency Operations Center
HCCOC	The Health Care Coalition of Orange County

Acronym	Term
HERM	Health Emergency Response Manager
HO	Health Officer
ICS	Incident Command System
ICU	Intensive Care Unit
IP	Improvement Plan
JEOC	Joint Emergency Operations Center
LEMSA	Local Emergency Medical Services Agency
LHD	Local Health Department
MACC	Multi-Agency Coordination Center
MCI	Mass Casualty Incident
MHCC	Medical Health Coordinating Center
MHOAC	Medical Health Operational Area Coordinator
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
NIMS	National Incident Management System
NRF	National Response Framework
OA	Operational Area
OCEMS	Orange County Emergency Medical Services
OCHCA	Orange County Health Care Agency
OCTA	Orange County Transportation Authority
Public Health and Medical System	An inter-connected system of public and private entities whose activities and responsibilities involve public health; environmental health; and medical services, including emergency medical services. The participants in the Public Health and Medical System include those involved in the delivery of health care in addition to those involved in the protection and promotion of public health and environmental health. (EOM)
RDMHC/S	Regional Disaster Medical Health Coordinator/Specialist or Coordination Program
REOC	Regional Emergency Operations Center
SEMS	Standard Emergency Management System
SEP	California State Emergency Plan

Acronym	Term
SOC	State Operations Center
WHO	World Health Organization