Los Angeles Operational Area

Mass Care Guidance

For Emergency Planners

December 15, 2010

Los Angeles County Operational Area Mass Care Guidance for Emergency Planners
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I. INTRODUCTION AND PURPOSE

The purpose of the Los Angeles Operational Area[1] (LAOA) Mass Care Guidance for Emergency Planners is to help planners establish strategies, plans, and procedures for providing mass care support to people affected during and after a catastrophic incident/event. The guidance is intended to help departments and agencies engage in coordinated planning that will allow for more seamless multi-jurisdictional response to incidents and thus provide better service to the citizens of the LAOA, who are impacted by disaster(s). Similarly, this guidance is intended to make a multi-county response to regional incidents more feasible. The accompanying Mass Care Annex Template will provide a working tool for city and county agencies to develop their mass care annexes to their emergency operations plans (EOP).

The LAOA is an area of over 4,800 square miles with a population of more than 10 million people and 88 individual cities. A major portion of the Los Angeles County is unincorporated and contains approximately 8% of the population.

This guidance is structured to be consistent with the Standardized Emergency Management System (SEMS), the National Incident Management System (NIMS),[2] and all relevant county, State, and Federal laws. All resources will be requested consistent with SEMS, NIMS, and mutual aid plans or applicable memorandums of understanding (MOU). The guidance is intended to assist in mass care planning; however, it does not generate legal requirements or duties. Nothing in this document alters or impedes the ability of local, State, Federal, and/or tribal nation government agencies to carry out their specific authorities or perform their responsibilities under all applicable laws, executive orders, and directives. This guidance does not alter the existing authorities of individual municipal or county agencies, and does not convey new authorities upon any local, State, or Federal official.

Through the planning process for mass care functions (e.g., sheltering, feeding, bulk distribution, basic first aid, and disaster welfare information), certain areas that support and coordinate with mass care were identified. Within this document, planners will find four annexes[3] that expound on key topics. They are: Household Pet Sheltering, Medical and Health, Non-Traditional Sheltering, and Transportation Management. In certain places, notations are made within the guidance that will point to these annexes; however, these directions are not

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[1] The Los Angeles County Operational Area is an intermediate level of the State Emergency Services Organization, consisting of Los Angeles County and all political subdivisions within the county. Los Angeles County Code Chapter 2.68.050.K Definitions.

[2] SEMS, NIMS, and other terms are defined in Appendix 8: Definitions.

[3] Annexes add specific information and direction to the guidance. They clearly describe the policies, processes, roles, and responsibilities that are important before, during, and after any emergency. While the guidance provides relevant broad, overarching information, the annexes focus on specific responsibilities, tasks, and operational actions that pertain to the performance of a particular function. Paraphrased from Comprehensive Preparedness Guide (CPG) 101. FEMA. March 2009.

comprehensive. If more information is sought on one of the topics for which there is an annex, please consult the annex for a more detailed description and understanding of the concept. Additionally, there are many appendices[4] that have been included to combine forms, processes, or information that would be important for mass care functions.

A. Applicability

This guidance is intended for government and non-government agencies in the LAOA that respond to disaster incidents/events. It is intended to be used by departments and agencies of the government of Los Angeles County, the 88 municipal governments that lie within the county, and the non-profit agencies that respond to disasters.

B. Scope

The scope of this guidance is the mass care mission. It is all-hazards in nature, meaning that this guidance applies to any hazard that may generate a demand for mass care services. As defined by the National Response Framework (NRF), mass care includes sheltering, feeding operations, emergency first aid, bulk distribution of emergency items, and collecting and providing information on victims to family members. At the Federal level, the mass care function is a part of the Emergency Support Function (ESF) #6 responsibilities.[5]

C. Methodology

The LAOA Mass Care Guidance was developed by the Los Angeles Critical Incident Planning and Training Alliance ("Alliance"), which was funded by the Regional Catastrophic Planning Grant Program (RCPGP). The Alliance is a multi-jurisdictional and multi-disciplinary partnership consisting of law enforcement, fire, emergency management, recreation and parks, and health agencies within LAOA. The purpose of the Alliance is to facilitate strategic regional catastrophic disaster planning among all disciplines and jurisdictions within the LAOA.

The Alliance recognized the importance of mass care in disaster response efforts. As a result, the Alliance's Mass Care Task Force spearheaded the development of this guidance. The contributing agencies to the guidance and annexes include the following:

1. American Red Cross (Red Cross)
2. California Department of Transportation (DOT)
3. California Highway Patrol (CHP)

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[4] Appendices provide relevant information not already addressed in the guidance. Typically, this includes lists of terms and definitions, forms used, or other necessary information. Paraphrased from Comprehensive Preparedness Guide (CPG) 101. FEMA. March 2009.

[5] Mass Care is defined in the National Response Framework ESF #6 Annex. DHS. January 2008. http://www.fema.gov/pdf/emergency/nrf/nrf-esf-06.pdf.

4. Hospital Association of Southern California (HASC)
5. Long Beach Department of Health and Human Services
6. Los Angeles Animal Services
7. Los Angeles County Department of Animal Care and Control (LACDACC)
8. Los Angeles County Department of Children and Family Services (LACDCFS)
9. Los Angeles County Department of Mental Health (DMH)
10. Los Angeles County Department of Public Health (DPH)
11. Los Angeles County Department of Public Social Services (DPSS)
12. Los Angeles County Emergency Medical Services (EMS) Agency
13. Los Angeles County Fire Department
14. Los Angeles County Metropolitan Transportation Authority (MTA)
15. Los Angeles County Office of Education
16. Los Angeles County Office of Emergency Management (OEM)
17. Los Angeles County Sheriff's Department
18. Los Angeles Department of Transportation
19. Los Angeles Emergency Management Department (EMD)
20. Los Angeles Fire Department (LAFD)
21. Los Angeles Housing Department
22. Los Angeles Police Department
23. Los Angeles Port Police
24. Pasadena Public Health Department
25. Riverside County Office of Emergency Services
26. San Bernardino Police Department
27. Simi Valley Office of Emergency Services

The California State Emergency Plan and Shelter Appendix of the Los Angeles County Multi-Hazard Functional Plan states that the DPSS is the lead agency for ESF #6, the mass care of people affected by disaster. The roles and responsibilities of DPSS in this function include:

1. Administer the disaster food stamp program.
2. Assist disaster victims in connecting with agencies that provide a variety of other benefits and services (e.g., Federal Emergency

Management Agency [FEMA] Individuals and Households Program, mental health services, and family reunification).[6]

3. Lead and coordinate the ESF #6 functions of mass care, emergency assistance, housing, and human services with State and Federal agencies, local governments, and nongovernmental organizations.
4. Coordinate agencies and organizations that provide disaster response support in the following areas:
   a) Sheltering
   b) Feeding
   c) Bulk distribution
   d) Emergency first aid
   e) Disaster welfare information
5. Use ESF #6 to support ESF #8, Public Health and Medical Services, in addressing the access and functional needs of those in the population who are defined as having special needs by the NRF[7]. Access and functional needs may be present in relation to a disaster before, during, or after an incident in one or more areas, including, but not limited to:
   a) Maintaining independence
   b) Communication
   c) Transportation
   d) Supervision
   e) Medical care
6. Use ESF #6 to coordinate assistance without regard to race, ethnicity, religion, nationality, gender, age, disability, English proficiency, or economic status of those who are seeking assistance as a result of a disaster.

[6] *FEMA Individual and Households Program—Fiscal Year 2009 Report to Congress.* Accessed online on June 9, 2010, at http://www.fema.gov/library/viewRecord.do?id=3684.

[7] FEMA ESF #6 and ESF #8 are defined in the National Response Framework. DHS. January 2008. http://www.fema.gov/emergency/nrf/index.htm.

II. SITUATION AND ASSUMPTIONS

A. Situation

1. This document is a product of ongoing catastrophic planning efforts and was developed in the context of a catastrophic event. As defined in the National Response Framework (NRF), a catastrophic incident is "any natural or man-made incident, including terrorism that results in extraordinary levels of mass casualties, damage, or disruption severely affecting the population, infrastructure, environment, economy, national morale, and/or government functions."[8] Planning for, responding to, recovering from, and mitigating potential damages of a catastrophic disaster:
   a) Requires a fundamental shift in traditional methods
   b) Requires cultural changes
   c) Requires an honest assessment of policies and laws that hinder a coordinated and expedient response and recovery
   d) Promotes cross-walking various risks and hazards to verify key concepts
   e) Must include survivors in all phases of the disaster management
   f) Must include the private sector in all phases of disaster management
2. Mass care facilities will be needed in the LAOA for both the direct and indirect effects of an emergency or disaster.
3. The operational area faces a wide range of natural and human-induced threats and hazards, which could result in a massive natural disaster or man-made incident.
4. A hazard analysis does not indicate a reasonably likely threat scenario that would result in displacement of the entire population of the operational area, or even a majority of its residents.[9] In a catastrophic incident, however, it is expected that large, heavily populated areas or segments of an area may need to be successfully evacuated or relocated and thus will create demand for significant mass care services.
5. In light of recent international events (Haiti Earthquake in 2010, Chile Earthquake in 2010, and earthquakes in China in 2008 and

[8] *National Response Framework.* (2008, January). Department of Homeland Security Federal Emergency Management Agency. http://www.fema.gov/pdf/emergency/nrf/nrf-core.pdf.

[9] *Threat Summary and Assessments for the County Of Los Angeles.* (1998, February 17). Los Angeles County Operational Area Emergency Response Plan (ERP), Part One, Section Seven. http://lacoa.org/PDF/OA%20ERP.pdf.

2010) and ongoing catastrophic planning efforts in southern California and other parts of the country, the importance of planning for a large-scale disaster is paramount to successful planning efforts. To add perspective the impacts of the Northridge Earthquake in 1994 compared to recent catastrophic consequence estimates are displayed in the following chart.[10]

Northridge Earthquake, 1994	Catastrophic Event Estimates
▪ 25,000-30,000 people homeless (from destruction itself or fear of indoor areas) ▪ Approximately 25,000 uninhabitable dwellings ▪ 5-week mass care operation ▪ 15,000+ Red Cross volunteers ▪ 37,700 families received assistance ▪ 1,730,228 meals served ▪ 22,000 people sheltered (up to 7,000 simultaneously) ▪ 39,700 people received mental health counseling ▪ 16,000 disaster welfare inquiries received ▪ 128 mobile feeding units served meals ▪ 47 fixed feeding sites	▪ Over 986,000 uninhabitable dwellings ▪ 542,000 people will require shelter (from destruction itself or fear of indoor areas) ▪ 2,500,000 people will require feeding support ▪ 38% of the population will suffer some level of distress

B. Critical Components to Success

1. Multi-agency and jurisdictional coordination, planning, and discussion include agreements and MOUs for mutual aid that should be negotiated and established well in advance of potential situations.

2. Effective and robust preparedness and training for Disaster Service Worker (DSW) means that DSWs should have a personal "go-kit" (e.g., extra clothing, shoes, toiletries, medications, and other items needed for extended duty) and prepared supplies at home to support their families. DSWs should also consider keeping their personal vehicles at no less than half a tank of fuel at all times.

3. Planning and collaboration with agencies that are responsible for the care and shelter of service animals and household pets is critical.

4. Mass care agencies and organizations can more effectively support the well-being of their household pet-owning populations by coordinating and communicating with household pet sheltering agencies in emergencies and disasters.

5. Non-governmental organization (NGO) involvement in all areas of mass care planning is also critical.

[10] Catastrophic event estimates are drawn from the Southern California Catastrophic Earthquake Response Plan data, the Great Shakeout Scenario and the American Red Cross Southern California Earthquake Concept of Operations.

6. DPSS, the operational area Care and Shelter Branch coordinator, should involve NGOs and community-based organizations (CBO) in their mass care response operations. These organizations often have long histories of support disaster response and many of their volunteers are pre-event trained and experienced in response.
7. An effective planning effort must be conducted pre-disaster in order to establish sufficient capability to support household pets following a catastrophic incident.
8. To supplement and increase the number of mass care-trained personnel available, the city and/or county will work to train its staff to support mass care operations.
9. Professional, CBO, NGO, and other volunteer organizations that have historically responded to disaster situations may be asked to respond for future incidents/events.
10. Local government will need to coordinate affiliated and spontaneous volunteers with mass care organizations requiring resources.
11. The plan will include preparation to utilize open-air environments for mass care needs when necessary.[11] Multi-agency attention will be required in open spaces to maintain crowd control and support any affected populations who have congregated.
12. Government resources will not be adequate to meet the needs of all the victims in a catastrophic incident/event. NGOs play a significant role in supporting government response to catastrophic events. This can be seen in the structure of the National Response Framework. All NGOs, including CBOs and FBOs, will work through Emergency Network Los Angeles, Inc. (ENLA) as the coordinating organization for representation at the county emergency operations center (CEOC). Local NGOs should coordinate with the appropriate Voluntary Organizations Active in Disaster (VOAD) in coordination with the local EOC. Elements of coordination with NGOs are interspersed throughout the document to highlight areas where this should be considered.

C. Assumptions

1. Although the majority of people will seek shelter with family and friends or in hotels/motels, the remainder will seek shelter in designated congregate care facilities.[12] Case studies show that between 5% and 10% of the affected population will seek shelter.

[11] See Annex C: Non-Traditional Sheltering for additional resources.

[12] Congregate care facilities as defined by the FEMA Mass Care Coordination Unit are general population shelters, respite centers, reception centers, heating/cooling centers, and medical support shelters, as well as unconventional sheltering facilities, such as berthing ships, base camps, and temporary construction.

2. Public education is required for effective mass care plan execution.
3. Although the city and/or county have overall responsibility for their jurisdictions, the Red Cross will serve, where possible, as the primary support agency responsible for operating traditional emergency shelters.
4. Mutual aid assistance from unaffected jurisdictions and from State- and Federal-level emergency agencies will be available.
5. Availability of external resources from unaffected jurisdictions, the State, and the Federal Government will depend on transportation infrastructure, and access to affected areas and areas providing mass care.
6. The CEOC will be activated for an incident that is severe enough to create a large mass care need. Consistent with the LAOA Emergency Response Plan (ERP), the CEOC will manage and coordinate between local governments to support operational area response.
7. The duration and scope of local, State, and Federal involvement will be scalable to the situation's severity and the assistance required by the affected population.
8. Approximately 30% of those seeking shelter will have access and functional needs. This population might include:[13]
    a) People who are seniors
    b) People who are medically fragile or dependent
    c) People who have limited English proficiency or are non-English speaking
    d) People who have limited mobility or hearing or vision impairment
    e) Unaccompanied minors
9. A percentage of those seeking shelter will need transportation provided for them.
10. Service animals are not household pets and must remain with the person to whom they are assigned.
11. Duplication of effort and benefits will be reduced as possible.

[13] The U.S. Census Bureau estimates there were more than 36 million people in California in 2008. In August 2008, the Governor's Office of Emergency Services, Office for Access and Functional Needs estimated that by 2010, there would be more than 11 million people with access and functional needs. http://www.google.com/url?sa=t&source=web&cd=3&ved=0CCMQFjAC&url=http%3A%2F%2Fwww.access2readiness.org%2Fatf%2Fcf%2F%257BC14CBB0E-FAC4-403F-96ED-286A512B4DDA%257D%2FGuidance%2520on%2520Integration%2520Final%25208-08.doc&ei=IP4STOP4GYH_8AadkK2dDA&usg=AFQjCNG9CCqRD21o7fyJil9kmXoy3Nm_FA

12. In a major disaster, the mass care function will require an influx of resources from outside the area. Receipt and distribution of these resources and supplies is contingent on the severity of the event, impact to transportation infrastructure, and the ability to move resources and supplies in and throughout the operational area.
13. In accordance with SEMS and NIMS, additional resources and assistance from outside the local jurisdiction shall be available to city governments through the operational area, and available to the operational area through the region.
14. Resources will be extremely limited following a disaster in which there has been widespread damage. Local jurisdictions will develop their own local resource base and identify vendors within the operational area to support mass care efforts.
15. Many people in the affected population who suffered some structural damage to their home following a major disaster will choose to remain on their property (i.e., camp out) versus going to a public disaster shelter. These people will still have needs and expectations for disaster assistance from local government.
16. In addition to opening disaster shelters, cities will open local assistance centers as a place for local affected population to go for disaster assistance (see Section X: Transition to Recovery).
17. All NGOs, including CBOs, will work through Emergency Network Los Angeles, Inc. (ENLA) as the coordinating organization for representation at the CEOC.
18. If a disaster occurs while school is in session and requires the school to become a temporary shelter-in-place site for its own student population, an alternative shelter site will be identified for the general population, or two separate areas within the school campus will be utilized, if space is available.
19. Essential public and private services will continue, as possible, during mass care operations.
20. People in the affected population will seek to bring their household pets into shelters (see Annex A: Household Pet Sheltering).
21. Federal ESF #6 support will coordinate with local and State response operations, as soon as possible, following a presidential emergency or disaster declaration and after a request for assistance has been made.[14]

[14] Under the NRF, ESF #6 Annex, ESF #6 coordinates the delivery of Federal mass care, emergency assistance, housing, and human services when State, local, and tribal response and recovery needs exceed their capabilities.

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III. ROLES

This is a list of the roles that the Los Angeles Operational Area (LAOA) agencies and departments might be anticipated to assume for mass care operations during an incident.

A. Responsibilities for Support of Mass Care Operations

1. City and/or county – The extent of city and/or county responsibilities in mass care is widespread. They include:

   a) Designating a city and/or county mass care coordinator. This person shall coordinate mass care planning and operations for the city and/or county. The assigned person may be the designated emergency manager for that jurisdiction, or a member of the Care and Shelter Branch staff, and should be well-versed in mass care.

   b) Developing a statement of understanding with the American Red Cross (Red Cross), which is the lead support agency in the LAOA on mass care. The statement of understanding helps to solidify the mutual working partnership between the city and/or county and the Red Cross. Contact the Red Cross for a copy of the standard agreement.

   c) Identifying and surveying potential shelter facilities. The city and/or county will work with the Red Cross, school districts, recreation and parks departments, and other government agencies to identify and survey potential shelter facilities. Additional attention should be given to identifying non-traditional shelter sites (see Annex C: Non-Traditional Sheltering for additional resources) and compliance of sites with the Americans with Disabilities Act (ADA).

   d) Coordinating multi-agency (e.g., fire, law enforcement, and schools) cooperation for support of mass care operations.

   e) Ensuring that agreements for facilities are in place and maintained on a routine basis. Terms of use and agency responsibilities are greatly clarified when agreements are in place prior to an event. The city and/or county will work with the Red Cross to develop applicable agreements.

   f) Training staff to operate disaster shelters. The city and/or county will work with the Red Cross to provide mass care partnership training to city and/or county employees who will assist in staffing disaster shelters as Disaster Service Workers (DSWs). Attention that is given to training government employees with the Red Cross's mass care partnership training will greatly increase staffing resources to open and operate shelters.

g) Providing mass care services. The responsibility for mass care belongs to local government(s). Planning for an event of catastrophic proportion will further highlight the need for local government and the Red Cross to understand their respective agencies' capabilities and capacities pre-event.

h) Working cooperatively with the Departments of Mental Health and Public Health to cross-train mental health and health services workers for emergency shelter operations. Due to the specific requirements of these positions, these DSWs should be appropriately credentialed and that information should be on-file. This information should be obtained by the Personnel Branch in the Logistics Section at the Emergency Operations Center (EOC). Some jurisdictions in the country have developed Web sites, on which individuals in these functions can enter their licensure and credential information pre-event.

2. Red Cross – The extent of Red Cross responsibilities in mass care is widespread. They include:

a) Preparedness

(1) Provide no-cost shelter training to government employees of the city and/or county. The Red Cross will provide mass care partnership training for city and/or county employees.

(2) Engage in cooperative mass care planning. The Red Cross will meet regularly with representatives of the city and/or county to engage in mass care planning and preparedness activities.

b) Response

(1) Through the Care and Shelter Branch of the County Emergency Operations Center (CEOC) Operations Section and in conjunction with the Department of Public Social Services (DPSS), provide staff the support, status of, and analysis for all mass care operations and shelters. Specific responsibilities include monitoring the status and operational area management of:

(a) The location, number, and status of emergency shelters

(b) The number of affected population in shelters

(c) The location and status of mass care distribution points and/or mobile feeding routes

(d) The location and status of non-food bulk relief supplies distribution

(e) InfoLine, in cooperation with other private human service providers, including the Red Cross, the Salvation Army, and Emergency Network Los Angeles, Inc. (ENLA)

(2) Provide mass care services. By congressional mandate and in accordance with its corporate policy, the Red Cross has a longstanding disaster relief mission. Red Cross mass care services may include:

(a) Emergency shelter

(b) Fixed and mobile feeding

(c) Emergency and basic first aid only

(d) Mental health support

(e) Disaster welfare information (DWI) services

(f) Assistance for other emergency needs

(g) Disaster preparedness education and shelter operations training

B. Roles of Agencies and Organizations Supporting Mass Care

1. City agencies

The extent of city resources is widespread. This guidance uses departments from the City of Los Angeles as examples of departments that play a role in mass care. Other cities may have different departments or agencies completing these tasks. This list is not exhaustive and planners should consult with their local jurisdictions for additional agencies.

a) The Los Angeles Fire Department – The fire department roles and responsibilities related to mass care include:

(1) Provide support to ensure fire safety in emergency shelters.

(2) Coordinate the use of Community Emergency Response Team (CERT) volunteers to support Red Cross shelter operations.

(a) Coordinating agencies responsible for CERT are strongly encouraged to coordinate cross-training through the mass care partnership training provided by the Red Cross to reduce personnel shortfalls.

(3) Coordinate with the Emergency Medical Services (EMS) Agency to assign assets to larger emergency shelters, whenever possible.

b) Los Angeles Police Department – The police department's role does not change, even in a major catastrophic emergency. The department remains responsible for the protection of life and property. Requests for police department resources should be routed through the CEOC.

c) Los Angeles Animal Services – The Department of Animal Services is responsible for caring for household pets and livestock brought to the shelters by the affected population. The Animal Services Department is part of the Care and Shelter Branch of the Los Angeles City EOC. When activated, Animal Services will provide a staff member to the Care and Shelter Branch. Animal Services also provides the following:

(1) Provide shelter-in-place capability for guests, workers, and volunteers.

(2) Coordinate with partners to determine needs at shelter sites for pets and service animals.

(3) Coordinate with volunteers on evacuations and the sheltering of animals.

(4) Notify the Department of Public Relations officer of the affected areas and where animals can be taken for temporary care and sheltering.

(5) Determine and request animal medical and food needs at sites.

(6) Provide small animal shelter at local animal shelter facilities.

(7) Provide a mobile animal shelter at a mass care shelter.

(8) Provide special assistance to those with service animals.

d) Los Angeles Recreation and Parks – In the event of a disaster, the agency makes its parks and facilities available to relief and disaster agencies for use as evacuation centers or mass care shelters. In a widespread disaster, DPSS and Recreation and Parks personnel may be used to assist staff from the relief agencies.

e) Los Angeles Unified School District (LAUSD) – The LAUSD Office of Emergency Services or the LAUSD EOC is the

point of contact (POC) for matters relating to the use of LAUSD public schools during emergencies. As per the standing Memorandum of Understanding (MOU) with the Red Cross, LAUSD is prepared to assist in matters related to the use of its schools in providing mass care. As a member of the Care and Shelter Branch in the Operation Section of the Los Angeles City EOC, LAUSD will coordinate the use of its schools as shelters with the Red Cross and the City of Los Angeles.

f) Los Angeles General Services Department (GSD) – The GSD provides personnel for the Logistics Section, and can provide resource support to the field as necessary and under the authority of the EOC manager. GSD's Office of Public Safety (OPS) also provides security to city facilities, such as city recreation and park facilities and libraries. When city facilities are used as shelters, GSD's OPS provides security.

2. County/LAOA resources

County resources may also be relevant for supporting local government's mass care response. The city and/or county may access county resources through the CEOC.

a) Los Angeles County Office of Emergency Management (OEM) – OEM is responsible for organizing and directing preparedness efforts of the Emergency Management Organization of Los Angeles County. OEM also staffs key positions in the CEOC during major events, and works with public, private, and nonprofit agencies to coordinate assistance and disaster relief following large-scale incidents.

b) Los Angeles County DPSS – DPSS is designated as the CEOC Branch coordinator for the Care and Shelter Branch. DPSS is also the operational area liaison with private, nonprofit human services agencies (e.g., community-based organizations [CBOs]) and the grocery industry. Additionally, DPSS may be able to provide local government with shelter staff and support people with access and functional needs, where necessary. In times of disaster, DPSS will supplement local jurisdictional response, as directed by the California Department of Social Services and the Governor.

c) Los Angeles County Department of Children and Family Services (DCFS) – DCFS is primarily concerned with the safety and well-being of the children in its care, the department's employees, and displaced minors left unaccompanied as a result of a disaster. In a major disaster, DCFS will provide a variety of services and programs including:

(1) Deploy DCFS staff to emergency Red Cross shelters to process the initial intake and registration of unaccompanied minors, including follow-up action to reunite them with their parents/guardians or other immediate family member in order to provide appropriate temporary or permanent placement when and where necessary.

(2) Use Kinship Care Services to provide information, resources, services, and support to relative caregivers and their children to enhance the family unit, safety, and reduced reliance on detentions.[15]

(3) Provide emergency shelter care services through providers that will facilitate short-term homes for children and youth who have suddenly been placed under the care of DCFS and urgently need interim shelter.

(4) Provide emergency shelter care services that are readily available within a two (2)-hour notice on a 24-hour/7-day a week basis, whereby necessities, such as meals, clothing, medical, dental care, and education support, will be provided.

(5) Provide emergency shelter care services that are intended for children (0 to 12 years), youth (13 to 17 years), sibling groups, or teen mothers and their infants, who have suddenly been placed under the care of DCFS and are in need of interim shelter.

(6) Support DPSS, on request, in provision of emergency welfare services, including staff at emergency shelters or relief programs to assist in interviewing affected population, processing requests for disaster assistance, and other related tasks.

(7) Continue the commitment to provide services to children under DCFS care, including the placement of children affected by a disaster.

d) Los Angeles County Office of Education (LACOE) – The LACOE is designated as the LAOA schools coordinator for matters relating to public schools during emergencies. As a support department to other county departments (including DPSS), the LACOE may be called upon to assist in matters

[15] Kinship Care Services is a consortium of organizations that support the well-being of children and youth. More information on this organization can be found at http://dcfs.co.la.ca.us/kinshippublic/resourceguide.html.

related to the use of schools in providing mass care. An LACOE representative is assigned to the Care and Shelter Branch in the CEOC.

(1) School health professionals, such as psychologists and nurses, could assist with mental health and health services, as well.

e) Los Angeles County Department of Parks and Recreation – In the event of a disaster, the role of the Department of Parks and Recreation is to make its parks and facilities available to mass care agencies for use as evacuation centers or emergency non-traditional shelters for affected populations. In a widespread disaster, DPSS and Parks and Recreation personnel may be used to assist in providing mass care services.

f) Los Angeles County Sheriff's Department – The Sheriff's Department is responsible for coordinating information to the affected public and managing its traffic control and the evacuation of people. Once DPSS and the Red Cross have established emergency shelter sites, the Sheriff's Department will render assistance, as needed. The county Sheriff's Department will act as the primary resource at these facilities.

g) Metropolitan Transportation Authority (MTA) – The MTA has the primary role for coordinating transportation providers in a major incident that would trigger activation of either the Los Angeles City or CEOC. The MTA is the primary source of mass transportation equipment used by the LAOA. Both buses and mass transit trains are available for use in evacuations, transport of equipment and supplies, and transport of victims to shelters, disaster assistance centers (DACs), and other relief locations. Requests for MTA resources are handled through the transportation coordinator in the Logistics Section of the CEOC.

h) Los Angeles County Department of Public Health (DPH) – In the mass care environment, the Los Angeles County Department of Public Health (DPH), through its Department Operations Center (DOC), in consultation with the Public Health Officer and in coordination with local health departments, may provide the following at the request of the CEOC (emergency planners should also go through their Disaster Management Area Coordinators to communicate with the EOCs):

(1) Specially trained DPH liaisons to work at the Los Angeles City or CEOC in the Operations Branch to

support ESF #8 (Health and Medical Services) and coordination of county response.

(2) Public health nurses (PHNs) may be provided to aid in the initial survey of potential shelter medical needs and general shelter site assessments. They may, for example, assess sites for the following:

(a) Water temperature

(b) Americans with Disabilities Act (ADA) compliance

(c) General living conditions

(d) Presence of infants

(e) Presence of people with disabilities

(f) Persons with obvious symptoms of illness

(3) Syndromic surveillance may be provided on report of widespread symptoms in shelter (see Contagious Diseases and Surveillance section for additional information).

(4) Community Health Services (CHS), a division of DPH, will function as the "field response" division of public health nursing.

(5) Medical personnel may be recruited from the Disaster Healthcare Volunteer (DHV) system, which includes the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)/Medical Reserve Corps (MRC).

(6) PHNs may be provided through memoranda of understanding (MOUs) to assist in supporting the Red Cross at shelters.

(7) The DPH Environmental Health Division may provide the following disaster response functions:

(a) Coordinate sanitation services with regard to food handling, mass feeding, medical and human waste disposal in shelters, and other emergency-related facilities.

(b) Determine the safety of the water supply and the safe use of potable and non-potable water.

(c) Under the Communicable Disease and Control Program of DPH, both Veterinary Public Health (VPH) and the Los Angeles County Department of Animal Care and Control

(LACDACC) have shelter assessment tools to assess animal sheltering quarters.

i) The Los Angeles County Department of Health Services (DHS), in the mass care environment and through its Department Operations Center (DOC), may provide the following at the request of the CEOC:

(1) Specially trained DHS liaisons to work at the Los Angeles City or CEOC in the Operations Branch to support ESF #8 (Medical and Health Services) and coordination of county response

(2) Additional personnel to support DPH and may coordinate transportation of shelter residents to the appropriate medical facility as needed

j) The Emergency Medical Services (EMS) agency, as a part of the DHS system, provides the following disaster response functions:

(1) Coordinate the immediate emergency medical response in a disaster.

(2) Facilitate the movement of casualties to designated definitive care sites.

(3) Coordinate the procurement, allocation, and distribution of medical personnel, supplies, equipment, and other resources under the agency's command as necessary.

(4) Assist in the temporary placement of medically fragile people in shelters as a last resort in the immediate aftermath of a disaster until the shelter operations team can safely transfer them to other local care facilities or to facilities outside the immediate area.

(5) Recruit medical personnel from the DHV system. For additional information, see Annex B: Medical and Health.

k) Los Angeles County Department of Animal Care and Control (LACDACC) provides the following disaster response functions:

(1) Provide a coordinated household pet emergency response system that is compliant with the Standardized Emergency Management System (SEMS), the National Incident Management System (NIMS), and all relevant county, State, and Federal laws.

(2) Serve as the lead agency in a multi-jurisdictional disaster involving animals, and coordinate the procurement and dissemination of animal feed and supplies to the sheltered household pets.

(3) Assist pet owners in the safe evacuation of their pets.

(4) Utilize surge capacity of animal shelters and foster care programs in the temporary care and feeding of pets and livestock.

(5) Provide temporary household pet sheltering adjacent to the human-sheltering sites, wherever possible.

(6) Maintain database management of the identification and location of evacuated household pets (may include microchip implants).

(7) Provide veterinary medical supervision of evacuation, sheltering, and care for the disaster-affected household pets.

(8) Work cooperatively with the veterinary community to provide animal health-related services during disaster response operations/activities.

(9) Provide training and management of a volunteer corps that will potentially assist in the evacuation and care of household pets.

(10) Organize mutual aid agreements (MAAs) with adjoining jurisdictions.

(11) Receive and disseminate disaster-related information to the veterinary medical community and the public.

(12) Take measures to prevent the spread of zoonotic and disaster-related illnesses.

(13) Collect and analyze health-related data in a disaster area, and establish response procedures to mitigate animal and human health-related problems.

l) Los Angeles County Department of Mental Health – In response to a disaster, the Department of Mental Health will augment the Public Health and Medical Division of DHS by providing crisis counseling services, as requested, through the CEOC. The department will coordinate and provide mental health services to community disaster victims and disaster emergency responders throughout the duration of the disaster and its recovery period. (For further description, see Annex B: Medical and Health).

The department provides the following disaster response functions:

(1) Provide specially trained mental health liaisons to work at the Los Angeles City or County EOC in the Operations Branch to support ESF #8 and the coordination of county response.

(2) Provide triage, education, assessment, and intervention of individuals impacted by disaster.

(3) Provide crisis counseling to support the psychological and emotional well-being of the shelter residents and the community.

(4) Maintain continuity of care for people with mental disorders who were receiving care prior to the disaster.

(5) Provide mental health outreach and education to schools impacted by disasters.

(6) Deploy licensed and trained staff to support mental health services in Red Cross shelters.

(7) Deploy licensed and specially trained staff to requesting county and city departments.

(8) Deploy trained staff to requesting hospitals.

(9) Provide support in psycho-education and normal reactions to abnormal events.

(10) Provide support in referrals and community resources.

(11) Conduct assessments and evaluations of shelter residents as needed.

(12) Provide support in conducting crisis counseling with shelter and other emergency response personnel.

(13) The department will be responsible for the coordination of other community counseling resources. If county mental health resources become exhausted, the department will coordinate with its contract providers for additional resources. If further support is still needed, the mutual aid plan will be activated.

m) Los Angeles County Community and Senior Services (CSS) Administers adult protective services (APS) for adults with developmental disabilities, including mentally disabled adults and older adults. In a disaster situation, CSS would provide

support to this community by contacting them or initiating a home check; be a resource for Functional Assessment and Service Teams (FAST); and assist unaccompanied seniors in shelters, as requested, by the Care and Shelter Branch.

Within CSS, the Area Agency on Aging (AAA) is responsible for identifying unmet needs, as well as planning, coordinating, and implementing programs that promote the health, dignity, and well-being of the county's older residents. AAA contracts with 49 community agencies to deliver services that promote independent lifestyles. These services include congregate and home-delivered meals, nutrition programs, integrated care management, and home-based care.[16]

3. The Red Cross

The Red Cross is a nationwide partner with local government in helping to fulfill government's legal responsibility of providing mass care for its citizens in a disaster. The partnership requires that local government and the Red Cross work cooperatively during the preparedness phase to clarify roles and responsibilities (as outlined below). It is strongly encouraged that local jurisdictions also work in cooperation with other volunteer disaster assistance organizations to provide disaster relief.

The Red Cross in Los Angeles County is the primary support agency to DPSS for the Care and Shelter Branch of the CEOC. This role and relationship is explained in detail in the LAOA Emergency Response Plan (ERP). Within Los Angeles County, the Red Cross is composed of nine individual chapters.

Mutual aid, significant physical and human resources may be available from neighboring Red Cross chapters in local counties. These resources may significantly add to available resources within Los Angeles County.

Additionally, the Red Cross maintains an extensive cadre of volunteers, a fleet of emergency response vehicles, mobile kitchens, and support vehicles across the nation. Additional resources, such as cots, blankets, bulk distribution items, and communication equipment are strategically located in warehouses across the country. These supplies will be used in any area that has been impacted by an incident/event; however, a full complement of resources and supplies for field activities will be contingent on the severity of the event, impact to transportation infrastructure, and the ability to move resources and supplies in and throughout the operational area.

[16] http://css.lacounty.gov/aaa-program-services.aspx

4. Emergency Network of Los Angeles (ENLA) – ENLA is the local VOAD in the LAOA. It is a network of LAOA nonprofit CBOs that provide assistance to individuals, families, and organizations following emergencies and disasters. ENLA works in coordination with government agencies and the private sector.
   a) ENLA is recognized by LAOA and the City of Los Angeles as the networking agency for CBOs.
   b) ENLA committees include Mass Care, Emotional and Spiritual Care, Long-term Recovery, and Development.
5. Volunteer Center of Los Angeles (VCLA) – VCLA is under contract with the county to provide management of Medical Reserve Corps (MRC) volunteers.
6. Community-Based Organizations (CBOs) – CBOs include various local organizations, such as faith-based organizations and ethnic support-based organizations. Many CBOs provide direct and ongoing services to people with access and functional needs during non-disaster times, and they are in a good position to support the recovery of more affected populations following a disaster. CBOs may support local jurisdictions with mass care, and with language and cultural sensitivity needs. They may also serve as a conduit for getting information to people who local government may have difficulty reaching.
7. Salvation Army – Through its various local organizations, and with the assistance of divisional headquarters, the Salvation Army Southern California Division serves Los Angeles County. The Salvation Army provides the following services to individuals and families:
   a) Mass care feeding (including mobile kitchen units)
   b) Sheltering
   c) Clothing distribution
   d) Counseling
   e) Assistance in home cleanup for seniors and people with disabilities
8. Local business and industry – Businesses often donate goods or services to assist the community in its recovery from a disaster. Cities and/or the county may establish pre-disaster agreements with local businesses to expedite the purchase or use of equipment and supplies required for mass care operations.

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IV. Assisting People with Access and Functional Needs

The affected population will likely include individuals who need additional or specialized assistance, such as people who have disabilities; live in institutionalized settings; are fragile older adults; are children; are from diverse cultures and have limited English proficiency; or need transportation assistance. FEMA, via the NRF and CPG 301, and the California Office for Access and Functional Needs describe access and functional needs populations as people whose members may have additional needs before, during, and after an incident in five functional areas: communication, medical care, maintaining independence, supervision, and transportation (C-MIST).[17,18] The local government terms may differ from the Federal terms. Additionally, there are several different categories of shelters used by different jurisdictions to accommodate people with access and functional needs. A certain portion of the shelter residents will be assessed upon arrival as having access and functional needs. (See Annex B: Medical and Health for additional information.)

Currently, no shelters in the LAOA are designated explicitly for populations that have medical or access and functional needs. Rather, people with acute medical needs are directed or transferred to hospitals and people with access and functional needs may be accommodated in any shelter. California statute precludes segregating access and functional needs populations within shelters; however, some population separation can occur, if appropriate and necessary, based on medical need.[19]

This section will provide information to facilitate planning and provide assistance to individuals with access and functional needs. Annex B: Medical and Health will expound upon these issues.

A. Seniors and People with Disabilities

When disasters occur, older and disabled people, who may already face health or ability challenges, are likely to be more susceptible to the difficulties of responding to and recovering from the disaster. Physical or

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[17] *Disaster Recovery Center Service Providers. Disaster Assistance Policy 9430.1. Interim*. (2008, October 1). Department of Homeland Security, Federal Emergency Management Agency. http://www.fema.gov/good_guidance/download/10304. Due to the interim nature of guidance contained within CPG 301, planners should check for updates to the guidance before finalizing plans.

[18] Guidance on Planning and Responding to the Needs of People with Access and Functional Needs: Identification of People with Access and Functional Needs. California OES—Office of Access and Functional Needs. Accessed online on May 25, 2010, at http://www.oes.ca.gov/WebPage/oeswebsite.nsf/Content/710D9E2F73772B8B8825749B00808615?OpenDocument.

[19] Guidance on Planning and Responding to the Needs of People with Access and Functional Needs: Sheltering. California OES—Office of Access and Functional Needs. Accessed online on May 25, 2010, at http://www.oes.ca.gov/WebPage/oeswebsite.nsf/Content/52DCF0D4BAAB01FB8825749B008086A6?OpenDocument.

mental disabilities may limit their capacity to respond or to seek help. Many older and disabled people require community support services (e.g., home-care support and senior centers) to live independently. Any emergency that disrupts those lifelines leaves them vulnerable. The following are some planning activities for assisting seniors and people with disabilities:

1. Maintain critical services – This includes items, such as durable medical equipment, consumable medical supplies, essential medications, communication access, and personal assistants.
2. Identify transportation access and functional needs – People with mobility impairments may require accessible transportation.
3. Identify access and functional needs during shelter registration – Use the Health and Human Services (HHS) Initial Intake and Assessment Form to identify needs that older or disabled people may have for special assistance.
4. Provide individualized shelter orientation – Shelter orientations help people with access and functional needs adjust to the shelter environment. A shelter can be especially challenging for those with visual impairments due to "landmarks" (e.g., cots, tables, and chairs) that may have been moved day-to-day.
5. Shelter accessibility – Pre-identify shelters that meet the accessibility standards that will enable people who have access restrictions to function with greater independence. See the Federal ADA Checklist for Emergency Shelters[20] for more information on accessibility standards.
6. Provide basic communication – Ensure that people with communication barriers receive and understand all shelter announcements. Keep language simple, and draw pictures, if necessary. Consider resourcing alternative format materials, talk boards, picture boards, notepads, pens, and pencils available for staff to use to communicate.[21]
7. Medications, supplies, and equipment – Physically disabled people may have less opportunity to access their personal items and emergency medical supplies before evacuating their home to

[20] http://www.ada.gov/shleterck.htm

[21] "Picture boards" and "talk boards" – Manual or electronic devices using viewable pictures and/or letters to communicate in situations where speech, auditory impairment, or limited language proficiency hinder communication.

"Alternative format materials" – These include materials, such as Braille, audio cassette, large print, computer diskette, CD-ROM, or human readers to assist those with disabilities, as defined in "Guidelines for Accessing Alternative Format Educational Materials," National Library Service for the Blind and Physically Handicapped (NLS), The Library of Congress.

disaster shelters. Refrigeration may be necessary for certain medications. Additionally, only nursing staff or health services can dispense medications within the shelter.

8. Privacy area – Create a section of the shelter that is separate from the general shelter residents for use as a privacy room for medical or other personal needs. This could include attending to personal hygiene needs.

9. Alternate care locations – In cases where entire group homes or care facilities evacuate to a public shelter, consider making smaller, alternative facilities or a separate area within the shelter available. Care facility staff can then evacuate to the alternate facility and continue to maintain care of the affected population outside of the mass care environment.

B. People Who Are Medically Fragile or Dependent

This includes people who live at home with the help of life-support systems (e.g., dialysis or respirators), as well as people who are severely ill and require home healthcare. It may include people with multiple chronic conditions requiring frequent monitoring to minimize exacerbations and thus decrease the need for emergency room care. In extreme cases, some may need to evacuate to an environment with backup electric power for their medical equipment. On a more temporary basis, it may include post-operative patients needing supervision and use of braces/crutches and special beds until full functionality returns.

1. Caregivers and equipment – People dependent on life-support equipment or home healthcare will need to bring the equipment and/or personal support they receive at home to the shelter with them. If necessary, an area of the shelter may be sectioned off to provide privacy.

2. Backup generators – Pre-identify shelter sites with backup generators.

3. Shelter isolation area – Designate a separate room or space within the facility for people who have health concerns (e.g., asthma, multiple chemical sensitivities, allergies, people with compromised immune systems, or cancer).

C. Limited English Language Proficiency

Mass care staff should be aware of and responsive to language and cultural differences. Considerations for supporting this population include:

1. Outreach pre-event – Create public messaging on preparedness and how to respond in a disaster in alternate languages, and how to work with non-English language media outlets (e.g., radio, TV, and newspapers) to disseminate the message to their listening communities. Identify CBOs that serve specific ethnic communities

and enlist their help to reach diverse non-English speaking populations.

2. Bilingual assistance – The city and/or county EOC should identify and prearrange for bilingual assistance or translation services to assist in reception and shelter operations.

3. Alternative format materials – See the above section, Provide Basic Communication.

D. Unaccompanied Minors

Following a disaster, unaccompanied minors may become separated from their families. Reunification of families, especially those with minors, should be a priority. Strategies to address supporting unaccompanied minors until they can be reunified with their family include:

1. Unaccompanied children should be tracked in shelters for the purpose of family reunification.

2. If a child arrives at the shelter without a parent, obtain as much information as possible about the parent or guardian.

3. Refer the child to Department of Children and Family Services (DCFS) or law enforcement officials immediately. Plan for a qualified staff person to supervise the unaccompanied minors until the child can be turned over to the custody of Child Protective Services (CPS) or law enforcement.

4. Unaccompanied children may be at increased risk for being abducted, abused, or neglected during a disaster. Until the CPS or law enforcement takes physical custody of the child, provide a secure and supervised location for the child. If custody has not been transferred to a parent/guardian or CPS within 12 hours, contact CPS directly or law enforcement through the CEOC.

5. If no parent/guardian or CPS is available, refer to the local DCFS or National Center for Missing and Exploited Children (NCMEC) regarding children missing or separated from their families due to a disaster incident/event. The NCMEC operates a National Emergency Child Locator Center (NECLC), which they will use during disaster events.

6. Consider involving child/adult welfare groups and agencies in disaster protocol development, planning, preparedness, response, and recovery to address these needs. Staff should be aware of protocols to manage unaccompanied minors, homeless youth, or self-evacuated youth who present at shelters.

7. Work with the appropriate law enforcement and legal authorities to develop a disaster protocol for the temporary care of unaccompanied children/minors and adults requiring care until reunified.

8. Child and adult care support groups, non-profits, and faith-based groups, such as the Baptist Child and Family Services (BCFS) and the National Association of Child Care Resource and Referral Agencies (NACCRRA), may provide assistance in providing care until parents, guardians, or caregivers can be located or longer-term arrangements can be made.
9. Consider mental health support for children.

E. Unaccompanied Adults Requiring Care

Following a disaster, unaccompanied adults requiring care may become separated from their caregivers. Reunification with caregivers should be a priority. Strategies to address supporting unaccompanied adults until they can be reunified with their caregivers include:

1. Use the registration lists from shelters to help locate displaced family members.
2. If an adult requiring care arrives at the shelter without a caregiver, obtain as much information as possible about the caregiver (e.g., name, phone number, and last known whereabouts).
3. Contact the Adult Protective Services Section of CSS or law enforcement officials immediately. Plan for a qualified staff person to supervise the unaccompanied adult until such a time as he/she can be turned over to the custody of CPS or law enforcement and a longer term solution is arranged.
4. Until the CPS or law enforcement takes physical custody of the person, provide a secure and supervised location for him/her. If custody has not been transferred to a guardian or authorized caregiver within 12 hours, contact CSS directly or law enforcement through the CEOC.
5. Consider involving adult welfare groups and agencies in disaster protocol development, planning, preparedness, response, and recovery to address these needs.
6. Work with the appropriate law enforcement and legal authorities to develop a disaster protocol for temporary care of unaccompanied adults requiring care until reunified.
7. Adult care support groups, non-profits, and faith-based groups, such as the BCFS, may provide assistance in providing care until guardians or caregivers can be located or longer-term arrangements can be made.
8. Consider mental health support for these adults, as needed.

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V. RECEPTION

Reception is a function that generally takes place immediately pre- and/or post-incident. This process is intended to register and track people in the affected population when they leave an affected area, move to congregate shelters, and then return home. If evacuation needs continue for an extended period, such as during a large-scale earthquake or weapon of mass destruction (WMD) event, the reception function may need to be extended.

A. Determine Locations of Arrival Points

Arrival points may have different forms. They may be an existing State or community welcome center that provides directions to shelters and relief facilities; a reception processing site (RPS), at which those who are evacuating are received and assessed for issues or needs (e.g., household pets and medical), and then transported to local shelters; or reception may take place directly at a shelter site.

1. Arrival points, if possible, should be located outside the impact area and accessible from main evacuation routes. They should be large enough and designed to support the anticipated quantity of the affected population. They should be accessible to and should accommodate people with disabilities. Ensure compliance with the Americans with Disabilities Act (ADA), the Architectural Barriers Act (ABA), and the Uniform Federal Accessibility Standards (UFAS). There should be provisions for alternative communication formats for those with limited English proficiency and/or with visual and/or auditory limitations.
2. Multiple arrival points may be required to accommodate the affected population and different modes of transportation. The support and resources needed at an arrival point will depend on the site's location in relation to the affected area, its regular and disaster purpose; resources available (e.g., human and material); incident scope; and the quantity and needs within the affected population (e.g., unaccompanied minors; those with access and functional needs; those with medical needs; people without identification; and individuals subject to judicial and/or administrative orders restricting their freedom of movement).

B. Provide Basic Services at Arrival Points

Arrival points are not specifically shelters, but are points at which to assess and transfer the affected population. As such, the services, even if reception takes place at a shelter, are not those of the shelter, but rather specific to the receiving and registration of the affected population.

1. The range of services provided will depend on the incident type and

magnitude, available resources and acquisition speed-to-scale,[22] decisions by onsite management, and the type of site (i.e., welcome center, RPS, and shelter). Basic services at a welcome center include restroom facilities and information. Additional services at RPSs could include first aid, hydration, and food. Additional services at a shelter may include those at a RPS, but also include sleeping accommodations and longer stays.

2. Ensure compliance with ADA/ABA/UFAS, and accommodate those with access and functional needs. In an RPS, establishing a dormitory area is advisable in order to provide rest for late-night arrivals. Separate areas should be arranged for unaccompanied minors, people without identification, and individuals subject to judicial and/or legislative orders restricting their freedom of movement.

3. Consider continuation or initiation of tracking of the affected population, their household pets, durable medical equipment, and personal items, if a tracking process is used.[23]

C. Determine Needs and Plans for Basic Arrival Point Site Logistics

Depending on the type of facility (e.g., RPS and shelter), the logistics will change based on the needs of that particular environment; however, the requirements for the reception function will remain the same.

1. Develop a plan for site setup and management. This should include operations management criteria, floor plan, equipment needs, and a logistics plan with written procedures, roles, and responsibilities; timeline for setup; traffic control; supplying and resupplying resources; security needs; and communications capabilities and requirements.

2. Coordinate with staff at shelters and other congregate care facilities, RPSs, EOCs, and support agencies, as applicable.

3. Develop MOUs/memorandums of agreement (MOA) with support agencies, and review them at the time of the incident to confirm that they are applicable to current needs.

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[22] Speed-to-scale refers to the amount of time it takes to reach a desired goal (e.g., How fast can a State open enough shelters to house 15,000 of the affected population?). Speed-to-scale analyzes which resources are necessary (e.g., facilities, cots, staff); the amount of time needed to acquire those resources (e.g., local staff versus staff flown in); and the percentage of the goal reachable at any given time up to achieving 100%. The analysis would include methods and strategies for accelerating the speed in which the goal can be reached.

[23] Durable Medical Equipment (DME) is defined in FEMA DAP 9525.4 as, "Equipment prescribed by a physician that is medically necessary for the treatment of an illness or injury, or to prevent a patient's further deterioration. This equipment is designed for repeated use and includes items such as oxygen equipment, wheelchairs, walkers, hospital beds, crutches, and other medical equipment."

4. Plan for appropriate transportation resources (e.g., buses and paratransit), if needed, to move the affected population to shelters.
5. Establish a public information mechanism in coordination with the public information officer (PIO) and EOC, to disseminate current information regarding the disaster, the affected areas, and current support services available. This information should be available in alternative formats and languages.
6. Develop procedures for closing/decommissioning arrival points.

D. Determine the Needs and Develop a Plan for a Possible Full-Service RPS

If a full-service, stand-alone RPS is used, there are additional logistical considerations beyond the basic logistics.

1. Assess if medical and contamination screening has been completed prior to arrival. If it has not been completed, assess the need and implement the process for this action.
2. Designate separate areas for household pet reception, vehicle staging, embarkation, debarkation from mass transportation, and evacuee parking, if needed.
3. Establish a provision of communication equipment, such as telephones and Internet-accessible computers for evacuee use, if possible.
4. Establish a provision of reunification support and welfare information, such as the Red Cross Safe and Well Internet-based system or a more localized resource.

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VI. SHELTERING

This section outlines overarching process considerations to identify, prepare, staff, activate, operate, and close shelters. The Red Cross Shelter Operations Management Toolkit is designed to give shelter managers the information and background needed to effectively manage and facilitate a Red Cross shelter. It includes operational tips, checklists, and best practices currently utilized. It also covers the processes and procedures established by the Red Cross National Headquarters and includes guidelines for opening, managing, and closing a shelter; shelter safety; job descriptions; and service animal guidelines. This information can be found on the Mass Care Planning CD.

A. Shelter Sites

1. Developing emergency shelter inventory

Identify and survey pre-event any local facilities that may potentially be used to shelter people in a disaster. The Red Cross maintains a list of potential shelter sites throughout LAOA in the National Shelter System (NSS) and holds agreements with numerous facilities. One resource is schools. Upon a request for use of district facilities by the Red Cross, school police will contact the requested site administrator and the Office of Emergency Services (OES). Each city and/or county should coordinate with the Red Cross for full shelter criteria and assessment, as well as maintain its own list or inventory of shelter facilities with basic facility data on:

a) Point of contact information

b) Location with address and GPS coordinates

c) Size of facility (square feet)

d) Sleeping space capacity

2. Types of potential shelter sites

a) Publicly-owned facilities include schools, recreation centers, senior centers, auditoriums, fairgrounds, and stadiums[24] (see Annex C: Non-Traditional Sheltering for more information on large complexes).

There are considerations to be assessed in regard to use of these facilities. Using schools for long-term sheltering during regular school session could negatively impact communities from resuming normal activities as soon as possible.

[24] California Education Code, Section 32282 "requires school districts to establish a procedure to allow a public agency, including the Red Cross, to use school buildings, grounds, and equipment for mass care and welfare shelters during disasters or other emergencies affecting the public health and welfare. It states that the district or county office shall cooperate with the public agency in furnishing and maintaining the services as the district or county office may deem necessary to meet the needs of the community."

Schools have been identified as a community service that will attempt to reopen quickly following a disaster.

b) Privately-owned facilities include faith-based organization facilities (e.g., churches, synagogues, and temples), private schools, recreation centers, community centers, and empty "For Lease" buildings (e.g., former grocery stores and department stores).

There are considerations to be made for use of these facilities as well. Some faith-based and private civic organizations may wish to be a shelter, but the facilities are small. This could result in larger staffing requirements and greater division of resources that strain the operation's resources. The facility owners, however, may be interested and willing to train their members to manage and staff these shelters. Empty buildings may be viable resources and provide larger space; however, consideration should be given to the lease costs and extended contract required. Many of these shelter sites will also not have facilities, such as toilets and showers, at all or in quantities necessary for sheltering, which will require pre-planning for portable resources.

3. Criteria for selecting shelter sites

a) Refer to Red Cross shelter guidance and references to shelter assessment and site selection in the Red Cross Shelter Operations Management Toolkit for details on recommended shelter space and space criteria. Non-traditional shelters will require a more robust shelter facility or site and greater resources. Annex C: Non-Traditional Sheltering for more information. Examples of recommended criteria include:

(1) Space (i.e., square footage) for sleeping

(2) Toilets, sinks/hand wash stations, and shower facilities

(3) Space for parking

(4) Registration area

(5) Shelter manager's office

(6) Health services area

(7) Mental health services area

(8) Emergency generator onsite

(9) Safety features (e.g., fire extinguisher and fire alarm)

(10) Building heating and cooling capacity

(11) Telephones and/or other communication

(12) Accessibility for access and functional needs

(13) Service animal accommodations

Service animals are not pets and must accompany their owner at all times, including in public shelters. Because of the more liberal interpretation of "service animal" by the ADA, cities and counties should consider how they may accommodate people with access and functional needs that have service animals. If possible, create a separate area within the shelter where owners with service animals can share space and care for their own service animals. The Care and Shelter Branch will work with LACDACC to provide additional supplies and equipment for service animals.

b) Survey of shelter sites

Work with the Red Cross or the sheltering organization to complete a Shelter Facility Survey of potential shelter sites (see the Red Cross Shelter Operations Management Toolkit for more information).

If direction and control is to be delegated to the Red Cross by the Care and Shelter Branch, ensure an agreement is in place.

4. Primary and secondary shelter sites

In opening disaster shelters, local jurisdictions should differentiate between primary and secondary shelter sites.

a) Primary shelter sites – Primary sites meet most of the criteria identified earlier in this section. They can handle large numbers of the affected population in shelters, and are accessible for access and functional needs. Primary sites receive priority status when there is a need to open disaster shelters, thus a significant pool of primary sites is preferred.

b) Secondary shelter sites – Secondary sites do not meet all criteria, yet they may be advantageous for neighborhood-based sheltering and, with some modifications, can fully accommodate people with disabilities.

5. Other types of potential shelter sites

   a) Non-Traditional

      (1) Mega shelters – These shelters are large, non-traditional facilities and are often generally used for public assembly (e.g., an arena, convention center, or stadium). These facilities have multi-agency coordination and a unified command (UC) structure. They are intended to accommodate longer sheltering needs (see Annex C: Non-Traditional Sheltering).

      (2) Open-space shelter sites – An open-space shelter is one in an open-land area where the displaced population may congregate to receive services to meet immediate needs and have space for emergency sheltering. These sites will have differing resources available on-site. Historically, these shelters have been set up in parks, golf courses, and large open spaces including parking lots and beaches. (See Sheltering for historical data.)

   b) Staff shelter sites – These shelters are for response personnel and family members.

      (1) Response personnel should be segregated from the shelter residents to prevent distractions and disruptions in their job performance, allowing the response personnel the ability to quickly deploy to assigned job locations when necessary, and giving shelter personnel separation from the shelter residents they serve.

      (2) These types of shelters should be located as close as possible to designated staging areas, base camps, or worksites.

      (3) Where possible, these shelters should house immediate family members of response personnel, as well.

      (4) Pre-determined emergency evacuation and shelter sites for DSW families can be effective, but it is vital that elected officials publicly support them because of the possible perception of preferential treatment. Determine which DSWs and families will be sheltered at designated sites.

      (5) Discussion should occur with the Red Cross to identify what support may be available for this type of shelter.

c) First responder mobilization centers – These staging and sheltering sites are primarily used by personnel from law enforcement, fire service, public works, military, and/or out-of-state support.

d) Household pet shelters

(1) Separate household pet shelters should be placed near the public shelters if possible. Appropriate supplies (e.g., food, water, cages, and kennels) and credentialed and trained staff should be provided. The layout of this shelter should be designed to meet the needs of the household pet population (e.g., sufficient areas for cages and open areas for walking/running).

(a) FEMA has a definition for "household pets" that determines allowed reimbursable costs for household pet sheltering.[25] States, cities, and counties may have different criteria for pet shelters that should be considered.

6. Other considerations

a) In situations in which medical concerns, issues, or needs expand beyond the capabilities and capacities of public shelters, the use of outside medical resources should be considered. Medical alternative care sites, based on the level of care needed, may need to be a consideration as one of the response strategies. Refer to Annex B: Medical and Health for more information.

b) Consider requirements in regard to the provision of services for "individuals subject to judicial and/or legislative orders restricting their freedom of movement."[26] This could include registered sex offenders; parolees and probationers; those living in rehabilitation centers and half-way houses; and any other people with freedom restrictions set by law.

B. Shelter Agreements

A shelter agreement, combined with a shelter facility survey, is used to establish understanding and agreement of use between the owner of the facility and the agencies using it as a shelter (see the Red Cross Shelter

[25] FEMA Disaster Assistance Policy (DAP) 9523.19 defines the term household pet as "a domesticated animal, such as a dog, cat, bird, rabbit, rodent, or turtle, which is traditionally kept in the home for pleasure rather than for commercial purposes, can travel in commercial carriers, and be housed in temporary facilities. Household pets do not include reptiles (except turtles), amphibians, fish, insects/arachnids, farm animals (including horses), and animals kept for racing purposes."

[26] *Evacuee Support Planning Guide*. (2009, July). Department of Homeland Security Federal Emergency Management Agency. http://www.fema.gov/pdf/government/evacuee_support_guide.pdf.

Operations Management Toolkit for more information). Included in the agreement are:

1. Authorization – For use of the facility and procedures for notification.
2. Access – For opening of the facility, including identifying a 24 hour key holder.
3. Terms of use – For use of facility equipment (e.g., radios, fax machines, TVs, and computers) and reimbursement or arrangements for use of utilities (e.g., gas, water, electricity, and telephones).
4. Length of use – For as short a period as possible, but continued use must be based on the mutual decision of both parties.
5. Return of facility – To the original condition, including the replacement or reimbursement for any damage or material supplies consumed.
6. Hold harmless agreement – Defends, holds harmless, and indemnifies the facility against any legal liability for actions that occur during the sheltering operation.

C. Establish Shelter Organization Support Structure

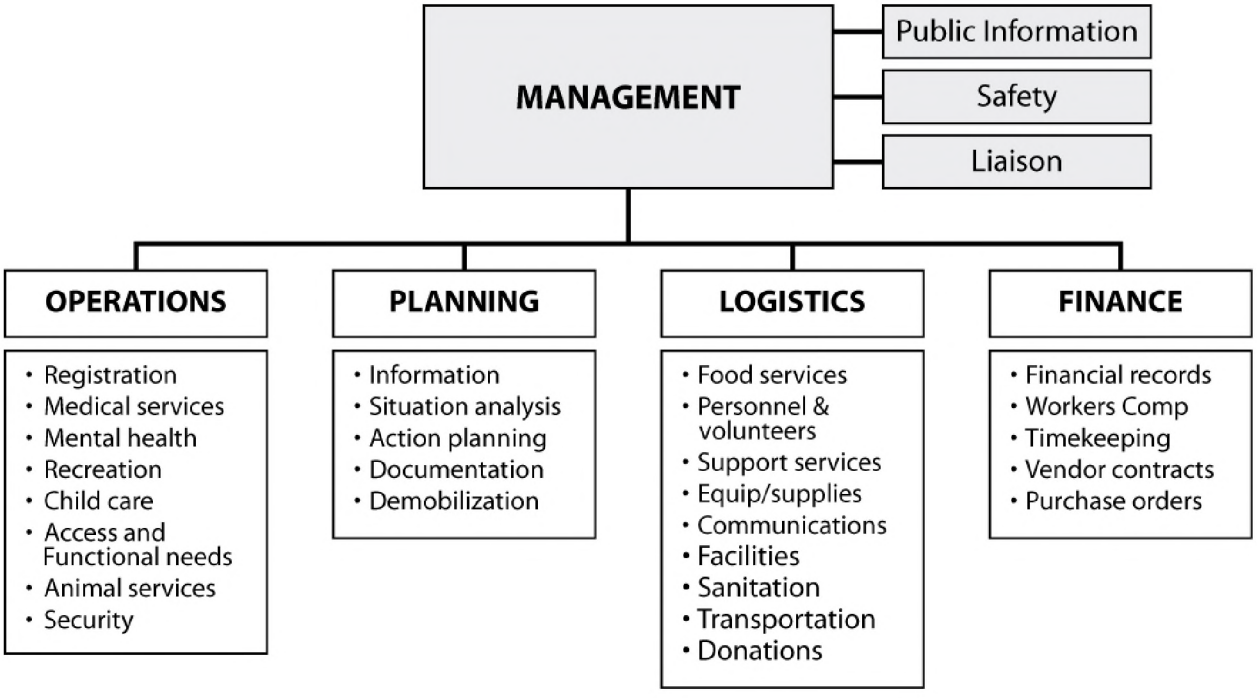

Figure VI.1: Shelter Organizational Support Structure

1. Set up a shelter operational organization structure with components, such as those in Figure VI.1. This design is based on an Incident Command System (ICS) model, and is flexible based on the scope, size, and requirements of a specific shelter and operation. Required functions include administration and oversight of the shelter; initial inspection of the facility for safety (and repeated inspection following secondary disasters that might affect it); initial and ongoing communication with the city and/or county EOC; registration and ongoing support of shelter occupants; and identification and support of people with access and functional needs.

2. Personnel from city/county resource

    a) Identify city and/or county agency employees who may be trained pre-event and pre-response as shelter managers and assistant shelter managers.

    b) Train city/county personnel resources.

        (1) Contact the Red Cross to set up mass care partnership training prior to the disaster. Possible sources from which to recruit staff may be:

            (a) City and/or county employees with specialized skills needed to support shelter operations, such as bilingual employees and employees with first aid and/or mental health training and credentials.

            (b) In cases in which schools become disaster shelters, school personnel may assist in their own facility.

            (c) Personnel who may support a mass care operation should participate in regular disaster exercises that simulate shelter activation.

    c) City and/or county emergency management personnel should maintain a roster of employees and volunteers in their jurisdiction who are trained as mass care workers. Their contact and availability information should be periodically updated.

        (1) Local governments should ensure that DSWs assigned to shelters have a completed background check.

        (2) Consider recruiting independent personnel working with governmental systems (e.g., recreational youth services) as spontaneous DSWs who have already received security screening.

D. Protocols for Opening a Shelter

The protocols for opening shelters include identifying the need for shelters and opening them when typical resources may be limited. For detailed information, refer to the Red Cross Shelter Management Operations Toolkit.

1. Deciding to open a shelter

The decision to open a shelter will vary upon the scope and size of the incident and should include appropriate multi-agency representation as a part of the Care and Shelter Branch in the EOC.

The agency/jurisdiction/EOC initiating mass care operations will develop an estimate of the shelter need (e.g., number of people to be sheltered) and then notify the Red Cross. The agency and the Red Cross will jointly determine appropriate shelter locations. The shelter location selection should consider the proximity to the event and secondary hazards (e.g., environmental hazards).

2. Costs

Cities and counties should refer to departments, California Assistance Act, and FEMA guidance for tracking and administration of costs and required paperwork for reimbursement opportunities associated with opening and managing shelters.

3. Staff

Volunteer DSWs need to be managed by the local government employing them, and may be accessed via the mutual aid system. The county will manage volunteers in accordance with the volunteer annex of the LAOA.

E. Shelter Operations

This sub-section provides an overview of the services, functions, and some of the resources necessary to support disaster shelters. Public shelters, at a minimum, provide safe haven and the provision of food. They may additionally provide other services, such as emergency first aid and mental health support.

This sub-section focuses on processes at an individual shelter. For detailed information in Shelter Management, refer to the Red Cross Shelter Operations Management Toolkit.

1. Prior to opening the shelter

a) Have the building Inspected – Ensure a building inspector clears the facility for use as shelter.

b) Establish communications – Establish communications between the city and/or county EOC and the shelter or agency providing direction to the shelter.

c) Request resources – Request necessary resources from the Logistics Section at the EOC (see Appendix 4: Shelter Logistics Supplies).

2. Opening the shelter

a) Coordinate for resources and supplies, including:

(1) Portable toilets, sinks/hand wash stations, and showers – As necessary, arrange for the installation of additional toilets and possibly shower facilities. It is recommended to provide one toilet and hand wash station for every 20 people in a shelter. Ideally, there should also be one shower for every 25 people in a shelter[27]. Local vendors need to be identified to fill this gap for shelters. Operational area coordination of vendor resources is critical to prevent and/or deconflict agreements into which local jurisdictions have entered.

b) Document operations – Keep records on all activities and expenses incurred by shelter operations.

c) Maintain contact with the EOC – Maintain ongoing contact with the city and/or county EOC to report the following:

(1) Operational updates

(2) Shelter capacity and occupancy

(3) Quantity of meals

(4) Supply status and needs

(5) Problems/issues

d) Coordinate with arrival points and reception, as appropriate – Some receiving jurisdictions may operate reception sites for the intake and distribution of the affected population to shelters or other appropriate facilities. Coordinate regularly with information on shelter status and capacity.

e) Activate and maintain vendor agreements and relationships, as necessary.

[27] International Association of Venue Managers Mega-Shelter Planning Guide, October 2010, p. 212-213. http://www.iavm.org/CVMS/mega_sheltering.asp

3. Shelter demobilization

   Shelters should remain open until multiple shelters are consolidated, and the affected population is moved closer to evacuated areas and can return to their homes or other arrangements for housing can be made.

   a) Determine triggers for demobilization.

      (1) Decreased number of affected population remaining

      (2) Incident-related "all clear"

      (3) Lack of activity over several days

   b) Develop effective media plan and outreach.

   c) Ensure the Care and Shelter Branch coordinates with shelter management for status updates.

   d) City and/or county EOC should coordinate with the Care and Shelter Branch of the CEOC to determine when shelters close.

   e) Local jurisdictions should identify any community resources and agencies that will be needed to ensure affected population has alternate housing arrangements.

   f) Determine which agencies can support the affected population's housing needs. Work with agencies in advance if there will be housing needs following demobilization (See Section X: Transition to Recovery for more information).

   g) Implement a media plan through the Joint Information Center (JIC), coordinated with the city/county EOC.

   h) The Logistics Section should obtain an inventory of surplus resources and their probable release times.

4. Administrative records

   a) The shelter management should keep accurate administrative records, including personnel and time; tracking of food, supplies, and repairs; and other expenses incurred by the emergency shelter operation. Review of FEMA reimbursement policies and requirements should be made and supported appropriately.

   b) Discussions should occur during planning phases to identify what types of administrative records will need to be shared through EOCs. Also, NGOs may have protocols that need to be considered.

   c) The Care and Shelter Branch should collect after-action reports from all shelters (see the Red Cross Shelter Operations Management Toolkit for more information).

d) Mass care personnel must plan for a method of tracking and registering each person initially entering and permanently leaving a shelter, including dates of arrival and departure. Additionally, provide a sign-in/sign-out process for shelter residents, as they leave and return during their stay.

5. Medical and Health support

Healthcare issues will arise in shelter facilities; therefore, support for access to adequate healthcare services is important. It is also necessary to maintain records on all health incidents and related actions taken (for further description, see Annex B: Medical and Health).

a) Agencies providing support in a mass care environment.

(1) Local public health agencies

(2) EMS agencies

(3) Mental health departments

b) Planning considerations

(1) First aid – Shelter personnel must plan to have basic first aid assistance available at the shelter. Identify staff with first aid training and inventory city employees for first aid skills.

(2) Local jurisdictions may need to plan to hire or contract for additional medical personnel from private sources, or request medical volunteers from the community, such as the MRC. Use of the Disaster Healthcare Volunteer (DHV) system or Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) database may be useful for resources and credential verification.

(3) Shelter residents with the appropriate healthcare training may be considered as support staff only after their credentials have been checked and verified through the local medical volunteer credentialing system.

(4) Medical Emergencies – If possible, call 9-1-1 for life-threatening emergencies and assistance with medical needs outside the capacity of the shelter. In the event 9-1-1 services are unavailable, alternative strategies may be required for addressing critical care needs. Planning efforts should seek to ensure an appropriate plan is in place to coordinate medical transport and communication from a shelter. Coordinate with the Health and Medical Branch in the Operations Section

of the EOC for other medical emergencies and transport destinations.

6. Environmental health services

The quality of life in any shelter environment with large numbers of people living in close quarters will be affected. Shelter planning should consider the environmental factors that may affect the overall health of shelter residents. This includes issues like the condition of the facility, food safety, sanitation, drinking water, sleeping areas, and other issues.

In certain types of events (chemical, biological, radiological, nuclear, or explosive), it is possible that persons arriving at shelters will be in need of decontamination prior to entry. This is a function outside of ESF #6 but should be coordinated during the planning process.[28]

7. Spiritual Care

Develop a process for accepting qualified and appropriate staff for support of spiritual care in shelters. The process should include criteria for appropriate staff credentials, management of this function, and accessing support, when needed.

a) Spiritual care should be provided by a volunteer appointed to serve as a chaplain by a public agency, or other recognized non-governmental organization. Pre-screened ordained clergy who are part of existing spiritual care teams and are trained in disaster spiritual care may also be used. These may include those who are endorsed by their religious body for ministry as a chaplain, or those who currently serve their agency as a chaplain.

b) Spontaneous spiritual care chaplains or clergy should not be used at a shelter without establishing a credentialing process.

c) Prescreened chaplains may also be secured through the Care and Shelter Branch coordinator, local fire departments, or the local community MRC Coordinator. Local MRCs may be sponsored by the local health department or a city agency. Contact your local health department or City Emergency Planning Department.

d) Spiritual care personnel must report to and work with the mental health lead at the shelter.

[28] *Los Angeles County Multi-Agency Radiological Response Plan Response Planning Guides, Volume II.* (2009, February). p. 52.

e) When considering spiritual care in shelters, identify separate co-location facilities, chapels, or prayer areas.

8. Language translation – Consider the following options for bilingual support.

   a) Bilingual members of the shelter residents – Ask bilingual individuals to volunteer and assist non-English-speaking shelter occupants.

   b) Bilingual volunteers – Seek city/county and non-profit disaster volunteers with bilingual skills.

   c) There are language line services that can be utilized at any time with access to 100 different language translators.

   d) CBOs with ethnic-specific services – Coordinate with CBOs that specialize in serving specific ethnic communities and have bilingual staff.

9. Transportation

   During the period in which the shelter is in operation, some people will require transportation to the shelter, as well as door-to-door transportation from the shelter to non-emergency medical and other appointments. In addition, people with access and functional needs may need paratransit assistance. Planning considerations include:

   a) Coordination with Logistics – Shelter personnel must plan to work closely with the Logistics Section of the EOC to provide transportation resources for the shelter residents when considering shelter emergency evacuations plans, relocation, or consolidation of multiple shelters, transport to individual medical services, or family reunification efforts. If service animals are involved, determine whether vehicles can accommodate them.

      (1) Transportation resources – Aside from local government and county resources (e.g., public transportation), other transportation resources for moving people may include school buses and commercial shuttle vans.

         (a) When considering a catastrophic scenario, make special provisions for natural gas or other non-gasoline based fuel, if vehicles utilizing such fuels are included in the planning efforts.

      (2) Paratransit resources – Identify local paratransit resources for the transport of people with mobility challenges or access and functional needs. In

addition, identify local taxi service to support the transportation needs of frail, older adults.

b) Transportation in an evacuation – Consider plans for moving large numbers of people if there is a need for a mass evacuation of community residents to disaster shelters, or from disaster shelters if a secondary hazard necessitates the evacuation of existing shelters by threatening the safety of shelter residents (see Annex D: Transportation Management for more information).

10. Communications to shelter residents in a shelter environment

Shelter personnel must plan for the collection, communication, and distribution of mass care information. This includes providing information to shelter residents about the disaster and about available relief services available, as well as information to support reunification.

a) Communication tools for shelter residents (these should be in alternative formats for people with disabilities):

(1) Bulletin boards – In an accessible location in the shelter

(2) Daily shelter briefings – At regularly scheduled times

(3) Telephones to facilitate communication between shelter residents and family members outside the area. Local telephone companies can bring in phone trailers to supplement shelter telephone capacity.

(4) Internet services and equipment, if possible

(5) Television and cable services

(6) PIO – PIO duties should be assigned in the shelter. The PIO would attend meetings and briefings offsite and provide verified information to the staff and shelter residents. PIO support from an EOC PIO may be requested from the local government EOC.

(7) Disaster welfare inquiries (DWIs) – Respond to DWIs (seeking to locate people who are presently unaccounted for) by coordinating with the shelter staff. The affected population should be encouraged to use the Red Cross Safe and Well website[29] to register their well-being. However, some people may decline to register with public search sites due to challenges, such as family disputes or domestic

[29] http://safeandwell.communityos.org/

violence. DWI registration should never be a shelter registration requirement for this reason.

(8) Additional resources – Electronic bulletin boards, traffic message signs, and satellite systems should also be considered. Los Angeles County 2-1-1 should be contacted and used for referring services for the shelter residents.

b) Communication tools for shelter management staff

(1) Telephones are the primary communication link between shelter facilities and the EOC. If telephones are down, an alternate communication plan should be coordinated with the primary sheltering agency (e.g., satellite phones, dedicated emergency radio networks, amateur radio operators, and runners).

(2) Reporting to the local EOC, DOC, and other appropriate coordination points on pertinent shelter information

(3) Types of communication:

(a) Medical transportation – General and emergency

(b) Logistical support – Personnel, equipment, services, and security

(c) Population reports

11. Social and personal needs for shelter residents

Given a significant disaster event, the affected population will begin to work toward recovery while in the shelter. Shelter personnel should plan to coordinate with external agencies and services via the Operations Section of the EOC to help meet the personal needs of the shelter residents. Some planning considerations are:

a) Childcare – Planners should initiate discussions pre-event regarding the provision of child care services to support parents in shelters with child supervision and care needs.

(1) Staff support – Arrange for staffing support from qualified and licensed city child care workers or from community volunteers with child care skills.

(2) Outside organizations – Organizations, such as Children's Disaster Services and Save the Children, can play critical roles on this topic.

b) Clothing – Emergency clothing may be needed. Donations should not be taken at the shelter, but only at a pre-

arranged, organized offsite location using a pre-determined system.

(1) Community donations – Local businesses may provide bulk clothing donations. Many FBOs coordinate clothing drives, but they should be discouraged from soliciting goods beyond the needs of the event or the organization's resources.

(2) Clothing – Organizations, such as Goodwill Industries International, Inc. and the Salvation Army, may provide clothing resources for direct distribution to the affected population.

c) Hygiene items – Shelter residents will need basic hygiene items, such as soap, a washcloth, toothbrush, toothpaste, a razor, and a comb (See Appendix 4: Shelter Logistics Supplies). Plan to obtain these items either through commercial vendors, the Red Cross, or donations from local businesses.

d) Interim to long-term housing assistance[30]

(1) Local housing departments may provide rental referrals.

(2) Housing and Urban Development (HUD) may provide rental assistance.

(3) FEMA may provide interim rental and housing assistance.

(4) Nonprofits – Nonprofit organizations (e.g., Catholic Charities and the Red Cross) have a daily presence in providing interim assistance, and may be available during events in which FEMA and HUD do not provide assistance. Many agencies that provide these resources during localized disasters are not available during catastrophic events. Coordinate through the Care and Shelter Branch of the CEOC to determine which agencies are providing long-term housing services that may include homeless sheltering programs.

(5) Housing resource list – Identify resources (e.g., hotels, motels, apartment complexes, local congregations, and trailer parks) with the potential to

[30] Specific guidance in this area is available from National Disaster Housing Strategy Resource Center, http://www.fema.gov/emergency/disasterhousing/.

provide post-disaster temporary housing for the affected population.

(6) Transitional support needs – Collaborate with family services providers and county social workers to support the affected population in their transition from the shelter into temporary or long-term housing.

e) Recovery Services – The affected population will need assistance in identifying where to go for services to meet their specific disaster recovery needs. Disaster relief organizations (e.g., the Red Cross, Salvation Army, and FEMA), along with other government, faith, and community-based relief programs, may all initiate recovery services for disaster victims. Local government should consult and initiate discussion with these organizations on recovery issues.

(1) Establish local assistance centers to facilitate the coordination of available recovery services and programs.

(2) Distribute resource lists – Develop resource lists with contact information and a description of available relief and recovery services for disaster victims.

(3) Information and referral services – Mass care personnel can work in coordination with community-based information and referral service programs, including 2-1-1, that are linked with hundreds of human service providers. Local libraries are an additional information and referral service.

(4) CBO collaboration – Mass care personnel will identify the needs of those in shelters and then coordinate, via the Logistics Sections of the EOC, with support agencies and relevant CBOs to arrange assistance. Collaborate with VOAD and CBO agencies to establish long-term recovery and unmet needs committees.

f) Replacement equipment – Older adults and people with access and functional needs will need to help to replace personal supplies and equipment if lost or damaged in the disaster (e.g., walkers, canes, orthopedic braces, wheelchairs, and hearing aids). The Care and Shelter Branch coordinator should work through local vendors to replace items.

(1) Unless a specific prescription is available, most orthotics, prosthetics, and other durable medical

equipment replacements should be coordinated with the Medical and Health Services Branch of the EOC.

g) Recreation – If large numbers of people are housed in the shelter, and if the shelter operation is prolonged, provide recreation opportunities for the shelter residents.

(1) Recreational supplies – Recreational supplies include videos, newspapers, books, games, and TV sets.

(2) Agencies with activities, group programs, and other forms of entertainment should be coordinated through the EOC, and should be considered away from the primary sleeping areas, if possible.

h) Waste management – Plan to arrange for daily garbage/waste removal. A major earthquake disaster will most likely disrupt regular service. Plan to have surge capacity of removal services.

(1) Maintenance, inspection, and regular cleaning of the facilities will need to be coordinated on an accelerated schedule to support the increased population. Ensure that local service agencies (plumbers, electricians, and janitors) are available for regular inspections and service of the shelter resources.

VII. Mass Feeding

This section outlines primary considerations when evaluating and planning for resources needed to provide basic sustenance to the general public.

A. Pre-Assessment

1. Demographics of impacted areas

a) Census information and local data

b) Specific dietary considerations

(1) Access and functional needs related to self-feeding

(2) Special dietary needs (allergies and food sensitivities)

(a) Most allergies and sensitivity challenges can be solved by ensuring a portion of the provided meal plan (about 10% of all meals served) has a vegetarian or protein-free option. Though stock meals (e.g., stew, chili, and soup) are the easiest to prepare, they also are prohibitive to those with specific dietary needs.

(3) Older adults

(4) Cultural considerations

(5) Child-appropriate diets

(6) Infant-appropriate formulas and food

c) Phases of feeding operations

(1) Immediate – Begins with event impact and ends with the establishment of supported field kitchens.

(2) Sustained – Begins when field kitchens and temporary feeding sites are established, and ends when the regular infrastructure is re-established.

(3) Recovery – Programs like Disaster Supplemental Nutrition Assistance Program (D-SNAP), Disaster Food Stamp Program (DFSP) and other post-relief resources should be identified and included in planning resources. The re-establishment of public feeding programs (e.g., food stamps, food banks, and local feeding charities) should be considered in this phase of planning.

d) Commodity typing – Identify resources by preparation, serving, and storage requirements.

(1) Tier 1: No equipment is needed to open, serve, or prepare food. No heating is needed. No refrigeration

is needed for storage (e.g. meal ready-to-eat [MRE], Heater Meal, granola, and dried fruits).

(2) Tier 2: Heating is ideal for the proper serving of food. Water may be required. Tools may be required to open or serve food. No refrigeration is needed (e.g., most canned soups, stews, and chili).

(3) Tier 3: Requires heating and/or water to prepare food, requires serving utensils, and does not require refrigeration (e.g., rice and pastas).

(4) Tier 4: Requires heating and/or water to prepare food, serving utensils, and refrigeration or freezing (e.g., meats, vegetables, and other perishables). Raw ingredients pose significant challenges to prepare food safely under mass care conditions. Use pre-cooked meats in this category, whenever possible.

e) Hydration – For existing public water utility resources, identify any potential threats or potential disruptions to supplies of ground and surface water using the Emergency Response Plan Guidance for Small and Medium Community Water Systems.[31] Public hydration plans should include some consideration for an interruption of these drinking water resources, and should be managed using a bulk distribution model (See Section VIII: Bulk Distribution).

(1) Coordinate with the Care and Shelter Branch of the CEOC to determine the resources available from the U.S. Army Corps of Engineers, such as purification units and mobile potable water trailers if bottled water or public utilities are unavailable.

f) Private or CBO partnerships – Local caterers, restaurant chains, hotels, and fast-food vendors may be operational, depending on the impact of the event and the level of private contingency planning. Many have in-depth planning for food storage, back-up power sources, and clear planning to re-establish business operations. Identify available resources and establish agreements with vendors suited to handle large-scale meal preparation (e.g., vendors that cater to correctional facilities, sporting arenas, and other mass gathering sites). Plan to re-assess the private partnership operational capabilities post-event.

[31] Emergency Response Plan Guidance for Small and Medium Community Water Systems to Comply with the Public Health Security and Bioterrorism Preparedness and Response Act of 2002. US EPA. http://www.epa.gov/safewater/watersecurity/pubs/small_medium_ERP_guidance040704.pdf.

g) Model of service delivery – Planners must consider varying service delivery models, such as distribution hubs (e.g., points of distribution, fixed feeding sites, and mobile feeding), and contextual assumptions that would influence the decision-making process. Models with scalable approach and timelines, such as the stand up of distribution hubs to distribute shelf-stable products prior to the stand up of field kitchens may greatly increase the efficiency of service delivery during a large to catastrophic event.

2. Production/Supply

a) Local stockpiles – CBOs, schools, and other establishments with existing stock, food banks, and other non-disaster feeding agencies may have existing stock. Also, government distribution centers and wholesale stores with large warehouses that support multiple retail stores should be considered. These sites often have a significant, secured food supply with backup power sources.

b) Local production – Manufacturing resources in the affected jurisdiction.

c) Externally controlled stockpiles – These include a national strategic stockpile, USDA foods, and school lunch programs.

d) Purchasing – Previously unaccounted for stock of supplies may be available from local retailers' wholesalers. If there are disruptions to infrastructure, plans should be in place to coordinate procurement of these resources through the Logistics Section as quickly possible. Initial procurement of potable water and Tier 1 or 2 food items should be the priority, with the intention of supporting a bulk distribution operation in the first few days. Many businesses that have the ability to secure Tier 4 bulk quantity food products for several days in a refrigerated warehouse should be encouraged to do so. Tier 4 food products (e.g., cooked meats) that were secured in the early hours of a mass power failure can be combined with many Tier 3 products to support an ongoing feeding operation without relying on external supply chains.

3. Distribution/Supply chain – Identify the sustainability of supply routes between intended food storage sites, food preparation sites, and food serving sites.

4. Food preparation

a) Mobile kitchen – Mobile kitchens have resources on board to prepare and serve food. Most commercial options are less than ideal for mass feeding due to the limited cooking speed

and a single-serving window. Some mobile kitchen vendors have all cooking resources attached to a container or trailer with a generator.

(1) Many agencies have access to mobile kitchen facilities. Meals on Wheels, the Salvation Army, and others may have mobile kitchens in the local jurisdiction.

b) Field kitchen – A field kitchen can be set up in a public outdoor site typically includes portable heating elements (e.g., propane and electric stoves), and can prepare food on any flat surface. Planners should work with local NGOs to determine the availability of these resources. Provisions should be made to supplement a field kitchen with available resources to maintain the maximum intended meal output, such as:

(1) Staff to accommodate preparation (e.g., cutting raw food), cooking stations (e.g., manning ovens, stoves, and skillets), and cleanup to ensure that appropriate sanitation standards are maintained. A staffing ratio of 1 preparer: 1 cook: 1 cleaner can be used for planning purposes.

(2) A trash/dumpster site should be kept well away from the food preparation site, and gray water disposal should be considered.

(3) Generators, flood lights, propane, diesel, gas, and potable water will need to be brought in to support the preparation of most cooked food products.

(4) Food storage in temperature-controlled food-grade containers (e.g., "Cambros") is needed to maintain food temperature safety, whether food is being temporarily stored during the food preparation or when the final product is stored for distribution.

c) Fixed kitchen – Institutional kitchens may be available to support serving operations either at or near the places of serving. FBOs, restaurants, or catering companies often have full-scale industrial kitchens that can be used for mass feeding.

d) Food-cooking equipment

(1) Mass care kitchens will have equipment typically found at mass gathering events. Depending on the equipment available when fully staffed, the following equipment can be evaluated to determine the rate of meal production.

(a) Convection ovens – These typically have 10 cooking pans and can cook food to safe temperatures in about 10 minutes. Roughly 2,500 8oz protein (e.g., meat) portions can be cooked per hour.

(b) Conventional ovens – They typically have no more than 3 or 4 pans and can take up to 50 minutes to raise food to safe temperatures. Roughly 100 protein (e.g., meat) portions can be cooked per hour this way.

(c) Tilt skillets – Forty gallon industrial skillets can be used to cook rice, beans, vegetables, or chopped meats. They can take 20 to 30 minutes to bring food to a safe temperature and can make up to 800 servings per hour.

(d) Jacketed steam kettle- Ten to 60 gallon industrial double boilers, called steam kettles, are often used in the production of soups, stocks, stews, chilies, pastas, and sauces. Depending on the food product, steam kettles can heat most food to safe temperatures in less than 30 minutes. Ten gallon kettles can produce about 200 to 300 6oz servings per hour.

(e) Large stovetop and 40 or 60 2-quart stock pots – These typically take about 45 minutes to cook the contents. They require constant attention to prevent food contents from burning. A 40-quart stock pot can produce 100 servings in the 45-minute cooking periods.

(f) Barbeque grills – They can use either wood or propane, and can typically cook one rack of any food product in about 10 minutes. Though this option is often considered in outdoor cooking venues because of the surface area needed, the number of servings that can be cooked on one rack at a time is typically very low.

e) Ensure that all local food safety codes are met in any mass-feeding environment. A certified food handler is required in feeding operations in permanent and wholesale food

facilities. Exceptions are those food service operations open on a temporary basis (i.e., feeding sites)[32][33]

(1) Food safety training, such as Food Handler (www.foodhandler.com/training.cfm) or ServSafe (www.servsafe.com/) should be considered.

5. Serving

a) Mobile units – These vehicles are capable of delivering hot or cold food, but with no or very limited independent food preparation capability. Examples include Red Cross Emergency Response Vehicles (ERVs) and the Salvation Army Disaster Response Units (DRUs).

b) Fixed site

(1) In shelter serving – Serving food in a shelter should comply with the environmental health guidelines for the shelter (see Annex B: Medical and Health for more information).

(2) Coordinate with the Red Cross or shelter manager to ensure that safe food-handling practices are followed.

(3) Vehicle drive-up serving – Hot meals may be served out in clam-shell containers at a bulk distribution site, or through some other fixed location. Ensure that all safe food-handling procedures are followed, and appropriate traffic safety guidelines are met.

(4) Mass gathering/public walk-up serving – Reception centers, shelters, or other public areas may require feeding at a fixed site that is not connected to a shelter. This serving model is ideal if personnel or other resources are limited and one site must be used to support several (e.g., when multiple shelters are a part of a larger campus). Coordinate with volunteer agencies to ensure that appropriate staffing is maintained, and safe food-handling procedures are followed.

6. Food sanitation

a) Hand-washing stations and worker safe-handling practices should be a top priority. Provisions for gloves, hair covers,

[32] A certified food handler is defined as "an owner, operator, or any other person at least 18 years of age, who supervises all or part of the food service operations within the facility and is responsible for training the operations' employees." Los Angeles County Code 11.11.040.

[33] LA County Code, Ordinance 11.11.060, Environmental Health

appropriate clothing, and onsite worker training and evaluations should be considered.

b) Equipment-washing stations (e.g., a three-compartment sink and high-speed heated water hose) are needed to ensure proper equipment safety. Also, sanitizer sprays/soaps should be considered as a way to properly prep the area.

(1) A potable water source will be needed for rinsing. Also, having water heated to a temperature of 150 degrees is ideal for washing.

(2) A grey water collection tank will be needed if sewer systems are not available.

(3) Food storage for both pre-cooked and cooked food, and heat-resistant containers, will need to be cleaned after use. Food-grade liners can reduce the cleaning time needed for many food stores.

B. Basic Menu Planning Tips

Plan menus of foods available, using an approximation of 2,000 to 2,500 calories per person, per day. Perishable, easily prepared foods (Tier 4) should be used first, if available, especially when refrigeration is a challenge. Anticipate additional meals will be needed (extra servings or uncounted populations) over the estimated count, whenever possible.

1. A basic meal should include 8oz of protein, 6oz of starch, and 6oz of vegetables/fruits, plus a drink. Combinations or alterations of these totals can be considered, such as a starch or fruit dessert option, a bread or chip-based food of smaller quantity, or a high-protein drink option.

2. When possible, the goal should be to provide two hot meals and one cold meal per person per day.

3. Water can and should be served, but also consider hot drinks (e.g., coffee) or drinks requiring refrigeration (e.g., juice). Though most drinks do not need to be served chilled, planning for iced or refrigerated beverages with the meal planning can help offset health issues caused in a hot climate, outdoor sheltering, or limited indoor cooling.

C. Meeting Special Diet Needs

Many vegetarian meals can meet multiple special dietary considerations, such as ethnic concerns, food sensitivities, and allergies. Consider planning as much as 10% to 15% of the regular meal plan to accommodate special dietary needs. Strive to meet as many special diet requests as possible, although resources to do so may be limited immediately following a disaster. Children may have more food

sensitivities than the general population, and infant food requirements should be evaluated and planned for, as needed.

D. Reporting Needs

Mass care personnel are responsible for reporting to the EOC a daily count of the number of meals prepared and distributed, number of fixed and mobile feeding sites/routes, and the projected number of meals required. In addition, uncooked food product quantity consumption rates and resupply requests should be considered and coordinated with onsite logistics planning efforts for future meal plans.

E. Non-Meal Feeding

Some agencies, such as the Red Cross and Salvation Army, can supply snacks and hot or cold drinks to first responders or other affected populations during non-meal times. These "canteen" vehicles or "canteening" operations vary in scope, but can be used to supplement needs when normal meals are otherwise unavailable (e.g., when kitchen facilities are not available due to resource availability). This may be the only method of food disbursement. Consider such feeding support on a larger scale using the guidance in Section VIII: Bulk Distribution, Consider providing 2,000 to 2,500 calories per person per day, and focusing on the distribution of a combination of protein and starch-based food products.

VIII. BULK DISTRIBUTION

This section outlines primary considerations when evaluating and planning for resources needed to provide essential supplies to the general public after a disaster. Bulk Distribution includes the distribution of emergency relief items to meet urgent needs through sites established within the affected area(s). These sites are used to distribute food, water, or other commodities in coordination with local, tribal, State, Federal governmental entities, voluntary agencies, and other private-sector organizations.

A. Distribution Methods

1. Mobile delivery is a method that utilizes vehicles to drive into an affected area and provide commodities at different drop locations or where the need is identified. This type of distribution is common in rural areas and where roads are damaged.
2. Direct delivery refers to direct coordination with a specific location (e.g., a shelter, feeding site, or hospital) for the delivery of specific items and quantities. These commodities could be food, water, and comfort kits. Direct deliveries are usually larger in size and more specific in commodity type than what is delivered through mobile delivery.
3. Points of distribution (PODs) are centralized points where supplies are delivered and the public travels to the site to pick up the commodities. Further guidance on the management of a POD can be found in the FEMA IS-26 Guide to Points of Distribution.[34]

B. Selection of Staff Management

Once a plan is in place for mobile delivery, direct delivery, or points of distribution, ensure appropriate agencies are notified of their role in the plan as far as management, coordination, and direct supervision of a unit.

Expectations of the unit manager, recruitment, and training requirements should be coordinated with the Logistics Section when activating a plan and assigning an appropriate manager.

C. Assign/Recruit Workers Based on:

1. Familiarity and training with equipment
2. Volunteer resources versus employees
3. Supply use and worker safety
4. Direct distribution jobs take little training and can be assigned to an unskilled workforce. Consider implementing the Adopt-a-POD program, where appropriate.

[34] http://training.fema.gov/EMIWeb/IS/is26.asp

D. Location Selection

1. Determine locations based on:

   a) A demographics and needs analysis

   b) The population density of surrounding areas

   c) The POD type and number of sites that are needed, or the expected scope of the operation

   d) Current methods of commodity distribution and existing supply chains

   A critical event infrastructure will need to be created based on available resources. As the Logistics Section of the EOC identifies the disaster supply routes that will be capable of supporting the Bulk Distribution operation, coordinate the intended site selection along those routes, while ensuring that the distance from the distribution centers and service delivery sites is minimized, where possible. Ensure other agencies are not duplicating efforts by encouraging joint operations at the established sites.

   Critical sites (e.g., medical centers and large shelters) will have an existing supply chain, and the intended routes for resupply can be used to support a Bulk Distribution operation. Ensure that existing supply routes will not be compromised by public traffic patterns when announcing the availability of a Bulk Distribution site to the public.

E. Registration of Workers

It is recommended that all workers are registered through some common means, and all workers that have direct interaction with the public should have undergone a background check. Worker compensation or liability coverage may need to be coordinated when establishing registration guidelines for a Bulk Distribution operation.

F. Plan activation

1. When activating a Bulk Distribution plan, ensure that resources are in place to support:

   a) Worker safety and injury liability

   b) Initial supply and resupply processes, including fuel for equipment and expendable equipment (e.g., gloves and vests)

   c) Communications between the field unit and Care and Shelter Branch of the EOC

   d) Coordination with the facility manager onsite

   e) Public notification and community relations

G. Supply/Resupply

Supplies to be issued during a Bulk Distribution operation will vary based on the type of disaster and the public need. A specific hazard analysis should help to identify which types of supplies could be obtained through post-event procurement and which should be stockpiled in advance.

1. Shelf-stable food – Typically MREs or other Tier 1 food products should be planned for consumption.
2. Water/Hydration – For sanitation reasons, individually bottled water is preferred, but other larger storage items may be considered for distributing potable water.
3. Ice and insulated coolers – A significant heat event occurring at the same time as a wide-area power outage may necessitate the distribution of ice. Coolers should be considered at first pickup, and ice only on subsequent pickups.
4. Portable dwellings – Includes tents and/or canopies for outdoor sheltering. See Annex C: Non-Traditional Sheltering for open-space shelter models.
5. Blankets – Blankets are considered life-saving commodities, particularly during cold weather or open-space sheltering situations.
6. Portable heaters/cookers – Depending on the food commodities available for distribution, portable cookers may need to be considered during first pickup.
7. Medical – Mass inoculations during a biological or radiological event are the most common types of this category.
8. Infant – Diapers, infant formula, wipes, and other specialized items should be identified in coordination with appropriate child service agencies.
9. Sanitation – This is limited to personal sanitation items (e.g., soap, toothpaste, and female hygiene items). See the Red Cross personal comfort kits for guidance. This category may also include face masks and hand sanitizers, in some situations.
10. Cleanup items – Bleach, shovels, work gloves, dust masks, tarps, and a wide variety of items can be considered when distributing items for damage cleanup.
11. Miscellaneous – Considerations based on need could be made for a wide variety of items that do not fall into any of the above categories. These items include sunscreen, insect repellant, flashlights/batteries, lip balm, and others.

H. Commodity Typing

When typing non-food related commodities for distribution, consider the category of product, the reason for including the category in the distribution plan (as based on public need) and developing types based on product available, and the complications of storage, distribution, and assembly/use by the end recipient. Wherever possible, identify the most ideal commodities for distribution and challenges that may be present. Storage, distribution, and use requirements will significantly differ depending on the commodity and distribution models (i.e., distribution of cots compared to personal hygiene items).

Refer to Section VII: Mass Feeding, Commodity typing, to ensure consistency with other mass care operations that are based on preparation, serving, and storage requirements.

I. Quantity Planning

An assessment of the demographics and affected populations obtained from the Planning Section in the local EOC will help to identify the initial necessary supply levels to prepare for. Bulk Distribution operations run by the Red Cross pre-load a service delivery site with supplies for 250 families for 3 days, and then evaluate the need based on consumption rates each day. The expected inventory levels can be projected several days out based on the daily reported consumption rates, and can be planned for accordingly.

J. Local Stockpiles

CBOs, schools, non-profits, non-disaster feeding programs, and FBOs have existing stockpiles of food, water, and medical supplies that could be used for a distribution program, whether managed directly or by the independent organization. An assessment of available resources will help to identify the key resources needed in affected areas and the identification of the most-needed items.

An assessment of available community programs will also help to identify which areas and demographics have the greatest need or are under-served during non-disaster times. These same areas will likely have the greatest demand when a Bulk Distribution plan is activated.

Local retailers and wholesalers may have additional stock locally maintained that could also be available for distribution. If there are disruptions to infrastructure, plans should be in place to coordinate the procurement of these resources through the Logistics Section of the CEOC.

K. Safety

The site manager will be the primary safety officer for staff at the scene. However, attention should be given to particularly dangerous situations.

As a precaution, plans should be in place to evacuate or close a Bulk Distribution operation due to site safety in any catastrophic event.

L. Demobilization

The need for a Bulk Distribution operation is often based on a lack of infrastructure (e.g., roadways, power, and water) to support normal distribution of food, water, or other supplies. Once the local infrastructure begins to support the normal business operations of the surrounding community, re-evaluate the need for a bulk distribution operation and consider closing. For example, if a POD is in the parking lot of a grocery store, once the electricity and roadways are back to working order and the store begins receiving stock, the POD may actually interfere with their operation.

It is important to remember that even if Bulk Distribution operations are able to close in some locations, others may actually see an increase in the number of people seeking support. Infrastructure restoration may be more difficult in some areas than in others, so each operation should be evaluated separately.

When closing, ensure that:

1. The site manager knows where to refer any remaining customers if other operations are still ongoing.
2. Any excess supply not given out is consolidated and shipped to another location to support other operations.
3. The Logistics Section is able to recover all equipment used at the site.
4. The public is sufficiently notified of the close of operations.
5. Final paperwork is recovered from the site, and staff is appropriately released.

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IX. Disaster Welfare Information

According to the National Response Framework, "Disaster Welfare Information includes services related to the provision of information about individuals residing within the affected area to immediate family members outside the affected area. It may also include services related to the reunification of family members within the affected area."[35]

A. Information Services

1. There are numerous systems available to assist in the connection of separated family members, such as the Red Cross Safe and Well Web site.

   a) The Red Cross Safe and Well Web site[36] is available 24/7 to support any disaster, and does not require activation.

   b) It is an open system that is available to all individuals.

2. Other independent reunification programs or systems may appear at the time of a disaster. Considerations should be given to whether these systems are confidential and reliable.

3. Consider having these resources available at all shelters to encourage reunification and reduce populations seeking shelter.

4. Due to family conflict and domestic disputes, some victims may not want to register on such information systems. In a disaster setting, these resources should never be required for registration, nor should registration data be openly searched for disaster welfare inquires.

B. Reunification

During an evacuation, the focus is on supporting immediate emergency need; thus, reunification may not be a priority until after the initial movement of the affected population is complete. Reuniting unaccompanied minors who are separated from their parents/guardians, and adults requiring care who are separated from a required caregiver, will be the priority.

Family Assistance Centers provide reunification services at designated locations through the following methods:

1. Arrange for communication capabilities so the affected population can make contact via telephone or Internet.

2. Use public information outlets to disseminate available assistance

[35] Emergency Support Function #6 – Mass Care, Emergency Assistance, Housing, and Human Services Annex. (2008, January). Department of Homeland Security Federal Emergency Management Agency. National Response Framework. http://www.fema.gov/pdf/emergency/nrf/nrf-esf-06.pdf.

[36] https://disastersafe.redcross.org/

and reunification program information in various formats and languages to accommodate people with disabilities and/or limited English proficiency.

3. Many private-sector organizations or NGOs may support reunifications through various resources.

   a) Volunteer pilot groups (e.g., Mercy Medical Airlift/Angel Flight) may support reunification of affected population by arranging air transportation in response to healthcare and other compelling human needs.

X. TRANSITION TO RECOVERY

Recovery planning should commence as soon as a disaster occurs. Typically, mass care activities during and following disasters last for short periods (i.e., several hours to several days). In such situations, it is not likely that there will be a need to focus on the transition to recovery programs during the mass care operations. However, in the aftermath of more lengthy and devastating events, some disaster victims may need mass care support for a more extended period (i.e., several weeks to several months). During extended mass care operations, it is helpful to provide disaster victims with information about disaster assistance programs so they will be better prepared to transition to recovery. Information about recovery programs can be provided in mass care facilities (e.g., shelters) or in other facilities (e.g., local assistance centers [LAC]) that are convenient to disaster victims.

A. The Role of LACs in the Transition to Recovery

1. When it is not feasible to disseminate information about post-disaster recovery programs within mass care facilities, communities should consider creating LACs as a one-stop source of disaster recovery assistance information.

2. Typically in the aftermath of presidential emergency or disaster declarations, FEMA will establish Disaster Recovery Centers (DRCs), where disaster victims can obtain information about and apply for different forms of disaster assistance. FEMA DAP 9430.1[37], October 1, 2008, describes FEMA's policy related to the use of DRCs. In situations where the use of both DRCs and LACs is being considered, FEMA and the affected State and communities should coordinate among themselves regarding activities of these facilities.

3. LACs serve as central clearinghouses for the dissemination of information about disaster assistance programs. LAC personnel should work with city and/or county EOC PIOs to coordinate communications to the public relating to LAC activities, as well as recovery from disasters.

4. Transportation Services – Both mass care facilities and LACs can serve as central sources of information relating to transportation assets that are being used following disasters, including the transportation of disaster victims who have no means for traveling to mass care facilities (e.g., older adults and people with disabilities).

5. Donations and volunteer management coordination will be carried out in accordance with the respective donations and management

[37] http://www.fema.gov/good_guidance/download/10304

annexes of the LAOA ERP. Cities may utilize these annexes or develop their own.

B. Roles and Services provided by Voluntary Agencies during Recovery

There are a variety of voluntary agencies that work with disaster victims in the aftermath of disasters, and these voluntary agencies provide a wide array of services. In addition, FEMA employs Voluntary Agency Liaisons (VAL) to serve as liaisons between FEMA and voluntary agencies. VALs should be integrated into plans to assist disaster victims in their transition from mass care to recovery. A list of some of the voluntary agencies that work with disaster victims is included in Appendix 6: References.

Voluntary agencies might provide such services as:

1. Advocacy on behalf of disaster victims, especially those with access and functional needs, to help them obtain needed resources and services
2. Case management and counseling on completing documentation that is required to apply for disaster assistance and providing emotional support to disaster victims
3. Child and older adults care services
4. Cleanup and re-building services to assist disaster victims in their efforts to repair their homes
5. Community outreach to educate individuals, businesses, churches, schools, and other organizations about ways they can assist disaster victims
6. Emergency assistance (e.g., food, clothing, and shelter)
7. Financial assistance, including funds to pay for funeral expenses and to help disaster victims begin their recovery
8. Healthcare services
9. Pet care services, including pet rescue and sheltering operations
10. Relocation services to help disaster victims move from impacted areas in the immediate aftermath of disasters and/or back to disaster areas once the situation has stabilized
11. Access and functional needs services to assist in identifying populations that have needs, and in meeting those needs
12. Training community-based volunteers to assist disaster victims or providing job skills training for disaster victims to facilitate their economic recovery from disasters

XI. ANNEX A: HOUSEHOLD PET SHELTERING

Many people refuse to evacuate without their pets. The Pets Evacuation and Transportation Standards (PETS) Act of 2006 amends the Stafford Act and requires evacuation plans to take into account the needs of individuals with household pets prior to, during, and following a major disaster or emergency. Since many mass care shelters do not permit household pets, it is the responsibility of local jurisdictions to establish household pet shelters. The mass care function is not responsible for household pets; however, mass care should communicate with the agency responsible for sheltering and caring for pets. Service animals are not considered household pets and must remain with their owner at all times.

In the event of an evacuation of household pets, cities within the operational area may have different guidelines on allowing household pets to travel on transportation vehicles being used to evacuate citizens from potential disaster areas to pet shelters. The planner needs to consider health and safety regulations in his or her jurisdiction regarding the way in which transportation will be arranged.

In order to support those who have evacuated and must reside temporarily in congregate care shelters, Los Angeles County Department of Animal Care[38] and Control (LACDACC) and Los Angeles Animal Services have plans in place to shelter pets that have been displaced by a disaster in the operational area and Los Angeles, respectively. Animal control officers, the Humane Society of the United States (HSUS) and private animal care shelters will assist in the sheltering of household pets. This section provides guidance on establishing, running, and demobilizing a pet shelter.

A. Roles

1. LACDACC is the lead agency for the county, unincorporated areas, and cities that contract with them for the support of pets that are affected by a disaster. Los Angeles Animal Services and some other local jurisdictions have their own departments, as well. The Animal Liaison Officer at the Emergency Operations Center (EOC) will coordinate the procurement and dissemination of animal feed, water, and supplies to the sheltered household pets.
2. The Animal Care and Health Unit Leader is the liaison for the independent animal control groups within the county.
3. Animal control officers, the Los Angeles Humane Society, the Society for the Prevention of Cruelty to Animals Los Angeles (SPCALA), and private animal care shelters will assist in the sheltering of small and large animals.
4. Veterinarians and/or the Veterinary Medical Association may

[38] The Los Angeles County Operational Area Animal Emergency Response Annex was approved in 2010 and should be reviewed as the primary source for further information.

provide trained, certified household pet shelter staff to guide shelter managers in the setting up and running of a congregate household pet shelter. The Southern California Veterinary Medical Association (SCVMA) Disaster Preparedness Committee is working on developing a Medical Reserve Corps (MRC) for area veterinarians interested in registering for, training for, and responding to disasters.

5. The LACDACC has a Memorandum of Understanding (MOU) with HSUS, in which HSUS will provide support for household pets that are brought to shelters by their owners.

6. The LACDACC plans to establish similar MOUs within other jurisdictions.

7. Jurisdictions should work with local and regional agencies, as well as the private sector, to identify household pet shelter and confinement resources, animal food and water sources, and supplies, as well as to establish MOUs for support of household pets affected by a disaster. Animal food is a major consideration when planning temporary shelters. Plan to have MOUs and/or contracts in place with pet food suppliers. In a wide-scale emergency, pre-agreed-upon relationships may help in the acquisition of limited resources.

B. Sites

1. Site criteria – For temporary household pet shelters, key planning criteria in site selection include open space where tents and cages could be set up, access to open space for exercise, and availability of water. Co-location or proximity to human shelter locations should also be a key consideration in selecting a pet shelter site.

2. Primary and Secondary sites – Local animal control services may open temporary household pet shelters in the city parks, veterinary health clinics, boarding facilities, kennels, or, if possible, co-locate them with human shelters.

3. Site reporting – All pet shelters being opened should communicate their status to the local EOC for central coordination.

C. Household Pet Shelter Setup

1. Site inspection – Those opening pet shelters should determine if their jurisdiction requires an assessment of the facility and/or that the facility passes a safety inspection before use. Elements under consideration could include:

a) Existing damages (document)

b) Restrooms for staff

c) Running water

d) Electricity

e) Adequate lighting

f) Ventilation

g) Waste disposal

h) Telephone and Internet capability

i) Back-up power sources

2. Shelter layout

a) Set up signage

b) Establish a secure perimeter and control access

c) Set up and stock the registration and intake area, the secondary decontamination area, the triage area, and the first aid area

d) Identify and set up animal-specific housing areas

e) Mark off a place for animal exercise and dog relief

3. Establish safety guidelines – Local jurisdictions are responsible for animal and staff safety, and must do all that they can to ensure that the public is protected from animal danger.

D. Livestock and Exotic Animals

Some members of the public have livestock or exotic animals as pets or economic assets. Livestock owners have the responsibility to prepare for evacuation of their livestock or pets in an emergency or disaster. Jurisdictions may plan to assist in the transport of these animals out of danger zones and in their sheltering. Establishing good relationships with stables and farms within jurisdictions is important. Exotic animals, such as snakes and monkeys, will need sheltering, especially if they are housed in sanctuaries that have to evacuate. Local zoos may be able to assist, but may also need local jurisdiction support when they have to evacuate.[39]

Ultimately, the owners/managers of zoos and wild/exotic animal sanctuaries are responsible for having an emergency response plan in place, as well as making arrangements for evacuation of these animals.

Evacuation to sites that can accommodate particular exotic animals should be considered. Depending on the types and varieties of animals, it is likely that they will have to be distributed to the appropriate sites that meet their needs in terms of space, environment, habitat, and care.

[39] Under the Pet Evacuation and Transportation Standards Act of 2006, costs to a jurisdiction for transport and sheltering of livestock and exotic animals are not federally reimbursable.

Livestock and exotic animals that are displaced and are roaming "at large," thereby creating a public safety issue, must be considered in planning. Animal Control, California Department of Fish and Game (CDFG), U.S. Department of Agriculture, U.S. Fish and Wildlife Service, and local public safety will need to be involved.[40]

E. Staffing

Many jurisdictions have limited staff available to run temporary household pet shelters. Animal control agencies will need most of their staff to run their household pet shelters and to manage owner turn-ins, and their officers will be picking up strays and mounting rescue efforts. In a regional response, many more staff will be needed.

1. Establish a pet shelter manager and staff. If possible, choose people who, in a disaster, will be managing the same facility or a similar one that they normally manage during non-disaster times.
2. Staff may include the following positions:
    a) Front desk manager
    b) Veterinary services manager
    c) Veterinarians
    d) Veterinary technicians
    e) Animal care technicians
    f) Animal behaviorist
    g) Psychologist or social worker for personnel and owner issues
    h) Human shelter liaison
    i) Safety officer
    j) Logistics coordinator
    k) Animal control officer (ACO)/security officer
    l) Personnel to unload and stock supplies, as well as runners and other volunteers
3. Veterinarians should be credentialed by the Veterinary Medical Reserve Corp (VMRC) via Southern California Veterinary Medical Association's (SCVMA) Disaster Committee to ensure licenses are current and in good standing.

[40] Animal Emergency Response Annex. Los Angeles Operational Area Emergency Response Plan. p. 13-14.

a) Use of out-of-state veterinarians must be determined by the appropriate credentialing organization.

4. It is advisable to organize staffing using the principles of the Incident Command System (ICS).

5. Training

   a) Shelter staff and volunteer personnel should complete an orientation that covers the general situation, shelter-specific setup, safety guidelines, shelter organization, and assignment.

   b) Staff and volunteers will receive just-in-time training, as needed, specific to their assignment.

   c) For pre-identified staff and volunteers, encourage pre-event training, such as the courses offered online for free by the FEMA Emergency Management Institute (EMI) on ICS and Animals in Disaster. Also, HSUS and the American Humane Association (AHA) offer training on how to set up emergency sheltering.

   d) Ensure that veterinary staff is licensed.

6. Volunteers

   a) Plan to develop relationships with animal care groups (e.g., AHA, HSUS, and SPCALA) that can provide trained and credentialed animal care personnel. Pre-identifying what resources these groups have will assist in deploying them when they are needed.

   b) Maintain a list of interested potential volunteers and their contact information. Possible volunteers may include students, retirees, and local and National Voluntary Organizations Active in Disaster (NVOADs).

   c) Los Angeles County and Los Angeles Animal Services or other animal control agencies have in-house volunteers who have been trained in small and large animal shelter care, including large animal transportation.

   d) Upon registration, identify any special skills the volunteer might have, and credential volunteers who are designated to work in a shelter.

F. Registration and Tracking

All household pets arriving at the shelter, regardless of whether they were rescued or are arriving with their owner, should go through a registration and tracking process.

1. A registration form should be completed for each pet that includes name, breed/description, age, weight, immunizations, any illnesses or injuries, and microchip information, if applicable. The name and contact information of the owner(s) should also be included on the form. In addition, any personal supplies owners bring for their pets should be labeled and listed on the registration form. A form needs to be completed for rescued household pets as well, identifying the location where the household pet was found. The registration form should be kept on file at the shelter with copies provided to the owner, and adhered to the pet carrier/crate.
2. All household pets should be scanned with a universal microchip scanner and must receive a tag that must be worn at all times. Some areas may want to institute a microchip policy. Tag and/or microchip numbers should be listed on the registration form. Chip implanting in household pets may be offered if the owners agree and the capability is present. If possible, household pets should also be photographed for record-keeping.

G. Animal Care

Pet shelters will provide protection from the elements, as well as food and water, for all evacuated and rescued household pets. Shelter management will also coordinate emergency veterinary services and assess the need for decontamination. Any medical care provided to a pet should be documented and released to the owner.

1. Basic care – Basic pet care at the shelter should include housekeeping, cleaning and sanitizing, pest control, housing, feeding, watering, and exercising. A species-specific veterinarian should be consulted regarding appropriate diets and feeding frequency. If the household pet shelter is co-located with a public shelter, household pet owners may be able to care for their household pets under the direction of household pet shelter staff.
2. Decontamination – Pets that have come in contact with floodwater or other hazardous materials should undergo decontamination and a health assessment. Primary decontamination may be performed by first responders in the field or outside of the shelter facility. Secondary decontamination may be necessary depending on the type of hazardous material(s) with which the household pet has come in contact. Secondary decontamination and a health assessment will be performed by a certified responder or staff member.
3. Triage and first aid – Emergency care will be prioritized based on the severity of animal conditions. Only qualified staff may provide first aid to animals. The triage and first aid staff must be able to provide emergency medical care.

4. Prevention and treatment of transmissible diseases – Transmissible diseases, including zoonotic diseases, which are shared between animals and people, could pose a threat to humans and household pets in a shelter environment. Basic animal management and disease control guidelines should be followed to maintain human and animal health and reduce the risk of disease transmission. Veterinarians should monitor animals for zoonotic and nosocomial[41] diseases to prevent transmission and minimize the threat to human and animal health. Obtain guidance from local animal services' jurisdictions on whether to vaccinate disaster-evacuated household pets on intake.
5. Isolation and quarantine – Isolation and quarantine serve to protect human safety and animal health by containing the spread of disease. Rabies isolation areas should be separate from other isolation and quarantine areas. Any clusters of disease (e.g., outbreaks), infectious diseases, and animal bites should be reported immediately to VPH at the EOC.
6. Death of a household pet while in a shelter – Despite best efforts, some household pets expire while in a shelter. If this occurs, a process should be in place to advise the owner of the death and then to coordinate with the owner either the reclaiming of the deceased household pet and its belongings, or disposition of the remains.
7. Coordination with appropriate mass animal fatality policies for the disposition of these animals.
8. Euthanasia – A veterinarian or licensed euthanasia technician should make the determination of when euthanasia is appropriate and which method should be administered.
9. Mortality management – Appropriate and efficient carcass disposal is required to protect human and animal health, the food supply, and the environment. In Los Angeles, the Department of Public Works (DPW) Sanitation Section removes dead animals.
10. Unclaimed or abandoned household pets – There are many reasons why a household pet may not be reunited with its owner, but resolving this issue can be very sensitive. The following are possible strategies to address this:
    a) Shelter policies include signed agreements to remove the household pet at the time of shelter closure.
    b) An animal or household pet abandonment policy that would include:

[41] Disease acquired while in and because of an animal shelter.

(1) Defining "abandonment"

(2) Publishing the location where "abandoned" animals will be sheltered

(3) Coordinating the reunification of owners with household pets that were rescued from an affected area (including location and status of rescued animal and dissemination of "Lost Animal Alert" to rescuers)

(4) Obtaining health regulation waivers, if applicable

(a) State and local statutes pertaining to unclaimed animals and lost property are a source of legal uncertainty in many states. In some states, pets displaced by a disaster are considered lost property, and the owner may retain extended rights to reclaim his/her property. However, most communities do not have the resources to hold unclaimed lost pets for an extended period of time. States and local communities should research these issues and accommodate existing statutes within their plans.

(b) Fostering policies include posting timelines for an animal's status from "abandoned" to fostering to adopted, as well as the credentialing protocol for animal fostering.

H. Communications

1. Public information

a) A pre-scripted message approved by the PIO and verified by the Animal Services Section at the EOC and ICP should include shelter locations, owner responsibilities, and other pertinent information to be disseminated through the public information system. Owners should be encouraged to bring pet immunization papers, carriers, leashes, muzzles, food dishes, and any required medicines. This information can be disseminated by various media outlets, such as TV, radio, Internet, Facebook, Twitter, and text alerts, and through press releases by the OEM.

b) Messaging during the sheltering period should include what supplies are desired for donations as needs arise, as well as visiting hours for owners.

2. Owner updates – Pet shelter management should remain in contact with mass care shelters. Regular updates should be provided to the

pet owners at the mass care shelters through means such as Web-based bulletin boards. Procedures should be implemented for owners to visit their pets. Each jurisdiction should decide whether owners will be allowed to help care for their pets.

I. Reunification

Household pet owners will be given an opportunity to be reunited with their animal(s). Information that is taken during the intake process will be utilized for reunification. In addition, reasonable measures will be taken to inform owners of the need for reunification and to promote its completion. Owners should provide the household pet shelter-issued tag or microchip number as proof of ownership and a photo with them and their pet. The American Animal Hospital Association has a free Internet-based look-up tool for microchips in partnership with various pet database organizations (e.g., American Veterinary Identification Devices (AVID) and Home Again).

J. Donations

During short-term or long-term sheltering operations, local animal food suppliers and citizens may wish to donate money or goods to the household pet shelter(s). The acceptance of these donations must be carefully documented through the city and/or county EOC and delivered to the appropriate shelter or shelter manager. If a general donation process is used by the operation as a whole, all donations should be directed to and requested from that source.[42]

K. Facility Cleanup and Repair

The facility should be decontaminated and disinfected to prevent the transmission of disease. The facility should be returned to its original configuration and order to the greatest extent practical.

L. Demobilization

All equipment and supplies will be returned to a ready state in order to ensure their availability for follow-on operations. Organize and secure all appropriate documentation.

M. Reimbursement

State and local governments that shelter the affected population from areas that received a Presidential Emergency or Disaster Declaration for a major disaster or emergency can seek reimbursement for eligible household pet and service animal-related costs through FEMA. The PETS Act established that eligible reimbursement costs include jurisdiction expenses to set up and operate household pet shelters, including

[42] The process of Volunteer and Donations Management is outlined in an annex to the County Emergency Operations Plan and should be coordinated through the appropriate EOC.

veterinary care and animal care staff costs.[43] Staff should be aware of appropriate documentation and record-keeping to be maintained for submission.

[43] *Disaster Assistance Policy 9523.19. Eligible Costs Related to Pet Evacuations and Shelter.* (2007, October 24). Department of Homeland Security Federal Emergency Management Agency. http://www.fema.gov/government/grant/pa/9523_19.shtm.

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XII. ANNEX B: MEDICAL AND HEALTH

A. Introduction and Purpose

The purpose of this annex is to elaborate on the medical, health, and mental health considerations in various shelter environments and to support the Emergency Support Function (ESF) #6 operations within the Los Angeles Operational Area (LAOA) Mass Care Guidance for Emergency Planners. The goal of this annex is to provide local planners with specific considerations and guidance on medical, health, and mental health planning for operations within the mass care environment that will enable them to develop informed and useful plans and planning documents. Providing this guidance to local planners offers a framework for strong plans. The ultimate goal is to promote the general health and well-being of shelter residents in disaster environments.

The daily health needs of the LAOA population are wide-ranging and attended to by a vast and complex health system, which includes public and private hospitals, specialty institutions, clinics, skilled nursing facilities, in-home providers, first responders, and others. Following a disaster, the daily medical, health, and mental health needs of the affected population will still exist, and the system will be additionally burdened by new illnesses and injuries resulting from the disaster.

1. Applicability

This annex is intended to assist emergency planners in understanding key medical and health considerations associated with service delivery in the mass care environment. The considerations and guidance within are designed to be applicable and scalable to any size shelter, city, or event.

2. Scope

The focus of this annex is limited to the medical, health, and mental health considerations within the Mass Care/ESF #6 environment.

As defined by the U.S. Department of Health and Human Services (HHS), the public health and medical services functions within ESF #6 include the following[44]:

a) Providing HHS medical workers to augment local health services personnel as appropriate

b) Providing medical care and mental health services for affected populations either inside or outside the shelter locations in accordance with appropriate guidelines used by local health officials

[44] *Emergency Support Function #6 – Mass Care, Emergency Assistance, Housing, and Human Services Annex.* (2008, January). Department of Homeland Security Federal Emergency Management Agency. National Response Framework. http://www.fema.gov/pdf/emergency/nrf/nrf-esf-06.pdf.

c) Providing technical assistance for shelter operations related to food, vectors, water supply, and waste disposal

d) Assisting in the provision of medical supplies and services, including durable medical equipment (DME)

(1) Coordinating emergency medical care in shelters as needed at the request of the affected states in accordance with appropriate guidelines used by local health agencies

3. Methodology

The Alliance recognized the importance of medical and health considerations for a larger disaster and incident response effort. This is especially apparent in a scenario in which hundreds of thousands of people are displaced in and around shelters for weeks and months. This annex is a compilation of practices and considerations collected from Alliance outreach and planning meetings with counterparts across the United States, health agencies in the LAOA, and other emergency preparedness guidance documents.

B. Assumptions

Historically, when planning for disasters and catastrophes, there has been an assumption that the medical and health infrastructure will be largely available as usual and that all medical, health, and mental-health related issues would be easily deferred to the nearest emergency department. As observed in other U.S. disasters of similar magnitude and the consequence projections[45] [46] [47] [48] of the Great ShakeOut scenario, the reality is that the vast majority of the health infrastructure will have limited capacity and operations for some period of time.

The following assumptions were used in the development of this annex and may be applicable in the development of local plans:

1. For a catastrophic incident occurring with notice, medical and

[45] *Disaster Earthquake Scenario Unveiled for Southern California.* (May 2008). U.S. Geological Survey. http://online.wr.usgs.gov/ocw/htmlmail/2008/May/22/20080522GSnr.html.

[46] *Golden Guardian 2008 Damage to Hospitals and Emergency Care Using Local (improved) Data.* October 2008. California OES-GIS.

[47] *Southern California Catastrophic Earthquake Integrated Work Group (IWG) 8—Public Health and Medical Estimate Report, Version 6.*

[48] Hospital functionality is a hospital's ability to support the amount of beds it has. During an earthquake, a hospital may still physically have the same amount of bed space, but it may lack the staff and equipment to support them. Reduction in hospital functionality can also be caused by the building structure being unsafe; lack of water, power, and other utility support; as well as a lack of support staff to secure the rooms, provide food and water, and maintain sanitary conditions.

health resources and assets can be secured, and there is time to move from an area of danger to an area of safety.

2. A catastrophic incident/event occurring with notice may destroy most of the medical, health, and mental health infrastructure in the impact zone, but most of the population will be out of harm's way and have access to unaffected or minimally affected infrastructure.

The catastrophic consequence projections of the Great California ShakeOut scenario have been used to frame the planning considerations and recommendations for this document. Relevant consequence projections from the Great ShakeOut scenario include the following:

- Magnitude 7.8 earthquake on the southern San Andreas Fault.
- 1,800 deaths, with additional deaths likely as a result of transportation infrastructure damage, resulting in delays in treating the injured.
- Approximately 50,000 ambulatory patients seeking care from the healthcare network.
  - Approximately 18,000 of these patients will present at emergency departments.
  - Approximately 32,000 of these patients will seek treatment in other outpatient settings.
- 80% hospital functionality across all institutions in Los Angeles County, with additional loss of functionality likely as a result of aftershocks.
  - Four hospitals require evacuation.
  - Approximately 20 hospitals are significantly damaged and can take on no new patients.

3. A no-notice catastrophic incident/event will likely leave the majority of the population in the impact zone, where the surrounding medical, health, and mental health infrastructure may be significantly damaged, destroyed, or otherwise unavailable.[49]

4. As time goes on, the medical, health, and mental health needs of shelter residents will fluctuate.

5. Current Planning Posture

   Currently, no shelters in the LAOA are designated explicitly for populations that have medical or access and functional needs. Rather, people with acute medical needs are directed or transferred

[49] Local building codes may prevent the reoccupation of certain medical facilities after an evacuation without an inspection. Planners should consult with jurisdictional authorities about what details should be considered in planning for these events.

to hospitals and people with access and functional needs may be accommodated in any shelter.

California statute precludes segregating access and functional needs populations within shelters; however, some population separation can occur, if appropriate and necessary, based on medical need.[50]

C. Current Medical and Health Roles and Responsibilities in the Mass Care Environment[51]

1. Red Cross

Information about the roles and responsibilities of the Red Cross can be found in Section III: Roles. The Red Cross health and mental health assistance may include the following:

a) Provide emergency and basic first aid, including infection control measures or isolation precautions, if needed.

b) Assess the health needs of and triage the shelter residents, including any medical needs.

c) Make appropriate community referrals for healthcare not available in the shelter.

d) Evaluate and arrange for transfer to a local healthcare facility or other appropriate site for clients who require a level of medical care not available within the shelter environment.

e) Ensure that sanitary conditions are maintained in the shelter, especially in the kitchen area, restrooms, and healthcare areas.

f) Identify and monitor safety hazards.

g) Arrange for the replacement of prescription medications for shelter residents who lost medication as a result of the disaster.

h) Monitor and assist with the healthcare needs of workers in the shelter.

i) Provide mental health support and crisis intervention for individuals with emotional or mental health issues.

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[50] *Guidance on Planning and Responding to the Needs of People with Access and Functional Needs: Sheltering*. California OES- Office of Access and Functional Needs. Accessed online on May 25, 2010, at http://www.oes.ca.gov/WebPage/oeswebsite.nsf/Content/52DCF0D4BAAB01FB8825749B008086A6?OpenDocument.

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2. Los Angeles County Department of Coroner

   The Los Angeles County Department of Coroner provides the following support:

   a) Handles the removal and storage of remains for fatalities that occur within the shelter.

   b) Provides guidance to shelter managers about the handling and storage of remains until they are able to be removed from the shelter.

3. Los Angeles County Department of Public Health[52]

   In the mass care environment, the Los Angeles County Department of Public Health (DPH), through its Department Operations Center (DOC), in consultation with the Public Health Officer and in coordination with local health departments, may provide the following at the request of the EOC/CEOC:

   a) Specially trained DPH liaisons to work at the Los Angeles EOC/CEOC in the Operations Branch to support ESF #8-Health and Medical Services and coordination of county response.

   b) Public health nurses (PHNs) may be provided to aid in the initial survey of potential shelter medical needs and general shelter site assessments. They may, for example, assess sites for the following:

      (1) Water temperature inspection

      (2) Americans with Disabilities Act (ADA) compliance

      (3) General living conditions

      (4) Presence of infants

      (5) Presence of people with disabilities

      (6) Persons with obvious symptoms of illness

      (7) Syndromic surveillance on report of widespread symptoms in shelter (see Contagious Diseases and Surveillance section for additional information)

[52] In addition to the Los Angeles County DPH, there are three distinct and independently operating municipal health departments within the LAOA: Pasadena Public Health Department, Long Beach Department of Health and Human Services, and the City of Vernon Health and Environmental Control Department. Each has unique planning and response protocols, as well as unique relationships with Los Angeles County departments, community agencies, and organizations within their city boundaries and with surrounding cities. This guide acknowledges the contributions of individual health agencies in disaster planning, the collaborative relationships that will be necessary in regional disaster planning, and the importance of the respective jurisdictional authority in decision making.

c) Triage at shelters is not currently part of the operational plan.

d) Community Health Services (CHS), a division of DPH, is the "field response" division of public health nursing.

e) Public health staff may be available as a supplementary resource per EOC assignment with the consent and direction of the Health Officer.

f) Medical personnel may be recruited from the Disaster Healthcare Volunteer (DHV) system (Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)/Medical Reserve Corps (MRC)).

g) PHNs may be provided through memoranda of understanding (MOUs) to assist in supporting the Red Cross at shelters.

h) DPH Environmental Health may provide the following disaster response functions:

(1) Inspect and report status of sanitation services for food handling and disposal of medical and human waste from shelters, and provide corrective actions.

(2) Determine the safety of the water supply and safe use of potable and non-potable water.

(3) Monitor service animals in shelters.

4. Los Angeles County Department of Health Services

In the mass care environment, the Los Angeles County DHS, through its Department Operations Center, may provide the following at the request of the EOC/CEOC:

a) Specially trained Department of Health Services (DHS) liaisons work at the EOC in the Operations Section to support ESF #8 (Medical and Health Services) and coordination of county response.

b) DHS may provide additional personnel to support DPH and may coordinate transportation of shelter residents to the appropriate medical facility as needed.

c) Once hospitals are fully functioning, DHS may partner with identified healthcare institutions to implement an adopt-a-shelter program. As planned for, this program seeks to provide skilled medical staff to shelter sites by matching individual institutions and shelters. Hospital staff will triage, provide basic intervention services, write prescriptions, and perform other basic health delivery services.

d) The Emergency Medical Services (EMS) Agency, as a part of the DHS system, provides the following disaster response functions:

(1) Coordinate the immediate emergency medical response in a disaster.

(2) Ensure timely and coordinated evacuation from hospitals or health facilities and provides medical assistance to ill and injured patients.

(3) Facilitate the movement of casualties to designated definitive care sites.

(4) Coordinate the procurement, allocation, and distribution of medical personnel, supplies, equipment, and other resources under the agency's command as necessary.

(5) Assist in the temporary placement of medically fragile people in shelters as a last resort in the immediate aftermath of a disaster until the shelter operations team can safely transfer them to other local care facilities or to facilities outside the immediate area.

(6) Recruit medical personnel from the DHV system. For additional information, see the Additional Planning Considerations Section in this annex.

5. Los Angeles County Department of Mental Health

In response to a disaster, DMH will provide disaster mental health services as requested through the EOC or through SEMS. The DMH will be the coordinating body for all mental health services within the LAOA.

The department will coordinate and provide mental health services to community disaster victims and disaster emergency responders throughout the duration of the disaster and its recovery period.

DMH provides the following disaster response functions:

a) Specially trained mental health liaisons to work at the EOC/CEOC in the Operations Section to support ESF #8 (Medical and Health Services) and to coordinate county response

b) Triage, education, assessment, and intervention of individuals affected by the disaster

c) Continuity of care for people with mental disorders who were receiving care prior to the disaster

d) Mental health outreach and education to schools affected by disasters

e) Licensed and trained staff to support mental health services in Red Cross shelters

f) Specially trained teams to respond to emergency workers as needed

g) Licensed and trained staff to Family Assistance Centers (FACs)[53]

h) Licensed and specially trained staff to the requesting county and city departments

i) Trained staff to requesting hospitals

j) Support for the psychological and emotional well-being of the affected population

k) Support in prescribing psychotropic medications

l) Support in psycho-education and normal reactions to abnormal events

m) Support in referrals and community resources

n) Assessments and evaluations of affected population

o) Support in debriefing with shelter and other emergency response personnel

DMH will be responsible for the coordination of other community counseling resources. If county mental health resources become exhausted, the department will coordinate with its contract providers for additional resources. If further support is still needed, the mutual aid plan will be activated.

6. Los Angeles County Department of Public Social Services

DPSS provides the following disaster response functions:

a) DPSS is designated as the Care and Shelter Branch Coordinator of the CEOC and is expected to respond to any natural or man-made disaster that requires the provision of emergency care and shelter for disaster victims. DPSS discharges this responsibility in cooperation with the American Red Cross, the Salvation Army, California Department of Social Services (CDSS), county departments

[53] Family Assistance Center (FAC): A proposed Los Angeles County plan provides a place for families of disaster victims (other than train or airplane accidents, which are managed by the National Transportation Safety Board (NTSB)) to obtain information about their loved ones, as well as emotional, social, and other support services including mental health.

assigned to support DPSS, local cities, and Federal agencies as designated in the NRF.

b) DPSS is the designated county disaster liaison with private, not-for-profit human services agencies and the grocery industry. DPSS discharges these responsibilities through relationships with the Grocery Industry Mutual Aid Council, California Department of Social Services, and Emergency Network Los Angeles (ENLA), which are the voluntary organizations active in disaster (VOAD) for the LAOA.

c) Resource requests by the Red Cross for durable medical equipment or first aid items may be submitted to the DPSS Care and Shelter Branch Coordinator who will submit a resource request to the Logistics section at the CEOC. If a shelter requests PHNs or mental health support nurses, that request would be forwarded to the DPSS Care and Shelter Branch Coordinator who will, in turn, request the appropriate health staffing from available agencies.

d) DPSS is responsible for continuity of public assistance programs (e.g., food stamps, Medi-Cal).

e) DPSS is responsible for management of the Emergency Food Stamp Program.

f) DPSS is responsible for outreach to In-Home Supportive Services (IHSS) at-risk consumers who may be affected by the disaster.

D. Persons with Access and Functional Needs

1. Defining Access and Functional Needs

It is estimated that at least 30%[54] of the general population will require some sort of assistance maintaining their independence, communication, or mobility in a disaster. Over time, the language used to define and describe these populations has evolved; however, regardless of the terminology, planners must prepare to assist these people in maintaining their health, safety, and independence in a mass care environment. Current planning guidance within California has largely discontinued using the

[54] The U.S. Census Bureau estimates there were more than 36 million people in California in 2008. In August 2008, the Governor's Office of Emergency Services, Office for Access and Functional Needs, estimated that by 2010, there would be more than 11 million people with access and functional needs. http://www.google.com/url?sa=t&source=web&cd=3&ved=0CCMQFjAC&url=http%3A%2F%2Fwww.access2readiness.org%2Fatf%2Fcf%2F%257BC14CBB0E-FAC4-403F-96ED-286A512B4DDA%257D%2FGuidance%2520on%2520Integration%2520Final%25208-08.doc&ei=IP4STOP4GYH_8AadkK2dDA&usg=AFQjCNG9CCqRD21o7fyJil9kmXoy3Nm_FA

terminology "special needs populations," "vulnerable populations," and "fragile populations" in favor of "access and functional needs populations."

Specific definitions regarding who exactly are considered to have access and functional needs vary, but the basic concept behind all definitions provides a function-based approach to planning and seeks to establish a flexible framework that addresses a broad set of common function-based needs irrespective of specific diagnoses, statuses, or labels (e.g., children, older adults, transportation disadvantaged).[55] The purpose of this function-based approach is to classify needs rather than individual people. Through this system, it is neither important nor necessary for planners to go to every community and identify the individual needs of each citizen. Rather, it is important for planners to understand the categorical needs of their citizens as a population and then plan the logistics of fulfilling those needs.

FEMA, via the NRF and CPG 301, and the California Office for Access and Functional Needs describe access and functional needs populations as people whose members may have additional needs before, during, and after an incident in five functional areas: communication, medical care, maintaining independence, supervision, and transportation (C-MIST).[56,57]

a) Communication

(1) Individuals who have limitations that interfere with the receipt of and response to information (e.g., hearing impairment, limited English language proficiency, cognitive disability) will need that information provided in formats (e.g., written, auditory, pictorial) they can understand and use.

(2) Individuals with some physical, cognitive, or behavioral disabilities or with language barriers may not be able to hear announcements, see directional signs, or understand how to get assistance.

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[55] *Comprehensive Preparedness Guide (CPG) 301, Interim Emergency Management Planning Guide for Special Needs Populations.* (2008, August 15). Department of Homeland Security, Federal Emergency Management Agency. http://www.fema.gov/pdf/media/2008/301.pdf.

[56] Ibid.

[57] *Guidance on Planning and Responding to the Needs of People with Access and Functional Needs: Identification of People with Access and Functional Needs.* California OES- Office of Access and Functional Needs. Accessed online on May 25, 2010, at http://www.oes.ca.gov/WebPage/oeswebsite.nsf/Content/710D9E2F73772B8B8825749B00808615?OpenDocument.

b) Medical Care

(1) Individuals who are not self-sufficient or who do not have adequate support from caregivers, family, or friends may need assistance with managing unstable, terminal, or contagious conditions.

(2) Some conditions may require observation and ongoing treatment; management of intravenous therapy, tube feeding, medication requiring skilled assistance, and vital signs; dialysis, oxygen, and suction administration; wound management; and power-dependent equipment to sustain life.

(3) These individuals require the support of trained medical professionals.

c) Maintaining Independence

(1) Individuals requiring support to be independent in daily activities may lose this support during an emergency or a disaster.

(2) Such support may include consumable medical supplies (e.g., diapers, formula, bandages, ostomy[58] supplies), durable medical or assistance devices/equipment (e.g., canes, wheelchairs, walkers, scooters), service animals, self-dispensed and maintained medication, and/or attendants or caregivers.

(3) Supplying needed support to these individuals will enable them to maintain their pre-disaster level of independence.

d) Supervision

(1) Before, during, and after an emergency, individuals may lose the support of caregivers, family, or friends or may be unable to cope in a new environment.

(2) If separated from their caregivers, some individuals may be unable to identify themselves, and, they may lack the cognitive ability to assess the situation and react appropriately.

[58] Tube or catheters for drainage.

e) Transportation

(1) Individuals who cannot drive or who do not have a vehicle may require transportation support for successful evacuation.

(2) This support may include accessible vehicles (e.g., lift-equipped or vehicles suitable for transporting individuals who use oxygen) or information about how and where to access mass transportation during an evacuation.

Using the C-MIST functional areas and framework allows emergency managers to conduct effective planning that anticipates the needs of various populations and integrates associated considerations in comprehensive planning efforts.

2. Key Considerations for Access and Functional Needs Planning

When conducting planning for people with access and functional needs, emergency managers should also consider the following:

a) Needs are often predictable.

(1) Anticipating what simple interventions, tools, and devices may be needed to facilitate independence in advance of an event reduces the burden on shelter staff and facilitates a more efficient and effective response.

b) The degree of need and associated support extends across a wide spectrum.

(1) Not all access and functional needs are complex. Each capability area may vary greatly depending on the needs. Some independence needs may be as simple as providing a cane and as complex as providing assistance with feeding and toileting. Access and functional needs, when appropriately addressed, may return a person to their pre-disaster capacity.

c) A person may have needs that fall into one or more C-MIST functional area.

(1) It is possible that an individual will have access and functional needs from several of the five C-MIST categories. Priorities based on the level of need and necessity for daily living should be considered.

d) The disaster may be the catalyst that results in a person requiring support in a C-MIST functional area. Persons

without health issues may develop them in a disaster environment, and the health of persons with health and/or medical needs may degrade in a disaster environment.

e) Incorporating community members with access and functional needs into planning activities enhances output and future response.

f) Homogenizing populations can lead to vague planning and unanticipated challenges.

The following sections seek to elaborate on the planning considerations associated with specific populations and needs that fall within the access and functional needs framework.

E. Persons with Medical and Health Needs

1. Medical Conditions

A subset of the shelter population will have specific medical conditions requiring care. Ideally, people with medical needs beyond the service capacity of the shelter will be transferred to a more appropriate level of care, such as an emergency department within a hospital. If the infrastructure and resources do not permit transfer, intervening strategies may be required. See the section on Response Strategies in this annex for more information.

Acute

Symptoms appear and can change or worsen rapidly.

- Broken bones
- Heart attack
- Influenza
- Appendicitis

Medical conditions can be broken down into two categories: acute and chronic. Acute conditions are illness and injuries with an abrupt onset of symptoms that may change or worsen rapidly, such as a bone fracture or heart attack. Chronic conditions, such as heart disease or asthma, develop and worsen over an extended period of time. Acute medical events can happen as a result of a chronic condition, for example a heart attack can be an acute event resulting from the chronic condition of heart disease.

Chronic

Develop and worsen over an extended period of time.

- Diabetes
- Heart disease
- Cancer
- Asthma

Both acute and chronic conditions can vary in severity and type of treatment required; however, all will require medical care at some point. For the purposes of this document, medical care is defined as the prevention, treatment, and management of

illness and the preservation of physical well-being through the services delivered by medical, nursing, and allied health professionals.[59]

In a catastrophic incident/event, it is likely that a subset of the population will have acute medical needs as a result of the event (e.g., sprains, broken bones, lacerations). Chronic conditions, if not appropriately managed, can deteriorate and become acute. For example, without access to appropriate medication and monitoring devices, people with diabetes can develop life-threatening complications. For many shelter residents, maintaining medication regimens will be the key to avoiding exacerbated conditions that required more advanced levels of care.

Shelter residents may not disclose their medical conditions and associated needs to shelter staffers.

2. Health Needs

For the purposes of this document, health is defined as a state of physical, mental, and social well-being. In a catastrophic event, all shelter residents will have general health needs though they will vary from person to person. For example, the health needs of a pregnant woman are different from those of other populations. These health needs will include nutritional, dietary, exercise, recreational, grooming, personal hygiene, proper sleep, and social needs. Due to resource shortages resulting from the event, not all general health needs will be able to be met. It is important for planners to consider the Mass Care Guidance for Emergency Planners for suggestions on how to optimize the shelter environment and available resources to assist their shelter population in maintaining healthy behaviors and routines.

3. Specific Medical and Health Needs

Some people who evacuate to a general shelter will require a higher level of care or monitoring by a caregiver or medical professional because of a pre-existing medical or health need. When possible and appropriate, those needs may be accommodated in a shelter; however, resources may not be available to meet all medical and health needs.

[59] Allied health professionals are clinical healthcare professions distinct from medicine, dentistry, pharmacy, and nursing. They work in healthcare teams to make the healthcare system function by providing a range of diagnostic, technical, therapeutic and direct patient care and support services that are critical to the other health professionals they work with and the patients they serve. They include paramedics, clinical psychologists, phlebotomists, and others (http://www.asahp.org/definition.htm).

Examples of these specific needs that may present within the shelter environment include[60]:

a) Individuals with severely reduced mobility (arthritis, muscular conditions, artificial limbs or prosthesis)

b) Persons who have any medical equipment that needs monitoring

c) Wheelchair bound persons with medical needs

d) Insulin-dependent diabetic unable to monitor their own blood sugar or to self-inject

e) Persons requiring assistance with tube feedings

f) Draining wounds requiring frequent sterile dressing changes

g) Patients with partial paralysis

h) Various ostomies, if unable to take care of themselves

i) Persons who require special medical diets

j) Persons with tuberculosis controlled by medication, but need monitoring for compliance

k) Persons whose disability prevents them from sleeping on a cot

l) Persons temporarily incapacitated, such as those in post-surgical recovery

4. Medical and Health Needs for Children and Young Adults

Children and young adults have social, dietary, recreational, and medical and health needs. Clinical differences to be considered and monitored include[61]:

a) Psychological differences (age-related response to trauma)

b) Immunologic differences (higher risks of infection)

c) Anatomic differences (size and more pliable skeleton)

d) Physiologic differences (higher metabolism, age-related variations in vital signs)

e) Developmental differences (inability to vocalize pain)

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[60] *UASI High Risk/Medical Needs Shelter Planning Template.* (2008, April). p. 16. http://www.emd.wa.gov/plans/documents/Planning_MedicalNeedsShelterPlan.pdf.

[61] *Pediatric Terrorism and Disaster Preparedness: A Resource of Pediatricians.* American Academy of Pediatrics. Accessed online on June 3, 2010, at http://www.ahrq.gov/research/pedprep/pedtersum.htm.

5. Assessment and Triage

As people enter a shelter, their medical, health, and mental health needs should be assessed. The purpose of this assessment is two-fold—first, to identify people with specific medical, health, and mental health needs and, second, to prioritize medical service delivery based on the severity and urgency of an individual's medical needs. The concept of prioritizing care based on need is known as triage. Under the best circumstances, there will be medical personnel skilled in triage and who can provide a thorough assessment of the shelter resident's medical and mental health needs. In other, less ideal situations, a volunteer with no experience or qualifications in formal triage may conduct assessments.

Triage

The method by which individuals are prioritized for assistance.

A number of tools and systems are available to assist in assessing medical, health, and mental health needs and triaging care. These include the HHS Shelter Intake Form, START[62], PsySTART™[63], and SWiFT[64]. Regardless of what system is used, the purpose of triage is to quickly identify the people with the most serious medical and mental health needs in order to provide them appropriate care. Additionally, shelter personnel should be prepared for the possibility that some portion of the population will not disclose their medical conditions, medications, and other medical, health, and mental health needs during the assessment process but may later require intervention or support for those needs.

F. Mental Health Considerations

Some portion of the shelter population will experience mental health issues while in residence. These mental health issues may result from the event itself or may be due to pre-existing mental health conditions.

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[62] Simple triage and rapid treatment (START) is a method used by first responders to effectively and efficiently evaluate all of the victims during a mass casualty incident. http://www.cert-la.com/triage/start.htm.

[63] PsySTART™ is a mental health triage tool that is used by healthcare and mental healthcare staff to assess the level of impact (dose exposure) following a disaster. It measures severe and extreme event exposures including witnessing traumatic injury and death of others, perceived life threat, traumatic loss of loved ones, injury or illness in self or family, and ongoing stressors such as housing, changes to livelihood and other daily stressors that may have evolved from the event. The PsySTART™ mental health triage system is currently be developed as a Hospital Preparedness Program (HPP) project though the Los Angeles County Emergency Medical Services Agency and the UCLA Center for Public Health and Disasters. http://www.cphd.ucla.edu/pdfs/PsySTART%20Rapid%20Mental%20Health_Web.pdf.

[64] The SWiFT tool provides a rapid determination of the level of need or assistance necessary for vulnerable older people during disasters. http://www.dmphp.org/cgi/content/full/2/Supplement_1/S45.

Emergency planners should plan strategies to identify and address the mental health needs of the sheltered population regardless of the cause.

If a shelter is being operated within Los Angeles County, the DMH will be the coordinating body for all mental health services.

Shelters opened by the Red Cross usually have disaster-trained licensed mental health professionals acting in a volunteer capacity who are available to assist individuals experiencing emotional and mental health issues. They are trained to provide psychological triage, crisis intervention, emotional care and support, and to assist individuals with problem solving. Sometimes clients need help beyond the capability of resources commonly found in a general population shelter. In those instances, Red Cross mental health workers make referrals to the community or may contact the Department of Mental Health for assistance in formally assessing an individual for treatment, medication, or hospitalization. Staffing in non-Red Cross shelters may not include licensed mental health professionals.

1. Initial Mental Health Assessment and Intervention

   As people enter a shelter and are assessed as part of the triage process, mental health needs should be prioritized based on severity and urgency of need just as medical needs are. Priority for intervention should be given to individuals with acute mental health needs, including those who appear to be a danger to themselves or others and those who appear to be acutely distressed. Whenever possible, people with acute mental health needs should be transferred to a facility where appropriate care can be provided, such as a psychiatric emergency room. If it is not possible to transfer a person to a higher level of care, efforts should be made to find a quiet, dimly lit space where they can remain until additional support is available. Additionally, onsite psychiatric evaluation and medication support may be requested via the EOC.

   Should a person appear to be a danger to themselves or others, they may need to be assessed for an involuntary psychiatric hold, also known as a 5150 application for adults and a 5585 application for minors. For more information on 5150/5585 applications see

Tab M: Involuntary Treatment- Detention of Mentally Disordered Persons for Evaluation and Treatment (WIC 5150 and 5585).

2. Maintaining Psychotropic Medication Regimens

As with all medications, it is important that psychotropic medication regimens be maintained within the shelter setting. During the shelter intake process (depending on the questions asked), shelter staff may be able to identify people taking psychotropic medication who require support either to take their medication or obtain additional supplies of their medication. Sensitivity should be used when inquiring about mental health and psychotropic medications, and shelter staff should be aware that not all people who take psychotropic medications will report doing so if asked. It is possible that some people will begin to experience psychiatric decompensation[65] as a result of no longer taking needed medication, and shelter staff should be prepared to assist these people in obtaining appropriate care.

3. Staffing and Coverage

Mental health staffing requirements will depend on shelter size and location of populations. The first few hours within a shelter environment may be chaotic, disorganized, and stressful for the entire sheltered population but more so for people already experiencing mental illness. To mitigate stress response and the potential for further deteriorating mental health, specialized mental health support should be provided as soon as possible. As soon as possible after an event, DMH personnel will call on the shelters and proactively engage and assess the needs of shelter residents.

Mental health staffing and outreach efforts are most effective when they are conducted in accordance with and matched to the demographic, language, and ethnic characteristics of the affected population. Effort should be made to work in cooperation with community leaders to understand diverse populations and craft outreach and messaging strategies appropriate to that community.

4. Minors

Children are often the first to be traumatized by the event and subsequently being separated from their caregivers can compound the trauma they experience. During Hurricane Katrina, children too young to speak or so traumatized they were unable to speak were found separated from caregivers making reunification challenging.

[65] Decompensation is the degradation or deterioration of mental health in an individual who, up until that point, has maintained his or her mental illness.

Efforts should be made to support child mental health, especially that of unaccompanied minors.

G. Response Strategies

The current planning posture within the LAOA only calls for a very limited amount of medical care to be delivered within the sheltering environment. As stated before, currently, there are no shelters in the LAOA that are explicitly designated for populations that have medical or access and functional needs. Rather, people with acute medical needs are to be directed or transferred to hospitals. In a catastrophic event, it is likely that the healthcare system, including the emergency medical transport system and local hospitals, will not be functioning to sufficiently meet the needs of the affected population, and, as a result, intervening strategies will be required.

For the purposes of future considerations, a number of response strategies that include various levels of medical and healthcare service delivery within the sheltering environment have been included. These are examples, and their presentation within this guide is strictly for informational purposes and does not obligate the LAOA to adopt or implement any ideas presented within.

There are many ways medical care can be integrated into sheltering operations. The strategies used are defined by the necessities of the emergency, the capabilities of the jurisdiction, plans, procedures, and agreements in place, and State and local statute. Various agencies and jurisdictions have used a variety of tactics to assist their citizens. The models presented here provide increasing levels of services within the shelter. Although, these strategies are presented as distinct from one another, all are part of a spectrum of care and the boundaries distinguishing one model from another are not necessarily finite. Additionally, resource availability and the needs of the affected population may require that medical and health service delivery within the shelter be scaled up and down over time.

The models are designed around the following assumptions:

1. Medical facilities traditionally run close to maximum occupancy.[66]
2. A sufficiently large disaster requiring mass sheltering will cause injuries and illnesses that will stress the local medical system.
3. Some people entering a shelter will do so with injuries and illnesses stemming from the disaster.
4. Some people entering a shelter may not report injuries sustained

[66] Hospital occupancy is a function of the number of patients within a hospital as compared to that of the total number of licensed beds.

from the event.

5. Some people entering a shelter will develop new injuries or illnesses requiring treatment during their time at the shelter.
6. Some people entering a shelter will have pre-existing, non-event–related injuries and illnesses that, at some point in their time at the shelter, may require intervention.
7. Some people entering a shelter will require triage and transport to a medical center due to injuries and illnesses.
8. Medical facilities may be damaged or may have a reduced capability to respond.
9. Shelter Model 1: Basic Shelter

Model Description	Shelter Model 1 is the basic shelter design that most nongovernmental organizations (NGOs) use to deliver mass care. Volunteers who have received basic first aid and CPR training, as well as shelter management courses, typically staff these shelters. They are designed to provide a safe place for their residents while providing for food and sleep needs. This model is largely non-medical and does not support medical care beyond basic first aid and self care. There are variants in other services provided based on the shelter's sponsoring organization. Some organizations will provide assistance finding permanent residence while others may assist with donations of clothing, toiletries, and other materials. The medical assistance provided in these shelters is also variable based on the organization and the personnel they are able to muster during an incident. In most cases, members of the shelter staff include people trained with first aid and CPR. Some organizations can supply a nurse or emergency medical technician to assist in triaging and transportation. However, this is not always the case, and there may be times when even first-aid trained personnel are unavailable. This shelter model will likely be insufficient in meeting the medical needs of shelter residents during a catastrophic event.

Pros	The basic shelter template is easy to execute. Most NGOs that support shelter operations can set up these shelters in nearly any building with short notice. During smaller incidents, when resources are readily available, shelters do not require a large amount of medical support as all people entering the shelter with medical needs not supported by the personnel in the shelter will be transferred to a facility that can support those needs.
Cons	The basic shelter template puts a large amount of strain on the EMS system, which will likely be responsible for transporting patients to a medical center. This model also puts significant strain on the hospital system, which will have to handle the influx of patients from the shelters, the casualties from the incident itself, and normal emergency calls. In smaller incidents, the pressure on the surrounding medical and EMS systems will be minimal, and they will likely be able to absorb the increased patient load. As the incident becomes larger and more complex, the ability to absorb patients decreases and the hospital system may not be able to take on patients who cannot be serviced at a general shelter due to a functional or access need (e.g., evacuated nursing home residents, people requiring dialysis) but otherwise would normally remain in home. In a catastrophic incident/event, the services and infrastructure (e.g., roads, communications) required for medical transport may be so significantly damaged that transporting patients to a medical facility may become impossible. In a catastrophic incident/event, people in need of medical care will have to remain within a shelter environment not designed to support their care until services and infrastructure improve.
Example	This is an approach employed by a number of NGOs, such as the Salvation Army, faith-based organizations, etc. The size and scope of their shelters depends on the incident and agreements with government agencies that support it. For example, a faith-based organization may set up a shelter within its facility and staff it with organization members. It then may use a local soup kitchen to supply food and donations from members to fill other resource supply needs.

10. Shelter Model 2: Entry Triage and Basic Care

Model Description	In this shelter model, the basic services of a shelter are augmented with skilled medical personnel who can triage people entering the shelter, provide basic level of care, and organize the transfer of people requiring more medical and health support than the shelter can provide. A nurse or emergency medical technician who can be supplied by a hospital, health system, or health department usually provides triage and basic care. A modification on this model would be to stage a physician, nurse practitioner, or physician assistant if appropriate and able. Staffing decisions and the scope of support that can be provided must be consistent with the scope of practice allowed by law. This model does not replace the Model 1 but simply augments it. Through Model 2, a jurisdiction can supplement an existing shelter with medical personnel rather than build a completely new shelter. In the cases where a basic shelter is augmented, the medical personnel usually operate outside of the general shelter's management. A nurse assigned to provide triage and basic care does not take control over any of the other shelter operations, and the shelter manager does not dictate the care given by the nurse. Both continue to operate based on their protocols and procedures. Medical personnel assigned to the shelter can assist in a number of ways. They can provide medical triage to shelter residents and, when necessary, coordinate transport to higher levels of care. If the person requires an intervention within the medical personnel's scope of practice, care can be provided within the shelter rather than transporting the resident to a medical facility, further stressing the system. As resources allow, medical personnel can also provide public health outreach to the shelter residents. They can take blood pressures, talk about preventative care, and assist residents in finding sources of prescription medication for people running low on existing prescriptions.

Pros	With medical support, shelters can provide basic care to residents beyond that of providing shelter, food, and water. Medical support allows for the proper triage of patients, coordination of transportation to a medical facility, and the reduction of burden on the healthcare system. Successful in incidents where people entering shelters are not likely to require a high-level of medical care. The shelter staff and medical staff operate largely independent from one another. Planning and training of shelter workers focuses on differences between shelter staff and medical personnel.
Cons	Depends on strict role definition and pre-event planning to train parties on individual roles and responsibilities. If an incident becomes protracted or generates casualties, this system will be unable to compensate for higher acuity patients. This system is most effective when people are not likely to require high-level medical care. Requires skilled human resources to deploy to a shelter, which may remove needed personnel from the response mission. Assumes an availability of personnel that may not exist due to the circumstances of the incident. For example, following an earthquake, personnel may be unable to report due to damaged infrastructure; they may be injured themselves or may first choose to ensure the safety and security of family before reporting to duty.
Example	During Hurricane Isabel, the Baltimore city government activated multiple shelters. The American Red Cross opened and operated shelters in schools throughout the city. The Baltimore Health Department provided a nurse for each shelter. The Baltimore City Fire Department stationed an ambulance and crew at every shelter, and the Baltimore City Police Department stationed officers at each shelter. The American Red Cross was in command of shelter operations. The nurses assisted in intake and worked with the EMS representatives in transporting people to a local hospital, and the police simply kept the peace. No one agency overruled the operations of another, and shelter operations ran well during its 36 hours of operation.

11. Shelter Model 3: Medical Collocation.

Model Description	When an incident reaches a level of complexity and impact that damages a large amount of infrastructure, including hospitals and the roads to hospitals, it may be necessary to set up shelters to help a large portion of the affected population. As the magnitude of an incident increases so does the likelihood it will cause injuries and exacerbate preexisting conditions, thus, increasing the proportion of the affected population entering shelters that will require medical attention. With hospital functions reduced and the transportation capacity to move patients to the hospital greatly damaged, it may become necessary to bring the medical care to the affected population. The idea of medical collocation of a shelter is anchored by the presumption that a hospital or other healthcare institution will set up, staff, and operate a clinical setting in a shelter either independently or with the support of local health, fire, and police departments. The clinical area, though in a shelter, is commanded by the responsible healthcare entity; whereas, the general shelter area is commanded by the sponsoring shelter organization (e.g., the American Red Cross, Salvation Army). This model ensures that general shelter operations never take on the responsibility of medical care outside of their scope of practice but allows for the transfer of residents requiring medical services to the clinic. Additionally, it allows healthy family members of people requiring clinical care to stay in the general population shelter while assisting their family members and thus reducing the burden on the clinical staff. The level of care the clinic can provide depends on the sponsoring healthcare entity's abilities, the needs of the affected population, the space available, and the capabilities of the space. For example, a hospital may not be able to sponsor a completely independently functioning hospital inside the shelter. Instead, they may only be able to support an outpatient style clinic with the idea to transport much more acutely injured or ill patients to a hospital based on the triage findings. On the other hand, a hospital may find its facilities completely destroyed or disabled necessitating the institution to set up a clinical setting outside of their normal facilities. They may chose to do this in a shelter so that their staff has a temporary home close to their clinical site and the local government can consolidate its security and supplies by guarding the shelter and collocated clinic at the same time.

	This system requires a large amount of physical space. The amount of space is proportional to the amount of services the clinical setting will provide. Outpatient treatments take up less space than a clinical setting that includes an intensive care unit and a surgical suite. For the purposes of collocation, the clinical setting may be in a building across the street from the shelter or a tent city built next to the shelter. In addition, the size increases in relation to the size population it is intended to serve. An outpatient clinic intended to provide services to 20,000 people would be much larger than a surgical suite designed to service 200. Amenities are another consideration. A small outpatient clinic will require trauma and other medical equipment, power, and x-ray machines but may be able to operate without running water as long as there is enough bottled water or a large enough tank full of water is provided. However, a clinical setting that includes a surgical suite will require a large amount of clean water, autoclave capabilities, and much more power. The availability of these resources should be a consideration when deciding if a collocation is possible and how it should be executed.
Pros	Allows for the extensive consolidation of resources. The shelter and the clinical setting can use the same resources to meet their needs. It also allows them to share a pool of food and water and, when the jurisdiction is supporting these efforts, allows them to send the materials to the collocated medical shelter site rather than to a shelter and to a hospital. The ability to treat people onsite reduces the burden on EMS, allowing them to conduct search and rescue missions rather than transporting people from a shelter to a hospital. In extreme incidents, where the homes of hospital staff are also destroyed, collocation with a shelter allows the clinic staff to stay in a safe environment close to their clinical setting. This model allows family and friends of injured or ill people to stay in the shelter near their loved ones where they can help care for them.
Cons	Requires a large amount of planning, training, resources, and buy-in from participating bodies and their leadership. In order for this model to be successful, hospitals or other healthcare institutions have to formally agree to provide support, work with planners

	from ESF #6, including the lead for shelter management, to build a plan that meets the needs of those sheltered under ESF #6 without taking over the shelter. Requires the healthcare entity to produce internal systems for sending staff, providing necessary equipment and materials, alerting and organizing staff, and maintaining minimum standards of care. Setting up a clinical setting requires a large amount of space and certain amenities. During a catastrophe, such as a major earthquake, a large enough footprint or critical utilities may not be available due to the infrastructure damage from the earthquake and its aftershocks. Some of this can be mitigated by planning a response that can adapt to the facilities available.
Example	A chief example of a collocated medical and general population shelter is the Qualcomm "Mega Shelter" used during the wildfires of 2007[67]. The Qualcomm shelter was established spontaneously, based on the needs of people evacuated from their homes as the fire spread. Though the shelter did not require long-term operation nor was the local infrastructure affected, the idea of collocating services was successfully tested.

12. Additional Response Strategies

a) Alternative Care Sites

Alternative care sites (ACS) are temporary facilities that offer services similar to a hospital. Hospitals are often the sponsors of these sites and use them to offset an influx into their main facility due to a disaster. The set up and operation of an ACS is usually handled completely by ESF #8. For information on an ACS collocated in a shelter, refer to Shelter Model 3.

Community planning, medical surge, and modeling tools, including many related to planning and operating an ACS, can be found online at the Agency for Healthcare Quality, Public Health Emergency Preparedness Web site[68].

Information regarding ongoing ACS planning activities within California can be found in *Development of Standards and*

[67] *After-Action Report–October 2007 Wildfires City of San Diego Response*. (2007). City of San Diego.
[68] http://www.ahrq.gov/prep/

Guidelines for Healthcare Surge during Emergencies: Alternate Care Sites[69] (draft). It is available online at the California Department of Health Services Web site.

b) Pharmacy Collocation

People will be entering shelters with preexisting conditions that require medication that they may not have brought with them when evacuating. Further, these individuals likely will not have proof of their prescription and may not even know what medication they take. These people will still need support, and some will not require full medical care and can be supported within the general population shelter.

These people are the ones who can benefit from the collocation of a pharmacy in a shelter. This concept brings the pharmacy to the affected population. The pharmacy personnel can come from local pharmacies, MRC, health departments, and other preapproved groups. The supplies can come from local pharmacies, stockpiles, distributors, and the Strategic National Stockpile.

H. Additional Planning Considerations

1. Spontaneous Shelters

Spontaneous and/or unaffiliated shelters will appear during a disaster. Planning needs to include policy decisions about what, if any, medical, health, and mental health services will be delivered to these sites. Planners should consider the possible implications and obligations associated with delivering services to these spontaneous and/or unaffiliated shelters. For example, does some level of service delivery constitute formally recognizing the shelters and obligate the jurisdiction to provide additional services?

Additionally, planners may want to consider the costs and benefits of delivering services to these shelters. For example, negative health outcomes could be mitigated by providing sanitation support (e.g., latrines, hand washing stations), and EMS and hospital burdens could be reduced by sending a health triage and referral team to the site.

2. Environmental Health

The quality of life in any shelter environment with large numbers of people living in close quarters will be affected by the quality of the living conditions. Shelter planning should consider the

[69] http://bepreparedcalifornia.ca.gov/NR/rdonlyres/3C71BC63-5B32-486E-A66F-917CC53E9A77/0/DraftAltCareSitesWTO.pdf

environmental factors that may affect the overall health of shelter residents. The Centers for Disease Control and Prevention (CDC) produces a checklist that can assist shelter workers in identifying deficiencies.[70] The survey includes questions about the facility, the food services, sanitation, drinking water, sleeping areas, and others.

In certain types of chemical, biological, radiological, nuclear, or explosive (CBRNE) events, it is possible that persons arriving at shelters will be in need of decontamination prior to entry. This is a function outside of ESF #6 but should be coordinated during the planning process.[71]

3. Contagious Diseases and Surveillance

All shelters should promote hand washing and personal hygiene to reduce the transmission of contaminants.[72]

Syndromic surveillance (i.e., checking for disease outbreaks) is important to reduce the spread of contagious diseases within the close living quarters of a shelter environment. Investigation and surveillance using DPH nurses in conjunction with Acute Communicable Disease Control (ACDC) would function as requested by shelter managers, shelter nurses, or the EOC.

It is conceivable that some shelter residents will be displaced from their homes while taking medication to treat tuberculosis. In a protracted shelter situation, patients undergoing long-term treatment for communicable diseases, such as tuberculosis, will need to be traced and identified to allow for the resumption of treatment. This may be determined on a case-by-case basis through coordination with the local public health department.

Other considerations from best practices outside the LAOA include the following:

a) Separation to reduce spreading of the disease. Plan to provide for the separation of people with suspected communicable diseases that can range from common colds to more severe influenza and intestinal infections.

b) Temporary infirmary. If necessary, set aside a part of the shelter as a section for the privacy and isolation of ill people.

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[70] See Tab F: CDC Environmental Health Shelter Assessment Form.

[71] *Los Angeles County Multi-Agency Radiological Response Plan Response Planning Guides, Volume II*. (2009, February). p. 52.

[72] See Tab O: Keeping Your Facility Healthy.

In addition, use this area to provide a higher level of care for people who are more medically fragile.

c) Pre-designated alternative facilities. Set up an alternate shelter facility and coordinate support through the operational area if a large number of people have a communicable disease in the shelter or if a large population needs ongoing medical assistance (e.g., the evacuation of residents from a medical care facility).

4. Prescription Drug and Medical Supplies Management

Many medications, even when taken regularly for months, are quickly eliminated or metabolized from the system. Skipped doses can result in an exacerbated condition that requires medical attention and treatment. As resource availability permits, effort should be made to identify people who have skipped medication doses and assist them in appropriately restarting their medication regimens. Due to resource limitations, some triaging and prioritizing of prescription drugs may be required.

The following are additional considerations for prescription management:

a) Prescription drug management. Some people within the shelter will have very individualized medication regimens that cannot be interrupted without consequences.

b) Storage of medication. Plan for the secured storage of medications; refrigeration is required for some medications (e.g., some insulin types).

c) Prescription refills. Plan to refill prescriptions, establish vendor agreements with local pharmacies, and clarify how to obtain medications post-disaster (e.g., with a current prescription, with a prescription phoned in by a licensed physician, with a prescription validated by another pharmacy, or with a prescription bottle).

d) Consumable medical supplies or DME. Plan for the secured storage, temperature, and disposal of gloves, catheters, sanitary napkins, dressings and swabs, wipes, etc. Plan for the use of medically approved sharps containers for used diabetic needles, and red infectious storage bags for contaminated bandages or dressings. Establish vendor agreements or agreements with local hospitals for their excess supplies. Label DME with the resident's name and contact number, and store them securely when not in use.

5. Disaster Healthcare Volunteers

In a catastrophic incident/event, supporting the medical, health, and mental health needs of shelter residents may be achieved using volunteers. A number of considerations and strategies can help planners and responders use volunteers effectively and efficiently.

Planners should make efforts to use pre-established volunteer registries and systems whenever possible. A number of volunteer registries, systems, and organizations are in place to conduct the pre-screening, training, and credentialing of volunteers. Using affiliated volunteers[73] precludes potential problems, such as liability issues, mismatching tasks and skill level, undertrained staffing, and others. While affiliated volunteers are preferred, planners should prepare for spontaneous, unaffiliated volunteerism.

Issues of liability, licensure, and scope of practice become especially important when working with medical volunteers. Organized systems, such as ESAR-VHP and MRC, exist to mitigate these challenges. ESAR-VHP is a Federal program that establishes and implements guidelines and standards for the registration, credentialing, and deployment of medical professionals in the event of a large-scale national emergency. The MRC provides the structure necessary to pre-identify, credential, train, and activate medical and public health volunteers. It is important to note that both ESAR-VHP and MRC are national systems and increasingly integrated, but they are locally initiated and applied.

Formerly known as Los Angeles County ESAR-VHP and MRC, the Los Angeles County Disaster Healthcare Volunteers (DHV) is a collaborative effort lead by the county of Los Angeles departments of Health Services, EMS Agency, and Public Health to eliminate the following problems:

a) Identification of medical, health, and mental health professionals and other volunteers at disaster sites

b) Validation of practice and license

c) Proper credentialing

d) Training

[73] "Affiliated volunteers are attached to a recognized voluntary or nonprofit organization and are trained for specific disaster response activities. Their relationship with the organization precedes the immediate disaster, and they are invited by that organization to become involved in a particular aspect of emergency management."
http://www.fema.gov/pdf/emergency/disasterhousing/ManagingSpontaneousVolunteers.pdf

Los Angeles County DHV[74] is part of a federally mandated, statewide, and nationwide effort to recruit and register healthcare volunteers in advance of the next disaster. In addition to the Los Angeles County Surge Unit, there are three MRC units within the program including MRC Los Angeles[75], Beach Cities Health District MRC[76], and Long Beach MRC.[77]

a) Los Angeles County Surge Unit[78]

The Los Angeles County Surge Unit is the "hospital ready" team for volunteers who wish to be assigned primarily to hospitals following disasters. Qualifications for this team include the following:

(1) Medical, health, or mental health professionals with a current unrestricted license who maintain an active practice and are currently on staff at an "acute care" hospital or another medical, health, or mental health setting in Los Angeles County

(2) Retired professionals who maintain current licensure and must have been employed in at least one of the settings mentioned above within the last five years

(3) People who must be interested in volunteering at hospital or alternative care site (e.g., clinic, first aid station, mobile medical asset, etc) following a disaster

Los Angeles County DHV utilizes the California Disaster Healthcare Volunteers System for credentialing and licensure verification.

To maximize resource availability, requests for volunteer support should be made through appropriate channels, such as the Care and Shelter Branch of the EOC/CEOC. When requesting medical and health specific volunteer support, requests should be framed in terms of the need rather than requesting specific resources. For example requesting assistance with basic first aid and minor wound care rather than asking for a doctor, as a physician may not be the best match for meeting that need.

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74 https://www.healthcarevolunteers.ca.gov
75 http://www.mrclosangeles.org.
76 http://www.medicalreservecorps.gov/detail.asp?id=41.
77 http://www.longbeach.gov/health/safety_prep/medical_reserve.asp
78 www.lacountydhv.org.

Once volunteers are available, efforts should be made to match tasks with the skill level of a volunteer. For example, it is a more efficient use of resources to task a physician with healthcare-related tasks than general support tasks such as food distribution.

Volunteer personnel should be aware of health and safety issues in the environment in which they are deployed, including possible shortage of fresh running water, fresh food, and other services; self-sufficiency for up to 48 hours may be necessary.

6. Community Emergency Response Teams

Community Emergency Response Teams (CERTs) are organizations of volunteer emergency workers who have received specific training in basic disaster response skills and who agree to supplement existing emergency responders in the event of a major disaster. CERT training often includes mass casualty triage, basic search and rescue, Incident Command System (ICS) knowledge, and basic first aid. These community volunteers, when deployed as CERT volunteers, can augment initial triage and first aid treatment under command and control of their sponsoring agency and can be an asset in the initial assessment and response. Additionally, involving CERT in preparedness and training activities pre-event can provide mutual benefit to the CERT and the larger community.

7. Importance of Disaster Workers and Family Preparedness

Shelter staff, including health workers supporting mass care, may be unwilling to go to work, stay at work, or safely concentrate on or cope with their work if they do not have assurances as to the safety of their own family and loved ones. Disaster workers and their families should prepare personal "go-kits," central "calling-in" points for family members, and designated, pre-determined meeting points in case no communication is possible.

8. Hospital-Shelter Coordination

In addition to moving people from shelters to hospitals for medical treatment, it is possible that in a catastrophic event there will be a need for hospitals to discharge patients to shelters (e.g., a medically stable patient who cannot return to his or her home because it was damaged).

Additionally, hospitals may require the support of ESF #6 functions to sustain their patients. For example, traditional hospital food service may be rendered inoperable and hospitals may request feeding support from more traditional shelter sources.

9. Fatalities Management

During a catastrophic incident/event, shelter residents may expire while within a shelter environment. Planners must take into account how remains and personal effects are to be handled when the local medical examiner or coroner's office is unable to immediately retrieve them. Remains may need to be stored for long periods, and shelters will require guidance on how this is to be accomplished.

The specific regulations guiding the handling of remains are described in local and State statutes. Planners should contact the appropriate departments responsible for the handling and disposition of remains and personal effects to ensure they understand all applicable guidance, laws, and regulations. They should contact agencies responsible for sheltering to ensure that these agencies understand the requirements guiding their handling of remains and that they have planned for such contingencies.

The following is a brief list of considerations on handling of remains and personal effects in a shelter during a catastrophic event:

a) Health safety. Remains should be moved to a separate area of the shelter so that they are not near sources of food or water. This area should be as cool as possible to reduce decomposition. Remains should not be put directly on ice.

b) Privacy and respect. The affected population includes a great many cultures with different requirements and taboos when handling remains. When possible, shelter staff should respect the wishes of the family members of the deceased. At a minimum, the body should be covered and handled with respect when it is moved to the storage area.

c) Legal considerations. When a shelter resident expires, there is a possibility that an investigation of some sort may need to take place. This can include the necessity to positively identify the remains (even if they self identified on entry of the shelter, this information may not be accurate) and to determine the cause of death. In order to assist investigators, shelter staff should record any observations about the circumstances of the death and be sure to keep all of the deceased's personal items including identification documents with them.

d) Reporting. Shelters must have a system in place to report the death of a resident. This can occur in any number of ways using any of the communications systems discussed in other sections of this guide.

For more information on fatalities management, see the *Mass Fatality Incident Management: Guidance for Hospitals and Other Healthcare Entities* guide published by Los Angeles County Emergency Medical Services.[79]

[79] *Mass Fatality Incident Management: Guidance for Hospitals and Other Healthcare Entities*. Los Angeles County Emergency Medical Services. Accessed online on May 25, 2010, at http://ems.dhs.lacounty.gov/ManualsProtocols/MFIM/MFIGuidanceForHospitals808.pdf.

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XIII. ANNEX C: NON-TRADITIONAL SHELTERING

A. Introduction

The Non-Traditional Sheltering Annex provides planners with strategies, tools, and resources to plan for the potential need, activation and operation of non-traditional shelters. This annex builds from the foundational guidance for traditional shelters found in the Mass Care Guidance for Emergency Planners.

In the United States, the foundations to begin this planning are the Federal Emergency Management Agency's (FEMA's) National Disaster Housing Strategy (NDHS) and the International Association of Venue Managers' (IAVM's) Mega-Shelter Planning Guide. These documents are referenced throughout the annex. However, the details for planning and operating non-traditional shelters must be further articulated, clarified, and/or determined at the operational area (OA). The Non-Traditional Sheltering Annex builds on FEMA's and IAVM's foundations to provide suggestions for planners to establish guidance and plans for non-traditional shelters at the local level.

History has shown that non-traditional sheltering occurs with greater frequency than the attention that is often given.[80] Following the 2009 earthquake and tsunami in American Samoa, non-traditional sheltering was present through the operational response. The City of Los Angeles After Action Report for the 1987 Whittier Narrows Earthquakes recognizes the City was unprepared for "persons choosing to live in informal encampments rather than their structurally sound homes."[81] The California Governor's Office of Emergency Services describes that following the 1994 Northridge earthquake that a "Housing Task Force was established compromised of local, state and federal agencies, the military, American

> "A catastrophic incident includes: resources at all levels being overwhelmed, lack of normal response strategies to be implemented, high numbers of casualties, thousands of displaced persons, isolation from normal resource channels, infrastructure disruption and long-term nationwide impacts."
> —2008 California Catastrophic Incident Base Plan
>
> "A catastrophic incident is defined as any natural or manmade incident, including terrorism, that results in extraordinary levels of mass casualties, damage, or disruption severely affecting the population, infrastructure, environment, economy, national morale, and/or government functions."
> —National Response Framework

[80] Tab P: Historical Listing of Non-Traditional Shelters in the United States provides a brief overview of the instances when non-traditional shelters have been used.

[81] City of Los Angeles, Emergency Operations Organization: "Whittier Narrows Earthquakes, After Action Report. Section 1, Page 7.

Red Cross and Salvation Army" to "set up tents and other support services" for the "over 20,000 people sheltered in park refuge sites."[82]

Within this annex, attention is given to two types of non-traditional shelters: mega-shelters and open-space shelters. These two models of sheltering are described from an all-hazards approach with the recognition that the execution will differ by type (i.e., notice or no-notice events), scope and magnitude of the incident. It should be noted that this document does not provide guidance on interim or transitional housing.

Local planners should understand that the discussion of non-traditional shelters requires a multi-agency approach as this model of sheltering is beyond the scope of any one agency and will only be successful by utilizing agencies and organizations that have expertise within the corresponding elements of the sheltering operation. Attention has been given to this need and this guidance provides planners with the tools and resources to develop a non-traditional shelter task force for the OA. The multi-agency approach is emphasized through the NDHS and IAVM's publication and the following citations from these respective documents further enforce the importance of non-traditional shelter planning.

> Major or catastrophic disasters require more intensive sheltering support. When the demand for shelters exceeds capacity or traditional shelters are not available, planners and emergency managers may need to use nonconventional sheltering options, such as cruise ships, tents, vacant buildings, military barracks, dormitories, prefabricated structures designed for congregate settings, or campgrounds (such as scouting camps).
>
> In major or catastrophic disasters, not only will the number of people requiring shelter support be large, but extensive damage to structures and the infrastructure will likely limit sheltering options and result in substantially longer shelter operational periods. Decisions on whether to use nonconventional shelters are based on the total demand for shelter services and the post impact assessment of structures that meet shelter standards.[83]

> For effective mega-shelter planning within a community, it is crucial that venue management and the various stakeholders determine the operational structure, table of organization, and roles and responsibilities for the shelters prior to a disaster incident.

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[82] Northridge Earthquake, January 17, 1994, Interim Report. California Governor's Office of Emergency Services. April 4, 1994. Page 23.

[83] National Disaster Housing Strategy.DHS. January 2009. p. 37.http://www.fema.gov/pdf/emergency/disasterhousing/NDHS-core.pdf.

Standards and indicators regarding site management, food service, potable water, hygiene, shelter resident privacy and confidentiality, media relations, and other details must also be addressed in the planning stages. All involved agencies must be included in the planning of mega-shelters, so that all identified parties understand their roles and responsibilities and those of the other agencies.[84]

> "Catastrophic events place exponentially greater demands on sheltering operations and generally require a new level of planning among community, State, and Federal officials. Such events rapidly exceed local shelter capacity and require assistance from the State and Federal governments….Nonconventional shelters may be required….All levels of government will need to work together to meet urgent needs, adjust to changing circumstances, and conduct operations in highly demanding, stressful situations. Following a catastrophic event, the lack of interim housing resources is so acute that stays in shelters may last for many months."
> —National Disaster Housing Strategy, p. 31

As an OA recognizes the scale and scope of the disasters it may face, it is the responsibility of local planners to plan for non-traditional shelter operations as history has shown that this sheltering model will be considered during a response. Moreover, historically the disaster affected public has congregated in open space sites and as a result local government and supporting response agencies must be ready to meet their immediate needs. The following pages provide guidance for defining the characteristics of a non-traditional shelters, assumptions, planning considerations, and shelter operations. This annex, together with the previously mentioned documents, should provide local planners strategies, tools, and resources to begin planning for non-traditional shelters.

B. Defining Characteristics of Non-Traditional Shelters[85]

This annex focuses on mega-shelter and open-space types of non-traditional sheltering models. Traditional emergency shelters are those sites that are most commonly used to provide lodging to disaster victims. Examples of facilities often used for traditional emergency shelters include high school basketball gyms, church auditoriums, and recreation centers. Often the responsibility falls to one or two agencies to plan for this type of sheltering, whereas a non-traditional shelter will require the action of

[84] International Association of Venue Managers Mega-Shelter Planning Guide, October 2010, p. 235. http://www.iavm.org/CVMS/mega_sheltering.asp

[85] Discussions and definitions rely heavily on the International Association of Venue Managers Mega-Shelter Planning Guide and the National Disaster Housing Strategy from the Federal Emergency Management Agency published January 2009. http://www.fema.gov/pdf/emergency/disasterhousing/NDHS-core.pdf

multiple agencies to ensure the appropriate resources are in place to support it operationally.

Additionally, planners should recognize the potential for a hybrid of a mega-shelter and open-space shelter types and the corresponding nuances that should be planned for. Open stadiums and arenas have seen this type of use in recent disasters.[86]

The defining characteristics of non-traditional shelters are:

1. Activated by local, State, or Federal governments
2. Extensive damage to structures and community infrastructure limits sheltering options and result in longer shelter operational periods.
3. Multi-agency coordination and management with a unified command system
4. Large, non-conventional sheltering facility—often those generally used for public assembly, such as an arena, convention center, cruise ship, vacant building, stadium, recreational field, parking lot, beach, campground, farm land, or open lot.[87] (For purposes of this annex, attention is given to two types of non-traditional shelters: mega-shelters and open-space shelters)
5. Accommodate clients with long-term needs beyond evacuation and emergency sheltering.[88]
6. Defining characteristics of mega shelters:
   a) A very large indoor facility, such as convention center, arena, or stadium

Recent studies by the U.S. Geological Survey and American Red Cross have estimated the number of displaced individuals in the Southern California area that will seek shelter in a catastrophic event to be in the hundreds of thousands. These numbers vastly outnumber projected available shelter space in any local jurisdiction and clearly indicate a need for non-traditional sheltering consideration.

[86] Draft Qualcomm Stadium Mega-Shelter Guide, September 2010, City of San Diego
[87] NDHS,
[88] International Association of Venue Managers Mega-Shelter Planning Guide, October 2010, p. 10. http://www.iavm.org/CVMS/mega_sheltering.asp

b) Additionally, meeting some or all of the above characteristics

7. Defining characteristics of open-space shelters:

a) Open-space shelters are a unique planning consideration and have occurred with regularity within emergency shelter models in recent years. As planners examine the need for non-traditional shelter options and, specifically, open-space shelter, mitigation must follow to clarify misconceptions, expectations, and identify potential political or public conflicts that may occur during planning processes.

> The Cajundome, a mega-shelter in Lafayette, Louisiana, accommodated 18,500 evacuees over 58 days. It provided 409,000 meals to evacuees and first responders. Houston's Reliant Park sheltered 27,100 evacuees over 37 days. The Dallas Convention Center and the Reunion Arena, also in Dallas, provided shelter for 25,000 for over 39 days and served 114,200 meals.
> —IAVM Shelter Task Force Senate Hearing Testimony on December 3, 2007, when discussing sheltering efforts after Hurricane Katrina.

b) Planners should note that open-space shelters may not be viable options to consider when confronted with disasters that occur during inclement weather or in response to a chemical, biological, radiological, or nuclear (CBRNE) event, as the effects of these types of disasters/events could pose significant risk to the shelter population.

(1) An open-space shelter occurs in an open-land area where the displaced population may congregate in tents, trailers, motor homes or other types of portable shelters to receive services to meet immediate needs and have space for emergency sheltering. These sites will have differing resources available on site. Historically, these shelters have been established in parks, golf courses, and large, open land, including parking lots and beaches.

(2) Spontaneous (self-identified) sites and planned sites:
Spontaneous sites are characterized by the following:

(i) An affected population identifies location and self-settles

(ii) Establishment of infrastructure and supporting programs occur after self-settlement

(b) Planned sites are characterized by the following:

(i) Settlement occurs after infrastructure and programs have been developed and prepared for the affected population.

(ii) Messaging explains that those who have not already evacuated or have self-settled at an unregistered site should evacuate to a planned settlement.

(3) Open-space shelters will include the gathering of the affected population and could include the following models:

(a) The most basic open-space option is the provision of an open space where people can gather in an organized fashion. At a minimum any planned site should have security, sanitation, first-aid and site supervision support. Initially limited resources are necessary, as the displaced population evacuating is instructed to bring their own supplies. However, as this option is prolonged in length, resource support will become an issue.

> Following the Northridge earthquake of January 1994, residents spontaneously settled Reseda Park bringing their own personal tents. American Red Cross, National Guard and other agencies stood up operations to support this population.
> —"Tent Dwellers riding it out" article in Los Angeles Times on January 26, 1994

(i) Planners should consider the contrast between traditional sheltering space guidelines and non-traditional sheltering space guidelines.

(ii) In some situations non-traditional sheltering, such as mega-shelters, may adequately provide space using traditional emergency shelter national standards.

(iii) In situations where open-space sheltering is needed, use of guidelines from international sources, such as The Sphere Project,[89] should be considered.

(b) High-tension fabric structures

(i) Large high-tension fabric structures may be erected to create covered spaces, creating protection from the elements.

> "The City was immediately confronted by a problem it first experienced following the 1987 Whittier Earthquake, that of thousands of people moving into parks and school yards near their homes and apartments. In many cases, the homes of these victims had been inspected and determined to be safe for occupancy. The high number of aftershocks, coupled with a history of further building failures during aftershocks in their native countries, caused many residents to refuse to return to their homes."
> —City of Los Angeles Northridge After-Action Report, January 17, 1994

These structures can often provide modern amenities, including running water, heating, air conditioning, and the ability to section off space.

(c) Soft-sided tents[90]

(d) Personal family tents[91]

(i) Emergency managers may consider encouraging affected populations to bring personal family tents to provide temporary shelter.

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[89] The Sphere Project was launched in 1997 to develop a set of minimum standards in core areas of humanitarian assistance. The aim of the project is to improve the quality of assistance provided to people affected by disasters, and to enhance the accountability of the humanitarian system in disaster response. One of the major results of the project has been the publication of the handbook, *Humanitarian Charter and Minimum Standards in Disaster Response*, which can be accessed online at http://www.sphereproject.org/ and http://www.sphereproject.org/content/view/27/84/lang,English/.

[90] Success Stories: When M*A*S*H meets Mush! FEMA. Published September 17, 2009 at http://www.fema.gov/news/newsrelease.fema?id=49514.

[91] Disaster Assistance in Samoa Tops $33 million. FEMA. Published March 17, 2010 at http://www.fema.gov/news/newsrelease.fema?id=50627.

(e) Provision of individual mats or cots

(i) Could include the setup of canopies to cover cots

c) The amount of space required per client and the types of services provided will determine the maximum occupancy of the shelter. This will vary depending on the type of disaster and the needs of the non-traditional shelter population. For planning purposes the OA will need to determine the minimal allocation of space per person residing in a non-traditional shelter.

(1) IAVM recommends 60 to 80 square feet of usable space per person for dormitory areas and 100 to 120 or more square feet of usable space per person for medical dormitory areas in mega-shelters.[92]

> "Providing shelters for disaster victims is a complex operation that requires collaborative planning across a wide range of organizations, timely decisions by local officials, and coordinated implementation among all involved, including nongovernmental organizations, the private sector, and various levels of government…In large-scale or catastrophic disasters, extended shelter stays may be required."
> --National Disaster Housing Strategy

(2) The American Red Cross recommends 40 to 60 square feet of sleeping space per person in traditional shelter models.[93]

(3) The Sphere Project recommends that, for longer term sheltering, "[t]he planning guideline of 484 ft^2 per person includes household plots and the area necessary for roads, footpaths, educational facilities, sanitation, firebreaks, administration, water storage, distribution areas, markets and storage, plus limited kitchen gardens for individual households."[94]

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[92] International Association of Venue Managers Mega-Shelter Planning Guide, October 2010, p. 237. http://www.iavm.org/CVMS/mega_sheltering.asp

[93] American Red Cross, Disaster Services Program Guidance, Mass Care, Sheltering August 2006

[94] Humanitarian Charter and Minimum Standards in Disaster Response, http://www.sphereproject.org/content/view/27/84/lang,English/.

C. Assumptions[95]

1. Traditional response timelines and levels of resources will not meet the needs of the affected populations in a catastrophic environment.[96]
2. Infrastructure disruption will prevent the normal flow of resources.
3. The type of non-traditional shelter to be used in the aftermath of a catastrophic disaster will be considered and selected after the incident has occurred.
4. Identification of non-traditional shelter locations, site surveys, and appropriate risk/safety assessments will be completed by the local jurisdiction.
5. Deconfliction of available facilities will occur prior to activating a site as a non-traditional shelter.
6. There may be times when communication channels from shelter management to unified command are limited.
7. There will be an increased need for multi-agency coordination to handle the complexity of mega-sheltering of any type.
8. Planning efforts have clarified staffing requirements for type(s) of non-traditional shelter(s) and the corresponding site(s).
9. Mega-shelter facilities/sites may have multiple uses such as adjacent household pet sheltering.
10. Non-traditional shelters will not be opened without an adequate number of trained workers.
11. Coordination of volunteers, vendors, and donations will be necessary for a successful response and recovery.[97]
12. Affected individuals will likely be unwilling to leave the vicinity of their residence, even if it is not habitable.
13. Services may be available in some shelters that evacuees did not have access to pre-disaster increasing their desire to remain in the shelter environment.
14. The expectation for services provided by all stakeholders (Government, CBO's, NGO's, FBO's, Private Sector) in non-traditional shelter will be greater than in a traditional shelter setting.

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[95] International Association of Venue Managers Mega-Shelter Planning Guide, October 2010, p. 17. http://www.iavm.org/CVMS/mega_sheltering.asp

[96] City of Los Angeles Northridge Earthquake After-Action Report. January 1994, p. 2.

[97] "After-Action Report – October 2007 Wildfires. City of San Diego.https://www.llis.dhs.gov/docdetails/details.do?contentID=30685 (Login Required).

15. In an earthquake scenario, residents will have concerns about going inside their houses or other structures.[98]
16. The private sector will play a significant role in contributing resources and services.
17. Consulates and international groups will be interested in supporting the response and ensuring that the needs of their constituents are met.
18. The concept of non-traditional sheltering will be met with considerable political and media interest.

> The 2009 response to the American Samoa Earthquake, Tsunami, and Flooding used over 1,500 tents that included different types: dome, Celina, and Yurts.—FEMA News Release March 17, 2010
>
> The 2009 response to flooding in the community of Eagle in Alaska included the use of soft-sided structures for health clinics. They were designed for extreme weather and have been used in Alaska and Afghanistan. It is a modular approach that enables customization and assembly in only a few hours. —FEMA News Release September 17, 2009

D. Planning Considerations

1. Creation of a non-traditional shelter planning task force:

   a) The creation and functioning of a non-traditional shelter task force will prove critical to the resiliency of the Operational Area. Identify and establish an OA non-traditional shelter planning task force that coordinates with local stakeholders identified below.

   b) The task force should be structured as a multi-agency stakeholder group representing and responsible for the planning, activation, and coordination of non-traditional shelters in a community and may be initiated by any stakeholder.

      (1) The task force should be directed by local representatives of the agency responsible for mass care and emergency management in the corresponding jurisdiction area.

   c) The task force should include representatives of:[99]

      (1) Local, State, and Federal emergency management agencies

[98] City of Los Angeles Northridge Earthquake After-Action Report. January 1994.

[99] "After Action Report – October 2007 Wildfires. City of San Diego. https://www.llis.dhs.gov/docdetails/details.do?contentID=30685 (Login Required), p. 27; p. 31.

(2) Local and State Department of Social Services and/or Care and Shelter Branch representatives (ESF-6/EF-6/Mass Care)

(3) Local elected officials

(4) Other local government departments

(a) Public Health, Fire, Parks and Recreation, Mental Health, Law Enforcement, Emergency Medical Services, Internal Services (Logistics), Animal Control, Children and Family Services, Community and Senior Services, Human Resources, Water and Power, and Planning Offices

(5) American Red Cross

(6) Salvation Army

(7) Voluntary Organizations Active in Disaster

(8) Access and Functional Needs representatives who can outline Americans with Disabilities Act (ADA) and other requirements and needs

(9) Private sector

(10) Real estate community and urban planners

(11) Facility/Venues management

(12) Academic subject matter experts

d) A core planning team of key stakeholders should be formed. This planning team should identify additional subject matter experts and representatives that can be included, as necessary.

(1) These subject matter experts could include representatives from the postal services, military, transportation, public works, local vendors (food, equipment, laundry, vehicles), and other essential suppliers of material resources.

e) The task force should be formed at the OA level and be scalable in approach and response to address the needs of local jurisdictions with varying levels of capability.

f) The activities of the non-traditional shelter planning task force should include the following:

(1) Determine the need for non-traditional shelters in mass care planning for the OA and region.

(a) Review current traditional shelter resources and plans.

(b) Review catastrophic scenarios to identify potential displaced population in jurisdiction.

(c) Determine the type and number of non-traditional shelters that should be considered.

(d) Local political leaders need to be part of the decision-making process regarding the range of types of non-traditional shelters that will be included in the planning.

(2) Identify authorities that outline roles and responsibilities.

(3) Assign roles and responsibilities for non-traditional shelters. This should clearly delineate who within the task force is responsible for which elements of the planning process.

(4) Develop, maintain, and implement any non-traditional shelter planning documents, strategies or plans created. This should also include specific site support plans.

(5) Determine the priority and frequency of meetings.

(6) Identify jurisdictional responsibilities and authorities.

(7) Identify disaster service workers and nongovernmental organizations that will support the shelter operation. Ensure that workers have been trained in basic shelter operation courses and advanced shelter management training.

(8) Determine whether the community's infrastructure can support a non-traditional shelter.

(a) Define site survey needs and infrastructure requirements.

(b) Define gaps.

(i) Which other agency can support filling those gaps? Specifically, pre-identify the types of state and federal resource support that is likely to be required to support non-traditional sheltering of a specific type and population level.

(9) Locate potential sites within the count and corresponding deconfliction.

(10) Exercise activations of non-traditional sheltering.

(11) Conduct a public education campaign for the public, media, and elected officials on the potential non-traditional shelter settings, expectations, and reasoning.

2. Political considerations – Implications for local government, organizations, and citizens:

a) Ensure all coordination regarding non-traditional shelters occurs through the city/county Emergency Operations Center (EOC).

> After Hurricane Andrew, open air shelters were formed to accommodate survivors. These locations drew visiting dignitaries and politicians, including the governor, congressional staff, and Federal executive leadership.
> —Miami New Times, June 23, 1993

b) Ensure effective outreach and communication with community elected officials.

c) Consider the process in which members of the task force are nominated or invited to join.

d) In the initial stage of the task force, attention should be given to the possibility of impacts to neighboring OAs.

(1) Consideration should be given to neighboring OAs when deciding the task force makeup.

(2) Potential financial impacts should be acknowledged and an education of policies and guidelines should be given to the task force. The following policies should be included:

(a) FEMA Disaster Assistance Policy (DAP) 9523.18, which discusses the Host-State Evacuation and Sheltering Reimbursement Policy.[100]

(b) FEMA DAP 9523.15, which dictates the policies for evacuation and sheltering financial reimbursements.[101]

[100] Memo on 9523.18 Host-State Evacuation and Sheltering Reimbursement Policy. FEMA. Published August 2008, at http://www.fema.gov/government/grant/pa/9523_18b.shtm.

[101] "Eligible Costs Related to Evacuations and Sheltering." FEMA. Published April 2007 at http://www.fema.gov/government/grant/pa/9523_15.shtm.

3. Identify and survey sites

Considerable attention should be made by local planners to identify potential non-traditional shelter sites alongside known risks and the needs of the jurisdiction. Factors, such as ownership of sites, hazards, and existing infrastructure, are a few of the considerations that should be identified during the planning process. The readiness of the OA will strengthen as site identification and corresponding surveys increase the options available to planners during the onset of a disaster. Tab J: Non-Traditional Shelter Facility Survey provides a draft framework for the surveying of potential non-traditional shelter locations.

a) Identification and corresponding activities

(1) Site ownership

(a) The OA will need to articulate the pros and cons of utilizing public and/or private sites.

(i) Attention should be given to recognize the concerns of site owners.

(b) Planners are encouraged to begin preliminary discussions with site management regarding establishing agreements.

(i) Planners should be ready to provide reimbursement guidance to sites.[102]

(2) Deconfliction of the potential for multiple designations for site use during site identification process and corresponding activities is necessary.

(3) Capabilities and capacities

(a) Spatial footprint, existing infrastructure, and location

(4) Hazard considerations

(a) Planners should identify all hazards and vulnerabilities of the site that may lead to risk or disruptions during operation. Hazards could include, flooding, tsunami inundation, commercial hazards such as potential for Hazmat releases, etc.

[102] FEMA Public Assistance Policies can be accessed online at http://www.fema.gov/government/grant/pa/9500toc.shtm. Section 9523.15 discusses eligible evacuation and sheltering costs.

b) Parking and traffic control

(1) Identify ingress and egress for shelter residents, staff, and guests.

(2) Identify main thoroughfares that will be closed to support shelter operations.

(3) Designate parking areas for each primary category of site user as well as ingress and egress routes.

c) Outdoor sheltering

(1) Required infrastructure

(a) Determine what impact adverse weather conditions, such as wind and rain, will have on the sheltered population and supplies.

(b) Drainage

(c) Elevation variations of site

(i) Golf courses or park sites may pose unique challenges of unleveled ground. Consideration should be given that some areas may not be suitable for this reason.

d) Stadiums, civic centers, and fairgrounds generally have a great deal of space and can accommodate larger shelters; however, acting as a shelter may force these facilities to cancel previously scheduled events. This could result in lost revenue, non-refundable fees, and the potential loss of those events to future bookings. While costs for use of the facility may be reimbursable by FEMA Public Assistance after a Federal declaration, lost revenue and fees are not. Such financial considerations should be made when considering these facilities/sites.

e) Tab J: Non-Traditional Shelter Facility Survey contains a site survey that has been developed using guidance by the International Association of Venue Managers, American Red Cross and other research.

4. Area demographics

a) Attention should be given to identifying the more populous geographic areas with the greatest projected housing damage and with significant numbers of low income residents that will likely seek assistance.

b) The large population at non-traditional shelters and the potential challenges (e.g. mental health, sanitation and

security) that could arise due to the size of the shelter and the length of time people will be living in the shelter should be emphasized and considered throughout the planning process.

c) Other demographic considerations include identifying the number of small children, Access and Functional Needs, elderly and other population groups that may require additional shelter support.

5. Agreements

a) Provide an example of necessary agreements and identify a list of planners who maintain comprehensive jurisdictional or organizational contract listings.

b) Coordination needs to occur to deconflict committed resources. Planning efforts should identify a lead agency committed to the organization, maintenance, and review of agreements that could become an issue if activated by more than one entity.

c) In developing agreements, the relationship with the vendor is important. The simple use of a standard template without interaction and understanding of each other's capabilities and expectations will not be effective.

d) Conduct regular monitoring and updates of memorandums of understanding (MOUs).

e) Ensure agreements clearly address financial arrangements for reimbursement, liability and agreement activation procedures.

f) National and regional vendors work differently. Some vendors will allow local stores to make decisions, while others require regional or national coordination.

g) Vendor agreements

(1) Maintain a roster of private sector businesses that can support mass care in areas identified as gaps[103]. The following is an abbreviated list of the types of material resources that may be needed[104]:

[103] City of Los Angeles Northridge Earthquake After-Action Report. January 1994, p. 4.

[104] International Association of Venue Managers Mega-Shelter Planning Guide provides an overview of specific tasks in the section, "Appendix E Mega Shelter Framework for Roles and Responsibility Coordination."

(a) Portable toilets, hand wash stations and portable showers

(b) Garbage removal/disposal

(c) Transportation

(d) Food

(e) Sanitation and janitorial services

(f) Heavy equipment

(g) Water

(h) Portable structures such as event tents

(i) Portable generators and light systems

(2) Planners and the task force should consider a tiered approach to organizing vendor agreements. Attention should be given to:

(a) Capacity/capabilities

(b) Standing inventories

(c) Ability to provide turn-key services

(d) Vendor location—whether it is outside of the OA or not and its proximity to the OA

(e) Amount of time needed to stand up operations

> At the Qualcomm Stadium shelter in San Diego in 2007 it was very important that disaster information was available, current, constant, and easily available in different formats for the shelter population.
>
> Also, the need for representatives of the access and functional needs communities to be a part of the non-traditional shelter planning team was identified.
> —City of San Diego After Action Report, October 2007 Wildfires

6. Public information

a) Public outreach/education

(1) Public messaging must prepare the public for the possible activation of a non-traditional shelter.

(a) Messaging must include descriptions of what life will be like in a non-traditional shelter. Attention should be given to informing the public about bringing items to support this

temporary residency and what items not to bring (e.g. high value jewelry).

b) Communications

(1) Planners should consider the myriad of communication challenges that will be faced during shelter operations especially in the first few days of operation when the public dial network may be inoperable or overloaded.

(a) For a mega-shelter, consider using its internal communication systems.

(b) For an open-space shelter, consider the types of resources that will need to be brought in.

7. Access and Functional Needs Planning[105,106]

a) Non-traditional shelter environments may have significant challenges due to their inherent characteristics. Substantial accommodations may need to be made to meet the needs of the entire shelter population and comply with ADA standards.

(1) Open-space shelters may need further modifications as limited or no infrastructure may be in place.

(2) Consideration must be given to potential lack of utilities will impact populations with dependencies on utilities for daily life (i.e.: dialysis, electric wheelchair, etc.)

8. Staffing[107]

Shelter operations will not be effective unless an adequate number of trained workers are available to support in all functions. The number of workers needed may be significantly higher than first estimates.

A capable core leadership team to manage the over-all site management and ensure that a human resource element is established as part of the management team is essential.

a) Identify workforce

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[105] "After Action Report – October 2007 Wildfires. City of San Diego.https://www.llis.dhs.gov/docdetails/details.do?contentID=30685 (login required), p. 31.

[106] International Association of Venue Managers Mega-Shelter Planning Guide, October 2010, p. 18, 65, 149 226. http://www.iavm.org/CVMS/mega_sheltering.asp

[107] Ibid, p. 22, 93, 219, 243.

(1) Traditional staffing sources must be used and may need to be augmented with employees of the facilities, spontaneous volunteers, and contracted staff.

b) Training

(1) Workforces must be trained for respective areas of roles and responsibilities, including shelter management.

c) Identification and creation of badges

d) Housing and services for staff

(1) Consideration must be given to where the staff will be housed and receive basic services.

(a) In the context in which a non-traditional shelter is activated, resources may not be available to transport or house staff off-site.

9. Client registration

a) Jurisdictions need to identify what information must be collected from shelter populations and the procedures that will be utilized to maintain the privacy of personal information. Local, State, and Federal reimbursement policies should also be consulted to ensure the proper level of documentation occurs and is maintained.

(1) Consideration should be given to determine what, if any, tracking requirements exist.

(a) Attention must be given to identifying any differences in American Red Cross and other NGO's policies prior to an event (i.e., types of information collected, confidentiality clauses, etc.).

(2) Implement appropriate public messaging.

b) For open-space shelters, if allowing drive ups, consideration should be given to registering vehicle license plate numbers and the number of individuals, as an initial phase of registration.

10. Logistics and resource management

a) Attention should be given to working with logistics agencies to identify resources available pre- and post-event. This includes local, State, Federal, private sector, and NGO resources.

b) Non-traditional resource levels need to be identified for an event of this magnitude. The following resources should be considered:

(1) Sheltering structures

(a) Personal family tents, soft-sided tents, and high tension fabric structures

(2) Power source

(a) Generators

(3) Sanitation[108]

(a) Toilets, hand washing stations, showers, and laundry facilities

(4) Lighting

(5) Additional infrastructure support (i.e., power grids, sewage, potable water, etc.)

11. Potential disruptions (Continuity of Operations Plan)

a) Attention should be given to possible disruptions during shelter operations. Continuity plans must be in place.

> "The use of non-traditional shelters also requires additional monitoring for potential, unexpected problems that could arise with extended use of these structures, such as checking for chemical sensitivities, logistical issues, additional support services, or other issues. With sufficient planning and adequate resources, these nonconventional facilities can provide shelter for large numbers of individuals and households."
> —National Disaster Housing Strategy

b) Disruptions have a higher potential to occur in a non-traditional shelter and may occur in a variety of forms (i.e., VIPs, including political figures with secret service, terrorism, civil unrest, supply chain interruption, or secondary hazards, etc.).

c) Procedures must be in place to support the high-risk population and secure assets in the event of an evacuation order due to secondary hazards.[109]

d) Utilize a shelter site's existing evacuation plan (if available) to develop its non-traditional shelter evacuation plan.

[108] Ibid, p. 46, 101, 245.
[109] Ibid, p. 240.

12. Administration and finance

    a) Consideration should be given to the increased administration needs and the subsequent staffing levels that may be needed.

    b) Additional attention should be given to coordinating with the logistics section through the EOC due to the increased challenges that may occur.

    c) Attention should be given to what types of information need to be tracked (i.e., staff hours, individual assistance (IA) registrations) to file for potential federal protective measures reimbursement following a presidentially declared disaster.

13. Recovery

    Given the catastrophic nature of an event assumed to require non-traditional shelters, normal recovery efforts and transitions will be altered in length and magnitude. It is important to the long-term recovery of any jurisdiction to retain its population after a disaster and make decisions that will enable the survivors to maintain residence in the area. The following considerations in a catastrophic environment can assist in this process.

    a) Accommodating the displaced population's return to a sense of normalcy, even in a shelter setting, is important. This can occur in many different ways, and will vary based on the culture and demographics of the local jurisdiction, but some considerations include:

        (1) Due to the severity of the disaster many of the displaced population may not have jobs to return to. Attention should be given to identifying opportunities for employment (gainful or volunteer). This may assist the larger recovery process and provide opportunities for income and personal involvement.

        (2) The provision of sanctioned activities for children, often childcare or school, by authorized personnel enables survivors to focus on their recovery efforts or employment during a disaster. A large portion of the workforce is often preoccupied with the care of their

After the October 2007 wildfires in San Diego, the California Assembly passed Bill 2327 related to the provision of relief services in shelter locations. It discusses the challenges encountered and additional considerations for planners.

families and the faster operations that can care for children begin, the more effective recovery becomes.

b) Local assistance centers (LACs) provide vital resources for recovery for survivors. Their activation and proximity to major shelters will increase the access of survivors and assist them in obtaining aid that will enable more effective recovery.[110] Planners should consider whether LACs will be co-located with non-traditional shelters, and if not, how transportation to the LACs will be arranged. Additionally, materials and messaging about recovery resources should be available in a variety of languages found in the jurisdictions.

E. Shelter Operations

The National Disaster Housing Strategy provides guidance regarding non-traditional shelters. Shelter operations for non-traditional shelters builds on the model set forth in a traditional setting, but are magnified in size, complexity, timeline and scope. Unlike traditional operations that are short-term and cater to populations of several hundred survivors that can largely return to their homes, non-traditional shelters could be available to serve hundreds to thousands of displaced individuals who may have significant damage to their residences, or no residences at all. This impact requires them to spend longer periods of time at the shelter and encounter needs and resources that are not necessarily considered in shorter term operational settings.

1. Activation

a) Triggers[111]

The decision to open a non-traditional shelter will be made by the local government. The following considerations may lead the local government to decide that a non-traditional shelter is the appropriate shelter type to accommodate the affected population. The Care and Shelter Branch of the local EOC will be the operational lead for the jurisdiction.

(1) The need for emergency sheltering exceeds the traditional sheltering resources (e.g. facilities, staff or logistical support capability) available in the jurisdiction.

[110] Section 8596 of the California Government Code provides additional planning considerations for recovery services co-located with a shelter. http://www.assembly.ca.gov/acs/acsframeset2text.htm.

[111] International Association of Venue Managers Mega-Shelter Planning Guide, October 2010, p. 10. http://www.iavm.org/CVMS/mega_sheltering.asp

(a) For example, 50 traditional shelters are needed to support an evacuated population of 5,000 people. However, only 40 traditional shelters are available after the incident. Recognizing this shortfall, this may trigger the need for a non-traditional shelter.

(2) Using the non-traditional shelter model provides a more targeted use of limited available resources.

(a) Following the previous example of 5,000 people needing shelter, if resources are only available for one central kitchen it may not be possible to deliver meals to 50 shelters. Thus, a non-traditional shelter may be more appropriate until additional resources are available.

(3) Examples of circumstances that may trigger the need for a non-traditional shelter include the following:

(a) Host communities anticipating the migration of evacuees

(i) In the event that 5,000 people are evacuating San Diego County towards Los Angeles County, it may be most appropriate to activate a single non-traditional shelter to provide a centralized reception to the large number of evacuees.

(b) Significant damage to infrastructure causing extensive and long-term damage to utilities, transportation, communications, etc.

(i) In the aftermath of a large disaster where it may be months until more permanent housing becomes available due to widespread damage, and the community seeks to close the traditional shelters at public schools to allow education to resume, it may be more appropriate to open a non-traditional shelter for those individuals unable to identify more permanent housing.

(c) Lack of shelter facility space close to impacted population

(i) School, jobs and social connections of impacted populations are far away from available traditional shelter locations.

(d) Self-settled congregation of displaced population in public space

(i) A non-traditional shelter should be considered in the event that disaster victims spontaneously congregate in an open space in the aftermath of an incident.

b) Activations do not necessarily indicate an immediate opening. It may take 24 to 72 hours to stage resources, prepare a location, and ensure safety for sheltering of displaced populations.

> "A layout of service locations was essential for health, safety, security, and traffic flow. This is essential prior to the admission of volunteers and evacuees into the care and shelter facility. It was difficult to relocate services after establishment of food, donations, commissary, children's area, sleeping quarters, personal hygiene area. Most everything crowded around the one access point which added unnecessary congestion and confusion to the area." —City of San Diego After Action Report, October 2007 Wildfires, page 29.

c) After ensuring necessary resources will be available, the decision to open a non-traditional shelter is made by the local jurisdiction in agreement with all support agencies.

d) Notification will occur with agencies that have an operational responsibility as identified from the non-traditional shelter task force.

(1) Notification may occur outside established procedures due to the escalated nature of non-traditional shelters.

e) Identification of sites

(1) This should take into consideration weather conditions, capacity needs, accessibility, potential pre-designation of site for other response activities, etc. The non-traditional shelter task force will have pre-identified potential sites for use.

f) Consider technical specialists necessary for the activation and implementation of a non-traditional shelter.

(1) This could include the utilization of task force members who wouldn't necessarily be included in the operational aspect of sheltering.

g) The execution of agreements prior to opening will ensure liability, terms of use, cost sharing/reimbursement etc. are understood by all parties.

2. Site Setup and Preparation[112]

a) Using Unified Command, at the direction of the local Care and Shelter Branch, the site command structure must include all agencies that have an operational role or responsibility.[113]

b) The amount of time needed to ensure minimum infrastructure (sanitation, security, communication, medical triage) is in place prior to the shelter opening will vary depending on the proximity and availability of resources.

(1) Identify resource gaps that must be filled prior to the opening of the non-traditional shelter.

(a) Non-traditional shelters require resources that are not normally found at the site or exceed basic capabilities of the facility.

(b) Opening of the non-traditional shelter may need to occur with a tiered availability of resources and services provided.

c) Complete the initial occupancy inspection for building safety and damage assessment.

d) Coordination should occur between local, State, and Federal agencies. This should be conducted in accordance with Standardized Emergency Management System (SEMS) and National Incident Management System (NIMS) processes.

e) Site layout must follow spatial guidelines agreed upon during planning phases.

3. Client Registration[114]

a) Registration is essential to ensure appropriate services and resources are available to shelter population. Traditional sheltering registration processes may be difficult in non-

[112] Ibid, p. 89.
[113] Ibid, p. 26.
[114] After-Action Report – October 2007 Wildfires. City of San Diego. https://www.llis.dhs.gov/docdetails/details.do?contentID=30685 (login required), p. 27 to 28.

traditional shelter settings. Anticipate challenges due to increased numbers of displaced population and lack of resources.

(1) Consider alternate strategies, such as mass reception centers or mobile teams, to assess clients within the shelter who have not yet been registered.

b) Registrations could take several days to accomplish depending on shelter population size and available staff.

c) For open air shelters, if allowing drive ups, consider registering by vehicle license plate and number of riders for overall shelter numbers and management, and register individuals and families in a separate process.

d) Consider issuing some form of identification to registered shelter residents.

4. Shelter management

a) Following standard sheltering procedures, all management of the shelter will be at the direction of the shelter manager/director.

b) Coordination with existing facility/venue owner and management is essential.

c) Entire operational sections may occur within a facility/venue with different leadership/authorities. Maintain a robust Incident Command System (ICS) structure.

d) When using the existing infrastructure within the facility/venue (e.g., sanitation) ensure the capabilities of the systems are not overwhelmed.

e) Use internal facilities plans and layouts for planning and coordination.

5. Shelter support activities

Ensure that the services that will be needed by the affected population are accessible in the non-traditional shelter.

a) Medical and Health

(1) Annex B: Medical and Health discusses the importance of health maintenance.

(2) Consideration should be given to identifying the needs and feasibility of housing a medical clinic on site. Refer to the Response Strategies section in Annex B: Medical and Health for information on providing health services beyond basic first aid.

(a) If additional treatment is provided at a non-traditional shelter, ensure that additional support services are available (i.e., electricity, pharmacy, examination equipment, durable medical equipment, etc.).

(3) Environmental concerns may include weather conditions, extreme temperatures, noise, air quality, and disaster-created hazards.

(4) Syndromic surveillance[115]

(a) Attention should be given to disease prevention and control due to increased population in confined areas.

(i) Methods and monitoring need to be in place to identify highly contagious diseases prior to outbreak.

(5) There are numerous other considerations including mental health, vector control, sanitation, and proper disposal of bio-hazardous waste.

b) Child support area

(1) Classes and planned activities

(2) Respite care

c) Public communication

(1) Access to Internet, U.S. Postal Service, television, radio, public phones

d) Client Services area

(1) Independent agencies providing unique services to the affected population

e) Client transportation services

(1) Emergency medical transport

(2) Essential non-emergency transport

(3) Recreation/elective transport

[115] International Association of Venue Managers Mega-Shelter Planning Guide, October 2010, p. 107, 124. http://www.iavm.org/CVMS/mega_sheltering.asp

f) Feeding area[116]

(1) Feeding considerations will include four areas: preparation area, snack/beverage area, serving area, and dining area.

(2) Identify if the food services capabilities of the site will be used.

(a) Food preparation, food storage, and food distribution

(3) A single food preparation site may be the most efficient means for a feeding operation at a non-traditional shelter site.

(b) This may or may not be on site.

(4) The number of individuals receiving meals may lead to extended wait times for food if food distribution points are not used.

(5) Determine policies for nonresident feeding.

(6) Ensure safe food handling practices in compliance with local health department standards.

(7) Plan for space needed during feeding times in consideration of multiple feeding times.

g) Recreation

(1) Organized entertainment activities

(2) Indoor and outdoor areas

6. Security and building access control[117,118]

a) Shelter planners must identify if the security staff of the facility is available and qualified to serve under command structure.

b) Identify perimeter security and access control needs.

(1) Install physical barriers where necessary or establish external patrol.

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[116] Ibid, p. 219.

[117] After-Action Report – October 2007 Wildfires. City of San Diego. https://www.llis.dhs.gov/docdetails/details.do?contentID=30685 (login required), p. 30.

[118] International Association of Venue Managers Mega-Shelter Planning Guide, October 2010, p. 55. http://www.iavm.org/CVMS/mega_sheltering.asp

c) Implement entry and exit policies for shelter access.

(1) Consider metal detectors and recording equipment.

d) Ensure staff and clients are aware of the various levels of access restrictions.

(1) Facility asset protection should be considered.

e) Establish internal patrol.

f) Coordinate with mental health and other activities to address specific concerns they may identify.

g) Strengthen internal access control language to ensure monitoring of children's areas, sleeping areas and bathrooms.

7. Communications[119]

In a non-traditional shelter site, operations will be spread throughout a large area that will require tools and processes far greater than at a traditional shelter site. However, available tools and resources (network bandwidth, electricity, weather, etc.) may be significantly limited due to the nature of the event.

a) Staff communication

(1) Internal communication will not fundamentally differ from a traditional shelter; however, the tools needed to communicate will. Staff will need to be comfortable using additional tools, such as local area networks and mobile communication devices.

(2) External communications will need to consider regular channels and schedules for communicating with local EOCs and media.

b) Communication to shelter population

(1) Traditional models of communicating to shelter populations may need to be significantly expanded to reach a

The natural regeneration of the environment in and around mass shelters and temporary planned or self-settled camps should be enhanced through appropriate environmental rehabilitation measures during the life of the temporary settlement. The eventual discontinuation of any such temporary settlements should be managed to ensure the satisfactory removal of all material or waste that cannot be re-used or that could have an adverse effect on the environment.

[119] Ibid, p. 26.

(a) Diverse and geographically spread out shelter population

(2) Mechanisms will need to be in place to verify the shelter population is receiving messages.

(a) Shelter population internal communications

(i) An internal newsletter may be an effective medium to communicate information to and from the shelter population.[120]

8. Demobilization[121]

The interest of the displaced population must continue to be a priority as demobilization occurs and as competing priorities become apparent. The factors and triggers for shelter demobilization include:

a) Resources can be downsized to a traditional shelter model

b) Lack of resources

c) Security concerns (evacuation order)

d) Advanced notice to both agencies, shelter populations, and the public

[120] The Village at Pass Christian, After-Action Report.

[121] International Association of Venue Managers Mega-Shelter Planning Guide, October 2010, pg 25, 240. http://www.iavm.org/CVMS/mega_sheltering.asp

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XIV. ANNEX D: TRANSPORTATION MANAGEMENT

A. Introduction and Purpose

The Los Angeles Operational Area (LAOA) Planning Guidance for Transportation to Mass Care Facilities includes successful practices, how-to suggestions, and techniques for addressing transportation concerns in the event of catastrophic emergency events. Its purpose is to support municipal planners within the LAOA to ensure that evacuation plans address how to safely transport evacuees to emergency shelters, as well as to foster planning continuity across jurisdictional boundaries within the LAOA.

Transportation may include private automobiles, buses, rail, wheelchair-accessible vehicles, vans, ambulances, military type transport vehicles, pedestrian evacuation, or other public or private transport. Identification of available transportation resources and coordination of those limited resources is paramount to any evacuation's success. The 2006 Nationwide Plan Review Phase 2 Report indicates that "a critical but often overlooked component of the evacuation process is the availability of timely accessible transportation—especially lift-equipped vehicles." Establishing solid agreements with vendors and detailing specialized services and equipment needed before an event is critical.[122]

This guidance includes best practices that can be tailored to your jurisdiction based on local conditions, available resources, and related contingencies.

1. Applicability

This guidance is meant to assist emergency planning professionals with the development of community evacuation and transportation plans, policies, and procedures in the face of hazards that would merit mass departure from a given populated geographic area in/around the LAOA.

2. Scope

The scope of this guidance document is transportation to and from mass care facilities; support for personal vehicle and pedestrian evacuation; transportation support to sheltering operations; non-emergency medical transport; and transportation support for people with access and functional needs. This document is all-hazards in nature, meaning that this guidance applies to any hazard that may generate a demand for transportation to mass care services.

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[122] *Comprehensive Preparedness Guide (CPG) 301, Interim Emergency Management Planning Guide for Special Needs Populations.* (2008, August 15). Department of Homeland Security, Federal Emergency Management Agency. http://www.fema.gov/pdf/media/2008/301.pdf. p. 35, lines 31-38.

Transportation to mass care facilities is an important part of the larger disaster and incident response effort, and transportation plans should include:

a) A firm foundation of legal authority

b) A list of roles and responsibilities for stakeholder agencies/organizations (both planning and activation)

c) A recommended command structure for the activated transportation branch during evacuation operations

d) Guidelines for levels of evacuation

e) Guidelines addressing personal vehicle evacuation and evacuation of vulnerable populations

f) Strategies for use of all transportation modes

g) Recommendations for transportation embarkation sites, evacuation routes, traffic and access control, and debarkation sites

h) Specific protocols for activation and demobilization of the transportation plan

(1) Applicable emergency plans and systems include:

(a) National Incident Management System (NIMS): Homeland Security Presidential Directive (HSPD) 5 directed the development of NIMS so that, on a national basis, responders from different jurisdictions and disciplines can more efficiently respond to disasters and emergencies.

(b) National Response Framework: The National Response Framework ("Framework") presents the guiding principles that enable all response partners to prepare for and provide a unified response to disasters and emergencies. The Framework defines the key principles, roles, and structures that organize the way first responders, decision makers, and supporting entities collaborate to provide a unified national response.

(c) California Emergency Plan: The California Emergency Plan, commonly referred to as "the State Emergency Plan" (SEP), is established under the authority of the Emergency Services

Act (ESA) and is in force throughout the state and its political subdivisions.

(i) Standardized Emergency Management System (SEMS): SEMS is the system required by Government Code §8607 (a) for managing the response to multi-agency and multi-jurisdiction emergencies in California. Local government agencies must use SEMS to be eligible for state funding of certain response-related personnel costs resulting from a disaster. SEMS is fully integrated with NIMS.

(ii) Operational Area Emergency Response Plan (OAERP): The Los Angeles County OAERP is created under the authority of County Ordinance 2.68 and addresses the operational area's planned response to extraordinary emergency situations associated with natural and man-made disasters and technological incidents.

(iii) California Disaster Health Operations Manual (CDHOM): The CDHOM provides guidance to local health departments (LHDs) on responding to disasters that require resources outside the response capability of the Operational Area.

(iv) California Disaster Medical Operations Manual (CDMOM): The CDMOM provides operational guidance for implementation of the California Disaster Medical Response Plan and Disaster Medical Systems Guidelines for incidents that require response coordination among multiple jurisdictions at all levels of government and the private sector.

B. Situation and Assumptions

1. General Considerations

When developing evacuation transportation plans, local jurisdictions should consider, at a minimum, the following three concerns:

a) Location, Distribution, and Characteristics of Evacuees

(1) Residents, employees, and others may be widely dispersed within the at-risk area

(2) Individuals with particular transportation needs (e.g., congregate housing, care facilities, incarceration facilities) should be anticipated

b) Modes of Transportation Available to Evacuees

(1) Evacuees are likely to travel in an evacuation in various modes of transportation (e.g., personal vehicle, pedestrian evacuation, public transit, etc.)

(2) Determine the proportion of evacuees with access and functional needs that will be able to reach designated transit pickup locations. Some evacuees will need to be picked up at their residences

(3) Determine parallel/redundant transportation routes and modes might be available in case others are damaged

c) Directions of Travel

(1) Consider likely directions evacuees will want to travel

(2) Consider likely areas of traffic congestion that correspond to population density and anticipated travel paths

(3) Consider transportation resources that may be available to provide assisted evacuation or to facilitate traffic flow and minimize congestion

2. Situation

a) The transportation function may be activated to support the transport of LAOA evacuees to mass care facilities.

b) The LAOA faces a potentially wide range of natural, technological, and human-induced threats and hazards that could require evacuation, care, and shelter.

c) Since the Olmstead Decision[123], people with access and functional needs are now integrated into communities. This

[123] The U.S. Supreme Court decision in the case of Olmstead v. L.C. and E.W. on June 22, 1999, affirmed the right of individuals with access and functional needs to live in their own communities instead of being forced to live in institutional settings, as laid out in the "integration mandate" of the Americans wiith Disabilities Act (ADA), which required public agencies to provide services "[i]n the most integrated

integration must be maintained in evacuation and sheltering operations.

d) In January 2008, the California Emergency Management Agency (Cal EMA) created the Office for Access and Functional Needs (OAFN)[124] to help support more effective evacuation and sheltering of older adults, people with disabilities and others with access and functional needs.

e) In neighborhoods or facilities with a high concentration of access and functional needs populations, sufficient and timely accessible transportation will be needed.

3. Assumptions

a) Due to ancillary risks, evacuation is a solution of last resort. Selective evacuation is much more likely than mass evacuation. Sheltering in place will be the most appropriate protective action for many incident scenarios.

b) Evacuation planners must understand the people who are likely to be evacuated before they can make key decisions about transportation modes, route selections, sheltering destinations, material supply, and other elements of an effective evacuation effort.

c) After a no-notice incident, movement on foot may be the first and sometimes the only choice for many evacuees. Evacuation transportation planning should address how to protect pedestrians at or near the location of the incident and how to support those with limited mobility.

d) Transportation planners should identify sidewalks and trails, crosswalks, intersections, bridges and tunnels, and other possible barriers that could impede pedestrian movement in a disaster incident.

e) Transportation resources used in the evacuation may differ depending on the situation and resource availability. Evacuation resources could include charter buses, school buses, paratransit, transit, railways, maritime resources, and aircraft. Various evacuation resources are described in more detail in Appendix 11: Transportation Management—Description of Transportation Modes for Planning.

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setting appropriate to the needs of qualified individuals with disabilities." http://supct.law.cornell.edu/supct/html/98-536.ZS.html.

[124] California Emergency Management Agency (Cal EMA) Office for Access and Functional Needs. http://www.oes.ca.gov/WebPage/oeswebsite.nsf/Content/7CC19449AF7EEC028825748E0059F8BE?OpenDocument.

f) Availability of transportation resources will depend upon:

(1) The nature and scope of the incident

(2) The time of day and day of the week during which the incident takes place

(3) If and where the transportation network sustained damage during the incident

(4) The proximity of the affected area to the location of various transportation resources

(5) Whether people need to be evacuated over long distances

g) In many incidents forcing evacuation and sheltering, local transportation infrastructure support resources will be committed, and additional help will be needed from the neighboring jurisdictions. This will be requested through the OA.

h) The CEOC will be activated for an incident severe enough to create a large-scale evacuation. Consistent with the Emergency Response Plan (ERP), the CEOC will manage and coordinate with local governments to support the OAs response efforts.

i) The duration and scope of local, state, and Federal involvement will be proportional to the situation's severity and the assistance required to protect and assist the affected population.

j) A percentage of those seeking transportation to mass care facilities and/or seeking shelter will have access and functional needs. This population may include:

(1) People with mobility disabilities

(2) People with visual or hearing impairments

(3) People who are dependent on medical devices, recovering from a medical procedure, or otherwise medically fragile

(4) People with mental impairments

(5) Older adults

(6) Unaccompanied minors

(7) People who have limited English proficiency

(8) People who are transportation dependent

k) Evacuees will seek to bring their pets with them, and many will ignore evacuation orders if forced to leave their pets or livestock behind. As a result, special planning must be conducted to accommodate animal transport and sheltering.

l) Service animals are not household pets and must remain with the person to whom they are assigned.

m) People with durable medical equipment must be permitted to remain with this equipment during transport.

n) Some evacuees will have a mental illness or may be experiencing emotional trauma as a result of the emergency and will need to be identified and referred to mental health professionals as soon as possible.

o) Local government will need to coordinate spontaneous unaffiliated volunteers to meet evacuation personnel requirements.

p) Visitors will likely be unfamiliar with routes and landmark facilities named in evacuation messages.

q) In cities where Intelligent Transportation System (ITS) assets are well developed, the transportation agency will have some of the most current information and the broadest overview of the traffic and pedestrian flow, making it imperative that the transportation agency actively participates in emergency management functions rather than simply playing a support role.

r) Evacuations forced by terrorist threat or attack will require more extensive security resources to ensure public safety, including protocols for sweeping transit equipment for improvised explosive devices (IEDs) and chemical dispersion devices.

s) The time of day of the incident may affect communications and public information strategies, as well as evacuation flow.

t) Power outages may impact the availability of gasoline and other fuels (e.g., compressed natural gas) and the viability of some key facilities.

C. Concept of Operations

1. Evacuation Orders

a) Local jurisdictions, operating at the SEMS field level, will ordinarily determine whether to evacuate communities within their jurisdiction. This is done on a case-by-case basis based upon the nature, scope, and severity of the emergency. In

certain circumstances, the CEOC may make recommendations on whether a jurisdiction should evacuate or shelter in place, and will help coordinate evacuation efforts as necessary.

b) The local governing body has primary responsibility for issuing an evacuation order. This authorization can be in the form of an ordinance, resolution, or order that the local governing body has enacted.

c) The decision on whether to evacuate or shelter in place must be carefully considered with the timing and nature of the incident. Although evacuation is an effective means of moving people out of a dangerous area, due to its complexity and the stress it puts upon the population, it is considered a solution of last resort.

d) Evacuation orders should be issued when there is a clear and immediate threat to the health and safety of the population and it is determined that evacuation is the best protective action.

e) Evacuation orders should be described as mandatory to promote public cooperation. Law enforcement will document the location of people refusing to evacuate by asking these people to sign waivers and provide next of kin contact information.

f) Once a local jurisdiction orders a mandatory evacuation, it is critical that public information dissemination, transportation, sheltering resources, and the security of private property are provided to a level where the public feels confident that evacuation is a better option than staying behind.

2. Transportation Movement Group

a) Evacuating jurisdictions should establish a Transportation Movement Group (TMG) to ensure communication and coordination between responding agencies. In most cases the TMG will include:

(1) Law enforcement (local, county, and state)

(2) Transportation (highways and ports)

(3) Transit (bus and rail)

(4) Social services (mass care)

(5) Service organizations serving persons with access and functional needs

(6) Private sector representatives, as appropriate

b) To maintain consistency with the NRF, it is recommended that the TMG be placed in the Movement Coordination Branch of the Operations Section within the EOC. Surface, maritime, and aviation units within the TMG may be activated, as appropriate, to support evacuation orders.

c) The TMG is charged with identifying transportation solutions and coordinating transportation resources to help meet evacuation and incident objectives.

d) It is recommended that the TMG consider dispatching liaisons to the Caltrans Traffic Management Center (TMC), the JIC, and affected EOC/CEOC as appropriate.

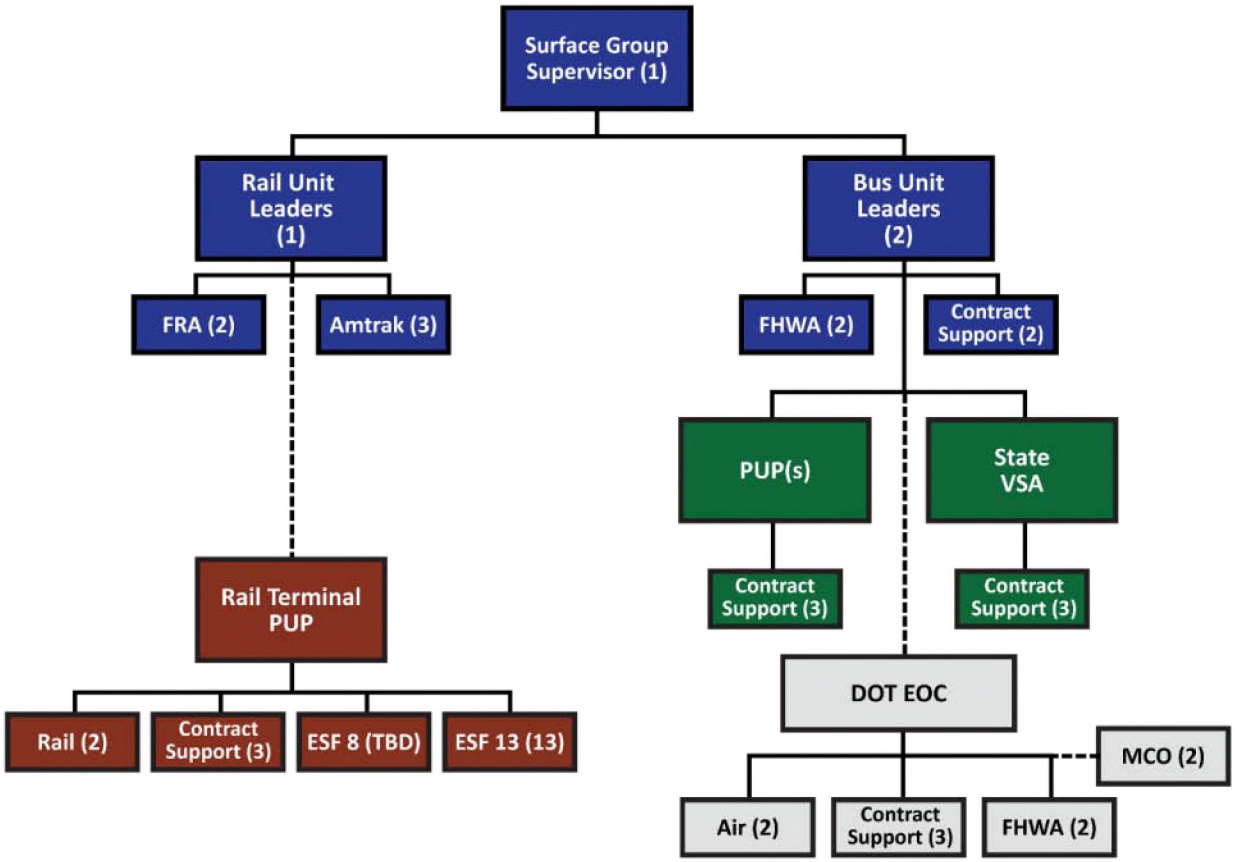

Figure 2: Organizational Chart—Movement Coordination Branch[125]

[125] *Supporting Bus Evacuation Operational Plan (Draft).* Department of Homeland Security Federal Emergency Management Agency. p 15, 46.

3. Evacuation Route Planning
   a) Primary evacuation routes in the LAOA consist of the major interstates, highways, and prime arterials.
   b) Local jurisdictions should pre-identify evacuation routes for probable hazards.
   c) TMTs should coordinate with CEOC to assess the viability of identified evacuation routes using real-time capacities of transportation infrastructure.
4. Vehicle Staging Areas
   a) Staging areas should be established for check-in and mobilization of transportation resources.
   b) Staging areas should be pre-identified based on hazard and risk assessments.
   c) Selection of staging areas should be made by the TMT based on incident impacts and evacuation resource needs.
5. Embarkation Points
   a) Possible embarkation points may include:
      (1) Local transit bus stops, as transportation-dependent residents and bus drivers will already be familiar with their locations.
      (2) Stores and other locations with large parking lots in areas where planners expect residents to drive to embarkation points.
   b) Given resource limitations and risk to responders, evacuees with access and functional needs who cannot reach these embarkation points should be collected curbside at their respective locations to the maximum extent possible.
6. Transportation Hubs
   a) Should be established outside of threatened areas for triage of evacuees and distribution to appropriate care facilities.
   b) The number and location of transportation hubs should be based on the population that will need transportation. Transportation hubs should be at easily identified locations.
   c) Municipalities may want to consider senior centers for use as transportation hubs, as these facilities are geographically dispersed, ADA compliant, include many infrastructure support resources such as water, bathrooms and back-up power, and are familiar to senior citizens.

d) The environment in a shelter may be chaotic. If possible, mental health personnel should be stationed at transportation hubs to conduct evaluations and assessments as deemed necessary. This will allow people who have sustained emotional trauma or are mentally ill to receive services and/or a referral to a higher level of treatment before they reach a shelter.

7. Evacuee Manifesting and Tracking Process[126]

a) Planners should determine strategies for tracking individuals who evacuate. Information typically captured for evacuee manifesting purposes includes:

(1) Name

(2) Address

(3) Driver's license number

(4) Cell phone number

(5) Associated family members with whom they are traveling

(6) Access and functional needs

b) Planners may consider use of color-coded bracelets designating evacuees by neighborhood of origin. This can be valuable during reentry.

c) Planners should ensure that sufficient technology and personnel are in place to prevent registration from becoming a bottleneck in the evacuation process.

d) Record takers must keep in mind that the information recorded is protected under the Privacy Act of 1974,[127] and proper safeguards are to be used when evacuee records are created, transported, handled, or shared.

8. Alert Notification and Emergency Public Information

a) Timely notification of evacuation orders is critical to an effective response. Transportation considerations that should be included in evacuation alert notification efforts include:

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[126] Several software packages have been developed specifically to track persons displaced in a disaster and have been used successfully for several large-scale disasters.

[127] *Privacy Act of 1974, 5 U.S.C. §552a.* (1974). Library of Congress. http://thomas.loc.gov/cgi-bin/bdquery/z?d093:S3418.

(1) Who and what regions should evacuate, explained in terms that the general public will understand

(2) Why and when residents should evacuate

(3) Designated evacuation modes and routes

(4) Transportation embarkation points and reception centers

(5) How service animals, pets, and livestock will be accommodated

D. Transportation Roles and Responsibilities

1. Transportation Management considerations

a) The TMG should work with Incident Command to ensure that jurisdiction-wide coordination and support are given to:

(1) Transportation continuity of operations assessments

(2) Identification and transport of persons with access and functional needs

(3) Identification of conventioneers, visitors, and others who may have unique evacuation needs

(4) Identification and transport of pets

(5) Tracking of activated and on-alert transportation resources

b) The TMG should coordinate with the operational area and assisting jurisdictions to ensure the following:

(1) Establishment of traffic control points

(2) Identification of pedestrian and vehicular evacuation routes

(3) Identification of transportation routes for goods and services

(4) Establishment of embarkation points, staging areas, and transportation hubs

2. Support Agencies

a) All support agencies should do the following:

(1) Track all department costs related to the response and recovery efforts

(2) Provide status information to the EOC

(3) Provide jurisdictional evacuation information to the public, as appropriate

b) Law Enforcement

(1) Mobilize law enforcement personnel and material resources to meet security requirements

(2) Prepare an operational security plan and train personnel on security transportation function(s)

(3) Maintain access control to speed departure of evacuees and expedite recycling of transportation resources

(4) Maintain security in evacuated zones

(5) Provide security and escort for transportation resources

c) Public Works

(1) Remove waste and debris to clear roadways

(2) Facilitate traffic management planning

(3) Erect barriers and provide assistance with alternate traffic routes

(4) Conduct engineering investigations

(5) Maintain and repair streets, sewer and storm drain systems, bridges, and streetlights

(6) Administer and monitor emergency contracts

(7) Provide damage assessments in coordination with CEOC

d) Transportation

(1) Working in partnership with emergency planners, transportation providers should conduct an assessment of transportation capabilities

(2) Provide transportation assets to meet evacuation requests of the TMG

(3) Assess status and capacity of transportation infrastructure, including disaster impact and pre-existing closures due to construction, etc.

(4) Develop a transportation management plan in coordination with Incident Command

(5) Assess evacuation demands in terms of continuity of operations, and curtail regular transportation service as appropriate

(6) Mobilize personnel and material resources to fulfill transportation service requests, including use of Freeway Service Patrols to assist with clearing disabled vehicles from freeways

(7) Activate emergency operations plans for vehicle staging, serving embarkation points, transportation of access and functional needs populations, etc.

e) Los Angeles/Long Beach Harbor Departments

(1) Move or evacuate any at-risk vessels from Harbor Department property or waterfront

(2) Coordinate with private sector to manage maritime transportation resources as demanded for public safety

(3) Participate in port security activities

(4) Activate operational plan for ship anchorage and ship movement to avert collision

(5) Direct Harbor Department personnel and volunteers from private industry

f) Medical, Health, and Human Services

(1) Coordinate specialized vehicles (e.g., ambulances) to assist transportation of individuals with access and functional needs

(2) Supply information to responders about locations of individuals with access and functional needs

(3) Provide outreach to persons with health needs and related service providers to ensure that they can safely evacuate

g) Department of Public Social Services

(1) Provide outreach to service providers to ensure that persons with access and functional needs have been notified and can safely evacuate

(2) Assist in the coordination of movement of people and supplies from shelter to shelter and in reception centers as requested by the Care and Shelter Branch in the CEOC

(3) Work collaboratively with the Internal Services Department (ISD) or General Services Department (GSD) within the LAOA to procure transportation, supplies, equipment, or additional personnel

h) Animal Control

(1) Implement and oversee evacuation of pets and livestock

(2) Coordinate triage of medically-fragile animals prior to transport

(3) Direct volunteers to assist with animal evacuations

i) Volunteer Organizations Active in Disaster (VOAD), such as Emergency Network Los Angeles (ENLA)[128]

(1) Coordinate public information through faith-based and other community organizations.

(2) Provide transportation resources of community and faith-based organizations to supplement resources from ISD or GSD

(3) Match volunteers to volunteer requests

(4) Manage transportation and distribution of donations

j) Fire

(1) Coordinate ambulances as needed to support emergency medical evacuations

(2) Provide rotary support to conduct infrastructure damage assessments with Fire Branch of the CEOC

k) County Internal Services Department (ISD) or city General Services Department (GSD)

(1) Coordinate with pre-determined private vendors and schools to secure evacuation resources, such as supplies, equipment, transportation assets, and trained personnel. These resources may be drawn from inside or outside the impacted area, as needed.

l) Private Sector

(1) TMOs coordinate with TMT regarding staggered evacuation planning

(2) Airport shuttle, taxi and charter bus companies, amusement parks, and other private sector stakeholders activate transportation assets, as requested, to augment MTA fleets

[128] ENLA is a network of Los Angeles County nonprofit, community-based organizations (CBOs) that provide assistance to individuals, families, and organizations following emergencies and disasters. ENLA is the VOAD for Los Angeles County. More information on ENLA is available at http://www.enla.org.

(3) Towing companies activate contingency contracts to support Public Works in clearing roadways

(4) Private ambulance service provides support to emergency medical evacuations

3. Assisting Jurisdictions

a) Activate EOC to ensure jurisdiction-wide coordination and support is given to:

(1) Traffic control and other field-level operations

(2) Crisis communication

(3) Continuity of Government and Continuity of Operations

(4) Coordination of local agency resources within the jurisdiction

(5) Inter-jurisdictional coordination between the evacuating jurisdiction, the receiving jurisdiction, and the operational area

(6) Tracking of all costs related to the response and recovery efforts

b) Provide agency representation to:

(1) Ensure that assisting jurisdiction resources are properly deployed

(2) Provide a liaison to the evacuating jurisdiction to support the TMG, including determining evacuation routes into the receiving jurisdiction

(3) Determine traffic control and evacuee assistance services that may be necessary in the receiving jurisdiction

(4) Evaluate the number and nature of the evacuating population and modes of transportation

(5) Estimate the arrival time of evacuees to reception and care facilities

(6) Coordinate messages with Public Information Officers (PIOs) and/or the JIC

E. Building Relationships with Transportation Partners

1. Identifying Transportation Resources

a) Identifying and fostering relationships with the myriad of transportation resources in the LAOA is essential to effective

evacuation. It is recommended that jurisdictions develop relationships with transportation agencies, service providers, and operators within the community whose resources may be needed during an evacuation.

b) In addition to MTA, Metrolink, and Access Services, there are a host of smaller transportation providers and hidden fleets that may be needed in case of evacuation orders. There are also specialized medical transportation service providers that will be crucial in the movement of individuals from hospitals, care facilities, etc.

c) An inventory of transportation assets should be developed that includes:

(1) Fleet size

(2) Types of vehicles

(3) Vehicle capacities

(4) Number and location of wheelchairs and wheelchair accessible vehicles

(5) Fuel type and range

(6) Vehicle fueling locations

(7) Turning radius

(8) Vehicle storage/layover locations

(9) Tactical communications equipment and capabilities

d) Working in partnership with transportation providers, planners should conduct an assessment of capabilities

e) Transportation resource requests should include a complete description of the mission, such as the number, location, and characteristics of the population that should be moved, so that transportation providers can best match equipment to need

f) All jurisdictions should be aware that transportation providers have service commitments that may limit real-time resource availability

g) It is recommended that jurisdictions identify the number of people who may be in need of evacuation transportation[129],

[129] The Healthcare Portability and Accountability Act (HIPAA) can limit the ability of service organizations to share information about their clients. It is possible, however, to pre-identify licensed care facilities, congregate senior housing, and other institutional facilities. Additionally, partner agencies serving people

and map those populations in relation to transportation assets, evacuation routes, and reception centers or shelters.

h) Local jurisdictions should seek to establish and maintain working relationships with advocacy and faith-based groups that serve the transportation-dependent members of their community

i) More information on the various transportation assets that might be used in an evacuation are provided in Appendix 11: Transportation Management—Description of Transportation Modes for Planning.

2. Memoranda of Understanding (MOUs)

a) In the highly charged environment of a large-scale disaster, the competition for response resources will be intense. While incident managers will prioritize according to need, pre-incident MOU will clarify the obligation of scarce resources and better support interagency communication and coordination during emergencies.

b) MOUs and Memoranda of Agreement (MOAs) should be cross-walked to minimize the risk of critical resources being over-committed.

c) Local jurisdictions are encouraged to develop MOUs/MOAs with additional transportation resources within their jurisdictional boundaries.

d) Local governments should consider developing contract language that mandates the use of vehicles purchased with government funds as part of its emergency powers, especially through DOT's Section 5300 funding resources.

e) It is also recommended that contingency contracts be developed for critical resources such as traffic barricades, heavy equipment, and personnel resources.

f) Contracting officers should be provided special training on emergency procurement standards and what procedures must be followed in order to expedite emergency purchase actions during emergency incidents.

g) Draft MOU language is available in a free toolkit from Cal EMA[130].

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with access and functional needs can serve as a conduit for rapid dissemination of evacuation information. For additional guidance contact the Cal EMA Office for Access and Functional Needs.

[130] http://tinyurl.com/CalEMAToolkit

F. Personal Vehicle and Pedestrian Evacuation

Evacuation orders create a sudden surge of vehicular and pedestrian traffic and can result in "spontaneous evacuation," as individuals choose to evacuate without being explicitly told to do so. This section focuses on planning considerations for the majority of the population evacuating in privately owned automobiles, as well as the unique challenges of pedestrian evacuations.

1. Public Education

a) Emergency managers should prepare the public in advance for the potential of evacuations. The Federal Highway Administration (FHWA) has identified the following pieces of information that must be communicated to the public:

(1) Preparations to carry out in advance (e.g., emergency ready kits, family evacuation plans).

(2) How an evacuation will be declared, and the meaning of different types of evacuation orders (e.g., mandatory vs. recommended).

(3) Support services are likely to be offered to evacuees

(4) Where to get information once an evacuation is ordered

(5) Where and how to get updated information once an evacuation is underway

b) Planners may also consider how they want motorists to use the local transportation network by examining the following options:

(1) Provision of maps showing various possible evacuation routes, including routes with limited availability for refueling

(2) Traffic signal coordination and/or implementation of limited contra-flow operations

2. Emergency Communications with Personal Vehicle Evacuees

a) Methods of communication

(1) The methods for communicating information to motorists will vary depending on the stage of the evacuation

(2) Television, Internet, telephone messages, and social networking may be helpful to announce an evacuation, but these methods will not reach most motorists during the evacuation

(3) Communications methods such as dynamic messaging signs, low-power highway advisory radio systems, and motorist information services (e.g., 511 telephone systems) may be more effective to impart information to motorists

b) Information critical to personal vehicle evacuees includes the following:

(1) Status of road closures or route changes

(2) Evacuation routes

(3) Alternative routes

(4) Food, fuel, and medical care along evacuation routes

(5) Hotel, motel, and RV park availability

(6) Shelter locations and proximity to major evacuation routes

(7) Pet friendly shelter locations

(8) Availability of kennels or temporary facilities for pets

(9) Availability of boarding stables for livestock

3. Planning Considerations for Pedestrian Evacuation

a) When a large-scale event prompts the evacuation of densely populated metropolitan areas, evacuation streams will include a large number of pedestrians

b) The Federal Highway Administration (FHWA) offers several approaches to managing pedestrian evacuation, as shown in Table 1: Conceptual Approaches for Managing Pedestrian Evacuations.

(1) Each of the approaches is based on no-notice high impact events that affect some part of a densely populated city

(2) Each approach shares the common objective of ensuring the safety and mobility of pedestrians and minimizing the effect they have on traffic congestion

c) Additional strategies planners can consider include the prohibition or minimization of private vehicle evacuation, pedestrian evacuation, or sheltering in place

d) Additionally, planners may consider designating routes specifically for buses or large capacity vehicles

Table 1: Conceptual Approaches for Managing Pedestrian Evacuations[131]

Approach	Strategic Objectives
1. Designate and manage separate evacuation corridors for outbound vehicles and for pedestrians.	▪ Minimize the need for complex logistical activities on the part of the transportation managers. ▪ Minimize the number of points where pedestrians and vehicles are in close proximity.
2. Provide dedicated evacuation transit hubs at the outer perimeter of the evacuation zone.	▪ Minimize the distance that evacuees travel on foot and are exposed to certain hazards. ▪ Provide a transit option for evacuees who began evacuation on foot due to lack of other options. ▪ Avoid putting disruptive activities like bus loading in and around the command and operations area. ▪ Increase the likelihood of having an appropriate space for gathering evacuees and loading buses. ▪ Avoid the need for extremely complex logistical activities by transit services.
3. Provide "bus bridges"[132] from area where large numbers of people are congregating to designated destination points.	▪ Reduce the magnitude of the number of evacuees on foot in the area which interfere with traffic. ▪ Take the buses into the evacuation zone to provide greater visibility of the option to be evacuated by bus. ▪ Give evacuees with limiting transportation conditions an alternative to walking. ▪ Provide a safe environment for evacuees when time or weather conditions are not conducive for walking. ▪ By using a short route loop, reduce the time it takes each bus to return to the staging area for another load.

[131] *Managing Pedestrians during Evacuation of Metropolitan Areas.* (2007, March) Federal Highway Administration, U.S. Department of Transportation. http://ops.fhwa.dot.gov/publications/pedevac/5_approaches.htm.

[132] "Bus bridge" is an industry term used to describe the deployment of buses to connect broken links of non-bus transportation modes. Bus bridges are most often used to shuttle passengers from one rail stop to another rail stop when the track in between the two stations is broken. Bus bridges are also sometimes used to connect airport concourses and to speed pedestrian evacuation to alternative modes such as a park and ride lot or rail station.

G. Persons with Access and Functional Needs

1. General Considerations

a) The state of California has placed great emphasis on emergency planning for people with access and functional needs (formerly referred to as "Special Needs Populations"), including establishment of the Cal EMA Office for Access and Functional Needs (OAFN). The purpose of OAFN is to support local jurisdictions in planning for the emergency needs of people with access and functional needs, and to integrate disability needs and resources into all aspects of emergency management systems in the state of California.

b) Individuals with access and/or functional needs include:

(1) People who have a physical disability, such as limited mobility or a hearing or vision impairment

(2) People who are dependent on electricity and/or durable medical equipment for survival (e.g., dialysis, oxygen, etc.)

(3) People with mental impairment necessitating caregiver support (e.g., those with Alzheimer's disease, mental illness, or a cognitive disability)

(4) Unaccompanied minors

(5) People who are medically fragile, recovering from a medical procedure, and/or were recently discharged following a hospital in-patient stay

(6) People who have limited English proficiency or are non-English speaking

(7) The frail

(8) People who are transportation dependent

c) Because the population of individuals encompassed by the term "access and/or functional needs" is so vast and has such diverse needs, planning for the provision of appropriate evacuation assistance is impossible without involving individuals from these communities, as well as representatives from organizations and agencies serving these groups.

d) Because people with access and functional needs often require more time to evacuate, emergency planners should consider a staged evacuation wherein evacuation recommendations are issued for people with access and/or mobility needs before the general evacuation orders.

e) In order to help first responders understand the capabilities and limitations of people with access and functional needs, consider training public safety personnel on moving and lifting people with varying access and functional needs. This training should include interpersonal sensitivity, basic communications, and the importance of retrieving medical or mobility equipment.

f) Transportation providers should be prepared to accommodate durable equipment on evacuation vehicles.

2. Evacuation Intelligence[133]

a) Understanding where individuals with access and functional needs live and work is essential to effective evacuation planning. The following is guidance on how to develop this sort of intelligence:

(1) Plan with ADA mandated transportation providers, health professionals, and service organizations to identify existing databases of individuals within your jurisdiction likely to require evacuation assistance.

(2) Identify and map licensed care facilities and congregate senior housing complexes.

b) Consider voluntary registries as a possible resource.

c) Identification of accessible transportation resources is important to speeding deployment of resources that meet the particular needs of vulnerable populations. Fleets that can be particularly helpful where access and functional needs populations are concerned include:

(1) Access services

(2) Regional center vendors

(3) Medicaid transportation providers

(4) Senior centers

(5) School district transportation systems

(6) Airport car rentals and shuttle buses/vans

(7) Healthcare center vendors

(8) NGO transportation providers (e.g., United Cerebral Palsy, regional and developmental centers and their vendors, adult day healthcare, senior centers, etc.)

[133] *After-Action Report–October 2007 Wildfires City of San Diego Response*. (2007). City of San Diego. https://www.llis.dhs.gov/docdetails/details.do?contentID=30685 (Login required).

3. Education

   a) All persons who rely on aids, such as wheelchairs, medications, canes, service animals, or durable equipment, should be made aware that they should bring this equipment during the evacuation process.

   b) Municipalities should consider special outreach efforts to ensure that these populations and relevant facilities, such as hospitals or nursing homes, understand their responsibilities in preparedness and client protection.

4. Frail Persons[134]

   a) The frail are more prone to falls on unsteady or steep inclines or stairs. Special training should be considered for anyone working with frail individuals during evacuations.

5. People with Medical Needs

   a) Individuals who require observation and/or ongoing treatment will require the support of trained medical professionals. This includes people who live at home with the help of life-support systems such as dialysis or respirators, as well as persons who are severely ill and require home healthcare, or who are reliant on medications or medical supplies.

   b) Persons dependent on life-support equipment or home healthcare will need to bring the equipment and/or personal support they receive at home with them whenever possible.

      (1) Medical equipment and supplies may require special handling and space accommodation during transport.

      (2) Some medications such as narcotics will require secure handling at debarkation points.

      (3) Some health services require frequent visits from outside specialists from the community, such as psychologists, therapists, physicians, nurses, and lab personnel, and therefore adequate parking or shuttle-type transportation may facilitate visits by health professionals.

      (4) Volunteers, caregivers, and family that provide care to individuals housed in shelters may also benefit from

[134] *Evacuating Populations with Special Needs.* (2009, May 8). Federal Highway Administration, U.S. Department of Transportation. http://ops.fhwa.dot.gov/publications/fhwahop09022/index.htm.

designated parking access or shuttle-transportation to and from shelter facilities.

c) Special planning may need to be considered for the medically fragile, including:

(1) General casualty evacuation, in which casualties with appropriate medical conditions are evacuated

(2) Partial casualty evacuation, for patients with the most severe conditions that can withstand evacuation

(3) Selective evacuation, for patients requiring specialty medical care unavailable in the impacted area or patients discharged or transferred to a lower level of care135

d) Some people who take medications may have memory difficulties. One strategy to help address this concern is to develop identification cards containing:

(1) Personal information such as name and address

(2) Emergency contact information

(3) Specific medical needs and a list of known allergies

(4) Required medication

This card can be pinned to clothing or hung around the neck at the time of evacuation.

e) Evacuating patients in disasters is a highly complex task. If large-scale patient evacuation is necessary, the National Disaster Medical System (NDMS) program may assist in moving patients identified by local health officials to unaffected communities.

6. People with Communications Needs[136]

a) Some people may need assistance with directions and locations to transportation embarkation points, as well as understanding signage.

b) Telephone messages, verbal directions on radio and television stations, large-type messages, and printed signs can be used to communicate evacuation orders and/or directives during the evacuation process to people with visual impairments.

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[135] *California Disaster Medical Response Plan.* http://www.emsa.ca.gov/pubs/pdf/emsa218a.pdf.

[136] *LAOA Mass Evacuation Process Guide*. (2009). Los Angeles Alliance.

c) Teletypewriters (TTY), television messages with open captioning or sign language, text messages, printed signs, and/or e-mail can be used to communicate evacuation orders and/or directives during the evacuation process to the hearing impaired.

d) American Sign Language interpreters should be used at news conferences, especially when announcing protective action recommendations.

e) The Cal EMA OAFN, Disaster Response Interpreters, and Department of Social Services may be resources for acquiring translators. Faith-based organizations can be another resource.

f) Picto-signage explaining basic evacuation actions required and evacuation transportation concerns should be considered for individuals who may have difficulty understanding written directions.

7. Unaccompanied Minors

It is important that planners give proper attention to the needs and protection of minors who may be unaccompanied by parents or other caregivers,[137] including plans for:

a) Reunification of unaccompanied minors with their guardians, including traffic control in and around schools or other facilities where reunification may occur

b) Secure areas for children who need referral to Child Protective Services.

8. Incarcerated and Institutionalized Individuals[138]

Prisons and institutional facilities are subjected to the same hazards as the general public, so municipalities must consider facility-specific planning:

a) Individuals in correctional settings are institutionalized to protect other members of society; people who are institutionalized in health-related settings are there for their own protection.

b) Institutional facilities, including correctional and health-related settings, are required to manage the evacuation of

[137] *California Disaster Medical Response Plan.* http://www.emsa.ca.gov/pubs/pdf/emsa218a.pdf.

[138] *Comprehensive Preparedness Guide (CPG) 301, Interim Emergency Management Planning Guide for Special Needs Populations.* (2008, August 15). Department of Homeland Security, Federal Emergency Management Agency. http://www.fema.gov/pdf/media/2008/301.pdf. p. 3, lines 3-13.

their resident population in coordination with, but separately from, general community evacuations.[139]

c) To reduce demand on limited evacuation resources, municipalities should consider hosting evacuation training and exercises with Congregate and Residential Care Facilities (CRCF). CRCFs include nursing homes, assisted living centers, drug treatment center group homes, foster homes, and adult and childcare facilities.

d) It is important to keep in mind that while nursing homes are required to have evacuation and emergency plans in place, not all residential care facilities are under the same requirements. Regulating authorities must be taken into consideration when planning for evacuation of CRCFs.

H. Animals

1. General Considerations

a) Like their owners, pets need identification documents, including call name, owner name, address, telephone, shot records, and medications. Plans should include providing the public with clear guidance regarding the necessity of having this information about their pets on-hand.

b) It is assumed that residents who have their own means of transportation will evacuate household pets and livestock.

c) Plans should address waste disposal, as well as feeding and watering depending on the duration of the evacuation, during the transportation process.

d) Transportation for animal waste disposal, used bedding, discarded or partially eaten food or supplies, or contaminated supplies or waste products should be kept separate from human pick-up and drop-off points.

e) Dedicated ingress and egress routes are recommended for technicians, veterinarians, lab personnel, volunteers, public health, and animal control to facilitate animal health service delivery.

2. Service Animals

Service animals are essential to the continued independence of persons with access and functional needs and should be evacuated

[139] *Evacuating Populations with Special Needs.* (2009, May 8). Federal Highway Administration, U.S. Department of Transportation. http://ops.fhwa.dot.gov/publications/fhwahop09022/index.htm.

with the person.[140] The ADA requires that service animals be permitted in any area accessible to the general public. This includes public transportation, shelters, and any other location accessible to the general public.

According to the U.S. Department of Transportation, service animals are not registered in any way, so responders must trust the evacuees' word in designating these animals as service animals. Additionally, planners must consider what to do in cases where animals are used for psychiatric and emotional disabilities, further complicating the designation as a service animal.

3. Household Pets and Livestock

Persons being displaced from their homes into evacuation centers often wish to bring companion animals with them. Having a pet nearby may serve as a source of comfort to someone who has lost his or her possessions and, perhaps, family members.[141] The PETS Act of 2006 requires that state and local emergency preparedness operational plans address the needs of individuals with household pets and service animals prior to, during, and following a major disaster or emergency.[142]

When evacuation of an area is called for, evacuees are encouraged to take their animals with them. The HSUS states that "animals that are turned loose or left behind to fend for themselves are likely to become victims of starvation, predators, contaminated food or water, accidents, or exposure to the elements."[143] Moreover, past evacuations have shown that pet owners may refuse to evacuate their homes if they are unable to bring their pet(s) with them, or will reenter disaster zones in order to retrieve animals that were left behind.

One of the most challenging issues for pet owners is finding shelter that accepts household pets or finding a pet shelter located next to a shelter where the owner stays so that owners can care for their pets. The following points should be taken into consideration when planning for household pets and evacuation:

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[140] *LAOA Mass Evacuation Process Guide*. (2009). Los Angeles Alliance. p. 13, 137.

[141] *Tips for Evacuating with Pets.* (2006, August 4). The Humane Society of the United States. http://www.hsus.org/press_and_publications/press_releases/tips_for_evacuating_with.html.

[142] *Pets Evacuation and Transportation Standards Act of 2006.* (2006, January 3). U.S. Congress. http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_bills&docid=f:h3858enr.txt.pdf.

[143] *Tips for Evacuating with Pets.* (2006, August 4). The Humane Society of the United States. http://www.hsus.org/press_and_publications/press_releases/tips_for_evacuating_with.html.

a) Residents who do not have access to vehicles will need to secure their pets in cages or carriers before they use public transportation and/or arrive at the embarkation points.

b) Emergency planners should develop a tracking methodology for evacuated pets. It is recommended that pet owners microchip their animals for identification purposes.

c) Use of vans and shuttle service drop off points will reduce the number of vehicles needing parking space near animal and pet friendly shelters.

d) MOUs need to be formalized with other agencies/organizations, especially for the transportation of large animals, such as horses. In addition, potential volunteer resources and private groups should be identified and tracked by local EOCs and the CEOC. Only non-emergency resources and personnel, such as public and private animal services agencies, will be used to rescue and transport animals during an evacuation effort. 144

I. Transportation In and Around Shelters

1. General

a) Shelter management plans should address ingress and egress of vehicles, embarkation and debarkation, supply drop off points and other traffic management issues. Traffic management at shelters is an integral part of larger traffic management planning and operations. Additionally, deployment and asset tracking should be linked with traffic management operations in and around shelters.

b) Overall objectives of the shelter traffic management plan include:

(1) Ensuring safety and security of all vehicular and pedestrian traffic in and out of the shelter site

(2) Keeping vehicular and pedestrian traffic flowing to avoid bottlenecks

(3) Coordinating the deployment and tracking of transportation assets with transportation management operations

c) Shelter managers should anticipate the need for an ongoing shelter traffic management plan. Jurisdictions should

144 *National Response Framework.* (2008, January). Department of Homeland Security Federal Emergency Management Agency. http://www.fema.gov/pdf/emergency/nrf/nrf-core.pdf. p.14.

develop guidelines on shelter exit and reentry for temporary shelters, as well as traffic management processes for long-term shelter situations.

d) Shelters should be equipped with appropriate interoperable communications systems, enabling shelter managers to coordinate transportation operations with the area command.

e) Availability of parking should be a consideration in the selection of shelter sites.

f) Shelters should have the capacity to be equipped with appropriate equipment for handling and managing materials and supplies (e.g. dollies, pallet jacks).

g) Consider using an alternate assembly point for staff to facilitate the turnover of staff during sheltering operations.

2. Safety

a) General Considerations

(1) Consider using high visibility ANSI 207-compliant145 traffic vests, as well as flashlights.

(2) Directional devices should be in place to alert and direct incoming and outgoing traffic.

(3) Specific arrangements should be made to accommodate movement of goods and services into and out of shelters to avoid traffic conflicts.

b) Pedestrian Ingress and Egress

(1) Separate receiving areas should be maintained for pedestrian traffic to minimize public safety risks.

(2) Signage, markings, and lane directions should be established, and supplemented with visual and audible aids for the sensory impaired.

3. Transportation Security

a) Vehicle Ingress and Egress

(1) Rings of traffic control and security:

(a) Outer: Law enforcement/security professionals, clearly identified with lighting and control/direction devices, to direct traffic into and out of shelter area.

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[145] *High-Visibility Public Safety Vests.* (2006, November 9). International Safety Equipment Association. http://www.nssn.org/search/DetailResults.aspx?docid=475953&selnode.

(b) Middle: Sufficient personnel to expeditiously receive and process inbound and outbound traffic.

(c) Inner: Sufficient personnel to expeditiously direct and physically assist inbound and outbound evacuees.

b) Vehicle Parking Areas

(1) All parking areas should be secured and patrolled with appropriate security practices in place.

c) Passenger Loading and Unloading Areas

(1) All loading and unloading areas should be secured and patrolled with appropriate law enforcement/security professionals.

(2) Law enforcement and security professionals should not be involved in the physical assistance of evacuees, as it may distract from their security responsibilities.

d) Shelter security should also be addressed as specified in the Mass Care Guidance for Emergency Planners.

4. Transportation during Sheltering Operations

a) General Considerations

(1) While the focus of many of the transportation needs will be during the evacuation and reentry phases, there will still be a need for transportation resources during any sheltering operation. This may include:

(a) Providing shuttles into the disaster area so that people can make repairs to their homes or meet with insurance adjusters, especially in cases where people need a safe place to stay at night but have repairs to do at their homes during the day.

(b) Providing transportation to transfer residents to temporary housing, back to their point of origin, or to another location.

(2) Depending on the services that are offered at the shelter and the immediate vicinity, transportation may be needed to meet shelter residents' basic needs, which may include things like cashing vouchers, doing laundry, getting medical care or mental health services, etc.

b) Shelter Transit Service

(1) It is important that shelter residents are not stranded and allowed to be as self-sufficient as possible. Permanent transportation solutions are needed for shelter residents to look for jobs, attend job training, and meet their basic needs.

(a) Transportation services should be accessible by populations with access and functional needs.

(2) To the greatest extent possible, public transit and school bus routes should be established to serve the shelter.

(3) A process should be established to modify transportation routes based on the needs of the shelter residents. Possible routes for consideration may include:

(a) Airport/bus station to shelter

(b) Hospital shuttle

(c) Medical appointments

(d) Shelter to local banks

(e) Shelter to shopping centers

(f) Shelter to hotels/ temporary housing

(g) Shelter to special events

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XV. APPENDIX 1: LEGAL MANDATES

The function of mass care is to provide temporary emergency relief to disaster victims, including a range of human services (e.g., food, shelter, healthcare, mental health support, etc.). The Care and Shelter Branch of the EOC/CEOC must be prepared for events, such as the terrorist attacks of September 11 and Hurricane Katrina, when mass care must go beyond standard government resources and embrace the commitment of other public and community partners to meet the need of mass care for our community and mutual aid mandates.

A. Legal Requirements for Local Government

1. California law sets the responsibility for emergency mass care at the local level. The California Health and Safety Code, the Emergency Services Act, and the California Master Mutual Aid Agreement (MAA) all outline responsibilities, planning requirements, and resource commitments.

    a) As per the Health and Safety Code Sections 34070 to 34072[146], local government is to provide—or contract with recognized community organizations to make—emergency or temporary shelter available for people made homeless by a natural disaster or other emergency.

2. California's State Emergency Plan147 and Standardized Emergency Management System148 (SEMS) also put local government at the first level of response for meeting the disaster needs of people in its jurisdiction. People seeking care and shelter immediately after a disaster will look first to local government for assistance. Local emergency ordinances outline local powers, roles, and responsibilities and provide for the development and adoption of local emergency plans.

3. All mass care plans must be compliant with the Americans with Disability Act149 (ADA). People with access and functional needs must have access to mass care programs, services, and facilities.

B. Legal Planning Considerations

1. Access and Functional Needs

    Congress has enacted several laws targeted at protecting the civil rights of specific individual "types." In general, the ADA prohibits

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146 http://law.justia.com/california/codes/hsc/34070-34082.html

147 http://www.oes.ca.gov/WebPage/oeswebsite.nsf/Content/79FCE3912398FA168825740F0060CE32?OpenDocument

148 http://www.calema.ca.gov/WebPage/oeswebsite.nsf/0/7386D576C12F26F488257417006C07A7?OpenDocument

149 http://www.ada.gov/

discrimination based on characteristics, such as age, gender, and disability. These Federal civil rights protections apply to emergency management of both government and nongovernment entities. Discrimination during a presidentially declared disaster is specifically prohibited, as stated in the Stafford Act.[150] Both State and local governments must also comply with Title II of the ADA in the emergency- and disaster-related programs and services.

2. Health Insurance Portability and Accountability Act (HIPAA)

a) HIPAA, Public Law 104-191[151], incorporates both privacy and security principles. The Privacy Rule asserts that privacy is an individual's "fundamental right" of protected health information, and includes the control of one's medical information and medical services. The rule strikes a balance of interest that permits use of information while protecting the individuals who seeks medical care. The following are planning considerations for HIPAA and information management:

(1) Review California laws/authorities regarding sheltering and performing healthcare/medical functions that make sheltering a specific covered entity or, otherwise, meet the definition of a covered entity that must comply with the HIPAA Privacy Rule.

(2) Shelters should follow the same HIPAA requirements as people, businesses, or agencies that are healthcare providers, healthcare clearinghouses, or health plans.

C. Codes and Regulations

The following is a list of a number of basic Federal, State, and local statutes, codes, ordinances, regulations, and other guidance relating to mass care. The list also identifies authorities that might come into play in the course of mass care operations, such as immunity of government workers and volunteers from liability, quarantines of individuals who have communicable diseases, and workers compensation coverage for people injured during sheltering operations. The cited authorities are not intended to be a comprehensive listing of every legal authority that might relate to mass care operations. Therefore, it is important that planners consult with their local legal counsel to identify and address legal issues that might arise in the course of mass care activities.

1. Federal

[150] Stafford Act, Sections 308-309, 1988.

[151] http://aspe.hhs.gov/admnsimp/pl104191.htm

a) 42 U.S.C. section 243 authorizes the Secretary of the Department of Health and Human Services to assist State and local governments in the prevention and suppression of communicable diseases and other public health emergencies and to assist State and local governments in the enforcement of quarantine and other health regulations.

b) FEMA Disaster Assistance Policies outline the eligibility and details for reimbursement following a disaster. Several of the policies that should be considered include the following:

(1) 9430.1152 describes the types of services offered at Disaster Recovery Centers.

(2) 9523.15153 dictates the policies for evacuation and sheltering financial reimbursements.

(3) 9523.18154 describes the reimbursement policy for host state evacuation and sheltering.

(4) 9523.19155 defines a household pet as "a domesticated animal, such as a dog, cat, bird, rabbit, rodent, or turtle, which is traditionally kept in the home for pleasure rather than for commercial purposes, can travel in commercial carriers, and be housed in temporary facilities."

(5) 9525.4156 discusses equipment prescribed by a physician that is medically necessary for the treatment of an illness or injury, or to prevent a patient's further deterioration.

c) Homeland Security Presidential Directive (HSPD) 5157, "Management of Domestic Incidents" establishes a single, comprehensive national incident management system.

d) HSPD-8, "National Preparedness"158 is a companion to HSPD-5 and identifies steps to facilitate improved coordination in response to terrorist attacks, major disasters and other emergencies.

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152 http://www.fema.gov/good_guidance/download/10304
153 http://www.fema.gov/pdf/government/grant/pa/policy.pdf
154 http://www.fema.gov/government/grant/pa/9523_18b.shtm
155 http://www.fema.gov/pdf/government/grant/pa/policy.pdf
156 Ibid.
157 http://www.fas.org/irp/offdocs/nspd/hspd-5.html
158 http://www.fas.org/irp/offdocs/nspd/hspd-8.html

e) Pets Evacuation and Transportation Standards Act of 2006, Public Law 109-308159, amends several sections of the Stafford Act and requires State and local governments to develop plans that take into account the post-disaster needs of people with household pets and service animals.

f) Robert T. Stafford Disaster Relief and Emergency Assistance Act160, as amended, 42 U.S.C. 5121 et seq. ("Stafford Act") establishes the Federal government's disaster assistance program and authorizes various forms of assistance following Presidentially-declared emergencies and major disasters.

g) The Americans with Disabilities Act (ADA) of 1990161, 42 U.S.C. 12101 et seq. prohibits discrimination based on disability. Title II of the ADA prohibits discrimination based on disability by all public entities, including State and local governments, and it also applies to public transportation by all public entities.

h) The Architectural Barriers Act of 1968 (ABA)162, 42 U.S.C. 4151 et seq., requires access to facilities designed, built, altered, or leased with Federal funds. Federal agencies are responsible for ensuring compliance with ABA standards when funding the design, construction, alteration, or leasing of facilities.

i) The Fair Housing Act of 1968163, as amended, was originally enacted as Title VIII of the Civil Rights Act of 1968.

j) The Federal Tort Claims Act164, 28 U.S.C. 2680, is a limited waiver of the Federal government's sovereign immunity. However, pursuant to 28 U.S.C. 2680(f), the Federal government is not liable for any claims based on damages caused by any imposition or establishment of quarantine by the United States.

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159 http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_public_laws&docid=f:publ308.109.pdf
160 http://www.fema.gov/pdf/about/stafford_act
161 http://www.ada.gov/statute.html
162 http://www.access-board.gov/about/laws/aba.htm
163 http://www.justice.gov/crt/housing/title8.php
164 http://www.law.cornell.edu/uscode/28/2680.html

k) The Health Insurance Portability and Accountability Act[165], Public Law 104-191, was enacted to safeguard confidential patient health information.

l) The Individuals with Disabilities Education Act of 1975[166], as amended, 20 U.S.C. 1400 et seq., governs how States and public agencies provide early intervention and special education to children with disabilities.

m) The Rehabilitation Act of 1973[167], as amended, 29 U.S.C. 791 et seq., prohibits discrimination on the basis of disability in programs conducted by Federal agencies, in programs receiving Federal financial assistance, in Federal employment, and in the employment practices of Federal contractors. Section 504 of the Act, 29 U.S.C. 794, created and extended civil rights to people with disabilities. Section 508 of the Act, 29 U.S.C. §794d and its implementing regulations at 36 Code of Federal Regulations (CFR) Part 1194 require Federal agencies to make their electronic and information technology accessible to people with disabilities.

n) The Volunteer Protection Act of 1997[168], P.L. 105-19, provides, with certain exceptions, that volunteers working with nonprofit organizations or governmental entities will not be liable for harm caused by their acts or omissions if they were acting within the scope of their responsibilities and were properly licensed, certified, or authorized to be performing the activities, which resulted in claims of liability.

2. State

a) California Civil Code, section 1714.5[169], provides that the State of California, its political subdivisions, and disaster service workers, which own, maintain, or are working in a building that is being used as a shelter or mass care center following a disaster, generally cannot be held liable for injuries sustained by people seeking shelter.

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[165] http://aspe.hhs.gov/admnsimp/pl104191.htm
[166] http://www.law.cornell.edu/uscode/20/1400.html
[167] http://www.eeoc.gov/laws/statutes/rehab.cfm
[168] http://thomas.loc.gov/cgi-bin/toGPObss/http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=105_cong_public_laws&docid=f:publ19.105.pdf
[169] http://law.onecle.com/california/civil/1714.5.html

b) California Disaster Assistance Act[170] (CDAA), California Government Code, sections 8680 et seq., authorizes State financial assistance for recovery efforts to counties, cities, and special districts after a State disaster has been declared.

c) California Education Code[171], section 32282, requires that school safety plans in California establish a procedure to allow public agencies (including the American Red Cross) to use school facilities for mass care during disasters.

d) California Emergency Services Act[172], as amended, California Government Code, sections 8550 et seq., authorizes the Governor to implement emergency powers following emergency declarations, established the California Emergency Management Agency (Cal EMA), created the California Emergency Council to act as an advisory body to the Governor, and established the SEMS.

e) California Government Code, section 11135[173], prohibits discrimination on the basis of race, national origin, ethnic group identification, religion, age, sex, color, or disability under any program or activity that is conducted or funded by the State.

f) California Government Code, section 855.4[174], provides that neither governmental entities nor their employees can be held liable for injuries resulting from their decisions to perform or not perform acts to promote the public health of the community.

g) California Government Code, section 8588.15[175], requires that representatives of the disabled community be included on all Standardized Emergency Management Specialist committees to ensure that the needs of the disabled are considered during the development of disaster plans, including those relating to sheltering.

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170 http://www.oes.ca.gov/operational/oeshome.nsf/pdf/california%20emergency%20services%20act/$file/esa-all8-06-final.pdf

171 http://law.onecle.com/california/education/32282.html

172 http://www.oes.ca.gov/operational/oeshome.nsf/pdf/california%20emergency%20services%20act/$file/esa-all8-06-final.pdf

173 http://www.spb.ca.gov/civilrights/documents/CALIFORNIA_CODES_11.pdf

174 http://law.onecle.com/california/government/855.4.html

175 http://law.onecle.com/california/government/8588.15.html

h) California Government Code, section 8608176, requires the California Office of Emergency Services to incorporate the California Animal Response Emergency System (CARES) into the SEMS.

i) California Government Code, section 8657177, states that volunteers who are registered with the California Office of Emergency Services or the disaster council of any local government in California are entitled to the same immunity from liability for their acts as volunteers or government employees.

j) California Health and Safety Code, section 101025178, requires the Board of Supervisors of each county in California to take steps to preserve and protect the public health of people within the counties.

k) California Health and Safety Code, section 1799.102179, provides that volunteers who provide medical or nonmedical care at the scene of an emergency cannot be held liable for their alleged acts or omissions.

l) California Health and Safety Code, sections 1797180 et seq., establishes the Emergency Medical Services Authority within the State's Health and Welfare Agency. The Emergency Medical Services Authority is responsible for, among other things, preparing disaster response plans to facilitate the provision of healthcare in the aftermath of disasters.

m) California Health and Safety Code, sections 34070–34082181, authorize the provision of shelter to people who become homeless as the result of natural disasters.

n) California State Emergency Plan182 (2009) outlines a State-level strategy to support local government efforts during large-scale emergencies.

o) Title 19, CCR Division 2, sections 2400 et.seq.183, are the "Standardized Emergency Management System

[176] http://law.onecle.com/california/government/8608.html
[177] http://law.onecle.com/california/government/8657.html
[178] http://www.lapublichealth.org/acd/procs/b73/Part%202.pdf
[179] http://law.onecle.com/california/health/1799.102.html
[180] http://law.onecle.com/california/health/1797.html
[181] See Footnote 146.
[182] See Footnote 147.

Regulations." These regulations establish the Standardized Emergency Management System (SEMS).

p) Title 19, CCR sections 2570 et seq., "The Disaster Service Worker Volunteer Program Regulations184," provide that disaster service worker volunteers are entitled to workers compensation benefits if they are injured while performing services to protect the public health and safety and to preserve life and property. The regulations also indicate that disaster service workers are generally immune from liability for disaster services they provide.

q) Title 22, CCR section 72551185, requires nursing facilities to develop disaster plans with the advice and assistance of county or regional and local planning offices.

r) Title 22, CCR section 87223186, requires residential care facilities for older adults to develop disaster plans, including planning relating to relocation sites for the residents of such facilities.

s) Title 24, CCR187 is known as the California Building Standards Code, and it contains the regulations that govern the construction of buildings in California, including accessibility regulations.

3. Local

a) Los Angeles County Code, section 2.68[188], authorizes the preparation and implementation of plans for the protection of life and property within Los Angeles County in the event of emergencies. The ordinance creates the Los Angeles Office of Emergency Management, and it also establishes an Emergency Management Council, which is responsible for overseeing the preparedness activities of the county's departments.

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183 http://www.cesa.net/library/SEMS%20Calif%20Code%20of%20Regs,%20Title%2019,%2012-95.pdf
184 http://www.oes.ca.gov/Operational/OESHome.nsf/PDF/Disaster%20Service%20Worker%20Volunteer%20Program%20(DSWVP)%20Guidance/$file/DSWguide.pdf
185 http://government.westlaw.com/linkedslice/search/default.asp?tempinfo=find&RS=GVT1.0&VR=2.0&SP=CCR-1000
186 Ibid.
187 http://www.dsa.dgs.ca.gov/Code/title24.htm
188 http://search.municode.com/html/16274/index.htm

- **Tab A: California Medical Volunteers, Principles of Operations**[189]

  This section is a summary of policies, procedures and guidance for local governments, state agencies, care delivery sites, and volunteer health professionals on the use of the California Medical Volunteers System in California.

  1. 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.
  2. 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.
  3. 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."
  4. Civil Code Section 1714.5 – appears to provide somewhat greater immunity, stating:
     a) "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

[189] Version 1.5 – March 13, 2008.

damage to property resulting from any act or omission in the line of duty, except one that is willful."

5. 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:

   a) "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."

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

   a) "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."

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

   a) "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.

b) 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."

8. 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.

This section shall not be construed to grant immunity from civil damages to any person whose conduct in rendering emergency care is grossly negligent.

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."

9. 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.

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XVI. APPENDIX 2: DEMOGRAPHICS

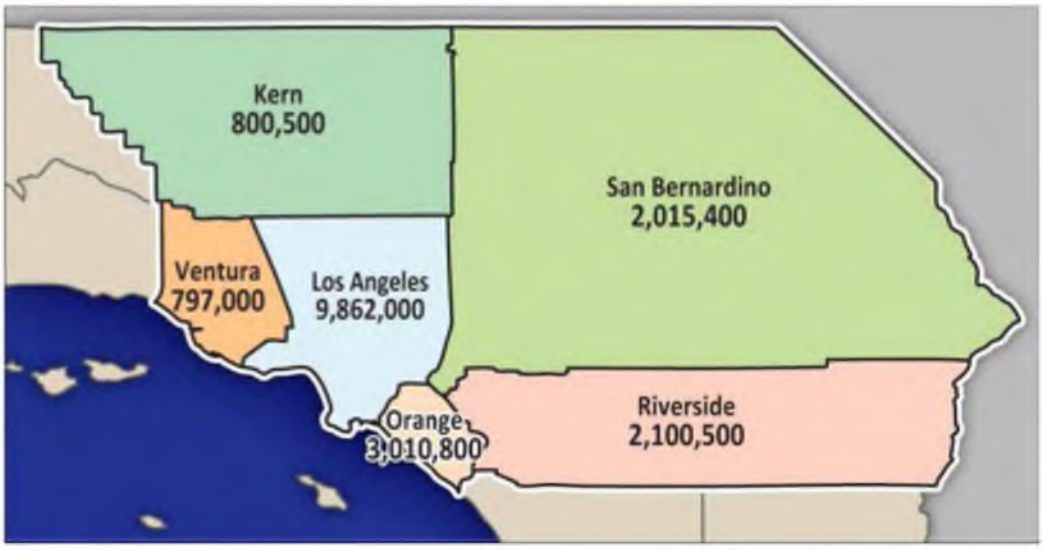
Part of preparing for the mass care mission is to understand the potential needs of the community in a major incident. Demographic information can help planners develop capabilities and strategies that are tailored to the needs of incident victims. This appendix presents some demographic information about the LAOA and surrounding areas.

A. County Populations

The following table presents the July 1, 2008, U.S. Census estimated population for the State of California, Los Angeles County, and surrounding counties.[190] The figures have been rounded to the nearest hundred for presentation in this guidance document.

Area	2008 Population
State of California	36,756,700
Los Angeles County	9,862,000
Kern County	800,500
Orange County	3,010,800
Riverside County	2,100,500
San Bernardino County	2,015,400
Ventura County	797,700

[190] The data source is the U.S. Census Bureau, "Annual Estimates of the Resident Population for Counties in California: April 1, 2000 to July 1, 2008," http://www.census.gov/popest/counties/tables/CO-EST2008-01-06.xls.



B. Age Groups in the LAOA

Based on the 2000 U.S. Census, the following table breaks down the resident population of LAOA by age group. For this purpose, the population estimates have been rounded to the nearest hundred.[191]

Group	2000 Population	Percentage
Under 5	737,600	8%
5 to 19	2,209,200	23%
20 to 64	5,645,900	59%
65+	926,700	10%
Total	9,519,300	100%

It should be noted that the Census Bureau estimated that between 2000 and 2008, the population of the LAOA jumped from 9.5 million to 9.8 million. However, age group data is not available for the more recent estimate.

C. Cities in the LAOA

The following table presents residential population estimates for municipalities within the LAOA[192]. Population numbers were rounded to the nearest hundred for purposes of this guidance.

[191] The data source for this table is Los Angeles Almanac, "Population by Age, Los Angeles County, 2000 Census," http://www.laalmanac.com/population/po09.htm.

City	2009 Population	City	2009 Population	City	2009 Population
Agoura Hills	23,300	Glendora	54,500	Palos Verdes Estates	14,000
Alhambra	89,200	Hawaiian Gardens	15,900	Paramount	57,900
Arcadia	56,500	Hawthorne	90,000	Pasadena	150,200
Artesia	17,600	Hermosa Beach	19,500	Pico Rivera	66,900
Avalon	3,500	Hidden Hills	2,000	Pomona	163,400
Azusa	48,900	Huntington Park	64,600	Rancho Palos Verdes	42,800
Baldwin Park	81,400	Industry	800	Redondo Beach	67,600
Bell	38,800	Inglewood	118,900	Rolling Hills	2,000
Bell Gardens	46,800	Irwindale	1,700	Rolling Hills Estates	8,100
Bellflower	77,200	La Cañada Flintridge	21,200	Rosemead	57,600
Beverly Hills	36,100	La Habra Heights	6,200	San Dimas	36,900
Bradbury	1,000	La Mirada	49,900	San Fernando	25,300
Burbank	108,100	La Puente	43,300	San Gabriel	42,800
Calabasas	23,700	La Verne	34,000	San Marino	13,400
Carson	98,200	Lakewood	83,500	Santa Clarita	177,200
Cerritos	54,900	Lancaster	145,100	Santa Fe Springs	17,800

[192] The data source is Chief Executive Office – LAOA, "Cities within the County of Los Angeles," version 6/18/09 (population data is cited as California Department of Finance January 2009), http://ceo.lacounty.gov/forms/09-10%20Cities%20Alpha.pdf.

City	2009 Population	City	2009 Population	City	2009 Population
Claremont	37,800	Lawndale	33,600	Santa Monica	92,500
Commerce	13,600	Lomita	21,000	Sierra Madre	11,100
Compton	99,400	Long Beach	492,700	Signal Hill	11,400
Covina	49,500	Los Angeles	4,065,600	South El Monte	22,600
Cudahy	25,900	Lynwood	73,200	South Gate	102,800
Culver City	40,700	Malibu	13,700	South Pasadena	25,800
Diamond Bar	60,400	Manhattan Beach	36,700	Temple City	35,700
Downey	113,500	Maywood	30,000	Torrance	149,100
Duarte	23,100	Monrovia	39,500	Vernon	100
El Monte	126,300	Montebello	65,700	Walnut	32,500
El Segundo	17,000	Monterey Park	64,900	West Covina	112,600
Gardena	61,800	Norwalk	109,600	West Hollywood	37,600
Glendale	207,300	Palmdale	151,300	Westlake Village	8,900
				Whittier	86,800

D. Communities in the City of Los Angeles

The table below presents population estimates for communities within the City of Los Angeles.[193] Population numbers were rounded to the nearest hundred for purposes of this guidance.

Community	2000 Population	Community	2000 Population	Community	2000 Population
Arleta	32,100	Del Rey	30,400	Hyde Park	26,500

[193] The data source is Los Angeles Almanac, "City of Los Angeles Population by Community and Race: 2000 Census," http://www.laalmanac.com/population/po24la.htm,

Community	2000 Population	Community	2000 Population	Community	2000 Population
Arlington Heights	15,100	Downtown	40,900	Jefferson Park	30,400
Atwater Village	14,900	Eagle Rock	28,000	Koreatown	62,100
Baldwin Hills	29,900	East Hollywood	48,200	La T una Canyon	3,400
Bel Air	7,900	Echo Park	25,500	Lake Balboa	14,600
Beverly Crest	12,300	El Sereno	42,900	Lakeview Terrace	30,800
Beverlywood	7,300	Elysian Park	5,600	Leimert Park	11,700
Boyle Heights	87,400	Elysian Valley	3,200	Lincoln Heights	29,100
Brentwood	38,600	Encino	49,200	Mar Vista	39,800
Cahuega Pass	2,900	Glassell Park	35,000	Mid-City	78,800
Canoga Park	71,000	Granada Hills	54,700	Mid-City West/Fairfax	46,600
Central Cit y East	17,700	Greater Mi d-Wilshire	65,300	Mission Hills	15,100
Chatsworth	41,300	Griffith Park/Los Feliz	40,600	Montecito Heights	9,000
Cheviot Hills	8,900	Harbor City	16,100	Mt. Washington	6,200
Chinatown & Historic L.A.	9,000	Harbor Gateway	39,900	North Hills	56,900
Crenshaw	10,200	Harvard Heights	14,000	North Hollywood	107,000
Crestview	17,300	Highland Park	53,900	Northridge	68,500
Cypress Park	11,900	Hollywood	123,400	Pacific Palisades/ Topanga S tate Park	27,200

Community	2000 Population	Community	2000 Population	Community	2000 Population
Pacoima	58,900	South LA	287,600	Valley Village	16,000
Palms	40,300	South Robertson	18,100	Van Nuys	136,400
Panorama City	65,200	Southeast LA	89,400	Venice	37,800
Pico-Union	23,000	Studio City	36,200	Watts	34,800
Playa del Rey	14,400	Sun Valley	80,600	West Adams	50,800
Porter Ranch	15,800	Sunland	13,300	West Hills	30,400
Reseda	59,600	Sylmar	69,600	West LA/Century City/Rancho Park	22,800
San Pedro	77,300	Tarzana	33,300	Westchester	36,900
Sawtelle	18,100	Terminal Island	1,400	Westlake	84,200
Shadow Hills	3,700	Toluca Lake	5,900	Westwood	47,800
Sherman Oaks	28,600	Tujunga	24,600	Wilmington	58,300
Silver Lake	41,200	University Hills	4,400	Wilshire Center	79,500
South Carthay	7,500	Valley Glen	42,100	Winnetka	18,600
				Woodland Hills	67,100

E. Unincorporated Areas in the LAOA

Although Los Angeles is a major metropolitan area, most of the land area of the LAOA is unincorporated. The table below presents population estimates for unincorporated communities within the LAOA. Unincorporated communities are not independent municipalities or jurisdictions. They have no local government other than that by the county.

All local public services are received from the county[194]. Population estimates have been rounded to the nearest hundred for use in this guidance.

Community	2000 Population	Community	2000 Population	Community	2000 Population
Acton	2,400	Hacienda Heights	53,100	South San Jose Hills	20,200
Alondra Park	8,600	La Crescenta-Montrose	18,500	South Whittier	55,200
Altadena	42,600	Ladera Heights	6,600	Val Verde	1,500
Avocado Heights	15,100	Lake Hughes		Valinda	21,800
Charter Oak	9,000	Lake Los Angeles	11,500	Valyermo	
Citrus	10,600	Lennox	23,000	View Park-Windsor Hills	11,000
Del Aire	9,000	Littlerock	1,400	Walnut Park	16,200
East Compton	9,300	Marina del Rey	8,200	West Athens	9,100
East La Mirada	9,500	Mayflower Village	5,100	West Carson	21,100
East Los Angeles	124,300	Pearblossom		West Compton	5,400
East Pasadena	6,000	Quartz Hill	9,900	West Puente Valley	22,600
Florence-Graham	60,200	Rowland Heights	48,600	West Whittier-Los Nietos	25,100
Gorman		South San Gabriel	7,600	Westmont	31,600
				Willowbrook	34,100

[194] The data source is the U.S. Census Bureau's 2000 Census. The data was accessed at Los Angeles Almanac, "Population of Unincorporated Communities, Los Angeles County," http://www.laalmanac.com/population/po28.htm.

F. LAOA Pet Estimates Table

	Households with Pets (%)[195]	**Average Number per Household**[196]	**Estimated Number of Pets in City of Los Angeles**[197]	**Estimated Number of Pets in LAOA**[198]
Dogs	37.2	1.7	806,571	1,981,799
Cats	32.4	2.2	909,114	2,233,754
Birds	3.9	2.5	124,353	305,543
Total	N/A[199]	N/A[200]	1,840,038	4,521,096

- **Tab B: 2009 Greater Los Angeles Homeless Count: A Summary Report.**

This information can be found on the following page.

[195] Based on 2007 research by the American Veterinary Medical Association, found online at http://www.avma.org/reference/marketstats/ownership.asp.

[196] Ibid.

[197] Based on the 2000 U.S. Census Bureau data indicating that there were 1,275,412 households in the City of Los Angeles. http://quickfacts.census.gov/qfd/states/06/0644000.html.

[198] Based on the 2000 U.S. Census Bureau data indicating that there were 3,133,774 households in Los Angeles County. http://quickfacts.census.gov/qfd/states/06/06037.html.

[199] Since the source data does not include how many households have more than one type of pet, meaningful totals cannot be determined for this column.

[200] Ibid.

Los Angeles Homeless Service Authority

Los Angeles Homeless Services Authority | 453 S. Spring Street, 12th Floor | Los Angeles, CA 90013

2009 Greater Los Angeles Homeless Count: A Summary Report

The primary purpose of the 2009 Greater Los Angeles Homeless Count was to determine how many people are homeless on a given day within the Los Angeles Continuum of Care (CoC) that is coordinated by the Los Angeles Homeless Services Authority (LAHSA). The U.S. Department of Housing and Urban Development (HUD) requires all Continuum of Care systems funded by HUD to complete a homeless count no less than every other year. There are approximately 43,000 (42,694) homeless people within the Los Angeles CoC of which two-thirds were unsheltered.

The Los Angeles CoC includes all of Los Angeles County, excluding the cities of Glendale, Long Beach, and Pasadena who administer and operate their own respective Continuum of Care systems. If the reported numbers for those cities (5,359 homeless people) were totaled with the Los Angeles CoC, the homeless population of Los Angeles County on a given day would be 48,053 people.

The 42,694 persons counted within the Los Angeles CoC includes 4,885 individuals that are members of a family. Additionally, of the total number, 24,915 or 58% were counted within the City of Los Angeles.

Table 1: Homeless Counts for Los Angeles Continuum of Care, Cities, and County

Area	Total # of Homeless Persons
Los Angeles Continuum of Care*	**42,694**
City of Los Angeles (24,915)	
Cities of Glendale, Long Beach and Pasadena	**5,359**
Los Angeles County	**48,053**

*Includes City of Los Angeles.

The 42,694 persons counted in 2009 represents a decrease of 38% when compared to the total number of homeless persons included in the 2007 Homeless Count. This marks a significant decrease in the number of homeless persons in the Los Angeles CoC, which is very encouraging. While many factors likely contributed to this decline, it is important to acknowledge new and expanded programs implemented by the Los Angeles CoC network of housing and service providers. Many of these new programs are funded by the County and City of Los Angeles, including the County's $100 million Homeless Prevention Initiative, the City Permanent Supportive Housing Program, and the expanded Section 8 voucher programs that specifically target homeless individuals and families. Most importantly, local housing and service providers are making an important paradigm shift - now more than ever, programs are centered on housing placement of homeless families and individuals and providing the tools and skills they need to stay housed. The City and County have embarked on an unprecedented expansion of collaborative effort to reduce homelessness in recent years and the results reflect their success. Additionally, while the methodology for the 2009 homeless count remained consistent with previous counts, enhancements to the data collection process such as the increased number of volunteers, expansion of census tracts covered, and the reduction of possible counting biases, have collectively enabled researchers to extrapolate more detailed information.

As in past years, the homeless count had to be conducted during the last 10 days of January as required by HUD. The 2009 homeless count was conducted from January 27 – 29. Persons were considered homeless and included in the count if they fell within HUD's definition of homelessness as follows:

> *"A person is considered homeless only when he/she resides in one of the three following places: 1) places not meant for human habitation such as cars, parks, sidewalks, and abandoned buildings; 2) an emergency shelter; or 3) transitional housing for homeless persons and who originally came from the streets or emergency shelter."*

The following table reveals the number of sheltered and unsheltered homeless persons for the Los Angeles CoC by Service Planning Area (SPA). The total number of homeless persons is 42,694 of which 14,050 or 33% were sheltered and 28,644 or 67% were unsheltered. The total number of homeless persons in the City of Los Angeles was 24,915 of which 9,145 or 37% were sheltered and 15,770 or 63% were unsheltered.

OVER▸

Table 2: Los Angeles Continuum of Care by Sheltered and Unsheltered Persons

Area	Sheltered		Unsheltered		Total
	#	%[1]	#	%[1]	#
Los Angeles Continuum of Care*	14,050	33	28,644	67	42,694
Antelope Valley (SPA 1)	444	18	1,975	82	2,419
San Fernando Valley (SPA 2)	1,515	46	1,797	54	3,312
San Gabriel Valley (SPA 3)	1,010	36	1,770	64	2,780
Metro Los Angeles (SPA 4)	5,121	46	5,972	54	11,093
West Los Angeles (SPA 5)	1,707	31	3,831	69	5,538
South Los Angeles (SPA 6)	2,157	25	6,357	75	8,514
East Los Angeles (SPA 7)	1,236	27	3,281	73	4,517
South Bay (SPA 8)	810	21	3,144	79	3,954
Unknown SPA	50	9	517	91	567

*Includes City of Los Angeles.

A survey was conducted between March and May of 2009 to gather information about the various sub-populations of homeless persons. Results below are provided for the City of Los Angeles and the Los Angeles CoC. The City numbers are also included in the overall CoC numbers.

Table 3: Subpopulation Survey of Los Angeles Continuum of Care and City of Los Angeles

Subpopulation*	Continuum		City	
	#	%[1]	#	%[1]
Chronic Homeless	10,245	24	6,195	25
Families (Members of)**	4,885	11	2,951	12
Individuals (Single)	37,809	89	21,964	88
Persons with AIDS or HIV-Related Illness	1,064	2	650	3
Persons with Mental Illness	10,387	24	6,056	24
Persons with Substance Abuse Problems	17,419	41	10,554	42
Veterans	6,540	15	4,107	16
Victims of Domestic Violence	3,762	9	2,206	9
Youth – Unaccompanied (Under 18)	638	2	311	1

*Only families and individuals are mutually exclusive and add up to 100% of the total homeless population. Other subpopulations are not mutually exclusive and a given person may fall into more than one subpopulation category.

**The total number of families in the Continuum of Care was 1,840

Approximately two-thirds of the total number of homeless persons were males and nearly one-third were females.

Table 4: Gender

Gender	#	%[1]
Adult Male	25,862	60%
Adult Female	13,730	32%
Male Children (Under 18)	2,026	5%
Female Children (Under 18)	1,076	3%
Total:	**42,694**	**100**

Table 5: Ethnicity

Ethnicity	#	%[1]
Black/African American	19,886	47
Hispanic/Latino	12,631	29
White/Caucasian	8,924	21
American Indian/Alaskan Native	783	2
Asian/Pacific Islander	470	1
Total:	**42,694**	**100**

Nearly half (47%) of the total number of homeless persons were Black/African American and more than one-fourth (29%) were Hispanic/Latino. Whites/Caucasians, American Indians/Alaskan Natives, and Asians/Pacific Islanders represented a little less (24%) than one-fourth of homeless persons.

A copy of the 2009 Greater Los Angeles Homeless Count Report can be obtained at **www.lahsa.org.** LAHSA will provide more detailed demographic information on its web site in the weeks ahead.

[1]All percentages are rounded to whole numbers.

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XVII. APPENDIX 3: MASS CARE FORMS

The following forms are sample forms, many of which are used within the LAOA. The only form that is required to be used is the HHS Initial Intake and Assessment Form. All others are recommended for use; however, jurisdictions should review and customize each form for their specific needs.

- **Tab C: HHS Initial Intake and Assessment Form**
- **Tab D: PsySTART Triage Tag**
- **Tab E: Department of Public Health, Environmental Health Shelter Checklist for Voluntary Organizations Active in Disasters**
- **Tab F: CDC Environmental Health Shelter Assessment Form**
- **Tab G: Los Angeles County Department of Animal Care and Control, Animal Facility Inspection Report**
- **Tab H: Sample Pet Shelter Volunteer Intake Form**
- **Tab I: Veterinary Public Health Animal Shelter Assessment Form**

These forms are found on the following pages.

INITIAL INTAKE AND ASSESSMENT TOOL - AMERICAN RED CROSS - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Date/Time: _____ **Shelter Name/City/State:** _____ **DRO Name/#:** _____

Family Last Name: _____

Primary language spoken in home: _____ **Does the family need language assistance/interpreter?:** _____

Names/ages/genders of all family members present: _____

If alone and under 18, location of next of kin/parent/guardian: _____ **If unknown, notify shelter manager & interviewer initial here:** _____

Home Address: _____

Client Contact Number: _____ **Interviewer Name (print name):** _____

INITIAL INTAKE	Circle	Actions to be taken	Include ONLY name of affected family member
1. Do you need assistance hearing me?	YES / NO ☐ ☐	If Yes, consult with Disaster Health Services (HS).	
2. Will you need assistance with understanding or answering these questions?	YES / NO ☐ ☐	If Yes, notify shelter manager and refer to HS.	
3. Do you have a medical or health concern or need **right now**?	YES / NO ☐ ☐	If Yes, stop interview and refer to HS immediately. **If life threatening, call 911.**	
4. Observation for the Interviewer: Does the client appear to be overwhelmed, disoriented, agitated, or a threat to self or others?	YES/ NO ☐ ☐	**If life threatening, call 911.** If yes, or unsure, refer immediately to HS or Disaster Mental Health (DMH).	
5. Do you need medicine, equipment or electricity to operate medical equipment or other items for daily living?	YES / NO ☐ ☐	If Yes, refer to HS.	
6. Do you normally need a caregiver, personal assistant, or service animal?	YES / NO ☐ ☐	If Yes, ask next question. If No, skip next question.	
7. Is your caregiver, personal assistant, or service animal inaccessible?	YES / NO ☐ ☐	If Yes, circle which one and refer to HS.	
8. Do you have any severe environmental, food, or medication allergies?	YES / NO ☐ ☐	If Yes, refer to HS.	
9. Question to Interviewer: Would this person benefit from a more detailed health or mental health assessment?	YES / NO ☐ ☐	If Yes, refer to HS or DMH.	***If client is uncertain or unsure of answer to any question, refer to HS or DMH for more in-depth evaluation.**
STOP **STOP HERE!** STOP	**REFER to:**	**HS Yes ☐ No ☐**	**DMH Yes ☐ No ☐**	**Interviewer Initial ____**

DISASTER HEALTH SERVICES/DISASTER MENTAL HEALTH ASSESSMENT FOLLOW-UP

ASSISTANCE AND SUPPORT INFORMATION	Circle	Actions to be taken	Comments
Have you been hospitalized or under the care of a physician in the past month?	YES / NO ☐ ☐	If Yes, list reason.	
Do you have a condition that requires any special medical equipment/supplies? (Epi-pen, diabetes supplies, respirator, oxygen, dialysis, ostomy supplies, etc.)	YES / NO ☐ ☐	If Yes, list potential sources if available.	
Are you presently receiving any benefits (Medicare/Medicaid) or do you have other health insurance coverage?	YES / NO ☐ ☐	If Yes, list type and benefit number(s) if available.	
MEDICATIONS	**Circle**	**Actions to be taken**	**Comments**
Do you take any medication(s) regularly?	YES / NO ☐ ☐	If No, skip to the questions regarding hearing.	
When did you last take your medication?		Date/Time.	
When are you due for your next dose?		Date/Time.	
Do you have the medications with you?	YES / NO ☐ ☐	If No, identify medications and process for replacement.	

INITIAL INTAKE AND ASSESSMENT TOOL - AMERICAN RED CROSS - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES			
HEARING	**Circle**	**Actions to be taken**	**Comments**
Do you use a hearing aid and do you have it with you?	YES / NO ☐ ☐	If Yes to either, ask the next two questions. If No, skip next two questions.	
Is the hearing aid working?	YES / NO ☐ ☐	If No, identify potential resources for replacement.	
Do you need a battery?	YES / NO ☐ ☐	If Yes, identify potential resources for replacement.	
Do you need a sign language interpreter?	YES / NO ☐ ☐	If Yes, identify potential resources in conjunction with shelter manager.	
How do you best communicate with others?		Sign language? Lip read? Use a TTY? Other (explain).	
VISION/SIGHT	**Circle**	**Actions to be taken**	**Comments**
Do you wear prescription glasses and do you have them with you?	YES / NO ☐ ☐	If Yes to either, ask next question. If No, skip the next question.	
Do you have difficulty seeing, even with glasses?	YES / NO ☐ ☐	If No, skip the remaining Vision/Sight questions and go to Activities of Daily Living section.	
Do you use a white cane?	YES / NO ☐ ☐	If Yes, ask next question. If No, skip the next question.	
Do you have your white cane with you?	YES / NO ☐ ☐	If No, identify potential resources for replacement.	
Do you need assistance getting around, even with your white cane?	YES / NO ☐ ☐	If Yes, collaborate with HS and shelter manager.	
ACTIVITIES OF DAILY LIVING	**Circle**	**Ask all questions in category.**	**Comments**
Do you need help getting dressed, bathing, eating, toileting?	YES / NO ☐ ☐	If Yes, specify and explain.	
Do you have a family member, friend or caregiver with you to help with these activities?	YES / NO ☐ ☐	If No, consult shelter manager to determine if general population shelter is appropriate.	
Do you need help moving around or getting in and out of bed?	YES / NO ☐ ☐	If Yes, explain.	
Do you rely on a mobility device such as a cane, walker, wheelchair or transfer board?	YES / NO ☐ ☐	If No, skip the next question. If Yes, list.	
Do you have the mobility device/equipment with you?	YES / NO ☐ ☐	If No, identify potential resources for replacement.	
NUTRITION	**Circle**	**Actions to be taken**	**Comments**
Do you wear dentures and do you have them with you?	YES / NO ☐ ☐	If needed, identify potential resources for replacement.	
Are you on any special diet?	YES / NO ☐ ☐	If Yes, list special diet and notify feeding staff.	
Do you have any allergies to food?	YES / NO ☐ ☐	If Yes, list allergies and notify feeding staff.	
IMPORTANT! HS/DMH INTERVIEWER EVALUATION			
Question to Interviewer: Has the person been able to express his/her needs and make choices?	YES / NO ☐ ☐	If No or uncertain, consult with HS, DMH and shelter manager.	
Question to Interviewer: Can this shelter provide the assistance and support needed?	YES / NO ☐ ☐	If No, collaborate with HS and shelter manager on alternative sheltering options.	
NAME OF PERSON COLLECTING INFORMATION:	**HS/ DMH Signature:**		**Date:**

This following information is only relevant for interviews conducted at HHS medical facilities: Federal agencies conducting or sponsoring collections of information by use of these tools, so long as these tools are used in the provision of treatment or clinical examination, are exempt from the Paperwork Reduction Act under 5 C.F.R. 1320.3(h)(5).

The authority for collecting this information is 42 USC 300hh-11(b) (4). Your disclosure of this information is voluntary. The principal purpose of this collection is to appropriately treat, or provide assistance to, you. The primary routine uses of the information provided include disclosure to agency contractors who are performing a service related to this collection, to medical facilities, non-agency healthcare workers, and to other federal agencies to facilitate treatment and assistance, and to the Justice Department in the event of litigation. Providing the information requested will assist us in properly triaging you or providing assistance to you.

PsySTART™ Disaster Mental Health/Human Services Triage System

NAME

CURRENT LOCATION

HOME ADDRESS (PRE-EVENT)

DRAFT

Age

[redacted]

EXPRESSED THOUGHT OR INTENT TO HARM SELF/OTHERS?		YES ■ NO ☐
FELT OR EXPRESSED EXTREME PANIC?		YES ■ NO ☐
FELT DIRECT THREAT TO LIFE OF SELF and/or FAMILY MEMBER? IF YES, CIRCLE ALL THAT APPLY ABOVE AND/OR LIST BELOW:		YES ■ NO ☐
SAW / HEARD DEATH or SERIOUS INJURY OF OTHER? IF YES, CIRCLE ALL THAT APPLY ABOVE AND/OR LIST BELOW:		YES ■ NO ☐
DEATH OF PARENT, SIBLING, FAMILY FRIEND, PEER, PET or OTHER SIGNIFICANT? IF YES, CIRCLE ALL THAT APPLY ABOVE AND/OR LIST BELOW:	YES ■ MULTIPLE LOSS YES ■ IMMEDIATE FAMILY	YES ■ NO ☐
RECEIVED PHYSICAL INJURY or ILLNESS TO SELF or FAMILY MEMBER? IF YES, CIRCLE ALL THAT APPLY ABOVE AND/OR LIST BELOW:		YES ■ NO ☐
TRAPPED or DELAYED EVACUATION?		YES ■ NO ☐
FAMILY MEMBER CURRENTLY MISSING OR UNACCOUNTED FOR? IF YES, LIST BELOW:		YES ☐ NO ☐

HOME NOT LIVABLE?	YES ☐	NO ☐	CONFIRMED EXPOSURE/CONTAMINATION TO AGENT? IF YES, LIST AGENT(S):	YES ☐ NO ☐
INDIVIDUAL WITH DISABILITY?	YES ☐	NO ☐		
SPECIAL HEALTHCARE NEEDS?	YES ☐	NO ☐	DE-CONTAMINATED?	YES ☐ NO ☐
UNACCOMPANIED MINOR?	YES ☐	NO ☐	RECEIVED MEDICAL TREATMENT FOR EXPOSURE/CONTAMINATION? (e.g. ANTIBIOTIC, ANTIDOTE, ETC.)	YES ☐ NO ☐
PARENT OF CHILD UNDER 18?	YES ☐	NO ☐	HEALTH CONCERNS TIED TO EVENT (EXPOSURE)?	YES ☐ NO ☐
SEPARATED FROM IMMEDIATE FAMILY DURING EVENT?				YES ☐ NO ☐
NO TRIAGE FACTORS IDENTIFIED				YES ■

[redacted] **PsySTART™** [redacted]

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CONFIDENTIAL INFORMATION: DO NOT RELEASE

EVACUATION SHELTERS

***The checklist is intended to assist Voluntary Organizations Active in Disasters to prepare for mass care and sheltering.

Safety	√	
	☐	2 fire exits with doors that swing in the direction of exit traffic.
	☐	Smoke detectors in the sleeping area.
	☐	Shelter population does not exceed building capacity.
	☐	Adequate number of shelter staff / volunteers.
	☐	Security available
	☐	Electricity working
Water	√	
	☐	Hot and cold **POTABLE** running water.
	☐	4-5 gallons/person/day of water should be available.
	☐	10-15 gallons/person/day for first aid use.
Toilets	√	
	☐	1 toilet for every 20 people.
	☐	Toilet paper, feminine hygiene, and diapers for children and adults.
	☐	1 hand-washing station for every 15 people.
	☐	Soap dispensers with soap.
	☐	Paper towel dispensers with paper towels.
	☐	Trash container at hand washing stations.
Ventilation	√	
	☐	Heating Ventilating Air Conditioning system working.
	☐	Room temperature between 68-85°F.
	☐	Facility well ventilated.
	☐	40-50 cubic feet of air space per person.
Solid Waste	√	
	☐	One (30-gallon) container, plastic bags and lid for every 10 people.
	☐	Dispose of garbage daily.
	☐	Medical waste separated from general waste.
	☐	Remote area for temporary storage of waste.
Personal Hygiene	√	
	☐	1 shower for every 15 people to bathe at least 2 times a week.
	☐	Soap, combs, razors, toothbrushes for each person.
	☐	Clean towels, blankets and sheets.
	☐	Laundry service or hampers for soiled towels, clothing, and linen.

Sleep Area	√	
	☐	Enough cots/bed/mats for each resident/staff
	☐	Cots/beds/mats spaced 3 feet apart, alternating head-to-toe.
	☐	Cots/beds/mats and pillows cleaned/laundered between occupants.
	☐	A minimum floor space of 30 square feet per person.
Sanitation	√	
	☐	Bodily fluid clean-up kit (*paper towels, garbage bags, absorbent, mop and mop bucket, disinfectant for norovirus*)
	☐	Sanitizing solution (*2 tsp of household bleach in 1 gallon water*)
	☐	Kitchens and bathrooms cleaned daily and as necessary.
	☐	Floors mopped or vacuumed daily and as necessary.
	☐	Food restricted from the sleeping areas.
	☐	No mosquitoes, fleas, flies, roaches, rodents.
Infection Control	√	
	☐	Full-time health professional on site for health supervision.
	☐	Residents screened for **fever, cough, skin rash or sores, open wounds, vomiting, and diarrhea**.
	☐	Staff/volunteers are free from any of the above symptoms.
	☐	Medical care services available.
	☐	Medical log book for tracking treatment.
	☐	Separate area designated for ill people based on symptoms.
	☐	Cots/beds/mats spaced 6 feet apart, alternating head-to-toe.
	☐	Restroom designated for ill people only.
	☐	Frequent hand-washing and hand sanitizer use
Child care	√	
	☐	Adequate caregiver to child ratio
	☐	Diaper changing area
	☐	Hand-washing station near diaper changing area.
	☐	Toys and contact surfaces cleaned regularly
	☐	Area free from choking hazards
	☐	Food/bottle preparation area
Pet care	√	
	☐	Animals located away from people and separately housed
	☐	Animal food and water available
	☐	Feces are properly disposed.
	☐	Animal clinic available.
	☐	Solid non-porous floors in pet area
	☐	Good ventilation in pet area
Outdoor Shelters	√	
	☐	Tents are set up on high, well-drained ground.
	☐	Tents are 16 feet x 16 feet and flame retardant.
	☐	6-8 people per tent.
	☐	Tents are separated at least 10 feet from each other.
	☐	No electrical wiring, heating, smoking, or open flame inside tents.

For more information:
http://www.cdc.gov/nceh/ehs/ETP/shelter.htm
Environmental Health Housing and Institutions Program at (626) 430-5590.

State Logo

ENVIRONMENTAL HEALTH ASSESSMENT FORM FOR SHELTERS

For Rapid Assessment of Shelter Conditions during Disasters

I. ASSESSING AGENCY DATA

[1]Agency /Organization Name _____ [90]Immediate Needs Identified: ☐Yes ☐No

[2]Assessor Name/Title _____

[3]Phone __ __ __ - __ __ __ - __ __ __ __ [4]Email or Other Contact _____

II. FACILITY TYPE, NAME AND CENSUS DATA

[5]Shelter Type ☐Community/Recovery ☐Special Needs ☐Other _____ [6]ARC Facility ☐Yes ☐No ☐Unk/NA [7]ARC Code _____

[8]Date Shelter Opened __ __/__ __/__ __ (mm/dd/yr) [9]Date Assessed __ __/__ __/__ __ (mm/dd/yr) [10]Time Assessed __ __ : __ __ ☐am ☐pm

[11]Reason for Assessment ☐Preoperational ☐Initial ☐Routine ☐Other _____

[12]Location Name and Description _____

[13]Street Address _____

[14]City / County _____ [15]State __ __ [16]Zip Code _____ [17]Latitude/Longitude _____/_____

[18]Facility Contact / Title _____ [19]Facility Type ☐School ☐Arena/Convention center ☐Other_____

[20]Phone __ __ __ - __ __ __ - __ __ __ __ [21]Fax __ __ __ - __ __ __ - __ __ __ __ [22]E-mail or Other Contact _____

[23]Current Census _____ [24]Estimated Capacity _____ [25]Number of Residents _____ [26]Number of Staff / Volunteers _____

III. FACILITY

[27]Structural damage	☐Yes	☐No	☐Unk/NA
[28]Security / law enforcement available	☐Yes	☐No	☐Unk/NA
[29]Water system operational	☐Yes	☐No	☐Unk/NA
[30]Hot water available	☐Yes	☐No	☐Unk/NA
[31]HVAC system operational	☐Yes	☐No	☐Unk/NA
[32]Adequate ventilation	☐Yes	☐No	☐Unk/NA
[33]Adequate space per person	☐Yes	☐No	☐Unk/NA
[34]Free of injury /occupational hazards	☐Yes	☐No	☐Unk/NA
[35]Free of pest / vector issues	☐Yes	☐No	☐Unk/NA
[36]Acceptable level of cleanliness	☐Yes	☐No	☐Unk/NA
[37]Electrical grid system operational	☐Yes	☐No	☐Unk/NA
[38]Generator in use, [39]If yes, Type_____	☐Yes	☐No	☐Unk/NA
[40]Indoor temperature _____ °F			☐Unk/NA

IV. FOOD

[41]Preparation on site	☐Yes	☐No	☐Unk/NA
[42]Served on site	☐Yes	☐No	☐Unk/NA
[43]Safe food source	☐Yes	☐No	☐Unk/NA
[44]Adequate supply	☐Yes	☐No	☐Unk/NA
[45]Appropriate storage	☐Yes	☐No	☐Unk/NA
[46]Appropriate temperatures	☐Yes	☐No	☐Unk/NA
[47]Hand-washing facilities available	☐Yes	☐No	☐Unk/NA
[48]Safe food handling	☐Yes	☐No	☐Unk/NA
[49]Dishwashing facilities available	☐Yes	☐No	☐Unk/NA
[50]Clean kitchen area	☐Yes	☐No	☐Unk/NA

V. DRINKING WATER AND ICE

[51]Adequate water supply	☐Yes	☐No	☐Unk/NA
[52]Adequate ice supply	☐Yes	☐No	☐Unk/NA
[53]Safe water source	☐Yes	☐No	☐Unk/NA
[54]Safe ice source	☐Yes	☐No	☐Unk/NA

VI. HEALTH / MEDICAL

[55]Reported outbreaks, unusual illness / injuries	☐Yes	☐No	☐Unk/NA
[56]Medical care services on site	☐Yes	☐No	☐Unk/NA
[57]Counseling services available	☐Yes	☐No	☐Unk/NA

VII. SANITATION

[58]Adequate laundry services	☐Yes	☐No	☐Unk/NA
[59]Adequate number of toilets	☐Yes	☐No	☐Unk/NA
[60]Adequate number of showers	☐Yes	☐No	☐Unk/NA
[61]Adequate number of hand-washing stations	☐Yes	☐No	☐Unk/NA
[62]Hand-washing supplies available	☐Yes	☐No	☐Unk/NA
[63]Toilet supplies available	☐Yes	☐No	☐Unk/NA
[64]Acceptable level of cleanliness	☐Yes	☐No	☐Unk/NA
[65]Sewage system type ☐Community ☐On site ☐Portable			☐Unk/NA

VIII. SOLID WASTE GENERATED

[66]Adequate number of collection receptacles	☐Yes	☐No	☐Unk/NA
[67]Appropriate separation	☐Yes	☐No	☐Unk/NA
[68]Appropriate disposal	☐Yes	☐No	☐Unk/NA
[69]Appropriate storage	☐Yes	☐No	☐Unk/NA
[70]Timely removal	☐Yes	☐No	☐Unk/NA
[71]Types ☐Solid ☐Hazardous ☐Medical			☐Unk/NA

IX. CHILDCARE AREA

[72]Clean diaper-changing facilities	☐Yes	☐No	☐Unk/NA
[73]Hand-washing facilities available	☐Yes	☐No	☐Unk/NA
[74]Adequate toy hygiene	☐Yes	☐No	☐Unk/NA
[75]Safe toys	☐Yes	☐No	☐Unk/NA
[76]Clean food/bottle preparation area	☐Yes	☐No	☐Unk/NA
[77]Adequate child/caregiver ratio	☐Yes	☐No	☐Unk/NA
[78]Acceptable level of cleanliness	☐Yes	☐No	☐Unk/NA

X. SLEEPING AREA

[79]Adequate number of cots/beds/mats	☐Yes	☐No	☐Unk/NA
[80]Adequate supply of bedding	☐Yes	☐No	☐Unk/NA
[81]Bedding changed regularly	☐Yes	☐No	☐Unk/NA
[82]Adequate spacing	☐Yes	☐No	☐Unk/NA
[83]Acceptable level of cleanliness	☐Yes	☐No	☐Unk/NA

XI. COMPANION ANIMALS

[84]Companion animals present	☐Yes	☐No	☐Unk/NA
[85]Animal care available	☐Yes	☐No	☐Unk/NA
[86]Designated animal area	☐Yes	☐No	☐Unk/NA
[87]Acceptable level of cleanliness	☐Yes	☐No	☐Unk/NA

XII. OTHER CONSIDERATIONS

[88]Handicap accessibility	☐Yes	☐No	☐Unk/NA
[89]Designated smoking areas	☐Yes	☐No	☐Unk/NA

XIII. COMMENTS *(List Critical Needs on Immediate Needs Sheet)*

XIV. IMMEDIATE NEEDS SHEET

Item #	Description

DATE VIOLATIONS CORRECTED

ANIMAL FACILITY INSPECTION REPORT

COUNTY OF LOS ANGELES ✦ DEPARTMENT OF ANIMAL CARE AND CONTROL
http://animalcontrol.lacounty.info

SCORE | GRADE

INSPECTION #☐1☐2☐3 OTHER
INSPECTION DATE: | COMPLIANCE DATE: | FILE #:
RECEIPT #: | GIVEN: ☐ YES ☐ NO
PHONE #: | PHONE #: | GRADE CARD TO BE POSTED AT: | TELEPHONE #:
BUSINESS NAME: | ADDRESS:
ADDRESS_#: | OWNER:
ADDRESS: # | TYPE OF OPERATION: DK☐CK☐PS☐GP☐AM☐AE☐AD☐WA☐MP☐ | KENNEL VETERINARIAN NAME:

See attached pages for documentation as to the exact nature of the violation(s) observed at the time of inspection.

☐ **No violations observed at the time of inspection.** ☐ **Complaint allegations not observed at time of inspection.**

SECTION I
(Point Value – 11 points for violations in each category)

	HOUSING FACILITIES			**MEDICAL CARE / HEALTH**
1.	☐	Incompatible animals housed together or in direct proximity	16.	☐ Isolation – sick / injured animals housed with healthy
2.	☐	Housing facilities are in disrepair – immediate risk	17.	☐ Animals with irremediable / serious suffering
3.	☐	Facility is seriously overcrowded – needs immediate correction	18.	☐ Animals with zoonotic diseases / public contact
			19.	☐ Untreated illness / injury
4.	☐	Ventilation / air quality – causes breathing difficulties	20.	☐ Seriously underweight animals
5.	☐	Ambient temperature – excessive heat or cold causing risk	21.	☐ Causing unfit animals to work
6.	☐	Primary enclosures insufficient for normal posture		**SANITATION**
7.	☐	Lack of shelter – high risk	22.	☐ Filthy – immediate risk
8.	☐	Lighting insufficient to properly clean / inspect	23.	☐ No cleaning supplies and / or materials
	FOOD		24.	☐ Waste disposal system absent or broken
9.	☐	No food available	25.	☐ Excessive vermin infestation – immediate risk
10.	☐	Food is spoiled	26.	☐ Excessive clutter – impossible to sanitize
11.	☐	Perishable food improperly stored – high risk		**SAFETY / SECURITY**
	WATER		27.	☐ Dangerous animals at risk of escape
12.	☐	No water available	28.	☐ Dangerous animals available for public contact
13.	☐	Water is contaminated	29.	☐ Lack of or insufficient fire repression system
	ANIMAL SAFETY		30.	☐ Predatory animals can readily gain access to animals
14.	☐	Animal injured or died due to act or omission		**EUTHANASIA PRACTICES**
15.	☐	Hazardous environment / equipment	31.	☐ Use of non-approved methods of euthanasia

SECTION II
(Point Value – 6 points for violations in each category)

	HOUSING FACILITIES		51.	☐ Dirty – moderate risk
32.	☐	Housing facilities are in disrepair – moderate risk	52.	☐ Waste disposal system insufficient
33.	☐	Facility is overcrowded – moderate risk	53.	☐ Moderate vermin infestation
34.	☐	Ventilation is stagnant – moderate risk	54.	☐ Moderate clutter – impeding sanitation
35.	☐	Ambient temperature – moderate risk		**SAFETY / SECURITY**
36.	☐	Insufficient shelter – moderate risk	55.	☐ Non-dangerous animals at risk of escape
37.	☐	Lighting poor – difficult to properly clean / inspect	56.	☐ Lack of emergency evacuation and / or plan
38.	☐	Housed primarily on wire floor (dog breeders H&S 122065.5)	57.	☐ Predatory animals can gain access to animals – moderate risk
	FOOD		58.	☐ Failure to provide proper notification by traveling circus / carnival (H&S 25989.1)
39.	☐	Not nutritionally sufficient for age, species, or other condition		**OPPORTUNITY FOR EXERCISE**
40.	☐	Perishable food improperly stored – moderate risk	59.	☐ Animals housed 24 hours not exercised daily
	WATER		60.	☐ Primary enclosure insufficient for daily housing
41.	☐	Large number of animals without water	61.	☐ Display of stereotypical behavior from cage stress
42.	☐	Water in danger of contamination	62.	☐ Adequate socialization (dog breeders H&S 122065(e))
43.	☐	Water receptacles damaged / incapable of proper disinfection		**PRESENCE OF ILLEGAL ANIMALS**
	ANIMAL SAFETY		63.	☐ Turtles with a carapace length of less than four (4) inches (CCR 2612.1)
44.	☐	Ill and / or injured animals without treatment / moderate risk		
45.	☐	Isolation facilities inadequate – moderate risk	64.	☐ Dyed live chicks, rabbits, ducklings, other fowl (PC 599)
46.	☐	Moderately underweight animals	65.	☐ Sale or gift of live chicks, rabbits, ducklings or other fowl (PC 599)
47.	☐	Animals with zoonotic disease / staff access		
48.	☐	Lack of access to veterinarian with species specific training	66.	☐ Dogs under 8 weeks (H&S 122155(b))
	SANITATION		67.	☐ Animals prohibited by F&G, USFWS, USDA, etc.
49.	☐	Greater than 24-hour accumulation of feces / waste		
50.	☐	Animal housing cannot be readily sanitized		

SECTION III
(Point Value – 2 points for violations in each subcategory)

	HOUSING FACILITIES			**FOOD**
68.	☐	Some disrepair – low risk	72.	☐ Uncovered food receptacles
69.	☐	Poor ambient temperature – low risk		**WATER**
70.	☐	Insufficient shelter – low risk	73.	☐ Several animals without water and displaying thirst
71.	☐	Lack of resting boards (dog breeders – H&S 122065(d))		

DENIAL:	BADGE #:	DATE:	GAVE REGULATIONS: ☐
APPROVAL:	INSPECTING OFFICER:	SUPERVISOR:	

		MEDICAL CARE / HEALTH			Failure to have present or on-call veterinarian – rodeos
74.	☐	Ectoparsites / Endoparasites			(PC 596.7 b)
75.	☐	Slightly underweight animals	78.	☐	Failure to have conveyance available for injured
76.	☐	Ill animals, minor injuries – low risk			animals
			79.	☐	Cobwebs
			80.	☐	Some vermin infestation – low

SECTION IV
(Points Value – 2 points for violations in each subcategory)

		CONSUMER PROTECTION (RETAIL PET SALES)			CONSUMER PROTECTION (DOG BREEDERS)
81.	☐	Dog / Cat Source, Age, and Health Information	88.	☐	Disclosure to Purchaser (H&S 122050)
		Statement (H&S 122140)	89.	☐	Records on Health, Status, and Disposition of Dogs
82.	☐	Written Notice of Purchaser's Rights (H&S 122190)			(H&S 122055)
83.	☐	Written Records – Dog and Cat (H&S 122145)	90.	☐	Written Notice of Purchaser's Rights (H&S 122100)
84.	☐	Disclosure on Cage (H&S 122215)			REQUIRED POSTINGS / INFORMATION
85.	☐	Information Available for Prospective Purchaser	91.	☐	Posting of emergency contact information (County
		Of Dogs (H&S 122220)			Code Title 10 Section 10.40.010 E)
86.	☐	Posting of Notice – Registration (H&S 122305, 122310)	92.	☐	Required rodeo reporting information
87.	☐	Turtles- CCR 2612.1			(County Code 10.39.010)
		a. Posted sign			
		b. Sales slip			

County Ordinances are available at: http://ordlink.com/codes/lacounty/index.htm

SCORE/GRADE

SCORE: (deductions) Section I: _____
Section II: _____
Section III: _____
Section IV: _____
Total: _____

GRADE: Final Score: (100 – Total Points Deducted) =
☐ A (90-100) ☐ B (80-89) ☐ C (70-79) ☐ Score (<70)

FINAL SCORE/ GRADE TO BE ENTERED ON PAGE ONE OF THIS REPORT

☐ **OTC Issued** **Reinspection Date**

COMMENTS

ANIMAL LISTING

DOG BREED	NO.	DOG BREED	NO.	CAT BREED	NO.	CAT BREED	NO.	FOWL/BIRDS	NO.	EXOTIC	NO.
TOTAL		TOTAL		TOTAL		TOTAL		TOTAL		TOTAL	

DOGS OVER 4 MONTHS		CATS OVER 4 MONTHS			
DOGS UNDER 4 MONTHS		CATS UNDER 4 MONTHS			
# OF DOGS VACCINATED		# OF CATS VACCINATED			
LIMIT # OF DOGS		LIMIT # OF CATS			

BUILDING STRUCTURE			KENNEL RUNS			CAGES		
Number	Type	Size	Number	Type	Size	Number	Type	Size

RODENTS	NO.	FISH			NO.	REPTILES	NO.
		SALT WATER					
		FRESH WATER					
TOTAL		# OF AQUARIUMS		TOTAL		TOTAL	

Sample Pet Shelter Volunteer Intake Form

Name _____ Age (If Under 18) _____

Phone—Day (Area Code Included) _____ Phone—Evening/Other _____

Address _____ City State ZIP _____

Skills

- ☐ Veterinary Medicine
- ☐ Small Animal Handling
- ☐ Exotics and Wildlife Handling
- ☐ Computer
- ☐ Other _____
- ☐ Animal Sheltering
- ☐ Farm Animal Handling
- ☐ Administration/Management
- ☐ Customer Service
- ☐ Animal Rescue
- ☐ Equine Handling
- ☐ Communications

Willing To Do

- ☐ Animal Care
- ☐ Animal Health Care
- ☐ Data Entry
- ☐ Other _____
- ☐ Animal Rescue
- ☐ Office Work
- ☐ Driving
- ☐ Shelter Cleanup
- ☐ Phones

Vaccination History

☐ Rabies Pre-exposure, Date_____ ☐ Tetanus, Date_____

☐ Hepatitis A, Date_____

Availability

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Morning							
Afternoon							
Evening							

Starting Date Available _____ For How Long (1 Week, 1 Month, Open) _____

Special Equipment / Resources Offered _____

SAMPLE

A. Sample Household Pet Rescue/Shelter Request Form

Form is to be completed as applicable by: (1) response workers in the disaster area, (2) pet owners evacuating from the affected area, (3) owners arriving at the pet shelter, and (4) owners calling with a rescue request. A separate request should be filed for each household pet. Form should accompany the animal during transport and be kept on file at shelter. A photograph of the animal to accompany the form is helpful for verifying identification at reunification.

Tag #_____

Location of Animal or Sighting

Date Time (AM or PM)

○ Dog ○ Cat ○ Other ____ Male ○ Female ○ Altered □

Breed Color Age Distinctive Markings (Note Injuries)

Collar License/Rabies/ID Tag Microchip

Any Supplies Brought With Animal (Carrier, Leashes, etc.)

Known Medical/Dietary Needs, Aggressions, or Destructive Habits

Name of Requesting Party Agency or Owner

Address City State ZIP

Description of Animal's Location

Work Phone (Including Area Code) Home Phone/Other

Temporary Address or Shelter Name City State ZIP

If Owner, Is Key Available? Yes ○ No ○ Location of Key _____

If No, Is Keyless Entry Authorized? Yes ○ No ○

Signature of Owner or Person Completing Form Date Time (AM or PM)

----------** For Shelter/Rescue Team Only **----------

Request Received by (Name) Date Time (AM or PM)

Action Taken

Emergency Medical Treatment Provided Treated by (Name/Phone Number)

Animal Taken To Address City State ZIP

SAMPLE

VETERINARY PUBLIC HEALTH
ASSESSMENT FORM FOR ANIMAL SHELTERS
For Rapid Assessment of Animal Shelter Conditions during Disasters
~~ vs. 6/29/09 ~~

I. ASSESSING AGENCY DATA

[1]Agency /Organization Name ___Veterinary Public Health and Rabies Control Program_____

[2]Assessor Name/Title _____ [113]**Immediate Needs Identified:** ☐ Yes ☐ No

[3]Phone __ __ __ - __ __ __ - __ __ __ __ [4]Email or Other Contact _____ [114]**Immediate Needs Resolved:** ☐ Yes ☐ No

II. FACILITY TYPE, NAME AND CENSUS DATA

[5]Shelter Type ☐ Fixed Shelter ☐ Other/Temporary _____ [6]ARC Facility ☐ Yes ☐ No [7]ARC Code _____

[8]Date Shelter Opened __ __/__ __/__ __ (mm/dd/yr) [9]Date Assessed __ __/__ __/__ __ (mm/dd/yr) [10]Time Assessed __ __ : __ __ ☐ am ☐ pm

[11]Reason for Assessment ☐ Preoperational ☐ Initial ☐ Routine ☐ Disaster/Incident _____

[12]Location Name and Description _____

[13]Street Address _____

[14]City / County _____ [15]State __ __ [16]Zip Code __ __ __ __ __ [17]Latitude/Longitude _____/_____

[18]Facility/Shelter Manager Contact / Title _____ / _____ / _____

[19]Phone __ __ __ - __ __ __ - __ __ __ __ [20]Fax __ __ __ - __ __ __ - __ __ __ __ [21]E-mail or Other Contact _____

[22]Current Census (dogs) _____ [23]Est. Capacity (dogs) _____

[24]Current Census (cats) _____ [25]Est. Capacity (cats) _____

[26]Current Census (other) _____ [27]Est. Capacity (other) _____ [28]If other, list species _____

[29]No. of Certified Staff / Volunteers _____ / _____ [30]Est. Census (humans) _____

III. FACILITY

[31]Structural damage, broken glass	☐ Yes	☐ No	☐ Unk/NA
[32]Security / law enforcement available	☐ Yes	☐ No	☐ Unk/NA
[33]Water system operational	☐ Yes	☐ No	☐ Unk/NA
[34]Hot water available	☐ Yes	☐ No	☐ Unk/NA
[35]HVAC system operational	☐ Yes	☐ No	☐ Unk/NA
[36]Adequate ventilation, Air Quality	☐ Yes	☐ No	☐ Unk/NA
[37]Adequate space per animal and owner	☐ Yes	☐ No	☐ Unk/NA
[38]Free of injury /occupational hazards	☐ Yes	☐ No	☐ Unk/NA
[39]Free of pest / vector issues	☐ Yes	☐ No	☐ Unk/NA
[40]Acceptable level of cleanliness	☐ Yes	☐ No	☐ Unk/NA
[41] Power available	☐ Yes	☐ No	☐ Unk/NA
[42]Generator in use, [43] If yes, Type_____	☐ Yes	☐ No	☐ Unk/NA
[44]Indoor temperature _____ °F			☐ Unk/NA

IV. FOOD (address human issues if co-location shelter)

[45]Food prep/serving area for people	☐ Yes	☐ No	☐ Unk/NA
[46]Food prep/serving area separate from pets?	☐ Yes	☐ No	☐ Unk/NA
[47]Hand-washing facilities available	☐ Yes	☐ No	☐ Unk/NA
[48]Is pet food stored appropriately?	☐ Yes	☐ No	☐ Unk/NA
[49]Source of pet food documented	☐ Yes	☐ No	☐ Unk/NA

[50]**Dog** food, quantity **dry** food _____

[51]**Dry dog** food source _____

[52]**Dog** food, quantity **canned** food _____

[53]**Canned dog** food source _____

[54]**Cat** food, quantity **dry** food _____

[55]**Dry cat** food source _____

[56]**Cat** food, quantity **canned** food _____

[57]**Canned cat** food source _____

[58]Other pet food _____qty _____

[59]Other pet food source_____

V. DRINKING WATER

[60]Adequate water supply for animals	☐ Yes	☐ No	☐ Unk/NA
[61]Safe water source (bottled water, water buffalo?)	☐ Yes	☐ No	☐ Unk/NA

VIII. SOLID WASTE GENERATED

[73]Adequate number of pet waste receptacles	☐ Yes	☐ No	☐ Unk/NA
[74]Liners in trash bins	☐ Yes	☐ No	☐ Unk/NA
[75]Cat litter boxes available	☐ Yes	☐ No	☐ Unk/NA
[76]Appropriate storage	☐ Yes	☐ No	☐ Unk/NA
[77]Sufficient cat litter, doggy bags, pee pads	☐ Yes	☐ No	☐ Unk/NA
[78]Appropriate handling of all waste	☐ Yes	☐ No	☐ Unk/NA

IX. ANIMAL INTAKE

[79]Intake table (pet ID, crate ID, photo of pet/owner)	☐ Yes	☐ No	☐ Unk/NA
[80]Animal Control present? Who? _____	☐ Yes	☐ No	☐ Unk/NA
[81]Is information on each animal complete?	☐ Yes	☐ No	☐ Unk/NA
[82]Guidelines provided to pet owners sheltered	☐ Yes	☐ No	☐ Unk/NA
[83]Leash provided to pet owner at check in, if needed	☐ Yes	☐ No	☐ Unk/NA
[84]Adequate staff required for registering, admitting, and care of animals	☐ Yes	☐ No	☐ Unk/NA
[85]Staff certified/trained for this purpose	☐ Yes	☐ No	☐ Unk/NA

X. SLEEPING AREA / ANIMAL HOUSING (Address human issues if co-location shelter)

[86]Adequate number of cots/beds/mats	☐ Yes	☐ No	☐ Unk/NA
[87]Adequate supply of towels	☐ Yes	☐ No	☐ Unk/NA
[88]Clean kennels, runs, enclosures	☐ Yes	☐ No	☐ Unk/NA
[89]Adequate spacing, species separated?	☐ Yes	☐ No	☐ Unk/NA
[90]Acceptable level of cleanliness	☐ Yes	☐ No	☐ Unk/NA
[91]Are pets allowed to sleep with owners	☐ Yes	☐ No	☐ Unk/NA
[92]If owners/pets co-located, is there 8' spacing between owner/pet groups	☐ Yes	☐ No	☐ Unk/NA

XI. COMPANION ANIMALS

[93]Companion animals present	☐ Yes	☐ No	☐ Unk/NA
[94]Animal care available (DVM, RVT, ACO, client)	☐ Yes	☐ No	☐ Unk/NA
[95]Designated animal area	☐ Yes	☐ No	☐ Unk/NA
[96]Acceptable level of cleanliness	☐ Yes	☐ No	☐ Unk/NA

XII. OTHER CONSIDERATIONS

[97]Are owners and pets sheltered in same area	☐ Yes	☐ No	☐ Unk/NA
[98]Are floors protected with plastic wrap?	☐ Yes	☐ No	☐ Unk/NA

VI. HEALTH / MEDICAL

[62]Reported outbreaks, unusual illness / injuries	☐ Yes	☐ No	☐ Unk/NA
[63]Medical care services on site (gloves, masks)	☐ Yes	☐ No	☐ Unk/NA
[64]Counseling services available	☐ Yes	☐ No	☐ Unk/NA

VII. SANITATION

[65] Are pets left unattended or unrestrained?	☐ Yes	☐ No	☐ Unk/NA
[66]Adequate number of toilets	☐ Yes	☐ No	☐ Unk/NA
[67]Adequate number of showers	☐ Yes	☐ No	☐ Unk/NA
[68]Adequate number of hand-washing stations	☐ Yes	☐ No	☐ Unk/NA
[69]Hand-washing supplies available	☐ Yes	☐ No	☐ Unk/NA
[70]Toilet supplies available	☐ Yes	☐ No	☐ Unk/NA
[71]Acceptable level of cleanliness	☐ Yes	☐ No	☐ Unk/NA
[72]Sewage system type	☐ Community ☐ Portable	☐ On site	☐ Unk/NA

XII. OTHER CONSIDERATIONS CONTINUED

[99]Co-location to human shelter	☐ Yes	☐ No	☐ Unk/NA
[100]Animal guardians allowed to care for own pet(s)	☐ Yes	☐ No	☐ Unk/NA
[101]Additional crates/carriers available for sheltering	☐ Yes	☐ No	☐ Unk/NA
[102]Biosecurity issues adequately addressed	☐ Yes	☐ No	☐Unk/NA
[103]Triage locations	☐ Yes	☐ No	☐ Unk/NA
[104]Treatment area	☐ Yes	☐ No	☐ Unk/NA
[105]Decontamination area	☐ Yes	☐ No	☐ Unk/NA
[106]Isolation area	☐ Yes	☐ No	☐ Unk/NA
[107]Restricted areas marked appropriately	☐ Yes	☐ No	☐ Unk/NA
[108]Signs posted where animals are allowed	☐ Yes	☐ No	☐ Unk/NA
[109]Are incidents documented and addressed	☐ Yes	☐ No	☐ Unk/NA
[110]Carcass storage available	☐ Yes	☐ No	☐ Unk/NA
[111]Carcass removal available	☐ Yes	☐ No	☐ Unk/NA
[112]Mortality / Morbidity statistics documented	☐ Yes	☐ No	☐ Unk/NA

[113]Check box at top of first page to indicate if immediate needs have been identified

[114]Check box at top of first page to indicate if immediate needs have been resolved

XIII. GENERAL COMMENTS

Item #	Description

XIV. IMMEDIATE NEEDS SHEET – CORRECTIVE ITEMS

Item #	Description

- **Tab J: Non-Traditional Shelter Facility Survey.**

Mega-Shelters and Open-air Shelters

Print all information. This form is generic and applies to many types of facilities, including open-air venues and large facilities that could be used for extremely large populations during a catastrophic event. This survey is intended to assess the structural components of the facility, not the internal management of a shelter (e.g., staffing, resources). Some of the questions on this form may not apply to every site; in this case, answer, "N/A" (not applicable).

Facility/Site Name: _____
Street Address: _____
Town/City: _____ **County:** _____ **State:** _____ **Zip Code:** _____
Mailing Address (if different): _____
Phone: (___) ___-___ **Fax:** (___) ___-___
Email address (if applicable): ___

EMERGENCY CONTACT INFORMATION:

List the contact information (i.e., name, phone number, and cell phone number) of the primary and secondary contacts who can authorize use of the facility:_____

_____

_____

List the contact information (i.e., name, phone number, and cell phone number) of the primary and secondary contacts who can open the facility 24/7:_____

_____

_____

Directions to the facility from the EOC. Use landmarks (e.g., highways, intersections, rivers, railroad crossings, etc.). Do not use landmarks likely to be destroyed or unrecognizable after the disaster. Include address and/or latitude and longitude if available. _____

_____

Latitude: ___ Longitude: ___

LIMITATIONS ON FACILITY/SITE USE

Some facilities/sites may only be available during certain times due to previously planned activities. Indicate the dates that the facility/site may be available.

☐ The facility/site expects to be available for use at any time during the year.
☐ The facility/site expects to be available **only** for use during the following time periods.
From: ___ to ___
From: ___ to ___
☐ The facility/site expects **not** to be available for use during the following time periods:
From: ___to ___
From: ___ to ___

Some facilities/sites have specific areas that cannot be used as an emergency shelter. Indicate restrictions on use of certain areas of the building/site or if the entire facility/site is available for use. _____

_____

_____

FACILITY/SITE LOCATION HAZARDS

Determine threats to the facility/site from secondary hazards of the disaster or from additional disasters. For example, following an earthquake, there is the initial consideration of building damage, but there are also secondary hazards to consider, such as liquefaction and tsunami.

Facility/Site Location:

Is the facility located above a storm tidal surge zone? ☐ Yes ☐ No

Does the facility have a first floor equal to or higher than the base flood elevation level for site? ☐ Yes ☐ No

Is the facility within a precautionary zone for facilities that manufacture, use, or store hazardous materials or within a zone that is environmentally contaminated and deemed unacceptable for sheltering by the Department of Environmental Quality and local emergency management? ☐ Yes ☐ No

Is the facility within the determined vulnerability zone (one mile) of an Emergency Planning and Community Right-to-Know Act (EPCRA) Superfund Amendments & Reauthorization Act of 1986 (SARA) Title III, Section 302 (Extremely Hazardous Substance) site? ☐ Yes ☐ No

Is the facility within the 10-mile vulnerability zone (i.e., emergency planning zone) of a commercial nuclear power plant? ☐ Yes ☐ No

Is the facility in an area with railroads, highways, or waterways that regularly carry significant quantities of hazardous materials? ☐ Yes ☐ No

Is the facility in an area with oil/gas wells, pipeline terminals, storage facilities, production facilities, or compressor stations? ☐ Yes ☐ No

Per appropriate Flood Insurance Rate Map (FIRM):

Is the facility above a 100-year flood plain or base flood elevation (BFE) ☐ Yes ☐ No

Is the facility above a 500-year flood plain or BFE? ☐ Yes ☐ No

Is the facility above a flash flood zone or BFE? ☐ Yes ☐ No

Is the facility subject to isolation due to riverine/ponding inundation of roadways? ☐ Yes ☐ No

Do the egress/ingress points have adequate flood drainage? ☐ Yes ☐ No

Is the facility subject to inundation or isolation due to containment failure of any levees, dams, or reservoirs? ☐ Yes ☐ No

Is the facility in an area anticipated to experience liquefaction following an earthquake? ☐ Yes ☐ No

Is the facility in proximity to areas of wildfire risk? ☐ Yes ☐ No

Is the facility on or at the base of steep slopes that may be at risk of a mudslide? ☐ Yes ☐ No

IF YES, describe the area with as much detail as possible. _____

_____

Is the facility in close proximity to lay-down hazards, such as very large trees or structures that could cause destructive collapse, or lay-down impact damage? ☐ Yes ☐ No

Is the facility perimeter located within 300 feet of sources of significant small, large/heavy, rollover, and/or falling debris? ☐ Yes ☐ No

FACILITY STRUCTURE

Facility Building Construction Type:

Is the facility within five miles of an evacuation route? ☐ Yes ☐ No

Does the facility meet State earthquake standards and building code requirements for the type of building it is (e.g., school, stadium)? ☐ Yes ☐ No

Is the facility able to pass a State health inspection (i.e., is there lead paint, asbestos, mold)? ☐ Yes ☐ No

Where possible, has a structural engineer certified that the building is capable of withstanding wind loads according to Minimum Design Loads for Buildings and Other Structures ASCE 7-88 structural design standards (formerly ANSI A58) or has an engineer signed off on items using the ASCE design standards (recommended)?
☐ Yes ☐ No

Is the facility's construction type reinforced concrete or steel or masonry load-bearing walls reinforced with steel rebar (recommended)? ☐ Yes ☐ No

Does the facility have a continuous load-bearing system from roof to foundation (recommended)?
☐ Yes ☐ No

Is the facility's existing connection roof-to-building structure anchoring in accordance with current building code (FBC) (recommended)? ☐ Yes ☐ No

Does the facility have solid exterior walls (e.g., masonry, concrete, metal) reinforced with steel rebar (recommended)? ☐ Yes ☐ No

Are the facility's exterior walls wind and debris/projectile resistant (e.g., not glass façade, heavy stone [granite], mechanical fastenings) (recommended)? ☐ Yes ☐ No

Are the facility's exterior walls insulated (recommended)? ☐ Yes ☐ No

If the facility has overhead or large doors (framing), has it been modified with additional bracing (recommended)?
☐ Yes ☐ No

Does the facility have skylights (not recommended)? ☐ Yes ☐ No

Does the facility have solid floor material (e.g., sealed concrete, tile, linoleum) (recommended)? ☐ Yes ☐ No

Facility Building Roof Construction:

Does the facility roof have a concrete flat roof–with/without metal decking–that is not susceptible to ponding (recommended)? ☐ Yes ☐ No

Does the facility roof use a hipped roof system that is gable–ended and metal (recommended)? ☐ Yes ☐ No

Is roof (if exposed) or attic space insulated (recommended)? ☐ Yes ☐ No

Does the facility roof have existing drainage (and/or scuppers if it has enclosed parapets)? (recommended)? ☐ Yes ☐ No

Does the facility roof have wood boards or tongue–and-groove deck-on-wood joists (not recommended)? ☐ Yes ☐ No

Does the facility roof slope greater than 30 degrees or open spans greater than 40 feet (not recommended)? ☐ Yes ☐ No

Does the facility roof have mechanical equipment on it (not recommended)? ☐ Yes ☐ No

Open-Air Site:

Is the site flat, open terrain? ☐ Yes ☐ No

IF NO, what degree of slope is present? ___

Is the site accessible to vehicles (including heavy vehicles such as buses)? ☐ Yes ☐ No

What type of ground surface does the site have? (e.g., grass, gravel, concrete)? _____

Is a secure perimeter around the site feasible? ☐ Yes ☐ No

Does the site have a system for drainage/runoff of rain water away from the facility? ☐ Yes ☐ No

Does the site have issues with pests (e.g., ant hills, rodents)? ☐ Yes ☐ No

Has the health department assessed the site and plan for sanitation/health considerations? ☐ Yes ☐ No

CAPACITY

Capacity for all facilities should be calculated using any space that could feasibly be used as sleeping space for an event. In an evacuation shelter (used 24–72 hours), capacity should be calculated using 15 to 20 square feet-per-person. In a facility that will be used for a longer time, use 40 to 60 square feet per person to determine capacity. A general formula for calculating total sleeping space capacity (factoring in needed support services space) is to multiply the total facility square footage by 75%–85% then divide by the per-person square footage to obtain final shelter space number. *(e.g., 5000 total square feet x 75% ÷ 20 square feet per person = 188 person capacity.)*

Total Square Footage of the Building/Site/Facility:_____ square feet

Capacity **Evacuation =** _____ **at** _____ **square feet**
General = _____ **at** _____ **square feet**

For open-air resourcing, use the prior capacity calculations in combination with calculations in the Material Support section. For long–term, open-air, temporary sheltering settlements, 485 square feet-per-person is the standard used by the Sphere Project. More information on the Sphere Project standards and guidance can be found in their Sphere Handbook.[201]

GENERAL FACILITY/SITE INFORMATION

SECURITY

Is the perimeter of the facility/site fenced? ☐ Yes ☐ No Number of entrances? ___
Does the facility/site have controlled access points? ☐ Yes ☐ No Type of controls? _____

Number of external doors in the facility: ___
Number of external doors that are fire doors (open from the inside only): ___
Describe all types of security measures available (e.g., fencing, closed-circuit television (CCTV) system, other security systems). _____

How many levels does the building have? ___ How many can be used for sheltering? ___
Describe the facility/site space (e.g., one large area, multiple rooms, hallways, open flat land)? Add diagram if possible. _____

FIRE SAFETY

Some facilities that appear to be suitable for sheltering may not meet fire codes based on building capacity. In the case of an open-air shelter, fire codes must be applied to alternate structures and the surrounding site. This list of questions is not meant to be exhaustive. It is recommended that local codes be examined to determine if the facility meets them. In addition, the fire department can be contacted to ensure compliance.

Is the facility/site able to pass fire marshal inspection and fire codes? ☐ Yes ☐ No
Does the facility have inspected fire extinguishers? ☐ Yes ☐ No
Does the facility have functional fire sprinklers? ☐ Yes ☐ No
Does the facility have smoke detectors? ☐ Yes ☐ No
Does the facility have a fire alarm system? ☐ Yes ☐ No
IF YES: ☐ Manual (pull-down) ☐ Automatic
Does the fire alarm directly alert the fire department? ☐ Yes ☐ No
In an open-air alternate structure, is the structural material fire retardant? ☐ Yes ☐ No

[201] Humanitarian Charter and Minimum Standards in Disaster Response, revised edition. The Sphere Project. 2004, p. 216. http://www.sphereproject.org/.

Is the facility accessible to emergency response vehicles? ☐ Yes ☐ No
Does the facility have accessible fire hydrants? ☐ Yes ☐ No
Comments from fire department, if available: _____

UTILITIES

Determine if the facility/site's utilities are operating and in working order and can support the proposed shelter (e.g., lighting, security, air quality). If facility could lose power or if a site does not have hardwired power, determine generator availability and capacity. This section is designed to evaluate the capabilities of the facility/site and to list the appropriate contacts in case the utilities fail.

Electricity/Power Source

Why type of electrical connections does the facility have (aboveground or underground)? _____

Does the facility have access to a secondary power grid connection? ☐ Yes ☐ No

Does the facility have an emergency generators onsite? ☐ Yes ☐ No **IF MULTIPLE:** Quantity ___
IF YES: ☐ Auto start ☐ Manual start Fuel type _____
IF YES: Capacity in kilowatts ___

IF YES: Shelter staff or support service able to operate it? ☐ Yes ☐ No

IF YES: Power for entire shelter? ☐ Yes ☐ No **IF NO:** What will it power? _____

IF YES: Operating time, in hours, without refueling, at rated capacity:

IF YES: Are there fuel tanks of appropriate size/specification for it? ☐ Yes ☐ No

IF YES: Is there a reliable refueling source? ☐ Yes ☐ No

IF YES AND IF THE GENERATOR HAS A WATER-COOLED SYSTEM: Is there a sufficient water source for operation? (air-cooled system preferred) ☐ Yes ☐ No

IF YES: In an open-air shelter, does each structure (e.g., individual or congregate tent) have a generator?
☐ Yes ☐ No

Has the open-air site been pre-wired for electricity? ☐ Yes ☐ No

Utility company name: ___

Contact name: ___ Emergency phone number: (___) ___-___

Generator fuel vendor: ___ Emergency phone number: (___) ___-___

Generator repair contact: ___ Emergency phone number: (___) ___-___

Specifically in open-air shelter sites, the following utilities may be available but resourced differently. If this is a survey of an open-air site, note specific information in regard to how utilities are used.

Heating ☐ Electric ☐ Natural gas ☐ Propane ☐ Fuel ☐ Oil
In an open-air environment, does each unit (e.g., tent, structure) have an independent source? ☐ Yes ☐ No
What is the power source? (e.g., generator, adjacent building, other source) ___
Utility/Vendor name: ___

Contact name: ___ Emergency phone number: (___) ___-___
Repair contact: ___ Emergency phone number: (___) ___-___

Cooling ☐ Electric ☐ Natural gas ☐ Propane
In open-air environment, does each unit (e.g., tent, structure) have an independent source? ☐ Yes ☐ No
What is the power source? (e.g., generator, adjacent building, other source) ___
Utility/Vendor name: ___
Contact name: ___ Emergency phone number: (___) ___-___
Repair contact: ___ Emergency phone number: (___) ___-___

Cooking ☐ Electric ☐ Natural Gas ☐ Propane ☐ No cooking facilities onsite
In open-air environment, does each unit (e.g., tent, structure) have an independent source? ☐ Yes ☐ No
What is the power source? ___
Utility/Vendor name: ___
Contact name: ___ Emergency phone number: (___) ___-___
Repair contact: ___ Emergency phone number: (___) ___-___
See the Food Preparation section below.

Telephones Available to shelter staff? ☐ Yes ☐ No Available to shelter residents? ☐ Yes ☐ No
Number of phones: ___ Locations: ___
Phones equipped for people with access and functional needs? ☐ Yes ☐ No **IF YES**, quantity: ___
Utility/Vendor name: ___
Contact name: ___ Emergency phone number: (___) ___-___
Repair contact: ___ Emergency phone number: (___) ___-___

Water ☐ Municipal ☐ Well(s) ☐ Trapped water
IF TRAPPED: Potable (drinkable) storage capacity in gallons: ___
Non-potable (undrinkable) storage capacity in gallons: ___
Utility/Vendor name: ___
Contact name: ___ Emergency phone number: (___) ___-___
Repair contact: ___ Emergency phone number: (___) ___-___
If municipal, well, or trapped water is non-potable, see Material Support section below.

Sewage ☐ Municipal ☐ Individual Facility Treatment System ☐ Septic Tank ☐ Portable Toilets
Sewage or disposal systems should be able to process at least 1.5 gallons of human waste per person per day.
Amount of sewage facility plumbing system will manage per day? ___
Amount of additional sewage local infrastructure's system can maintain per day? ___
Amount of sewage disposal portable toilet vendor can maintain per day? ___
Utility/Vendor name: ___
Contact name: ___ Emergency phone number: (___) ___-___
Repair contact: ___ Emergency phone number: (___) ___-___

ACCESSIBILITY FOR PEOPLE WITH ACCESS AND FUNCTIONAL NEEDS

Determine if the facility/site is accessible for people with access and functional needs. No single deficiency in the following list makes a facility/site non-compliant or unfit for consideration. There are many acceptable temporary mechanisms that can make a facility/site accessible. The Department of Justice's *ADA Checklist for Emergency Shelters* is a resource for an Americans with Disabilities Act (ADA) facility survey checklist is t.[202]

Access to facility/site

☐ Curb cuts (minimum 35 inches wide)
☐ Accessible doorways/entrance openings (minimum 35 inches wide)
☐ Automatic doors or appropriate door handles
☐ Ramps (maximum 8.33% slope, minimum 35 inches wide) Are ramps: ◯ Fixed ◯ Portable
☐ Lift for multi-stories
☐ Accessible stable and firm walkways (minimum 36" wide)
☐ Tent pads and tent platforms[203]

- Clear ground space: 48" on all usable sides, except where conditional exceptions apply
- Surface: stable and firm
- Slope: 1:33 maximum, except asphalt, concrete, or boards = 1:48
- Tent platform: 19" maximum above surface

Accessible and accommodating toilet stalls/portable toilets and hand washing stations

☐ Grab bars (33-36 inches wide) ☐ Sinks @ 34 inches in height
☐ Stall (38 inches wide) ☐ Towel dispenser @ 39 inches in height

Showers (fixed or portable)

☐ Shower stall (minimum 36 inches by 36 inches) ☐ Grab bars (33–36 inches in height)
☐ Shower seat (17–19 inches high) ☐ Hand-held spray unit with hose
☐ Fixed shower head (48 inches high)

Accessible and accommodating food service areas/cafeterias

☐ Tables (28–34 inches high)
☐ Serving line (counter) (28–34 inches high)
☐ Aisles (minimum 38 inches wide)

Accessible telephones

☐ Maximum 48 inches high ☐ TDD available ☐ Earpiece (volume adjustable)

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[202] *ADA Checklist for Emergency Shelters*. U.S. Department of Justice, Civil Rights Division. July 2007. http://www.ada.gov/pcatoolkit/chap7shelterchk.htm.

[203] Draft "Final Accessibility Guidelines for Outdoor Developed Areas."—While this is not directly related to sheltering, this document may provide useful information. It "establishes accessibility guidelines pursuant to the Architectural Barriers Act (ABA) for camping facilities, picnic facilities, viewing areas, outdoor recreation access routes, trails, and beach access routes that are constructed or altered by or on behalf of the Federal government." U.S. Access Board. As accessed online on March 4, 2010, at http://www.access-board.gov/news/outdoor-draft.htm.

SANITATION

TOILETS

The recommended ratio for toilet facilities is one toilet (stall or urinal) for 20 people. Count only facilities that will be accessible to shelter residents and shelter staff. *Projected population ÷ 20 = projected needed number of toilet facilities.*

Number of toilets available:
Men ___ Women ___ Unisex ___ People with Access and Functional Needs* ___
Projected need:
Men ___ Women ___ Unisex ___ People with Access and Functional Needs* ___
Total available:
Men ___ Women ___ Unisex ___ People with Access and Functional Needs* ___
Number of toilets needed:
Men ___ Women ___ Unisex ___ People with Access and Functional Needs* ___
**Quantity of toilets for people with access and functional needs should be listed as portion of the overall quantity (e.g., of the 10 men's toilets, 4 of them are accessible to men with access and functional needs.)*

Adequate site location for portable toilet area (Local department of health should be consulted for appropriate standards):
Does the area have adequate space? ☐ Yes ☐ No
Projected number of units ÷ square feet per unit = projected square feet needed
Required square footage ___
Available square footage ___
Does the area have access for cleaning vehicles/equipment? ☐ Yes ☐ No
Does the area have adequate drainage? ☐ Yes ☐ No
Is the area adequate distance from population? ☐ Yes ☐ No

SINKS/HAND WASHING STATIONS

The recommended ratio of sinks or hand washing stations is 1 for 20 people.

Number of sinks available:
Men ___ Women ___ Unisex ___ People with Access and Functional Needs* ___
Projected need
Men ___ Women ___ Unisex ___ People with Access and Functional Needs* ___
Total available:
Men ___ Women ___ Unisex ___ People with Access and Functional Needs* ___
Number of sinks needed:
Men ___ Women ___ Unisex ___ People with Access and Functional Needs* ___
**Quantity of sinks/hand wash stations for people with access and functional needs should be listed as portion of the overall quantity (e.g., of the 10 men's sinks/hand wash stations, 4 of them are accessible to men with access and functional needs.)*

Adequate site location for portable hand washing stations (located adjacent to toilets):
Does the area have adequate space? ☐ Yes ☐ No
Projected number of units ÷ square feet per unit = projected square feet needed
Does the area have access to a water source? ☐ Yes ☐ No
Does the area have adequate drainage? ☐ Yes ☐ No

Is the area adequate distance from population? ☐ Yes ☐ No

SHOWERS

The best case scenario for showers is 1 shower for every 25 residents. If a facility does not have enough showers, there might be a nearby facility that could supplement shower facilities; otherwise, portable showers may need to be acquired.

Number of showers available:
Men ___ Women ___ Unisex ___ People with Access and Functional Needs* ___
Projected need
Men ___ Women ___ Unisex ___ People with Access and Functional Needs * ___
Total available:
Men ___ Women ___ Unisex ___ People with Access and Functional Needs * ___
Number of showers needed:
Men ___ Women ___ Unisex ___ People with Access and Functional Needs * ___
**Quantity of showers for people with access and functional needs should be listed as portion of the overall quantity (e.g., "Of the 10 men's showers, 4 of them are accessible to men with access and functional needs.")*

Are there any limitations on the availability of showers (time of day, etc.)? ☐ Yes ☐ No
Alternatives for showers onsite: ___
Alternatives for showers offsite: ___
Adequate site location for portable showers (Local department of health should be consulted for appropriate standards):
Does the area have adequate space? ☐ Yes ☐ No
Projected number of units = square feet per unit = projected square feet needed
Required square footage ___
Available square footage ___
Does the site have access to a water source? ☐ Yes ☐ No
Does the area have adequate drainage? ☐ Yes ☐ No
Is the site adequate distance from population? ☐ Yes ☐ No

FEEDING SUPPORT SPACE

FEEDING AREA

☐ None onsite ☐ Snack Bar (seating capacity:___) Cafeteria (seating capacity:___)
☐ Other indoor seating (describe, including size and capacity estimate): ___
☐ Other outdoor seating (describe, including size and capacity estimate): ___
Total estimated seating capacity for eating: ___
Comments related to feeding: _____

(Local department of health and guidance from food service organizations such as the Red Cross should be used for appropriate safe food handling standards.)

FOOD PREPARATION AND/OR STORAGE AREAS

These areas are required or need to be available for food preparation and/or storage of feeding supplies (e.g., shelf-stable meals—meals, ready-to-eat (MREs), heater meals). See Material Support Space section for food supply

considerations. The physical space for food preparation, storage, and feeding should be calculated separately as additional space to the shelter capacity space listed earlier.

(Local department of health and guidance from food service organizations such as the Red Cross should be used for appropriate safe food handling standards.)

☐ No kitchen onsite ☐ Warming kitchen ☐ Full-service kitchen ☐ Mobile kitchen onsite
☐ Facility uses mobile kitchen onsite
Central kitchen or food service contact: ___ Phone Number: (___) ___-___
☐ Facility uses central kitchen or catering vendor (meals are delivered)
Central kitchen or food service contact: ___ Phone Number: (___) ___-___
Number of meals "per meal" that can be produced): ___

Requirements for mobile kitchen area (Indicate quantity and size (sq. ft.) as appropriate).

Area of parking lot for kitchen—size and distance from shelter: ___

Is parking lot concrete? ☐ Yes ☐ No **IF NO**, what type: ___

Does the area have access to a power source? ☐ Yes ☐ No

Does the area have access to water source? ☐ Yes ☐ No

Does the area have adequate drainage? ☐ Yes ☐ No

Describe the ingress/egress to the kitchen area (e.g., tractor trailer or box truck accessible, traffic patterns, pedestrian traffic)? _____

_____

_____

Who owns this kitchen? _____

Who will staff kitchen? _____

Is the proposed kitchen staff unionized? ☐ Yes ☐ No

Equipment in Onsite Kitchen (Indicate quantity and size (sq. ft.) as appropriate).

Is kitchen space commercial-grade? ☐ Yes ☐ No

Refrigerators	___	Walk-in refrigerators	___	Ice machines	___
Freezers	___	Walk-in freezers	___	Braising pans	___
Burners	___	Griddles	___	Warmers	___
Ovens	___	Convection ovens	___	Microwave ovens	___
Steamers	___	Steam kettles	___		
Sinks	___	Dishwashers	___		

MATERIAL SUPPORT SPACE

Planning for Tents for Open-Air Site

Should an open-air format be required, various types of tents (also called "soft-sided shelters" or "tension fabric structures") and methods for site use can be chosen. Calculate the number of tents required for this site (e.g., *projected population ÷ number of people housed per tent = projected number of tents needed.)*

Projected shelter population ÷ Quantity/tent: ___

- Total available: ___

Tents needed: ___

Tents for this site will include:

☐ Single tents per family in a congregate area Quantity: ___
☐ Single tents per family distributed for home use Quantity: ___
☐ Large multi-family tents Quantity: ___
☐ Extremely large congregate care tension fabric structures (e.g., event tents) Quantity: ___

Type of tents (Make/Model): ___
Size(s) of tents: ___
Capacity per tent: ___
Wind load: ___
Method for anchoring (e.g., stakes, poles, anchoring onto/into grass, dirt, concrete):___
Specifications (e.g., material, water-proof, access, ground barrier): ___
Amenities (e.g., air conditioning, heating, cooking): ___

Planning for Meal Storage Space

For facility survey purposes, it is helpful to think in terms of three to five days of meals with no outside assistance. If shelf-stable meals are stored at the facility, in order to determine the space required, calculate the required number of meals then their approximate packaging size (e.g., *projected population x 2 meals per day x 5 days = projected meal supply quantity; then, projected meal supply quantity ÷ number of meals per box ÷ number of boxes per pallet.)*

Projected need ___
- Total available ___
Meals needed ___

Does the facility/site have adequate storage for the appropriate quantity of feeding supplies? ◯Yes ◯No
Total square footage of food storage space: ___
Is food storage space is climate-controlled? ◯Yes ◯No
Is storage space secured/security-controlled? ◯Yes ◯No

Planning for Drinking Water Storage Space

The recommended amount of potable water to have on-hand per evacuee is one gallon per day for 3–5 days. Calculate the amount of storage required to determine space needs (e.g., *projected population x 3–5 days = projected number of gallons of water needed.)*

Projected need ___
-Total available ___
Gallons of water needed ___

Does the facility/site have adequate storage for this quantity of water supplies? ◯Yes ◯No
Total square footage of food storage space: ___
Is food storage space is climate-controlled? ◯Yes ◯No

Is storage space secured/security-controlled? ☐Yes ☐No

SITE ACCESSIBILITY AND PARKING AREA
This is a parking area (e.g., grass, gravel, paved) in which to receive transportation-assisted evacuees and in which shelter residents and staff may park their vehicles, as well as the access routes and methods surrounding it.

Accessibility to Facility/Site
Is the facility located near transportation modes (e.g., airports, bus terminals) ☐Yes ☐No
Does the facility have a minimum two-lane asphalt road leading up to an entrance/parking area? ☐Yes ☐No

Parking Area

Does the facility have a parking lot/area? ☐Yes ☐No
Does the parking area have multiple entrances and exits? ☐Yes ☐No
Does the parking area have perimeter lighting? ☐Yes ☐No
What type of material is the lot made of (e.g., asphalt, concrete, grass, gravel, other)? _____

Number of vehicle spaces available in the parking area: ___
Number of handicap vehicle spaces available in the parking area: ___
Is the parking area accessible (ingress/egress/turn-around) by tour-size buses? ☐Yes ☐No
Number of buses able to be in the parking area at one time (dropping off): ___
Number of buses able to be in the parking area at one time (parking): ___
Does the facility/site have an external entrance large enough to accommodate buses? ☐Yes ☐No
Number of buses at entrance at one time: ___
Covered over people? ☐Yes ☐No Covered over buses? ☐Yes ☐No

FACILITY SUPPORT SERVICES AREAS

RECEPTION AREA
This is an area at which to receive and register shelter residents. This space should be calculated separately as additional space to the shelter capacity space listed earlier.

Does the facility have a lobby/entrance area that could accommodate a large standing population? ☐Yes ☐No
Number of people: ___
Does the facility have available reception supplies (e.g., tables, chairs, snake line barriers)? ☐Yes ☐No
Number of tables: ___ Number of chairs: _____ Length/Number of barriers/stanchions: ___

ADMINISTRATION AND STAFF AREAS
These are areas in which shelter management staff can conduct office tasks and in which staff members can break or shelter away from the general population. This space should be calculated separately as additional space to the shelter capacity space listed earlier.

Is the area separate from the general evacuee population (e.g., individual rooms, barriers)? ☐Yes ☐No
Does the area have space for separate administration and staff break space? ☐Yes ☐No

Total square footage for administration area needed/preferred: ___
Total square footage available for administration area: ___

Description of administration area (e.g., layout, access) _____

_____

_____

_____

Total square footage for staff area needed/preferred: ___
Total square footage available for staff area: ___
Description of staff area (e.g., layout, access) _____

_____

_____

_____

HEALTHCARE SCREENING/CARE AREA (HEALTH AND MENTAL HEALTH)

This is an area for providing basic health screening of shelter residents on initial entry and during their stay. This space should be calculated separately as additional space to the shelter capacity space listed earlier.

Total square footage for healthcare area needed/preferred: _____
Total square footage available for healthcare area: _____
Description of healthcare space (e.g., layout, beds, secure pharmaceutical storage area, access): _____

_____

_____

_____

Number of rooms available: ___ Number of beds or cots available: ___
Number of rooms needed: ___ Number of beds or cots needed: ___
Does the area provide privacy (e.g., individual rooms, barriers)? ☐Yes ☐No
Is the area capable of providing secure storage for pharmaceuticals if credentialed staff is available for maintenance and distribution of such stored items? ☐Yes ☐No

CHILD CARE AREA

This is an area in which to provide child care. This space should be calculated separately as additional space to the shelter capacity space listed earlier.

Total square footage for child care area needed/preferred: ___
Total square footage available for child care area: ___
Description of child care space (e.g., layout, access) _____

_____

_____

_____

Does the area provide secure access and exit (e.g., individual rooms, barriers)? ☐Yes ☐No

LAUNDRY FACILITIES

Generally, shelters do not have access to laundry facilities. Availability of such facilities is considered an extra convenience for shelters open longer than a week and not a necessity. This space should be calculated separately as additional space to the shelter capacity space listed earlier.

Number of clothes washers: ___ Number of clothes dryers: ___
Will only shelter workers have access to these machines, or will they also be available to shelter residents?
Shelter workers only ☐ Yes ☐No

Shelter residents ☐ Yes ☐ No
Are laundry facilities coin-operated? ☐ Yes ☐ No
Special conditions or restrictions: _____

CLIENT CASEWORK AREA

This is an area that external agencies/organizations (e.g., Federal Emergency Management Agency (FEMA), Red Cross, social services) will use to work with clients. This space should be calculated separately as additional space to the shelter capacity space listed earlier. Attention should be given to space with some degree of privacy, where possible.

Does the area allow for crowd control by security (consult law enforcement for needs)? ☐ Yes ☐ No
Total square footage for casework area needed/preferred: ___
Total square footage available for casework area: ___
Description of casework area (e.g., layout, access) _____

Supplies needed for casework (e.g., tables, chairs): _____

ADDITIONAL INFORMATION

Does the entity that owns the shelter facility plan to manage it? ☐ Yes ☐ No
Is there a current written agreement to use the facility? ☐ Yes ☐ No
Is the facility within 10 miles of community support services? (e.g., shopping, health services) ☐ Yes ☐ No
Are local infrastructure agencies (e.g., fire services, emergency medical services (EMS), hospitals, public works) able to support additional population? ☐ Yes ☐ No

IF NO, what can the local infrastructure support? ___
IF NO, what might be brought in to increase the capacity of the local infrastructure? ___
Does the facility have a separate/adjacent/accessible area for the care of household pets? ☐ Yes ☐ No
IF YES, describe the area with as much detail as possible. ___

Groups associated with the facility

Owner's staff required when using facility? ☐ Yes ☐ No
Paid feeding staff required when using facility? ☐ Yes ☐ No
Union members required when using facility? ☐ Yes ☐ No
Other: ___ Required ☐ Yes ☐ No
Other: ___ Required ☐ Yes ☐ No
Will any of the above groups be trained or experienced in shelter management?
IF YES, list: _____

RECOMMENDATIONS/OTHER INFORMATION (Be specific):

___

••••• Attach a sketch or copy of the facility floor plan •••••

Survey completed/updated by:

Printed Name	Signature	Date completed
Printed Name	Signature	Date completed

XVIII. APPENDIX 4: SHELTER LOGISTICS SUPPLIES

Supplies to support a shelter operation can vary depending on numerous variables that can include, but are not limited to, the season, type of incident or disaster, and type of facility being used. Consider the following two inventory lists as a sample of supplies and resources to consider and plan for when planning shelter operations. The first is an exhaustive shelter inventory list and the second is a more targeted list of supplies for pre-staged shelter trailers for 100 unit shelters.

100 Unit Exhaustive Shelter Inventory List			
	Recommended Items (Overview of Shelter Supplies)	**Amt**	**On Hand**
	Cots, regular	90	
	Cots, assessable – over-sized	10	
	Blankets (2 per person)	200	
	Kits (kits are itemized in the following):		
	Administration kit (office supplies and forms)	1	
	Canteen kit	1	
	Comfort kit (1 per person)	100	
	Entertainment kit	1	
	Health services (medical/nursing) kit	1	
	Sanitation kit		
	Resources CD	1	
	Other Supplies to Consider		
	Toolkit (screwdriver, hammer, pliers, wrench)	1	
	Trash cans, large (administration, canteen, medical, and restrooms)	1	
	Administrative Kit (Office Supplies)	**Amt**	**On Hand**
	Calculator	1	
	Envelopes, medium, clasp	25	
	File folders (50 per box)	1	
	Newsprint sheets (tubes)	5	
	Paper clips (100 per unit)	3	
	Paper, writing pads, misc. sizes	24	

100 Unit Exhaustive Shelter Inventory List			
	Pencils with erasers (12 per box)	1	
	Ballpoint pens (12 per box)	3	
	Phone message book	1	
	Rubber bands (package)	1	
	Ruler	1	
	Scissors	1	
	Stapler and staples (5,000 per box)	3	
	Sticky notes, misc. sizes and colors	12	
	Tape, duct (roll)	1	
	Tape, masking (roll)	1	
	Tape, scotch with plastic dispenser	3	
	Volunteer ID	50	
	Other Supplies to Consider for Administrative Kit		
	Binder clips (boxes)	5	
	Clipboards, legal size	10	
	Clock, battery or spring-wound	1	
	Easels to hold signs	4	
	Extension cord, heavy duty	3	
	Felt-tip markers, broad	1	
	Identity wrist bands, misc. colors	200	
	Magnifying glass	3	
	Map of area	1	
	Megaphone	1	
	Paper towels (canteen, medical, and restrooms)	3	
	Paper, copier (ream of 500)	1	
	Pencil sharpener, manual	2	
	Staple remover	3	
	Telephone book of local area	1	
	TTY equipment	1	
	Walkie-talkies for staff	4	
	Whistle, with lanyard	3	

100 Unit Exhaustive Shelter Inventory List			
	Administrative Kit (Forms)	**Amt**	**On Hand**
	Daily Shelter Log	50	
	Daily Shelter Report	30	
	DIS Form #1492 DRO Reg for DSHR Members	50	
	Disclosure Tracking Form	5	
	Disclosure Tracking Form Connection	2	
	Excess Resource Inventory Form	2	
	Facility/Shelter Opening Checklist Form	5	
	Field ID Kit Box #4213	3	
	Initial Intake and Assessment Tool	150	
	Initial Intake and Assessment Tool Instructions	4	
	MC Resources Form #6455	50	
	Release of Facility Form	2	
	Shelter Agreement Form	3	
	Shelter Facility Survey Form #6564	3	
	Shelter Info Poster Kit #P906	1	
	Shelter Registration (Spanish) Form #5972S	100	
	Shelter Registration Form #5972	150	
	Sign-in/Sign-out sheets (affected population, staff, and visitors)	25	
	Staff Request Form #6512	25	
	Supply Requisition Form #6409	50	
	Canteen Kit	**Amt**	**On Hand**
	Can opener, manual	1	
	Coffee, regular and decaffeinated (enough for 500 servings)	500	
	Coffee filters (box)	1	
	Coffee maker (50 cups)	1	
	Creamer, non-dairy (containers)	4	
	Disposable food prep gloves (box of 500)	1	
	Drink cambro (5 gallon)	2	

100 Unit Exhaustive Shelter Inventory List			
	Forks, spoons, and knives (200 each)	200	
	Garbage bags (32 gallon)	100	
	Hot/cold cups	3000	
	Napkins	1000	
	Plates	300	
	Stir sticks (box of 1,000)	1	
	Sugar, regular – Equal, Sweet'N Low, and Splenda (each)	1000	
	Water bottles (16.9 fl. oz each)	500	
	Other Supplies to Consider for Canteen Kit		
	Aluminum foil (roll)	1	
	Baby bottles	20	
	Baby formula, regular and soy-based (1 container each)	2	
	Bowls, disposable	300	
	Emergency food packets, extended shelf-life		
	Food, nonperishable (each)	500	
	Food prep utensils – knife, spoon, spatula, ladle, and tongs (1 each)	1	
	Gatorade, for dehydration issues (bottles)	50	
	Hot cocoa (servings)	100	
	Hot tea (servings)	100	
	Pet food for service animals (bag)	1	
	Plastic wrap (roll)	1	
	Portable stove	1	
	Pots, for boiling water	2	
	Powdered milk, regular	1	
	Powdered milk, soy	1	
	Soap, dishwashing	1	
	Sponges or dishcloths	10	
	Water filter	4	
	Water purifier (1 bottle treats 50 gallons)	5	
	Waterproof matches (boxes)	3	

100 Unit Exhaustive Shelter Inventory List			
	Comfort Kit	**Amt**	**On Hand**
	Chapstick (tubes)	100	
	Cleansing novelettes (each)	1000	
	Cotton swabs (100 per box)	1	
	Dental floss (each)	100	
	Denture cleaner tablets (approx. 60 in box)	5	
	Deodorant (1.5 oz)	100	
	Hairbrushes and 8-inch combs (each)	100	
	Lotion (2 oz bottles)	100	
	Plastic re-sealable bags, re-sealable to hold comfort items	100	
	Razors, disposable and shaving cream (2 oz each)	100	
	Shampoo (8 oz)	100	
	Soap (3.5 oz)	100	
	Toothbrush, with holder	100	
	Toothpaste (8.5 oz)	100	
	Towels and washcloths (each)	100	
	Entertainment Kit	**Amt**	**On Hand**
	Activity books (all ages)	10	
	Cards	12	
	Coloring books and colored pencil set (crayons will melt)	12	
	DVDs/Videos	6	
	Sanitation Kit	**Amt**	**On Hand**
	Disinfectant (bottle)	1	
	Face masks, disposable (boxes)	5	
	Facial tissue (boxes)	10	
	Gloves, sterile (100-count box – can be used for medical)	1	
	Toilet paper (rolls)	10	
	Trash bags, feminine hygiene and diaper/Depends (100-bag box)	1	

100 Unit Exhaustive Shelter Inventory List			
	Other Supplies to Consider for Sanitation Kit		
	Raised toilet seats for access and functional needs	2	
	Shower chairs for access and functional needs	2	
	Toilet chairs for access and functional needs	2	
	Health Services Kit (Medical/Nursing)	**Amt**	**On Hand**
	Acetaminophen tablets, children's chewable (box)	1	
	Acetaminophen tablets, 325 mg (bottle of 100)	1	
	Allergy medicine, Claritin and regular Benadryl (1 each)	2	
	Antacid liquid, Mylanta (bottle)	1	
	Antacid tablets, Tums (box)	1	
	Anti-diarrhea medication (bottle)	1	
	Aspirin, 80 mg and 325 mg (1 bottle each with 100 tablets)	2	
	BLS First Aid Kit – kit should include:	1	
	Alcohol wipes	10	
	Abdominal pads (5 in x 9 in)	2	
	Adhesive bandages (1 in x 3 in)	16	
	Antibiotic ointment, triple (4 oz)	1	
	Band-aids, strips, various sizes (box)	1	
	Bee sting kit	1	
	Blood pressure/stethoscope kit – pediatric, regular, XL (1 each)	3	
	Cold packs	2	
	CPR mask	1	
	Disposable airway kit	1	
	Eye pads	4	
	Eye wash, sterile (bottle)	1	
	Gauze rolls (1 in x 6 yd)	2	
	Gauze rolls (4 in)	2	
	Glucose, instant (tube)	6	
	Medical exam gloves (pair)	5	
	Scissors, bandage, and shears (1 each)	2	

	100 Unit Exhaustive Shelter Inventory List		
	Space blanket	1	
	Splints	2	
	Sterile dressings (3 in x 3 in)	10	
	Sterile dressings (4 in x 4 in)	20	
	Trauma dressing (12 in x 30 in)	1	
	Triangular bandages	2	
	Waterproof tape (1 in and ½ in, each)	1	
	Iodine wipes/swabs	10	
	Caladryl lotion (bottle or 25 per package)	1	
	Contact lens cleaner (bottle)	1	
	Cotton-tipped sterile applicators		
	Depends (boxes)	5	
	Diapers, disposable, misc. sizes (boxes)	5	
	Disinfectant wipes		
	Electrolyte tablets (50 per package)	2	
	Feminine hygiene supplies, tampons, pads (boxes)	5	
	Ibuprofen, 200 mg	100	
	Ipecac syrup, 1 oz	1	
	Medication storage box	1	
	Petroleum jelly (individual packets)	100	
	Pseudoephedrine tablets, 30 mg	24	
	Saline solution, soft pack, 250 cc	2	
	Salt packet	15	
	Sunscreen, PABA free, SPF 15 (bottle)	1	
	Thermometer, oral – blue or battery hand-held	4	
	Throat lozenges (2 per packet)	100	
	Tongue blades	20	
	Tweezers	1	
	Other Supplies to Consider for Health Services Kit		
	A&D ointment (individual packets)	10	
	Activated charcoal (poison-control measure)	1	

100 Unit Exhaustive Shelter Inventory List			
	Automatic external defibrillator (AED)	1	
	Burn cream/spray	1	
	Cot, accessible with waterproof mattress	1	
	Cot, regular with waterproof mattress	2	
	Crutches (various sizes)	1	
	Diaper rash ointment	1	
	Emesis basin	1	
	Ensure for non-diabetics, also supplement for diabetics	various	
	Ibuprofen liquid	1	
	Laxatives/stool so fteners, M ilk of M agnesia, C olace, Senokot – natural and OTC		
	Measuring cups and syringes	various	
	Pacifier	6	
	Pedialyte	6	
	Sharps container (11 gallon)	1	
	Smelling salts	4	
	Snakebite kit	1	
	Wheelchairs, misc. sizes	various	
Toolkit		**Amt**	**On Hand**
	Multifunctional tool – screwdriver, pliers, scissors, knife, etc.	1	
	Safety glasses	2	
	Work gloves	2	
Other Supplies to Consider for Toolkit			
	Bleach (canteen, restrooms)	1	
	Broom and dustpan	1	
	Caution tape (roll)	1	
	Child safety plugs (packages)	5	
	Disinfecting cleaner	1	
	Duct tape	1	
	Emergency generator	1	

100 Unit Exhaustive Shelter Inventory List			
	Emergency poncho (for shelter staff)	10	
	Fire extinguisher (A-B-C type) (administrative, canteen)	2	
	Flashlights and batteries	4	
	Folding shovel	1	
	Gloves, disposable, non-latex only (medical, sanitation)	1	
	Hand sanitizer (canteen, medical, sanitation)	3	
	Mop and bucket	1	
	Multi-functional tools – hammer, axe, wedge, and pick	1	
	Nails (assorted box)	1	
	Plastic sheeting (roll)	1	
	Portable heater	1	
	Radio with batteries	1	
	Rope (1/2 in)	1	
	Safety cones	4	
	Safety vests (for shelter staff)	2	

100 Unit Shelter Trailer Inventory			
	Trailer Summary	**Amt**	**On Hand**
	Cots	100 ea	
	Blankets	200 ea	
	Drink cambro (5 gallon)	2 ea	
	Coffee maker (50 cups)	1 ea	
	Ice chest	2 ea	
	Folding tables	2 ea	
	Folding chairs	4 ea	
	Disposable shower towels	2 cs	
	Tarps (1 big, 1 small)	2 ea	
	Comfort kits	6 cs	
	Child comfort kits	2 cs	
	Administration kit	1 ea	
	Chocks	2 ea	

100 Unit Shelter Trailer Inventory			
	Administrative Kit (Office Supplies)	**Amt**	**On Hand**
	Empty file holders	20 ea	
	Hanging holders	25 ea	
	Ball point pen (12 ea)	2 bx	
	Pencils (12 ea)	1 bx	
	Pencil sharpener	1 ea	
	Scotch tape	2 rl	
	Scissors	1 ea	
	Paper clips (100 ea)	2 bx	
	Staples (5000 ea)	1 bx	
	Stapler	1 ea	
	Calculator	1 ea	
	Sticky notes (misc. sizes & colors)	3 ea	
	Blue painters tape	1 rl	
	Rubber bands	1 pk	
	Writing pads (misc. sizes)	6 ea	
	Permanent markers	3 ea	
	Newsprint sheets	5 ea	
	Clip boards	2 ea	
	Administrative Kit (Forms)	**Amt**	**On Hand**
	Shelter Facility Survey (F 6564, Rev. 02/07)	2	
	Shelter Agreement (Rev. 12/07)	5	
	Facility Use Agreement 12/07	5 ea	
	Facility/Shelter Opening/Closing (Rev. 12/07)	5	
	5972 Shelter Registration Rev 2/07	150 ea	
	5972S Shelter Registration 2/07	150 ea	
	Initial Intake & Assessment Tool 6/08	150 ea	
	Initial Intake & Assessment Tool Instructions	2 ea	
	Shelter Log 2/07	50 ea	
	1492 DRO Registration 8/05	50 ea	
	Requisition (F 6409)	25 ea	

100 Unit Shelter Trailer Inventory			
	5692 Inventory Record 8/98	25 ea	
	Daily Shelter Report Rev 4/01	30 ea	
	6455 Resource Record 04/05	50 ea	
	6512 Staff Request 4/06	50 ea	
	Shelter Operations Management Toolkit	1 ea	
	Volunteer ID (temporary sticker)	25 ea	
	4213 Field ID Kit (Signage)	1 bx	
	4213S Spanish Field ID Kit (Signage)	1 bx	
	906 Shelter Info Poster Kit	1 pk	
	906S Spanish Shelter Info Poster Kit	1 pk	
Mass Care Kit		**Amt**	**On Hand**
	Napkins	1000 ea	
	Plates	300 ea	
	Banquet packs	200 ea	
	Hot/cold cups	3000 ea	
	Paper towels	4 rl	
	Toilet tissue	6 rl	
	Garbage bag (32 gallon)	2 rl	
	Flash lights and batteries	4 ea	
	Non-latex gloves	1 bx	
	Anti-bacterial hand sanitizer	2 ea	
	Napkins	1000 ea	
	Coffee	5 lbs	
	Creamer	1 cs	
	Sugar	1 cs	
	Artificial sweetener	1 cs	

- **Tab K: National Commission on Children and Disasters: Interim Report—Supplies for Infants and Toddlers in Mass Care Shelters and Emergency Congregate Care Facilities**

This information can be found on the following page.

APPENDIX C: SUPPLIES FOR INFANTS AND TODDLERS IN MASS CARE SHELTERS AND EMERGENCY CONGREGATE CARE FACILITIES

This document was facilitated by the National Commission on Children and Disasters with guidance from subject matter experts in emergency management and pediatric care. The document identifies basic supplies necessary to sustain and support 10 infants and children up to 3 years of age for a 24 hour period. The guidance is "scalable" to accommodate 10 or more children over a longer period of time.

The National Commission on Children and Disasters recommends state and local jurisdictions provide caches of supplies to support the care of children in mass care shelters and emergency congregate care facilities for a minimum of 72 hours. The amount of supplies cached in an area should be based upon the potential number of children up to 3 years of age that could be populating the local shelters and facilities for a minimum of 72 hours, as determined by an assessment of current demographic data for the jurisdiction.

Depending on the nature of the event, a 24-72 hour supply of essential child-specific supplies should be on site prior to the opening of a shelter or facility. However, in situations where this is not possible, supplies should still be available for immediate deployment and delivered on site within 3 hours.

Such a level of preparedness is critical due to the high vulnerability of this population.

(Guidance begins on next page.)

REQUIRED PERISHABLE SUPPLIES		
Quantity	Description	Comment
40 Jars	Baby Food - Stage 2 (jar size is 3.5 - 4 oz)	Combination of vegetables, fruits, cereals, meats
1 box (16oz)	Cereal - single grain cereal preferred (e.g. rice, barley, oatmeal)	Rice, barley, oatmeal or a combination of these grains
See Note	Diaper wipes - fragrance free (hypoallergenic)	Minimum of 200 wipes
40	Diapers - Size 1 (up to 14 lbs.)	Initial supply should include one package of each size, with no less than 40 count of each size diaper
40	Diapers - Size 2 (12 - 18 lbs.)	
40	Diapers - Size 3 (16 - 28 lbs.)	
40	Diapers - Size 4 (22 - 37 lbs.)	
40	Diapers - Size 5 (27 lbs. +)	
40	Pull Ups 4T - 5T (38 lbs. +)	
320oz	Formula, milk-based, ready to feed (already mixed with water) ++	**Breastfeeding is the best nutritional option for children and should be strongly encouraged.**
64oz	Formula, hypoallergenic-hydrolyzed protein, ready to feed (already mixed with water) ++	
320oz	Formula, soy-based, ready to feed (already mixed with water) ++	
1 Quart	Oral Electrolyte solution for children, ready-to-use, unflavored (e.g. Pedialyte) - **Dispensed by medical/health authority in shelter ++**	Do not use sports drinks. The exact amount to be given, and for how long, should be determined by an appropriate medical authority (doctor or nurse). To be used in the event an infant/child experiences vomiting or diarrhea, and the degree of dehydration.
See Note	Nutritional Supplement Drinks for Kids/ Children, ready-to-drink (e.g., Pediasure, Kids Essential/Kids Boost) - **Dispensed by medical/health authority in shelter**	**** Not for infants under 12 months of age **** Requirement is a total of 40-120 fl. oz per day; in no larger than 8 oz bottles.

Note: See "Supplemental Information" for additional information regarding the items followed by "++."

REQUIRED NON-PERISHABLE SUPPLIES & EQUIPMENT		
Quantity	Description	Comment
25	Infant feeding bottles (plastic only) ++	4 - 6 oz. size preferred (to address lack of refrigeration)
30	Infant Feeding Spoons ++	Specifically designed for feeding infants with a soft tip and small width. Can be used for younger children as well.
50	Nipples for Baby Bottles (non-latex standard) ++	2 per bottle
25	Diaper Rash Ointment (petroleum jelly, or zinc oxide based)	Small bottles or tubes
100 pads	Disposable Changing Pads	At least 13x18 in size. Quantity is based on 8-10 diaper changes per infant per day
10	Infant bathing basin	Thick plastic non-foldable basin. Basin should be at least 12" x10" x 4"
See Note	Infant wash, hypoallergenic	Either bottle(s) of baby wash (minimum 100 oz.), which can be "dosed out" in a disposable cup (1/8 cup per day per child) or 1 travel size (2oz) bottle to last ~48 hrs per child.
10	Wash cloths	Terry cloth/cotton - at least one per child to last the 72 hr period
10	Towels (for drying after bathing)	Terry cloth/cotton - at least one per child to last the 72 hr period
2 sets	Infant hat and booties ++	Issued by medical/health authority in shelter
10	Lightweight Blankets (to avoid suffocation risk)	Should be hypoallergenic, (e.g., cotton, cotton flannel, or polyester fleece)
5	Portable Crib	To provide safe sleeping environments for infants up to 12 months of age
2	Toddler potty seat	That can be placed on the seat of an adult toilet, with handles for support. One each should be located in both a Men's and Women's restroom
1 pack	Electrical Receptacle Covers	Minimum 30 (Note: Prioritize covering outlets in areas where children and families congregate (family sleeping area, children's areas, etc.)

Note: See "Supplemental Information" for additional information regarding the items followed by "++."

RECOMMENDED PERISHABLE SUPPLIES		
Quantity	Description	Comment
	Baby Food – Stage 1 (jar size ~ 2.5 oz)	Combination of vegetables, fruits, cereals, meats
	Baby Food - Stage 3 (jar size ~ 6 oz)	Combination of vegetables, fruits, cereals, meats
	Diapers - Preemie Size (up to 6 lbs.)	As needed for shelter population
	Healthy snacks that are safe to eat and do not pose a choking hazard **(intended for children 2 years and older)**	Should be low sugar, low sodium: yogurt, applesauce, fruit dices (soft) (e.g., peaches, pears, bananas), veggie dices (soft) (e.g., carrots), 100% real fruit bite-sized snacks, real fruit bars (soft), low sugar/whole grain breakfast cereals and/or cereal bars, crackers (e.g., whole grain, "oyster"/mini)

RECOMMENDED NON-PERISHABLE SUPPLIES & EQUIPMENT		
Quantity	Description	Comment
	Sip Cups (support for toddlers) ++	

Note: See "Supplemental Information" for additional information regarding the items followed by "++."

SUPPLEMENTAL INFORMATION	
Description	Supplemental Notes
Formula	Use of a powered formula is at the discretion of the jurisdiction or shelter operator. If using powdered preparation of the formula should be conducted by appropriately trained food preparation workers. Water used should be from an identified potable water source (bottled water should be used if there is any concern about the quality of tap or well water). Hypoallergenic hydrolyzed formula can be provided in powdered form—(1) 400 gram can—but only if potable water is accessible.
Infant Feeding Bottles and Nipples	Each time nutritional fluids, formula and/or other infant feeding measures (including breast milk in a bottle) are distributed by trained, designated shelter staff and/or medical professionals, clean, sterilized bottles and nipples must be used. Note: After use, bottles are to be returned to the designated location for appropriate sterilization (and/or disposal). Bottle feeding for infants and children is a 24/7 operation and considerations must be in place to provide bottle feeding as needed (On average, infants eat at minimum 5-8 times daily). **Note to staff: Sterilizing and cleaning** Sterilize bottles and nipples before you use them for the first time by putting them in boiling water for 5 minutes. Nipples and bottles should be cleaned and sterilized before each feeding. If disposable bottles and nipples are not available and more durable bottles and nipples will be re-used they must be fully sterilized before each feeding. To the greatest extent possible bottles and nipples should be used by only one child. In the event parents want to use their own bottles and nipples, shelter staff should provide support for cleaning these items between feedings. Support such as access to appropriate facilities for cleaning (not public restrooms).

SUPPLEMENTAL INFORMATION *(continued)*	
Description	Supplemental Notes
Note regarding all feeding implements for Infant/Children	There is a specific concern with cleaning and sanitizing of all feeding implements associated with infants and children (infant feeding bottles/ nipples, spoons, sip cups, etc.). These items will require additional attention by food preparation staff to ensure they are sanitary as a means of reducing food borne illness. Staff medical/ health staff should be consulted on best means of raising awareness among shelter residents and enlisting their support for these extra sanitary measures. Feeding implements such as spoons and sip cups should be cleaned using hot soapy water provided potable water is available. When the item is being cleaned to give to another child the item must be sterilized.
For the following items: infant bathing basin, lightweight blankets, diaper rash ointment, wash cloths, and towels	Consider pre-packaging the listed items together and providing one package to each family with children. Note: additional blankets and towels will be necessary for families with more than one child.

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XIX. APPENDIX 5: RESOURCES

Agencies are encouraged to identify additional resources in their own community through personal contact, networking, survey, and outreach. The following resource list is alphabetized by and within each category.

Access and Functional Needs Resources - Language Translation	Location Served
AT&T Language Services www.languageline.com	Nationwide
Fluent Language Solutions www.fluentls.com	Countywide
Lifesigns Interpreting Services for the Deaf www.lifesignsinc.org	Statewide
Translators, Inc. www.translators.com	Countywide
VSP Charity Program – Sight for Students www.sightforstudents.org	Countywide
Worldwide Interpreters www.e-wwi.com	Worldwide
General Mass Care Resources	**Location Served**
Adventist Community Services www.communityservices.org Provides emergency goods and supplies, and warehouse operations.	Worldwide
American Baptist Men www.abmen.org Assists with housing assessments, debris removal, and housing cleanup operations.	Worldwide

American Jewish World Services (AJWS) www.ajws.org Fosters civil societies' sustainable development and human rights.	Worldwide
American Red Cross (Red Cross) www.redcross.org Provides fixed/mobile feeding stations, sheltering, cleaning supplies, comfort kits, first aid, food, clothing, rent, home repairs, household items, and medical supplies.	Worldwide
Ananda Marga Universal Relief Team (AMURT) www.amurt.net Renders immediate medical care, food and clothing distribution, stress management, and community and social services. AMURT also provides long-term development assistance and sustainable economic programs to help disaster-affected people.	Worldwide
Brethren Disaster Ministries www.brethren.org Provides volunteers to clean up debris and to repair or rebuild homes.	Worldwide
Catholic Charities, Department of Relief Services www.catholiccharitiesla.org Emphasizes ongoing and long-term recovery services for individuals and families, including temporary housing assistance for low-income families, and counseling programs for children and older adults.	Los Angeles County
Christian Contractors Association www.ccaministry.org Provides home construction and rebuilding assistance.	Nationwide
Christian Disaster Response (CDR) www.cdresponse.org Provides disaster assessments, fixed/mobile feeding facilities, and in-kind disaster relief supplies. CDR also coordinates and stockpiles the collection of donated goods through its regional centers.	Worldwide
Christian Reformed World Relief Committee www.crwrc.org/pages/crwrc.cfm Provides advocacy services to assist disaster victims in finding permanent, long-term solutions to their disaster-related problems, as well as housing repair and construction, needs assessment, cleanup, childcare, and other recovery services.	Worldwide

Church of Jesus Christ of Latter Day Saints www.lds.org/ldsfoundation Provides warehousing and distribution of emergency goods.	Worldwide
Church of the Brethren www.brethren.org/site/PageServer?pagename=serve_brethren_disaster_ministries Provides childcare services and home reconstruction for impacted families.	Nationwide
Church World Service Disaster Response www.cwserp.org Provides support and training to long-term recovery organizations and staff, as well as warehousing, distribution of donated goods, and maintenance of online training and preparedness resources.	Worldwide
Episcopal Relief and Development (ERD) www.er-d.org	Worldwide
FEMA National Response Framework Annex, Emergency Support Function #6 www.fema.gov/pdf/emergency/nrf/nrf-esf-06.pdf	Nationwide
FEMA Post Disaster Food and Water Resources www.fema.gov/rebuild/recover/foodandwater.shtm	Nationwide
Friends Disaster Service (FDS) www.friendsdisasterservice.org Provides volunteer labor coordination and victim advocacy.	Nationwide
International Orthodox Christian Charities (IOCC) www.iocc.org Provides funding to long-term recovery organizations, and emotional and spiritual care.	Worldwide
Mennonite Disaster Service (MDS) www.mds.mennonite.net Provides housing cleanup, home repair, and reconstruction.	Worldwide
Mercy Corps www.mercycorps.org Provides emergency relief services.	Worldwide

National Disaster Interfaith Network (NDIN) www.n-din.org Provides a coordinated network of local, regional, and State inter-faith disaster organizations.	Nationwide
National Organization for Victim Assistance www.trynova.org	Nationwide
Nazarene Disaster Response (NDR) www.crossroadsonthecoast.com/ndr.htm Provides volunteer coordination and long-term recovery support.	Worldwide
Presbyterian Disaster Assistance – Presbyterian Church (U.S.A.) www.pcusa.org/pda Provides recovery program funding and capacity building.	Worldwide
Society of St. Vincent de Paul (SVDP) www.svdpusa.org Provides long-term recovery case management and distribution of clothing and donated goods.	Nationwide
Southern Baptist Disaster Relief www.namb.net Provides mobile feeding units, childcare, cleanup, temporary repairs, reconstruction, counseling, and translation.	Worldwide
Taiwan Buddhist Tzu Chi Foundation www.tzuchi.org Provides distribution of food and donated goods, support for medical services, and counseling.	Worldwide
The Salvation Army www.salvationarmyusa.org Provides mass and mobile feeding, temporary shelter, counseling, medical assistance, and distribution of donated goods.	Worldwide
United Church of Christ (UCC) www.ucc.org/disaster Provides funding and capacity building for environmental and technological disasters, and long-term recovery organizations.	Worldwide
United Methodist Committee on Relief http://new.gbgm-umc.org/umcor/	Worldwide

United Sikhs www.unitedsikhs.org Provides humanitarian relief and coordination of recovery volunteers.	Worldwide
Voluntary Organizations Active in Disasters (VOAD) www.nvoad.org	Nationwide
World Vision www.worldvision.org Provides warehousing and distribution of donated goods.	Worldwide
Recovery Resources	**Location Served**
FEMA – General post-disaster information www.fema.gov/rebuild/index.shtm	Nationwide
FEMA – National Disaster Housing Strategy www.fema.gov/emergency/disasterhousing	Nationwide
Islamic Circle of North America-Relief (ICNA Relief) www.reliefonline.org Provides long-term recovery case management and humanitarian aid.	Worldwide
Lutheran Disaster Response www.ldr.org Provides long-term recovery case management.	Worldwide
United Jewish Communities (UJC) www.ujc.org Provides funding for Jewish long-term recovery and re-development organizations.	Worldwide
Referral and Miscellaneous Services Resources	**Location Served**
2-1-1 Los Angeles County (referral service) www.211Los Angelescounty.org	Countywide
Alzheimer's Association www.alz.org	Nationwide
American Red Cross Safe and Well Web site https://disastersafe.redcross.org	Worldwide
California Insurance Dept www.insurance.ca.gov	Statewide

California Kids www.californiakids.org	Statewide
California Office of Family Planning (perinatal services) www.cdph.ca.gov/programs/ofp	Statewide
Caregiver Resource Services www.californiacrc.org	Statewide
Community Access Center (independent living center) www.ilcac.org	Countywide
County Medical Services Program for Medically Indigent Adults www.cmspcounties.org	Statewide
Family Service Association (human services, child development, housing, and senior services) www.familyservicerivca.org	Countywide
FEMA Emergency Management Institute (EMI) http://training.fema.gov Offers independent study courses online that relate to mass care IS-197.EM. Special Needs Planning Considerations for Emergency Management IS-197.SP. Special Needs Planning Considerations for Service and Support Providers IS-700.A. National Incident Management System (NIMS): An Introduction IS-806. Emergency Support Function (ESF) #6: Mass Care, Emergency Assistance, Housing, and Human Services	Nationwide
Food Stamp Program and California Food Assistance Program www.dss.cahwnet.gov/foodstamps	Statewide
Healthy Families (low-cost health, dental, and vision) www.healthyfamilies.ca.gov	Statewide
Healthy Kids (low-cost health, dental, and vision) www.californiahealthykids.org	Statewide
HICAP (counseling about Medicare and other issues) www.cahealthadvocates.org/HICAP	Statewide
Homeless Health Care Los Angeles (HHCLA) http://hhcla.org	Countywide

Long-Term-Care Ombudsman www.vcrivco.org/ombudsman.html	Countywide
Medicare www.medicare.gov	Nationwide
Los Angeles County Department of Education www.lacoe.edu	Countywide
Los Angeles County Department of Public Social Services (DPSS) http://dpss.co.Los Angeles.ca.us	Countywide
Los Angeles County DPSS In-Home Support Services (IHSS) http://dpss.co.Los Angeles.ca.us/AdultServices.aspx	Countywide
Los Angeles County Office on Aging (referral) www.rcaging.org/opencms/Programs_Services/index.html	Countywide
Los Angeles County Veterans Service http://dmva.co.la.ca.us	Countywide
VA Greater Los Angeles Healthcare System, U.S. Department of Veterans Affairs www.losangeles.va.gov	Nationwide
Voluntary Organizations Active in Disaster (VOAD) - Local www.calvoad.org/cc_voad_socal.html	Countywide
Voluntary Organizations Active in Disaster (VOAD) – National www.nvoad.org	Nationwide
Volunteer Center of Los Angeles County (VCLA) www.vcrivco.org	Countywide
Women, Infants, and Children (WIC) Supplemental Nutrition www.fns.usda.gov/wic	Nationwide
Animal Service Resources	**Location Served**
American Humane Association (AHA) www.americanhumane.org	Nationwide
American Kennel Club (AKC) www.akc.org	Nationwide
American Society for the Prevention of Cruelty to Animals (ASPCA) www.aspca.org	Nationwide

American Veterinary Medical Association (AVMA) www.avma.org	Nationwide
Association of American Veterinary Medical Colleges (AAVMC) www.aavmc.org	Nationwide
California Veterinary Medical Association (CVMA) www.cvma.org	Statewide
Code 3 Associates www.code3associates.org	International
Humane Society of the United States (HSUS) www.humanesociety.org	Nationwide
International Fund for Animal Welfare (IFAW) www.ifaw.org	International
Noah's Wish www.noahswish.org	Nationwide
Paws of Life www.pawsoflife.org/index.html	Nationwide
Pet Finders www.petfinder.com	Nationwide
Pet Harbor www.petharbor.com	Nationwide
Search and Rescue Dogs of the United States www.sardogsus.org	Nationwide
Search Dog Foundation www.searchdogfoundation.org	Nationwide
Southern California Veterinary Medical Association (SCVMA) www.scvma.org	Statewide
United Animal Nations www.uan.org	Nationwide
United States Department of Agriculture (USDA) Animal Welfare http://awic.nal.usda.gov/nal_display/index.php?info_center=3&tax_level=1	Nationwide
Veterinary Medical Assistance Teams www.avma.org/vmat/default.asp	Nationwide

Medical Health Services Resources – Mobility Devices	Location Served
Action Mobility and Medical Supply (800) 601-2109	Countywide
American Red Cross (Red Cross) www.redcross.org	Worldwide
Medical Teams International www.medicalteams.org/sf/Home.aspx	Nationwide
Salvation Army www.salvationarmy-socal.org	Worldwide
Medical Health Services Resources – Pharmacies	**Location Served**
Costco – www.costco.com	Nationwide
CVS – www.cvs.com	Nationwide
Rite-Aid – www.riteaid.com	Nationwide
Sam's Club – www.samsclub.com	Nationwide
Target – www.target.com	Nationwide
Walgreens – www.walgreens.com	Nationwide
Wal-Mart – www.walmart.com	Nationwide
Mental Health Services	**Location Served**
American Red Cross (Red Cross) www.redcross.org	Worldwide
FEMA – Post Disaster Mental Health Considerations www.fema.gov/rebuild/recover/cope.shtm	Nationwide
Los Angeles County Department of Mental Health http://dmh.lacounty.gov	Countywide
National Organization for Victim Assistance www.trynova.org	Nationwide
SNAP: Specific Needs Awareness Planning http://ceo.lacounty.gov/pdf/press_releases_2007/SNAP%2001-04%20-07.pdf	Countywide

Trauma Intervention Program (TIP) of Southwest County (volunteer counselors) www.tipnational.org	Southwest County
Transportation Resources	**Location Served**
Los Angeles County Metropolitan Transportation Agency www.metro.net	Countywide
School District Buses Contact local school districts	Countywide
Legal Services Resources	**Location Served**
FEMA Disaster Legal Services Program www.fema.gov/assistance/process/additional.shtm#2	Nationwide
American Bar Association's Young Lawyers Division www.abanet.org/yld	Nationwide

XX. APPENDIX 6: REFERENCES

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XXI. APPENDIX 7: ACRONYMS

Abbreviation	Description
AAA	Area Agency on Aging
ABA	Architectural Barriers Act
ACO	Animal Control Officer
ADA	Americans with Disability Act
AED	Automated External Defibrillator
AHA	American Humane Association
AJWS	American Jewish World Services
AKC	American Kennel Club
AMURT	Ananda Marga Universal Relief Team
APS	Adult Protective Services
ASPCA	American Society for the Prevention of Cruelty to Animals
AVID	American Veterinary Identification Devices
AVMA	American Veterinary Medical Association
BCFS	Baptist Child and Family Services
Cal EMA	California Emergency Management Agency
CBO	Community-Based Organizations
CCR	California Code of Regulations
CDAA	California Disaster Assistance Act
CDFG	California Department of Fish and Game
CDR	Christian Disaster Response
CEOC	County Emergency Operations Center
CERT	Community Emergency Response Team
CFR	Code of Federal Regulations
CFS	Children and Family Services
CPS	Child Protective Services
CSS	Community and Senior Services
CVMA	California Veterinary Medical Association
DAC	Disaster Assistance Centers
DAP	Disaster Assistance Policy
DCFS	Department of Children and Family Services
DHS	Department of Health Services
DHV	Disaster Health Volunteer
DME	Durable Medical Equipment
DMH	Department of Mental Health
DOC	Department Operations Center
DPH	Department of Public Health
DPSS	Department of Public Social Services
DPW	Department of Public Works
DRC	Disaster Recovery Center
DRU	Disaster Response Unites
DSW	Disaster Service Worker
DWI	Disaster Welfare Inquiries
EARS	Emergency Animal Rescue Services
EMI	Emergency Management Institute

Abbreviation	Description
EMS	Emergency Medical Services
EMSA	Emergency Medical Services Agency
ENLA	Emergency Network Los Angeles, Inc.
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
ERP	Emergency Response Plan
ERV	Emergency Response Vehicles
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Function
FAST	Functional Assessment and Service Team
FDS	Friends Disaster Service
FEMA	Federal Emergency Management Agency
FHWA	Federal Highway Administration
FRA	Federal Railroad Administration
GSD	General Services Department
HAZMAT	Hazardous Materials
HHS	Health and Human Services
HS	Health Services
HSPD	Homeland Security Presidential Directive
HSUS	Humane Society of the United States
HUD	Housing and Urban Development
ICNA	Islamic Circle of North America
ICS	Incident Command System
ID	Identification
IDEA	Individuals with Disabilities Education Act
IFAW	International Fund for Animal Welfare
IHSS	In-Home Support Services
IOCC	International Orthodox Christian Charities
JIC	Joint Information Center
LAC	Local Assistance Centers
LACDACC	Los Angeles County Department of Animal Care and Control
LACOE	Los Angeles County Office of Education
LAOA	Los Angeles Operational Area
LAUSD	Los Angeles Unified School District
MAA	Mutual Aid Agreements
MAC	Medical Alert Center
MCO	Movement Coordination Officer
MDS	Mennonite Disaster Service
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MRC	Medical Reserve Corps
MRE	Meal Ready to Eat
MSSP	Multiple Senior Services Program
MTA	Metropolitan Transportation Authority
NACCRRA	National Association of Child Care Resource and Referral Agencies
NCMEC	National Center for Missing and Exploited Children

Abbreviation	Description
NDIN	National Disaster Interfaith Network
NDR	Nazarene Disaster Response
NECLC	National Emergency Child Locator Center
NGO	Non-Governmental Organization
NIMS	National Incident Management System
NRF	National Response Framework
NSS	National Shelter System
NVOAD	National Voluntary Organizations Active in Disaster
OA	Operational Area
OEM	Office of Emergency Management
OES	Office of Emergency Services
OPS	Office of Public Safety
PDA	Presbyterian Disaster Assistance
PETS	Pets Evacuation and Transportation Standards
PIO	Public Information Officer
POC	Point of Contact
PPE	Personal Protective Equipment
PUP	Pick-up Point
Red Cross	American Red Cross
RPS	Reception Processing Site
SCCA	Southern California Chaplains' Association
SCVMA	Southern California Veterinary Medical Association
SEMS	Standardized Emergency Management System
SNAP	Specific Needs Awareness Planning
SPCA	Society for the Prevention of Cruelty to Animals
SPCALA	Society for the Prevention of Cruelty to Animals Los Angeles
SVDP	Society of St. Vincent de Paul
TDD	Telecommunications Device for the Deaf
TIP	Trauma Intervention Program
TTS	Temporary Treatment Site
TTY	Teletypewriter
UASI	Urban Area Security Initiative
UCC	United Church of Christ
UFAS	Uniform Federal Accessibility Standards
UJC	United Jewish Communities
USDA	United States Department of Agriculture
USPHS	United States Public Health Service
VAL	Voluntary Agency Liaison
VCLA	Volunteer Center of Los Angeles
VOAD	Voluntary Organizations Active in Disaster
VPH	Veterinary Public Health
VRMC	Veterinary Medical Reserve Corp
VSA	Vehicle Staging Area
WIC	Women, Infants, and Children
WMD	Weapon of Mass Destruction

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XXII. APPENDIX 8: DEFINITIONS

2-1-1 Los Angeles County: 2-1-1 is a toll free number available 24 hours a day, 7 days a week, and is staffed by operators who are trained to provide callers with information and referrals for social services.

Access and Functional Needs: Access and functional needs as defined by the National Response Framework may be present before, during, or after an incident in one or more areas and may include, but are not limited to, maintaining independence, communication, transportation, supervision, and medical care. Utilize ESF #6 to coordinate assistance without regard to race, ethnicity, religion, nationality, gender, age, disability, English proficiency, or economic status of those who are seeking assistance as a result of a disaster.

Acute: Acute conditions are illnesses and injuries with an abrupt onset of symptoms that may change or worsen rapidly, such as a bone fracture or heart attack.

Affected Population: Anyone who has been displaced, injured or suffered some loss due to a disaster.

Alliance, the: Los Angeles Critical Incident Planning and Training Alliance ("the Alliance"), which was funded by the Regional Catastrophic Planning Grant Program (RCPGP). The Alliance is a multi-jurisdictional and multi-disciplinary partnership consisting of law enforcement, fire, emergency management, recreation and parks, and health agencies within LAOA. The purpose of the Alliance is to facilitate strategic regional catastrophic disaster planning among all disciplines and jurisdictions within the greater Los Angeles area.

American Red Cross (Red Cross) Safe and Well Program: This is a program that allows people to register themselves as "safe and well" following a disaster. Those affected by a disaster can visit the Red Cross Web site. They can select from a standard list of messages and communicate information to their family members, letting them know of their well-being.

Annex: Annexes add specific information and direction to the guidance. They clearly describe the policies, processes, roles, and responsibilities that are important before, during, and after any emergency. While the guidance provides relevant, broad, overarching information, the annexes focus on specific responsibilities, tasks, and operational actions that pertain to the performance of a particular function. Paraphrased from Comprehensive Preparedness Guide (CPG) 101. FEMA. March 2009.

Appendix: Appendices provide relevant information not already addressed in the guidance. Typically, this includes lists of terms and definitions, forms used, or other necessary information. Paraphrased from Comprehensive Preparedness Guide (CPG) 101. FEMA. March 2009.

Arrival Point: Any facility or point of entry into a host state or jurisdiction that provides assistance to the affected population. This includes transfer points,

RPSs, Welcome Centers, Information Points, shelters, and other congregate facilities.

Bulk Distribution: Emergency relief items (e.g., food items, water, ice, and cleaning supplies) to meet urgent needs are distributed through sites established within the affected area or via mobile distribution.

Chronic: Chronic conditions, such as heart disease or asthma, develop and worsen over an extended period of time.

Community-Based Organization (CBO): A non-profit organization that works to serve its community. This includes both secular and faith-based organizations.

Community Emergency Response Team (CERT) Program: Educates people about disaster preparedness for hazards that may impact their area and trains them in basic disaster response skills, such as fire safety, light search and rescue, team organization, and disaster medical operations.

Disaster Health Volunteer Program (DHV): California system to credential and track healthcare volunteers.

Disaster Recovery Center (DRC): A readily accessible facility or mobile office where applicants may go for information about FEMA or other disaster assistance programs.

Disaster Service Worker (DSW): A volunteer or employee of an agency or organization who responds to and works on a disaster operation.

Disaster (Emergency) Supplemental Nutrition Assistance Program (DSNAP): The Stafford Disaster Relief and Emergency Assistance Act of 1988 allows distribution of emergency SNAP benefits (i.e., a program through which eligible clients receive food products, rather than benefits intended for purchasing food) to victims of a Presidentially-declared major disaster.[204] DSNAP includes the Disaster Food Stamp Program (DFSP).

Disaster Welfare Information: Facilitates notification and communication from inside and outside disaster-affected areas to helping individuals initiate contact with or seek missing family members and loved ones.

Durable Medical Equipment (DME): Defined in FEMA DAP 9525.4 as "[e]quipment prescribed by a physician that is medically necessary for the treatment of an illness or injury, or to prevent a patient's further deterioration. This equipment is designed for repeated use and includes items such as oxygen equipment, wheelchairs, walkers, hospital beds, crutches, and other medical equipment."

[204] Details of Oregon's DSNAP program may be found at http://apps.state.or.us/caf/fsm/06fs-i.htm, or general information regarding SNAP at Feeding America can be accessed at http://feedingamerica.org/our-network/public-policy/supplemental-nutrition-assistance-program.aspx.

Emergency First Aid: Emergency first aid consists of basic first aid and/or referral to appropriate medical personnel and facilities.

Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP): State-based emergency systems for the advance assessment and registration of volunteer health professionals to facilitate their activities during public health and other emergencies.

Feeding: Feeding is provided to victims through a combination of fixed sites, mobile feeding units, and bulk distribution of food. Feeding operations are based on sound nutritional standards to include meeting requirements of victims with special dietary needs to the extent possible.

FEMA Individuals and Households Program: Based on a requirement in the Post-Katrina Emergency Management Reform Act (P.L. 109-295) to conduct an Individuals and Households Pilot Program, this "pilot program was to provide timely and cost-effective temporary housing to individuals and households affected by a disaster by funding repairs to existing multi-family rental housing units under section 689i(a)(4) of the Stafford Act."

Go-Kit: A kit that affected populations are encouraged to bring with them to the shelter and includes such items as blankets, a change of clothes, basic toiletries, and prescription medications.

Health: A state of physical, mental, and social well-being.

HIPAA, Public Law 104-191**:**[205] Incorporates both privacy and security principles. The Privacy Rule asserts that privacy of protected health information is an individual's "fundamental right", and includes the control of one's medical information and medical services. The rule strikes a balance of interest that permits use of information while protecting the individuals who seek medical care.

Household Pet(s) (Federal Definition): A domesticated animal, such as a dog, cat, bird, rabbit, rodent, or turtle, that is traditionally kept in the home for pleasure rather than for commercial purposes, can travel in commercial carriers, and can be housed in temporary facilities. Household pets do not include reptiles (except turtles), amphibians, fish, insects/arachnids, farm animals (including horses), and animals kept for racing purposes. (For the State's definition, contact the State ESF lead agency responsible for pets.)[206]

Joint Information Center (JIC): The Joint Information Center (JIC) structure provides a supporting mechanism to develop, coordinate, and deliver messages to the public. It supports the Incident Commander or Unified Command and the associated elements of the ICS.

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[205] http://aspe.hhs.gov/admnsimp/pl104191.htm

[206] Evacuee Support Guide. FEMA. July 2009. http://www.fema.gov/pdf/government/evacuee_support_guide.pdf.

Jurisdiction: An entity within a certain geographical area. For purposes of this guidance, Los Angeles County is the geographical area.

Local Assistance Centers (LAC): Serve as central clearinghouses for the dissemination of information about disaster assistance programs. LAC personnel should work with city and/or county EOC Public Information Officers to coordinate communications to the public relating to LAC activities, as well as recovery from disasters.

Los Angeles County Community and Senior Services (CSS): Community and Senior Services provides direct services to seniors and at-risk individuals. The department also provides services through a network of over 500 community agencies that contract with CSS to provide programs for the citizens of LAOA.

Los Angeles County Office on Aging Call Center: The Office on Aging connects seniors, adults with disabilities, family members, professionals, and the public at large with assistance, referrals, education, and advocacy.

Los Angeles Operational Area: The Los Angeles County Operational Area is an intermediate level of the State Emergency Services Organization, consisting of the county and all political subdivisions within the county.[207]

Mass Care: Defined by the National Response Framework (NRF) as including sheltering, feeding, emergency first aid, bulk distribution of emergency items, and disaster welfare information (i.e., collecting and providing information on victims to family members). At the Federal level, the mass care function is a part of the Emergency Support Function (ESF) #6 responsibilities.

Meal-Ready-to-Eat/Heater Meal/Shelf Stable Meal: Pre-packaged individual meal, some with internal chemical self-heating units, which can be stored for extended periods without refrigeration.

Medical: The maintenance or restoration of health via the prevention and treatment of disease or injury.

Medical Reserve Corps (MRC): The Medical Reserve Corps (MRC) supports the health and safety of communities across the country by organizing and utilizing public health, medical, and other volunteers. MRC units are community-based and supplement existing emergency and public health resources during times of disaster and non-disaster. The MRC coordinates medical and public health professionals who want to volunteer such as physicians, nurses, pharmacists, dentists, veterinarians, and epidemiologists.

Multiple Senior Services Program (MSSP): A Medi-Cal Waiver program designed to meet the needs of frail, Medi-Cal-eligible seniors. Medi-Cal is California's Medicaid program.

[207] Los Angeles County Code Chapter 2.68.050.K Definitions.

Mutual Aid: Mutual aid is the voluntary provision of services and facilities by agencies or organizations to assist each other when the requestor's existing resources prove to be inadequate.

National Incident Management System/Incident Command System (NIMS/ICS): NIMS is a system mandated by Homeland Security Presidential Directive (HSPD) 5 that provides a consistent nationwide approach for Federal, State, local, and Tribal governments; the private sector; and nongovernmental organizations to work effectively and efficiently together to prepare for, respond to, and recover from domestic incidents, regardless of cause, size, or complexity. The Incident Command System (ICS) provides a flexible yet standardized core mechanism for coordinated and collaborative incident management, whether for incidents where additional resources are required or are provided from different organizations within a single jurisdiction or outside the jurisdiction, or for complex incidents with national implications.

National Response Framework (NRF): The National Response Framework "presents the guiding principles that enable all response partners to prepare for and provide a unified national response to disasters and emergencies - from the smallest incident to the largest catastrophe. The Framework establishes a comprehensive, national, all-hazards approach to domestic incident response."[208]

National Shelter System (NSS): The FEMA National Shelter System (NSS) is a comprehensive, Web-based database created to support Federal, State, and local government agencies and voluntary organizations responsible for Mass Care and Emergency Assistance. The FEMA NSS allows users to identify, track, analyze, and report on data for virtually any facility associated with the congregate care of people and/or household pets following a disaster.[209]

Nongovernmental Organization (NGO): As defined in the NRF, an NGO is an entity with an association based on interests of its members, individuals, or institutions. It is not created by a government, but it may work cooperatively with government. Such organizations serve a public purpose, not a private benefit. NGOs, including voluntary and faith-based groups, provide relief services to sustain life, reduce physical and emotional distress, and promote the recovery of disaster victims. Often these groups provide specialized services that help individuals with disabilities. NGOs and voluntary organizations play a major role in assisting emergency managers before, during, and after an emergency.[206]

Non-Traditional Shelter: Large, non-conventional sheltering facility—often those generally used for public assembly such as an arena, convention center,

[208] National Response Framework. FEMA. January 2008. http://www.fema.gov/pdf/emergency/nrf/nrf-core.pdf.

[209] NSS, FEMA. Accessed online on June 9, 2010 at http://www.fema.gov/about/regions/regioni/bridge8-3.shtm.

cruise ships, vacant buildings, stadiums or recreational fields, parking lots, beaches, campgrounds, farm land, or open lots.[210]

Operational Area: An operational area consists of a county and all political subdivisions within the county area. Operational areas coordinate inter-jurisdictional emergency operations and mutual aid.

Paratransit: Examples of paratransit service include taxis, dial-a-ride, vanpools, and subscription services.

Point of Distribution (POD): A centralized point where supplies are delivered and the public travels to the site to pick up the commodities (e.g., pre-packaged meals, water, tarps, ice, etc.). Further guidance on the management of a POD can be found in the FEMA IS-26 Guide to Points of Distribution.

Public Information Officer (PIO): Works in coordination with the Joint Information Center (JIC) to provide a supporting mechanism to develop, coordinate, and deliver messages to the public.

Reception Processing Site (RPS): A site established as an entry point into a host state or jurisdiction to track and process government transportation-assisted evacuees; provide mass care services; assign the affected population to congregate care facilities; provide health screening; and provide for the general support of other needs. An RPS may or may not be co-located with a Debarkation Site.[206]

Service Animal: As defined by the ADA, a service animal is any guide dog, signal dog, or other animal individually trained to provide assistance to an individual with a disability, including but not limited to assisting individuals with impaired vision, hearing, or mobility; providing minimal protection; or performing rescue work. Service animals are not pets and will remain with their owners at all times.[206]

Shelter: A facility and/or site containing an existing structure or requiring the construction of a temporary structure using non-traditional material (e.g., tents, open air) for the purposes of providing relief and services to affected populations.

Shelter-in-Place: "Shelter-in-place" means to take immediate shelter where you are—at home, work, school, or in between, for example, during a hazardous materials incident when chemical or radiological contaminants are released into the environment.

Speed-to-Scale: Refers to the amount of time it takes to reach a desired goal (e.g., How fast can a State open enough shelters to house 15,000 of the affected population?). Speed-to-scale analyzes which resources are necessary (e.g., facilities, cots, staff); the amount of time needed to acquire those resources (e.g.,

[210] International Association of Venue Managers Mega-Shelter Planning Guide and the National Disaster Housing Strategy from the Federal Emergency Management Agency published January 2009. http://www.fema.gov/pdf/emergency/disasterhousing/NDHS-core.pdf.

local staff versus staff flown in); and the percentage of the goal reachable at any given time up to achieving 100%. The analysis would include methods and strategies for accelerating the speed in which the goal can be reached.

Standardized Emergency Management System (SEMS): The system required by Government Code §8607(a) for managing response to multi-agency and multi-jurisdiction emergencies in California. SEMS consists of five organizational levels, which are activated as necessary and include: (1) field response; (2) local government; (3) operational area; (4) regional; and (5) State. SEMS incorporates the use of the Incident Command System (ICS), the Master Mutual Aid Agreement, existing mutual aid systems, the operational area concept, and multi-agency or inter-agency coordination.

Triage: The method by which individuals are prioritized for assistance.

Vector Control: Control of an area against animals or insects that are capable of transmitting disease or are a public health nuisance.

Zoonotic Disease: An animal disease that can be transmitted to humans.

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XXIII. APPENDIX 9: MEDICAL AND HEALTH RESOURCES

- **Tab L: California Medical Volunteers**[211]

  The following is a summary of policies, procedures and guidance for local governments, state agencies, care delivery sites, and volunteer health professionals on the use of the California Medical Volunteers System in California.

  1. In order to receive workers' compensation benefits, California Medical 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.
  2. 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.
  3. 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, California Medical 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.
  4. 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

[211] Principles of Operations v.1.5 – March 13, 2008.

apply in cases of willful intent, unreasonable acts beyond the scope of DSW training, or if a criminal act is committed.

- **Tab M: Involuntary Treatment- Detention of Mentally Disordered Persons for Evaluation and Treatment (WIC 5150 and 5585).**
- **Tab N: Guidelines for Establishing and Maintaining a Diapering Station in an Evacuation Center.**
- **Tab O: Keeping Your Facility Healthy.**

This information can be found on the following pages.

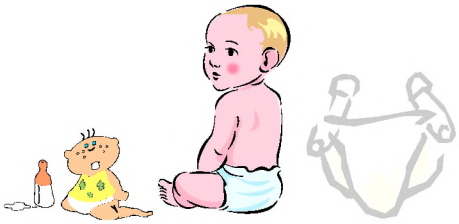
Involuntary Treatment- Detention of Mentally Disordered Persons for Evaluation and Treatment (WIC 5150 and 5585)

When any person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, or any person designated by the director of the County of Los Angeles Department of Mental health may, upon probable cause, take or cause to be taken, the person into custody and place him or her in a facility designated by the county and approved by the State Department of Mental Health as a facility for 72- hour treatment and evaluation.

Such facility shall require an application in writing stating the circumstances under which the persons conditions was called to the attention of the officer, or any person designated by the director of the County of Los Angeles Department of Mental Health. If the probable cause is based on the statement of a person other than the officer, or any person designated by the director of the County of Los Angeles Department of Mental Health, such person shall be liable in a civil action for intentionally giving treatment which he or she knows to be false.

It is the policy of the County of Los Angeles Department of Mental Health (Policy No. 202.3) that no person in Los Angeles County may initiate an application for 72- hour evaluation and treatment to a facility so designated by the County unless that person is a peace officer, parole/probation official as specified in Penal Code Sections 2960-2978, or a person designated in accordance with the guidelines set forth in this policy (Policy No. 202.3).

Guidelines for Establishing and Maintaining a Diapering Station in an Evacuation Center[1]



1. **One station** should be available for approximately every **12 diapered children**.

2. Place the diapering station **near hand washing facilities**. If this is not possible, make a water-less hand gel product available at the diapering station, but place it out of the reach of children.

3. Diaper changing surface should be made of **non-porous material**.

4. Ideally, a **rail or similar barrier** should surround the diaper changing surface to help protect children from falls.

5. Provide **disposable materials**, such as paper towels or butcher paper, to cover the diapering surface before each use.

6. Provide **baby wipes** for child and diapering station clean-up.

7. Place a **covered trash receptacle**, preferably with a foot-operated opening mechanism, near the diapering area.

8. Keep **paper towels and a disinfectant solution** in a spray bottle at the diapering station, but out of the reach of children
   - Disinfectant solution may be made by mixing **¼ cup** bleach in 1 **gallon** of water.

9. Post **cleaning/disinfecting instructions** at each station.
   - If evacuation center guests are responsible for cleaning and disinfecting the diapering stations after each use, train them in **proper technique**. A videotape entitled," The ABC's of Childcare Development: Diapering" is available from the CDC.[2]

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[1] *Centers for Disease Control and Prevention, cdcinfo@cdc.gov*

Keeping your Facility Healthy

Encourage and model good hygiene habits

- **Avoid touching your eyes and mouth.**
- **Cover coughs and sneezes with a tissue or your sleeve.**
- **Wash hands often, using soap and warm water for 20 seconds. (When soap and water are not available, use hand sanitizer).**

Follow these tips to help create a healthy environment at your facility and prevent the spread of diseases.

Practice good housekeeping habits at your facility

- Open windows to help maintain fresh air in shared areas.
- Provide tissue and hand sanitizer at entrances, desks, and other locations in your facility.
- Provide lined trash cans to throw away used tissues.
- Keep surfaces clean by wiping them down with a disinfectant several times a day.
- Keep common areas free from personal items by double-bagging them as people enter the facility.

Separate people who are sick

- Avoid close contact with people who are sick. (Stay 3 feet away from them if you can).
- Encourage sick staff to stay home until 24 hours after their symptoms are gone.
- People who are sick should sleep and eat meals in a separate room (if possible).
- People who are sick should seek emergency medical care if they have:
  - Trouble breathing
  - Chest pain
  - Trouble keeping liquids down

Extra tips for residential facilities:

- Use a dishwasher or hot water and detergent to clean eating utensils.
- Avoid “hugging” dirty laundry when handling it to prevent contaminating yourself.
- Consider canceling or postponing group activities.
- Create physical barriers between beds using sheets or curtains.
- Arrange beds so that people lay head-to-toe relative to each other.

For more information visit www.ph.lacounty.gov

This publication was supported by Grant/Cooperative Agreement Number U90/CCU917012-08 from CDC.
Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

County of Los Angeles Public Health

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XXIV. APPENDIX 10: NON-TRADITIONAL SHELTER RESOURCES

- **Tab P: Historical Listing of Non-Traditional Shelters in the United States**

1906 San Francisco Earthquake	There were an estimated 300,000 people left homeless following the 7.7+ magnitude earthquake. The Army built 5,610 redwood and fir "relief houses" to accommodate 20,000 displaced people. The camps had a peak population of 16,448 people, but by 1907 most people had moved out. The camps were then re-used as garages, storage spaces, or shops. The cottages cost on average $100–741 to put up.[212]
1926 Tri State Tornado	Tent cities erected by Red Cross in Griffin, IN.[213] 'They were also prominent in Murphysboro, IL, with its eight thousand homeless citizens, and in the decimated villages of Griffith and De Soto.[214]
1926 Miami Hurricane	Tent cities erected by the Navy, Army, and Red Cross.[215]
1927 Texas Tornado	Tent city erected for those left homeless after a tornado in Rock Springs, Texas.[216]
1928 Okeechobee Hurricane	Tent cities were established in West Palm Beach, FL, that housed 222 people over a span of three weeks.[217]
1937 Mississippi River Flood	Numerous tent cities erected in the highlands around the Mississippi River. A single camp received 15,000 refugees and ten additional centers were spotted.[218]
1947 Des Moines Flood	Tent city erected by Red Cross in Ottumwa, IA, for 30 families.[219]
1947 Oklahoma Tornado	Tent city erected on football field.[220]

[212] http://realtytimes.com/rtpages/20060418_quakehistory.htm.
[213] http://news.google.com/newspapers?id=QagLAAAAIBAJ&sjid=pFQDAAAAIBAJ&pg=4065,607252.
[214] http://books.google.com/books?id=zXwhIUY9qIYC&pg=PA69&lpg=PA69.
[215] http://news.google.com/newspapers?id=kMMhAAAAIBAJ&sjid=aZ0FAAAAIBAJ&pg=3861,6811625.
[216] http://news.google.com/newspapers?id=v54NAAAAIBAJ&sjid=IkwDAAAAIBAJ&pg=3093,3917157.
[217] http://news.google.com/newspapers?id=B9ktAAAAIBAJ&sjid=O9gFAAAAIBAJ&pg=2367,4818502.
[218] http://news.google.com/newspapers?id=ElMaAAAAIBAJ&sjid=IScEAAAAIBAJ&pg=7079,4070772.
[219] http://news.google.com/newspapers?id=Vo0hAAAAIBAJ&sjid=CJgFAAAAIBAJ&pg=1457,4746281.

1950 Mississippi River Flood	Tent city established by Red Cross and National Guard near East Prairie, MS. 100 tents were erected.[221]
1957 Hurricane Audrey	Tent city established in Cameron, LA. 500 tents were erected.[222] [223]
1989 Loma Prieta Earthquake	Dozens of tent cities erected at Ramsey Park in Watsonville, CA; the Red Cross erected an army tent camp for 125 campers.[224] [225] [226]
1992 Hurricane Andrew	Tent cities opened three months after the storm in Dade County, Florida. They were erected at Harris Field, in Homestead, and in Florida City. The Army cleared 14 acres of parkland to erect tent facilities. 2,000 people stayed in the facilities.[227] [228] [229] [230]
1994 Northridge Earthquake	Tent city erected in Los Angeles. There were six tent cities erected in North Hollywood and the San Fernando Valley. 4,631 people were camped out in five tent cities.[231] [232] [233]
1994 Washington State Wildfire	Tent city erected at Entiat High School and another at a nearby park.[234]

[220] http://news.google.com/newspapers?id=ynQdAAAAIBAJ&sjid=lFgEAAAAIBAJ&pg=2457,1465816.
[221] http://news.google.com/newspapers?id=j7MfAAAAIBAJ&sjid=7tYEAAAAIBAJ&pg=1154,1495628.
[222] http://news.google.com/newspapers?id=B4YeAAAAIBAJ&sjid=hMsEAAAAIBAJ&pg=2668,5010489.
[223] http://oralhistory.blogs.lib.lsu.edu/tag/hurricane-audrey/.
[224] http://news.google.com/newspapers?id=VwgjAAAAIBAJ&sjid=Ps4FAAAAIBAJ&pg=1357,5437742.
[225] http://www.nytimes.com/1989/11/03/us/watsonville-journal-a-lost-city-of-tents-is-legacy-of-quake.html.
[226] http://news.google.com/newspapers?id=hE0yAAAAIBAJ&sjid=KOYFAAAAIBAJ&pg=6863,1826363.
[227] http://www.encyclopedia.com/doc/1P2-1025879.html.
[228] http://www.crid.or.cr/cd/CD_GERIMU06/pdf/eng/doc8864/doc8864-contenido.pdf.
[229] http://webcache.googleusercontent.com/search?q=cache:g7t43mS57lUJ:web3.unt.edu/news/story.cfm%3Fstory.
[230] http://news.google.com/newspapers?id=j6AaAAAAIBAJ&sjid=iSwEAAAAIBAJ&pg=5508,3768225&.
[231] http://news.google.com/newspapers?id=7bsRAAAAIBAJ&sjid=Be0DAAAAIBAJ&pg=5042,6231535.
[232] http://www.nytimes.com/1994/01/23/us/the-earthquake-health-concerns-mounting-as-tents-rise-after-quake.html?pagewanted=all.
[233] http://www.nytimes.com/1994/01/28/us/thousands-of-quake-victims-moving-out-of-tent-cities.html?pagewanted=1.
[234] http://news.google.com/newspapers?id=0OsyAAAAIBAJ&sjid=-gkEAAAAIBAJ&pg=4383,4948956.

2002 Hayman Fire	Tent city established near Lake George, CO, in a city park.[235]
2004 Hurricane Ivan	Frail, older adults, and sick residents unable to get out were moved to the 72,000-seat Louisiana Superdome, where 200 cots were placed. It was also discussed that the dome could also be opened as a one-night last resort for able-bodied storm refugees.[236]
2005 Hurricane Katrina	250 people in tent city on New Orleans City Hall; 65 people in tent city in Waveland, Mississippi; tent city set up under I-10, estimated to house 200 people; tent city constructed by FEMA in Long Beach, Mississippi; tent city constructed by the Navy in Pass Christian, Mississippi, to house 1,000.[237] [238] [239] [240] [241]
2005 Hurricane Katrina Superdome	Approximately 9,000 residents and 550 National Guardsmen rode out the night in the Superdome as Katrina came ashore. The Louisiana National Guard said that the number of people taking shelter in the Superdome rose to around 15,000 to 20,000 as search and rescue teams brought more people to the Superdome from areas hit hard by the flooding.[242]
2005 Hurricane Katrina Cajundome	Over 17,000 survivors arrived at Lafayette's Cajundome wet, tired, hungry, and scared, in need of medical attention and certainly in shock. The Red Cross, Homeland Security, and the International Association of Venue Managers gathered together in July of 2006 to develop plans for future "mega shelters" based upon the successful Cajundome model.[243]

[235] http://www.rockymountainnews.com/news/2002/jun/28/hayman-war/.
[236] http://www.greatdreams.com/weather/hurricane_ivan.htm.
[237] http://www.cbsnews.com/stories/2007/11/16/national/main3516943.shtml?source=RSSattr=HOME_3516943.
[238] http://www.cbsnews.com/stories/2005/09/06/earlyshow/living/main818683.shtml.
[239] http://blogs.usatoday.com/oped/2008/06/katrina-survivo.html#more.
[240] http://www.gadling.com/2008/02/11/tent-city-in-new-orleans-does-in-fact-exist/.
[241] http://www.globalsecurity.org/security/library/news/2005/10/sec-051003-nns01.htm.
[242] http://www.spiritus-temporis.com/louisiana-superdome/hurricane-katrina.html.
[243] http://www.dhh.louisiana.gov/offices/publications/pubs-231/Acadiana%20Spirit%20Rising.pdf.

2005 Hurricane Katrina Reliant Astrodome	The first bus carrying evacuees arrived at Reliant Astrodome in less than 24 hours of the call where cots, blankets, bathroom and showering facilities, food, and toiletries were already in place. The 350-acre property housed over 27,000 evacuees. The complex accommodated 59,679 volunteers during these efforts. The Reliant Park Complex was the largest natural disaster shelter in United States history.[244]
2005 Hurricane Katrina Dallas Convention Center	The city of Dallas housed 1,000 people inside Reunion Arena and 7,200 at the Dallas Convention Center.[245]
2005 Hurricane Rita	Tent city erected at City Park after Hurricane Katrina and used by Hurricane Rita survivors as well (estimated use of roughly 100 tents and 150 motor homes during Rita; over 1,000 during Katrina).[246]
2007 California Wildfires	Tent city constructed for 200 people in Dulzura. Another tent city was constructed by sailors at the Naval Amphibious Base Coronado to house 500 people, and a tent city of 10,000 was allowed at the San Diego NFL stadium (Qualcomm). At Qualcomm, thousands of tents, many set up by relief organizations, provided temporary roofs, while hundreds of people slept on open-air cots. Some older adult evacuees were housed in stadium club boxes. Aggressive efforts by disaster-response officials to bring supplies helped ensure civility. A heavy police contingent and National Guard troops stood by just in case.[247] [248] [249]
2008 Hurricane Ike	Tent city constructed in Lufkin, Texas, for 800 people.[250]

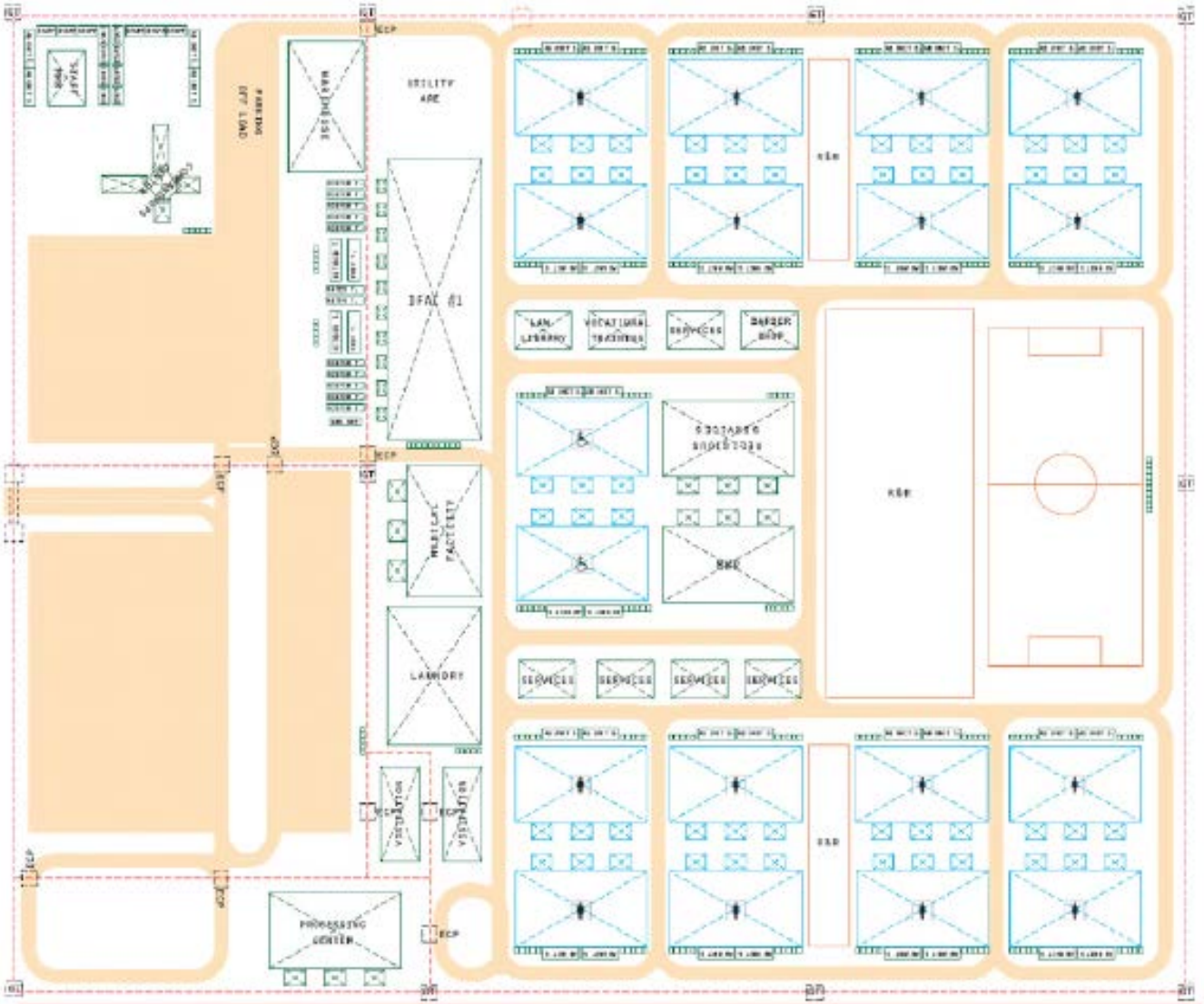
[244] http://www.reliantpark.com/en/rel/5/
[245] http://www.smudailycampus.com/2.6641/katrina-refugees-come-to-dallas-1.967780
[246] www.2004hurricanes.com/rita/index.html+hurricane+rita+%22tent+city%22&cd=10&hl=en&ct=clnk&gl=us.
[247] http://sosdfireblog.blogspot.com/2007/11/tents-going-up.html.
[248] http://www.af.mil/news/story.asp?id=123072957.
[249] http://www.msnbc.msn.com/id/21435605/.
[250] http://www.ktre.com/Global/story.asp?S=9017237.

- **Tab Q: Sample 5,000 Person Camp.**
- **Tab R: Sample Conceptual 50-acre 10,000-man Mass Care Base Camp.**

These layouts can be found on the following pages.

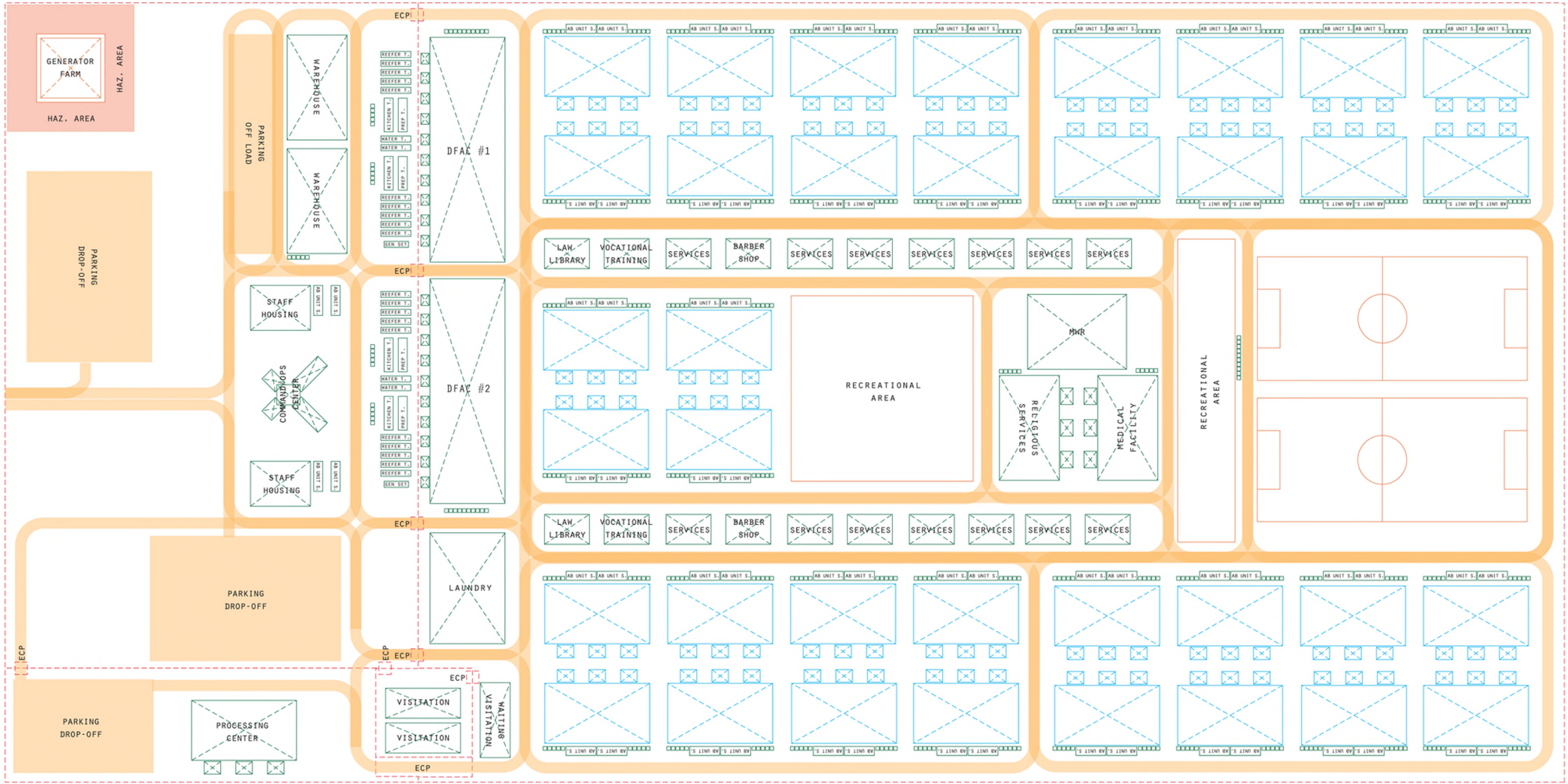
Base Camp Sketch

CSS ERT 30 ACRE MASSCARE 5,000 MAN BASE CAMP



This sketch is not to scale.
For review and comment only; not final layout.

CSS ERT 50 ACRE MASSCARE 10,000 MAN BASE CAMP



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XXV. Appendix 11: Transportation Management—Description of Transportation Modes for Planning

This appendix includes information about specific types of transportation assets that may be used during evacuations. Each mode of transport has its own set of advantages and limitations. Planners using this information should keep in mind that each of the modes or resources described below may or may not be available following a catastrophic event. Additionally, planners wishing to use a particular asset should engage the organization responsible for that asset in appropriate planning to ensure access to the resource during an emergency.

A. Ground Transport: Motor Vehicle

1. Planning Considerations for Motor Vehicles

a) If the highway system has been damaged or if the roadway infrastructure is affected, motor vehicles will not be able to get through.

b) Debris may make roads impassable. Once cleared, residual debris and glass may affect vehicles' tires.

c) Bridges and underpasses may be unstable. Following an earthquake incident, roads and bridges may have to be inspected following each aftershock. This would slow the traffic and evacuation process for motor vehicles.

d) If the electricity is out, traffic control systems, such as signals and intelligent transportation systems (ITS) will not be functioning properly.

e) In the event of flooding, motor vehicles will not be able to pass through low-lying areas.

f) If there is damage to gas pipelines, vehicles may not be able to get fuel.

g) If there is no electricity (and no backup generator), the fuel will not be able to be pumped.

h) If communications are not already available onboard the motor vehicle, some mode of communication will have to be identified, and the operators will have to be trained to use it.

i) Communications networks for gas stations may be down, and pay-at-the-pump and credit/debit transactions may be unavailable. The stations may only be able to accept cash.

j) When planning for paratransit vehicles and taxis, consider that the space limitations inside those vehicles may mean that families become separated. If this is the case, family reunification will be an issue.

k) Proper record keeping is an absolute necessity to ensure that private companies and non-profits are reimbursed for expenses they incur. It is also important that they are monitored to ensure that they are reporting correctly to avoid fraud and abuse.

l) Agreements need to be developed for reimbursement for usage and damages.

2. Transit Buses

a) Advantages

(1) The buses are readily available and have great mobility.

(2) They have a relatively quick response time.

(3) They are familiar to the public.

(4) Maintenance of buses and training of personnel are based on federal standards.

(5) They use established and standardized communications systems.

b) Limitations

(1) Buses typically have just two wheelchair securement locations for people who use wheelchairs and mobility devices.

(2) Compressed natural gas (CNG) buses are limited to fixed refueling points.

(3) Large vehicles have wider turning radii, take up more space on the road, and may not be able to travel down certain roads.

(4) The buses may have other service obligations that they must meet.

(5) Each bus can accommodate two wheelchairs, and a majority of the buses are lift-equipped.

3. School Buses

a) Advantages

(1) The buses are readily available and have great mobility.

(2) They have a relatively quick response time.

(3) Maintenance of buses and training of personnel are based on federal standards.

(4) They use established and standardized communications systems.

b) Limitations

(1) The buses have limited space for people in wheelchairs and mobility devices.

(2) CNG buses are limited to fixed refueling points.

(3) During the school year, buses will already be tasked with a dedicated route.

(4) During the summer and holidays, it may be harder to find and recall bus drivers.

(5) Large vehicles have wider turning radii, take up more space on the road, and may not be able to travel down certain roads.

(6) The bus drivers are often private contractors and therefore may not be as willing to participate in a public evacuation.

(7) Planners should consider including wording regarding the use of personnel and resources in emergency situations as part of school bus contracts.

4. Paratransit[251]

a) Advantages

(1) Paratransit has a relationship with its current riders.

(2) The buses are accessible by a wide variety of mobility devices.

(3) Training of personnel is based on federal standards.

(4) The buses are capable of going directly to an individual home.

(5) The buses include four to six wheelchair tie-downs.

b) Limitations

(1) The buses have limited space for passengers.

(2) They may not be able to accommodate mobility devices larger than the federal requirement of 30 inches wide, 48 inches long, and 600 lbs. in total weight (rider and mobility device).

[251] http://www.asila.org/home/.

(3) The bus drivers are often private contractors and therefore may not be as willing to participate in a public evacuation.

(4) Their overall capacity is generally smaller than the capacity of school or transit buses.

5. Intercity Motor Coach/Charter Buses

a) Advantages

(1) Some buses are lift-equipped and wheelchair-accessible.

(2) They have fewer day-to-day obligations than a transit or school bus.

(3) There is an abundant supply in the Los Angeles area.

(4) They have overhead and underbus cargo areas.

(5) They have on-board restrooms.

b) Limitations

(1) Private resources have no legal obligation to respond.

(2) Some buses have scheduled routes, assignments, or other priorities and may not be available for service.

(3) There is limited space for people with wheelchairs or mobility devices.

6. Vehicles for Hire (Taxis, Limousines, etc.)

a) Advantages

(1) There is an abundant supply in the area.

(2) They are licensed by the appropriate local authority.

(3) They include a variety of sizes and types that can be fit to particular requirements.

b) Limitations

(1) There is a public perception that passengers will have to pay for the service.

(2) Contracting with taxi services could lead to bandit taxis taking advantage of evacuees.

(3) There is limited space for passengers.

(4) Most vehicles for hire are not wheelchair accessible.

(5) Large numbers of vehicles relative to the population being serviced can increase congestion on the roads.

(6) Because of the decentralization of these resources, it may be difficult to coordinate them.

7. Buses and Vans of Churches, Nongovernmental Organizations, and Private Schools

a) Advantages

(1) Some individuals in the target evacuation population will already have a relationship with the churches, nongovernmental organizations (NGOs), and/or private schools.

(2) These buses and vans are already geographically dispersed within the community.

(3) These buses may be located at or associated with sites that also serve as shelters.

(4) There may be no cost associated with these resources.

b) Limitations

(1) These resources and organizations may be unfamiliar to some citizens.

(2) The buses and vans may already be committed to another route or assignment.

(3) Maintenance of vehicles and driver training may not be held to any consistent standard.

(4) During holiday times, it may be harder to recall drivers.

(5) Pets may not be welcomed on the buses and vans.

(6) These resources may already be in use serving the associated organizations or communities and therefore may not be publicly available.

8. Shuttle Buses and Vans

a) Advantages

(1) Buses and vans are readily available and have great mobility.

(2) They may have a relatively quick response time.

b) Limitations

(1) Buses and vans have limited space for people with wheelchairs or other mobility devices.

(2) Operators may encounter physical and legal barriers to accessing some urban areas.

(3) Operators may already have a fixed route and not be available to assist.

9. Correctional Facility Buses and Vans

a) Advantage

(1) During a lockdown situation during a disaster, these buses and their drivers may be available.

(2) Maintenance of buses and training of personnel are based on federal standards.

(3) They use established and standardized communications systems.

b) Limitations

(1) There is a public stigma/perception against transporting "free" citizens in a corrections vehicle.

(2) These resources may already be committed to transporting or evacuating inmates.

B. Ground Transport: Rail

While rail evacuation is limited by track service area and limited boarding platforms, the access constraints are offset by the potentially large numbers of passengers able to be moved and the ability to transport multiple evacuees with access and functional needs.

1. Urban/Light Rail (Intra-City Commuter Rail)

a) Capacity, Range, and Cycle Time

(1) Urban rail car capacity is approximately 124 each.

(2) In a maximum load, a train may carry up to 1,860 passengers.

(3) The range is 500 miles, and the cycle time is up to 10 minutes per train.

b) Accessibility for Access and Functional Needs Populations

(1) Staging and access areas will be limited in space. Most stations are smaller than other types of rail transportation.

(2) Commuter rail stations are equipped with elevators and are generally easily accessible.

(3) Cars have open areas for individuals with access and functional needs, which includes room for attendants, service animals, and mobility equipment.

c) Considerations

(1) Commuter rail systems have the ability to transport large numbers of evacuees in a single trip but are limited by track service area, right of way, and access/boarding areas.

(2) The infrastructure (e.g., tracks, power source, and control devices) may be damaged by the event. If there is major damage to the power supply and no damage to underground tube routes, trains could be removed by High Rail Vehicles (Gas Powered Trucks), which could be used to transport emergency personnel and supplies from one part of the city to another.

(3) Trains that require specialized operators and electrical power are limited in range to local services but may be able to intersect with other rail systems.

(4) There are no onboard services (e.g., restrooms, water dispensers, etc.).

(5) Boarding and onboard security will be required.

(6) The Metro system is separate from Metrolink and other rail properties in the LAOA.

(7) Some of the stations have large parking areas that may be used for staging and assembly.

2. Metrolink Commuter Rail

a) Capacity, Range, and Cycle Time

(1) Car capacities range from 140 to 150 seated, with a 300 crush capacity. Typically, a train will consist of six cars and one locomotive for a total capacity of approximately 850 passengers seated, with a 1,600 crush capacity.

(2) Locomotives may travel up to 900 miles and can access the Amtrak system.

(3) Loading and unloading time is approximately 10 minutes.

(4) Cycle time is 15 minutes from arrival to departure.

b) Accessibility for Access and Functional Needs Populations

(1) This resource has generally good accommodations for access and functional needs populations. All stations meet ADA requirements. Some stations have elevators, although these may be inoperable during an incident.

(2) Boarding and detraining is simple and direct.

(3) Space is available for attendants, service animals, and mobility equipment.

(4) Onboard restroom facilities (one restroom per car) are accessible to passengers with access and functional needs.

c) Considerations

(1) This resource has the ability to transport large numbers of evacuees in a single trip.

(2) It is able to transport evacuees over relatively long distances.

(3) It is limited by track service areas, right of way, and access/boarding areas.

(4) Infrastructure (e.g., tracks, power source, and control devices) may be damaged by the event.

(5) Locomotives are diesel powered. They do not rely on electricity for power but will require power for signaling, switching, and communications.

(6) In addition to a crew and 2,000 gallons of fuel per locomotive, onboard security will be required.

(7) Each car has one accessible restroom and one drinking water dispenser.

(8) Many of the stations have large parking areas that may be used for staging and assembly.

3. Amtrak Intercity Service

a) Capacity, Range, and Cycle Time

(1) Passenger rail cars come in varying configurations.

(2) Lounge cars will seat between 31–53 passengers while older, single-level cars have either 60 or 84 seats.

(3) Double-deck Superliner cars have 12 seats in the lower level and 62 in the upper level.

(4) At maximum load, a train may carry up to 1,000 passengers per train (20 cars, 50 persons per car).

(5) Locomotives are capable of traveling up to 900 miles per fuel load.

(6) Passenger loading and unloading time is approximately 10–20 minutes.

(7) Cycle time is minimal from arrival at the evacuation boarding point to the departure.

b) Accessibility for Access and Functional Needs Populations

(1) Generally good accommodations are available for access and functional needs populations.

(2) Room is available for attendants, service animals, and mobility equipment.

(3) The lower level Superliner coaches are accessible to individuals with access and functional needs.

(4) All restrooms are accessible to individuals with access and functional needs.

c) Considerations

(1) Intercity rail transport has been effectively employed in past disasters due to its ability to transport large numbers of evacuees in a single trip.

(2) Intercity rail is able to transport hundreds of passengers relatively long distances (hundreds of miles) within service areas.

(3) Most passenger cars are equipped with a restroom, and a number of cars are configured for food and water services.

(4) Intercity rail is limited by track right of way and access/boarding areas.

(5) Infrastructure (e.g., tracks, power source, and control devices) may be damaged by the event and may require specialized operators.

(6) The locomotives require large amounts of fuel (2,500 gallons per locomotive) and have generally less passenger room than urban/light rail services.

(7) Onboard security will be required.

(8) A major assembly point may be Union Station, connecting with light rail and other transportation modes.

d) Employment of intercity rail services will require considerable pre-incident planning with Memoranda of Understanding (MOUs) in place to facilitate their mobilization.

C. Marine Transport

1. Overarching Considerations

a) While all water-borne transport is limited by the ability to properly dock and load, these constraints are offset by the ability to transport large numbers of passengers and many evacuees with access and functional needs.

b) Marine facilities may be isolated from damaging events that occur inland, or they may be the focal point of major damage due to a tsunami or earthquake.

c) Marine assets offer the ability to assemble a large number of evacuees in a secure environment. Resources in the LAOA vary from the large ports of Long Beach and Los Angeles to the many private marinas and dock operations. The former offers assets of ferry boats, excursion ships, and large cruise ships. The latter can provide smaller excursion and tour boats.

d) The mobilization time will vary widely. While all private operations will require MOUs and pre-incident planning, the larger the ship and crew, the greater amount of preparation and mobilization time is required.

e) Given the geographic location of the LAOA, marine transportation is limited to providing personnel or equipment transport to Catalina Island and coastal marinas and responding to ferry/cruise ship emergency "Mayday" scenarios.

2. Ferry

a) Capacity, Range, Size, and Cycle Time

(1) Ferries can transport 100 to 450 ambulatory persons per ship with a range of 100–300 miles.

(2) Cycle time is 15–20 minutes for loading.

(3) Typical travel speed will cover 34–39 knots.

(4) Ferry length varies but is typically around 40 meters.

(5) Ferry draft varies but is typically about three meters.252

b) Accessibility for Access and Functional Needs Populations

(1) Ferry boats have space and access facilities for mobility devices and the ability to configure space for passengers with access and functional needs.

c) Considerations

(1) Ferries have been successfully employed in several major disasters.

(2) Their flexibility and size will move large passenger loads efficiently for extended time periods.

(3) A large number of passengers may be assembled in the docking area within a secure environment and cycled out rapidly if the pre-incident planning allows for rapid mobilization.

(4) Passengers may be transported via ferry to a shelter area, or other means of transportation, outside the disaster impact zone.

(5) Ferries require no special fuel.

(6) With a qualified crew of 3–5 and a licensed boat operator with a specific tonnage requirement, they are virtually self-sufficient.

(7) Ferries require a dock area of sufficient draft and boarding capability and a security presence at the dock and onboard.

(8) Most ferry boats are equipped with restrooms that are accessible by individuals with access and functional needs.

3. Excursion/Tour Boat

a) Capacity, Range, Size, and Cycle Time

(1) Excursion/Tour boats can transport from 35 to as many as 500 individuals per boat with a range of 100–300 miles.

(2) Cycle time will include 15–20 minutes to load and unload.

(3) Speeds may approach 26 knots.

252 A ship's or boat's "draft" is the minimum depth of water it can safely navigate.

(4) Boat length varies but is typically around 20 meters.

(5) Boat draft varies but is typically about one meter. 253

b) Accessibility for Access and Functional Needs Populations

(1) Excursion/Tour boats have designated access and functional needs areas and the potential for apportioned deck space.

c) Considerations

(1) Excursion/Tour boats are able to cache and serve food and water.

(2) A large number of passengers may be assembled in the docking area within a secure environment.

(3) Passengers may be transported to shelter areas or to other means of transportation within a safe and secure area.

(4) Excursion/Tour boats require no special fuel.

(5) With a crew of 3–5 and a licensed boat operator with a specific tonnage requirement, they are virtually self-sufficient.

(6) They may require a portable quay to load and unload passengers.

(7) Mobilization time is minimal if pre-incident planning and MOUs are in place.

4. Cruise Ships

a) Capacity, Range, Size, and Cycle Time

(1) Cruise ships will hold 800 to 5,000 passengers each and are able to travel several thousand miles over a time span of approximately two weeks.

(2) They require several hours to load and unload.

(3) Travel speed is 22–30 knots maximum.

(4) Cruise ship length varies but is typically around 300 meters.

(5) Cruise ship draft varies but is typically about nine meters. 253

b) Accessibility for Access and Functional Needs Populations

[253] A ship's or boat's "draft" is the minimum depth of water it can safely navigate.

(1) Cruise ships offer areas for medical treatment and large spaces for access and/or functional needs populations.

(2) Cruise ships are equipped with multiple passenger and freight elevators.

c) Considerations

(1) Cruise ships are mostly self-contained in terms of fuel, communications, food, and water.

(2) They are able to receive and transport thousands of evacuees at a time.

(3) The dock loading areas are able to accommodate thousands of people in a secure environment.

(4) Cruise ships require deep draft docking areas, room to maneuver in the harbor, and large numbers of crew and support staff.

(5) Mobilization time is considerable, even with pre-incident planning and contracting procedures.

(6) While cruise ships do not need external power, they require thousands of gallons of fuel to operate.

(7) Cruise ships are amply equipped with restrooms, food services, and dining facilities that are available to individuals with access and functional needs.

5. Other possible maritime resources include:

a) Military

(1) Landing Craft Air Cushion (LCAC)

(2) Landing Ship Docking (LSD)

b) Commercial

(1) Cargo Container Ships

(2) Fishing Vessels

c) Private Pleasure Craft

6. More planning information is available from the following sources:

a) Southern California Area Maritime Security Plans

b) Water Emergency Transportation Authority, San Francisco, CA (http://www.watertransit.org/files/EMPlan/EWTSMP061809.pdf)

c) U.S. Coast Guard, Long Beach/Los Angeles (http://homeport.uscg.mil/)

d) Washington State Transportation Emergency Planning (http://www.wsdot.wa.gov/)

e) Emergency Planning Templates and Checklists, King County, Washington (http://www.emd.wa.gov/)

D. Air Transport

Air evacuation involves coordination among multiple agencies including federal, state, and local partners, as well as private sector air operators. In a catastrophic disaster, the aviation system may be damaged or disrupted. This may include physical damage to runways, taxiways, and ramps, and/or to the support infrastructure. Careful planning and execution is needed to ensure the complex aviation operation system is fully functional. This includes damage assessment, immediate repairs and restoration of navigation services, airspace and air traffic control operations, emergency power, and lighting.

1. Fixed-Wing Aircraft

a) Capacity, Range, and Cycle Time

(1) Fixed-wing resources can carry up to several hundred evacuees at a time at a range of hundreds of miles.

(2) Typical passenger aircraft can carry from 40 evacuees up to 300 per aircraft.

(3) These resources will require up to 15 minutes to load and unload and immediately return to service, fuel permitting.

b) Typical aircraft capacity and range

(1) Civilian examples

(a) A-300: 138; 3,200 miles

(b) MD 80: 150; 1,900 miles

(c) 757: 166; 2,700 miles

(d) 767: 230; 3,500 miles

(2) Military examples

(a) C-9: 60; 1,100 miles

(b) C-130: 92 ambulatory passengers, 72 stretcher patients; 2,000 miles

(c) C-17: 100; 2,300 miles

(d) C-5: 73, 3,000 miles

c) Accessibility for Access and Functional Needs Populations

(1) In proper configuration, specialized aircraft can transport relatively large numbers of non-ambulatory individuals.

(2) Mechanized lift platforms are required for civilian aircraft and, unless the unit is a specialized plane, seating is limited for individuals with access and functional needs.

(3) Military aircraft will have full dropdown ramp access and may be configured for access and functional needs passengers, though procedures will be required for securing passengers and mobility devices within the aircraft.

d) Considerations

(1) These resources can travel long ranges. They cover great distances in a short time.

(2) They require runways, dedicated crews, specialized fuel, and support.

(3) Following an earthquake or tsunami, runway and ramp areas must be surveyed by a specialized damage assessment team.

(4) Other required support includes ground security, shelter, water and restrooms for waiting evacuees, boarding security and passenger manifesting, communications and air traffic control systems, and sufficient supply of proper types of fuel.

(5) Flow of evacuees must be closely coordinated with the Air Operations Branch of the Operations Section of the EOC/ CEOC to ensure safe and smooth flow of air assets into and out of evacuation hubs. While the air evacuation is the most expensive (cost per passenger) method of emergency evacuation, it offers the ability to rapidly relocate a given population of up to 300 evacuees. This may be appropriate in the relocation of populations to an area of appropriate care and shelter.

e) More planning information is available from the following sources:

(1) Regional Cooperation, Coordination, and Communication among Airports during Disasters,

American Public University System
(http://www.airportstudy2009.com)

(2) California Air National Guard
(http://www.ca.ang.af.mil)

2. Rotary-Wing Aircraft

a) Capacity, Range, and Cycle Time

(1) Capacities range from four to eight in smaller units and up to 50 in military craft (CH 47 Chinook).

(2) The range is up to 200 miles.

(3) Loading time is up to 10 minutes, and air speed is approximately 150 mph.

b) Accessibility for Access and Functional Needs Populations

(1) Unless specially configured for individuals with access and functional needs, rotary-wing aircraft are generally unsuited for this segment of the population.

(2) Space will also be at a premium for service animals and mobility devices.

c) Considerations

(1) The advantage of rotary-wing aircraft is that they have virtually unlimited landing and takeoff capability. This offsets their limited capacity per trip.

(2) Except in extreme cases in which limited access prevents any other evacuation method, especially in cases with individuals with access and functional needs, rotary-wing aircraft may not be the most suitable transportation method.