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Executive Summary

Common in many disasters is the need for local jurisdictions to shelter displaced persons that have been evacuated from their place of residence. Many of these displaced individuals have medical needs that require some level of skilled medical care to assist them in maintaining their usual level of health and avoid the need for hospitalization. The Guidance for Sheltering Persons with Medical Needs is developed to assist local jurisdictions in addressing this need by planning for and operating medical shelters. It provides local jurisdictions with a framework and operational guidance to meet the medical needs of displaced persons during an emergency. This guidance provides statewide standardization on key concepts and issues regarding sheltering persons with medical needs while being flexible to allow local jurisdictions to adapt the guidance to meet jurisdiction- and incident-specific requirements.

California’s need to shelter persons with medical needs is considerable. California is the most populous state in the country with over 38 million residents and a geographic area covering 163,696 square miles, the third largest in the nation. California experiences disasters on a regular basis and can expect the number of displaced persons in need of medical care during a disaster to escalate. In 1997, the Winter Storms in California caused the evacuation of over 150,000 people from their communities. Approximately 50,000 individuals were displaced during the 2003 California Cedar Fires. The 2007 Southern California Wildfires caused the evacuation of approximately half a million residents. In each one of these emergencies, it is estimated that 5 – 10 percent of the displaced populations required medical care while housed within a shelter.

In California, the elderly population is expected to grow more than twice as fast as the total population. By 2020 it is expected that there will be a statewide increase of 122 percent for individuals in the 65 and older age group. The 85 years and older age group is projected to increase at an even faster rate. As California’s population grows, and the aging population increases, the number of persons in need of medical care during a disaster will continue to escalate.

An aging population is also associated with an increase in medically dependent individuals with chronic medical needs. According to the Centers for Disease Control and Prevention, the number of individuals who are dependent upon medical care, medication assistance, and sophisticated medical equipment is growing nationwide. Approximately 60 percent of baby boomers have been diagnosed with at least one chronic medical condition such as arthritis, diabetes, heart disease and hypertension. In California, 46 percent of the population (approximately 16 million) has chronic health conditions. Nearly half of those have multiple chronic conditions.

With an increasingly aging population, an expanding number of individuals with chronic medical conditions, and minimal hospital surge capacity, it is likely that California’s future disaster incidents will cause serious stress on the existing healthcare delivery system. One way to mitigate this stress is to
Sheltering Persons with Medical Needs

utilize medical shelters to increase the capacity to shelter persons, thereby minimizing a surge at existing healthcare facilities.

Medical shelter activities include significant responsibilities for local government, community healthcare professionals and nongovernmental organizations. Medical shelter operations may require these partners to accept new responsibilities and cooperate in unprecedented ways.

The Guidance for Sheltering Persons with Medical Needs includes the following sections:

Part I – Foundational Knowledge discusses medical shelters, the continuum of care, an overall integrated concept of medical care, medical shelter roles and responsibilities, legal considerations, and an overview of the medical shelter planning process. Part I is a prerequisite to Parts II and III.

Part II – Medical Shelter Guidance contains planning information related to establishing and operating a medical shelter, medical shelter coordination, site considerations, support services, infrastructure operations, staffing, supplies, pharmaceuticals, equipment, intake, triage, medical operations, fatality management, administration, demobilization, finance, and reimbursement.

Part III – Medical Shelter Toolkit includes sample forms, checklists, and other materials to assist jurisdictions as they develop and work to strengthen their own plans for sheltering persons with medical needs.

To inform the project, the California Department of Public Health called on stakeholders to identify the greatest needs and challenges of local government in sheltering persons with medical needs. A review of current practices review was conducted to identify lessons learned from real world events and call out key components, operational approaches and tools that should be considered for incorporation into the California Guidance. Over 100 existing plans, guidance documents and articles were reviewed. Other sources included multiple interviews with subject matter experts having field level sheltering experience, and input from a multi-disciplinary local and State workgroup. This work is consolidated in a companion volume titled, California Department of Public Health Sheltering Persons with Medical Needs: Current Practices Review.

The Guidance for Sheltering Persons with Medical Needs contains flexible, scalable concepts. Each local jurisdiction will need to evaluate these concepts within relevance to their specific needs; the document should not be considered a mandate or requirement of the State of California. It is intended to augment and not replace local planning efforts.

The Guidance for Sheltering Persons with Medical Needs may be useful to a variety of readers, including public health, emergency management, social services, the disability community, and various non-governmental organizations. It is written so that individuals will differing levels of experience can understand its key concepts. This guidance is intended for a broad audience including those who have
Sheltering Persons with Medical Needs

not developed a medical shelter plan, as well as for those who are looking to update their plans. For jurisdictions without existing plans, the guidance can be used as a starting point in developing a framework to address the many complex issues that arise when sheltering persons with medical needs during an emergency. For those jurisdictions with existing plans, the guidance is offered as support to strengthen and update those plans by providing issue-specific guidelines and tools developed from lessons learned during recent events. Application of this guidance will be based upon local plans and policies, the complexity of the incident, and the availability of skilled staff and resources.
PART I
Foundational Knowledge
PART I: FOUNDATIONAL KNOWLEDGE

1. Overview

Part I: Foundational Knowledge will walk the reader through the foundational elements of medical shelters. It provides background information and context for medical shelters by:

- Presenting the role of medical shelters within the continuum of care;
- Defining medical shelters as temporary sites within the continuum of care that may be established during an emergency to expand the existing healthcare delivery system;
- Presenting potential medical shelter roles and responsibilities for local response partners as well as the State and federal government;
- Addressing legal considerations for medical sheltering; and
- Providing an overview of the medical shelter planning process.

2. Continuum of Care

2.1. The Continuum of Care

On a day-to-day basis the health care delivery system includes a comprehensive range of delivery sites where medical services are provided. These sites include home health, clinics, skilled nursing facilities, medical offices, and hospitals in addition to other health care facilities. During an emergency, this continuum of care expands to accommodate medical needs through the expansion of existing healthcare delivery sites and the creation of new temporary sites where care will be delivered. The range of sites within a community’s continuum of care will vary based on the needs of the emergency and the Operational Area plan to organize the continuum of care to maximize the use of available healthcare resources.

The continuum of care model described in the California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies, Volume II: Government-Authorized Alternate Care Sites depicts the expansion of the existing healthcare delivery system to meet patient care demands during a healthcare surge. Although it incorporates field treatment sites and government authorized alternate care sites, it does not address sheltered populations with medical needs that are displaced by the emergency.

Emergencies where large numbers of individuals with medical needs are displaced from their homes can also create a strain on the existing healthcare system. In many cases these individuals can maintain their usual health at home, but when displaced may need some level of medical care to
Sheltering Persons with Medical Needs

avoid hospitalization. If their medical needs are not met within the shelter, the existing healthcare system can quickly become overwhelmed, creating a healthcare surge.

Figure 1 depicts healthcare services within the continuum of care that are expanded during an emergency to incorporate temporary sites including medical shelters that may be established to assist the existing healthcare delivery system prevent or alleviate a healthcare surge.
Figure 1 – Continuum of Care

<table>
<thead>
<tr>
<th>Incident</th>
<th>Phase 1: Emergency</th>
<th>Phase 2: Healthcare Surge</th>
<th>Phase 3: Establishment of Government Authorized Alternate Care Sites (ACS)</th>
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- Field Treatment Site(s)
- Existing Healthcare Facilities
- Surge - Capacity Override
- Existing Facility Assets outside Operational Area
- Existing Facility Assets within Operational Area
- State and Federal Resources
- Government Authorized ACS (includes Mobile Field Hospitals)
- Medical Shelters alleviate pressure on the healthcare surge continuum by diverting certain individuals up front who might have otherwise been sent to healthcare facilities.
- Activation of any site within the healthcare surge continuum is incident-driven (i.e., not all sites will be activated for all incidents).
In Figure 1, movement through the continuum of care shown begins with the impacted population represented in the red box. Some individuals within this population will have medical needs. As the incident progresses, the population will move from left to right as shown by the directional arrows. Affected individuals requiring medical care will be directed to a site capable of meeting their needs.

The top portion of Figure 1 focuses on the movement of affected individuals with injuries or advanced medical conditions that may be best served by an existing healthcare facility. As time passes, the healthcare facilities may experience an influx of patients that eventually exceeds capacity leading to a healthcare surge and patient care may move from individual based care to population based.

The bottom portion of the figure adds sheltering to the continuum. This population includes individuals with medical needs that have been displaced from their place of residence as a result of the emergency. These individuals may have their needs served within a shelter environment.

2.2. Definitions within the Continuum of Care

Table 1 provides additional clarification and detail on the temporary sites depicted within the continuum of care model shown in Figure 1. It provides definitions, indications for activation, and the typical lead agency for each site. These temporary sites are usually defined as field treatment sites, general population shelters, medical shelters, and government authorized alternate care sites.

<table>
<thead>
<tr>
<th>Location Name</th>
<th>Definition</th>
<th>Possible Indications for Activation</th>
<th>Lead Agency</th>
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<tr>
<td>Field Treatment Site (FTS)</td>
<td>Temporary location for triage, emergency medical treatment, management and care of casualties in a field setting, usually when permanent medical facilities are unavailable or lack capacity. Stabilized patients requiring a higher level of care are transported to receiving facilities when possible. FTSs are generally intended to operate for up to 48 hours or until injured/ill patients stop arriving.</td>
<td>Casualty incident expected to exceed local patient care capacity. Protracted, large-scale response with multiple casualties. Planned event where the provision of medical treatment is anticipated, not necessarily when resources are overwhelmed.</td>
<td>Activated by local Emergency Medical Services for onsite field incidents. May also be activated in coordination with the Operational Area Emergency Operations Center Medical Health Branch. Staffed by local Emergency Medical Services and medical providers (e.g., California Medical Assistance Teams).</td>
</tr>
<tr>
<td>General Population Shelter</td>
<td>Temporary location where mass care is provided to displaced persons. General populations include individuals with access and functional needs and those requiring basic first aid.</td>
<td>Displacement of a population from their place of residence.</td>
<td>Typically activated and staffed by local government and the American Red Cross in coordination with the Operational Area Emergency Operations Center.</td>
</tr>
</tbody>
</table>
## 2.3. Medical Shelters

Two types of shelters are identified in this guidance document: general population and medical. Medical shelters meet the medical needs of the impacted population and serve to expand response capacity by placing certain individuals into a shelter rather than sending them to a healthcare facility. Medical shelters represent one option or tool within the continuum of care that can be established to meet the medical needs of displaced individuals during an emergency. They may be established at any point in the continuum of care based on the locally determined need and resource availability. Following is an explanation of the role of these shelters in relation to the other temporary medical care sites established during an emergency within the continuum of care.

<table>
<thead>
<tr>
<th>Location Name</th>
<th>Definition</th>
<th>Possible Indications for Activation</th>
<th>Lead Agency</th>
</tr>
</thead>
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<tr>
<td>Medical Shelter</td>
<td>Temporary location providing medical care and support to displaced individuals to maintain their level of health during an incident. Individuals from the impacted community in these shelters receive assistance with needs that require skilled medical care but not hospitalization.</td>
<td>▪ Displacement of a population with medical needs. ▪ Immediate needs of the incident exceed the ability to accommodate the impacted population in “like facilities” (e.g.: Skilled Nursing Facility evacuation). ▪ Need to reduce the strain on the overall healthcare system. ▪ Persons require a higher level of medical skill, resources or infrastructure than can be provided in a general population shelter.</td>
<td>Typically activated by local public health and Emergency Medical Services Agencies with support from social services or the mass care and shelter lead for the Operational Area. ▪ Staffed by local public health, Emergency Medical Services and medical personnel.</td>
</tr>
<tr>
<td>Government Authorized Alternate Care Site</td>
<td>Location not currently providing healthcare services to be converted to enable the provision of healthcare services to support, at a minimum, inpatient and/or outpatient care required after a declared catastrophic emergency. Sites are not part of the expansion of an existing healthcare facility. They are designated under the authority of the local government when existing healthcare facilities are unable to meet demand for services. A Government Authorized Alternate Care Site may be a Mobile Field Hospital.</td>
<td>▪ Overall healthcare system has exhausted available resources through surge, with additional capacity still required. ▪ Incident creates need for increased acute medical care capacity.</td>
<td>Typically activated by local government via a public-private partnership and can be supported by local public health, Emergency Medical Services and medical providers (e.g., California Medical Assistance Teams).</td>
</tr>
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2.3.1. Intended Purpose of Medical Shelters

The intent of a medical shelter is to address the medical needs of individuals who have been displaced from their place of residence as a result of the disaster and require temporary housing and medical support. The medical needs of these individuals require medical care beyond what can be accommodated in a general population shelter, but not complex or severe enough to necessitate hospitalization.

The goal of a medical shelter is to assist displaced individuals in maintaining their usual level of health during an emergency. Many displaced individuals have chronic medical conditions and may experience difficulty due to the stress of the disaster, or lack of planning or resources. Individuals who generally can manage their health at home through routine doctor visits and prescribed medications may experience an exacerbation of symptoms related to their underlying disease. For example, some individuals with chronic obstructive pulmonary disease may have increased respiratory problems as a stress response to the incident. Others with hypertension or diabetes may experience varying blood pressure or glucose levels that are normally controlled with routine medications. Although these individuals do not require hospitalization, they may need medical care to adjust their medications or require more frequent monitoring of their condition.

Application of this guidance is flexible based upon the jurisdictional resources, the judgment of the medical shelter clinicians and the individual’s right to self-determination. Given these considerations, the following examples provide situations where a medical shelter may be appropriate:

- An individual with insulin dependent diabetes may experience changes in their usual level of health during an emergency. If this individual is closely monitored and medications adjusted accordingly by skilled medical professionals, hospitalization can be avoided. However, this individual cannot be accommodated in a general population shelter if their needs require continuous medical monitoring.

- An asthmatic that normally controls their medical condition with maintenance medications experiences increased medical needs due to the stress of the incident or decreased air quality as in a fire incident may need a change in medication or frequent nebulizer treatments. If properly managed, this individual can be housed in a medical shelter and not impact the local emergency services such as ambulances and emergency rooms.

2.3.2. Differentiating Medical Shelters from Other Temporary Sites

Medical Shelter vs. General Population Shelter

Medical and general population shelters differ in the level of medical support they can provide. As a rule, general population shelters cannot provide continuous skilled medical support. They are not equipped or staffed to provide medical care beyond basic first aid, assistance with self-care, and community level nursing when licensed nurses are available.
In California, the American Red Cross is the primary response organization that operates general population shelters during disasters in coordination with local government. In most cases American Red Cross has the ability to provide access to medical care outside of the shelter, and assist with self-care by providing transportation services, prescription refills, and storage of medications needing refrigeration. However, it does not have the ability to provide continuous medical monitoring including on-going medical treatment or medication adjustment. Medical shelters are established to meet individual needs which require this type and level of support.

Figure 2 provides an example of the difference in care provided by each site. Transfers between these sites may occur according to the individual’s condition and required level of support.

**Medical Shelter vs. Government Authorized Alternate Care Site**

Medical shelters differ from government authorized alternate care sites in that medical shelters may be activated prior to the occurrence of a declared medical surge, are established to provide medical care to displaced individuals, and not intended to absorb the excess patient load that healthcare facilities experience during a health care surge.

Government authorized alternate care sites may be established during a pandemic or other similar emergency where the entire healthcare system is impacted, necessitating a move into population based care. Local governments may choose to activate government authorized alternate care sites to care for individuals who would otherwise receive hospital level care, but due to the healthcare surge, no hospital beds are available. Such sites are established as a last resort to assist in depressurizing healthcare facilities when the entire system is experiencing a healthcare surge.

In contrast, medical shelters may be activated early in an incident to lessen the impact of an increased need for medical support. Medical shelters address the healthcare delivery from the front end preventing a surge on the existing healthcare delivery system. They can be utilized to divert certain individuals with medical needs away from healthcare facilities, reducing resource demand on the healthcare system and preventing the need for a community-wide surge.

**Medical Shelter vs. Field Treatment Sites**

Medical shelters differ from field treatment sites by the level of medical care and support provided. Field treatment sites are established as temporary locations for triage, emergency medical treatment, and management and care of casualties in a field setting. These sites are usually set up when permanent medical facilities are unavailable or lack capacity. The intended level of care at these sites is to treat and release minor injuries and/or stabilize patients and transport them to a higher level of care when possible. These sites are not designed to provide housing and feeding or hospital level care. The support provided at medical shelters includes both care and shelter and skilled medical care. Medical shelters are intended for displaced populations and not for treating and releasing individuals back into the community.
2.3.3. Medical Shelter Activation Considerations

The decision to activate a medical shelter is based upon each jurisdiction’s defined role for the site and the needs of the incident. Generally, jurisdictions may consider activating a medical shelter if a notable percentage of their population requires or will likely require continuous medical support beyond what is available in a general population shelter.

Consideration should be given to the activation of a medical shelter following an incident if there is a disruption or strain on the public health and medical system and displaced individuals have medical needs.

Other considerations may include an emergent evacuation of a healthcare facility. Although existing healthcare facilities (e.g. skilled nursing facilities and hospitals) are required to have their own emergency plans which include evacuation, in some circumstances the immediacy of the incident will preclude the ability of a healthcare facility to evacuate their patients to a “like facility”. In this situation, medical shelters may be a viable short term alternative.

2.3.4. Medical Shelters within the Continuum of Care

The role of the medical shelter within the continuum of care will largely depend on the roles and responsibilities assigned by the jurisdiction, the availability of resources, and the complexity of the incident. Two examples that follow depict how a medical shelter could be utilized in relation to other sites within the continuum of care:

- **An earthquake scenario.** As a result of an earthquake, the existing healthcare system may experience an overwhelming influx of patients creating a medical surge. The situation may require local jurisdictions to implement surge strategies including the establishment of temporary sites to deliver medical care. Field treatment sites can be established to treat and release or stabilize and transfer victims injured as a result of the incident. Establishing field treatment sites will decrease the load on hospital emergency departments as a result of field triage and the treatment and release of persons with minor injuries. Other strategies may include expanding healthcare facility capacity. Whereas field treatment sites address the immediate medical needs of individuals injured or affected by the incident, they do not meet the longer medical needs of displaced individuals. Medical shelters are another tool local jurisdictions can use to reduce the impact on healthcare facilities. Medical shelters are used to address the medical needs of displaced individuals that would otherwise seek minor medical care at a hospital, but have medical needs could not be met in a general population shelter.

- **A fire scenario.** If a large number of individuals are evacuated from their homes, a jurisdiction may elect to activate a medical shelter to house displaced individuals that need medical care above what can be provided in general population shelters, but do not require hospitalization. This would avoid a surge in the existing healthcare delivery system.

Most displaced individuals with medical needs that existed prior to the incident can be accommodated through the medical support provided at shelters. Typically those with significant injuries and medical conditions resulting from the incident will require medical care from the existing
healthcare system such as a hospital or clinic. This may also be true of individuals with pre-existing conditions that have decompensated.
Sheltering Persons with Medical Needs

Figure 2 – Sheltering Within the Continuum of Care

The diagram illustrates the continuum of care for individuals with medical needs, ranging from general population shelters to hospital-level care. It categorizes populations based on their medical needs and the level of care they require.

**General Population Shelter**
- Locations: General Population Shelter
- Target Populations: General Population
- Intent: General Population Shelters meet the needs of the general population and accommodate those with disabilities, access and/or functional needs.
- Load: Primary: Mass Care

**Medical Shelter**
- (co-located or stand-alone)
- Guidance: Medical Shelter Guidance
- Medical Needs Population
- Intent: These shelters serve stable medical populations displaced during an incident. This population requires skilled care beyond what can be provided in a General Population Shelter. The Medical Shelter provides sufficient medical care to ensure the sheltered individual maintains his or her usual level of health.
- Load: Primary: Health and Medical Support: Health and Medical

**Hospital Level Care**
- Healthcare Planning and CDPH Standards and Guidelines for Healthcare Surge During Emergencies
- Acute / Unstable Population
- Intent: Inpatient/Outpatient: Facilities providing inpatient/outpatient care will treat patients who present with general inpatient or outpatient care requirements.
- Critical: Facilities providing critical care will treat patients with complex and/or critical care requirements, such as surgery or intensive care unit needs. Every attempt should be made to keep critical care patients in hospitals.
- Load: Primary: Health and Medical Support: Mass Care

**Clinical Judgment and Flexibility**
- The structure above is dependent on the clinical judgment of those providing the level of care specified and the right to self-determination of the shelter seeker. The system is intended to be flexible and to depict the intent of each location; actual operations may vary depending on the availability of skilled staffing, physical resources, and infrastructure.

**Field Treatment Sites (FTS)**
- FTS are not discussed in this model because they are part of the Healthcare Surge Continuum and are not considered a shelter. The role of an FTS is displayed in the attachment titled Comprehensive Emergency Healthcare Continuum.
2.4. Functional Needs Support Services

In November 2011, the Federal Emergency Management Agency released *Guidance on Planning for Integration of Functional Needs Support Services in General Population Shelters*. The document provides guidance to emergency managers and shelter planners in understanding the requirements related to sheltering children and adults with functional support needs in general population shelters. Individuals requiring functional needs support may have physical, sensory, mental health, cognitive, and intellectual needs that affect their ability to function independently, especially in the aftermath of disasters. Others who may require functional needs support include women in late stages of pregnancy, the elderly and people needing bariatric equipment. Bariatric equipment is equipment and supplies that are designed for larger or obese patients.

Though written as guidance for general population sheltering, it describes a process to integrate functional needs support services in any planning effort including medical shelters. Planning for functional needs support includes issues such as:

- Communication assistance and services when completing the medical shelter registration and other forms;
- Availability of durable medical equipment, consumable medical supplies and personal assistance services;
- Access to medication to maintain physical and mental health functions;
- Provision of sleeping accommodations (e.g., universal/accessible cots or beds and cribs; placement, modification, or stabilization of cots or beds and cribs; provision and installation of privacy curtains);
- Access to orientation and way-finding via a personal assistant;
- Assistance for individuals with cognitive and intellectual needs;
- Availability of auxiliary aids and services necessary to ensure effective communication;
- Access to an air-conditioned and/or heated environment;
- Availability of refrigeration for medications;
- Availability of food and beverages appropriate for individuals with dietary restrictions;
- Provision of food and supplies for service animals;
- Access to transportation for individuals who may require a wheelchair-accessible vehicle and/or individualized assistance, and transportation of equipment required because of an access or functional need;
- Assistance with locating, securing, and moving to post-disaster alternative housing, which includes housing that is accommodating to the individual’s functional support needs.

The full Guidance on Functional Needs Support document is available at

3. Roles and Responsibilities

OBJECTIVES FOR SECTION:

- Identify the various partners involved during medical shelter plan development
- Consider what partners would be appropriate to engage in the planning process

The following section provides an overview of the primary agencies involved in medical shelter planning and response. These agencies include governmental organizations at the local, state and federal level as well as nongovernmental organizations.

3.1. Involving Planning and Response Partners at the Local Level

Public and private organizations must work together to effectively implement a medical shelter operation. During the planning process, these organizations have the opportunity to agree upon roles and responsibilities in such a way to make post-incident activities move more quickly and efficiently. Table 2 provides a summary of common medical shelter roles and responsibilities for entities at the local level. Considerable variance in roles and responsibilities exists throughout the State depending upon a jurisdiction’s organization and established operating procedures. As roles and responsibilities are determined, operational triggers need to be identified.

Table 2 delineates possible assignments of roles. A “P” in the Table designates a primary role in the associated function, while an “S” represents a support role for that agency. Local jurisdictions should determine if this model meets local needs.

<table>
<thead>
<tr>
<th>Functions</th>
<th>Public Health</th>
<th>Emergency Medical Services</th>
<th>Emergency Management</th>
<th>Social Services</th>
<th>Mental Health</th>
<th>Healthcare Facilities</th>
<th>Skilled Nursing &amp; Long Term Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activating</td>
<td>P</td>
<td>S</td>
<td></td>
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<tr>
<td>Opening</td>
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</tr>
<tr>
<td>Equipping (non-medical)</td>
<td>P</td>
<td></td>
<td>S</td>
<td>S</td>
<td>S</td>
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<td>S</td>
</tr>
<tr>
<td>Equipping (medical)</td>
<td>P</td>
<td>S</td>
<td>S</td>
<td></td>
<td>S</td>
<td>S</td>
<td>S</td>
</tr>
<tr>
<td>Staffing (non-medical)</td>
<td>P</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
</tr>
<tr>
<td>Medical Staffing</td>
<td>P</td>
<td>S</td>
<td>S</td>
<td></td>
<td>S</td>
<td>S</td>
<td>S</td>
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<tr>
<td>Volunteers</td>
<td>P</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
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<td>S</td>
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<tr>
<td>Deactivation/Closing</td>
<td>P</td>
<td></td>
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<td>S</td>
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<tr>
<td>Finance</td>
<td>P</td>
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</tbody>
</table>

Additional detail is provided below on each of the organizations that may be involved in medical shelter operations and planning at the local level.
3.1.1. Public Health
In collaboration with emergency medical services agencies, local public health departments are typically the lead agency in health and medical emergency functions, and have a role in all aspects of medical sheltering, including:

- Coordination of planning, response, and recovery;
- Coordination of medical shelter activation;
- Determining the need for medical authority to operate a medical shelter;
- Coordination of staffing resources;
- Deployment of Disaster Healthcare Volunteers;
- Designation and operation of medical shelter sites;
- Coordination of closure of medical shelter sites;
- Provision of basic medical care.

At the local level, one of the biggest challenges to medical shelter operations is the ability of public health and medical entities to access available resources. Each of the participants in the Public Health and Medical Emergency System within an Operational Area should understand the processes used to request health and medical resources. The California Public Health and Medical Emergency Operations Manual outlines a standardized resource requesting process in accordance with the process established by the Standardized Emergency Management System.

3.1.2. Emergency Medical Service Providers
Emergency medical services providers play an essential role during an emergency by triaging, treating and transporting patients to an appropriate health care facility. Once a medical shelter is established, triage protocols should be communicated to the emergency medical services providers to assist them in effectively triaging appropriate individuals to the medical shelter. Emergency medical services providers may also be able to provide paramedics and emergency medical technicians to assist in staffing the medical shelter.

Medical shelter plans should include a medical plan that includes a standby ambulance at or near the shelter to provide emergency transportation as needed for clients with decompensating medical conditions.

3.1.3. Social Services
In many local jurisdictions within California, social service agencies are often designated as the local mass care lead agency. Social service agencies may coordinate with emergency management and non-governmental organizations to plan, staff, equip and operate general population shelters. However, roles vary greatly among jurisdictions in the ability of social services agencies to support sheltering activities. When medical shelters are co-located with general population shelters, social services or the mass care lead may provide support services or
resources to medical shelter operations. Social services may also assist in the identification of individuals with medical needs.

3.1.4 Emergency Management
Emergency management agencies are typically support the local lead agency for mass care including general population sheltering; however, in some jurisdictions emergency management will serve as the lead mass care agency. Emergency management may initiate the activation of a medical shelter once a need has been identified and will often coordinate logistics for medical shelters. These activities often occur through the jurisdiction’s emergency operations center.

3.1.5. Mental Health
Mental health providers have a vital role in ensuring the continuation of care, treatment and housing for clients within the behavioral health system at the medical shelter. They may be involved in assessing and activating the response to behavioral health issues at a medical shelter. In some jurisdictions mental health may formulate plans to ensure medical health professionals are available to provide behavioral health services at medical shelter sites.

3.2 State Level Government Agencies
The State Emergency Plan identifies State agency roles based on Emergency Functions (EFs). Agencies are assigned a lead or support role for each EF. Medical sheltering requires a unified response which involves EF 6 – Mass Care and Shelter and EF 8 – Public Health and Medical as the EFs most relevant to medical sheltering. The lead State agency for these EFs is the California Health and Human Services (CHHS) Agency. The departments within CHHS identified as having a lead role in State level support of EF 8 are the California Department of Public Health and the Emergency Medical Services Authority. The Department of Social Services is the State department with primary responsibility for EF 6 respectively. Table 3 summarizes the roles of the State Departments of Public Health, Social Services and the Emergency Medical Services Authority in relation to EF-8, EF-6 and medical sheltering as stated by the State Emergency Plan. The support roles of other State agencies are described within the State Emergency Plan.
## Table 3 – State Roles and Responsibilities

<table>
<thead>
<tr>
<th>Agency/Department</th>
<th>SEP EF-8 Role</th>
<th>SEP EF-6 Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Public Health</td>
<td>Collaborates with local health department and the Emergency Medical Services Authority on medical shelter mission; provides guidance and resources as appropriate.</td>
<td>Supports the Department of Social Services in coordinating public health and emergency medical concerns and needs in general population shelters are addressed. Coordinates with Emergency Medical Services Authority to assist in identifying medical staff to support general population shelters.</td>
</tr>
<tr>
<td></td>
<td>Ensures the safety of food, drugs, medical devices and other consumer products in the disaster area. Regulates bottled drinking water plants and distributors and drinking water haulers to ensure the safety of water used as emergency supplies of drinking water. Provides support to local health departments for infectious disease surveillance and outbreak response, food safety and sanitation standards in shelters. License and certifies healthcare facilities.</td>
<td></td>
</tr>
<tr>
<td>Department of Social Services</td>
<td>Coordinates with supporting state agencies to ensure that public health and emergency medical concerns and needs in shelter populations are addressed.</td>
<td>Identifies state agency resources that may be available for support in care and shelter. Serves as the lead agency in coordinating resources needed to support mass care and shelter response and supports agencies in transitioning individuals from mass care to separate family living. Assists in the coordination of the reception of displaced persons at sheltering locations, including assisting with identification of and inquiries about displaced persons, and coordinates language translation services.</td>
</tr>
<tr>
<td></td>
<td>Provides supportive services on nonmedical mass care needs at medical shelters.</td>
<td></td>
</tr>
<tr>
<td>Emergency Medical Services Authority</td>
<td>Coordinates emergency medical preparedness with other local, state and federal agencies having a disaster response role. Responds to medical disasters as requested by mobilizing and coordinating mutual aid resources and state mobile medical assets. Manages the federal sponsored ESAR-VHP System as the California Disaster Healthcare Volunteer system</td>
<td>Assists in coordinating state mobile medical assets to support local response.</td>
</tr>
</tbody>
</table>

### 3.3. Federal Agencies

Federal assistance may be requested, consistent with existing plans and procedures regarding declarations for assistance. Local jurisdictions should utilize the standardized process outlined in the California Public Health and Medical Emergency Operations Manual in accordance with the progression of response requirements outlined by the Standardized Emergency Management System. Federal Medical Stations, Disaster Medical Assistance Teams, the National Disaster Medical
Sheltering Persons with Medical Needs

System and Veterans Health Administration may be viable federal resources to assist with medical shelter operations.
3.4. Volunteers

3.4.1. American Red Cross
The American Red Cross provides mass care in coordination with government and private agencies. In most local jurisdictions, the American Red Cross is designated as the primary community-based organization responsible for care and other disaster relief services.

American Red Cross may have the responsibility to establish shelters for the general population during a disaster. It provides shelter, food and coordinates services to displaced persons and is also responsible for compiling and reporting information on shelter-seeking populations. The information includes the number of displaced, residing within the shelter, and unmet needs. American Red Cross’s recently revised their concept of operations allows registered nurses to provide community level of medical care in a shelter environment. This level of care will be based on the qualifications of American Red Cross medical personnel who present at the shelter site.

In a medical shelter, the American Red Cross may provide staff or wrap around services such as housing and feeding to assist with operations. The level of integration between the American Red Cross and other responding entities will vary depending upon the level of pre-planning and available resources.

3.4.2. Medical Reserve Corps
The Medical Reserve Corps is comprised of local volunteer medical and public health professionals such as physicians, nurses, pharmacists, dentists, veterinarians and epidemiologists. Medical Reserve Corps members may provide staffing and support for medical shelters.

3.4.3. Community Emergency Response Team
Community Emergency Response Teams organized by local law enforcement or emergency management agencies, educate volunteers within a community to prepare 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.

Using their training, Community Emergency Response Team members may be able to assist in staffing medical shelters. While not medically trained, Community Emergency Response Team members may serve as support staff or, in some cases, personal assistants.

3.4.4. Spontaneous Unaffiliated Volunteers
After a disaster, spontaneous unaffiliated volunteers often arrive at shelters ready to help. These volunteers may be skilled and capable of meeting significant needs within a medical shelter. In
order to leverage this potentially valuable workforce, jurisdictions should undertake efforts to anticipate and manage them. Operational plans should identify these volunteers to supportive roles.

3.5. Other Participants and Programs

3.5.1. California Medical Assistance Team
California Medical Assistance Teams are health care providers such as physicians, nurses, pharmacists, paramedics, emergency medical technicians and support staff capable of providing disaster medical support in medical shelters. California Medical Assistance Teams, coordinated by the Emergency Medical Services Authority, are a part of the State’s tiered disaster medical response system and provide services to augment and/or re-establish medical care in areas of the State where hospitals or medical care systems have been damaged or overwhelmed.

3.5.2. Health Care, Skilled Nursing and Long-Term Care
Each health care facility is responsible to have a detailed written plan and procedures to address potential emergencies and disasters. These plans include the identification of “like-facilities” to accommodate residents if evacuation is required. When the use of a “like-facility” is not possible event, a healthcare facility may seek medical shelters for temporary use for those persons not requiring acute medical care. The healthcare facility should provide skilled staff, records, pharmaceuticals and any portable equipment to sustain care at the medical shelter until a more appropriate facility can be identified and transportation arranged.

3.5.3. Private Sector
The private sector includes facility owners, pharmacies, members of the disability community, contractors and other stakeholders. The private sector is often the primary provider of critical services to the public and possesses knowledge and resources to supplement and enhance public efforts. Planners should approach medical sheltering with a whole-community perspective and take into account the ability of private sector resources can augment medical sheltering operations.

3.5.4. Disaster Healthcare Volunteers
The Disaster Healthcare Volunteers is a statewide program, managed through an electronic database, which recruits, registers, credentials, tracks, identifies, deploys and maintains currently licensed volunteer healthcare professionals and makes them available to Operational Areas for response activities to emergencies.
3.5.5. Disaster Service Workers

Disaster service workers are individuals who support emergency response efforts under the direction of a person having authority to command the aid of citizens during a state of war emergency, a state of emergency, or a local emergency. Public employees are identified by State statute as disaster service workers. Depending on their skill sets and the event circumstances, disaster service workers may be available to help staff and operate medical shelters.

4. Legal

OBJECTIVES FOR SECTION:

- Anticipate the challenges that will arise in medical shelter operations due to legal, licensing and liability issues
- Promote understanding among local stakeholders of critical protections
- Identify areas for plan development

4.1 Authority for Medical Shelters

There is considerable State authority for the establishment of shelters by local governments to house people under emergency conditions. For example, each county and chartered city is required to adopt a comprehensive, long-term general plan,¹ and each plan must contain a safety element which includes a safety element for the protection of the community from various risks such as earthquakes, floods and fires.² Specifically for flood hazards, the safety element must contain comprehensive goals, policies, and objectives locating, when feasible, new essential public facilities outside of flood hazard zones, including hospitals and health care facilities, and emergency shelters.³ The State Department of Social Services is authorized to provide funding to local governmental agencies and non-profit organizations that are prepared to provide emergency shelter to persons who have been rendered homeless as the result of a natural disaster.⁴

Further, the State and its political subdivisions are authorized to proclaim a “shelter crisis” upon a finding that a significant number of persons within their jurisdiction are without the ability to obtain shelter, and that the situation has resulted in a threat to the health and safety of those persons.⁵ Such a proclamation not only authorizes political subdivisions to allow displaced persons to obtain shelter in designated public facilities, it also suspends regulatory standards for housing, health and safety with respect to additional public facilities established under the emergency, and provides

¹ Govt. Code, §65300.
² Govt. Code, §65302(g)(1).
⁴ See Health & Saf. Code, §34072.
⁵ Govt. Code, §8698.2.
limited immunity from liability for the ordinary negligence of the political subdivision in providing the
emergency housing.\(^6\)

State statute also acknowledges that both public and private buildings or premises may be used as
emergency mass care centers, first aid stations, temporary hospital annexes, or as other necessary
facilities for mitigating the effects of a natural, manmade, or war-caused emergency, and provides
that the owners and operators have qualified immunity for injuries to persons who come seeking
refuge, treatment, care or assistance during an emergency.\(^7\)

There is no explicit authority for a “medical shelter.” However, the provision of medical care at
emergency shelters or in related facilities during a proclaimed emergency is implicitly authorized by
some of the provisions of law previously described. Further, the law provides for the performance of
services during an emergency by disaster service workers,\(^8\) and anticipates that those services will
include medical care. The California Emergency Management Agency is required to develop a plan
for the use of volunteers, including the definition and identification of volunteer skills and resources
typically required by State and local governmental agencies during a proclaimed state of
emergency.\(^9\) The various classifications of disaster service workers include medical personnel who
will staff casualty stations, establish and operate medical and public health field units, and assist in
hospitals, out-patient clinics, and other medical and public health installations.\(^10\) There would be no
reason to include such a classification if there was no intention that medical care be provided in
emergency shelters.

### 4.2. Liability of State/Local Government for Medical Shelter Operations

The extent to which a governmental entity operating a shelter and providing medical care in it can
be held liable for injuries sustained by persons receiving shelter and care depends heavily upon the
circumstances under which the shelter is operated, as well as the circumstances surrounding the
harm. Arguably, governmental entities carrying out their responsibilities under the State Emergency
Services Act have broad immunity for their discretionary acts and omissions.\(^11\) However, in order to
enhance immunity from liability for the medical and shelter components of a medical shelter, a
proclamation of a local emergency or a state of emergency under the Emergency Services Act is
recommended.\(^12\) Such a proclamation (1) triggers the immunity from liability for medical providers
designated in Government Code section 8659, (2) triggers the immunity from liability for disaster
service workers in Civil Code section 1714.5(b), (3) ensures that the local agency is protected by the

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\(^6\) Govt. Code, §8698.1.
\(^7\) Civil Code, §1714.5(a).
\(^8\) See Govt. Code, §3100, et seq.; Labor Code, §4350, et seq.
\(^9\) See Govt. Code, §8599.2.
\(^10\) Cal C.C.R., §2572.1(j).
\(^11\) See Govt. Code, §8655.
\(^12\) See Govt. Code, §8630, et seq.
immunities afforded under the section 6255 of the Emergency Services Act, and (4) ensures the
applicability of the immunity provided by Civil Code section 1714.5(a) for the owner or operator of
the facility in which the shelter is located.

Other forms of emergency proclamations by government officials provide may also offer some legal
protection. Declaration of a “shelter crisis” would afford some immunity from liability, but only for
the shelter component of the medical shelter. There would be no protection from liability for
harm caused by the medical services rendered.

The declaration of a “local health emergency” under Health & Safety Code section 101080 may also
be an option, but only if there has been some form of chemical or biological release giving rise to the
emergency. Such a declaration would only provide qualified immunity to physicians, hospitals,
pharmacists, respiratory care practitioners, nurses, or dentists providing care at the express or
implied request of authorized officials. It would not provide any immunity from liability to the
shelter operator for injuries related to the provision of shelter.

4.3. Licensing Requirements for Medical Shelters
A medical shelter may meet the definition of a clinic, intermediate care facility, skilled nursing
facility, or acute care hospital for purposes of state licensing requirements, depending on how the
shelter is established, the services it provides and the length of time patients remain in the shelter.
However, because medical shelters will likely be established in unconventional and non-medical
settings and on short notice, it is unlikely that such a facility could satisfy statutory requirements for
licensing of a health care facility. Even if the facility could satisfy the licensing requirements, the
short duration that the shelter would remain open and the immediate circumstances under which
the shelter would be operating would likely make licensing infeasible. Nevertheless, unless the
licensing requirements have been suspended by executive order pursuant to Government Code
section 8571 under a proclaimed state of emergency, the possibility remains that a local
governmental entity that opens a medical shelter could be cited for operating an unlicensed clinic or
health facility.

Any organized outpatient health facility that provides direct medical, surgical, dental, optometric, or
podiatric advice, services, or treatment to patients who remain less than 24 hours is considered by
law to be a clinic. This would include medical shelters that keep patients for less than 24 hours.
Clinics are subject to licensure unless operated by the state, a county, or a city, or unless they meet
the definition of a community or free clinic. A medical shelter may be subject to separate health

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13 Govt. Code, §8698, et seq.
14 Health & Saf. Code, §101085(c).
15 Health & Saf. Code, §1200
16 Health & Saf. Code, §1206(b).
facility licensing requirements. The term “health facility” means any facility, place, or building (other than a clinic) that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, physical or mental, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, for one or more persons, to which the persons are admitted for a 24-hour stay or longer. Consequently, if the medical shelter is keeping patients for more than 24 hours, it may be deemed a health facility for licensing purposes. The type of health facility license needed may depend upon the nature of the services provided. It is unlikely that a medical shelter as described in this guidance would meet the definition of a “general acute care hospital,” which means a health facility that provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. However, a medical shelter could be considered a “skilled nursing facility” or an “intermediate care facility,” depending upon the extent of the services provided.

A "skilled nursing facility" is a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. An “intermediate care facility” is a health facility that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care.

Unless the clinic and health facility licensing requirements have been suspended in the operational area, it is recommended that medical shelters avoid keeping patients for more than 24 hours (in order to be classified as a clinic), and be operated by the state, a county or a city, in order to avoid a licensure requirement. If it becomes necessary to keep patients in a medical shelter more than 24 hours, and a suspension of health facility licensing requirements has not been ordered, it is recommended that the jurisdiction consult with the regional office of the Licensing and Certification Division of the California Department of Public Health on how to best protect the health and safety of shelter patients.

4.4. Liability Protections for Public Employees and Volunteers

If a public employee, including a state, city or county employee, is assigned disaster-service activities, that public employee is deemed to be a disaster service worker. Volunteers, whether registered or convergent, are also considered to be disaster service workers. During a proclaimed emergency under the Emergency Services Act, disaster service workers have immunity from liability for civil damages, either on account of personal injury to or the death of any person or damage to property,

18 Health & Saf. Code, §1250(a).
19 Health & Saf. Code, §1250(c).
20 Health & Saf. Code, §1250(d).
21 Govt. Code, §3100.
22 Govt. Code, §3101.
resulting from any act or omission while performing their disaster services anywhere within any
discretionary area covered by the emergency, unless the act or omission was willful.23

4.5 Liability Protections for Skilled Medical Staff

In addition to the immunities available to volunteer disaster service workers, those volunteers
serving in a medical shelter who are physicians, pharmacists, respiratory care practitioners, nurses,
or dentists enjoy additional immunity from liability for any injury sustained by any person by reason
of those services, regardless of how or under what circumstances or by what cause those injuries are
sustained, unless the injury results from an act or omission. Persons assigned to work in a
medical shelter who do not fall into one of these professional categories would have the immunity
described in section 4.4, above, only.

4.6 Liability Protection Requires an Emergency Proclamation

If no emergency has been proclaimed under the Emergency Services Act, a volunteer is subject to
liability for harm caused by the volunteer’s want of ordinary care, unless the volunteer or public
employee is engaged in disaster-related training activities. The volunteer may be entitled to
representation by the local governmental agency just as a public employee would be, but there
would no immunity under the Emergency Services Act or the laws pertaining to disaster service
workers. There may, however, be immunity available under the Good Samaritan laws, depending
upon the facts.24

4.7 Liability Protections for Property Owners

The owners and operators of either public and private buildings, or premises used as emergency
mass care centers, first aid stations, temporary hospital annexes, or as other necessary facilities for
mitigating the effects of a natural, manmade, or war-caused emergency have qualified immunity
injuries to persons who come seeking refuge, treatment, care or assistance during an emergency.25
If a “shelter crisis” has also been proclaimed, the proclamation also provides limited immunity from
liability to the local agency for the ordinary negligence of the local agency in providing the
emergency housing.26

4.8 Liability for Co-located Shelters/Medical Shelters

Whether the operator of a shelter co-located with a governmentally-operated “medical shelter” can
be held responsible for injury caused by the medical shelter may depend upon the extent to which
the shelters are organizationally and contractually distinct. Organizations operating shelters under

23 Civil Code, §1714.5(b).
25 Civil Code, §1714.5(a).
26 Govt. Code, §8698.1.
contract with a public agency should carefully define the boundaries of their operation to avoid any express or implied responsibility for the co-located medical shelter.

5. Medical Shelter Operational Planning

OBJECTIVES FOR SECTION:

- Develop a jurisdiction-specific planning process for medical sheltering
- Identify a Core Planning Team
- Determine the best method to understand the situation within the jurisdiction
- Understand plan resource requirements and availability
- Develop, review and disseminate a complete medical shelter plan
- Implement and maintain the plan
- Train and exercise the plan

As with all aspects of emergency preparedness, medical sheltering should be planned in advance of a potential incident or emergency. This portion of the Part I, Foundational Knowledge of the guidance provides detail regarding the medical shelter planning process and will assist in implementing the operational guidance provided in Part II, Medical Shelter Guidance.


5.1 Step 1: Establish Core Planning Team

It is recommended that the core medical shelter planning team include individuals with diverse roles within the jurisdiction, e.g., in emergency management, public health, volunteer organizations, the private sector. Table 4 lists the functions required for medical shelter planning, as well as examples of organizations that could be responsible for those functions during the planning process.

Many Operational Areas have existing planning teams or other committees that establish the minimum planning and operational requirements for Government Authorized Alternate Care Sites. With minor modification, these teams are well suited for medical shelter planning.
Table 4 – Medical Shelter Core Planning Team

<table>
<thead>
<tr>
<th>Function</th>
<th>Example of Organization(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency management and coordination</td>
<td>Local emergency management agencies</td>
</tr>
<tr>
<td>Behavior health</td>
<td>Mental health providers</td>
</tr>
<tr>
<td>Medical staffing</td>
<td>Hospital staff, long term care, emergency medical services other medical staff, medical volunteers</td>
</tr>
<tr>
<td>Set-up, operation and management</td>
<td>American Red Cross and volunteer organizations, local public health departments</td>
</tr>
<tr>
<td>Security</td>
<td>Law enforcement, American Red Cross and other volunteer organizations, private sector</td>
</tr>
<tr>
<td>Client transport</td>
<td>Emergency medical services</td>
</tr>
<tr>
<td>Client information management</td>
<td>Public health, healthcare community, emergency medical services</td>
</tr>
<tr>
<td>Procurement and coordination of supplies,</td>
<td>Emergency management, public health, emergency medical services, the American Red Cross and other volunteer organizations, local pharmacist associations/groups</td>
</tr>
<tr>
<td>equipment and pharmaceuticals</td>
<td></td>
</tr>
<tr>
<td>Mass care (housing and feeding)</td>
<td>Social services, emergency management, law enforcement, American Red Cross and other volunteer organizations</td>
</tr>
<tr>
<td>Access and functional needs</td>
<td>Social services, private sector provider organizations, animal services, public health</td>
</tr>
<tr>
<td>Facility management</td>
<td>Private sector, emergency management, American Red Cross and other volunteer organizations</td>
</tr>
</tbody>
</table>

5.2 Step 2: Determine Need for Medical Shelter

The objective of Step 2 is to create a common operating picture among planning partners by clearly describing the conditions that could require a medical shelter. This common operating picture can be defined by:

- Determining the type and prevalence of hazards within a community which, when they occur, typically create impacts requiring a medical shelter (examples provided below).
- Defining the potential medical needs of the community’s population by reviewing community demographics, location of individuals with access and functional needs, and key facilities such as hospitals.
- Defining the capacity of existing healthcare facilities and reviewing their plans for surge and evacuation.
- Understanding the capacity and limitations of organizations involved in the operation of general population shelters.

The examples below are common impacts created by disasters which have previously been the trigger to activating medical shelters.
EXAMPLE: IMPACTS OF INCIDENTS REQUIRING A MEDICAL SHELTER

- Displacement of individuals with medical needs
- Insufficient surge capacity in existing healthcare system (e.g., due to damage to hospitals)
- Persons require higher level of medical skill, resources or infrastructure than can be provided in a general population shelter

5.2.1. Identify Community Hazards and Vulnerabilities

Local jurisdictions are encouraged to review hazard and vulnerability assessments. In considering the historical data of past events which have occurred in their communities, planners may be able to identify the future need for medical shelters.

As part of this effort, planners should research the demographics of the parts of the community most vulnerable to the identified hazards, identify service providers within that community, look for previously completed plans, and identify potential planning stakeholders.

EXAMPLE: SOURCES OF INFORMATION TO UNDERSTAND COMMUNITY HAZARDS AND VULNERABILITIES

- Annual hazard and vulnerability assessments
- Hazard mitigation plans
- Local emergency operations plans
- Hospital community - hazard vulnerability analyses
- Data about historical incidents
- Other local organizations (e.g., the local chapter of the American Red Cross), utilities, businesses and members of the planning team
- Census data (population demographics including age groups, language barriers and mapping)
- Community and governmental agencies supporting populations with access/functional needs
- Medical assistance providers, suppliers and distributors
5.2.2. Interview Organizations

In order to fully understand the community’s hazards and possible future need for medical shelters, planners should interview individuals from organizations involved in previous shelter planning initiatives. These interviews should attempt to validate community hazards and vulnerabilities and identify past lessons learned. Agencies to consider interviewing include the American Red Cross, the local mass care lead, and the functional and access needs community.

5.2.3. Prepare Written Analysis of Findings

Local jurisdictions should conclude Step 2 with a detailed written analysis of their findings. They should summarize the projected medical needs within their community, the hazards which could displace or exacerbate the situations of medical needs individuals, the current capacity to meet medical needs, and shortfalls where the need for additional resources should be anticipated. By identifying the shortfalls in the existing approach to meeting medical needs after an event, a jurisdiction can better define the need and role for a medical shelter. For example, a jurisdiction with a large number of limited English proficiency residents may need to identify methods to provide language assistance (e.g., bilingual personnel, interpreters, translated documents) after an event.

Several tools to assist with this pre-event planning phase are available in Part III: Medical Shelter Toolkit. Findings should be revisited throughout the planning process so that the evolving plan may be updated as further information is gathered.

5.3. Step 3: Develop Plan Assumptions and Resource Estimation

Planners should identify goals, objectives and tactics to meet the intent of the medical shelter. In order to plan for medical shelters, assumptions must be agreed upon and detailed resource estimations completed.

5.3.1. Develop Key Assumptions

The medical shelter planning team should develop assumptions on the following factors:

- Factors such as the number, type and location of casualties; the status of roads and the emergency transportation system; and other factors such as weather, day of the week, time of day, etc. will strongly influence the demand for medical care, sheltering and availability of medical resources. However, these factors cannot be predicted because the impact of the incident is unknown until it occurs;
- The magnitude of the disaster and disruptions to communications systems will require decision makers to act with limited information regarding the number, type and location of casualties;
- Affected populations will adopt strategies that appear to be most effective for obtaining medical services. This will result in convergence on known medical facilities such as
hospitals and clinics, regardless of their operational status. Affected populations will also
converge on medical shelters if their location is known to the public;
• Medical shelters will require significant resource coordination. All information management
and resource requesting should follow the standardized process that implements the
Standardized Emergency Management System.

5.3.2. Estimate Resource Needs
Planners should identify the resources needed to accomplish the identified operational
approach. Generally speaking, the needed resources typically fall into three categories: 1) staff,
2) supplies and 3) infrastructure. Part III: Medical Shelter Toolkit includes references to assist
planners in identifying what resources they will likely need.

EXAMPLE: ANTICIPATED RESOURCE NEEDS
☐ Type of staff (medical and non-medical)
☐ Type of pharmaceuticals, medical supplies and equipment
☐ Type of care and shelter supplies (e.g. cots, food services, etc.)

As planners identify the resources needed to operate a medical shelter, they should determine
where these resources can be obtained. Some resources may be available within the jurisdiction
and others may need to be obtained from outside sources. Emergency resource directories
should be created or updated to include local resources and vendors and agreements that may
be used to assist the jurisdiction in obtaining the resources that exceed the local capacity.
Jurisdictions may consider contracting with an agency or vendor to provide services for the
medical shelter either in part or whole (e.g. medical staffing, food service, janitorial services etc.).
Planners should collaborate with neighboring jurisdictions when developing resource directories
and specifically when contracting for emergency services to minimize multiple demands for the
same resources from the same vendor.

5.4. Step 4: Write the Plan
The plan should be written and presented in a way that readers can quickly identify options and find
solutions. Although this guidance does not provide a sample plan format, Part II: Medical Shelter
Guidance includes the key components that should be addressed in a medical shelter plan; however,
adjustments should be made according to the jurisdiction’s needs. Once a draft plan is complete,
the planning team should circulate it to obtain comments from organizations with identified
responsibilities.

As part of the local planning process, the jurisdiction will need to determine where the document
will reside. Medical shelter plans may appear as an annex to a jurisdiction’s emergency operations
plan or public health plan, or may exist as a stand-alone document.
Procedural documents (e.g., Standard Operating Procedures/Standard Operating Guidelines) should provide tactical level details not addressed in the plan. Part III: Medical Shelter Toolkit provides sample procedural documents under the Medical Operations section.

5.5. Step 5: Approve and Disseminate the Plan

Once the plan is written, it is recommended that it be integrated into local approval processes. Obtaining approval is vital to gaining the widest possible level of acceptance of the plan throughout the jurisdiction and is also important in establishing the authority required for changes and modifications.

Once approved, the local jurisdiction should distribute the plan and maintain a record of the people and organizations that receive a copy. The plan should be available in alternate formats upon request.

5.6. Step 6: Implement the Plan

Evaluating the effectiveness of plans involves a combination of training events, exercises and real-world incidents to determine whether the goals, objectives, decisions, actions and timing outlined in the plan lead to a successful response.

5.6.1. Training

In order to be ready to implement the plan, training must be conducted to ensure all partners and participants involved understand their roles and responsibilities within the plan. Position specific training should be provided to those with specialized roles so they have the knowledge, skills and abilities to support medical shelter operations. In most cases, the lead agency for medical shelters will establish a standardized curriculum to be implemented by each trainer. The considerations below are designed to help develop the standardized material.

**KEY CONSIDERATIONS INCLUDE:**

- Annual competency training on medical procedures and equipment for clinical staffing
- Training should be organized in “modules” that can be presented in an 8-hour session or three 2 ½ hour sessions (e.g. shelter management, shelter logistics, nursing, etc.)

Training should consist of orientation to the operation of a medical shelter. If possible, pre-event training regarding medical procedures should be completed once a year. It is recommended that the course be based upon “modules” that can be presented in an 8-hour session or three 2 ½ hour sessions. The following is an example of training topics that could be offered:
SAMPLE TOPICS FOR THE MEDICAL SHELTER ORIENTATION TRAINING:

- Overview of medical shelter operations
- Roles and responsibilities
- Shelter operations - opening, maintaining and closing
- Admission process
- Logistics
- Consumable medical supplies, durable medical equipment
- Assess and functional needs considerations
- Emotional counsel and mental health
- Nursing competency training on protocols, procedures and equipment
- Service animals

5.6.2. Exercises

The planning team should establish the requirements and schedule for medical shelter plan exercises and identify a point of contact for coordinating exercise participation. Participation in other national, regional or state exercises should also be included. Collaboration with other local jurisdictions is critical to ensure the appropriate agreements are in place to facilitate the most efficient response.

Medical shelter exercises should follow the Homeland Security Exercise and Evaluation Program life cycle. The Homeland Security Exercise and Evaluation Program recommends that an exercise program follow a cycle that begins with discussion-based exercises and moves to operations-based exercises so that there is a gradual increase of the level at which plans are tested.

Discussion-Based Exercises

Medical shelter discussion-based exercises should be the first step in validating the plan content. Such exercises may include seminars, workshops and tabletop exercises. These types of exercises are typically used to disseminate, highlight and validate critical aspects of new or newly updated plans, policies, mutual aid agreements and procedures. Thus, they are exceptional tools for familiarizing agencies and personnel with newly established or updated jurisdictional capabilities.

Operations-Based Exercises

Once the basic elements of the medical shelter plan are validated through discussion-based exercises, the experience gained and lessons learned should be applied in operations-based exercises, including drills, functional exercises and full-scale exercises. Such exercises can serve to clarify roles and responsibilities, identify gaps in resources needed to implement plans and procedures, and improve individual and team performance.
5.7. Step 7: Maintain the Plan

KEY CONSIDERATIONS INCLUDE:

- A schedule and strategy for plan maintenance should be established
- No plan should go for more than a year without being reviewed

All plans should be annually reviewed and updated. Plans should evolve as lessons are learned, new information and insights are obtained, and priorities are updated. The inclusion of old information, ineffective procedures, incorrect role assignments and outdated laws can severely disrupt emergency operations. The priorities for a jurisdiction may change over time as the makeup of the included communities changes, resources expand or contract, and capabilities evolve.

This step ensures continuity in the planning process and involves incorporating the information gained by exercising medical shelter plans and re-starting the planning cycle. Jurisdictions should identify the organization responsible for maintaining the plan and establishing the process by which the plan will be reviewed and revised.

The timeframe in which to review and revise a plan is the responsibility of each local jurisdiction. In establishing these timelines, jurisdictions should consider reviewing and updating the plan after the following:

- A change in operational resources (e.g., policy, personnel, organizational structures, management processes, facilities, equipment);
- A formal update of planning guidance or standards;
- Each activation or exercise;
- A change in the jurisdiction’s demographics or hazard profile;
- A change in the perceived importance of medical sheltering in addressing community risk;
- The enactment of new or amended laws or ordinances.
PART II
Medical Shelter Guidance
Part II: Medical Shelter Guidance

1. Overview

Part II of the guidance for sheltering persons with medical needs is intended as a roadmap to strengthen the ability of local jurisdictions to effectively prepare for medical shelter operations. This guidance can be used in companion with medical shelter tools found in Part III: The Medical Shelter Toolkit. It is scalable and can be applied to localities with expansive or limited resources. Part II: Medical Shelter Guidance is organized to plan for and operate a medical shelter.

<table>
<thead>
<tr>
<th>Part II Sections</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishing a Medical Shelter</td>
<td>Shelter activation triggers</td>
</tr>
<tr>
<td>Shelter Operations and Coordination</td>
<td>Operational approaches to medical shelter operations</td>
</tr>
<tr>
<td>Site Considerations</td>
<td>Considerations in selecting a physical shelter site</td>
</tr>
<tr>
<td>Support Services and Infrastructure Related Operations</td>
<td>Nonmedical essential services</td>
</tr>
<tr>
<td>Staffing</td>
<td>Staffing considerations</td>
</tr>
<tr>
<td>Supplies, Pharmaceuticals and Equipment</td>
<td>Supplies and pharmaceutical needs</td>
</tr>
<tr>
<td>Intake and Triage</td>
<td>Client screening, intake and registration processes</td>
</tr>
<tr>
<td>Medical Operations</td>
<td>Level of medical care provided in medical shelter</td>
</tr>
<tr>
<td>Fatality Management</td>
<td>Facilities-related planning</td>
</tr>
<tr>
<td>Administration</td>
<td>Documentation, procurement, timekeeping and tracking</td>
</tr>
<tr>
<td>Demobilization</td>
<td>Shutting down the medical shelter and transitioning back to the community</td>
</tr>
<tr>
<td>Finance and Reimbursement</td>
<td>Cost accounting and reimbursement</td>
</tr>
</tbody>
</table>

Each of these sections will reference tools that local jurisdictions may consider adopting for medical shelter plans and operation. Each available tool can be identified by the icon below and found in Part III: Medical Shelter Toolkit.

SAMPLE TOOL ICON - see the toolkit for tool

2. Establishing a Medical Shelter

OBJECTIVES FOR SECTION:

• Understand the overall process for establishing a medical shelter
This section outlines the process of activating and operating a medical shelter. While the process of establishing a medical shelter may be different in each jurisdiction, it will generally occur in two phases:

- **Phase One: Preparation to Activate**
  In most cases, the responsibility for activating a medical shelter resides with a local government agency, such as emergency management, public health, social services, or emergency medical services. For best results, opening a medical shelter should be a collaborative and coordinated process with healthcare providers, selected non-governmental organizations, and local government representatives. This should be determined during the plan development process and is detailed in Part I: Foundational Knowledge.

- **Phase Two: Operations and Coordination**
  Once a medical shelter is activated and operational, activities will focus on the delivery of medical support services. During this phase, additional resources will be required to staff and coordinate services and should be requested through the Operational Area Emergency Operations Center.

### 3. Activation

**OBJECTIVES FOR SECTION:**
- Identify activation triggers for medical shelters
- Understand the initial process for the establishment of a medical shelter
- Understand key activation planning considerations

#### 3.1. Activation Criteria

**KEY CONSIDERATIONS IN THIS SECTION INCLUDE:**
- [ ] Determine local jurisdiction criteria for activating a medical shelter;
- [ ] Activate all applicable contracts for services, facilities, staff and other resources;
- [ ] Coordinate with team members, staff and volunteers to establish a reasonable time frame in which to become fully operational.

Jurisdictions will need to determine its criteria for activating a medical shelter. Following are examples of criteria to consider:

- The incident has led to, or is anticipated to lead to, disruption of or strain on the public health and medical system with impacted and displaced individuals having a medical need that will not likely be adequately supported in a general population shelter. Shelter clients require continuous medical support, resources or infrastructure not provided or available in a general
population shelter; the immediate needs of the incident exceed the ability of healthcare 
facilities to accommodate the impacted population.

3.2. Preparation to Activate

Once medical shelter activation is triggered, jurisdictions should notify key personnel such as the 
shelter management staff and facility contacts and implements initial activation activities.

Initial activities should focus on appointing key personnel, according to the medical shelter staffing 
plan, and enacting response efforts. Activities may include:

- Requesting a local emergency proclamation, as outlined in local procedures;
- Assigning a medical shelter manager to initiate the jurisdiction’s medical shelter plan and 
  assume responsibility for medical shelter operations. If multiple medical shelters are required, a 
  medical shelter manager should be assigned to each shelter;
- Ensuring key positions of the incident command structure are staffed and supported to meet 
  the needs of the medical shelter operations.
- Distributing job action sheets to assist in determining initial activation steps for each position.

Activities will simultaneously focus on the site of the medical shelter. Activities may include:

- Identifying which physical location will be activated for medical shelter operations and 
  performing a site reassessment. The designated site representative should accompany the 
  medical shelter manager to complete the assessment of the area. This assessment should 
  document the condition of the facility and any facility equipment that will be utilized;
- Coordinating with the general population shelter and local mass care lead if the medical shelter 
  is collocated with a general population shelter;
- Securing the facility, including controlling traffic flow of individuals and vehicles and identifying 
  one primary and secondary entry point. Assign initial security personnel to the shelter site. 
  Personnel must secure areas not to be used during shelter operation and secure exterior doors 
  not being utilized as entrances from outdoor entry;
- Coordinating with Emergency Medical Service providers to triage and transport clients to the 
  appropriate shelter or medical facility;
- Establishing a secure location to receive supplies, pharmaceuticals and equipment.

Secondary efforts will focus on organizing the medical shelter setup after the site has been assessed 
and properly secured. At this point key staff should prepare to receive supplies and make 
preparations for client arrival. Activities at this stage include:

- Alerting points of contact with stakeholder agencies of staffing needs; scheduling and mobilizing 
  staff for security, environmental, administrative, clinical, pharmaceutical and personal 
  assistance services;
- Coordinating with team members, staff and volunteers to establish a reasonable time frame for 
  the medical shelter to become operational;
- Alerting and notifying administrative and setup staff to prepare the site;
- Performing a full cleaning of the shelter site;
• Obtaining, requesting, delivering and distributing resources according to medical shelter layout;
• Activating all applicable contracts for services, staff, supplies, pharmaceuticals and equipment;
• Taking inventory of all delivered resources;
• Posting all necessary interior and exterior signs;
• Setting up the shelter site according to the planned site layout.

During this phase, shelter staff should be reminded to make appropriate personal preparations based upon the anticipated number of hours away from home. This may be caused by an inability to leave the medical shelter because of the incident or other complicating factors. These preparations include:

• Making arrangements for family members and pets;
• Locating personal supplies;
• Providing current contact information to key points of contact;
• Reviewing the medical shelter plan and becoming familiar with roles and responsibilities.
• Ensuring a process for accommodating the arrival of the medical shelter staff and volunteers, establishing the registration and intake desk, issuing identification, credentialing and shift schedules;
• Performing a final health and safety facility walkthrough to ensure compliance and a safe shelter environment;
• Distributing supplies throughout the shelter, ensuring the availability of a secure area, and identifying procedures and policies for proper storage;
• Preparing feeding services, water and storage of supplies;
• Addressing privacy issues, including communicating policies to shelter staff on maintaining privacy of clients, establishing VIP visitation procedures (media and elected officials may seek information about shelter operations), and;
• Communicating the discharge plan for clients including the policies for self-discharge, transfer to higher care, recordkeeping and other key administrative tasks needed for reimbursement, tracking and future planning;
• Initiating planning for demobilization, returning resources to the place of origin, managing client and staffing records, and transferring site management back to the facility owner.

Medical Shelter Activation Tools

Series of sample key documents needed to initiate medical shelter operations includes activation checklists, facility walkthrough, job action sheets, incident action plan, and other relevant information.
4. Shelter Operations and Coordination

OBJECTIVES FOR SECTION:

- Identify operational approaches to medical shelter operations
- Determine the need for memoranda of understanding or agreement

4.1. Operational Approaches

Two primary approaches to the structure of medical shelters exist: stand-alone and collocated. Co-location, also described as side-by-side, implies that the medical shelter is established in close proximity to another shelter site, generally a general population shelter. The two shelter sites might not be located in the same room or building but are close enough to share certain wrap-around services, maximizing resource utility. Examples of shared wrap-around services include feeding, bulk distribution, trash disposal and security. In many situations, co-location is the preferred method because it lessens the administrative and supportive services requirements through the sharing of responsibilities. However, collocation requires a higher level of collaboration with other agencies involved in the provision of sheltering. In addition, it may be challenging to clearly differentiate the two shelter types to the public and responders.

A stand-alone medical shelter operates without shared support services from another shelter site. In this instance, the medical shelter will be a more intensive undertaking and require additional planning and preparedness. While more resource intensive, this approach allows for the greatest flexibility by requiring a lessened degree of integration with the general population shelter. In this approach it may also be easier to differentiate the general population shelter from the medical shelter sites because of the unique physical local of each.

Choosing the preferred operational approach will greatly impact all aspects of shelter planning and operations. Jurisdictions should carefully consider this decision, review available shelter sites and work with the applicable stakeholders within the community to determine the preferred approach.

Jurisdictions may consider looking for a contractor to provide services for the medical shelter, in whole or part. Various vendors may provide services to assist the jurisdiction in meeting the needs of the impacted community during medical shelter operations.

4.2. Memorandum of Understanding or Agreement

The medical shelter planning team coordinates with the appropriate entities to establish agreements such as memoranda of understanding for the acquisition of a site, resources and staff. Agreements should be established with emergency management, healthcare organizations, volunteer organizations, coalitions, planned shelter sites and other stakeholders prior to an incident.
Agreements should clearly describe the strategy and processes for preparing for and responding to an incident. In addition, agreements should clearly delineate roles, responsibilities and liability. Collocated medical shelters should closely coordinate agreements with general population shelters for overlapping support services.

4.3. Resource Management

California’s mutual aid system exists to provide resources and support to the State’s political subdivisions when their own resources are inadequate to cope with the disaster. This mutual aid system allows the progressive mobilization of resources to and from emergency response agencies, local governments, Operational Areas, regions and the State.

As resources are exhausted, or exhaustion is imminent, requests for any medical and health resource that cannot be obtained locally or through existing agreements should follow the standardized resource ordering procedures in accordance with the Standardized Emergency Management System outlined in the California Public Health and Medical Emergency Operations Manual.

4.4. Medical Shelter Organizational Structure

The organizational structure of a medical shelter can impact the efficiency and effectiveness of overall shelter operations including staffing and resource decisions. This organizational structure should follow Incident Command System principles to ensure its integration into the overall emergency response effort.

The organizational chart displayed in Figure 3 depicts the essential functions needed to carry out medical shelter operations. The chart is based on Incident Command System principles, and therefore, the number of actual positions that are individually staffed is scalable based on operational needs, span of control, and resources available. Highlighted functions indicate functions that could be shared when co-locating a medical shelter with a general population shelter.
In many cases, the situation will not require individual staffing for each function listed in the functional chart. In keeping with Incident Command System principles, any function not staffed is rolled up into the responsibility of the next higher level of management. For example, the shelter manager could assume the command and general staff functions and oversee the clinical staff caring for the medical needs of the clients. The number of clinical staff required should be based on client needs and resources available. The Planning and Finance/Administration functions of the organization could be conducted off-site from the Medical Shelter by the Operational Area Emergency Operations Center or the Public Health and Medical Departmental Operations Center. This structure is shown in Figure 4.
Sheltering Persons with Medical Needs

Whatever size or structure is used, Incident Command System principles should be followed, allowing for Shelter operations to be closely coordinated with the overall emergency response.

4.5. Medical Shelter Coordination Positions

Key roles within a medical shelter are described in Table 6. More detailed description of all the potential positions needed to operate a medical shelter can be found in job action sheets available in Part III: Medical Shelter Toolkit.

<table>
<thead>
<tr>
<th>Medical Shelter Position</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Shelter Manager/Director (Commander)</strong></td>
<td>Retains overall responsibility for the medical shelter and serves as lead. This person is responsible for directing resources, setting objectives to be accomplished and approving the strategy and tactics to be used. He/she must report to a higher authority as determined by the jurisdiction.</td>
</tr>
<tr>
<td><strong>Medical Director</strong></td>
<td>Directs clinical care by establishing client care protocols, providing assessment and diagnosis as needed and provides physician orders for treatment and medications as needed.</td>
</tr>
<tr>
<td><strong>Liaison Officer</strong></td>
<td>Supports the shelter manager through coordinating with representatives from agencies or organizations supporting or assisting sheltering activities. The Liaison Officer will be especially important if the medical shelter is collocated with another shelter site.</td>
</tr>
<tr>
<td><strong>Safety Officer</strong></td>
<td>Ensures that operations are conducted in a way that guarantees the safety of the staff and clients. Supervises safety of staff and clients. Ensures that proper PPE, infection control guidelines and sanitation are followed. Assists in safe demobilization.</td>
</tr>
<tr>
<td>Medical Shelter Position</td>
<td>Task</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>PIO</strong> (Note: May be integrated into Operational Area, Emergency Operations Center, Departmental Operations Center)</td>
<td>Responds to all media requests for information according to established media relations policy for the medical shelter. Drafts press releases for media. Coordinates with media and VIPs. Coordinates escort for media and VIP, if necessary. This function should be coordinated from a location other than the shelter site and may be the responsibility of an emergency operations center, public health department operations center or field level incident commander.</td>
</tr>
<tr>
<td><strong>Operations Section Chief</strong></td>
<td>Manages clinical operations at the medical shelter and implements activities described within the medical shelter plan. Coordinates and orient clinical staffing at medical shelter to triage, intake and all policies and procedures. Ensures staff follows universal infection control guidelines. Supervises all attendants and ensures that supplies are adequate for continued client care and client records are properly maintained.</td>
</tr>
<tr>
<td><strong>Triage Unit Supervisor</strong></td>
<td>Oversees the intake, assessment, triage and/or transfer of clients to more appropriate facilities. Supervises non-clinical and nursing staff to ensure that they are working according to triage protocols. Ensures that forms and client records are initiated for each client and that clients are triaged appropriately.</td>
</tr>
<tr>
<td><strong>Registration Unit</strong></td>
<td>Registers all clients, caregivers, and family members.</td>
</tr>
<tr>
<td><strong>Triage Unit</strong></td>
<td>Provides initial nursing assessment of clients, completes intake and assessment forms and consent forms, identifies clients who need to be transferred, informs staff, and refers these clients to holding area until transfer occurs. Provides client and caregiver ID numbers and completes tracking and valuables forms as needed. Gives client valuables to Logistics Unit and client prescription medications to the Nursing Unit, both for locked storage.</td>
</tr>
<tr>
<td><strong>Health and Medical Branch Director</strong></td>
<td>Oversees the care and discharge of all clients in the medical shelter. Supervises nursing staff. Coordinates maintenance of medicine and supply inventories with Medical Director and Logistics. Ensures that forms and client records are maintained for each client. Directs client care plans. Fields complaints from clients.</td>
</tr>
<tr>
<td><strong>Treatment Group</strong></td>
<td>Provides nursing care to clients including completing medical shelter forms in client charts to record medications and status, requesting physician orders (if necessary), providing first aid, implementing standing orders and policies, conducting rounds, documenting activities and following universal infection control guidelines.</td>
</tr>
</tbody>
</table>
## Sheltering Persons with Medical Needs

<table>
<thead>
<tr>
<th>Medical Shelter Position</th>
<th>Task</th>
</tr>
</thead>
</table>
| **Planning Section Chief** | Assists in strategic planning of operations for medical shelter. Obtains relevant information about emergency for advance planning (24 hours) in medical shelter. Maintains information on the current and forecasted situation and on the status of resources assigned to the medical shelter. Conducts regular meetings and briefings with shelter staff and volunteers to provide updates on the status of the shelter and care of clients. Submits status information to shelter manager for approval before submitting to a higher coordinating entity (Emergency Operations Center/Departmental Operations Center) for coordination.  
  - Collects, evaluates and disseminates operational information related to the medical shelter and preparation of action plans, situational reports and staffing plans.  
  - The Planning Section is comprised of the Documentation Unit, Situation Unit and Resource Unit. |
| **Logistics Section Chief** | Ensures all logistical needs at medical shelter are met (e.g. cots, blankets, beds, signage, television, communications, water, power, computer access, ADA accommodations, janitorial, etc.). Ensures site is secure throughout operation and cleaned in demobilization. Coordinates facilities management, transportation, supplies, equipment maintenance and fuel, food services, communications and information technology support.  
The Logistics Section is comprised of the Support Branch and the Services Branch. |
| **Food Group Supervisor** | Plans regular and special dietary meals, works with finance to procure all drinks, snacks, meals for staff and clients. Requests and supervises feeding staff to maintain all food serving areas, assures safe storage and disposal of food. |
| **Supply Group Supervisor** | Coordinates logistics involved in initial receipt of cache items and set up of medical shelter. Helps to obtain additional shelter supplies if requested and provides ongoing inventory management and facility cleaning and maintenance. Under Logistics Chief, demobilizes the medical shelter. |
| **Staff & Volunteer Registration Unit** | Checks staff and volunteers in and out. Receives and reports staffing issues such as no-shows and updates staffing lists as needed. Creates organization chart with staff names on white board. |
| **Administration Section Chief** | Ensures that all costs associated with medical shelter are documented and submitted to the Departmental Operations Center or Emergency Operations Center. May also be involved in client registration, medical insurance, client tracking, etc. Manages all administrative, financial and cost analysis considerations surrounding the medical shelter.  
The Administration Section is comprised of the Timekeeping Unit, Compensation Unit and Claims Unit. |
4.6. Job Action Sheets

Job action sheets provide the user with a series of actions to consider when serving in specific roles within the shelter management structure. Part III: Medical Shelter Toolkit provides sample job action sheets for potential medical shelter positions. The items listed in the tools are minimum considerations for developing job action sheets.

The job action sheets provided are designed to be customized, although planning teams are encouraged to maintain the prescribed format and terminology as a means of ensuring standardization of each individual position’s primary function. The format also allows for the job action sheets to be used to preliminarily document actions taken during the incident and assist in developing a chronology of events, problems encountered, and decisions made.

Medical Shelter Job Action Sheets
Provides sample job action sheets for potential functions within the medical shelter organizational structure.

5. Site Considerations

OBJECTIVES FOR SECTION:
- Identify key considerations for medical shelter site selection, including size considerations
- Understand the approach to site assessment
- Develop model site configuration

5.1. Site Selection

KEY CONSIDERATIONS IN THIS SECTION INCLUDE:
- Publicly owned structures should be considered for medical shelter sites;
- A medical shelter should be accessible to at least two roadways;
- The site should have limited entranceways and should be controllable for security;
- Clinical care requirements for the facility must be determined.

Choosing a quality site for the medical shelter is essential. If possible, the chosen site will be accessible to existing infrastructure or services. For example, locating a medical shelter near an acute care facility may allow certain services to be shared between the sites. The following general considerations should be made when selecting a site:

- General population shelter sites: Coordination should occur with the local mass care lead to identify sites which have been selected as potential general population shelters and determine
their suitability for medical shelter operations. Jurisdictions should clearly communicate the
status of these facilities to ensure that they are not assumed to be available for both functions.

- Faith-based owned facilities and Community Centers: These facilities are often utilized for
shelters as they can generally accommodate a large number of persons and may have feeding
facilities on the premises;

- Armories and other public buildings: These structures are particularly well-suited for use as
shelters because they are publicly owned structures, which are easier to secure rapidly during
an incident;

- Schools: Schools including colleges and universities often make good medical shelters as they
can offer shelter to large numbers of persons; however, jurisdictions must take steps to
minimize the disruption of educational services. When a school is used as a shelter, it will be
used in accordance with school district policy and procedure. The restoration of educational
services in schools used as shelters is a vital ingredient to recovery of the disrupted community.
When school property is used, an agency representative should be assigned to coordinate the
sharing of resources between schools and school districts to ensure that the needs of students
are met prior to the re-establishment of educational services;

- Parks facilities and other open spaces: In some instances, jurisdictions may utilize recreational
park facilities or fairgrounds as a location for a medical shelter. Tents and other portable
structures may be utilized in open spaces such as parks or parking lots to establish a medical
shelter site. This approach is generally not recommended because use of temporary facilities
will increase logistical requirements such as utilities;

Other lodging facilities: This may include privately owned arenas, sports stadiums or gymnasiums.
Arrangements should be made in advance with owners or managers of potential sites for a medical
shelter; optimal attributes of medical shelters are identified by the Department of Justice, Americans
with Disabilities Act Accessibility Guidelines. These attributes include but are not limited to:

- Emergency power (fixed generators);
- Close proximity to emergency medical services;
- Heating and cooling capabilities;
- Refrigeration;
- Back-up or portable oxygen supplies;
- Water supply and waste disposal system;
- Food supply and preparation area for special diets;
- Accessible parking for transporting those with medical needs;
- Drop-off areas that are clearly marked, close to the entrance and have curb cuts (35 inches in
width);
- Entrance that is well marked with automatic doors (or less than 5 lb. resistance, appropriate
door handles and doorways, minimum width of 35 inches);
- Path of wide and clear travel to registration, sleeping area, food area, toilet and shower area,
medical area, TV/computer area, phone/communication area, and quiet area;
Sheltering Persons with Medical Needs

- Signage that is clear and easy to understand in exterior area, sleeping area, toilet and shower area, food area, medical area, TV/computer area, phone/communication area including TTY, and quiet area;
- Access to laundry facilities.
- Toilet and Shower Area:
  - 1 stall/shower for every 15 persons;
  - Shower stalls - 36 inches by 36 inches, roll-in accessible;
  - Toilet stalls - 38 inches in width (some with raised toilets);
  - Grab bars - 33-36 inches in height;
  - Shower head - 48 inches in height;
  - Paper dispenser - 19 inches in height;
  - Sink - 34 inches in height;
  - Towel dispensers - 39 inches in height;
  - Automatic doors or manual doors with no more than 5 lb. resistance.

If a site that is compliant with the Americans with Disabilities Act is not available, certain temporary accommodations can be made so it is suitable for sheltering. These accommodations include:
- Portable ramps;
- Shower seats;
- Portable commodes with screens;
- Grab bars;
- Transfer boards;
- Table-level public phones or access to cellular phones.

Other accommodations may include minor modifications to the building itself. These modifications may require the written permission of the owner/operator of the site. Coordination with building code enforcement may be necessary to ensure that the use of the site and any modifications to the building are within regulations. Building modifications may include but are not limited to:
- Widening doorways by removing doors not designated as fire doors;
- Widening work areas by repositioning furniture, partitions or equipment;
- Installing a temporary ramp;
- Repositioning paper towel dispensers in restrooms;
- Designating parking spaces for disabled workers and clients.

A medical shelter should be accessible to at least two roadways to provide continued access in the event that one roadway becomes blocked or inaccessible. Roadways should connect directly to the medical shelter property.

<table>
<thead>
<tr>
<th>Site Assessment and Selection Tool</th>
<th>Provides detailed criteria for selection and assessing a potential medical shelter site before an incident occurs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Walkthrough Form</td>
<td>Provides an abbreviated site assessment as part of</td>
</tr>
</tbody>
</table>
5.2. Site Assessment

Once a site has been identified, a thorough on-site assessment should be conducted. This assessment should confirm that the location is structurally sound and safe for clients. The following should be assessed:

- Environmental safety (ensure the building is safe for clients and staff to enter);
- Functionality of utilities including electrical power, ventilation, heating, air conditioning, water and plumbing;
- Functionality of telephone and other communications systems;
- Functionality of backup power, if available;
- Proper space needed for client care (this may involve contacting an identified moving company to move furniture from the facility such as desks, etc.);
- Proper level of cleanliness;
- Availability of fire extinguishers;
- Availability of a supplemental morgue (consider alternatives which would place morgue outside the shelter site. This may include refrigerator trucks or other viable alternatives);
- Security (identify exits and entrances, ensure the building can be “locked down”);
- Storage (locate supply rooms and identify areas where pharmaceuticals and other sensitive material will be safely stored);
- Disposal (identify an area where hazardous waste and other disposal materials can be stored until they can be picked up).

5.3. Site Size

During initial activation, the number of clients who can safely be sheltered in a selected facility should be confirmed. The allocation of space will be determined by the incident. The total size and number of beds will be directly influenced by factors such as site layout, number of clients, client acuity and resource availability.

The American Red Cross recommends 40 square feet per client for persons sheltering longer than 72 hours. Clients with wheelchairs lift equipment, personal care assistants and service animals may require approximately 100 square feet of space per client. A sample floor layout for a 50 bed medical shelter is included in Part III: Medical Shelter Toolkit.

5.4. Physical Configuration

The variation of site types, medical needs, and the duration of the incident will dictate the physical requirements and configuration of the shelter. The following considerations should be taken into
account when choosing the physical configuration of the medical shelter; however, jurisdictions may
decide that not all of these areas are required:

- Entrance: The main entrance to the shelter maintains the flow of staff and clients coming
into and out of the medical shelter. A secondary entrance may be utilized for the delivery of
resources;
- Command post: The command post may be set up in the main office area of the site;
- Registration and triage: Registration and triage may be set up near the main entrance;
- Central supply: An area should be designated as central supply where all supplies coming to
the shelter will be secured and maintained;
- Staff quarters: These may be designated rooms apart from client areas;
- Client care area: The client care area should be set up using medical cots, if available. These
cots are larger and higher off the ground than standard general population shelter cots. The
client care area configuration may include divided sections for the following client care units:
  - Prescriptions/minor care;
  - Adult unit;
  - Pediatric unit;
  - Psychiatric unit;
  - Isolation unit (large enough for four persons).
- Aisles should be at least 36 inches wide to allow wheelchairs to pass through. Cots should be
placed so that adjacent cots are aligned “head-to-toe”. Some medical cots should be set up
against the wall to make them more stable and thus easier for clients who are wheelchair
users to transfer in and out of. Clients with respiratory illness should be housed in a separate
room from other shelter clients.
- Pharmacy and drug dispensing area;
- Waiting areas;
- Privacy area: If privacy screens are available, they may be set up in the client care area or a
separate, designated room to allow clients privacy when performing necessary self-care. For
example, clients who are not ambulatory and thus cannot walk to bathrooms, perform
personal hygiene and/or change clothes without assistance portable privacy screens may be a
suitable option for providing privacy at the individual’s cot;
- Food service: Areas utilized for serving food should be located away from client care areas.
Availability of food services for staff and clients may be required 24 hours a day/7 days a
week;
- Hygiene: Portable hand washing stations should be located in triage areas, client care units,
and pharmacy areas;
- Emergency exits must be clearly marked;
- Security: Controlled entrances should be established for all staff, volunteers, clients and
visitors.
5.5. Physical Configuration Planning Considerations

Jurisdictions should take special note of support for motorized wheelchairs. Placing the chair at the head of its owner’s bed creates a compact storage area and provides a sense of security well as a platform for personal effects, including assistive breathing equipment.

Sudden disasters may bring clients whose motorized wheelchairs need immediate charging and all motorized wheelchairs will need to charge at some point. Charging motorized wheelchairs can create a significant draw on electrical circuits while charging. This is an important consideration, and should be dealt with in the context of other power demands such as breathing machines or other equipment. Jurisdictions should consider a process that distributes power-consuming clients across multiple walls and/or circuits.

Medical Shelter Flow and Layout
Provides sample site configurations and process for client throughput.
Medical Shelter Rules
Provides sample rules for medical shelter clients.

Figure 5 offers an image of what a 10 x 10 client area might look like for those clients requiring wheelchairs, lift equipment, personal care assistants and/or service animals.
6. Support Services and Infrastructure-Related Operations

OBJECTIVES FOR SECTION:
- Identify key considerations for support services including housekeeping, hazardous and medical waste management, service and personal animal care, security, transportation and food services
- Identify key considerations for infrastructure-related operations including signage, medical devices, medical gases, and power and lighting

6.1. Housekeeping and Environmental Services

KEY CONSIDERATIONS IN THIS SECTION INCLUDE:
- Housekeeping is responsible for the initial cleaning and ongoing maintenance of the site to meet sanitary standards appropriate for clients;
- Environmental services should ensure proper waste disposal;
- The medical shelter may choose to pre-establish executable contracts for housekeeping services and medical waste management.

Maintaining the medical shelter site involves both housekeeping and environmental services considerations. Depending on the size of the shelter, teams can be established or vendors can be contracted to perform these services.

At the onset of activating the medical shelter, housekeeping is required to bring the shelter site to sanitary standards appropriate for staff and clients prior to opening the site for client intake. Once the shelter is opened, orderliness and cleanliness must be maintained throughout operations. As shelter operations are demobilized, plans should include returning the site to a sanitary condition.

Considerations for housekeeping activities include the following:
- General cleaning of surfaces and walls within client areas using appropriate detergents and disinfectants;
- Picking up trash in and around the site;
- Laundering bedding and other cloth goods;
- Ensuring cleanliness of medical shelter support areas such as kitchen facilities, staff sleeping quarters, restroom and shower facilities;
- Providing special care of carpeting and other cloth furnishings;
- Cleaning spills of bodily fluids.

The medical shelter may enlist the support of environmental services staff to complete more complex tasks related to the shelter environment. A primary consideration for environmental services at a medical shelter is waste management. Aspects of waste management that should be considered include:
• Evaluation of the capacity of on-site sewage or septic systems to handle increased sewage flow.
  An assessment of the potential public health risk of a septic system failure or overflow should be conducted;
• Projecting the need for commercial chemical toilets including number required, delivery, servicing and location in relation to the shelter;
• Projecting the need for additional solid waste disposal resources, such as adequate number and size of garbage bins, trash receptacles, trash bags and location to store solid waste until trash collection service resumes;
• Disposal of sharps and other bio-hazardous waste;
• Disposal of hazardous materials;
• Disposal of medical and other waste (solid and liquid).

Medical waste disposal presents considerations for medical shelters including:
• Separation of medical waste from the solid waste stream needs to be maintained;
• Chemical and radiological wastes must be separated and segregated from medical waste to avoid contamination; waste not contaminated with bodily fluids may be disposed of in regular trash cans;
• The designated storage area for medical waste must display the appropriate “bio-hazard” symbols.

If a medical shelter is collocated with a general population shelter, only one hazardous waste site needs to be established for both shelters. The medical shelter staff should coordinate with the general population shelter in preparing the site for waste disposal.

In addition to waste disposal, environmental services may have a role in other areas that impact the quality of the shelter environment including pest control and food handling conditions.

Prior to an incident, jurisdictions may choose to research and identify suitable vendors and execute stand-by contracts for many of the services discussed in this section.

6.2. Hazardous Materials Response

KEY CONSIDERATIONS IN THIS SECTION INCLUDE:

☐ Decontamination efforts should be coordinated with the local hazardous materials response team.

Decontamination may be needed at the medical shelter as clients may have been exposed to hazardous substances as a result of the incident or another spill. Many jurisdictions choose to coordinate this activity with the fire or local hazardous materials response team. Medical shelter plans should include procedures for runoff containment and management. Most hazardous waste and decontamination efforts will require specific personal protective equipment and specialized training for staff. Local, state, and federal laws that regulate these activities must be followed.
6.3 Service and Household Animal Care

Medical shelter staff will need to work cooperatively with animal caretakers to address animal sheltering for household pets. Due to the potential for allergies and sanitary issues, household pets should not be allowed within the site unless a separate kennel area is created.

Medical shelters must make exceptions to “no pets” or “no animals” policies to allow clients to be accompanied by service animals as needed. Service animals are working animals, not pets. Under the Americans with Disabilities Act, a service animal is any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability including physical, sensory, psychiatric, intellectual or other mental disability. This includes dogs that guide people who are blind or have low vision and a variety of other functions that service animals perform for people with disabilities. Other species of animals - whether wild or domestic, trained or untrained - are not service animals for the purposes of this definition.

Many service animals are easily identified because they wear special harnesses, capes, vests, scarves or patches. When no identifier is present, according to the United States Department of Justice, shelter staff may legally ask only two questions to determine if an animal is a service animal.

- Is this a service animal required because of a disability?
- What work or tasks has the animal been trained to perform?

If the answers to these questions indicate that the animal has been trained to work or perform tasks or services for a person with a disability, it qualifies as a service animal and must be allowed to accompany its owner anywhere other members of the public are allowed to go.

Service animals need to be readily accessible to the handler. Service animals should remain with their handlers and should not be required to be kept in a separate kennel area. Handlers are responsible for the feeding, grooming, relieving and control of their service animals. When an individual with a service animal registers in a medical shelter, staff must be prepared to identify a relief area designated for the use of service animals and a clean-up procedure for the area.
6.4 Security

KEY CONSIDERATIONS IN THIS SECTION INCLUDE:

- Choose a shelter site with a limited number of entranceways;
- Choose a shelter site with storage for pharmaceuticals and sensitive medical materials;
- Assign non-security staff to monitor entrances and exits and conduct rounds of the site;
- Identify and track clients, staff and visitors;
- Work with local authorities and private security entities to address heightened security needs;
- Any emergency situation should be reported to the shelter manager.

Planners should engage local law enforcement agencies in planning for medical shelter security. Security is both the physical presence of personnel, including assigned staff and trained law enforcement personnel, and actions taken before and during operations. Security is a continuous need at a medical shelter and should be considered on a 24/7 basis. The primary goal is to ensure the safety of staff and clients. The level of security required will depend on the emergency and location of the medical shelter site.

There are a range of reasons why, in the aftermath of an emergency that necessitates the establishment of a medical shelter, such a shelter should be considered a vulnerable location, not the least of which is the fact that pharmaceuticals will be present on the premises. As such, jurisdictions should carefully consider the role of security within the shelter setting.

The first priority for security is assuring control of the physical site of the medical shelter. Selecting a site where access can be easily controlled is preferable and will ensure the safety of both staff and clients and help maintain the orderly flow of personnel and clients coming into and out of the medical shelter. When securing the facility, primary and secondary entrances should be established. The primary entrance is for clients and staff; the secondary entrance may be utilized for resources delivered to the shelter.

Shelter staff should ensure that unused areas are secured and clearly identified as “off-limits” to clients. All shelter staff should assist in monitoring these areas to ensure compliance. “Do Not Enter” signs should be posted and in some instances colored tape may also be used to block entry.

Exterior doors not being used as entrances should be secured from outside entry but allow for emergency exit. Secured doors should not be allowed to be propped open for any reason.

Traffic control strategies need to be instituted for vehicles and foot traffic. This includes controls and policies for media access and personnel.
Security activities should be coordinated with the facility owner and law enforcement to gain information regarding known risks. If risks are identified, mitigation measures should be taken to limit impact.

Once operational, security personnel have an ongoing responsibility to ensure that staff and clients are provided with a safe environment. Security of the site needs to include situational risk assessment and procedures to screen and limit weapons or other hazardous substances into the medical shelter.

Shelter staff and volunteers need to be clearly distinguished from other shelter occupants by using badges, color-coded shirts, hats and/or vests.

Security staff will assist in enforcement of shelter rules. Signage identifying service areas and acceptable conduct should be prominently displayed for shelter occupants as well as shelter staff and volunteers.

As part of shelter operations, security staff needs to develop processes for:
- Ensuring the security of the pharmaceuticals provided to the medical shelter;
- Controlling access into the shelter;
- Controlling access within the shelter;
- Identifying and tracking clients, staff and visitors;
- Working with local authorities to address heightened security needs;
- Working with private security entities to address heightened security needs;
- Accessing communication links with local law enforcement or security services.

In some instances, uniformed personnel may be needed to provide the shelter with the necessary security, from activation to deactivation. This activity should be coordinated with law enforcement agencies. However, uniformed officers may be better utilized in other aspects of response operations. Local jurisdictions should consider the possibility that shelter staff may be required to take on the responsibility of assisting in monitoring each area for client compliance to established rules.

**6.4.1. Site Lock-down**

A site lockdown is a situation where access into and out of the medical shelter is tightly restricted or even entirely precluded. Events that may trigger a lock-down include mass contamination, picketing, demonstrations and acts of violence, sit-ins, passive resistance, civil disobedience, gang activity or other disturbances. A site lock-down is intended to isolate and control access to the medical shelter while caring for the safety of the clients, visitors, staff and property. If a lock-down is deemed necessary by the jurisdiction, the shelter manager and security personnel should be engaged in all decision making. Requests for additional assistance, including law enforcement, should be routed according to local policies and procedures.
Sheltering Persons with Medical Needs

Shelter staff should secure the exterior and reduce the shelter from two entrances (client and staff entrance and delivery of resources entrance) to a single point of entry. If the medical shelter is collocated, security efforts (including lock-down efforts) should be coordinated with the general population shelter manager.

6.5 Transportation

Clients may require transportation while residing within a shelter. Transport needs may be medically or non-medically related. Some clients will require trained medical staff and/or specialized equipment during transportation. Advanced life support ambulances may be needed to transport clients to a hospital when their medical condition has deteriorated, requiring a higher level of care. Other clients may transportation to specialized medical services such as dialysis. Non-medical transport needs may include relocating a client to a general population shelter when their condition has improved to the point where staying in a medical shelter is no longer appropriate or needed. Transportation may also be required for re-entry into the community once the shelter is deactivated.

Considerations should be made for the type of transportation clients will require (i.e., medical or non-medical) and procedures developed for documenting a client’s condition upon departure. As such, medical shelter plans should include strategies to ensure that vehicles and drivers are available and appropriate for individuals with access and functional needs. Even if appropriate public or private transportation is ordinarily available, there should be a contingency plan for transporting people and their life-sustaining equipment if this transportation is disrupted.

In preparation to transport clients, vehicles should be identified to be able to accommodate wheelchairs, scooters or other mobility aids as well as equipment and supplies if needed (e.g., portable oxygen, portable toilets, communication devices, service animals). Potential sources for such vehicles are listed in Table 7. Each vehicle type should be assessed for its ability to meet the needs of the client and provide the required support during transport.

### Table 7 – Potential Vehicle Sources

<table>
<thead>
<tr>
<th>Potential Accessible Vehicle Sources</th>
<th>Fixed route buses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local school districts with lift-equipped school buses</td>
<td></td>
</tr>
<tr>
<td>Community Emergency Medical Services</td>
<td>Area agencies on aging</td>
</tr>
<tr>
<td>Vans from places of worship</td>
<td>Regional center vendors</td>
</tr>
<tr>
<td>Local assisted living facility vans</td>
<td>Taxi systems</td>
</tr>
<tr>
<td>Local community and public transit vehicles</td>
<td>Fire and Police (non-medical emergency services)</td>
</tr>
<tr>
<td>Para-transit services</td>
<td>Adult day health care vehicles</td>
</tr>
<tr>
<td>Airport shuttle buses</td>
<td>Rail</td>
</tr>
<tr>
<td>Health care center vendors</td>
<td>Private vehicles</td>
</tr>
</tbody>
</table>
Sheltering Persons with Medical Needs

Assets currently being utilized for a government provided service, such as school buses, ambulances, or local route/transit busses, may be the easiest to obtain during an incident. Through preplanning, additional assets may be identified through privately held sources. Each identified source of transportation assets should be assessed for the quantity, type, capability and availability.

Once an assessment of available resources is complete, a guideline for use should be established. This asset use guideline is intended to determine the level of medical support that can be provided in transit. Jurisdictions should consider what staff and resources will be required to meet the determined level of medical support. Apart from emergency medical service vehicles, the assumption is that staff and resources, including a driver, will need to be provided for each asset obtained by the jurisdiction. Table 8 offers a sample approach to transportation asset classification.

**Table 8 – Sample Transportation Assets**

<table>
<thead>
<tr>
<th>Type and Level of Transportation</th>
<th>Description</th>
<th>Guidelines for Use of Transportation</th>
<th>Staff Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular Coach Bus or other Automobile</td>
<td>Greyhound bus or similar, approximately 50 seats available</td>
<td>Clients can sit in an automobile, bus, taxi, truck or other conventional vehicle without requiring any special assistance or equipment (other than personal portable oxygen supply).</td>
<td>1 Driver</td>
</tr>
<tr>
<td>Medical Supported Bus</td>
<td>Same as regular coach bus above, with the addition of medically trained staff and limited medical supplies</td>
<td>Clients are medically/psychologically stable to tolerate bus transportation in a sitting position and may require medical/nursing assessment and intervention.</td>
<td>1 Driver</td>
</tr>
<tr>
<td>Para-Transit Bus</td>
<td>Bus with accommodations for those with access and functional needs, will often have a lift</td>
<td>Clients are either ambulatory with assistance and require a mechanical lift to get into a vehicle or can sit upright in a wheelchair which can be secured in a van. No special medical equipment is required other than personal portable oxygen supply.</td>
<td>1 Driver</td>
</tr>
<tr>
<td>Type and Level of Transportation</td>
<td>Description</td>
<td>Guidelines for Use of Transportation</td>
<td>Staff Required</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Regular Coach Bus or other Automobile</td>
<td>Greyhound bus or similar, approximately 50 seats available</td>
<td>Clients can sit in an automobile, bus, taxi, truck or other conventional vehicle without requiring any special assistance or equipment (other than personal portable oxygen supply).</td>
<td>1 Driver</td>
</tr>
<tr>
<td>Litter Bus</td>
<td>Bus modified to allow for the transport of individuals on a cot or stretcher</td>
<td>Clients are medically/psychologically stable to tolerate bus transportation in a lying position and may require medical/nursing assessment and intervention.</td>
<td>1 Driver 1 Emergency Medical Service personnel per 15 clients</td>
</tr>
</tbody>
</table>
| Ground Ambulance                | Traditional ambulance, can carry 1 to 2 clients per occurrence | Clients meet one or more of the following criteria for transport by ground ambulance:  
  - Require continuous hemodynamic and cardiac monitoring.  
  - Require continuous intravenous (IV) medication drip and require monitoring, such as an IV pump or similar method for delivering precise amounts.  
  - Have orthopedic injuries that require appliances or other acute medical conditions (e.g., cervical traction, unstable pelvic fracture, active labor, etc.) that prohibit the client from traveling on an alternative method of transport.  
  - Require advanced cardiac monitoring. | 2 Emergency Medical Service personnel |
# Sheltering Persons with Medical Needs

<table>
<thead>
<tr>
<th>Type and Level of Transportation</th>
<th>Description</th>
<th>Guidelines for Use of Transportation</th>
<th>Staff Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular Coach Bus or other Automobile</td>
<td>Greyhound bus or similar, approximately 50 seats available</td>
<td>Clients can sit in an automobile, bus, taxi, truck or other conventional vehicle without requiring any special assistance or equipment (other than personal portable oxygen supply).</td>
<td>1 Driver</td>
</tr>
<tr>
<td>Air Transport</td>
<td>Typically a rotor wing aircraft or helicopter capable of transporting serious clients will include medical personnel and advanced lifesaving supplies.</td>
<td>Clients have a medical condition that prohibits them from being transported safely by any means other than in an ambulance and lying on a stretcher. They may also require special medical equipment during transport, e.g., oxygen (when personal portable supply is unavailable), ventilator, suction devices, and/or other biomedical equipment. Typically these clients will have conditions requiring rapid transportation or are located in an area where other transportation assets are unable to gain access.</td>
<td>1 Pilot 2 Emergency Medical Service personnel</td>
</tr>
</tbody>
</table>

Clients should be assessed according to transportation needs. This assessment will help the shelter manager determine the number of resources needed and coordinate with the larger incident response. Prior to departing the shelter, each client’s condition should be noted and a briefing provided to transport personnel. Medical records should be provided to the transport personnel if available.

In planning for transportation, jurisdictions may also consider:

- Having a process determined pre-event for reimbursing transit providers for their services;
- Establishing the flow of traffic at the shelter;
- Ensuring traffic route and parking lot remains accessible at shelters;
- Monitoring parking and drop-off of clients at shelters;
- Directing emergency and supply vehicles to appropriate locations;
- Clearly identifying parking, loading and unloading zones at shelters.

### 6.6. Food Services

**KEY CONSIDERATIONS IN THIS SECTION INCLUDE:**

- Accommodate individuals who may require special dietary accommodations;
Sheltering Persons with Medical Needs

Document all recommendations for accommodations or changes to existing diet orders.

Food and potable water are essential services in all medical shelters. In most communities, if a medical shelter is collocated with a general population shelter, feeding falls under the mass care function. Coordination with the mass care lead and select non-governmental organizations should be considered. If a shelter is not collocated, consideration should be given to the strategies listed below.

**Dietary Planning**

In order to meet the needs of the greatest number of people in the shelter, menus that are low sodium, low fat and low sugar should be developed. Staff should be cognizant of the following guidelines:

- Review food labels and ingredients lists to avoid particular client allergens. See the Feeding and Food Allergy Awareness Tools in Part III: Medical Shelter Toolkit for more information;
- Persons involved with special food services should make sure that they thoroughly understand the required procedures and techniques for the client’s needs. If uncertain, shelter staff should seek guidance and clarification;
- It is important that all recommendations for changes to existing diet orders be documented in writing. These recommendations may be caused by a change in the client’s condition or a physician’s order;
- Special precaution should be taken to ensure that client food allergies are taken into consideration.

When planning for the provision of food at medical shelters, basic considerations include:

- Water (1 gallon/person/day);
- Individual juice bottles;
- Health/protein drinks (e.g., Ensure, Zone, etc.);
- Powdered or single serve drinks;
- Instant tea and coffee;
- Non-perishable food;
- Canned meat, fish, fruit or vegetables;
- Bread in moisture proof packaging;
- Canned soups and nonperishable milk;
- Crackers, cracker sandwich packages, party mixes, other dry snacks;
- Dry cereals and oatmeal containers;
- Packaged ketchup, mustard, or mayonnaise;
- Meals Ready to Eat;
- Cookies, dried fruit, hard candy (especially for diabetics);
- Hand can opener;
- Bottle opener;
- Paper products;
- Service utensils and plates appropriate for those with access and functional needs;
Sheltering Persons with Medical Needs

- Straws (preferably bending straws).

Pre-planning and contingency strategies to ensure the provision of food and water are paramount.

Basic food services planning and operational considerations include coordinating for external delivery of food, snacks and drinks. Jurisdictions may consider arranging support services with external facilities that may have extra capacity to prepare and deliver meals to medical shelter sites during early operations. These may include:

- Vendor provided ready-to-eat meals/shelf stable meals;
- The American Red Cross, Salvation Army or other non-governmental organizations may be able to support the feeding operation with prepared meals and other food items such as snacks, crackers and ready-to-eat foods;
- Hospitals;
- Fast food or restaurant-prepared meals;
- Schools;
- Community supported homeless shelters may be able to assist or provide resource information and contacts.

A medical shelter may use the same food used in the general population shelter, but additional dietary and mobility concerns must be considered. Collocation can greatly facilitate meeting dietary needs.

**Food Preparation at a Medical Shelter**

If medical shelter operations include an on-site feeding operation, basic planning considerations include:

- Notifying and collaborating with local environmental health agencies to implement food storage and preparation processes that adhere to local regulations;
- Ensuring viable transportation of food and equipment to the medical shelter site;
- Ensuring food items are kept off the floor and on shelves to preclude vermin, bug infestation and contamination;
- Checking expiration dates of all perishable supplies received or caches of supplies;
- Ensuring adequate preparation and distribution facilities, including access to refrigeration and heating capacity;
- Providing essential services items including paper plates, plastic cups, utensils and trash collection receptacles, and removal services;
- Ensuring safety precautions are instituted with staff assigned to oversee the operations as food is brought into the shelter, handled, serviced and stored;
- Providing food storage to prevent food spoilage or food borne outbreaks. Staff and volunteers assisting with food service need to be trained in safe food handling techniques to reduce the risk of food-borne illness;
- Staggering and coordinating multiple feeding shifts;
- Securing safe water, such as a source for bottled water, in the event that the public water supply is shut off or contaminated;
Sheltering Persons with Medical Needs

- Planning to serve water throughout emergency shelter operations. Further, significant additional amounts of water will be needed for other emergency shelter operations including cooking, cleaning, and personal hygiene;
- Identifying storage space for bottled water and any non-perishable food items. The recommended quantity for emergency water is one gallon of water per person per day.

Dietary Needs
Providing nourishment for individuals with special dietary needs in a medical shelter may require coordination with various agencies for food, supplies and equipment. Individuals with health conditions such as diabetes, congestive heart failure, food allergies, hypertension and renal failure have dietary restrictions. If these restrictions are not followed, the individual may be at risk for significant adverse effects. In addition, some individuals have conditions that affect swallowing and cannot take in thin liquids or chew hard solids. Food choice considerations need to include:
- Food allergens;
- Food consistency;
- Sodium, fat, and sugar content.

Plans should include provisions to ensure meals and snacks are provided to all shelter clients including children and adults with specific dietary needs and restrictions. Plans should also include a process for responding quickly to unanticipated dietary needs and restrictions that are identified when the client enters the shelter. It is critical that information about any special dietary needs or restrictions be obtained, documented and communicated to the entity responsible for meal and snack preparation immediately as well as ensuring this information is made available to those responsible for providing or serving the food.

6.7. Clothing and Personal Items
Provisions must be made for providing basic clothing and personal items for clients, including replacing glasses and wheelchairs. Many individuals may be displaced without adequate time to secure personal items. Commonly needed hygiene items include razors, toothbrushes, shampoo, soap, tissue paper and shaving cream. Jurisdictions should work with nongovernmental organizations that may be able to assist in furnishing these items.

Jurisdictions should also consider the management of donations which may occur after an incident. Donations from outside the impacted area and even within the community often overwhelm the ability to catalogue, warehouse and distribute these supplies. Many times donations include blankets, clothing and other personal items that can be used within a medical shelter. Jurisdictions should work with select non-governmental organizations, Operational Area members, other agencies
and the business community to effectively organize and manage these donations outside of the medical shelter location.

6.8. Signage

Having proper signage in place when the medical shelter opens will help staff move clients more efficiently throughout the facility and assist in communication to individuals with access and functional needs. Signage should direct clients to key locations throughout the facility. The following table represents possible signs and recommended placement. Signage should be appropriate to the needs of the population; this may require signs to be published in multiple languages and formats.

<table>
<thead>
<tr>
<th>Medical Shelter Signage and Pictograms</th>
<th>Provides sample signage based upon common functions performed in a shelter setting.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Shelter Talk Boards</td>
<td>Provides sample boards which may be utilized to communicate with individuals with an access or functional need.</td>
</tr>
</tbody>
</table>
### Table 9– Possible Signage

<table>
<thead>
<tr>
<th>Type of Sign</th>
<th>Placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Picture Board</td>
<td>Near the registration and information areas. To be used to help persons who have difficulty verbalizing their needs.</td>
</tr>
<tr>
<td>Medical Shelter Registration</td>
<td>On the wall or on the table of the registration area</td>
</tr>
<tr>
<td>Medical Shelter Information</td>
<td>1 near the entrance/registration area with an arrow and 1 near the information area</td>
</tr>
<tr>
<td>Shelter Office</td>
<td>1 near the entrance/registration area with an arrow and 1 near the office</td>
</tr>
<tr>
<td>Do Not Enter</td>
<td>Post signs to indicate the areas that people may not enter or use. Security will need to ensure that people stay out of areas designated as off limits</td>
</tr>
<tr>
<td>Exit</td>
<td>Use these signs to indicate the main exit. This does not account for emergency exit signage which is addressed per local regulation.</td>
</tr>
<tr>
<td>Medical Services</td>
<td>Area for client care</td>
</tr>
<tr>
<td>Isolation – Do Not Enter</td>
<td>Area for clients with contagious conditions</td>
</tr>
<tr>
<td>Hospice</td>
<td>Area for hospice clients</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>Area for children and infants</td>
</tr>
<tr>
<td>Triage Area</td>
<td>Area for screening clients</td>
</tr>
<tr>
<td>Animal Holding</td>
<td>Area where animals can be taken or relinquished to animal shelter, needs to be coordinated with local animal shelter lead</td>
</tr>
<tr>
<td>Staff Only</td>
<td>Area where clients are not allowed</td>
</tr>
<tr>
<td>No Smoking</td>
<td>Post signs at all entrances and throughout the shelter as shelters are no smoking facilities in California</td>
</tr>
<tr>
<td>Oxygen in Use</td>
<td>Areas where oxygen is in use</td>
</tr>
<tr>
<td>Waiting Area</td>
<td>Area where clients may wait to receive certain services, including transportation</td>
</tr>
</tbody>
</table>

When placing signage, it is important to post appropriate signs for clients with access and functional needs (e.g. pictograms, large print and language translation for written directions).

Continuous assessments by staff should determine the need for additional signage. Jurisdictions may consider developing and providing access to pre-developed signs.

### 6.9. Heating, Ventilation, and Air Condition, Power and Lighting

Jurisdictions should ensure that the selected site is capable of supporting heating, ventilation and air conditioning, electrical power and lighting for shelter operations. The availability of a primary and auxiliary power supply should be a critical consideration when deciding whether to open a medical shelter, as power is required by a number of life sustaining devices which clients may require. The power grid and auxiliary emergency electric power capability need to be sufficient to power receptacles utilized to run oxygen concentrators, oxygen nebulizers and other medical equipment.
When a medical shelter is activated, it should be listed with public utilities as a high priority facility for power maintenance and restoration.

Appropriate personnel should be present and on-site to operate, maintain and repair the backup power supplies at times when the medical shelter is occupied. Planners should ensure that sufficient fuel stores are available for continuous generator use at full load.

Jurisdictions should also ensure that sufficient and safe supplies are available to route power where it is needed (i.e. extension cords of adequate size, plug strips, tape to secure cords to the floor, etc.). This allocation of power to client care areas is particularly important early in the activation of a shelter site. Depending upon the size of the shelter operation, jurisdictions will want to consider the number and location of power outlets in the sleeping, client care and common areas of the site.

Lighting is also a critical consideration at a shelter site. In many instances, the selected site will already have some degree of lighting; the shelter staff should determine its adequacy. Jurisdictions should ensure the availability of additional lighting (fixed or mobile). This may be especially true for areas designated for providing client medical care (e.g. wound care or dressing change). In addition, local jurisdictions should consider that, in the evening and during night shifts, sleeping areas are traditionally kept darker while client care and common areas remain lit. As such, local jurisdictions may consider an appropriate lighting plan to account for those differences.

If a medical shelter is collocated with a general population shelter, power and lighting should be coordinated and a unified plan developed.

### 6.10. Medical Gases

Depending on the nature of the event, individuals who require the assistance of medical gases, such as oxygen, may register at the medical shelter with limited or no additional supplies of those gases. In anticipation of this situation, agreements should be established with multiple oxygen providers for the provision of medical gas during shelter operations. During activation, these providers should be contacted immediately to begin transporting oxygen and other gases.

Clients requiring 24-hour oxygen or who are dependent on electricity to operate their medical devices needs should be evaluated to ensure that their needs can be met. The preferable method of administering oxygen in a shelter environment is through the use of liquid oxygen, particularly for those clients receiving oxygen 24 hours per day or otherwise being administered a high volume of oxygen. Medical shelter staff needs to be trained on the management of oxygen therapy, how to set up and refill oxygen cylinders, and the correct way to store medical gases.

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Oxygen Guidelines

Provides an overview of key considerations related to medical oxygen delivery and storage.
Sheltering Persons with Medical Needs

6.11. Medical Devices

Clients who regularly use medical devices such as ventilators, dialysis machines, pumps and monitors may present to the medical shelter. In preparation for these clients, jurisdictions may consider developing a list of the most commonly used devices. This list could be used to identify devices present at the medical shelter and those which may have to be obtained. For devices which are more complicated to use, general handling and operating guidelines should be made available. Jurisdictions should identify, prior to an event, vendors and healthcare providers with the resources to supply medical devices for clients that do not bring their own with them to the shelter. For pre-identified shelter locations, jurisdictions should ensure those locations contain wide doorways, hallways and ramps so clients with access and functional needs are able to access the devices.

In many instances clients will bring their own medical devices. Each piece of equipment should be tagged with the Disaster Identification Number issued to its owner.

Renal Dialysis Planning Considerations

Provides an overview of key planning considerations related to the provision of dialysis during medical shelter operations.

7. Staffing

OBJECTIVES FOR SECTION:

- Determine staffing requirements for shelter operations
- Appropriately plan for anticipated staff
- Access Job Action Sheets for more detailed position descriptions

7.1. Planning for the Workforce

Planners must consider staffing needs for site set-up, site administration, clinical operations, support functions and command. Plans should anticipate staffing needs for the initial four to six days of operation. Medical shelters may be staffed by local government employees, community organizations, contractors, volunteers and others. It is important that shelter staff understand that the incident may require them to fill various positions and take on new responsibilities over time.

The number of licensed medical care providers necessary will depend on the medical acuity and number of the clients housed within the shelter. For example, clients with more complicated medical conditions requiring more intensive nursing care (e.g. frequent wound care or suctioning) may necessitate a greater number of registered nurses. Depending on the licensing requirement for medical shelters, a Governor’s executive order may be necessary to waive current California staffing requirements. The Table 10 provides a sample clinical staffing model for a medical shelter, based on common practices observed in the State of Texas.
**Table 10 – Sample Clinical Staffing Ratios**
(50 Person Medical Shelter, 12 hour shifts)

<table>
<thead>
<tr>
<th>Staff/Volunteer</th>
<th>Number</th>
<th>Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Director (low acuity medical needs)</td>
<td>2</td>
<td>Around the clock coverage 24/7</td>
</tr>
<tr>
<td>1 RN/LPN per 20 clients</td>
<td>3</td>
<td>24/7, 7 days a week</td>
</tr>
<tr>
<td>Nurse Director (high acuity medical needs)</td>
<td>5</td>
<td>24/7, 7 days a week</td>
</tr>
<tr>
<td>1 RN/LPN per 10 clients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologist per 250 clients</td>
<td>1</td>
<td>Dayshift, 7 days a week</td>
</tr>
<tr>
<td>Respiratory Therapist per 100 clients</td>
<td>1</td>
<td>24/7, 7 days a week</td>
</tr>
</tbody>
</table>

### 7.2. Staff Shift Schedules

In the initial stages of response, shelter hours are generally assigned two 12 hour shifts per day. Although 12-hour shifts may cause hardship on the staff, the benefit of a longer shift provides consistency for shelter management and clients and generally more efficient coordination because of comfort with operations. Consistency can bring stability to the shelter environment; if possible, staff should not be rotated out of one shelter site into another. Staff should remain assigned to the same site for the duration of the operation or until their skills are no longer required.

Shelter management should enforce a system for mandatory breaks to prevent overwork. An observed practice of the American Red Cross is that after six days of support, one day of rest is required. After the initial stages, as additional staff members are identified and shelter operations are established, the shelter manager may consider adjusting the shift schedule to better accommodate existing shelter staff and client needs.

Staff should ensure that they arrive at the shelter for their shift in sufficient time to overlap with outgoing staff for the shift debrief. Upon arrival they should sign in and record their time worked on a timesheet. Keeping detailed records is critical to tracking and reimbursement.

### 7.3. Staff Training

**Part I: Foundational Knowledge** discusses medical shelter training conducted prior to an incident. This section assumes that the incident has occurred and the jurisdiction needs additional staff resources that may be unfamiliar with medical shelter operations.

Just-in-time training refers to rapid training courses designed to familiarize staff with processes and operations. This training should cover the operations and administration of the medical shelter as well as directions on using equipment, medical supplies and other materials. Just-in-time training can take place in any area of the shelter. On-site and/or just-in-time training courses may include:
• Site operations and procedures;
• Client tracking and client valuables tracking;
• Report procedures, check-in procedures, credentialing;
• Personal protective equipment, medical evaluation and testing, infection control, FIT testing;
• Medical records keeping, storage, and chain of command;
• Communication procedures;
• Obtaining prescription procedures;
• 911 protocols;
• Standing orders;
• Logistics.

Jurisdictions should consider their just-in-time training needs and develop the appropriate courses prior to the incident.

7.4. Credentialing and Personnel Verification for Clinical Staff

It is recommended that credentialing occur away from the shelter site, at a location focused on the administrative processing of incident-related volunteers. However, it is understood that this may not always be possible and local jurisdictions may not have the staffing capacity during response activities. Medical volunteers should be identified by skill set and deployed based upon resource requests from the medical shelter.

Medical shelter staff should verify that all licensed professionals arriving to work at the shelter have verified credentials. Once the health professional’s identity and ability to practice has been verified, the medical volunteer should be assigned according to need.

Credentialing Verification Form
Provides form to capture key information related to credentialing personnel.

7.5. Clinical Operations Staff Planning

Staff-to-client ratios are an important consideration for clinical operations. The following sample ratios may be considered, however, jurisdictions should confirm their intended approach with applicable regulations:

• One nurse manager per site;
• One nurse per 20 clients of lower acuity, one nurse per 10 clients for higher acuity;
• Personal Assistant Services as required;
• One physician per five medical shelter sites of low acuity, one physician per site for high acuity;
• One psychiatrist on-call for up to five medical shelter sites;
• One respiratory technologist per 100 clients.

Jurisdictions should validate these projections throughout the planning process. The staffing pattern should be adjusted based on the site layout, actual number and needs of individuals and availability of resources. The needs of the population within the medical shelter may justify an increase or
decrease in the number and type of staff present; thus, continual assessment is required to ensure adequate support is available.

7.6. Clinical Staff

During an incident, availability of clinical staff for the medical shelter may be limited as many will be engaged in providing care at healthcare facilities. This may necessitate arrangements in the non-governmental, public and private sectors for clinical staff. Jurisdictions should explore the use of non-practicing licensed professionals and utilize professional registries, local government resources and relationships with clinics, private physician offices and medical schools for the recruitment of clinical staff. The California Disaster Healthcare Volunteer system can assist local jurisdictions identify available clinical staff.

It is difficult to determine exactly how many clinical staff will be required to provide care in a medical shelter. The level of care delivered will largely depend on the needs of clients, availability of staff and healthcare resources. Planners should utilize identified staff-to-client ratios to develop an approximate projection of clinical staffing needs.

If additional clinical staffing is required from outside of the Operational Area, it may be requested through the resource management process. Clinical resources may be available through the California Disaster Healthcare Volunteer program, mutual aid or a request for state and federal assets.

7.7. Medical Director

Jurisdictions should determine what agency is responsible for identifying and appointing a Medical Director as this function is essential to clinical operations. Medical direction should be provided by a licensed physician, who will provide the medical authority under which the shelter clinical staff operates. In most cases, the government entity that authorizes the shelter should provide a Medical Director or an authorized designee.

The Medical Director should be available for the duration of the shelter operation for medical consultation, which can occur virtually or in person. This individual should be prepared to serve in an advisory role for all clinical staff. Guidance from the Medical Director may be sought whenever clinical staff needs physician consultation.

7.8. Shelter Management

All management activities should be facilitated through the medical shelter command structure. Utilization of this structure will facilitate the integration of all shelter staff into a single incident action plan. This coordination of effort will result in optimum medical care for clients. Command roles at the medical shelter will typically be staffed by local government. Lines of succession should be established for each of these key roles during the planning process. The shelter manager is ultimately responsible for all activities at the shelter site.
Ensuring the health and welfare of the staff providing services to medical shelter clients is an important consideration in shelter management. While the overall mission remains focused on the client, the medical shelter manager must also account for staff well-being. The shelter manager is responsible for ensuring that all staff (including the command and general staff) receive adequate breaks for meals and rests, including adequate time for a daily sleep shift. A staff-only break area separate from the clients and dining areas should be established in the shelter layout. Efforts should also be made to set aside a portion of the shelter for a staff “bunk room” where staff can sleep in the event that returning home for their sleep shift would be too difficult.

7.9. Setup Staff
Planners should determine the number of staff required to set up the medical shelter. Factors for consideration include the necessary site conditions for medical shelter configuration and set-up; cleaning, engineering, and access and functional needs; and availability of storage space for supplies and equipment.

Resources from non-clinical sources may be sought to assist with this task. In some instances, jurisdictions may wish to pursue memoranda of understanding/agreement and vendor agreements to support this activity.

Setup staff should be given detailed instruction on how to appropriately establish the site. Layout schematics may help; a sample is available in the Part III: Medical Shelter Toolkit.

Setup is generally overseen by the medical shelter manager, who has the ultimate responsibility to ensure that the site is prepared to receive clients.

7.10. Support Staff
A medical shelter will require the participation of numerous support staff. The services that such staff may need to provide includes, but is not limited to, administrative, food service, child care, laundry, traffic control, security, engineering, spiritual health, housekeeping, transportation services, and facility maintenance.

Jurisdictions should identify during the pre-event planning process community organizations that can, in the aftermath of an event, either provide individuals or assist in identifying individuals who would be willing to volunteer to render these services. This would significantly assist jurisdictions in quickly and efficiently standing up and staffing a medical shelter. Some jurisdictions may find it helpful to establish prior to an event contracts with outside agencies or vendors for some support activities.
8. Pharmaceuticals, Supplies and Equipment

OBJECTIVES FOR SECTION:

- Account for pharmaceutical needs in medical shelters
- Describe the consumable medical supplies and durable medical equipment needed
- Plan for staging and deployment of medical shelter supplies

8.1. Maximizing the Sustainability of Resources

Planning for sustainability should help to maximize the use of limited resources. The recommendations provided in this section may be used as a guide to determine the types and quantities of pharmaceuticals, supplies and equipment to acquire as well as the method of obtaining and deploying these resources. As resource needs are identified, planners should ask the following questions:

- Who will supply the items;
- Who will deliver the items;
- Who will set up the equipment;
- Whose responsibility is it to return the items post-disaster?

Maximizing sustainability will require identifying needed resources, developing a comprehensive inventory of existing resources, determining gaps and developing procurement strategies.

It is the duty of the medical shelter staff to ensure that supplies are disbursed appropriately and to determine who should receive resources in the event of inadequate supply.

8.2. Pharmaceuticals

There are federal and State laws, rules, and regulations related to the storage, preparation, distribution, dispensing, administration, documentation and disposal of medications. For this reason it is important that jurisdictions have a pharmacist on staff prior to the activation of a medical shelter and be prepared to seek guidance from appropriate federal and State authorities.

In order to fill new and refill prescriptions for clients at a medical shelter, jurisdictions should contract with local pharmacies and hospitals or establish an in-house pharmacy under the supervision of the Medical Director. Both options require detailed planning prior to an event to insure procedures are in place for obtaining, storing, dispensing, administering, documenting and disposing of medications.

For security purposes and to minimize the amount of set-up required at the medical shelter, the preferred option is to utilize local retail pharmacies and hospitals to fill new and refill prescriptions for clients of the medical shelter. Considerations and planning that need to be detailed under this option – all under the responsibility of the Medical Director - include:
Sheltering Persons with Medical Needs

- Ordering process for prescriptions, bulk medications, IV solutions, etc.;
- Pickup or delivery of prescriptions;
- On-site storage and security of prescriptions;
- Dispensing of prescriptions;
- Disposal of unused medications.

Some retail pharmacy chains have mobile pharmacy capability which may be utilized to provide temporary pharmacy services to the shelter.

The second option is to establish an in-house pharmacy at the shelter. Pharmacy and medical supplies would be ordered under the auspices of the Medical Director’s state medical license and Drug Enforcement Agency registration. This option requires much more extensive advance planning as well as logistical support during an event. The most critical barrier to this option is the location for delivery of pharmaceuticals. Drug wholesalers will only ship to the address on the Drug Enforcement Agency registration. Supply and delivery alternatives could include shipment of the pharmaceuticals to the Medical Director’s office and then secondary delivery to the medical shelter, or an agreement to have the medical shelter stocked and re-supplied from a licensed local pharmacy. Either way, logistical support to move product to and from the shelter must be in place.

Additionally, considerations that must be addressed at the shelter include:
- Process of filling and dispensing large quantities of prescriptions;
- Alternate mechanism for billing third parties (e.g. insurance companies);
- Source, delivery and storage of ancillary supplies;
- Professional personnel to staff the pharmacy;
- Security for storage and dispensing areas.

Regardless of which option is selected, pharmaceuticals need to be on hand to meet prescriptions and over-the-counter product needs.

After dispensing, storage responsibilities may reside with the individual client, who is responsible for safeguarding, storing and administering their own medication. If that is not practical (due to the need for refrigeration, concerns regarding drug security, or the ability of the client to self-medicate) clients’ prescription medications should be kept in a locked container used exclusively for that purpose. These medications should be returned to the client upon discharge.

8.3. Supplies and Equipment

The medical shelter should be prepared to treat clients requiring an array of specific supplies, equipment and staff. Despite best efforts and advance planning, some persons will arrive at the shelter without the durable medical equipment and/or medications they require.

Jurisdictions should include a process for locating, purchasing and storing as many of the supplies and equipment as possible and practical to meet the needs of a medical shelter. In some instances, resources will be sought in the private sector. Jurisdictions should develop provider agreements with agencies to ensure that necessary equipment and supplies that have not been purchased and
stored will be available during an emergency or disaster. For supplies which are stored, jurisdictions should develop agreements to maintain the resources so they are prepared for deployment.

Components of medical needs shelter supply and equipment plans should include:

- Furniture such as hospital beds and lounge chairs, bedding, and privacy screens;
- Contracts negotiated with the appropriate vendors for items such as pharmaceuticals, oxygen tanks, portable generators, and linens;
- Delivery and transportation arrangements;
- Documented inventory procedures;
- Developed re-supply procedures;
- Contract provisions to operate the equipment and perform periodic maintenance as required when generator equipment is kept on-site;
- Janitorial services including the provision of cleaning supplies and paper products;
- Arrangements for the delivery, maintenance and retrieval of portable toilets when needed.
- A full listing of the supplies and equipment that should be located and/or stored prior to an incident is included in Part III: Medical Shelter Toolkit.

**Supplies and Equipment Checklists**

Provides a series of detailed checklists outlining needed resources at a medical shelter site, including consumable medical supplies and durable medical equipment.

8.3.1. Durable Medical Equipment

Durable medical equipment may be necessary on-site at the medical shelter. Supplies may include accessible cots, beds, canes, shower chairs and other items which can be decontaminated and potentially reused.

In the case of a medical shelter, universal access cots should be utilized to the extent possible. They provide a wider sleeping surface, thicker mattress and higher surface. This makes the cot more versatile when dealing with clients who may have trouble getting in and out of low beds. Eighteen inches is generally not enough for self-transfer in and out of wheelchairs.

8.3.2. Consumable Medical Supplies

Consumable medical supplies may be necessary on-site at the medical shelter. These supplies are usually disposable items meant for individual client use and may include antibacterial wipes, plastic bags and latex gloves.

8.4. Staging and Deployment

Pharmaceuticals, supplies and equipment may be staged and deployed to a mobilization center prior to and during response. Plans to retrieve items from their locations and transport them to the medical shelter should immediately follow medical shelter activation. The following points should be taken into consideration:
Sheltering Persons with Medical Needs

- Identifying needed supplies such as cots, linens, gowns and medical supplies;
- Packaging in a cart or trailer “first push” supplies for easy and rapid deployment;
- Preparing a detailed inventory of items including available quantities;
- Planning how items will be moved and transported to the shelter site, including the path of travel between the storage site and destination;
- Establishing instructions and plans for setting up items once resources are deployed (e.g. tents, tables, and generators).

A “first push” consists of the essential items required to initiate the establishment of a medical shelter. These supplies may also be maintained by a jurisdiction in the form of a cache or be readily available through some type of vendor agreement.

Jurisdictions may review the toolkit to better determine their anticipated initial resource needs when establishing a medical shelter.

| Durable Medical Equipment Supplies Checklist | Provides a list of medical supplies for medical shelter operations. |
| Consumable Medical Supplies Checklist | Provides a list of medical equipment for medical shelter operations. |

9. Communications

Effective internal (within the shelter) and external (to the incident command structure, other agencies and the media) communication is essential during an incident response. Shelters should have documented mechanisms for internal and external communications. It is critical that these communication approaches are interoperable and integrated into emergency operations plans for the Operational Area.

OBJECTIVES FOR SECTION:
- Define key considerations for internal medical shelter communications
- Describe methods to meet access and functional needs in communication activities
- Define key considerations for external communications relating to medical shelters

9.1 Internal Communications

The primary means of communication between staff, clients and other stakeholders within the shelter includes written signage, verbal commands, portable two-way short range radios, intercom systems, bullhorns, information technology and other devices.

Information technology required at the medical shelter should comply with applicable laws and federal regulations (see legal section for additional detail). Software and hardware selected should be interoperable with existing systems and other response stakeholders. Information technology functions may include:
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- Client tracking, clinical information sharing, and data storage;
- Systems for third party reimbursement;
- Inventory management systems;
- Emergency management software systems.

Children and adults who have access or functional needs should be given the same information provided to the other clients, using methods that are understandable and timely. Prior to the incident, auxiliary aids and services necessary to meet the communication needs of all persons in the shelter should be identified and made immediately available. External resources may need to be sought to provide:

- Interpreters (Spanish and other foreign languages, sign language, etc.);
- Television with captioning;
- Information technology/computer services;
- TTY – TDD;
- Computer Assisted Real Time Translation;
- Note taking.

Medical Shelter Talk Boards
Provides sample signage based upon common functions performed in a shelter setting.

Medical Shelter Signage and Pictograms
Provides sample boards which may be utilized to communicate with individuals with an access or functional need.

9.2. External Communications

Effective external communication with other agencies is important to share accurate and timely information about the medical shelter operations and communicate resource needs. The shelter manager should have access to redundant communications capabilities. Depending upon the incident, some communication systems may not be functional, necessitating the need for multiple communication venues. Examples of communication resources may include telephone, radio, internet and publicly available media. An amateur radio is another viable redundant communication resource that might be considered.

For communication with external agencies, jurisdictions should utilize established systems to the extent possible. Pre-planning may help identify what physical resources would be needed at the shelter site. In addition, the presence of a qualified operator with technical expertise may be required in some instances.

The activation of external communications should occur immediately upon the establishment of the medical shelter and remain functional throughout the operation.
10. Medical Shelter Admission

OBJECTIVES FOR SECTION:
• Understand basic screening considerations
• Implement an intake, triage and registration process

10.1. Overview
As clients enter the medical shelter, they should be assessed to determine the appropriate level of care required. This task is intended to efficiently triage clients into treatment categories, enabling the clinical staff to provide the best care possible to the greatest number of clients. Through this process, clients who are not appropriate for medical shelters will be identified and transferred to locations better suited to meet their needs, such as a licensed healthcare facility or a general population shelter. Final determination of the types of individuals who can be served at the medical shelter should be made by the shelter manager in collaboration with the Medical Director based upon resources and staff available.

The process outlined below is an example of the activities that should occur as a client is admitted to the medical shelter. It is understood that in many situations, this process will need to be modified to meet local needs. If the medical shelter is collocated with a general population shelter, intake and triage should be coordinated with the mass care lead and general population shelter operations to avoid duplication of efforts in gathering client demographics and history. If the event is large enough, multiple stations may be necessary for each function described.

The figure below offers a graphical depiction of the overall admission process. Detailed descriptions are offered in the following pages for screening, triage, registration and intake. Each activity has a unique role in assuring that clients’ medical needs are met.

**Figure 6 – Admission Process**

Prior to the arrival of clients, staff should establish areas of the shelter for different classifications of medical needs and conditions. These areas will be established based upon each shelter’s layout and staffing and the health status of the population. Discussing this prior to client arrival will facilitate the placement of clients once they complete the admission process and will minimize the relocation
of clients within the shelter in the future. General considerations may include (but are not limited to) pre-designated locations for:

- Clients with mobility challenges. This section should be placed closest to the restrooms;
- Clients with wheelchairs or other large equipment. This section should be placed in American Disabilities Act compliant cot areas of 100 square feet (10x10);
- Clients with similar medical requirements. This grouping is designed to facilitate distribution and management of medicine and equipment and other supply logistics as well as to identify clients who need more advanced monitoring and care.

Within the client care area, configuration should include divided sections for the following specific categories of client care:

- Prescriptions/minor care;
- Adult unit;
- Pediatric unit;
- Psychiatric unit;
- Isolation unit (large enough for single family).

The configuration should maximize provider access to clients who are segregated by services and the client demographics.

10.2. Screening Considerations

As clients begin to arrive at the shelter site, an initial screening should be performed to ensure that the medical shelter has the capacity to meet their needs; this screening does not need to be a detailed triage. During this step of the admission process, the following should be considered:

- As clients are often the best judge of their medical needs, screening should be an open discussion with the client. Staff should encourage full communication;
- Whether the individual is contaminated or contagious must be determined and actions taken accordingly;
- A personal assistant, nonmedical shelter staff member should escort individuals from their mode of transportation to the intake/triage/registration area;
- The shelter personal assistant should ask the client to complete the medical shelter intake form and determine if the client has been brought to the appropriate shelter.
- If the client appears, based upon initial impressions, to be suitable for a medical shelter:
  - Have the client sign a “consent to treatment” form and a “release of information form”.

Each client should be permitted and encouraged to bring one adult caregiver to the shelter. Additional members of the client’s immediate family should be permitted on a case-by-case basis, considering the well-being of the other family members and the ability of the shelter to support their needs without compromising the safety and well-being of other clients.

Individuals deemed ineligible for admission to the medical shelter because they do not require medical support should be referred to the general population shelter. Individuals deemed ineligible
because their needs are more advanced and cannot be met by the shelter should be referred and transported to a hospital or other healthcare facility capable of meeting their needs. If a client appears to have an acute medical need, staff should access emergency medical care and transport. A process for accessing emergency medical services should be established.

Client Packet

Provides a series of tools which may be utilized as a client enters a medical shelter and thorough their stay, includes intake assessment form, consent for admission and treatment, ongoing medical record, and other relevant tools.

10.3. Triage

Triage will efficiently sort the clients into treatment categories which should be defined during the establishment of the medical shelter. Screening and triage may occur as the same function, depending on the size of the medical shelter.

In order to provide the best care possible to the greatest number of clients, clients should be classified according to their medical needs. The triage staff will most likely not be involved in direct client care because it would slow down the processing of new client arrivals, although exceptions should be made when life threatening issues present themselves. If immediate lifesaving or emergency care is required, resources should be made available to meet the client’s needs. It is recommended that an emergency medical ambulance be available on-site to augment the services required in these situations.

During triage, medical staff should:

- Obtain a brief history and perform a nursing assessment (to include basic personal information, ongoing medical needs and allergies and the presence of alcohol or drugs) and document any access or functional needs;
- Document physician’s orders and prescriptions, if available (may be able to obtain this information from client’s medication bottles);
- Confirm that the client should be sheltered in the medical shelter and not transferred to another facility;
- Provide information containing shelter rules to the client;
- Assign a tracking number to each client. The number should be identified with the client’s name, address, and phone number. One helpful approach is to provide tracking numbers on wristbands and place a color-coded sticker on each to identify the type of care required. The same colored sticker will be placed on the client’s care forms, which will be given to the nursing staff. An example of the color coded system is displayed in table 11 (if local jurisdictions use a color coding system, they should be aware of confidentiality concerns. Additionally, clients may be considered vulnerable if their condition is known by other shelter clients.);
- Complete the shelter intake form, which should including the following:
  - Current medical status;
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- Functional or communication limitations/barriers;
- List of all medications and the amounts being taken and/or brought with them. Any medication the client needs and does not have should be verified and, and staff are responsible for ensuring that all medication is labeled with the client’s name;
- List of all medical equipment the client needs and/or has brought with them; label all equipment with the client’s name;
- List of all companions accompanying the client;
- Disaster-related medical conditions or pre-existing condition flare up;
- Any dietary needs;
- Specific services rendered;
- Cause of injury or illness;
- Documentation of care to specify moment of care or stabilization;

- Indicate whether treatment is for medical stabilization or maintenance medical care.

If clients are triaged to remain at the medical shelter, the client’s medical needs should be addressed. Shelter staff will:

- Assign the client to a specific area of the medical shelter, depending on his or her medical needs.
- Once a client is assigned to a specific location within the shelter, an identifier should be established to ensure clients are properly accounted and cared for by medical staff assigned to the client care area.

Those clients who are critical and awaiting transportation to a health care facility should be closely monitored until an emergency medical services unit arrives and a transfer has taken place. All triage records will be forwarded with the client, and the shelter registration form will be annotated with transfer information.

Triage personnel will be assigned other duties after the initial surge intake is completed or as directed by the nurse manager.

Table 11 – Sample Triage Color Codes

<table>
<thead>
<tr>
<th>Color</th>
<th>Client Type</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>Allergy</td>
<td>Individual has an allergy. Red wristband alerts staff to look in the client’s medical record for additional information.</td>
</tr>
<tr>
<td>Yellow</td>
<td>Fall Risk</td>
<td>Individual has a propensity to fall. Staff will monitor clients closely to determine if they need personal assistance.</td>
</tr>
<tr>
<td>Purple</td>
<td>Do Not Resuscitate</td>
<td>Individual has expressed an end-of-life wish, staff should be made aware.</td>
</tr>
</tbody>
</table>

Medical Shelter Triage Tools

Provides a sample triage approach for medical shelter operations.
10.4. Registration

In order to prepare for registration at a medical shelter, upon notice of the medical shelter’s activation (and preferably before clients begin to arrive), the following actions should be taken by the Registration Unit:

- Print registration forms;
- Set up an intake and registration table in a clear and accessible area and ensure staff have needed supplies to accommodate people with access and functional needs;
- Ensure adequate signage is posted in and around the shelter site;
- Assign registration staff as “greeters” to assist shelter clients from drop off area to registration;
- If needed, use wheelchairs to move shelter clients and their belongings.

| Client Ongoing Medical Record | Provides a sample form for capturing ongoing client care information. |
| Client Medical Administration Record | Provides a sample form for capturing the administration of medical care to medical shelter clients. |

10.4.1. Registration Process

During registration, the following processes should be completed and the appropriate information gathered. Each client should be assigned a Disaster Incident Number. Registration information that should be collected on the registration form includes:

- Incident name;
- Date/time admitted;
- Registered by;
- Site where displaced person entered the system;
- Client Disaster Incident Number;
- Triage number;
- List of all companions/caregiver;
- Client name (first and last);
- Sex;
- Date of birth/Age;
- Telephone number (home and cell);
- Primary language;
- Insurance information;
- Social security number;
- Medi-Cal/Medicare ID number;
- Personal medications and/or equipment necessary to administer medications such as nebulizers/inhalation machines;
- Do-not-resuscitate orders. These must be presented to the shelter staff during the registration and intake process in order for the order to be followed;
- Personal hygiene materials (e.g. toiletries, linens, child care needs);
- Personal belongings such as several changes of clothes.
Caregivers will be registered along with the client they are accompanying. Their names will be indicated on the client’s registration forms and they will be assigned to the same area of the shelter, if appropriate.

10.4.2. Ongoing Registration Tasks
Registration staff should perform the following tasks once clients have been registered:

- Ensure the registration area is staffed at all times;
- Track clients when/if they leave the shelter and when they return to maintain an accurate population count.

10.5. Intake
During the final phase of the admission process, the client will be placed in a specific location within the medical shelter and medical care will be administered. Staff performing intake should:

- Refer to the client’s registration form for all demographic data and basic personal information;
- Determine if the person needs a hospital bed, medical cot or a general population shelter cot;
- Have staff escort the client to their assigned area;
- Provide orientation of shelter layout and operations to include restrooms, food services, common areas and client care locations;
- Use medical shelter forms in client charts to record medications and client status, request physician orders as appropriate and request additional resources to care for clients.

11. Medical Operations

Objective for Section:

- Understand the foundations of medical operations at a medical shelter
- Determine the level of care provided and need for protocols
- Plan for client transfer to and from medical shelters

Medical care during the operation of a medical shelter is defined as the utilization of skills, diligence and reasonable exercise of judgment in furtherance of optimizing population outcomes that a reasonably prudent person or entity with comparable training, experience or capacity would have used under the circumstances.

Once a shelter is operational, monitoring staff, supplies and potential problems or safety concerns will be a priority. It is the responsibility of the shelter manager to keep the local jurisdiction appraised of the events occurring at the medical shelter, including:

- Staff Shortages: Staff shortages should be reported according to local resource requesting procedures. If additional local resources cannot be identified, the local jurisdiction should work with their Operational Area to request resources following the standardized processes outlined in the California Public Health and Medical Emergency Operations Manual.
Supply Shortages: Supply shortages should be reported according to local resource requesting procedures. If additional local resources cannot be identified, the local jurisdiction should work with their Operational Area to request resources following the standardized processes outlined in the *California Public Health and Medical Emergency Operations Manual*. Only essential supplies should be requested.

11.1. Level of Care Provided

**KEY CONSIDERATIONS IN THIS SECTION INCLUDE:**

- The level of care provided at a medical shelter should not exceed the level of staff skills and resources available.

Care provided at a medical shelter is not intended to replace all services found in a healthcare facility. Any person who presents or develops the need for a level of care beyond that which can be provided at a medical shelter should be transferred to an appropriate healthcare facility.

Clinical staff will provide care within their scope of practice based on their training and qualifications and are not expected to provide care beyond their professional level of expertise or comfort.

The Skills Matrix in Part III: Medical Shelter Toolkit provides guidelines on the level of care that may be provided at each site within the healthcare continuum. Ultimately, the care provided at a medical shelter will be determined by resource availability, staff training and qualifications, scope of practice issues and incident-specific client needs. All considerations should be adapted to local capabilities through the planning process and subsequently serve as a reference during the registration and triage process.

A guide to the classification of symptoms and conditions, management of chronic pre-existing conditions, emergency care guidelines and management of specific conditions is included in Part III: Medical Shelter Toolkit. Local jurisdictions should work to determine the appropriate protocols for medical shelter operation and these protocols should be approved in consultation with the Medical Director. Local jurisdictions might use the approved protocols in any of the following situations:

- In an emergency when no physician is available;
- When specific order(s) for individual clients have not been written by an attending physician;
- When the clinical staff is not able to reach the responsible physician for specific orders;
- When access to a medic/ambulance or hospital is delayed;
- When clients have minor health problems that do not require the immediate attention of a physician;
- If there is no physician on record, the Medical Director should be contacted.

Client orders issued by the Medical Director supersede any protocols and must be documented appropriately and clearly. Should these orders exceed the level of care available at the medical shelter, shelter staff should make arrangements for the client to be transported to an existing
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healthcare facility capable of meeting their needs. The need for emergency treatment should be
determined by the client’s condition rather than by the type of injury or illness. If emergency
treatment is required, the client should be relocated to a hospital via emergency medical services.

Nursing staff will provide services and procedures ordered by a physician, so long as the procedures
can be supported by the level of care available at the medical shelter. The Medical Director will
determine which procedures can and cannot be performed at the shelter based on resources, staff
and safety of the clients. If a client needs a procedure that cannot be performed at the shelter, they
will be transferred to a medical facility for the procedure. Ordinarily, invasive procedures are not
performed at the medical shelter. All procedures performed by shelter staff will be documented in
the client’s medical record.

Skills Matrix

Provides a sample of differing levels of care for various sites within the healthcare
continuum.
Provides a series of tools relevant to the operation of medical shelters, includes
triage tools, skills matrix, shelter level of care matrix, sample medical shelter
protocols and standing orders.

Medical Operations

11.2. Infection Control

Medical shelters are considered temporary and are not expected to administer healthcare service in
the traditional sense. However, infection prevention and control strategies are critical to identifying
potentially infectious or acutely ill individuals and preventing the spread of disease within the
shelter. Appropriate placement of individuals within the shelter should be the first line of
precaution; this is covered in detail in the Admission section of this guidance.

Universal precautions and body substance isolation precautions should be utilized. Individuals with a
communicable disease or those requiring acute medical care should be transferred to an existing
healthcare facility as soon as feasible. In situations in which potentially contagious individuals
cannot be transferred, shelter staff must implement infection prevention and control intervention to
decrease the risk of disease spread within the medical shelter.

Disinfection procedures should be followed to decontaminate reusable medical equipment and
other medical shelter supplies. Jurisdictions should refer to local public health and infection control
guidelines when establishing procedures for the medical shelter.

One of the methods by which a medical shelter can protect the health and safety of its workforce is
in the provision of personal protective equipment to shelter staff. Personal protective equipment
must be issued in consideration of the environmental conditions at the medical shelter in order to provide the proper level of protection.

11.3. Mental Health
Crisis counseling should be made available to help relieve grieving, stress or mental health problems caused or aggravated by the incident. Mental health services may be required for both clients and staff. A location should be established away from the client area for individuals who have difficulty coping; this area can also be used to treat staff.

Mental health services in a medical shelter may include providing psychological first aid, mental health assessment, counseling and/or education; offering therapeutic intervention such as stress management; providing general assistance; making rounds to watch for signs of agitation, depression or confusion; and/or providing recommendations for treatment and medications (while at the medical shelter and once the client is discharged), as needed. Staff should only provide mental health treatment within their scope of practice and licensure.

A private area within the shelter or at an external location should be designated as the “counseling area”. Staff can use this area to provide counseling to clients and staff who need mental health assistance. Additionally, staff trained in crisis mental health should be available within the main shelter to assist clients and staff as needed.

11.4. Decompensating Clients
Decompensation refers to medical and/or psychological complications that result in a downturn in a client’s health. Pre-existing conditions, both physical and psychological, are frequently exacerbated during times of extreme stress.

Previously healthy individuals may decompensate and develop new medical or mental health needs. Medical shelter staff should be aware of the potential for a client to decompensate at any point during the operation of the medical shelter. Medical shelter staff should watch clients for signs of decompensation including loss of appetite, inability to fall or stay asleep, psychological downturn, becoming socially withdrawn or showing signs of aggression. Any decompensating clients should be evaluated and the decision must be made as to whether or not they need to be transferred to a hospital or like facility.

11.5. Transfer of Medical Care
As clients decompensate, it may be appropriate for them to be transferred to another facility more capable of meeting their needs. Likewise, a client’s condition may improve, allowing them to be transferred to a general population shelter. In either situation, the client’s condition should be documented and a formal transfer should occur. Determining what a formal transfer of a client
entails should be considered by the jurisdiction as part of the medical shelter planning process. Any transfer would be approved by the medical director or lead clinician at the site.

11.6. Discharge
Discharge may occur for a number of reasons: a client may require a higher or lower level of care or the medical shelter may be closed or relocated. The following outlines a sample process to be considered when discharging a client because of medical shelter closure:

- Information obtained during the shelter admission process, including the names of family, friends and home health agencies involved with the client and information on how the client arrived, should be made available to the family member, guardian or facility that takes custody of the client once the decision to close the shelter is made;
- The name of the client will be documented and categorized in the jurisdictions records according to method of departure (e.g., public transportation, friends, family, or other means);
- At the time of departure, nursing staff and/or mental health workers, if available, will assist clients with the necessary arrangements including phone calls to public transportation, a home health agency, or a family member;
- For clients who depend upon electricity for life sustaining support, staff should verify an address for the client and the availability of power;
- If no arrangements can be made to transport the client home, or if the home is uninhabitable, social services may be notified to provide assistance in locating temporary housing. It may also be necessary to contact a local nursing home to arrange for temporary placement. Every effort should be made to insure that individuals are moved back to the least restrictive environment;
- Upon client departure, the time and date will be recorded and notification will be provided to the shelter manager.

### Client Discharge Assessment
Provides form to capture essential information as clients are discharged from medical shelter.

11.7. Client Relocation Contingency
Unanticipated circumstances may require a medical shelter to evacuate or close. Once the decision to evacuate a medical shelter is made and a location is chosen, the medical staff will prepare clients for the evacuation and evaluate all for transportation assistance on a priority needs basis. All necessary medications and personal items will be transported with the shelter client. Unnecessary personal belongings will be placed in a safe location within the site and retrieved for distribution after the medical shelter is declared safe to enter.
12. Fatality Management

OBJECTIVES FOR SECTION:
- Understand fatality management and how to coordinate with local law enforcement, healthcare agencies, emergency management and the local medical examiner/coroner.

Jurisdictions should conduct mass fatality planning. In most cases, this coordinated by the local Sheriff-Coroner, Coroner or Medical Examiner. Fatality management may require coordination with other organizations to ensure the proper recovery, handling, identification, transportation, tracking, storage and disposal of human remains and personal effects. Planning should also be conducted to provide services for the certification of cause of death as well as access to mental/behavioral health services for the family members, responders and survivors of an incident.

Refrigerated storage capacity and body bags for deaths occurring at the medical shelter should be anticipated in some instances. If a temporary morgue is required, considerations for the selection of a site might include:

- Proximity to disaster site;
- Electricity;
- Refrigeration;
- Hot and cold running water;
- Restrooms;
- Adequate office space;
- Ventilation;
- Large open area of sufficient size;
- Area for securing valuables;
- Parking;
- Security from public.

13. Administration

OBJECTIVES FOR SECTION:
- Understand the importance of early and continuous documentation
- Identify the process for client and valuables tracking
- Plan for other administrative tasks such as: procurement, timekeeping and human resources
13.1. Documentation

Many administrative functions associated with medical shelter operations may occur away from the shelter site or will be coordinated closely with the jurisdiction’s established process for documentation, finance and administration.
13.2. Client Tracking

KEY CONSIDERATIONS IN THIS SECTION INCLUDE:

- The tracking process should begin as soon as the client enters the medical shelter;
- Demographic information is gathered or transferred from the registration forms to the tracking forms;
- A unique Disaster Incident Number for each client is assigned to track the individual throughout stay, discharge or transfer.

Client tracking should begin as soon as a displaced person enters the sheltering system. Tracking systems should be integrated with existing state and local systems. In order to facilitate client tracking, the following actions should be undertaken:

- Maintain count of all clients within shelter;
- Make preparations for paper-based tracking in case of reduced technology capabilities;
- Alphabetize and organize all registration information and verify count;
- Recruit volunteers and work with the triage and intake teams to assign clients to appropriate areas;
- Provide assistance to all visitors and ensure that they sign in;
- Coordinate tracking with local and state emergency management, emergency medical services, healthcare organizations and other jurisdictional partners. Ensure that systems between jurisdictions are interoperable.

In order to use the tracking system a unique Disaster Incident Number for each client will need to be assigned. The Disaster Incident Number should track the client throughout his or her stay, discharge or transfer. Each local jurisdiction may design their own policies but suggested procedures include:

- Identify one location to create and distribute Disaster Incident Numbers to avoid duplication and maximize a common operating picture;
- Adhere to federal and State privacy protection regulations and standards for tracking systems;
- Verify that the Disaster Incident Number comprises two specific elements of identification:
  - The first two digits could be the California county code where that client entered the system during the emergency. County codes are 1 to 58. Those counties that have a single-digit county code would place a 0 in front of the first digit;
  - The remaining digits may be a number from 1 to 9,999,999, which would be used to specifically identify each displaced person within that county;
- The Disaster Incident Number can be assigned at any of the following entry points and/or locations:
  - Hospital;
  - Government authorized alternate care site/field treatment center;
  - Emergency Medical Services;
  - General population shelter;
13.3. Valuables Tracking

While clients should be advised not to bring valuables with them, it is likely that many will. These valuables may include cash, checks, wallets (and their contents), keys, jewelry or miscellaneous papers. Jurisdictions will need to decide if they want to assume the responsibility for these items. If the shelter is collocated with a general population shelter, this activity should be coordinated. The following represents example of steps which may be taken to store and track client valuables:

1. A secure area for storage of client valuables should be established;
2. The procedure for discharging valuables to family members should be developed. This should include a tag and tracking form which is filled out during the registration process. Jurisdictions should use the disaster identification number issued to the client to track their belongings. This concept should also be applied to any personal durable medical equipment or devices that clients bring to the shelter;
3. During the registration process, clients should sign a waiver which notes that the medical shelter is not responsible for lost valuables. Additionally, clients should be advised that any valuable or cash worth more than $20 will not be properly secured in the shelter.

13.4. Medical Record and Records Retention

A medical record should be initiated for each client at the time of registration and stored in the medical shelter while the facility is in use. Additionally, ownership of medical records upon shelter closure must be considered, and a decision must be made as to where to send these records. Security, privacy and administrative burden should be considered when choosing the location to which medical records will be sent. Possible locations to which medical records may be transferred include:

1. The local health department;
2. The contracting agent who runs the shelter;
3. The site where the client originated;
4. The site where client was discharged.
13.5. Paper-Based Medical Records

Paper-based medical records may be necessary in the case of limited technology at the medical shelter or in certain situations where there is a critical infrastructure failure. A paper-based medical record system may solve any interoperability issues that exist between hospitals or other care sites from which the clients originated because of technological interoperability issues which commonly exist. However, a paper based system will require additional labor to input data, track clients and maintain records.

13.6. Human Resources

Field-based human resource functions such as staff time sheets, staff credentialing, establishing maximum work hours, managing any disputes, staff absences and compensation policies and rates should be handled by the shelter manager.

13.7. Time Keeping

To ensure accurate accounting and reimbursement of emergency response expenditures, staff and volunteers involved in the response must complete and submit accurate time sheets of all time incurred to the Timekeeping Unit.

Volunteer labor and equipment records should include, for each volunteer, a record of hours worked, location, description of work performed and equivalent information for equipment and materials. Recording each volunteer’s time in and time out is an efficient means to capture the total hours worked per day.

The Administration Section Chief should ensure that emergency response staff time and payroll expenses are accurately captured for potential reimbursement.

13.8. Procurement of Resources

KEY CONSIDERATIONS IN THIS SECTION INCLUDE:

- Resources can be obtained through vendor managed inventories, MOUs, local stockpiles or state/federal government resources;
- Relationships should be established and contracts/MOUs should be put in place prior to an incident;
- Contractors should be thoroughly vetted to ensure they provide required services.
It is important to develop an emergency resource directory that includes a comprehensive inventory of all supplies needed to activate the medical shelter in order to determine resource gaps and develop strategies to meet those gaps. Obtaining these resources may be done through:

- Vendor managed inventories;
- Agreements;
- Local stockpiles;
- Mutual aid;
- State/federal government resources.

The procurement function may not be conducted at the shelter site. In many jurisdictions, this may occur at the Emergency Operations Center or Departmental Operations Center. This may make better use of financial and administrative resources if multiple medical shelters are operational simultaneously and resource procurement can be centralized.

Items/services can be purchased and stored by the local jurisdiction or vendor. Establishing vendor relationships should be a priority even if resources are being stored so that ramp up of resources can occur should the stockpile be depleted. It is necessary to verify that vendors provide maintenance during storage to ensure that everything works correctly during an incident. When evaluating contractors it is important to:

- Understand the process for the rotation of stock and inventory (control management);
- Understand the “days-on-hand” inventory of the vendors. Determine an inventory management or manual process to identify daily consumption during operations;
- Clarify the process for the delivery of material to the medical shelter, identify any “disaster clauses” within the contract and understand the requirements of the vendor;
- Identify the vendor lead time of critical supplies, pharmaceuticals and equipment;
- Identify payment terms.

Additional resources can be requested through the resource requesting process. Resource requests should be as specific as possible to ensure resource needs are met.

If the medical shelter is expected to be collocated, storage areas, vendors and transportation to retrieve stored goods should be coordinated.

14. Demobilization

**OBJECTIVES FOR SECTION:**

- Understand the demobilization process
- Describe the importance of a relocation contingency
- Promote the early consideration of a seamless transition back to the community
Demobilization is the process by which a medical shelter is closed and ceases operation. This decision often lies with a higher decision making body than the shelter manager. If a decision is made to demobilize a shelter, coordination with various response partners will be required to return clients to pre-incident conditions and properly restore the shelter site.
The decision on when to close the medical shelter should incorporate the following factors:

1. Impact of the incident on the shelter client’s home;
2. Urgency of need to return the site to normal conditions;
3. Time of day;
4. Political or medical impact;
5. Availability of transportation resources.

14.1. Transitioning Clients Back to the Community

KEY CONSIDERATIONS IN THIS SECTION INCLUDE:

- A concerted effort should be made to move clients back into an environment with a similar level of care as at their pre-disaster location;
- Exit screening should be conducted and documentation of any existing illnesses/diseases/injuries should be made.

Depending on the status of the client, they should be transitioned to facilities similar to where they were prior to the incident. If a client is too ill to return to their pre-disaster locations or if the client is without a suitable dwelling, transport to a healthcare facility should be arranged. It is important to allow a reasonable amount of time and assistance for locating suitable housing for clients when they cannot return to their original locations.

14.2. Closing the Shelter Facility

KEY CONSIDERATIONS IN THIS SECTION INCLUDE:

- Clients should be discharged and the shelter should be closed by incrementally decreasing staff, equipment and supplies, until the shelter is completely shut down;
- Arrange for the transfer of medical records and/or establishment of storage procedures and location;
- Ensure that all areas of the shelter are restored to pre-shelter conditions.

Once all clients can be safely discharged or transported, the medical shelter can be closed. The following tasks should be considered when planning for the closure of a shelter:

- Arrange for the transfer of medical records and/or establishment of storage procedures and location to ensure future availability of records and documentation;
- Terminate ongoing contracts or arrangements;
- Identify resources and equipment that are no longer needed;
- Coordinate pickup and transportation of supplies;
- Ensure that all areas of the center are restored to pre-shelter conditions;
- Prepare an after action report and conduct an assessment of efforts, resources, actions, leadership, coordination and communication in order to improve future operations.
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15. Finance and Reimbursement

OBJECTIVES FOR SECTION:
• Understand the importance of cost accounting and the reimbursement process

15.1. Cost Accounting
Accounting for the costs associated with the operation of a medical shelter may occur away from the shelter site and should be coordinated with the local jurisdiction. The cost accounting system utilized must separate all disaster-related costs from other activities and capture the information necessary to justify disaster-related costs. The accounting system should identify and document separate costs in each of the following categories:

• Labor Costs:
  o Force account labor hours by individual, rates of pay, duty assignment and work locations.
    The Federal Emergency Management Agency uses the term “force account” to refer to local government personnel and equipment;
  o Temporary hires by individual, hours of work, rates of pay;
  o Breakdown of fringe benefits for regular employees and emergency hires, both regular and overtime rates.

• Equipment and Contract Costs:
  o Equipment used for eligible disaster recovery work, hours of use, applicable equipment rates charged (local rates or government cost code), location of work and name of employee operator;
  o Services contracted for and/or purchased for use on eligible work, location of work purchase orders, costs and invoices to support the costs;
  o Listing of equipment damaged and cost to repair or replace.

• Other Supporting Records:
  o Labor policies in effect at the time of disaster;
  o Insurance adjustments, settlements, and other documents and records related to project worksheets;
  o Volunteer labor and equipment records to include, for each volunteer, a record of hours, location, description of work performed, and equivalent information for equipment and materials. the Federal Emergency Management Agency recommends that each volunteer’s time in and time out be recorded as a means to capture the total hours worked per day;
  o Photographs of work sites before and after, labeled with location and date;
  o Mutual aid and assistance agreements in effect;
  o All other documents or costs associated with the disaster.

Accounting records must be supported by such source documentation as cancelled checks, copies of paid bills, payroll sheets, time and attendance records, etc.
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Charge capture is the process of collecting charges for services, supplies and pharmaceuticals provided to clients during a healthcare encounter. The suggested minimum data list for charge capture consists of the following:

- Client name;
- Medical record number;
- Date of service;
- Capture units/dose/quantity;
- Department in which services were provided;
- Service description.

15.2. Reimbursement

The tracking and monitoring of potentially eligible expenses is critical so that when and if funding becomes available, the applicant is in a position to maximize reimbursement and other forms of assistance as part of the recovery process. Jurisdictions also need to consider if they will be seeking reimbursement of costs through long term care facilities and if Medicare/Medicaid will be sought for reimbursement for services provided.

Federal funds may not be available until a disaster is federally declared by the president. Though the Federal Emergency Management Agency has traditionally focused on property losses due to a disaster, in the past, temporary but substantial population displacement has resulted in funds being appropriated for the payment of some medical services.
Appendix 1: Bibliography

The California Department of Public Health identified and researched the latest guidance documents, plans, studies and other reference materials from national, state and local government agencies, private institutions and nonprofit organizations to complete the current practices review. Documents from Arizona, California, Connecticut, Florida, Mississippi, New Hampshire, North Carolina, North Dakota, New York, Pennsylvania, South Carolina, Texas and Virginia, and numerous non-governmental organizations were identified, analyzed and utilized in the planning process.

Summary of Plans Reviewed

Multiple plans from various jurisdictions were incorporated into the guidance document. Notable plans include:

Alabama
- State of Alabama Support Strategy Plan

California
- Alameda County Disaster Shelter Plan for Medically Fragile Persons
- Alameda County Operational Area Emergency Management Organization, A Guide for Local Jurisdictions In Care and Shelter Planning
- County of Orange Operational Area, Orange County Emergency Plan, Mass Care and Shelter Annex
- Contra Costa Health Services, Draft Medical Needs Shelter Plan
- Los Angeles County
  - Annex for Care and Shelter Operations of People with Disabilities and the Elderly
  - Operational Guidelines for Care and Shelter Operations of People with Disabilities and the Elderly – Attachments
- Napa County Health and Human Services Agency Emergency Operations Plan – Appendix 7, Attachment A, Medical Needs Shelter Plans
- San Bernardino
  - County Mass Care and Shelter Plan
  - Mass Care and Shelter Concept of Operations
- San Joaquin Shelter Plan

Florida
- 2008 Statewide Emergency Shelter Plan
- Desoto County Special Needs Shelter Plan
- Florida Department of Health, Taylor County Health Department Special Needs Shelter Plan
- Highlands County Health Department (Florida), Special Needs Shelter Plan, Annex 11, July 2007
- Special Needs Shelter Plan, Annex 11 of the All Hazards Response Plan
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Mississippi
- Disaster and Emergency, Special Medical Needs Shelter Plan, Emergency Care Guidelines, Functional Annex 1.01
- Mississippi State Department of Health, Special Medical Needs Shelter Plan, Functional Annex 1.0, August 11, 2008

Missouri
- Special Needs Sheltering, Protocols for Local and County Level Emergency Management

New Hampshire

New Jersey
- Office of Emergency Management, Specialized Shelter Planning Template, July 2008

New York
- Alternate Care Site Medical Plan

New York, New Jersey, Connecticut
- Regional Disaster Housing Plan

North Carolina
- Pitt County Disaster Plan for Functionally and Medically Fragile Populations

Pennsylvania
- City of Philadelphia Mass Care and Shelter Plan

South Carolina

Virginia
- Fairfax County VA Medical Shelter Plan

Summary of Guidance Documents reviewed
Guidance documents, studies and other relevant materials were also consulted. Notable documents whose current practices were incorporated include:

Agency for Healthcare Research and Quality
- Disaster Alternate Care Facilities: Selection and Operation
- Mass Medical Care with Scarce Resources: A community planning guide

American Nurses Association
- Adapting Standards of Care under Extreme Conditions: Guidance for Professionals during Disasters, Pandemics, and Other Extreme Emergencies

American Red Cross
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- American Red Cross - Northern California Earthquake Concept of Operations - Annex to the All Hazards Plan
- American Red Cross, Health Services Client Health Record F2077 (rev. 07-06)
- American Red Cross Health Services Protocol
- Memorandum of Understanding between the American Red Cross and California Department of Social Services
- Memorandum of Understanding between the American National Red Cross and State of South Carolina
- Memorandum of Understanding between the Federal Emergency Management Agency and the American Red Cross

Arizona
- Shelters for Special Needs Populations

Baptist Child and Family Services (BCFS)
- Presentation: Functional Needs Support Services for General Population Shelters
- BCFS as a Best Practice – Kit

California
- California Emergency Medical Services Authority
  - Emergency Medical Services Authority Field Treatment Site Guidelines, 2008
  - Emergency Medical Services Authority Medical Shelter Guidance, 2001
  - Emergency Medical Services Authority Medical Shelter Toolkit, 2001
  - Public Comment on the Draft Emergency Medical Services, Field Treatment Site Guidelines Response Form
- California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies (all volumes)
- California Public Health Nursing Disaster Handbook, California Conference of Local Health Department Nursing Directors, 2008
- County of Riverside
  - Alternative Sites for Care Draft
- Initial Impressions Report, Southern California Fires 2007, What we learned, how we worked
- Santa Barbara County
  - Public Health Department, Shelter Planning Resource Guide
  - Public Health Department Policies and Procedures for Emergency-General Sheltering, Medical Sheltering, Alternative Care, Mass Prophylaxis
  - Santa Barbara County Public Health Department, Operational Tools
  - Santa Barbara County Public Health Department, Organization Charts and Diagrams
- Stanislaus County, California Emergency Preparedness Site Assessment Toolkit

Centers for Disease Control and Prevention
- Disaster Planning Vulnerable Older Adults
- Federal Medical Station Fact Sheet
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1. Preparing Healthcare Systems for Large-Scale Surge Incidents
2. Public Health Preparedness Capabilities National Standards for State and Local Planning
3. Congressional Research Office
   - Civil Liability of Volunteer Health Professionals
4. Connecticut
   - Emergency Supportive Care Shelter Planning Guidance
5. Florida
   - Americans with Disabilities Act, ADA Checklist for Emergency Shelters
   - Enhancing Florida’s Medical Surge Capacity through State Medical Response System and State Medical Response Teams
   - Florida Department of Health, Office of Public Health Nursing, (Draft) Resource Typing
   - Florida Department of Health
     - Asset Team Types
     - Office of Public Health Nursing, Special Needs Shelter Staff, Training Recommendations
     - Office of Public Health Nursing, Team Typing, Special Needs Shelters Team
     - Region 3, Regional Public Health Emergency Response Team Exercise, After Action Report
     - Region 6, Special Needs Strike Team Assembly Drill, After Action Report
     - Special Needs Shelter Planning - Technical Assistance Guide
   - Florida Department of State, Special Needs Shelter Administrative Code
   - Florida Medical Reserve Corps Network Fact Sheet
   - Florida Statutes for Special Needs Shelters
   - Leon County Health Department, Special Needs Shelter Procedure
   - Scope for the State and Medical Response Teams (SMRT) and State Medical Response Systems (SMRS)
   - State of Florida, Emergency Support Function 8 - Health and Medical Services, Disaster Behavioral Health Response (DBHR), Standard Operations Procedures
   - Special Needs Shelters: Lessons Learned from the Florida Hurricanes
6. Inclusion Research Institute
   - Promising Practices for Evacuating People with Disabilities, Evacuation Study
7. Medical Reserve Corps
   - Guide to Medical Special Needs Shelters, A Guide for Local Medical Reserve Corps Units
8. New York
   - New York City School Health Forms
9. North Dakota
   - Emergency Medical Service Pandemic Surge Protocols and Public Safety Answering Point Pandemic Surge Protocols
   - North Dakota Shelter Types
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South Carolina
- Memorandum of Understanding between the Salvation Army (a Georgia Corporation) and the South Carolina Emergency Preparedness Division

Texas
- Medical Special Needs Planning Toolkit

United States Department of Health and Human Services
- Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources during Large-Scale Emergencies
- Medical Surge Capacity and Capability: The Healthcare Coalition in Emergency Response and Recovery
- Medical Special Needs Evacuation, Reception, Sheltering and Repatriation Planning Checklist
- Special Needs Planning Checklist

United States Federal Emergency Management Agency
- Guidance on Planning for Integration of Functional Needs Support Services in General Population Shelters
- Lessons Learned Information Sharing, Mass Care: Shelter Compliance with the Americans with Disabilities Act

United States Federal Medical Stations
- Concept of Operations, Federal Medical Stations Baseline

Washington
- Public Health - Seattle and King County Healthcare Coalition Toolkit

Primary Articles
Primary articles were consulted. Notable articles whose current practices were incorporated include:

- Bolster, C.J. Mobile Hospital Provides Care when Disaster Strikes: When Disaster Strikes, A Well-Thought-Out Plan Goes a Long Way in a Successful Deployment of Emergency Services
- Franco, C., Toner, E., Waldhorn, R., Maldin, B., O’Toole, T., Inglesby, T.V., Systematic Collapse: Medical Care in the Aftermath of Hurricane Katrina
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Gavagan, T.F., *Hurricane Katrina: Medical Response at the Houston Astrodome/Reliant Center Complex*


Klein, K.R., Nagel, N.E., *Mass Medical Evacuation: Hurricane Katrina and Nursing Experiences at New Orleans Airport*

Millin, M.G., Jenkins, J.L., Kirsch, T., *A Comparative Analysis of Two External Healthcare Disaster Responses Following Hurricane Katrina*

Saunders, J.M., *Vulnerable Populations in an American Red Cross Shelter After Hurricane Katrina*


Sanford, C., Jui, J., Miller, H.C., Jobe, K.A., *Medical Treatment at Louis Armstrong New Orleans International After Hurricane Katrina: The Experience of Disaster Medical Assistance Teams WA-1 and OR-2*