Los Angeles County Healthcare Coalition

Governance Document

2012

INTRODUCTION

Overview of Los Angeles County

Los Angeles County, California covers over 4,000 square miles and has 75 miles of coastline. The County consists of 88 incorporated cities and 136 unincorporated areas with a combined population of over 10 million people. The City of Los Angeles is the largest city in the county; home to nearly 4 million residents. The county possesses many unusual geographic, economic, transportation, demographic, cultural, and socioeconomic characteristics that make it unique. It also has the world's fifth busiest airport, Los Angeles International Airport that is the second busiest international gateway in the United States. Los Angeles County also has the nation's two main seaports, the Port of Los Angeles and the Port of Long Beach, that serve as leading gateways for the regional economy and the entire country.

Overview of Los Angeles County Healthcare System

To support this complex County is a similarly complex and large healthcare system. There are three public health agencies that operate within the county, Long Beach Department of Health and Human Services, Los Angeles County Department of Public Health and Pasadena Department of Public Health, each with their own health codes, authorities, and programs. The Department of Health Services is a separate department within the County structure and the Emergency Medical Services Agency, which serves as the Hospital Preparedness Program Coordinator, is a division of the Department of Health Services. The Emergency Medical Services Agency functions as the Medical and Health Operational Area Coordinator and in this role is responsible for ensuring the development of medical and health disaster plans that address preparedness, response, recovery and mitigation functions for the medical and public health community. During events/emergencies the Departments of Health Services and Public Health are designated to provide for the organization, mobilization, coordination, and direction of medical and health services, both public and private.

In coordinating the healthcare system, the County must work with 104 acute care hospitals (four that are County owned and operated and two Veterans Administration facilities), comprised of 73 hospitals that provide basic emergency services. A subset of these 73 hospitals includes 14 designated Trauma Centers and 13 designated Disaster Resource Centers. Additionally, the healthcare sector includes hundreds of clinics, close to 500 skilled nursing facilities, over 200 ambulatory surgery centers, 258 dialysis centers, more than 1,000 home health and home care providers and 58 Emergency Medical Services provider agencies (34 public and 24 private).

Los Angeles Healthcare Coalition

To assist the healthcare system in Los Angeles County with preparation, response and recovery from any large scale event/emergency, the Coalition was developed. The Public Health and Medical Disaster Coalition Advisory Committee is being established to address issues that affect emergency preparedness in the healthcare setting. The Advisory Committee membership includes all healthcare partners, including but not limited to: Los Angeles County Departments of Health Services EMS Agency, Public Health and Mental Health, Los Angeles County Office of Emergency Management, the Hospital Association of California, the Community Clinic Association of Los Angeles County, Hospitals, Community Clinics, Dialysis Centers, Long Term Care, Ambulatory Surgical Centers, Home Health & Hospice and EMS Provider Agencies.

PURPOSE

The Los Angeles County Healthcare Coalition is a network of healthcare organizations, government agencies and providers working together to strengthen emergency preparedness, response and recovery. The Coalition works to ensure integration and coordination across the healthcare system so that adequate medical surge capacity and capability is available during a mass casualty and/or large scale event.

The Coalition's work includes the following:

Planning – Sector specific workgroups address how each sector could to provide care to its population of patients after events/emergencies. Additionally, how it could assist in enhancing the overall capacity of the healthcare system in response to the demand that is created during and following a disaster.

Hazard Vulnerability Assessments are completed by each coalition member, as well as at the County level with the focus on impact to Public Health, Healthcare Services and Mental.

Additionally, planning on subject specific topics that involve representatives from across the healthcare sectors are continuing. Examples include the Mass Fatality Management Guidance and the Evacuation/Shelter in Place Guidance.

Training - Providing emergency preparedness training and educational opportunities for pre-hospital, hospital and outpatient healthcare personnel that will respond to a terrorist incident or other public health emergency. Topics include:

- Hospital Incident Command System (HICS)
- Clinic Incident Command System (CICS)
- Nursing Home Incident Command System (NHICS)
- Hospital Disaster Management Training (HDMT)
- Preparing Hospitals and Clinics for the Psychological Consequences of a Terrorist Incident or Other Public Health Emergency
- Pediatric Surge Plan: Pediatric Clinical Management
- WMD Hospital Mass Casualty Decontamination
- Mass Casualty Incident Triage for Physicians
- Response Activities related to Situational Awareness and Resource Requesting
- Anticipate, Plan & Deter – Staff resilience
- Other training activities as identified

Exercises - Conducting exercises at a County wide level as part of the Statewide Medical and Health Exercise program that is conducted annually to create consistency in response. Additionally, under the Disaster Resource Center structure, conducting geographically focused exercises.

Resource and Information Sharing - Implementation of the California Department of Public Health and Medical Emergency Operations Manual guidelines for Communication, Information Sharing and Resource Requesting.

Response – The Emergency Medical Services Agency, as the Medical and Health Operational Area Coordinator, works with the Coalition members and their individual organizations to

establish coordinated systems to share information and resources in response to events/emergencies. During a response, the Emergency Medical Services Agency is the central point of contact and coordinates the County wide medical response.

STRUCTURE

Los Angeles County is organized under a single Healthcare Coalition. The work of the Coalition is carried out either through healthcare sector specific workgroups, topic specific multi-disciplinary workgroups and/or through the Disaster Resource Center program.

Los Angeles County developed and implemented the Disaster Resource Center program in 2004 to effectively deal with the size and complexity of the County and healthcare system. Each Disaster Resource Center is assigned to one of ten geographical areas. The Disaster Resource Centers are tasked to work with the healthcare entities in their geographical region to enhance overall preparedness.

REGIONAL BOUNDARIES

The County of Los Angeles is the geographical area served by the Los Angeles County Healthcare Coalition.

PRIMARY MEMBERS

The Department of Health Services Emergency Medical Services Agency is the convener of the Los Angeles County Healthcare Coalition and works collaboratively with the Department of Public Health on ensuring that medical and health preparedness, response, recovery and mitigation activities are carried out. The EMS Agency and Public Health serve as the co-chairs for the Healthcare Coalition Disaster Advisory Committee.

ESSENTIAL PARTNER MEMBERSHIP

A. Hospitals (84 participating hospitals)
B. Veterans Administration Hospital representatives
C. Community clinics (members of the Community Clinic Association and LAC Department of Health Services clinics)
D. LAC Department of Mental Health
E. LAC Office of Emergency Management
F. Community Clinic Association of Los Angeles County
G. Hospital Association of Southern California
H. California Association of Healthcare Facilities
I. End Stage Renal Disease Network 18 and Dialysis Centers
J. Skilled Nursing Facilities
K. Ambulatory Surgery Centers
L. Home Health and Home Care Agencies
M. EMS Provider Agencies

ADDITIONAL PARTNERSHIP/MEMBERSHIP

A. Emergency Network of Los Angeles
B. American Red Cross
C. LAC Department of Coroner

ORGANIZATION

LEADERSHIP

The Los Angeles County Healthcare Coalition has established a governance structure, which is administered by the Emergency Medical Services Agency and supported by the Agency staff assigned to the Hospital Preparedness Program.

ADVISORY COMMITTEE

The Advisory Committee is comprised of representatives from hospitals and other healthcare organizations and agencies that are integral in a medical response to events/emergencies. The advisory committee provides organizational and emergency management expertise and has the following duties:

- Assess the level of healthcare preparedness within Los Angeles County
- Make recommendations concerning additional healthcare preparedness, response and recovery activities which should be implemented within the County
- Develop policy and guidance

The following entities are represented on the Advisory Committee:

- Department of Health Services, Emergency Medical Services Agency - Chair
- Department of Public Health – Co-Chair
- Department of Mental Health
- Office of Emergency Management
- Hospital Association of Southern California
- Hospitals, which represent Disaster Resource Centers, Small and Medium size Community Hospitals, Academic Hospital System, Trauma Centers, Pediatric Hospitals, Department of Health Services Hospitals and Veterans Administration Hospitals
- Community Clinic Association of Los Angeles County
- Clinics, which represent member of the Community Clinic Association of Los Angeles County and the Department of Health Services clinics
- Private Practicing Physicians
- EMS Provider Agencies (public and private providers)
- Long-Term Care providers
- Specialty service providers (dialysis, ambulatory surgery centers, home health and hospice care agencies)
- American Red Cross

Representatives from other sectors and/or community based organizations will be asked to attend Advisory Committee meetings on an ad-hoc basis.

See Appendix I for the Bylaws of the Public Health and Medical Disaster Coalition Advisory Committee.

HEALTHCARE COALITION PARTICIPATION

The Los Angeles County Healthcare Coalition members have various avenues and opportunities to participate in preparedness activities, test their capabilities and share best practices. These include but are not limited to the following:

- Bi-monthly Disaster Resource Center Meetings
- Disaster Resource Center Coordinator Meetings
- Trauma Surge Committee
- Burn Surge Committee
- Pediatric Surge Committee
- Skilled Nursing Facility Steering Committee
- Community Clinic Association of Los Angeles County Disaster Committee
- Ambulatory Surgery Center Workgroup
- Trainings
- Exercises

PARTICIPATION REQUIREMENTS

Coalition members that receive funding to support their preparedness activities will enter into formal agreements with Los Angeles County. These agreements address the receivables and deliverables, including participation in Coalition activities. The agreements also address mutual assistance during response to an event/emergency.

Coalition members that do not receive direct funding, but benefit from the tools, trainings, exercises and expertise that are part of the overall healthcare preparedness in the County, will document their participation in the Coalition by signing the *Commitment to Participate*.

ROLES AND RESPONSIBILITIES IN *PREPAREDNESS*

LOS ANGELES COUNTY EMERGENCY MEDICAL SERVICES AGENCY

Disaster Resource Center Coordinators Planning Meetings
This is a gathering point for Disaster Resource Center managers to identify and address planning gaps, and share new or revised procedures for responding to an event/emergency. The Disaster Resource Center Program Manager (Los Angeles County Emergency Medical Services Agency staff) hosts these planning meetings, which take place at least six times a year, usually bi-monthly. Meeting minutes are distributed to all participants and are maintained by the Program Manager.

Information Sharing
During the preparedness/planning phase, information is disseminated on an on-going basis via the Disaster Resource Center network and meetings that are held in the ten designated geographical areas. Another means of information sharing with coalition participants is the dissemination of information directly through the various healthcare sectors' association.

Throughout the year, the Emergency Medical Services Agency may conduct conferences and other meetings to share information with Coalition participants. An example of this is the annual Hospital Orientation meeting conducted during the fall of each year. This meeting provides information related to the funding that is available, the contracting process and plans and procedures that have been developed over the course of the prior year.

Exercises and Training
The Emergency Medical Services Agency is the lead in planning the County's participation in the annual Statewide Medical and Health Exercise. This planning involves meetings, planning conferences, training sessions, and table top exercises, culminating in a functional or full scale exercise and followed by an evaluation conference. The participation/collaboration of all healthcare coalition participants is required for members that receive preparedness funding and is highly encouraged for all other Coalition participants. Additionally, the Emergency Medical Services Agency continues to provide no or low cost training for healthcare coalition members.

Equipment and Supply Cache
A cache of equipment and supplies is maintained at the County level as well as specific caches that have been established at each of the 13 Disaster Resource Centers. These caches are maintained on an on-going basis to ensure a level of continuous readiness.

DISASTER RESOURCE CENTERS

Disaster Resource Center Regional Planning Meetings
This is a gathering point within a designated geographical area, where healthcare organizations come together to develop relationships, refine facility specific plans and procedures for responding to any disaster or emergency facing a healthcare facility or the community. The Disaster Resource Center serves as the host or assists in the planning of these meetings, which take place at least six times a year, usually bi-monthly. Meeting minutes are distributed to all umbrella organization participants and are maintained by the hospital Disaster Resource Center Coordinator.

Information Sharing
During the preparedness/planning phase information is disseminated via the Disaster Resource Center meetings that are held in the ten designated geographical areas.

Exercises
The Disaster Resource Centers assume a role in the planning or assisting in the planning of exercises. Each Disaster Resource Center conducts the following:

- Tabletop Exercise: Annually
- Functional Exercises: Sections of the Regional Response Guidelines are tested through actual hands-on exercises during a three-year period (e.g., deployment of tents, movement of equipment, decontamination, etc).
- Full Scale Exercises: One full-scale exercise is conducted in conjunction with hospital and community involvement during a three-year period. (This can be accomplished by incorporating Disaster Resource Center and umbrella organizations coordination components during the annual Statewide Medical and Health Exercise.)

After-Action Reports are distributed to all umbrella participants and the Disaster Resource Center Program Manager, and are maintained by the hospital Disaster Resource Center Coordinator. The Disaster Resource Center Program activities support hospitals and other healthcare organizations in meeting accrediting and licensing bodies' emergency management requirements, as well as regulatory requirements related to emergency management.

Equipment and Supply Cache
The Disaster Resource Centers maintain their equipment and supply caches in accordance with the contractual requirements. A complete list of supplies, equipment and pharmaceuticals are included in the Appendix (Reference No. 1102.13, 1106, 1106.1, 1106.3).

ESSENTIAL PARTNER MEMBERS

Planning Meetings
Coalition participants are encouraged to attend their geographical area Disaster Resource Center meetings as often as possible, and any funded Coalition participant is contractually required to attend 100% of these meetings.

Exercises and Training
Coalition participants are encouraged to participate in all tabletop exercises, available trainings and the annual Statewide Medical and Health Exercise, and any funded Coalition participant is contractually required to participate as delineated in the agreement.

Establish Relationships
All coalition participants are strongly encouraged to engage and establish relationships with their local emergency partners (Fire/EMS Provider Agencies and Law Enforcement), their city's emergency management staff, and other entities that may be needed during an event/emergency, such as utilities, vendors or other support services. These relationships will be invaluable during an event/emergency of any magnitude, particularly as there may be needs outside of the medical and health arena.

Preparedness Plans and Emergency Supply Caches

Coalition participants are strongly encouraged to develop and maintain facility specific and sector specific preparedness plans that are appropriate for their role in the healthcare community. The focus of this planning should be on how to continue to provide services, following an event/emergency, to the population they serve on a daily basis. Additionally, they are encouraged to develop and maintain an emergency supply cache including but not limited to food, water, medical supplies, and pharmaceuticals.

ROLES AND RESPONSIBILITES IN *RESPONSE*

LOS ANGELES COUNTY EMERGENCY MEDICAL SERVICES AGENCY

The Role of Public Health and Medical System Coordination in Emergency Management
Within the Public Health and Medical System, coordinating functions exist at the level of the Operational Area (County), Mutual Aid Region and the State. Within the Operational Area the Medical and Health Operational Area Coordination Program coordinates the Medical and Health functions across the County with both private and public entities that provide medical and health services. For Los Angeles County, the Emergency Medical Services Agency performs this coordination role, with the Agency Director being designated as the Medical and Health Operational Area Coordinator. Los Angeles County Department of Public Health functions as the lead County agency for coordinating public health response activities and the Department of Health Services Emergency Medical Services Agency functions as the lead for coordinating the medical response activities, including emergency medical services.

During a response to an event/emergency, the Emergency Medical Services Agency will not direct the internal activities of any healthcare organization, but will provide the overall medical coordination for patient destination, patient transportation, resource requesting, obtaining situational awareness and providing this information horizontally and vertically. These activities are conducted through the activation of the Los Angeles County Department of Health Services Department Operations Center. The flow of information and communication may vary by healthcare sector, for example the communication with hospitals is directly through the Department Operations Center while communication with skilled nursing facilities will occur through the Department of Public Health, Health Facilities Inspection Division. They will coordinate the response and recovery efforts with this sector and if Health Facilities Inspection Division identifies additional resource needs to assist the impacted skilled nursing facility they will coordinate this with Public Health and/or Health Services.

Operational Guidelines
When an event/emergency occurs that is significant enough to impact the medical and health system of the County, the Emergency Medical Services Agency will conduct an assessment poll of hospitals using ReddiNet™ to determine impact on each facility and their ability to continue operations, and the estimated number of victims they could receive. Additionally, a general message will be sent using ReddiNet™ and other communication tools to ensure all healthcare facilities are aware of the event and to provide other information such as the medical and health implications, the level of activation of the Department of Health Services Department Operations Center, contact information for reporting needs and requesting medical and health resources.

ESSENTIAL PARTNER MEMBERS

Hospitals (including Disaster Resource Centers)

Operational Guidelines
The primary goal for hospitals is to maintain operations and increase capacity and potentially capability. This is done in order to preserve the life and safety of existing patients, victims of the event/emergency and ensure appropriate healthcare delivery to the community.

During a response to an event/emergency, hospitals will activate their surge plans to create additional capacity within their facility. Typically they will activate their Hospital Command Center and work collaboratively with the Emergency Medical Services Agency to accept and treat persons that are ill or injured as a result of the event/emergency.

Communication/Information Sharing
Following an event/emergency, hospitals will respond to the polls sent out by the Emergency Medical Services Agency. The initial poll will be tailored to the specific event and will be used to determine the number and category (immediate, delayed and minor) of victims each 9-1-1 receiving hospital has capacity for, the number and category of inpatient beds that are available in each hospital (Hospital Bed Availability) and any impact to the hospital's infrastructure depending on the event .

If a hospital identifies resource needs that cannot be filled through their normal day-to-day processes they should utilize their own disaster caches. If the need still exists they can contact the Department of Health Services Department Operations Center for medical resources and their city Emergency Operations Center for non-medical resources (e.g. potable water, portable lighting).

Clinics

Operational Guidelines
The primary goal for clinics following an event/emergency is to maintain operations and continue to provide care to their current patients and if needed, where possible expand operations (extend hours of operation) to accept the lower acuity patients to relieve stress on acute care hospitals.

Clinics are an integral part of the patient treatment options during a disaster. Patients will present where they typically receive care and may not be aware that all services are not available at all medical facilities. Clinics and hospitals must work together to ensure that patients are treated or triaged to the most appropriate service provider. However, clinics may find they are not able to transfer all of the patients they normally transfer to hospitals during an event/emergency and may need to provide the best care possible until such transfer is available.

Communication/Information Sharing
Following an event/emergency, clinics may be asked to respond to an assessment poll sent out by the Community Clinic Association in conjunction with the Emergency Medical Services Agency. The poll will be tailored to the specific event.

The clinics may utilize any of the tools that they have and these tools should be tested throughout the year. This includes using ReddiNet™, telephones (landlines/cellular), hand held portable radios or any other means that have been arranged between agencies.

If a clinic identifies resource needs that cannot be filled through their normal day-to-day processes they should utilize their own disaster caches. If the need still exists they can then contact the Community Clinic Association and/or the Emergency Medical Services Agency for medical resources and their city Emergency Operations Center for non-medical resources (e.g. potable water, portable lighting).

Skilled Nursing Facilities

Operational Guidelines
The primary goal for skilled nursing facilities following an event/emergency is to maintain operations and continue to provide care to their residents. When an emergency event impacts or is threatening to impact a skilled nursing facility, the Health Facilities Inspection Division of Public Health should be notified. Health Facilities Inspection staff will work with the skilled nursing facilities to determine their status in relationship to the event, what their plans are to safeguard their residents, and determine if they have any resource needs.

Based on the event/emergency, if residents must be moved they should first consider moving the residents to other skilled nursing facilities. The next option would be for the resident to stay with family, if possible, and lastly moving the residents to a shelter location. Shelter locations will require sending staff to provide care and assistance to their residents at the shelter site.
If evacuation of the skilled nursing facility is warranted, the expectation is that the skilled nursing facilities will have identified their relocation site ahead of time and perform the evacuation. If needed, the Health Facilities Inspection staff will assist with the identification of available beds for displaced residents and can work with the California Department of Health Care Services to authorize emergency medical transport for Medi-Cal recipients.

If the impacted or receiving facilities needs permission to house patients in alternative areas or in numbers exceeding their licensed capacity, the facility must obtain authorization from Health Facilities Inspection Division. The skilled nursing facility will need to describe how the plan they are seeking permission to employ is the best plan to ensure the safety, health, and as much as possible, the rights of the residents in their care. Health Facilities Inspection Division will then give temporary permission to the facility to implement their plan, or will work with the facility to identify an alternative plan.

Communication/Information Sharing
Immediately upon recognizing any emergency condition that will require any intervention that may impact the residents, the skilled nursing facility should utilize their Resource Manual and contact the Health Facilities Inspection Division.

Dialysis Centers

Operational Guidelines
The primary goal for dialysis centers following an event/emergency is to maintain operations and continue to provide dialysis treatments to its clients and support other dialysis centers that are impacted by the event/emergency by providing services to their clients. The End Stage Renal Disease Network 18 will be available to the dialysis center and work with those that are part of Network 18 to ensure that clients needing dialysis are provided the service. Network 18 will work with individual dialysis centers to determine their status in relationship to the event and whether they have any resource needs. If the impact of the event expands beyond the span and control of Network 18 and additional assistance is need, Network 18 should contact the Emergency Medical Services Agency for assistance.

Ambulatory Surgery Centers

Operational Guidelines
The primary goal for Ambulatory Surgery Centers following an event/emergency is to complete any surgery/procedure that is in progress and to assess their ability to continue to provide their routine services or whether they need to reschedule their patients. This will be determined based on the impact of the event/emergency on the facility and the surrounding community.

In a large impact disaster, Ambulatory Surgery Centers can be used to supplement surgical services, off-loading minor surgeries from hospitals. Since Ambulatory Surgery Centers have generator capacity, they may be considered as a site for home health agencies to partner with and be utilized as charging centers for patients that have durable medical equipment that requires access to electricity (i.e. ventilators, home oxygen concentrators, IV and parenteral pumps)

Home Health and Home Care Agencies

Operational Guidelines
The primary goal for Home Health and Home Care Agencies following an event/emergency is to maintain operations and continue to provide services to its clients and support other Home Health and Home Care Agencies that are impacted by the event/emergency by providing services to their clients.

Emergency Medical Services Provider Agencies

Operational Guidelines
The primary goal for Emergency Medical Services Provider Agencies following an event/emergency is to maintain 9-1-1 response capabilities. In mass casualty events, Emergency Medical Services Providers will work closely with the Emergency Medical Services Agency and following the established policies (Reference No. 519-519.5d) will triage and sort victims, provide prehospital treatment and transportation to the identified destination (usually acute care hospitals) for definitive medical care.

ROLES AND RESPONSIBILITIES IN *RECOVERY*

LOS ANGELES COUNTY EMERGENCY MEDICAL SERVICES AGENCY

Recovery Plans

Once the immediate response is underway, recovery planning must also be addressed. Recovery activities for the Emergency Medical Services Agency will be focused on resuming the day-to-day functions of the Emergency Medical Services Agency, as during the initial response the Agency resources (staff) will be focused on coordinating the medical response through the staffing of the Department Operations Center and the County Emergency Operations Center.

Recovery activities also include documentation of the activities and resources used to support reimbursement for the services provided in support of the medical response. Appropriate ICS forms should be utilized to document the event to enhance the potential to receive/recover funding from FEMA.

Lessons Learned / After-Action Reports

Once the situation is stable, lessons learned critique process should be conducted at affected facilities. If the event required Emergency Management involvement, the EMS Agency would be the coordinating agency for the critique process. Each facility should have guidelines in place to conduct an internal critique process.

ESSENTIAL PARTNER MEMBERS

Once the immediate response is underway, recovery must also be addressed. Recovery activities at healthcare facilities will be focused on the facilities Continuity of Operations plans, ensuring that essential services are available to the community. Recovery will also include financial recovery and documentation to support reimbursement for the services provided in support of the medical response. Appropriate ICS forms should be utilized to document the event to enhance the potential to recover funding from FEMA.

Recovery focuses on resuming the day-to-day functions of the healthcare facility.

Short -Term Recovery

This process is initiated as the response is underway and focuses on returning the facility to pre-event status taking into account issues related to staffing, supplies and equipment, communications, EMS services, facility use, medical records, standards of care and finance.

Intermediate to Long-Term Recovery

This process will assure that all of the above services are *back to normal*. Monitoring of staff, patients, residents, and volunteers will take place over a period of time to watch for signs of stress, illness or needed intervention. Keep in mind that ‘normal’ may not be as we know it pre-event/emergency.

HEALTHCARE CONTINUITY PLANNING

Healthcare continuity planning augments Emergency Operations Plans, strengthening an organization’s capacity to scale their response to a range of events that may impact their operations. It is a proactive process that identifies and prioritizes critical functions and

information technology software/applications used by the facility. Healthcare continuity planning measures the impact if there is a threat to the critical functions and information technology software/applications and addresses Recovery Time Objectives and the resources (i.e. staff, supplies and information technology applications) that are needed to ensure the ongoing provision of services.

Healthcare facilities need to plan and be prepared for a major disaster occurring in Los Angeles County, which would significantly disrupt essential operations and potentially damage infrastructure support systems (water, power, phone systems, medical gas, etc.) further impacting essential operations. The disaster recovery planning needs to address processes to handle critical business functions during the first 24 hours, and then incrementally such as 24 - 48 hours, 48 hours to seven days, seven - 30 days and beyond 30 days (if needed). This planning includes downtime procedures, which are response strategies to accommodate the disruption in service and recovery strategies on how to return to normal operations.

COUNTY OF LOS ANGELES
PUBLIC HEALTH AND MEDICAL
DISASTER COALITION ADVISORY COMMITTEE

BYLAWS

Article I. Purpose

The purpose of the Los Angeles County Public Health and Medical Disaster Coalition Advisory Committee (DCAC) shall be to address issues that affect emergency preparedness, response and recovery by:

A. Promoting quality in the delivery of disaster patient/victim care services, by assessing the level of healthcare preparedness and making recommendations on activities that should be implemented to address any gaps.
B. Supporting the needs of healthcare organizations while ensuring the needs of the community are met.
C. Developing and implementation of effective practices including planning, education, and evaluation as they relate to emergency preparedness.
D. Promoting interaction and collaboration across all sectors of the healthcare community to ensure a coordinated and effective response to disasters.
E. Providing recommendations on County policies and procedures and the allocation and prioritization of any available grant funding.

Article II. Membership

Section I - Eligibility

Membership on the committee is extended to any healthcare organization in Los Angeles County and the healthcare associations that represent the various healthcare sectors, which include but are not limited to hospitals, clinics, skilled nursing facilities, ambulatory surgery centers, dialysis centers, home health, hospice agencies and emergency medical services providers. Other members include key government agencies such as the Los Angeles County's Office of Emergency Management, Departments of Health Services, Public Health, Mental Health and Coroner and other non-governmental agencies that play a key role in emergency management to include the American Red Cross and representatives from Emergency Network of Los Angeles.

Section II - Officers of the Committee

The Department of Health Services Emergency Medical Services Agency is the convener of the DCAC. The Hospital Preparedness Program (HPP) Coordinator and the Executive Director Public Health Emergency Preparedness serve as the committee co-chairs.

Section III - Duties of Chair

A. The Co-Chairs shall:
    1. Preside over all meetings.
    2. Rule on all points of order.

3. Represent the DCAC at public functions or appoint a DCAC member to do so, on their behalf.
4. Sign all official documents.
5. Ensure that minutes are maintained.

Section IV - Committee Voting Membership Structure

A. See attached for the organizations that are voting members.

Article III. Meetings and Activity Requirement

A. Regular meetings of the DCAC shall be held at 9:30 a.m. on the first Wednesday in the months of February, May and October at the EMS Agency. Additional meetings may be held as determined by the Co-Chairs.
B. The Committee shall review, evaluate and make recommendations on issues related to healthcare emergency management and the medical and health coordination system. For an agenda item that requires action, consensus will be reached by the voting members present at the meeting for the action to be taken.
C. EMS Agency staff will attend all meetings of the Committee and maintain official minutes. The minutes shall be distributed to all Committee members prior to each scheduled meeting.
D. Special subcommittees and/or workgroups may be appointed by the chairpersons, from time to time, to address specific issues that are compatible with the purposes of the DCAC.

Disaster Coalition Advisory Committee Membership	Number	Lead	Alternate
Government Representatives			
EMS Agency/Public Health Co-Chairs	2	Kay Fruhwirth/Alonzo Plough	Roel Amara/Dee Bagwell
Department of Mental Health	1	Barbara Engleman	Ana De La Torre
Office of Emergency Management	1	Ashu Palta	TBD
Hospitals			
DRC Coordinator	1	Connie Lackey	Lane Moody
Veterans Administration	1	Jenny Gonzalez	Ted Gegoux
Trauma Center	1	Donna Early	Desiree Thomas
Academic Hospital	1	Kurt Kainsinger	Amy Kaji
Community Hospital	1	Charlene Janz	Chris Riccardi
Pediatric Hospital (CHLA)	1	Kathy Stevenson	Bridget Berg
LAC DHS Hospital	1	Chris Celentano	Essense Wilson
HASC	1	Ryan Burgess	Jaime Garcia
Other Healthcare Sectors			
CCALAC	1	Trevor Rhodes	Bryan Nolan
CCALAC Member Clinic	1	TBD	TBD
LAC DHS Clinic	1	TBD	TBD
Long Term Care (one from each LAC CAHF Chapter, 2 Lead and 2 Alternate)	2	Sergey Yezucghian	TBD
		Kevin McGuire	TBD
Primary Care	1	Peter Katona	
Ambulatory Surgery Center	1	TBD	TBD
Dialysis Center	1	TBD	TBD
Home Health	1	TBD	TBD

Disaster Coalition Advisory Committee Membership	Number	Lead	Alternate
EMS Providers			
Fire/EMS appointed by Los Angeles Area Fire Chiefs Association	1	TBD	TBD
Private Ambulance Company appointed by LAC Ambulance Association	1	TBD	TBD
Other Members			
American Red Cross	1	TBD	TBD
Subject Matter Experts (invite as needed)			
Coroner			
Law Enforcement			
ReddiNet Staff			
Licensing and Certification			
Emergency Network Los Angeles			