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Development of Standards and Guidelines for Healthcare Surge during Emergencies

Declarations and Triggers

DECLARATIONS & TRIGGERS

3 **NOTE:** This document was developed with input from a broad group of stakeholders representing
4 constituent organizations with diverse perspectives and technical expertise. The purpose of
5 eliciting a wide range of input was to ensure the information contained in this document was as
6 comprehensive and as sound as possible.
7

8 **Although the individuals referenced and the organizations they represent have provided many**
9 **constructive comments, information and suggestions, they were neither asked nor did they agree**
10 **to endorse the conclusions or recommendations represented here or in subsequent iterations.**

11 **Introduction**

12
13
14 Providing healthcare during a large scale public health emergency presents significant challenges for
15 healthcare facilities, licensed healthcare professionals, and communities. During emergency events,
16 healthcare systems must convert quickly from their existing patient capacity to “surge capacity” - a
17 significant increase beyond usual capacity - to rapidly respond to the needs of affected individuals. The
18 demands of the emergency may prevent compliance with the existing healthcare standards. Just as
19 California has healthcare standards for use with a normal operations, it is essential that California provide
20 guidelines that identify the extent to which existing standards can be flexed or waived for healthcare
21 delivery during emergencies.
22

23 Surge planning for the healthcare system is a substantial and complex challenge. In a time of significant
24 disaster, a successful plan must provide flexibility to address capacity (volumes of patients) and
25 capabilities (types of illnesses) that emerge above baseline requirements. The issues addressed are
26 diverse and include standards of practice during an emergency, liability of hospitals and licensed
27 healthcare professionals, reimbursement of care provided during an emergency, operating alternate care
28 sites, and planning considerations for surge operations at individual hospitals.
29

30 Upon completion of this project, stakeholders will have access to a *Standards and Guidelines Manual* that
31 will serve as a reference manual on existing statutory and regulatory requirements identifying what will be
32 flexed or modified under different emergencies; *Operational Tools* that include forms, checklists and
33 templates to facilitate and guide the adoption and implementation of statutory and regulatory
34 requirements outlined in the *Standards and Guidelines Manual*; and a *Training Curriculum* outlining
35 intended audience, means of delivery and frequency of training that will enable adherence to the policies
36 and overall readiness of the healthcare delivery system.
37

38 **Declarations and Triggers**

39
40 The Declarations and Triggers outputs will form the basis for the deliverable as it defines what a surge is,
41 identifies the point(s) at which the healthcare system would transition from normal operations to "surge
42 mode", justifies the need for declarations and emergency orders, and assesses the powers and
43 authorities of personnel who make the declarations.
44

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Surge- Declaration and Triggers Narrative

This Document provides a common understanding of what a healthcare surge is and is not in the context of the overall deliverable. The Narrative contains an operational definition of surge, as well as an understanding of the powers and authorities involved in surge response.

1 Introduction and Background of Surge

1.1 Various Concepts of “Healthcare Surge”

The phrase “healthcare surge” means different things to people from different disciplines. To the operators of healthcare facilities, whether they are hospitals, clinics, or other kinds of health care facilities, it can refer to routine increases in the number of patients which push the facility to or even beyond the limitations imposed on that facility by regulatory agencies. To the regulatory agencies, it can refer to those routine situations in which a waiver of certain regulatory requirements to facilitate patient care is justified. To local and regional emergency response planners it can refer to situations in which a sudden increase in demands on the healthcare system overwhelms local resources, requiring the waiver of regulatory mandates and activating mutual aid. However, to statewide emergency response planners surge refers to an overwhelming increase in demands for medical care services arising out of a moderate to severe emergency. In such circumstances, the combined federal, state and local public and private resources to provide care consistent with optimal patient outcomes may be exhausted, and the exercise of extraordinary powers may be necessary to allow more effective disaster mitigation to occur.

The purpose of this document is not to address the concept of “healthcare surge” in all its permutations. Healthcare providers and regulators have well-established procedures for addressing routine fluctuations in the demand for emergency medical services, and are not here addressed. Hospital, local and regional emergency planners have Emergency Operations plans and procedures and the Standardized Emergency Management System (SEMS) to address larger local emergencies and to invoke mutual aid from adjacent jurisdictions and facilities, which can permit the timely augmentation of resources to respond to the increased demand.

1.2 “Healthcare Surge” Defined

This document addresses “healthcare surge” caused by a significant or catastrophic event which implicates the extraordinary emergency powers of the Governor available under the California Emergency Services Act.¹ As will be discussed below, defining what constitutes a “healthcare surge” in this context is a necessary first step under SEMS for local government to inform state government when extraordinary measures may be warranted, and to determine the substance of the extraordinary measures taken to mitigate the effects of the emergency.

Thus, for purposes of this document, “healthcare surge” means the following:

“A Surge Event is proclaimed in a local health jurisdiction when an authorized local official, such as a local health officer or other appropriate designee², using professional judgment determines, subsequent

¹ Govt. Code, §§8550, et seq.

² Depending upon the jurisdiction, the designated official may be the director of emergency services, the director or medical director of the local emergency medical services agency, or medical health operational area coordinator. A description of these officials is provided later in this document.

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89 to a significant event or circumstances, that the healthcare delivery system has been impacted, resulting
90 in an excess in demand over capacity and/or capability in hospitals, community care clinics, public health
91 departments, other primary and secondary care providers, resources, and/or emergency medical
92 services. The local official uses the situation assessment information provided from the healthcare
93 delivery system partners to determine overall local healthcare jurisdiction/operational area medical and
94 health status..”
95
96

97 2 The Exercise of Extraordinary Powers Based 98 on Healthcare Surge 99

100 2.1 The Progression of Medical Mutual Aid in Response to a 101 Mass-Casualty Event 102

103 When a mass-casualty event occurs, resources within individual hospitals are mobilized under an incident
104 command system, such as HICS, to deal with the actual or anticipated influx of patients. If conditions
105 within the hospital are sufficiently strained, the hospital may consult with regulatory agencies to determine
106 if specific requirements related to staffing and patient management can be waived to maximize the
107 hospital's response capabilities.³ If circumstances become overwhelming, the hospital may, following
108 local Emergency Medical Services Agency's policies, divert incoming ambulance patients to other
109 hospitals. The hospital may also draw upon resources from other hospitals and facilities to augment its
110 response capabilities.
111

112 At this point in the progression, a “healthcare surge” within the meaning of this document does not yet
113 exist. However, the hospital administrators can inform appropriate local governmental officials (see
114 discussion below) about the limitations of their resources and, more importantly, to request additional
115 resources. This is the first step in the process of identifying a “healthcare surge.”
116

117 Local governmental resources would be activated to provide medical mutual aid. Local officials may
118 contact and request aid from other local jurisdictions in the operational area. When local resources in the
119 operational area are overwhelmed, it may be determined that a condition of “healthcare surge” exists in
120 the operational area.
121

122 The medical and health status of the operational area will be communicated, for example, by the medical
123 health operational area coordinator (MHOAC) or other authorized official, to Regional and State
124 Emergency Operations Centers. The State Emergency Operations Center can draw upon resources
125 statewide to acquire requested mutual aid.
126

127 Finally, the Governor has the additional authority to proclaim a “State of Emergency,” which can make the
128 resources of state agencies available to mitigate the effects of the emergency. In addition, the
129 Governor's Office can, if needed, request federal resources after proclaiming a “State of Emergency.”
130

131 2.2 Regulatory Standards as Potential Obstacles to Mitigating 132 Medical Disasters 133

³ Health & Saf. Code, §1276.

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134 Up until this point, the focus of the emergency response is the acquisition of requested mutual aid.
135 However, a disaster could be so severe that mutual aid resources statewide are exhausted. For
136 example, it is conceivable that a pandemic of influenza could cause a medical and health disaster in
137 every operational area of the state, with no operational area having resources to share because all
138 jurisdictions are utilizing every available resource to mitigate the disaster within their operational area.
139 Further, it may not be possible in all circumstances to deliver requested medical mutual aid to an affected
140 operational area in a timely fashion. For example, a severe-magnitude earthquake in the San Francisco
141 Bay region could make roads and bridges into San Francisco impassable, while at the same time causing
142 a “healthcare surge” within that operational area.

143
144 In addition to the consequences of such a proclamation which occur by operation of law, the ESA
145 authorizes the Governor during a “state of emergency” to suspend any regulatory statute, or statute
146 prescribing the procedure for conduct of state business, or the orders, rules, or regulations of any state
147 agency, where the Governor determines and declares that strict compliance would in any way prevent,
148 hinder, or delay the mitigation of the effects of the emergency.⁴ The Act also authorizes the Governor to
149 make, amend, and rescind orders and regulations necessary to carry out the provisions of the Act, and
150 further provides that the orders and regulations have the force and effect of law.⁵

151
152 The effect of a suspension of regulatory statutes and regulations can have several consequences.
153 During the period of the proclaimed emergency and suspension, the suspended statutes and regulations
154 have no force and effect. Consequently, regulatory and law enforcement agencies cannot prevent or
155 penalize persons for failing to comply with the statute or regulation. Further, the statute or regulation
156 cannot provide a basis for finding negligence as a matter of law, which can lessen the potential for civil
157 liability should a person be unintentionally harmed by emergency response activities. The absence of
158 specific regulatory restraints can serve as an incentive for persons to act beneficially to mitigate the
159 effects of the emergency and generally to protect the health and safety and preserve the lives and
160 property of the people of the state without fear of subsequent criminal, administrative or civil liability.

161
162 In a medical or health disaster, a suspension of appropriate healthcare-related regulatory statutes and
163 regulations could be used to increase the capacity and/or capability of providers of care to render medical
164 services which, under normal standards, might not be available. Most medical care in California is
165 delivered by persons and entities in the private sector who are highly regulated through the imposition of
166 licensure and certification requirements. Under normal circumstances, a failure to comply with these
167 requirements can result in criminal, administrative, and/or civil liabilities. Not all requirements, however,
168 are indispensable under all circumstances to protect the consumer. For example, a mandated nurse-to-
169 patient staffing ratio, while consistent with expectations for patient care under normal circumstances, may
170 be unworkable in an emergency. This requirement may even be an obstacle to providing care to the
171 increased number of patients in need of care, if hospitals divert ambulance patients for lack of adequate
172 nurse staffing.⁶

173
174 Generally, state regulatory agencies have administrative discretion in the enforcement of regulatory
175 requirements. During an emergency, the state, including its political subdivisions, is responsible for the
176 mitigation of the effects of the emergency.⁷ If the strict enforcement of a regulatory requirement will serve
177 as a disincentive to persons who can assist the state in mitigating the effects of the emergency, it would
178 be in the interest of the state to administratively relax its enforcement of that requirement.

179

⁴ Govt. Code, §8571.

⁵ Govt. Code, §8567.

⁶ 22 Cal. Code Reg., §70217. This regulation does allow for some flexibility where a healthcare emergency (i.e., an unpredictable or unavoidable occurrence at unscheduled or unpredictable intervals relating to healthcare delivery requiring immediate medical interventions and care) causes a change in the number of patients on a hospital unit. However, the hospital must demonstrate that prompt efforts were made to maintain required staffing levels.

⁷ See Govt. Code, §8550.

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180 However, the relaxation of administrative or criminal enforcement of a requirement does not eliminate the
181 requirement itself. The requirement is still the law, and as such could provide a basis for the imposition of
182 civil liability. Everyone, including every medical practitioner, is responsible for any injury occasioned to
183 another by his or her want of ordinary care or skill in the management of his or her property or person,
184 unless the injured person has, willfully or by want of ordinary care, brought the injury upon himself or
185 herself.⁸ The failure to exercise ordinary care is commonly referred to as negligence.

186
187 What constitutes ordinary care by a medical practitioner or facility is determined in part by whether the
188 care conforms to the standard exercised by prudent practitioners acting under the same or similar
189 circumstances. Ordinary care may also be determined by the standard established by statutory and
190 regulatory requirements applicable to the medical provider. Thus, failure to comply with these
191 requirements, even if not enforced by the regulatory agency, can establish negligence as a matter of law
192 and lead to liability if the failure to comply with the requirement is a proximate cause of harm to a person.

193
194 The determination of what constitutes ordinary care is generally made by the courts, often long after the
195 act or omission which gave rise to the alleged claim or injury. It can be difficult even under normal
196 conditions to describe what constitutes ordinary care by a medical practitioner. What constitutes ordinary
197 care under conditions of disaster may be even less certain. Thus, a provider of medical care faced with a
198 perceived need during an emergency to deviate from the normal standards of care to save a disaster
199 victim's life may have no way of knowing with any degree of certainty prior to rendering care whether
200 rendering assistance may subsequently subject him or her to civil liability. If the perceived risk of liability
201 is too great, the provider may choose to withhold care, or may feel bound to provide care and utilize
202 scarce resources for the one patient rather than benefit a number of patients.

203

204 2.3 Immunities from Liability Available in an Emergency

205

206 To some extent, the Legislature has already recognized this dilemma. There are several statutes
207 providing qualified immunity to persons rendering aid during an emergency. These immunity provisions
208 instruct the courts not to impose liability in specified emergency circumstances. Thus, if the immunity
209 applies, there can be no liability. This, in turn, may reduce the need for a suspension of regulatory
210 requirements, because the immunity already contemplates that the standard of care is altered in
211 emergency circumstances.

212

213 Therefore, before examining more closely the authority and procedures for suspending regulatory
214 statutes or promulgating emergency orders and regulations, or what regulatory statutes, or state agency
215 orders, rules or regulations, if suspended, would assist in the mitigation of the effects of a medical and
216 health emergency, we must first examine the immunities available by law for emergency care.

217

218

219 *For Healthcare Services During a Proclaimed Emergency at Request of Responsible Government Official*

220

221 Under the ESA, any physician or surgeon (whether licensed in this state or any other state), hospital,
222 pharmacist, nurse, or dentist who renders services during any state of war emergency, a state of
223 emergency, or a local emergency at the express or implied request of any responsible state or local
224 official or agency is immune from liability for any injury sustained by any person by reason of such
225 services, regardless of how or under what circumstances or by what cause such injuries are sustained.⁹
226 This immunity, however, does not apply "in the event of a willful act or omission."

227

228 It has been argued that the phrase "willful act or omission" completely negates the immunity, because
229 every act undertaken by a health facility or professional to render services during an emergency is willful,
230 i.e., the product of a deliberate choice. However, there does not appear to be any case to support such

⁸ Civil Code, §1714.

⁹ Government Code, §8659.

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231 an interpretation of Government Code section 8659. To the contrary, cases interpreting section 2395 of
232 the Business and Professions, the “Good Samaritan” statute for physicians (see below), which contains
233 an identical exclusion for a “willful act or omission,” have repeatedly supported the application of immunity
234 notwithstanding very deliberate actions on the part of the defendants in those cases to treat their patient.
235 For example, in *Burciaga v. St. John’s Hospital*,¹⁰ a pediatrician summoned under emergency
236 circumstances to the delivery room administered suction and applied oxygen to an infant in respiratory
237 distress, then secured a transfer of the infant to a neonatal unit in a different hospital, and was still found
238 to be immune. Similarly, in *Bryant v. Bakshandeh*,¹¹ an urologist who was summoned to assist in the
239 catheterization of an infant patient prior to surgery, but despite repeated attempts was unable to do so
240 due to complications, was also found to be immune.

241
242 As a general rule, the purpose of statutory construction is to ascertain the intent of the legislature so as to
243 effectuate the purpose of the law.¹² The clear purpose of the Government Code section 8659 is to induce
244 providers of medical care to render emergency aid to individuals who otherwise would not receive it. To
245 construe section 8659 to exclude any deliberate attempt to render emergency aid would completely
246 defeat the statute’s apparent purpose. Although it remains unclear precisely what the Legislature
247 intended by the words “willful act or omission,” it seems obvious that it did not intend that the qualification
248 would negate the purpose of the statute altogether.

249
250 The immunity provided by section 8659 is distinctive in other ways. Unlike the immunity provided by the
251 Good Samaritan statute for physicians (see below), the services rendered do not need to be emergency
252 care. It appears sufficient that the care was rendered at the express or implied request of an authorized
253 official. Also, unlike the immunity provided to disaster service workers under the ESA (see below), the
254 providers of care do not need to be registered disaster services workers in order to receive the immunity.
255 The facility or professional simply needs to fall within one the licensure categories described in the
256 statute.

257
258 *For Emergency Care at the Scene of an Emergency*

259 2.3.1.1.1 Business and Professions Code section 2395 provides immunity from civil damages to
260 physicians for acts and omissions in rendering emergency care in good faith at the scene of an
261 emergency. The statute specifically includes, but is not limited to, the emergency rooms of hospitals in
262 the event of a medical disaster within the meaning of the phrase “the scene of an emergency.” The
263 phrase “medical disaster” specifically refers to a duly proclaimed state of emergency or local emergency
264 declared pursuant to the ESA. It applies to acts or omissions which occur after the declaration of a
265 medical disaster and those which occurred prior to such declaration but after the commencement of such
266 medical disaster.

267
268 Similar provisions exist for nurses,¹³ dentists,¹⁴ licensed vocational nurses,¹⁵ physician’s assistants,¹⁶ any
269 person providing on-scene emergency care,¹⁷ physicians providing instructions to EMT-II’s or
270 paramedics,¹⁸ law enforcement and emergency response personnel providing on-scene emergency
271 care,¹⁹ and public entities and emergency rescue personnel providing emergency care.²⁰ In some cases,

¹⁰ *Burciaga v. St. John’s Hospital* (1986) 187 Cal.App.3d 710.

¹¹ *Bryant v. Bakshandeh* (1991) 226 Cal.App.3d 1241

¹² *Calatayud v. State of California* (1998) 18 Cal. 4th 1057, 1064.

¹³ Bus. & Prof. Code, §2727.5

¹⁴ Bus. & Prof. Code, §1627.5.

¹⁵ Bus. & Prof. Code, §2861.5.

¹⁶ Bus. & Prof. Code, §3503.5

¹⁷ Health & Saf. Code, §1799.102.

¹⁸ Health & Saf. Code, §1799.104.

¹⁹ Health & Saf. Code, §1799.106.

²⁰ Health & Saf. Code, §1799.107.

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272 the immunity will not apply where the person is grossly negligent.²¹ In other cases, it will apply if the
273 person acted simply in good faith.²²

274

275 *For Failure to Obtain Informed Consent Under Emergency Conditions*

276 2.3.1.1.2 Physicians and surgeons are also immune from civil damages for injuries in emergency
277 situations in their office or in a hospital on account of a failure to obtain fully informed consent where the
278 (1) the patient was unconscious, (2) the lack of informed consent was due to the provider's reasonable
279 belief that a medical procedure should be undertaken immediately and that there was insufficient time to
280 fully inform the patient or a person authorized to give such consent for the patient.²³ Either criteria could
281 easily apply under emergency conditions. However, it is unclear whether the concept of "insufficient time"
282 applies only to the needs of the patient being treated, or includes a lack of time due to an overwhelming
283 number of patients requiring treatment.

284

285 *For Lawfully Ordered Services by Disaster Service Workers*

2.2862 In an emergency, the service of persons not already employees of the state will be utilized.
287 These persons may be volunteers, or they may be impressed into service.²⁴ The state Office of
288 Emergency Services is required to develop a plan for state and local governmental agencies to utilize
289 volunteer resources during a state of emergency proclaimed by the Governor.²⁵ Whether a volunteer or
290 someone impressed into service, a person providing disaster relief is referred to as a "disaster service
291 worker."²⁶ In addition, all state and local public employees are, by law, disaster service workers.²⁷
292 Disaster service workers are covered, to the extent funds are available, by worker's compensation for
293 injuries sustained in the course of training for or providing relief work.²⁸ Volunteer disaster service
294 workers are not compensated, but may be reimbursed for expenses.²⁹

2.2953 Disaster service workers are also entitled to the same immunities as public employees,³⁰ and if
296 performing services during a proclaimed disaster under the ESA are also immune from civil damages on
297 account of personal injury to or death of any person or damage to property resulting from any act or
298 omission in the line of duty, except one that is willful.³¹

299 Some volunteers will be medical staff, who will staff casualty stations, establish and operate medical and
300 public health field units; assist in hospitals, out-patient clinics, and other medical and public health
301 installations.³² These persons would have immunity for their negligent acts and omissions.

302

303 *For Facilities Used as Mass Care Centers*

304

305 The same Civil Code section that provides immunity for disaster service workers provides immunity to
306 anyone, including a public agency, who owns or maintains any building or premises which is used as a
307 mass care center, first aid station, temporary hospital annex, or other necessary facility for mitigating the

²¹ See, e.g. Bus. & Prof. Code, §2727.5, applying to nurses.

²² Health & Saf. Code, §1799.102, applying to any person outside of an emergency room or place where care is usually offered.

²³ Bus. & Prof. Code, §2397.

²⁴ See Govt. Code, §204; "The State may require services of persons, with or without compensation: . . . in protecting life and property from fire, pestilence, wreck and flood."

²⁵ Govt. Code, §8599.

²⁶ Govt. Code, §3101.

²⁷ Govt. Code, §3100.

²⁸ See Labor Code, §3600.6, §§3211.9-3211.93a, and §§4350-4355; 19 Cal. Code Reg. 2570, et seq.

²⁹ 19 Cal. Code Reg. 2570.2.

³⁰ Govt. Code 8657.

³¹ Civil Code, §1714.5; the exception here is essentially identical to the Good Samaritan exception for physicians, and the exception to the specific provider immunity in a declared emergency under Govt. Code section 8659, discussed above.

³² 19 Cal. Code Reg. 2572.1(j).

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308 effects of an emergency. The immunity is from liability to any person, who has entered to seek refuge,
309 treatment, care or assistance and while in or upon the premises, for injuries sustained as a result of the
310 condition of the building or premises, or as the result of any act or omission, or as a result of the use or
311 designation of the premises as a mass care center, first aid station, temporary hospital annex, or other
312 necessary facility for emergency purposes. The only exclusions are the willful acts of the owner or
313 occupant or their employees.³³

314
315 *For Health Facilities with Inadequate Resources*

316 2.3.1.3.1 By law, emergency services and care must be provided to any person upon request for any
317 condition in which the person is in danger of loss of life, or serious injury or illness, at any health facility
318 licensed by the State that maintains and operates an emergency department to provide emergency
319 services to the public when the health facility has appropriate facilities and qualified personnel available to
320 provide the services or care.³⁴ However, the health facility, its employees, nor any physician and
321 surgeon, dentist, clinical psychologist, or podiatrist are immune from liability in any action arising out of a
322 refusal to render emergency services or care if the refusal is based on the determination, exercising
323 reasonable care, that the person is not suffering from an emergency medical condition, or that the health
324 facility does not have the appropriate facilities or qualified personnel available to render those services.³⁵

325
326 *For Hospital Rescue Teams*

327
328 For purposes of the immunity provision, a “rescue team” is a special group of physicians and surgeons,
329 nurses, and employees of a health facility who have been trained in cardiopulmonary resuscitation and
330 have been designated by the health facility to attempt, in cases of emergency, to resuscitate persons who
331 are in immediate danger of loss of life.³⁶ So long as good faith is exercised, any act or omission of any
332 rescue team of a licensed health facility, or operated by the federal or state government, a county, or by
333 the Regents of the University of California, done or omitted while attempting to resuscitate any person
334 who is in immediate danger of loss of life, is immune from any liability that might otherwise be imposed
335 upon the health facility, the officers, members of the staff, nurses, or employees of the health facility,
336 including, but not limited to, the members of the rescue team, or upon the federal or state government or
337 a county.

338
339 *For Violation of Statute or Ordinance under Emergency Orders*

340
341 As previously discussed, violation of a statute can provide the basis for a claim of negligence as a matter
342 of law. In an emergency, however, it is a misdemeanor to refuse or willfully neglect to obey any lawful
343 order or regulation promulgated or issued under the ESA.³⁷ Such orders and regulations may compel a
344 person to violate a statute. Consequently, the law also provides that the violation of any statute or
345 ordinance shall not establish negligence as a matter of law where the act or omission involved was
346 required to comply with any regulation, directive, or order of the Governor promulgated under the
347 California Emergency Services Act.³⁸ In addition, a person cannot be prosecuted for a violation of any
348 statute or ordinance when the violation was required in order to comply with any regulation, directive, or
349 order of the Governor.³⁹

350

³³ Civil Code, §1714.5.

³⁴ Health & Saf. Code, §1317(a).

³⁵ Health & Saf. Code, §1317(c).

³⁶ Health & Saf. Code, §1317(g).

³⁷ Govt. Code, §8665.

³⁸ Civil Code, §1714.6.

³⁹ Civil Code, §1714.6.

351 2.4 Suspension of Regulatory Statutes Where Needed to Expand
352 Availability of Care

353
354 For purposes of the following discussion, we must assume that the Governor has determined that,
355 despite all the mutual aid provided and the immunities available to professionals and facilities providing
356 emergency care, extraordinary measures must be taken to suspend regulatory statutes under
357 Government Code section 8571 in order to induce providers of medical care to render emergency aid to
358 individuals who otherwise would not receive it. Whether this point is ever achieved may depend upon
359 several factors. For example, some organized health systems may have a contractual responsibility to
360 provide medical care to their members even under disaster conditions, and therefore may be willing to
361 provide care to their customers despite a perceived increased risk of liability. There may also be good
362 reasons, from the standpoint of maintaining good will in the community, for a health facility to do
363 everything within its power following a disaster to provide the medical care services needed by the
364 community. Many of the immunities discussed in the proceeding paragraphs would apply, and these
365 immunities may be sufficient to justify the provision of services despite degraded circumstances.

366
367 Nevertheless, there may be a sufficient number of health facilities for which the availability of immunity is
368 uncertain. It is possible that these facilities will continue to provide care as best they can under the
369 circumstances, hoping that subsequently the courts will agree that the circumstances altered the standard
370 of ordinary care or that an immunity will be found to apply. However, some could refuse to provide care
371 beyond what is enabled by activation of the hospital incident command system, because it cannot provide
372 services at a level normally consistent with ordinary care. There is no general statutory or regulatory
373 requirement that healthcare providers be available to provide care to the public under all circumstances.⁴⁰
374 ⁴¹ Indeed, this fact accounts for the existence of the Good Samaritan laws discussed above.⁴²

375
376 Therefore, the Governor may be persuaded to suspend those regulatory requirements perceived to be an
377 obstacle to the emergency mitigation effort. The suspension would be implemented through an executive
378 order of the Governor either suspending specific regulatory requirements, or delegating to another state
379 official, e.g. the Director of the Office of Emergency Services, the Emergency Medical Services Authority,
380 or the Department of Public Health, the authority to suspend requirements consistent with the Governor's
381 authority to do so. The proclamation of a state of emergency alone is not sufficient to effectuate a
382 suspension. The proclamation would also need to include a separate order as described above, or would
383 need to implement pre-approved standby orders of a similar nature.⁴³

384
385 It should be emphasized that, until such an order is issued subsequent to a proclamation of a state of
386 emergency, no regulatory requirement is suspended (except to the extent that the regulatory agency has
387 waived enforcement⁴⁴). Therefore, medical providers not operating under emergency conditions offering
388 immunity must ascertain the existence and scope of the proclaimed state of emergency, and extent and
389 applicability of any suspension of regulatory requirements.
390

⁴⁰ There is an immunity from liability for refusal to treat based on a determination that the health facility does not have the appropriate facilities or qualified personnel available to render those services. (Health & Saf. Code, §1317(c).

⁴¹ Hospitals with emergency departments are required under the Emergency Medical Treatment and Labor Act (EMTALA) to provide a screening and stabilization within the abilities of the staff and facilities available prior to transferring the patient to another facility. (42 U.S.C. 1395dd.) This federal requirement can be waived by the Secretary for Health and Human Services under 42 U.S.C. 1320b-5(b)(3).

⁴² See, e.g., Business & Profs. Code, §§1627.5, 2395, 2727.5, 2861.5, and 3503.5.

⁴³ At present, no standby orders suspending healthcare standards exist.

⁴⁴ Health & Saf. Code, §1276.

391 **2.5 Issuance of Emergency Regulations Amending Standards of**
392 **Care**

393
394 In addition to the Governor’s authority to suspend regulatory requirements, the Governor is also
395 authorized to issue necessary orders, rules and regulations to carry out the provisions of the ESA. These
396 orders and regulations have the force and effect of law.⁴⁵ As previously noted, willful violation of these
397 orders and regulations is a misdemeanor.⁴⁶ Such orders and regulations could be used during a medical
398 and health emergency to establish altered standards of care consistent with the ESA’s goal of preserving
399 lives.

400
401 As with the suspension of regulatory requirements, the decision to issue orders or regulations altering
402 standards of care will depend upon several factors. For example, to what extent will the provision of
403 mutual aid avoid the need to alter standards of care? To what extent will the available immunities provide
404 sufficient protections to professionals and facilities providing emergency care? Given these factors, is an
405 alteration of the standards of care necessary to induce providers to render emergency aid to individuals
406 who otherwise would not receive it?

407
408 Orders and regulations of the Governor must be in writing, and take effect immediately. Thus, a
409 proclamation of emergency alone is insufficient to change the standard of care. A separate order, or
410 implement of pre-approved standby orders in conjunction with the proclamation, would be needed.
411

412 **2.6 Commandeering of Facilities and Personnel**

413
414 During a proclaimed state of emergency, the Governor is authorized to commandeer or utilize any private
415 property or personnel deemed by him necessary in carrying out the responsibilities hereby vested in him
416 as Chief Executive of the state.⁴⁷ The power to commandeer is exists only under a state of emergency,
417 and may only be exercised by the Governor or an authorized designee. It is not available under a local
418 emergency. It must also be distinguished from other, more commonly used methods, such as contracts
419 and agreements, to obtain necessary resources.

420
421 It is conceivable that this power could be exercised to take over the operations of any facility that is
422 unwilling to risk providing expanded services due to a perceived increased risk of liability. However, it is
423 unclear how an order to commandeer a facility or personnel would be implemented. Further, the state is
424 required to pay the reasonable value of the property or personnel commandeered or used.⁴⁸
425
426

427 **3 Emergency Preparedness and Response in**
428 **California**

429

430 **3.1 California Emergency Services Act⁴⁹**
431

⁴⁵ Govt. Code, §8567.
⁴⁶ Govt. Code, §8665.
⁴⁷ Govt. Code, §8567.
⁴⁸ Govt. Code, §8567.
⁴⁹ Govt. Code, §§8550, et seq.

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432 The California Emergency Services Act (ESA) recognizes the State's responsibility to mitigate
433 the effects of natural, manmade, or war-caused emergencies which result in conditions of disaster or in
434 extreme peril to life, property, and the resources of the state, and generally to protect the health and
435 safety and preserve the lives and property of the people of the state.⁵⁰ To insure adequate preparations
436 to deal with emergencies, the ESA confers emergency powers upon the Governor and upon the chief
437 executives and governing bodies of political subdivisions of the State, provides State assistance for the
438 organization of local emergency response programs, and creates the Office of Emergency Services
439 (OES) within the Office of the Governor.

440
441 The ESA recognizes the need to assign emergency functions to State agencies and to coordinate and
442 direct the emergency actions of those agencies. It provides for the rendering of mutual aid by the State
443 and its political subdivisions to carry out the purposes of the ESA. Further, the ESA makes it State policy
444 that all State emergency services functions be coordinated as far as possible with the comparable
445 functions of its political subdivisions, of the federal government, of other states, and of private agencies of
446 every type, to make the most effective use of all manpower, resources, and facilities for dealing with any
447 emergency that may occur.
448

449 3.2 Role of the Governor

450
451 The Governor is given broad powers under the ESA. Some powers granted to the Governor have been
452 previously discussed, e.g., the power to make, amend and rescind orders and regulations having the
453 force and effect of law,⁵¹ to suspend regulatory statutes and regulations,⁵² and the power to use and
454 commandeer property and personnel.⁵³ In addition, the Governor has powers which are specific to the
455 type of emergency proclaimed.⁵⁴ For example, during a state of emergency, the Governor has authority
456 over all agencies of State government and the right to exercise all police power vested by law in the State
457 within the area designated.⁵⁵ Also during a state of emergency, the Governor can direct all state
458 government agencies to utilize and employ state personnel, equipment, and facilities for the performance
459 of any and all activities designed to prevent or alleviate actual and threatened damage due to the
460 emergency, and he can direct them to provide supplemental services and equipment to political
461 subdivisions to restore any services which must be restored in order to provide for the health and safety
462 of the citizens of the affected area.⁵⁶

463
464 In carrying out his/her responsibilities under the ESA, the Governor is assisted by the California
465 Emergency Council.⁵⁷ Among other duties, the California Emergency Council must consider,
466 recommend, and approve orders and regulations that are within the province of the Governor to
467 promulgate.⁵⁸ This would include orders and regulations to suspend regulatory requirements or to amend
468 standards of care.

469
470 The Governor is also assisted by the Emergency Response Team for State Operations,⁵⁹ whose task is
471 to improve the ability of state agencies to resume operations in a safe manner and with a minimum of
472 delay if their operations are significantly interrupted by a business interruption.⁶⁰

⁵⁰ Govt. Code, §8550.

⁵¹ Govt. Code, §8567.

⁵² Govt. Code, §8571.

⁵³ Govt. Code, §8572.

⁵⁴ There are three types of emergencies under the ESA; state of war emergency, state of emergency, and local emergency. (See Govt. Code, §8558.)

⁵⁵ Govt. Code, §8627.

⁵⁶ Govt. Code, §8628.

⁵⁷ Govt. Code, §8575, et seq.

⁵⁸ Govt. Code, §8579(b)(1).

⁵⁹ Govt Code, §8549.10.

⁶⁰ Govt Code, §8549.13.

473 **3.3 Governor’s Office of Emergency Services**

474
475 The Office of Emergency Services (OES) is created by the ESA in the Governor’s Office.⁶¹ The Governor
476 is required to assign all or part of his powers under the ESA to the Office of Emergency Services,⁶² but
477 cannot delegate to OES his/her authority to issue orders and regulations.⁶³ During a state of emergency
478 or a local emergency, the Director of OES is responsible to coordinate the emergency activities of all
479 state agencies in connection with such emergency.⁶⁴ It does so through the State Operations Center
480 (SOC) and Regional Emergency Operations Centers (REOC).

481
482 OES has established three OES Administrative Regions, the Southern Region, the Coastal Region, and
483 the Inland Region.⁶⁵ These Administrative Regions coordinate emergency management in the six mutual
484 aid regions created by the Governor (see The Concept of Mutual Aid, below).

485
486 Within the SOC, the REOCs and Operational Area Emergency Operations Centers, the ICS structure
487 organizes emergency response disciplines into Branches under the Operations Section. The Medical and
488 public health issues are handled by the Medical and Health Branch.

489

490 **3.4 State Emergency Plan**

491
492 The Governor is responsible to coordinate the State Emergency Plan and programs necessary for the
493 mitigation of the effects of an emergency. He is also responsible for coordinating the preparation of local
494 plans and programs, and to see that they are integrated into and coordinated with the State Emergency
495 Plan and the plans and programs of the federal government (and of other states) to the fullest possible
496 extent.⁶⁶ By law, the State Emergency Plan is in effect in each political subdivision of the state, and the
497 governing body of each political subdivision is obligated to take whatever action may be necessary to
498 carry out its provisions.⁶⁷

499
500 As part of the state plan, the Governor can assign to a state agency any activity concerned with the
501 mitigation of the effects of an emergency of a nature related to the existing powers and duties of the
502 agency, including interstate activities. Such an assignment makes it the duty of the agency to undertake
503 and carry out that activity on behalf of the state.⁶⁸

504
505 In accordance with the State Emergency Plan, the Governor can plan for the use of any private facilities,
506 services, and property and, when necessary, and when in fact used, provide for payment for that use
507 under the terms and conditions as may be agreed upon.⁶⁹ This planning authorization is consistent with
508 the Governor’s power, described above, to commandeer property and personnel.⁷⁰

509

510 **3.5 Emergency Medical Services Authority**

511

⁶¹ Govt. Code, §8585.
⁶² Govt. Code, §8586.
⁶³ Govt. Code, §8587.
⁶⁴ Ibid.
⁶⁵ California State Emergency Plan, 2005, pp. 8, 9.
⁶⁶ Govt. Code, §8569.
⁶⁷ Govt. Code, §8568.
⁶⁸ Govt. Code, §8595.
⁶⁹ Govt. Code, §8570.
⁷⁰ Govt. Code, §8572.

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512 The Emergency Medical Services Authority (EMSA)⁷¹ is required by law to respond to any medical
513 disaster by mobilizing and coordinating emergency medical services mutual aid resources to mitigate
514 health problems.⁷² The State Emergency Plan (see below) designates the EMSA as the lead state
515 agency for the medical response to an emergency.⁷³ Also, EMSA is responsible under the Plan for
516 medical situation status and analysis in conjunction with the Department of Health Services.⁷⁴

517
518 Generally, any attendant in a publicly or privately owned ambulance must possess evidence of
519 specialized training as set forth in the emergency medical training and educational standards for
520 ambulance personnel established by EMSA.⁷⁵ However, this requirement does not apply in any state of
521 emergency declared under the ESA when it is necessary to fully utilize all available ambulances in an
522 area and it is not possible to have the ambulance operated or attended by persons with the qualifications
523 required by EMSA.⁷⁶

524

525 3.6 State Department of Public Health

526

527 The State Department of Public Health (DPH)⁷⁷ is designated the lead for the public health component of
528 the Medical and Health Services operations set forth in the State Emergency Plan (see below).⁷⁸ Both
529 EMSA and DPH share responsibility for the lead in the Medical/Health Branch. Also, DPH, in conjunction
530 with EMSA, is responsible under the Plan for public health situation status and analysis.⁷⁹

531

532 DPH is also the agency which regulates acute care hospitals and many other health-related facilities.⁸⁰
533 Therefore, during the early stages of an incident when acute care hospitals are reaching the limits of their
534 capacity, hospital administrators may contact the Licensing and Certification Division of DPH in their
535 region to obtain waivers of specific regulatory requirements.⁸¹

536

537 3.7 The Concept of Mutual Aid

538

539 Mutual aid is a concept under which separate jurisdictional or organizational units share and combine
540 resources in order to accomplish their mutual goals. The ESA recognizes that, during emergencies, the
541 rendering of mutual aid by State government, including all its departments and agencies, and its political
542 subdivisions will be necessary to mitigate the effects of the emergency. Public agencies are authorized
543 by law to enter into joint powers agreements, and these agreements can be for the purposes of providing
544 assistance to each other.⁸² However, given the number of cities and counties in the State, it would be
545 impractical to require that each jurisdiction have a separate agreement with each other jurisdiction in
546 order to assist each other in the event of an emergency.

547

⁷¹ Health & Saf. Code, §§1797.100, et seq.

⁷² Health & Saf. Code, §§1797.150.

⁷³ California State Emergency Plan, 2005, p. 58.

⁷⁴ California State Emergency Plan, 2005, p. 56.

⁷⁵ Health & Saf. Code, §1797.160.

⁷⁶ Ibid.

⁷⁷ Health & Saf. 100100, et seq.; effective July 1, 2007, the public health duties of the State Department of Health Services are transferred to the new State Department of Public Health, Health & Saf. Code, §131000, et seq.

⁷⁸ California State Emergency Plan, 2005, p. 58.

⁷⁹ California State Emergency Plan, 2005, p. 56.

⁸⁰ Health & Saf. Code, §§1200, et seq.

⁸¹ Health & Saf. Code, §1276.

⁸² Govt. Code, §6502.

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548 Accordingly, one purpose of the ESA is to make it unnecessary for public agencies to execute written
549 agreements to render aid to areas stricken by an emergency.⁸³ It accomplishes this goal by authorizing
550 state and local public agencies to exercise mutual aid powers in accordance with the California Disaster
551 and Civil Defense Master Mutual Aid Agreement, and local plans, ordinances, resolutions and
552 agreements.⁸⁴ The Master Mutual Aid Agreement requires that each party develop a plan providing for
553 the effective mobilization of all its resources and facilities, both public and private, to cope with any type of
554 disaster.⁸⁵ These plans are known as “mutual aid operational plans.” Under the ESA, a duly adopted and
555 approved emergency plan is deemed to satisfy the Master Mutual Aid Agreement’s requirement for a
556 “mutual aid operational plan.”⁸⁶

557
558 As previously discussed, the Governor is authorized to divide the state into mutual aid regions for the
559 more effective application, administration, and coordination of mutual aid and other emergency-related
560 activities.⁸⁷ A “mutual aid region” is part of the state, not local, emergency services organization, and is
561 established to facilitate the coordination of mutual aid and other emergency operations within an area of
562 the state consisting of two or more county operational areas.⁸⁸ (See discussion of Operational Areas,⁸⁹
563 below.) Currently, the State is divided into six mutual aid regions for general mutual aid coordination.⁸⁹
564 Each mutual aid region consists of designated counties/operational areas.

565
566 Within each mutual aid region, there may be a Regional Disaster Medical and Health Coordinator
567 (RDMHC), who is appointed by the Directors of EMSA and DHS.⁹⁰ The RDMHC must be either a county
568 health officer, a county coordinator of emergency services, an administrator of a local EMS agency, or a
569 medical director of a local EMS agency (see below for a discussion of these officials). The job of the
570 RDHMC during an emergency is to coordinate the acquisition of requested medical or public and
571 environmental health mutual aid in an affected region to deliver to the area affected by the disaster. In a
572 proclaimed emergency and at the request of EMSA, DHS or OES, an RDMHC in an unaffected region
573 may also coordinate the acquisition of requested mutual aid resources in his/her region.⁹¹

574
575 Mutual aid is not limited to aid between jurisdictions in California. The Governor may also enter into
576 reciprocal aid agreements or compacts, mutual aid plans, or other interstate arrangements for the
577 protection of life and property with other states and the federal government, either on a statewide or a
578 political subdivision basis.⁹² The State has entered into two interstate compacts; the Interstate Civil
579 Defense and Disaster Compact⁹³ and the Emergency Management Assistance Compact.⁹⁴ The State
580 can also seek federal mutual aid by requesting a Presidential Declaration of an Emergency or Major
581 disaster under the provisions of the Stafford Act.⁹⁵ A Presidential declaration makes federal assistance
582 programs available, depending on the level of the declaration, as outlined in the Federal Response Plan,
583 which includes contributions from several federal agencies and non-governmental organizations, such as
584 the American Red Cross.

585

⁸³ Govt. Code, §8615.

⁸⁴ Govt. Code, §§8617, 8561.

⁸⁵ California Disaster and Civil Defense Master Mutual Aid Agreement, ¶1.

⁸⁶ Govt. Code, §8615.

⁸⁷ Govt. Code, §8600.

⁸⁸ Govt. Code, §8559(a).

⁸⁹ California State Emergency Plan, 2005, pp. 8, 10.

⁹⁰ Health & Saf., §1797.152(a).

⁹¹ Health & Saf., §1797.152(b).

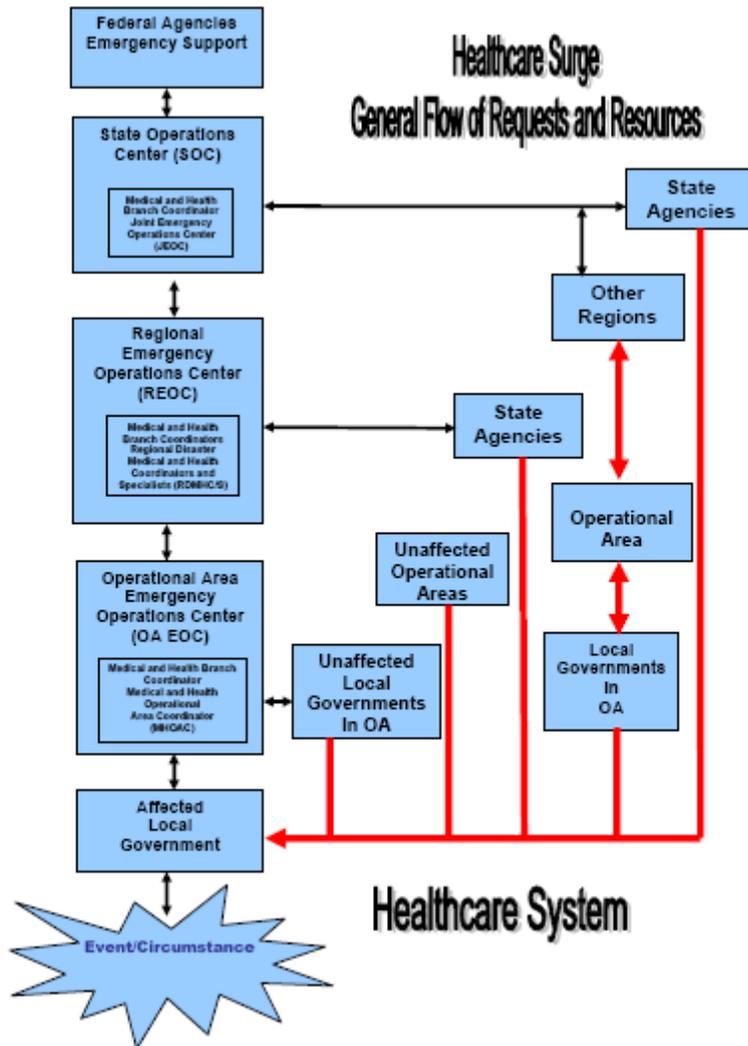
⁹² Govt. Code, §8619.

⁹³ Govt. Code, §§178, et seq.

⁹⁴ Govt. Code, §179.5, et seq.; inoperative effective March 1, 2007; for proposed extension of operability, see AB 1564 (Nava), 2007-2008 Session.

⁹⁵ Robert T. Stafford Disaster Relief and Emergency Assistance Act, P.L. 93-288, 100-707, and 106-390, 42 U.S.C. §5121, et seq.

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586
587

588 3.8 Local Emergency Plans and Local Disaster Councils

589

590 The ESA defines "emergency plans" to mean those official and approved documents which describe the
591 principles and methods to be applied in carrying out emergency operations or rendering mutual aid during
592 emergencies. These plans include such elements as continuity of government, the emergency services
593 of governmental agencies, mobilization of resources, mutual aid, and public information.⁹⁶ During a state
594 of emergency, outside aid must be rendered in accordance with approved emergency plans, and public
595 officials are required to cooperate to the fullest extent possible to carry out such plans.⁹⁷

596

597 Cities and counties are authorized to create disaster councils by ordinance.⁹⁸ If created, the disaster
598 council is responsible for developing emergency plans.⁹⁹ The plans must meet any condition constituting
599 a local emergency or state of emergency, including, but not limited to, earthquakes, natural or manmade

⁹⁶ Govt. Code, §8560.

⁹⁷ Govt. Code, §8616.

⁹⁸ Govt. Code, §8610.

⁹⁹ Ibid.

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600 disasters specific to that jurisdiction, or state of war emergency, and must provide for the effective
601 mobilization of all of the resources within the political subdivision, both public and private.¹⁰⁰

602
603 The primary motivation for organizing a disaster council is that the disaster council can register “disaster
604 service workers.” Under the ESA, the OES is authorized to adopt regulations for the classification and
605 registration of disaster service workers.¹⁰¹ The regulations provide that a disaster service worker is a
606 person registered either with OES, a state agency authorized to register disaster service workers, or a
607 disaster council.¹⁰² Registered disaster service workers can be afforded worker’s compensation benefits
608 and liability protections for their acts and omissions during an emergency.

609
610 Disaster councils may become accredited by the Office of Emergency Services, by agreeing to comply
611 with the ESA and submitting to the office a certified copy of the ordinance which provides for the disaster
612 council and its leadership, the local emergency organization and compliance with the ESA.¹⁰³ The main
613 reason for a disaster council to receive and maintain accreditation is that the term “disaster service
614 worker,” for purposes of worker’s compensation benefits, only applies to person registered by an
615 “accredited disaster council” or a state agency.¹⁰⁴ Thus, if a volunteer is registered with an unaccredited
616 disaster council, the volunteer arguably is not a “disaster service worker” for purposes of worker’s
617 compensation coverage.

618
619 The governing body of a city or county is authorized to provide by ordinance or resolution for the
620 organization, powers and duties, divisions, services, and staff of the emergency organization.¹⁰⁵ This
621 ordinance or resolution, in effect, authorizes individuals within the city or county to take actions in
622 accordance with the emergency plan. The city or county can also authorize public officers, employees,
623 and registered volunteers to command the aid of citizens when necessary during a state of war
624 emergency, a state of emergency, or a local emergency.¹⁰⁶

625
626 It is the legal duty of each organizational component, officer, and employee of each political subdivision of
627 the state to render all possible assistance to the Governor and to the
628 Director of the Office of Emergency Services in mitigating the effects of an emergency. Their emergency
629 powers are subordinate to any emergency powers exercised by the Governor.¹⁰⁷

630

631 3.9 Standardized Emergency Management System

632

633 The Standardized Emergency Management System (SEMS) is a system for managing the response to
634 multiagency and multi-jurisdictional emergencies in California.¹⁰⁸ OES has developed regulations to
635 implement SEMS.¹⁰⁹ All state agencies are required to use SEMS to coordinate multiple jurisdiction or
636 multiple agency emergency and disaster operations.¹¹⁰ Every local agency, in order to be eligible for any
637 funding of response-related (i.e., personnel) costs under disaster assistance programs, must also use
638 SEMS to coordinate multiple jurisdiction or multiple agency emergency and disaster operations.¹¹¹ This

¹⁰⁰ Ibid.

¹⁰¹ Govt. Code, §8585.5.

¹⁰² 19 Cal. Code Reg. 2570.2

¹⁰³ Govt. Code, §8612; 19 Cal. Code Reg. §2571.

¹⁰⁴ Labor Code, §3211.92.

¹⁰⁵ Govt. Code, §8610.

¹⁰⁶ Govt. Code, §8610.

¹⁰⁷ Govt. Code, §8614.

¹⁰⁸ In a letter dated September 28, 2006, the Director of OES certified to the federal Department of Homeland Security the compliance of SEMS with the National Incident Management System (NIMS) for fiscal year 2006.

¹⁰⁹ 19 Cal. Code Reg., §2400, et seq.

¹¹⁰ Govt. Code, §8607(d).

¹¹¹ Govt. Code, §8607(e).

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639 means that local emergency plans must also incorporate SEMS, assuming the local government wants to
640 be reimbursed for emergency personnel costs.

641

642 *Incident Command System (ICS)*

643

644 SEMS is required to be based in part on the concept of the Incident Command System (ICS),¹¹² which
645 had been developed and used by the fire services to respond to all types of emergencies. The system
646 standardizes the organizational structure and terminology used by every response agency. ICS
647 recognizes that every response, regardless of size, requires that five management functions be
648 performed:

649

650 1) Management – the function of setting priorities and policy direction, and coordinating the response;

651 2) Operations – the function of taking responsive actions based on policy;

652 3) Planning/Intelligence – the function of gathering, assessing and disseminating information;

653 4) Logistics – the function of obtaining resources to support operations; and

654 5) Finance/Administration – the function of documenting and tracking the costs of response
655 operations.

656

657 Even the issuance of a speeding ticket involves each of these five ICS functions, i.e. a policy against
658 speeding, the intelligence gathering which detects and identifies a speeding driver, the operation of
659 pulling the driver over and issuing the citation, the logistics of providing the equipment (car, radar, ticket
660 book) needed to conduct the operation, and the administrative tracking of submitting the citation into the
661 court system. At the other extreme there may be a multi-jurisdictional wildland fire involving the same
662 functions, i.e. a policy of protecting lives and property, intelligence and planning on how to stop the fire,
663 operations in which firefighters and equipment are committed to the fireline, logistics to obtain, equip
664 and support the firefighting operation, and finance/administration to determine how to pay for it all.

665

666 As an incident expands in scope, the ICS expands and adapts with it. When multiple jurisdictions or
667 agencies become involved, a “unified command” management organization is formed, under which
668 members representing different organizations at the Incident Command Post establish a common set of
669 objectives and strategies and a single incident action plan.

670

671 *Multi-Agency Coordination System*

672

673 Together with ICS, SEMS incorporates the Multi-Agency Coordination (MACS),¹¹³ in which jurisdictions
674 and organizations work together to coordinate and prioritize the allocation of resources and emergency
675 response activities. In practical application, facilities, equipment, personnel, procedures and
676 communications are integrated into a common system under an organization typically located as part of
677 an emergency operations center. The multi-agency organization does not direct operational activities, but
678 rather ensures situational and resource status awareness, helps establish policies and priorities, acquires
679 and allocates resources, plans for anticipated resource requirements, and provides strategic coordination.

680

681 *Mutual Aid*

682

683 SEMS also embraces the concept of mutual aid, discussed above.¹¹⁴ SEMS applies this concept by
684 recognizing five organizational levels for response. The levels are, in the order in which the levels
685 become involved in the response under the mutual aid concept:

686

687 1) Field – where diverse local response organizations (law enforcement, fire, public health) use their
688 own resources to carry out tactical decisions and activities;

¹¹² Govt. Code, §8607(a)(1); Cal.Code Reg., §§2401, 2402(l), and 2405.

¹¹³ Govt. Code, §8607(a)(2); 19 Cal.Code Reg., §2401, 2402(n).

¹¹⁴ Govt. Code, §8607(a)(3); 19 Cal. Code Reg., §2415; See *Emergency Management in California*, OES, 2003, p. 8.

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- 689 2) Local – where local governments, e.g. cities, counties and special districts, manage and
690 coordinate the emergency response and recovery.
691 3) Operational Area – the entity that coordinates resources, the provision of mutual aid, emergency
692 response and damage information.
693 4) Regional – manages and coordinates resources and information among operational areas.
694 5) State – this level is responsible for statewide resource allocation. If State resources are
695 inadequate, this level is integrated with federal agency resources.
696

697 It should here be emphasized that, under the ESA, unless the parties to a mutual aid agreement
698 expressly provide otherwise, the responsible local official in whose jurisdiction an incident requiring
699 mutual aid has occurred remains in charge at such incident, including the direction of personnel and
700 equipment provided him through mutual aid.¹¹⁵ Thus, the fact that higher organizational levels become
701 involved in coordinating resources and information does not mean that officials at that higher level take
702 charge of the incident.
703

704 *Operational Area*

705
706 The State and regional levels have been discussed previously and are reflected in the ESA. The
707 Operational Area (OA) is also defined in the ESA, and is a required concept of SEMS.¹¹⁶ For purposes of
708 SEMS and the ESA, the OA consists of a county and all political subdivisions within the county area, and
709 serves as an intermediate level of the state emergency services organization.¹¹⁷ The governing bodies
710 of each county and of the political subdivisions in the county are authorized to organize and structure their
711 OA. An OA is used by the county and the political subdivisions comprising the OA for the coordination of
712 emergency activities and to serve as a link in the communications system during a state of emergency or
713 a local emergency.¹¹⁸
714

715 There are 58 OAs in California. Practically speaking, the OA for purposes of SEMS is embodied in its
716 emergency operations center (EOC). An EOC is a location from which centralized emergency
717 management can be performed.¹¹⁹ Political subdivisions within a county may have their own EOCs in
718 addition to the Operational Area EOC. OES has an Operational Area Coordinator attached to each OA.
719

720 The OA EOC must be distinguished from DOCs, or department operations centers. Under SEMS, a DOC
721 is an emergency operations center used above the field level by a specific discipline (e.g., flood
722 operations, fire, medical, hazardous material), or a governmental unit (e.g., Department of Public Works
723 or Department of Health).¹²⁰ There may be as many DOCs as there are public agencies involved in the
724 response above the field level.
725

726 *Communications*

727
728 Finally, SEMS addresses the concept of emergency communications by supporting networks to ensure
729 that all levels of government can communicate during a disaster. Two systems have been established:
730

- 731 1) The Response Information Management System (RIMS) – an electronic data management system
732 that links emergency management offices throughout California.
733
734 2) The Operational Area Satellite Information System (OASIS) – a portable satellite-based network
735 that provides communication when land-based systems are disrupted.
736

¹¹⁵ Govt. Code, §8618.

¹¹⁶ Govt. Code, §§8559(b), 8605, and 8607(a)(4);

¹¹⁷ Govt. Code, §§8559(b), 8605.

¹¹⁸ Govt. Code, §8605.

¹¹⁹ 19 Cal. Code Reg., §2402(f).

¹²⁰ 19 Cal. Code Reg., §2402(c).

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737 In addition, there are discipline specific communications systems, such as the California Health Alert
738 Network (CAHAN). CAHAN is the emergency preparation and notification system used by the California
739 Department of Health Services and all emergency preparedness stakeholders and partners associated
740 with public health. CAHAN contains both an alerting system that provides rapid notification of
741 emergencies to all public health stakeholders and partners and a highly secure web-based document
742 repository used for the creation and collaboration of information pertaining to preparation and/or response
743 to various incidents or events.
744
745

746 3.10 Medical and Health Disaster Plans

747
748 If an operational area has a medical health operational area coordinator (MHOAC), the MHOAC is
749 responsible for the development of a discipline-specific operations plan known as the “medical and health
750 disaster plan” for the provision of medical and health mutual aid for the operational area. The medical and
751 disaster plans must follow the SEMS.¹²¹
752

753 At a minimum, the medical and health disaster plan, policy, and procedures must include all of the
754 following relevant to healthcare surge:

- 755 (1) Assessment of immediate medical needs.
- 756 (2) Coordination of disaster medical and health resources.
- 757 (3) Coordination of patient distribution and medical evaluations.
- 758 (4) Coordination with inpatient and emergency care providers.
- 759 (5) Coordination of out-of-hospital medical care providers.
- 760 (6) Coordination and integration with fire agencies personnel, resources, and emergency fire
761 prehospital medical services.
- 762 (7) Coordination of providers of nonfire based prehospital emergency medical services.
- 763 (8) Coordination of the establishment of temporary field treatment sites.
- 764 (9) Health surveillance and epidemiological analyses of community health status.
- 765 (10) Provision or coordination of mental health services.
- 766 (11) Provision of medical and health public information protective action recommendations.
- 767 (12) Investigation and control of communicable disease.¹²²
768

769 During a medical and health disaster, the MHOAC is responsible for implementing this plan, and
770 coordinating with the Regional Disaster Medical and Health Coordinator, e.g., on the acquisition of state
771 resources or the movement of patients to other jurisdictions.
772

773 3.11 Persons Responsible for Local and Regional Emergency 774 Response Related to Healthcare Surge

775
776 Thus far, we have discussed the role of the following State officials at the State and, to some extent,
777 regional levels in emergency preparedness and response:
778

- 779 1. Governor
- 780 2. California Emergency Council/State Emergency Response Team
- 781 3. Office of Emergency Services (OES)
- 782 4. Emergency Medical Services Authority (EMSA)
- 783 5. Department of Health Services (DHS)
- 784 6. OES Administrative and Mutual Aid Regions

¹²¹ Health & Saf. Code, §1797.153.

¹²² Health & Saf. Code, §1797.153(c).

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785 7. Regional Disaster Medical and Health Coordinator.
786

787 It is often said that all emergencies are local. We have already discussed the role of the Operational Area
788 for purposes of SEMS, and the fact that the Operational Area consists of the political subdivisions of the
789 state within a county . Therefore, we now discuss the local officials involved in emergency response as it
790 relates to healthcare surge.

791
792 *Local Governing Body*
793

794 The local governing body can be either the county board of supervisors or a city council. These bodies
795 are authorized to proclaim a “local emergency.” They may also designate an official by ordinance who
796 can proclaim local emergencies.¹²³ During a proclaimed local emergency, political subdivision of the state
797 have full power to provide mutual aid to any any affected area in accordance with local ordinances,
798 resolutions, emergency plans, or agreements,¹²⁴ and state agencies are authorized to provide mutual aid
799 in accordance with mutual aid agreements, or upon direction from the Governor.¹²⁵
800

801 The local governing body is also authorized during a local emergency to promulgate orders and
802 regulations necessary to provide for the protection of life and property, including orders or regulations
803 imposing a curfew within designated boundaries where necessary to preserve the public order and
804 safety.¹²⁶
805

806 *County Director of Emergency Services*
807

808 Counties may appoint a County Director of Emergency Services, however in absence of this, by virtue of
809 his/her office, the county sheriff serves in this role.¹²⁷ The county director of emergency services has all
810 the duties prescribed by state law and executive order, the California Disaster and Civil Defense Master
811 Mutual Aid Agreement, mutual aid operational plans, and by county ordinances and resolutions.¹²⁸
812

813 *County Emergency Medical Services Agency/Medical Director*
814

815 Each county is authorized to develop an emergency medical services program. Each county developing
816 such a program must designate a local EMS agency. It may be the county health department, or a
817 separate agency established and operated by the county. It may also be an entity with which the county
818 contracts or a joint powers agency created for the administration of emergency medical services by
819 agreement between counties.¹²⁹
820

821 Every local EMS agency shall have a full- or part-time licensed physician and surgeon as medical
822 director, to provide medical control and to assure medical accountability throughout the planning,
823 implementation and evaluation of the EMS system.¹³⁰
824

825 *Health Officer*
826

827 Each county is required to appoint a health officer.¹³¹ The county health officer is responsible to enforce
828 and observe in the unincorporated territory of the county, the orders and ordinances of the board of

¹²³ Govt. Code, §8630.

¹²⁴ Govt. Code, §8631.

¹²⁵ Govt. Code, §8632.

¹²⁶ Govt. Code, §8634.

¹²⁷ Govt. Code, §26620.

¹²⁸ Govt. Code, §26621.

¹²⁹ Health & Saf. Code, §1797.200.

¹³⁰ Health & Saf. Code, §1797.202(a).

¹³¹ Health & Saf. Code, §101000.

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829 supervisors pertaining to the public health and sanitary matters, orders, including quarantine and other
830 regulations, prescribed by DHS, and statutes relating to public health.¹³²

831
832 There is similar authority for the appointment of city health officers.¹³³ However, most cities contract with
833 the county health officer to provide local public health services.¹³⁴ At present, only three cities in
834 California operate their own public health departments.

835
836 Both city and county health officers are authorized, regardless whether or not an emergency is declared,
837 to take measures as may be necessary to prevent the spread, or the occurrence of additional cases, of
838 any communicable disease that he or she reasonably believes may exist within his or her jurisdiction.¹³⁵
839 This includes the power to quarantine and isolate persons, animals or places, conduct investigations and
840 examinations, and to disinfect where necessary to protect public health.¹³⁶ The local health officer can
841 also require, during an outbreak of disease, or when an outbreak appears imminent, that health care
842 providers disclose their inventories of critical medical supplies, equipment, pharmaceuticals, vaccines, or
843 other products that may be used for the prevention of, or may be implicated in the transmission of
844 communicable disease.¹³⁷

845
846 In addition, during any "state of war emergency," "state of emergency," or "local emergency," a local
847 health officer is authorized to take any preventive measure within his or her jurisdiction that may be
848 necessary to protect and preserve the public health from any public health hazard. For purposes of this
849 authorization, the term "preventive measure" means abatement, correction, removal or any other
850 protective step that may be taken against any public health hazard that is caused by a disaster and
851 affects the public health.¹³⁸

852
853 In some jurisdictions, the local health officer is authorized by the governing body to declare a local
854 emergency.¹³⁹ A local health officer may also declare a "local health emergency" whenever there is an
855 imminent and proximate threat of the introduction of any contagious, infectious, or communicable
856 disease, chemical agent, noncommunicable biologic agent, toxin, or radioactive agent, in the jurisdiction
857 or any area thereof affected by the threat to the public health.¹⁴⁰ However, such a declaration does not
858 carry all the implications of a "local emergency." Only the immunity granted to hospitals, physicians and
859 other medical practitioners under section 8659 of the Government Code (see above) is implicated.¹⁴¹
860 Otherwise, the declaration only authorizes the exercise of mutual aid,¹⁴² allows the exchange of health
861 information, and authorizes the determination of the cause of the emergency.¹⁴³

862
863 When an incident first arises, the local health officer may issue an order authorizing first responders to
864 immediately isolate exposed individuals that may have been exposed to biological, chemical, toxic, or
865 radiological agents that may spread to others. Such an order lasts only two hours, but may be sufficient
866 time to allow the health officer to reach the scene of the incident, and to issue more comprehensive
867 orders if needed.¹⁴⁴

868
869 *County Director of Environmental Health*
870

¹³² Health & Saf. Code, §101030.

¹³³ Health & Saf. Code, §101460.

¹³⁴ Health & Saf. Code, §101375.

¹³⁵ Health & Saf. Code, §101175.

¹³⁶ See, generally, *Health Officer's Practice Guide for Communicable Disease Control*, 2007, DPH.

¹³⁷ Health & Saf. Code, §120176.

¹³⁸ Health & Saf. Code, §§101040, 101475.

¹³⁹ Govt. Code, §8630.

¹⁴⁰ Health & Saf. Code, § 101080.

¹⁴¹ Health & Saf. Code, §101085(c).

¹⁴² Health & Saf. Code, §101085(b).

¹⁴³ Health & Saf. Code, §101085(a)(2), (3).

¹⁴⁴ Health & Saf. Code, §101080.2(a).

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871 Some counties have separated the public health and environmental health responsibilities of the local
872 health officer by creating a comprehensive environmental health agency.¹⁴⁵ During a local emergency or
873 a state of emergency, the county director of may be responsible for the coordination of emergency
874 response under his/her jurisdiction. However, during a health emergency declared by the board of
875 supervisors, or a county health emergency declared by the local health officer (see above), the local
876 health officer shall have supervision and control over all environmental health and sanitation programs
877 and personnel employed by the county during the state of emergency.¹⁴⁶

878
879 *Medical Health Operational Area Coordinator*

880
881 Each OA may appoint a Medical Health Operational Area Coordinator (MHOAC). The MHOAC may be
882 the local health officer and the county emergency medical services coordinator acting jointly, or a
883 separate person appointed by these officials. , is responsible, under the local emergency plan, to
884 coordinate with inpatient and emergency care providers, assess medical needs, and coordinate disaster
885 medical and health resources, among other things.¹⁴⁷

886
887 In the event of a local, state, or federal declaration of emergency, the MHOAC must assist the OES
888 operational area coordinator in the coordination of medical and health disaster resources within the OA.¹⁴⁸
889 The MHOAC is also the point of contact in that OA, for coordination with the RDMHC, the OES, the
890 regional office of the OES, and DHS, and EMSA.

891
892 *County Coroner*

893
894 Each county in California has either a Sheriff/Coroner, a Coroner, or a Medical Examiner.¹⁴⁹ His/her duty
895 is to manage the remains of deceased persons within the county, their personal effects if necessary,¹⁵⁰
896 and to inquire into the cause of deaths under specified circumstances.¹⁵¹ In a mass casualty event also
897 involving mass fatalities, this officer serves as the OA Coroner Mutual Aid Coordinator.¹⁵² The state is
898 divided into seven coroners mutual aid regions, and each region has a Coroners Regional Mutual Aid
899 Coordinator.

900
901 Each operational area Coroner/Medical Examiner is advised to develop local contingency plans to deal
902 with mass fatality events, including those involving chemical, biological and radiological contamination of
903 human remains. These plans should also address issues such a storage capacity for human remains,
904 and disposition of remains, including cremation, isolated burial, mandatory mass disposition, and return to
905 family.¹⁵³

906

907 3.12 Healthcare Surge Emergency Response

908

909 When a mass-casualty event occurs, hospitals would activate Emergency Operations Plans and mobilize
910 under an incident command system, such as the Hospital Incident Command System (HICS) to manage
911 the actual or anticipated influx of patients. If conditions within the hospital are sufficiently strained, the
912 hospital may consult with regulatory agencies to determine if specific requirements related to staffing and
913 patient management can be waived to maximize the hospital's response capabilities. If circumstances
914 become overwhelming, the hospital can divert inbound ambulance patients, or patients that have been

¹⁴⁵ Health & Saf. Code, §101275.

¹⁴⁶ Health & Saf. Code, §101310.

¹⁴⁷ Health & Saf. Code, §1797.153.

¹⁴⁸ Health & Saf. Code, §1797.153(d).

¹⁴⁹ See Govt. Code, §§24000, 24010, and 24300,

¹⁵⁰ Govt. Code, §§27460, et seq.

¹⁵¹ Govt. Code, §§27490, et seq. and 27520, et seq.

¹⁵² Coroners Mutual Aid Plan, OES, 2006, p. 11.

¹⁵³ Coroners Mutual Aid Plan, OES, 2006, p. 16.

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915 medically screened and deemed stable for transfer to other hospitals, or to alternate care sites
916 established by local authorities.

917
918 All private entities, e.g., private hospitals, clinics, pre-hospital providers, and ambulance services, would
919 obtain their necessary day-to-day support and operational resources through their internal systems and
920 suppliers. However, it is important even at this stage for healthcare providers to early establish their
921 contacts with the local/OA medical and health coordinators to apprise them of the provider's status and
922 anticipated needs. The reliance upon internal systems and suppliers would hold true until the impact of
923 the situation overwhelmed the entities' normal support mechanisms or a local or state of emergency was
924 declared.

925
926 Under these conditions, the specific entity's logistical functions would place their medical and health-
927 related support or resource requests through the local jurisdictional medical and/or health coordinator. It
928 is important to note that, during a declared local or state of emergency, private entities must direct their
929 requests for medical and health support and resources through the SEMS process and procedures, and
930 also through Multi-Agency Coordinating Groups to coordinate activities and establish allocation of scarce
931 resources among competing entities.

932
933 The local medical and health coordinator for the affected jurisdiction would identify the situation, contact
934 the MHOAC if necessary, and request the resources that are needed based on the event. The MHOAC,
935 in cooperation with the OES OA Medical Health Branch Coordinator in the EOC, would attempt to acquire
936 the needed resources within the OA.

937
938 At this point in the progression, a "healthcare surge" within the meaning of this document does not yet
939 exist. However, a request for additional resources represents the first step in establishing the existence
940 of surge. If the demands for resources become overwhelming at the local level, then the "healthcare
941 surge" status of that OA would be changed to reflect that a surge exists in that OA.

942
943 The MHOAC can request mutual aid from other OAs, and contact the RDMHC for regional assistance.
944 The RDMHC, in coordination with the Regional Medical Health Branch Coordinator in the Regional EOC,
945 would attempt to acquire the needed resources within the region.

946
947 The Medical Health Branch Representative in the State Operations Center would be notified. The
948 Medical and Health Branch Representative (either from CDHS or EMSA) would coordinate with the CDHS
949 Department Operations Center (CDHS DOC), Emergency Medical Services Authority Department
950 Operations Center (EMSA DOC) or when co-located, the Joint Emergency Operation Center (JEOC). The
951 medical and health branch in the SOC would coordinate with unaffected regions. CDHS and EMSA
952 would fill the request at the State level from resources under their control and would be responsible for
953 processing the resource request. If the requests cannot be filled from within the state, the State would
954 then contact the CDC to request deployment of federal resources.

955
956 At any point in this progression, a "local emergency" or "state of emergency" could be proclaimed. Once
957 a state of emergency is proclaimed, even RDMHCs from unaffected regions can be utilized to coordinate
958 the acquisition of requested mutual aid on behalf of the affected region.

959
960 Finally, if the Governor has determined that, despite all the mutual aid provided and the immunities
961 available to professionals and facilities providing emergency care, extraordinary measures must be taken
962 to suspend regulatory statutes under Government Code section 8571 in order to enable providers of
963 medical care to render emergency aid to individuals who otherwise would not receive it. In addition, the
964 Governor could issue orders and regulations to establish altered standards of care consistent with the
965 ESA's goal of preserving lives, or to commandeer property and personnel.

966

967 **3.13 Termination of the Emergency**

968

969 A local emergency proclaimed by a designated local official terminates by operation of law after seven
970 days, unless the proclamation has been ratified by the local governing body.¹⁵⁴ If a local emergency has
971 been proclaimed by the local governing body, the governing body must review the need for continuing the
972 local emergency at its regularly scheduled meetings until the emergency is terminated.¹⁵⁵ The governing
973 body must proclaim the termination of the local emergency at the earliest possible date that conditions
974 warrant.¹⁵⁶

975

976 Similarly, the Governor must proclaim the termination of a state of emergency at the earliest possible date
977 that conditions warrant.¹⁵⁷ All of the powers granted to the Governor under the ESA for a state of
978 emergency terminate upon the proclamation.¹⁵⁸ Thus, to the extent that the Governor has suspended
979 regulatory statutes or altered standards of care by regulation, those suspensions and alterations would
980 automatically end when the Governor proclaims the termination of the state of emergency.

981

¹⁵⁴ Govt. Code, §8630(b).

¹⁵⁵ Govt. Code, §8630(c).

¹⁵⁶ Govt. Code, §8630(d).

¹⁵⁷ Govt. Code, §8629.

¹⁵⁸ Govt. Code, §8629.

982

983

4 Surge Monitoring Tool

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985

The Surge Monitoring Tool provides a systematic methodology to approach healthcare surge in order to measure the movement away from "normal" operations to an overall systematic surge on the local, regional, and state level.

986

987

988

989

A Surge Event is proclaimed in a local health jurisdiction when an authorized local official, such as a local health officer or other appropriate designee¹⁵⁹, using professional judgment determines, subsequent to a significant event or circumstances, that the healthcare delivery system has been impacted, resulting in an excess in demand over capacity and/or capability in hospitals, community care clinics, public health departments, other primary and secondary care providers, resources, and/or emergency medical services. The local official uses the situation assessment information provided from the healthcare delivery system partners to determine overall local healthcare jurisdiction/operational area medical and health status.

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Healthcare Delivery System Status

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999

During a healthcare surge the authorized local official will use color-coded descriptors to designate the status of the local healthcare jurisdiction/operational area's (OA) healthcare delivery system. This designation will be made using the professional judgment of the authorized local official, and will provide other OAs, the RDMHC/RDMHS and State agencies, with a clear understanding of the local healthcare jurisdiction/OAs status.

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1004

- **GREEN:** Local health jurisdiction system/OA is operational in usual day-to-day status. No assistance required.
- **YELLOW:** Most healthcare assets within the local health jurisdiction are experiencing a surge and are able to manage the situation within their organizational frameworks. No assistance required.
- **ORANGE:** The healthcare assets in the local health jurisdiction require the participation of additional healthcare assets within the health jurisdiction to contain the situation.
- **RED:** Local health jurisdiction is not capable of meeting the demand for care, and assistance from outside the local health jurisdiction/OA is required.
- **BLACK:** Local health jurisdiction not capable of meeting the demand for care, and significant assistance from outside the local health jurisdiction/OA is required.

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4.1 Levels of Surge Event Proclamation

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Local Surge Event

- Occurs when options to meet the demand for care are exceeded within the local health jurisdiction and require the assistance of contiguous OAs.
- Proclamation will render relaxation of certain regulations and standards.

1020

1021

1022

1023

Regional Level Surge

- Occurs when options to meet the demand for care are exceeded within the healthcare region and require the assistance of the state.
- Proclamation will render increased relaxation of regulations and standards.

1024

1025

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1028

¹⁵⁹ Depending upon the jurisdiction, the designated official may be the director of emergency services, the director or medical director of the local emergency medical services agency, or medical health operational area coordinator.

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- 1029 Statewide Level of Surge
- 1030 - Occurs when options to meet the demand for care are exceeded at the state level and
- 1031 require outside assistance.
- 1032 - Proclamation will render highest level of relaxation of regulations and standards.
- 1033
- 1034

5 Surge Level Enabling Authorities

1035

1036 **The Surge Level and Enabling Authorities Chart illustrates the relationship between the level**

1037 **of surge and the enabling triggers to implement relative surge response activities. The Chart**

1038 **includes the five levels of a local surge event, as well as a regional level surge and statewide**

1039 **level of surge.**

1040

1041

1042 There is a direct correlation between the level of surge and the related trigger to initiate the authority

1043 to provide the appropriate regulatory and statute flexing. It is important to note that depending on the

1044 severity of a local healthcare surge, as described in the Surge Monitoring Tool, regulatory agency

1045 waivers may not suffice in terms of providing adequate flexibility, and a local emergency proclamation

1046 may be issued to increase the options of response.

1047

Surge Level	Local Surge Event					Regional Level Surge	Statewide Surge Level
	Green	Yellow	Orange	Red	Black		
Enabling Triggers to Implement Surge Response	Regulatory Agency Waiver	Regulatory Agency Waiver	Regulatory Agency Waiver/Local Emergency Proclamation	Local Emergency Proclamation	Local Emergency Proclamation	State of Emergency Declaration	Federal Emergency Declaration

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6 Surge Orders, Suspensions, and Administrative Actions

This document provides Surge Orders, Suspensions, and Administrative Actions that will be pre-drafted in order to facilitate timely and appropriate regulatory assistance during a healthcare surge.

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6.1 Standby Order for Surge Suspension

1. Pursuant to section 8571 of the Government Code, the Director of Emergency Services (or DHS and EMSA) shall suspend such regulatory statutes, or statutes prescribing the procedure for conduct of state business, or the orders, rules, or regulations of any state agency, where the Director (or DHS and EMSA) determines and declares that strict compliance with the statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency.

(See below for lists of statutes/regulations to be suspended.)

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1071
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1077

6.2 Regulations to Alter Standard of Care

1. All persons providing medical care within the affected area may render such care for the purpose of saving the greatest number of lives, and shall have no obligation to commence, render or continue care where, in the good faith judgment of the person(s) responsible for medical triage, the allocation of medical resources to render care to the individual would be inconsistent with the goal of saving the greatest number of lives.

2. To the extent possible, all persons injured shall be provided palliative care, regardless of individual chances for survival.

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6.3 Regulations to Expand Immunities

1. For purposes of Government Code section 8659, the term “hospital” includes any temporary hospital annex, intermediate care facility, skilled nursing facility, clinic, mass care, first-aid station or other facility utilized to mitigate the effects of the emergency.

2. (Pandemic Influenza Only) - A public entity, public employee, or volunteer participating in the national immunization program to respond to the pandemic influenza emergency shall not be liable for an injury cause by an act or omission in the promotion of a community immunization program or the administration of vaccine in a community program, including residual effect of the vaccine, unless the act or omission constitute willful misconduct.

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1090 6.4 Regulations to Implement Population Based Outcomes/Ethics

1091

1092 1. Section 4733 of the Probate Code (relating to advanced directives) is hereby suspended within the
1093 affected area and in such other areas as the Director of Emergency Services determines to be
1094 necessary to mitigate the effects of the emergency.

1095

1096 2. For purposes of section 2397 of the Business and Professions Code, within the affected area, and
1097 such other areas as the Director of Emergency Services determines to be necessary to mitigate the
1098 effects of the emergency, the term "insufficient time" shall include both insufficient time to obtain
1099 informed consent prior to responding to the medical needs of the patient, and a lack of time to obtain
1100 informed consent due to competing demands to treat other patients suffering from the effects of the
1101 emergency.

1102

1103 3. Whenever in the affected area the persons authorized by section 7100 of the Health and Safety Code
1104 to control the disposition of the remains of a deceased person is not immediately available, or is unable
1105 to take possession of the remains of the deceased person in a manner consistent with the preservation
1106 of public health and safety as determined by the local health officer, the county coroner may control or
1107 dispose of the remains of the deceased person in any manner consistent with the preservation of public
1108 health and safety or the instructions of the local health officer, including mass or individual interment,
1109 cremation, or cold storage if reasonably available. A provider of health care in the affected area in
1110 possession of the remains of a deceased person is not responsible to comply with the terms and
1111 conditions of any advanced healthcare directive pertaining to the disposition of remains. The coroner
1112 shall maintain records regarding the manner of disposition. The decision by the local health officer or
1113 the county coroner in selecting the manner of control or disposition of the remains shall be deemed an
1114 act of discretion.

1115

1116 4. In making decisions whether to commence, render, or continue medical care, other than palliative
1117 care, an individual with a pre-existing medical condition requiring care shall be evaluated on the same
1118 basis as an individual whose medical condition is the result of the emergency.

1119

1120 5. A person or entity providing medical care within the affected area shall have no liability for a decision
1121 in good faith to withdraw or withhold medical care from an individual upon learning of a reasonably
1122 apparent emergency requiring his or her immediate attention elsewhere, or upon instructions from a
1123 superior to assume duties elsewhere. Such decisions shall be deemed an exercise of discretion for
1124 purposes of section 820.2 of the Government Code.

1125

1126 6.5 Administrative

1127

1128 1. Letter to HHS Secretary requesting waiver pursuant to 42 USC 1320b-5 of:

1129

1130 a. HIPAA: Requirement to Obtain Patient Consent to speak with family or friends

1131 45 CRR 164.510; 42 U.S.C. 1320b-5(b)(7)(A)

1132 b. HIPAA: Requirement to Honor Opt Out Request Obtain for Facility Directory

1133 45 CRR 164.510; 42 U.S.C. 1320b-5(b)(7)(A)

1134 c. HIPAA; Requirement to Distribute Notice

1135 45 CRR 164.520; 42 U.S.C. 1320b-5(b)(7)(B)

1136 d. HIPAA; Patients Right to Request Privacy Restrictions and Confidential Communications

1137 45 CRR 164.522; 42 U.S.C. 1320b-5(b)(7)(C)

1138

1139 2. Letter to HHS Secretary requesting waiver pursuant to 42 USC 247d of vaccine adverse reaction
1140 reporting (Pandemic Flu only) under 42 USC 300aa-14, -25.

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- 1141
1142 3. Statutes/Regulations to be considered for suspension:
1143 **Public Health Reporting**
1144 Cancer Registry Reporting
1145 Health & Saf. Code 103875, et seq.
1146 Burns & Smoke Inhalation Reporting
1147 Health & Saf. Code 13110.7
1148 **Health Facility Administration**
1149 Transfers of Patients; Violations
1150 Health & Saf. Code 1317.4
1151 Inventory of Medical Supplies
1152 Health & Saf. 120176
1153 Unusual Occurrence Reports
1154 22 CCR 70737, 71535
1155 Medication Errors Reporting
1156 Bus. & Prof. Code 4125; 16 CCR 1711
1157 Occupational Illness & Injury Reporting
1158 Labor Code 6409; 8 CCR 14003
1159 Work-Related Fatalities Reporting
1160 8 CCR 342
1161 **Criminal Behavior**
1162 Child Abuse & Neglect Reporting
1163 Penal Code 11164, et seq.
1164 Elder & Dependent Abuse Reporting
1165 Welf.& Inst. Code 15600, et seq.
1166 OSHPD Reporting Requirements
1167 Health & Saf. 128765, et seq.
1168
1169 Not Included:
1170 Disease Reporting
1171 Health & Saf. Code 120130; 17 CCR 2500
1172 Birth Reporting
1173 Health & Saf. Code 102400
1174 Death Reporting
1175 Health & Saf. Code 102775
1176 Cancer Registry Reporting
1177 Health & Saf. Code 103875, et seq.
1178 Burns & Smoke Inhalation Reporting
1179 Health & Saf. Code 13110.7Violence against Hospital Personnel
1180 Health & Saf. Code 1257.7
1181 Violence against Community Healthcare Worker
1182 Labor Code 6332
1183 Suspicious Injury Reports
1184 Penal Code 11160, et seq.
1185 Gunshot, Knife Wound Reporting
1186 Penal Code 11161.8
1187 Safe Medical Device Reporting
1188 21 USC 360
1189 Joint Commission Sentinel Event Reporting
1190 JCAHO Manual PI.1.10, 2.20, 3.10
1191

1192 6.6 Alternate Care Sites

1193

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- 1194 1. Any hospital, mobile hospital, temporary hospital annex, mass care center, first-aid station, or other
1195 similar facility established by any public entity in the effected area shall be exempt from the
1196 requirements of Division 2 and Part 7 of Division 107 of the Health and Safety Code. Such facilities
1197 shall be established and operated in accordance with the State Emergency Plan and local
1198 emergency plans. The Licensing and Certification Division of the State Department of Health
1199 Services shall, to the extent reasonably possible, advise public entities on reasonable and
1200 appropriate measures under the circumstances to protect the health and safety of persons in the
1201 facility.
1202
- 1203 2. Letter to HHS Secretary requesting waiver pursuant to 42 USC 247d of CLIA requirements under
1204 42 USC 263a.
1205

6.7 Existing Facilities

- 1206
- 1207
- 1208 1. Letter to HHS Secretary requesting waiver under 42 USC 1320b-5 of EMTALA required
1209 examination and treatment of emergency med. conditions & women in labor under 42 USC 1395dd.
1210
- 1211 2. Statutes/Regulations to be considered for suspension:
1212

Acute Care Hospitals

Nurse Staffing Ratio

22 CCR 70217

Gen. Acute Care Hospitals; Conversion of Space for other uses.

22 CCR 70805

Gen. Acute Care Hospitals; Limitation to Licensed

Beds

22 CCR 70809

Gen. Acute Care Hospitals; Out of Scope

Supplemental Services

22 CCR 70301

Gen. Acute Care Hospitals; Out of Scope

Special Services

22 CCR 70351

Skilled Nursing Facilities

Skilled Nursing Facilities; Conversion of Space for other uses.

22 CCR 72603

Skilled Nursing Facilities; Limitation to Licensed Beds

22 CCR 72607

Intermediate Care Facilities

Intermediate Care Facilities; Conversion of Space for other uses.

22 CCR 71605

Intermediate Care Facilities; Limitation to Licensed Beds

22 CCR 73609

Acute Psychiatric Hospitals

Acute Psychiatric Hospitals; Conversion of Space for other uses.

22 CCR 71605

Acute Psychiatric Hospitals; Limitation to Licensed Beds

22 CCR 71609

Primary Care Clinics

Primary Care Clinics; Conversion of Space for other uses.

22 CCR 75072

1244

1245

1246

DECLARATIONS & TRIGGERS

1247

1248 6.8 Personnel

1249

1250 1. Statutes/Regulations to be considered for suspension:

1251

1252 **Physicians**

1253 Physician, Inactive

1254 Bus. & Prof. Code 702

1255 Bus. & Prof. Code 902

1256 Physician, Retired

1257 Bus. & Prof. Code 2439

1258 Physician, Federal/Military;

1259 Practice Outside Federal Facility

1260 Bus. & Prof. Code 715, 718

1261

1262 **Pharmacists**

1263 Pharmacist, Inactive

1264 Bus. & Prof. Code 702

1264 Pharmacist, Out-of-State

1265 Bus. & Prof. Code 900

1266

1267 **Dentists**

1268 Dentist, Federal;

1268 Practice Outside Federal Facility

1269 Bus. & Prof. Code 715

1270

1271 **Nurses**

1272 Nurse, Federal;

1272 Practice Outside Federal Facility

1273 Bus. & Prof. Code 715

1274

1275 6.9 Supplies, Pharmaceuticals & Equipment

1276

1277 1. Statutes/Regulations to be considered for suspension:

1278

1279 Pharmacists: Only Pharmacist May Dispense

1280 Prescription Drugs

1281 Bus. & Prof. Code 4051

1282 Pharmacy: Requirement for Prescription to Dispense Prescription Drugs

1283 Bus. & Prof. Code 4059

1284 Pharmacists; Labeling, Employee Ratio, and Consultation Requirements

1285 Bus. & Prof. Code 4062

1286 Bagley-Keene Open Meeting Act as to Pharmacy Board where purpose is to consider

1287 waiver of requirements under

1288 Bus. & Prof. Code 4062.

1289

1290 6.10 Funding Sources

1291

1292 1. Letter to HHS Secretary requesting waiver of Title XVIII (Medicare, 42 U.S.C. 1395, et seq.), Title
1293 XIX (Medicaid, 42 U.S.C. 1396, et seq.), and Title XXI (State Children's Health Program, 42 U.S.C.
1294 1397aa, et seq.) administrative conditions for assistance under 42 U.S.C. 1320b-5 and 5141.

1295

1296 2. Waiver by CDHS of documentation requirements if authorized by federal law.

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7 Declarations and Triggers Tool

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This tool provides a quick action reference for suggested changes in legal/operation requirements to facilitate a more effective surge response. This operational tool includes the enabling governmental actions that are required in order to implement the suggested changes.

Declarations and Triggers Tool

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	X+			Liability/Standards of Care Civil Liability for Negligence Duty to Provide Ordinary Care Civil Code 1714			And Governor's Order/Regulation	
	X	X		Immunity Statutes Physician & Surgeon; Good Faith Emergency Care at Scene (includes ER) Bus. & Prof. Code 2395		Proclamation Only	Proclamation Only	
	X	X		Physician ; Services at Request of Authorized Official, unless willful Govt. Code 8659		Proclamation Only	Proclamation Only	
	X	X		Nurse; Services at Request of Authorized Official, unless willful Govt. Code 8659		Proclamation Only	Proclamation Only	

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	x	x		Dentist; Services at Request of Authorized Official, unless willful Govt. Code 8659 Disaster Service Worker; Performing Work Ordered In Line of Duty, unless willful		Proclamation Only	Proclamation Only	
	x	x		Civil Code, 1714.5 Hospital; Services at Request of Authorized Official, unless willful Govt. Code 8659 Pharmacist; Services at Request of Authorized		Proclamation Only	Proclamation Only	
	x	x+		Official, unless willful Govt. Code 8659		Proclamation Only	Proclamation; Expand by Order to include Clinics. Etc.	
	x	x		Owner or Occupant of Building Used as Mass Care Center, First Aid Station, Temp. Hospital Annex Civil Code 1714.5		Proclamation Only	Proclamation Only	

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				Population Based Outcomes/Ethics Health Care Providers; Requirement to Comply with Advanced Health Care Directive Probate Code 4733			And Governor's Order/Regulation	
	X+			Health Care Providers; Informed Consent Bus. & Prof. Code, 2397 (Insufficient Time Includes Time Needed to treat other patients) Disposition of Remains; Where Person			And Governor's Order/Regulation	
	X+			Authorized is Unavailable within Specified Time;Records Health & Saf. Code 7100 Special Needs Populations; Entitlement to Treatment			And Governor's Order/Regulation	
				on Same Basis as the Able-bodied Health & Saf. Code 1317 Withdrawal of Patient Care			And Governor's Order/Regulation	
	X+			Health & Saf. Code 1317			And Governor's Order/Regulation	

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	x+		x	Administrative Medical Records; Service, Availability Health & Saf. Code 1250.05; 22 CCR 70747, 70751 HIPAA			And Governor's Suspension/Order	
x+	x			HIPAA: Requirement to Obtain Patient Consent to speak with family or friends 45 CRR 164.510; 42 U.S.C. 1320b-5(b)(7)(A) HIPAA: Requirement to Honor Opt Out Request Obtain for Facility Directory 45 CRR 164.510; 42 U.S.C. 1320b-5(b)(7)(A)			Proclamation Only	Proclamation & HHS Waiver
x+	x			HIPAA; Requirement to Distribute Notice 45 CRR 164.520; 42 U.S.C. 1320b-5(b)(7)(B)			Proclamation Only	Proclamation & HHS Waiver
x+	x			HIPAA; Patients Right to Request Privacy Restrictions and Confidential Communications 45 CRR 164.522; 42 U.S.C. 1320b-5(b)(7)(C)			Proclamation Only	Proclamation & HHS Waiver

Declarations and Triggers Tool

Quick Action Reference				Suggested Changes in Legal/ Operational Requirements for More Effective Surge Response	Enabling Governmental Actions to Implement Suggested Changes			
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FED	SOE	LE	RA					
				Facility Reporting Requirements (Non-Claims) <i>Public Health/Vital Statistics</i> Disease Reporting Health & Saf. Code 120130; 17 CCR 2500			And Governor's Suspension/Order	
	X+			Birth Reporting Health & Saf. Code 102400			And Governor's Suspension/Order	
	X+			Death Reporting Health & Saf. Code 102775			And Governor's Suspension/Order	
	X+			Cancer Registry Reporting Health & Saf. Code 103875, et seq.			And Governor's Suspension/Order	
	X+			Burns & Smoke Inhalation Reporting Health & Saf. Code 13110.7			And Governor's Suspension/Order	

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	X+			<i>Health Facility Administration</i> Transfers of Patients; Violations Health & Saf. Code 1317.4 Inventory of Medical Supplies			And Governor's Suspension/Order	
	X+		X	Health & Saf. 120176 Unusual Occurrence Reports 22 CCR 70737, 71535 Violence against Hospital Personnel Health & Saf. Code 1257.7	CDHS		And Governor's Suspension/Order And Governor's Suspension/Order And Governor's Suspension/Order	
	X+			Violence against Community Healthcare Worker Labor Code 6332			And Governor's Suspension/Order	
	X+			Medication Errors Reporting Bus. & Prof. Code 4125; 16 CCR 1711 Occupational Illness & Injury Reporting			And Governor's Suspension/Order	
	X+			Labor Code 6409; 8 CCR 14003			And Governor's Suspension/Order	

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	X+			Work-Related Fatalities Reporting 8 CCR 342 <i>Criminal Behavior</i>			And Governor's Suspension/Order	
	X+			Suspicious Injury Reports Penal Code 11160, et seq. Child Abuse & Neglect Reporting Penal Code 11164, et seq. Elder & Dependent Abuse Reporting			And Governor's Suspension/Order And Governor's Suspension/Order	
	X+			Welf. & Inst. Code 15600, et seq. Gunshot, Knife Wound Reporting Penal Code 11161.8			And Governor's Suspension/Order And Governor's Suspension/Order	
	X+			OSHPD Reporting Requirements Health & Saf. 128765, et seq.			And Governor's Suspension/Order	

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x				<i>Federal Reporting Requirements</i> Vaccine Adverse Reaction Reports 42 USC 300aa-14, -25 Safe Medical Device Reporting 21 USC 360				HHS Waiver; 42 USC 247d
				Joint Commission Sentinel Event Reporting JCAHO Manual Pl.1.10, 2.20, 3.10				

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				Alternate Care Sites Mobile Hospitals, Hospital Annexes				
	X+		X	Acute Care Basic Services Regulations 22 CCR 70100, et seq.			And Governor's Suspension/Order	
	X+			Acute Care Licensing Requirements Health & Safety Code 1253			And Governor's Suspension/Order	
X				CLIA; Receipt and Testing by Certified facility only 42 U.S.C. 263a OSHPD Approval of Plans Health & Saf. Code 129750, et seq.			And Governor's Suspension/Order	HHS Waiver; 42 USC 247d
	X+			Mass Care Centers, First-Aid Stations, Shelters Clinic Licensing Requirements Health & Saf. Code 1200, et seq.			And Governor's Suspension/Order	

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				Existing Facilities All Facilities				
	X+			Structural Safety of Health Facilities Health & Saf. Code 129680, 129990; 24 CCR 102 Medical Waste Management			And Governor's Suspension/Order	
	X+ X+			Health & Saf. Code 117600, et seq. Fire Safety Code Compliance 19 CCR 1.09			And Governor's Suspension/Order And Governor's Suspension/Order	

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				Federal Labor Standards				
				Duty of Employer to Furnish Workplace Free of Hazards; Comply with Regulations 29 U.S.C. 654 Emergency action plans 29 CFR 1910.38 Hazardous Materials Regulations				
				29 CFR 1910.101-.126 1910.120 - Hazardous Waste 29 CFR 1910.1000-1450, App. B				
				Personal Protective Equipment 29 CFR 1910.132-.139 and App. B 1910.132 - General 1910.133 - Eye and Face Protection				
				1910.134 - Respiratory Protection (also App. A-D) 1910.136 - Foot Protection 1910.138 - Hand Protection				

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				State Labor Standards Jurisdiction of Cal-OSHA				
	X+			Labor Code 6307			And Governor's Suspension/Order	
	X+			Minimum Labor Standards Labor Code 90.5			And Governor's Suspension/Order	
	X+			Requirement to Provide Safe Workplace Labor Code 6400			And Governor's Suspension/Order	
	X+			Requirement to Provide Safety Devices and Safe Practices Labor Code 6401			And Governor's Suspension/Order	
	X+			Emergency Action Plans 8 CCR 3220			And Governor's Suspension/Order	
	X+			Hazardous Waste Management 8 CCR 5192-E			And Governor's Suspension/Order	
	X+			Injury and Illness Prevention Program 8 CCR 3203			And Governor's Suspension/Order	

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	X+		X	Acute Care Hospitals Scope of Services 22 CCR 70011	CDHS		And Governor's Suspension/Order	
	X+		X	Nurse Staffing Ratio 22 CCR 70217 Gen. Acute Care Hospitals; Out of Scope	CDHS		And Governor's Suspension/Order	
	X+		X	Supplemental Services 22 CCR 70301 Gen. Acute Care Hospitals; Out of Scope	CDHS		And Governor's Suspension/Order	
	X+		X	Special Services 22 CCR 70351 Posting of Policy on Patients' Rights 22 CCR 70707	CDHS CDHS		And Governor's Suspension/Order And Governor's Suspension/Order	

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				Gen. Acute Care Hospitals; Conversion of Space for other uses.				
	X+		X	22 CCR 70805	CDHS		And Governor's Suspension/Order	
	X+		X	Gen. Acute Care Hospitals; Limitation to Licensed Beds 22 CCR 70809	CDHS		And Governor's Suspension/Order	
	X+			Joint Commission Business Continuity Plans Medical Control at Emergency Scene Health & Saf. Code 1798.6			And Governor's Suspension/Order	
	X+			Management of Dangerous Persons Welf. & Inst. Code 5150			And Governor's Order/Regulation	
X				EMTALA; Required Examination and Treatment of emergency med. Conditions & Women in Labor 42 USC 1395dd				HHS Waiver; 42 USC 1320b-5

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FED	SOE	LE	RA		<u>Regulatory Agency Waiver</u>	<u>Local Emergency Proclamation</u>	<u>State of Emergency Proclamation</u>	<u>Federal Disaster Proclamation/HHS Waiver</u>
				Skilled Nursing Facilities				
	X+		X	Skilled Nursing Facilities; Scope of Services 22 CCR 72301	CDHS		Suspension/Order	
	X+		X	Skilled Nursing Facilities; Conversion of Space for other uses. 22 CCR 72603	CDHS		And Governor's Suspension/Order	
	X+		X	Skilled Nursing Facilities; Limitation to Licensed Beds 22 CCR 72607	CDHS		Suspension/Order	
	X+		X	Intermediate Care Facilities Intermediate Care Facilities; Scope of Services 22 CCR 73301, 76301, 76853	CDHS		Suspension/Order	
	X+		X	Intermediate Care Facilities; Conversion of Space for other uses. 22 CCR 73605	CDHS		And Governor's Suspension/Order	
	X+		X	Intermediate Care Facilities; Limitation to Licensed Beds 22 CCR 73609	CDHS		And Governor's Suspension/Order	

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	X+		X	Acute Psychiatric Hospitals Acute Psychiatric Hospitals; Conversion of Space for other uses. 22 CCR 71605	CDHS		And Governor's Suspension/Order	
	X+		X	Acute Psychiatric Hospitals; Limitation to Licensed Beds 22 CCR 71609	CDHS		And Governor's Suspension/Order	
	X+		X	Primary Care Clinics Primary Care Clinics; Scope of Services 22 CCR 75026	CDHS		Suspension/Order	
	X+		X	Primary Care Clinics; Conversion of Space for other uses. 22 CCR 75072	CDHS		And Governor's Suspension/Order	

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				Correction Treatment Centers				
	X+		X	Correctional Treatment Centers; Scope of Services 22 CCR 79597 Long-Term Care Facilities Prohibition on accepting patient if cannot provide adequate care	CDHS		Suspension/Order Suspension/Order	
	X+			Health & Saf. Code 1418.6 Transportation				
	X+			Ambulance emergency care equipment & supplies 13 CCR 1103.2			Suspension/Order	
	X+			Required Course Content; EMT-I & EMT-P 22 CCR 100075, 100159			Suspension/Order	

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				Personnel Professional Licensing Physicians & Surgeons				
	X+ X+ X			Physician, Inactive Bus. & Prof. Code 702 Bus. & Prof. Code 902 Physician, Out-of-State Bus. & Prof. Code 900			And Governor's Suspension/Order And Governor's Suspension/Order Proclamation Only	
	X+			Physician, Retired Bus. & Prof. Code 2439 Physician, Federal/Military;			And Governor's Suspension/Order	
	X+			Practice Outside Federal Facility Bus. & Prof. Code 715, 718 Pharmacists			And Governor's Suspension/Order	
	X+ X+			Pharmacist, Inactive Bus. & Prof. Code 702 Pharmacist, Out-of-State Bus. & Prof. Code 900			And Governor's Suspension/Order And Governor's Suspension/Order	

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	X+			Dentists Dentist, Federal; Practice Outside Federal Facility Bus. & Prof. Code 715 Nurses			And Governor's Suspension/Order	
	X+			Nurse, Federal; Practice Outside Federal Facility Bus. & Prof. Code 715			And Governor's Suspension/Order	
	X	X		Nursing Care, Public Disasters & Epidemics Bus. & Prof. Code 2727		Proclamation Only	Proclamation Only	
				Nursing Care, Gratuitous Care by Friends or Family Bus. & Prof. Code 2727 Professional Scope of Practice/Supervision				
	X	X		Physician Assistants Physician Assistant; Practice w/o Supervising Physician Bus. & Prof. Code 3502.5		Proclamation Only	Proclamation Only	

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				Supplies, Pharmaceuticals & Equipment Pharmacists: Only Pharmacist May Dispense Prescription Drugs			Suspension/Order	
	X+			Bus. & Prof. Code 4051 Pharmacy: Requirement for Prescription to Dispense Prescription Drugs			Suspension/Order	
X	X	X		Bus. & Prof. Code 4059 Pharmacists; Dispensing w/o Prescription Bus. & Prof. Code 4062 Pharmacists; Labeling, Employee Ratio, and Consultation Requirements		Proclamation Only Waiver by Pharmacy Board. Governor's Suspension/order	Proclamation Only Proclamation and Waiver by Pharmacy Board. Governor's Suspension/order	Proclamation Only Waiver by Pharmacy Board. Governor's Suspension/order.
X+	X+	X+		Bus. & Prof. Code 4062				

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				Funding Sources Medi-Cal Billing Waiver of Documentation Requirement				
X+	X			If Permitted by Federal Law Welf. & Inst. Code 14115 Federal Funding			Proclamation Only	Proclamation Major Disaster; HHS Waiver 42 USC 1320b-5, 5141
				Medicare Administrative Conditions for Assistance Title XVIII; Social Security Act				Proclamation Major Disaster;
X+	X			42 U.S.C. 1395, et seq. Medicaid Administrative Conditions for Assistance Title XIX; Social Security Act			Proclamation Only	HHS Waiver 42 USC 1320b-5, 5141
X+	X			42 USC 1396 et seq.			Proclamation Only	Proclamation Major Disaster; 5141
X+	X			State Children's Health Program; Conditions for Assistance Title XXI; Social Security Act 42 USC 1397aa, et seq.			Proclamation Only	Proclamation Major Disaster; 5141