Contra Costa County
Medical-Health Preparedness Coalition

EMERGENCY PREPAREDNESS PLAN

Introduction

This plan outlines the roles and responsibilities of the Contra Costa County Medical-Health Preparedness Coalition (CCMHPC) in preparing and responding to health care emergencies within Contra Costa County, California. This document demonstrates the foundation for health care and medical readiness in the CCMHPC. The Coalition Emergency Preparedness Plan focuses on the preparedness efforts of the Coalition while detailing its structure, governance, and plans to prepare medical and health care entities to respond to emergencies in Contra Costa County and provide support to regional partners through mutual aid/assistance. The Office of the Assistant Secretary for Preparedness and Response (ASPR) highlights that the benefit of the health care Coalition is not limited to emergency preparedness and response activities. They also note several other benefits, including: meeting regulatory compliance and accreditation requirements, networking, accessing clinical and non-clinical expertise, sharing best practices, addressing the needs of the community, and reducing risk.[1]

1.1 Overview of Contra Costa County

A. **Contra Costa County** is one of nine counties in the San Francisco Bay Area, and is the ninth most populous county in all of California. It occupies the northern portion of the East Bay region, and is primarily suburban. The county population was estimated at 1,147,439 in 2017, and it has a total area of 804 square miles (of which 716 square miles is land and 88 square miles is water), according to the United States Census Bureau. Concord, Richmond, and Antioch are the largest cities in the county, with populations of 122,067, 103,701, and 102,372 respectively[2].

The Hayward, Calaveras, Concord, and the Clayton-Marsh Creek-Greenville Fault-lines all run through different parts of the county. These slip-strike faults and the Diablo thrust fault near Danville are capable of significantly destructive earthquakes, and many lesser faults are present in the area that cross critical infrastructure such as water, natural gas, and petroleum product pipelines, roads, highways, railroads, and BART rail transit. Additionally, Contra Costa has a number of active refineries; Chevron, Shell Oil, Terso, and Dow Chemical can all pose a threat to the health and safety of its residents. The Contra Costa Public Health Services System employs more than 4,250 individuals. Only 6% of the CCHS budget is from the County's general fund. The remaining 94% is supported by federal and state funding programs, such as Medi-Cal and Medicare, as well as program grants and fees.[3]

B. **Health Care System**

Contra Costa is home to eight hospitals, including one county hospital and seven within the Kaiser, Sutter, John Muir, and the Tenet Health networks. John Muir Medical Center, located in Walnut Creek, is the only Trauma Center (Level 2). Veteran's Affairs of Northern California Health Care System has an outpatient facility housed in Martinez. This facility offers a full range of medical, surgical, mental health, and diagnostic outpatient services, and includes the Center for Rehabilitation and Extended Care. Other health care services include: 10 county-run federally qualified health centers, several urgent care centers, outpatient surgery centers, dialysis centers, clinics, and skilled nursing facilities.

Contra Costa Health Services is the largest department of the county government, and is composed of the following divisions: Behavioral Health Services, Health, Housing and Homeless Services, Contra Costa Health Plan, Contra Costa Regional Medical Center and Health Centers, Hazardous Materials, Environmental Health, Public Health, and Emergency Medical Services. Together, these departments promote and protect the health and well-being of the residents of Contra Costa County. The Public Health and EMS division are the lead agencies for providing Emergency Support Function (ESF) 8 in a disaster. The Public Health Officer and the EMS director are the lead role for the Medical and Health Operational Area Coordination (MHOAC) Program.

C. MHOAC Program Overview

The MHOAC Program serves several functions. The designated individual in this role operates as chief coordinator for disaster medical and health resources, and serves as the single Point Of Contact for coordination with the Regional Disaster Medical and Health Coordinator/Specialist, (RDMHC/S), the State Emergency Medical Services Authority, (EMSA) and the state Department of Public Health, (CDPH). Under state statute, the Health Officer is the local MHOAC and the EMS Agency Director serves as the alternate local MHOAC.

The MHOAC is available twenty-four (24) hours a day, seven (7) days a week, by contacting the Contra Costa Sheriff's Office (CCSO) Communications Center. Following an assessment of local resources, the MHOAC may request or provide mutual aid as conditions warrant. The MHOAC or their designee acts as the single-ordering authority for the county's operational area medical and health mutual aid requirements.

1.2 Purpose of Plan

A. This plan serves as the baseline document for medical and health facilities and partners to prepare for emergencies affecting the health care system in Contra Costa County. The Coalition's work includes planning, resource and information sharing, training, testing operational capabilities through drills and exercises, operational response, and transitioning to continuity of operations and recovery. The work is centered around the HPP's four core capabilities and detailed in the Work Plan section of this document.

1.3 Scope

A. This preparedness plan serves all members and partners of the CCMHPC. This plan does not supersede the California Public Health and Medical Emergency Operations Manual, local Emergency Response Plans, or individual facilities' Preparedness and Response Plans. This document should act as an annex or a guide to those other facility plan(s) to identify how a facility integrates within an operational area or provides support to regional jurisdictions affected by emergencies.

1.4 Administrative Support

A. This document shall not replace or adversely affect each member's Disaster Plans, or other plans, agreements or guidelines in effect, nor shall they supersede any existing mutual aid agreement or agreements.
B. The Charter and Bylaws shall not be interpreted or construed to create an association, joint venture, separate legal entity or partnership among the member bodies, or to impose any partnership obligation or liability upon any health or other member jurisdiction.
C. No member shall have any undertaking for, or on behalf of, or to act as an agent or be an agent or representative of, or to otherwise bind any other member body.
D. The Coalition meets the deliverables of the HPP. A contract is held between the state of California and Contra Costa Health Services. Contract requirements and fiduciary roles are held between these two entities. The Coalition Chair in their role as the HPP Coordinator will ensure the requirements of this contract are executed as directed.
E. In keeping with its purpose, Coalition members shall not encumber themselves with any other binding contract or fiduciary role, nor is it obligated to perform any specific administrative, fiscal or disciplinary function.
F. This document must be approved by a simple majority of the vote at the Coalition meeting that this has been introduced and become effective immediately.

G. Amendment of these bylaws may take place at any meeting by the voting process defined in sections 2.4.5 and 2.4.7. A copy of such proposed amendment(s) is distributed at least 30 days in advance of such a meeting to all Members, and attached to the written notice for that meeting.
H. The most recent date of approval will be displayed in the footer of all pages.

Coalition Bylaws

2.1 Purpose of the Coalition

A. Mission Statement

The Contra Costa County Medical Health Preparedness Coalition will support the local health care community and other response agencies to jointly plan for and respond to human-caused or natural emergencies by promoting intra-operational area cooperation and sharing of resources.

B. Purpose

The CCMHPC is a voluntary multidisciplinary, multiagency coalition created to coordinate health care mitigation, preparedness, response and recovery and for all-hazard emergencies by:

1. Promoting quality in the delivery of disaster patient/victim care services by assessing the level of health care preparedness and making recommendations on activities that should be implemented to address any gaps.

2. Promoting interaction and collaboration across all sectors of the health care community to ensure an effective, coordinated response to emergencies and disasters.

3. Ensuring that the above activities, consider the interests of residents, industry, private and public agencies, and governmental bodies of Contra Costa County. Thus, the primary role of the Coalition is to provide for communication, coordination and collaboration among the participating agencies in these activities.

2.2 Coalition Boundaries

The geographical area included in this Coalition shall be within Contra Costa County.

2.3 Coalition Members

Membership in the Coalition is open to all health care organizations that exist in Contra Costa County and that agree to work collaboratively and coordinate emergency prevention, mitigation, preparedness, response, and recovery activities. The Coalition will target the 17 centers for Medicare and Medicaid provider types listed in the Emergency Preparedness Rule (2017). The appropriate provider types in Contra Costa County include:

I. Hospitals
II. Hospices

III. Long Term Care/ Skilled Nursing Facilities
IV. Clinic and Rehabilitation Services (Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology)
V. Inpatient Psychiatric Care
VI. Community Mental Health
VII. Organ Procurement Organizations
VIII. Home Health Care Services
IX. Ambulatory Care Services
X. End-Stage Renal Disease- Dialysis
XI. All-inclusive Care for the Elderly (PACE)
XII. Intermediate Care for Individuals with Disabilities
XIII. Psychiatric Residential Treatment Facilities (PRTFs)
XIV. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
XV. Federally Qualified Health Centers

A. Coalition partners include, but are not explicitly limited to: private medical or health services, a consortium representative, emergency preparedness agencies, and emergency services and governmental bodies with an interest in the provision of health care in Contra Costa County during disasters and other states of emergency.
B. Members of the Coalition consist of representatives authorized by the participating entities, which are those entities that have an interest in contributing to the purpose of the Coalition.
C. The Coalition, on an ongoing basis, will review the composition of membership, and actively recruit and invite participation of representatives to ensure that membership is inclusive of all eligible partners.
D. Establishment of voting rights is delineated under section 2.4.7.
E. Member organizations should assign one or more representatives to attend Coalition meetings. The representative(s) should have the authority to represent and speak on behalf of the member organization.
F. If an individual representing an organization withdraws from participation, the members of that organization should help appoint a new representative to appropriately fill their role.

2.4 Organizational Structure/Governance

2.4.1 Coalition Membership

A. Active Members: health care and medical entities (voting)
B. Partners: non-medical entities (non-voting)
C. Invited guests, inactive members (non-voting)
D. Officers

2.4.2 Membership Responsibilities

A. Provide representation at Coalition meetings and activities.
B. Participate in collaborative operational area preparedness planning.

C. Participate in the development of collaborative emergency response plans and surge capacity plans.
D. Contribute to creating and attaining Coalition priorities, goals, and contractual deliverables (as applicable).
E. Vote on questions placed before the membership.
F. Participate in sub-committees and workgroups as requested by members or individuals and organized under the umbrella of the Coalition. These subcommittees and workgroups may exist and function temporarily or long term as needed.

2.4.3 Officers

As one of the lead divisions for ESF 8, the Contra Costa Health Services EMSA is the convener of the Coalition and the Emergency Preparedness Manager serves as the Coalition Chair. In the Emergency Preparedness Manager's absence, the Coalition will be chaired by the EMS Emergency Preparedness Manager's designee.

2.4.3.1 Duty of Officers

A. **The Chair shall:**
   I. Preside over all meetings.
   II. Represent the CCMHPC at public functions, or appoint a CCMHPC member designee to do so on their behalf.
   III. Sign all official documents.
   IV. Appoint Steering Committee members after the vote.
   V. Ensure that minutes are maintained.
   VI. See that all notices of meetings are sent in a timely manner and are posted on the EMS website.
   VII. Be the custodian of the records of the Coalition.

B. The Steering Committee member shall:
   I. Agree to the position for two years, and assist the Chair in finding a replacement should they resign prior to end of the commitment.
   II. Attend quarterly meetings representing their health care services level (i.e. Hospital, clinic, skilled facility, etc.)
   III. Assist the chair with identifying gaps and target capabilities to develop an annual work plan.
   IV. Assist the chair with budget priorities.
   V. Assist the chair with the sustainment and development of the Coalition.
   VI. Assist to develop reports to share with leadership, executives and the Emergency Medical Care Committee (EMCC).

2.4.4 Role of Leadership

A. The CCMHPC Chair reports Coalition activities to the EMCC. The CCMHPC Chair may, on occasion, ask the EMCC committee to vote on matters that require executive level consideration from clinicians and community leaders. The Coalition will discuss these matters and vote to have

the chair ask the EMCC to address the issues presented to them. The EMCC acts as an advisory body to its county board of supervisors and local EMS agency on all matters relating to EMS. The committee has the key leadership personnel, which includes: hospitals, EMS, emergency management agencies, public health, and other public and private organizations. This provides a better synergy of the system and executive buy-in, and ensures that emergency preparedness and response are at the forefront of topics presented to the county board of supervisors. The CCMHPC Chair will provide, at a minimum, bi-annual reports prepared by the CCMHPC Steering Committee to provide updates on gaps and capabilities reported by the Coalition.
The EMCC bylaws are included in Appendix 5.3 of this document.

2.4.5 Conducting Business

A. The Chairperson will set the agenda, and oversee and facilitate the meetings.
B. A minimum of 10 members (may be a combination of voting and non-voting members) must be present to conduct business (excluding voting, as noted in Sections 2.4.6, 2.4.7 and 2.4.8 of this article).
C. The Coalition shall review, evaluate, and make recommendations on issues related to health care emergency management and the medical and health coordination system.
D. From time to time, special subcommittees and/or workgroups may be appointed by the chairperson to address specific issues that are compatible with the purposes of the Coalition.

2.4.6 Work Groups

A. Work Groups and the Work Group Leader will be set by the approval of the Coalition.
B. Work Groups may create and disband subgroups at their pleasure for accomplishing focused tasks. Subgroups will channel all opinions and actions through the parent Work Group.
C. The Coalition will approve any opinions to be expressed publicly or actions to be taken by a Work Group or Subgroup in advance.

2.4.7 Voting Eligibility

A. Voting is restricted to Voting (Active) Coalition Members.
B. Voting members must have a signed formal agreement (hospitals) or *Commitment to Participate* letter on file.
C. Voting Coalition members must be health care entities identified in section 2.4.3 of this document, and will perform an active role in emergency response.
D. Attendance by a representative of a member organization present at least 60% of the annual activities provided to the Coalition define Voting (Active) Coalition members with the right to vote.
E. Attendance by a representative of a member organization at less than 60% of the annual activities will place their organization in an "inactive status" and be defined as a Non-Voting (Inactive) member without the right to vote.
F. Attendance by a representative of non-medical facilities or a member organization invited by EMS to share expertise and discuss certain topics define Invited Nonmembers without the right to vote.

Invited nonmembers may fully engage in Coalition discussions and activities, but shall have no vote.

2.4.8 Votes/Approval

A. Each Voting (Active) organization representative shall have one vote. A member cannot delegate a second party to vote in any Coalition business with an exception. A consortium representative may represent their clients' voting wishes.
B. Coalition voting will be taken only in meetings where a quorum is present. A quorum will be recognized when six or more Voting (Active) Members are present at in a meeting, which has been announced to all members at least one week in advance.
C. Voting will take place either in person or via email.
D. All issues moved to a vote will be distributed by email to all CCMHPC representatives.
E. For valid voting, 2/3rds of the Voting (Active) Members must participate in the vote.
F. Absent Voting (Active) Members will be presented an opportunity to vote via email. Absentee Voting (Active) Member votes may be received for up to five business days from the date of the meeting when the vote was held.
G. Yes, No and Abstain votes are counted in the response pool. No replies to voting polls are not considered as part of the response pool.
   E.g., 24 Active Members are asked to vote. For validity, 2/3rds of the Active Membership must respond, in this case 16. Eight vote Yes, four vote No, two vote Abstain, and 10 do not respond to the voting poll. The vote result cannot be used to act on the issue.
H. Voting results shall be determined by a simple majority of the 2/3rds of the Voting (Active) Members.

2.4.8.1 Special Voting

A. The Coalition may hold special votes that occur outside of the regular Coalition meetings by email, online survey, or conference call. When such votes are conducted, there shall be a reasonable opportunity (five business days) for all members to have input prior to the vote.

2.5 Meetings

A. General meetings will be held at a time, place and frequency approved by the members. Electronic ("Virtual") meetings are allowed, if available.
B. Special meetings of the membership may be called upon reasonable, advance notice to all members. Additional meetings may be held as determined by the Chair.

2.6 Communication

A. Written notice and agendas for all meetings of the membership shall be transmitted at least 5 business days in advance of the meetings.
B. EMS Agency staff will attend all meetings of the Coalition and maintain official minutes. The minutes shall be distributed to all Coalition members prior to each scheduled meeting.
C. The minutes of the general meeting shall be sent out to the general membership within two weeks following the meeting. The minutes will have copies of all documents on which the Coalition has provided a requested opinion, approval, or action.

2.7 Risk Assessments

A. Health care facilities are encouraged to submit their individual Hazard Vulnerability Assessment (HVA) annually. They should retain records of this submission for certification compliance. The CCMHPC will aggregate this data to create a Coalition HVA.
The CCMHPC has identified the following top three threats to impact the Coalition and ultimately the health care delivery system in Contra Costa County:
#1 Natural Hazards: Earthquake
#2 Technological Hazards: Information System Failure
#3 Natural Hazards: Fire
Further details of the CCMHPC HVA for 2017 can be found in Appendix 5.1.
B. The CCMHPC will review the HVA annually to discuss health care resource gaps that may include equipment and supplies, trained and experienced staff, inadequate plans and policies, or any other resource essential for response. Coalition activities will include prioritizing and mitigating the identified gaps.

Coalition Objectives

3.1 Maintenance and Sustainability

A. Contra Costa Health Services is the Local Health Department (LHD) and serves as the lead in ESF 8 will facilitate collaboration with Coalition members during preparedness and response. The program lead will be responsible for chairing the CCMHPC and identifying Steering Committee members. The Chair and Steering Committee will participate in quarterly planning activities to ensure the Coalition stays focused on improving preparedness and response capabilities.
B. Every five years the US Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR), establishes core capability guidelines as part of the Hospital Preparedness Program. These guidelines describe what the health care system must do to prepare for and respond to emergencies that impact the public. The most recent capabilities are found in the *2017-2020 Health Care Preparedness and Response Capabilities.* The capabilities focus on helping individuals receive adequate care and resources during emergencies, decrease deaths, injury and illness related to emergencies and promote resiliency within the health care delivery system. This document and further guidance developed by the CDPH will aid the CCMHPC in establishing both

short-term and long-term strategic goals and objectives. The *2017-2020 Health Care Preparedness and Response Capabilities* are referenced in Appendix 5.5. Coalition members and non-members will identify health care system gaps annually; they will determine activities related to the capabilities to address these gaps by participating in the work plan process with the Coalition Chair.

C. Funding for the CCMHPC is reliant on federal funding for the day-to-day activities and maintenance of the Coalition. Federal funding constraints may require the Coalition to identify other funding mechanisms to ensure viability of the program. Funding mechanisms may include: training and exercise fees, collecting dues from participating members and other grant resources. Prior to any implementation of fees or dues, a special voting process will be held.

D. In 2017, The Center for Medicare and Medicaid (CMS) released the *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers* (CMS Preparedness Rule). This rule established national emergency preparedness requirements for all 17 provider types receiving federal funding. The Coalition will assess and identify the regulatory requirements set forth for preparedness and aid in addressing any legal or regulatory requirements (local, state and federal) that can occur during response. The CCMHPC Work plan identifies how the Coalition will assist CMS facilities and supplier types with adhering to the requirements of the Emergency Preparedness Rule.

Work Plan

4.1 Roles and Responsibilities

The Coalition will adhere to key components of a robust emergency preparedness plan. This includes:

A. Risk Assessment and Planning. Each facility should conduct an individual HVA. This systematic approach will help facilities recognize hazards that may affect their ability to provide services. This assessment should be reviewed and updated annually. Coalition members are encouraged to submit their HVAs to the Coalition as well as compare them to the Contra Costa County Hazard Mitigation Assessment which is completed every five years.

(I) The HVA is an essential tool to assist facilities in planning and preparing for emergencies and disasters. Coalition members are encouraged to form emergency preparedness planning teams within their facilities to address gaps identified through the HVA and further gap analysis. Additionally, Coalition members are encouraged to attend any community planning meetings. Response occurs at the local level, so health care facilities must be at the table for any local planning. Members can contact the Coalition Chair to identify any meetings they should attend. Members are encouraged to retain documentation of contacting and/or attending local planning meetings.

B. Policies and Procedures

Coalition members are expected to develop and implement emergency preparedness policies and procedures specific to their organizations/facilities. The key elements of these policies should include an emergency plan, risk assessment and communication plan. These policies and procedures are expected to be reviewed and updated annually. These emergency plans should adhere to certification and licensure standards. Plans might address:

I. The provision of substance needs for staff and patients when evacuated or sheltering in place;
II. A system to track staff and patients when sheltering or relocating during emergencies;
III. Evacuations;
IV. A means to shelter in place staff, patients, visitors and volunteers;
V. Patient documentation system that protects confidentiality (HIPAA compliant);
VI. The use of volunteers;
VII. Arrangements with other providers to receive patients from your facility if operations can no longer be sustained; and,
VIII. Waivers and alternate care sites.

C. Communication Plans

Each Coalition member is expected to develop and maintain a communication plan that complies with local, state and federal laws. This plan should be reviewed and updated at least annually. A Communication Matrix is included in the Appendices that provides information for facilities related to contact local, regional and state emergency preparedness/management resources for the operational area. Communication plans are recommended to include:

I. Contact information for staff, physicians, entities under arrangement, and volunteers
II. Contact information for hospitals or other receiving health care facilities
III. Contact information for local, regional, state, tribal and federal emergency preparedness staff and other sources of assistance.
IV. Primary and alternate means for communicating with local, regional, state and tribal emergency management agencies.
V. A method for sharing information and medical documentation as necessary with other health care providers to maintain continuity of care.
(a) This process should be HIPAA compliant
(b) Timely and accurate
(c) Readily available for patients being sheltered in place
(d) Able to be disseminated across providers, including outside jurisdiction
VI. Electronic information should be backed up both within and outside of the facilities geographic location.
VII. A means to disseminate information about general condition and location of patients under the facilities' care. This must follow 45 CRF 164.510 (b) 4.
VIII. Provision for hospitals, and critical access facilities; a method to provide information about the hospital's occupancy, needs and its ability to provide assistance
IX. Additional provision for a LTC / SNF: A method for sharing information from the emergency plan that the facility has determined appropriate for residents and their families.

D. Training and Testing

Facilities are expected to develop and maintain training and testing programs specific to their emergency plan, risk assessment, policies/procedures, and communication plan. This program should be reviewed and updated at least annually. The CCMHPC will facilitate exercise coordination for its members to align the operational area response plans with Coalition member's plans.

I. All facilities must provide initial training to all new and existing staff, individuals providing services under arrangement and volunteers.
II. Emergency preparedness training must occur annually.
III. Maintain documentation.
IV. Staff should be able to demonstrate emergency procedures through testing.
V. Testing must include conducting exercises annually, based on CMS guidance. For the majority of Coalition members, this includes one individual/facility based exercise and one additional full-scale exercise that is community-based. If a community-based exercise is not available, the facility should conduct a facility-based exercise in its place.
VI. Testing/exercising should be analyzed and documented.

4.2 Coalition's Work/Training

The Coalition's work and training are detailed annually in the HPP Work plan submitted to the California Department of Public Health. The work plan details gaps identified by the Coalition, and provides strategic focus for planning, training and exercising of the Coalition.
The detailed work plan will be attached in Appendix 5.7 and updated each year in June, during plan review.

A. Planning.

1. The CCMHPC encourages each member to assemble focused workgroups within their facilities/agencies to develop robust emergency preparedness plans. Each Coalition member will complete an HVA to assist in identifying gaps to include in their planning efforts.
2. Coalition members are encouraged to attend local (city) and Operational Area (OA) planning meetings to build relationships and be included in their planning efforts.
3. Coalition members are to attend quarterly CCMHPC meetings to discuss and plan how to address health care needs of the population during an emergency or disaster. Meetings may focus on specific topics to help Coalition members understand their role in a particular response, such as Mass Fatality Management, Vulnerable Populations, and Burn Care.
4. Workgroup meetings help provide further concentration on key elements of the CMS Emergency Preparedness Rule as well as other topics.

B. Training

Several educational and training opportunities are provided to Coalition members annually and include:

1. Hospital Incident Command (HICS) Refresher Training
2. Nursing Home Incident Command (NICS) Training
3. Staff Personal and Workplace Preparedness
4. ReddiNet Training
5. Hazmat First Receiver Operations and Decontamination
6. California Emergency Operations Manual and MHOAC Program Training
7. Medical Counter Measures
8. CHEMPACK Activation and Use
9. Medical Surge, and Triage
10. Bleeding Control and Tourniquet Application
11. Other training and activities as identified

C. Exercises

1. Monthly redundant communication and situational status reporting drills
2. Information Sharing and Resource Sharing Drills
3. The annual Countywide exercise, as part of the Statewide Medical and Health Exercise program
4. Hospital Surge Test
5. Other geographic or operational specific exercises as requested by Coalition members
6. Encouragement to attend regional and/or federal training through outside agencies such as FEMA, Center for Domestic Preparedness or Urban Area Security Initiative (UASI).

Appendices

i. 5.1 Detailed HVA
ii. 5.2 Commitment to Participate
iii. 5.3 EMCC Bylaws
iv. 5.4 EOM and MHOAC Program Manual
v. 5.5 2017-2020 Health Care Response Capabilities
vi. 5.6 Communication Matrix
vii. 5.7 HPP Work Plan and Budget
viii. 5.8 Multi Year Training Plan (MYTP)
5.9 Commitment to Participate Form for Coalition Members

Appendix 5.1: Detailed HVA

Each year, health care entities submit updated HVAs to the CCMHPC. Health care facilities are required through accreditation standards, to complete an HVA annually. Facilities must update their information based on any incidents that have occurred in order to help identify new threats. Additionally, they are to share these assessments with the Operational Area to improve preparedness efforts. This data represents the compilation of 27 HVAs collected from the health care facilities between 2016 and 2017. The number represents a mix of hospitals, clinics, skilled nursing facilities, dialysis centers and outpatient surgery.

Perceived hazards are placed into three main categories: Natural, Technical, and Human. Of these categories, the top three threats are identified. As detailed in the graph below, the CCMHPC top perceived hazard is an earthquake, followed by information systems failure, and lastly fire. These threats should be compared to the local Contra Costa County Hazard Mitigation Plan to determine more specifically the hazards to the medical system (2017).

CONTRA COSTA HEALTH SERVICES

CCMHPC Hazard and Vulnerability Assessment

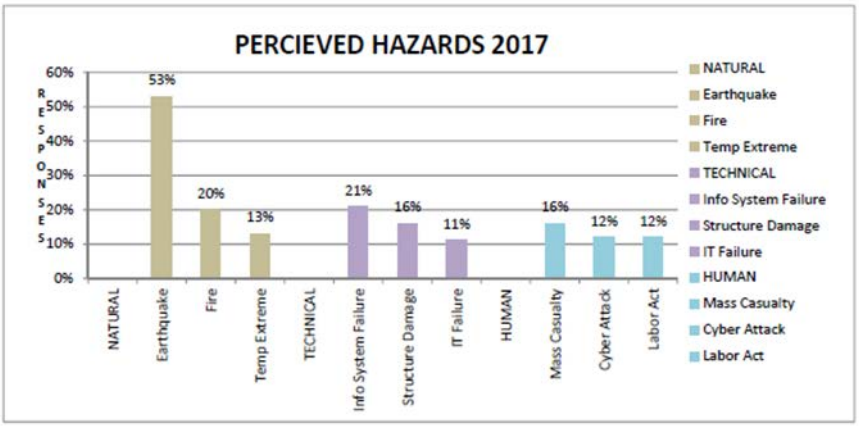

Table 16-6. Hazard Risk Ranking

Hazard Ranking	Hazard Event	Category
1	Earthquake	High
2	Landslide	High
3	Severe Weather	Medium
4	Wildfire	Medium
5	Dam and Levee Failure	Medium
6	Flood	Medium
7	Sea Leve Rise	Low
7	Tsunami	Low
8	Drought	Low

The chart above highlights the top nine natural hazards identified by the Contra Costa Emergency Services Agency. Contra Costa County Hazard Mitigation Plan can be accessed here: https://www.contracosta.ca.gov/6416/Current-Local-Hazard-Mitigation-Plan

Sources:

[1]https://www.phe.gov/preparedness/planning/hpp/reports/documents/2017-2022-health care-pr-capablities.pdf

[2] https://www.census.gov/quickfacts/fact/table/contracostacountycalifornia/PST045217#viewtop

[3]https://en.wikipedia.org/wiki/Contra_Costa_County,_California#Geography

Appendix 5.2 Commitment to Participate Form

Contra Costa Medical-Health Preparedness Coalition
Commitment to Participate

Primary Coalition Contact Information		
First Name:	Last Name:	Title:
Fax:	Cell Phone:	Office Phone:
Email address:	SAT Phone:	
Alternative Coalition Contact Information		
First Name:	Last Name:	Title:
Fax:	Cell Phone:	Office Phone:
Email address:		
Mailing/Shipping Address		
Company or Agency Address:		
City:	State:	ZIP Code:

HEALTH CARE FACILITY (VOTING MEMBER)	NON-HEALTH CARE FACILITY (NON-VOTING MEMBER)
Type of Facility _____	☐ CBO (Community Based Organization) ☐ Other _____

PARTICIPATION AGREEMENT and RECEIPT OF GOVERNANCE STRUCTURE	
Per the HPP Coalition Governance Structure, quarterly coalition meetings should be attended in person by at least one (1) representative for each member organization. The representative is required to attend at least 60% of the coalition activities in order for their organization to receive HPP funds each fiscal year (dependent on availability).	
Print Name:	Title:
Signature:	Date:

Appendix 5.3: EMCC Bylaws

Emergency Medical Care Committee
Contra Costa County, California
BY-LAWS

The Emergency Medical Care Committee (EMCC) acts as an advisory body to the County Board of Supervisors, the Local EMS Agency, and the County Health Services Director on all matters relating to Emergency Medical Services.

I. AUTHORITY

The Contra Costa County Board of Supervisors (Authority), established the Contra Costa County EMCC (Resolutions 68/404, 77/637, 79/460 and by Board Order on February 24, 1998) in accordance with the California Health and Safety Code Division 2.5, Chapter 4, Article 3, to act in an advisory capacity to the Board and the County Health Services Director on matters relating to emergency medical services.

II. DUTIES

A. The duties of the EMCC as specified in the California Health and Safety Code Section 1797.274 and 1797.276 are to review the operations of each of the following at least annually:

1. Ambulance services operating within the county.
2. Emergency medical care offered within the county, including programs for training large numbers of people in cardiopulmonary resuscitation and lifesaving first aid techniques.
3. First aid practices in the county.

B. The EMCC shall, at least annually, report to the Authority and the local EMS Agency its observations and recommendations relative to its review of the ambulance services' emergency medical care and first aid practices and programs for training people in cardiopulmonary resuscitation and lifesaving first aid techniques, and public participation in such programs in the county. The EMCC shall submit its observations and recommendations to the County Board of Supervisors which it serves, and shall act in an advisory capacity to the County Board of Supervisors and to the County EMS Agency on all matters relating to emergency medical services as directed by the Board.

III. MEMBERSHIP

Membership of the EMCC consists of twenty-four (24) members and two (2) ex officio, non-voting members comprised of the following:

A. Consumer representatives: One (1) representative from each of the five (5) supervisorial districts appointed by the Board of Supervisors.
B. One (1) representative nominated from each of the following organizations or groups and appointed by the Board of Supervisors:
    1. Alameda-Contra Costa Medical Association – from a Contra Costa County Receiving Hospital
    2. American Heart Association
    3. American Red Cross

4. California Highway Patrol
5. Communications Center Managers' Association
6. Contra Costa Fire Chiefs' Association
7. Contra Costa Police Chiefs' Association
8. Emergency Nurses Association – from a Contra Costa County Receiving Hospital
9. Hospital Council, Bay Area Division – from a Contra Costa County Receiving Hospital
10. Public Managers' Association
11. Trauma Center (Contra Costa Contract)
    a. Contra Costa Office of the Sheriff
    b. Contra Costa Health Services – Behavioral Health

C. One (1) representative selected from each of the following groups, nominated by the Health Services Director and appointed by the Board of Supervisors:
1. Ambulance Providers (Contra Costa 9-1-1 Service Contract)
2. Air Medical Transportation Provider (Contra Costa Authorized)
3. EMS Training Institution
4. Private Provider Field Paramedic
5. Public Provider Field Paramedic
6. Emergency Department Physicians – from a Contra Costa County Receiving Hospital

D. The EMS Director and the EMS Medical Director shall serve as ex officio non-voting members.

IV. APPOINTMENT PROCESS

The EMS Agency will contact each of the agencies, organizations and groups listed in Section A above, to solicit nominations for one (1) representative prior to the expiration of its representative's term.

A. The nominations received from Section III B will be submitted to the Clerk of the Board for the Board of Supervisors' consideration and appointment.
B. The Health Services Director will consider suggested names received from Section III C and will provide nominations from these groups for the Board of Supervisors' consideration and appointment.
C. Membership will terminate automatically if an appointed member no longer meets the criteria for the seat held.

V. TERMS

A. EMCC members shall serve for a term of office not to exceed two (2) years.
B. All terms will expire on September 30th on even-numbered years. There shall be no limit on the number of consecutive terms that an EMCC member may serve.
C. Any Board-appointed member choosing to resign from the EMCC must notify the EMCC Chair and the EMS Director.
D. Each resigning EMCC member should also notify one's membership entity of their resignation.
E. The EMS Agency will follow the initial appointment procedure to fill a position for the remainder of a term when there is a resignation or lack of participation.

VI. OFFICERS

A. The officers of the EMCC shall be a Chair and a Vice Chair.
B. Officers shall be elected by the EMCC membership to serve for two (2) years or until their successors are elected. The term will begin on December 1st and terminate on November 30th of odd-numbered years.
C. Officers may not be elected for more than two (2) consecutive terms in the same office. In the event of a vacancy in the Chair position, the Vice Chair automatically assumes the Chair position. In the event of a vacancy in the Vice Chair position, the EMCC will elect a new Vice Chair from among its current membership at its next regular public meeting subsequent to the officer's resignation.

VII. DUTIES OF OFFICERS

A. The Chair shall preside over all meetings of the EMCC in addition to serving as the Chair of the Executive Committee. The Chair will be a spokesperson for the EMCC and assure that the EMCC is informed about County emergency medical services issues and needs.
B. The Vice Chair shall assume the duties of Chair in the absence of the Chair and shall render assistance as requested by the Chair.
C. In the absence of the Chair and Vice Chair, one of the two non-officer Executive Committee members present at the meeting shall preside.

VIII.EXECUTIVE COMMITTEE

A. The Executive Committee is established to conduct the business of the EMCC between regular meetings and shall be comprised of the:
    1. EMCC Chair
    2. EMCC Vice Chair
    3. Two (2) non-officer EMCC members
B. EMCC members elected to the Executive Committee will serve for two (2) years or until their successors are elected. The term will begin December 1st, and terminate on November 30th of odd-numbered years. Executive Committee members may be elected to consecutive terms.
C. The Executive Committee shall be subject to the direction of the EMCC and none of its acts shall conflict with action or directions of the EMCC.
D. The Executive Committee shall meet at the request of the Chair, or at the request of a majority of the members of the Executive Committee.
E. Whenever issues must be voted on at Executive Committee meetings in which other EMCC members are in attendance, the voting shall be limited to Executive Committee members.

IX. NOMINATING COMMITTEE

A. The EMCC Chair shall appoint a three (3)-member nominating committee from the membership prior to the June EMCC meeting of odd-numbered years.
B. Current officers may not be members of the Nominating Committee.

C. This committee shall solicit one or more names for each office. The nominated ballot shall be presented at the September meeting, at which time nominations from the floor may be added to the slate. The slate of nominees shall be voted on and elected at this September meeting.
D. Nominations and election of the two non-officer Executive Committee members will be handled in the same manner as the nomination of EMCC officers.
E. Whenever a vacancy occurs on the Executive Committee, the EMCC shall elect an EMCC member to fill the vacant position to complete the remainder of the existing term of office.

X. MEETINGS

A. Regular meetings of the EMCC shall be held quarterly, at least four (4) times per year, or more often as deemed necessary. Meetings will convene at 4:00 pm on the second Wednesday of March, June, September and December, unless otherwise directed by the EMCC or its Executive Committee.
B. The EMCC Chair may call special meetings as deemed necessary upon proper public notice.
C. A quorum for the EMCC shall consist of a majority of the filled seats.
D. Staff support for the EMCC will be provided by the County EMSA.

XI. ATTENDANCE

A. EMCC members shall attend EMCC meetings.
B. A member who cannot attend a meeting must notify the Chair and may have one excused absence in a twelve month period.
C. Whenever a member does not attend two regularly scheduled meetings, within a rolling twelve month period, complete their Brown Act requirements or fails to meet the criteria for sitting on the advisory body the EMS Agency shall notify the nominating agency/organization of the absences and request appropriate action.
D. Members must complete the required Ethics and Brown Act training provided by the County within three months of appointment and submit the ”Training Certification for Member of County Advisory Body” form to EMS staff prior to participating at any meeting.
E. Members who do not complete the Ethics and Brown Act training within 3 months may not further participate until the requirement is fulfilled.
F. Ethics and Brown Act training is recommended to be completed every two years while serving on a County Advisory Committee.

XII. VOTING

All motions placed before the EMCC shall be approved or rejected by the majority of membership.

XIII. AD HOC COMMITTEES

A. The EMCC membership may create ad hoc committees to address EMS related matters.
B. The EMCC Chair shall appoint chairs and members of any ad hoc committees.
C. Ad hoc committee members must be members of the EMCC.
D. Ad hoc committees shall meet at the request of the ad hoc committee Chair upon proper public notice.

E. A quorum shall be more than 50% of the appointed members.
F. EMS Agency shall provide a staff member to attend each ad hoc committee meeting.

XIV. PARLIAMENTARY AUTHORITY
Meetings of the EMCC will be conducted by the Chair following generally accepted parliamentary procedures.

XV. AMENDMENT
These by-laws may be amended by a two-thirds affirmative vote at any regularly scheduled meeting of the ECC provided the amendment has been submitted in writing to all members ten (10) working days prior to the meeting.
Revised: 9/14/2015
Approved by EMCC: (10/9/2015)
Approved by BOS: (01/05/2016)

Appendix 5.4: Medical and Health Operational Area Coordination (MHOAC) Program Manual

The California Medical and Health Operational Area Coordination Program Manual can be accessed and downloaded at the following link:

https://www.cdph.ca.gov/Programs/CCLHO/CDPH%20Document%20Library/MedicalandHealthOperationalAreaCoordinationManual.pdf

Appendix 5.5: 2017-2020 Health Care Response Capabilities

The 2017-2020 Health Care Response Capabilities Document can be accessed here:

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html

Appendix 5.6: Communication Matrix (Attachment)

CCHS Communications Matrix Quick Reference Sheet

Audience **Communication System/Method**
Section 1: CCMHPC Facility
***Individual System Policy and SOP for internal communication**
Section 2: CCMHPC Providers/Partners
EMS Main line: (925) 646-4690 Fax: (925) 646-4379
Coalition Email (day-to-day): medhealthcoalition@hsd.cccounty.us
ReddiNet-for all facilities with patient care beds. (Must have login)
Disaster Email (when DOC is activated): Branch.EMS@hsd.cccounty.us
Sheriff's Dispatch: 925-646-2441 (after hours contact for EMS Duty Officer, Public Health Officer, Hazmat, Environmental Health)
Satellite Phones: EMS 1-254-241-5937, 1-2542-241-5938
CAHAN-must sign-up https://login.cahan.ca.gov/GSS_SSO/Login.aspx
Infection Control Practitioner Notification Individual Provider Blast
Public Health Communicable Disease Reporting Line: 925-313-6740
Media - CCHS Community Education & Information Unit - Communications Officer - 925-313-6268 Social Media: FB: https://www.facebook.com/ContraCostaEMS/ twitter: @ContraCostaEMS
RACES-Request from Contra Costa Office of Emergency Services
*Individual Facility: Acute Care Facility Resource Guide
Section 3: Public
CWS: https://cwsalerts.com
Emergency Alert System-Community Nixel (sign up)
Media – KCBS 740 AM | http://www.kcbs.com/pages/2846.php
Health Emergency Information Line (1-888-959-9911)
CCHP Advice Nurses – 1-877-661-3230 option 1
CCHS public web site (www.cchealth.org)- Community Education & Information Unit 925-313-6268 Social Media: FB: https://www.facebook.com/ContraCostaHealthServices/ Twitter: @CoCoHealth
211 can fax info to them 925-939-1933, www.211Database.org
CCTV – Cable, Comcast Ch. 27; Astound Ch. 32
CBOs Blast Fax
NOAA Radios
Local EOC
County EOC- Joint Information Center: 925-313-9646

5.7 HPP Work Plan and Budget (Submitted to CDPH)

5.8 Multi Year Training Plan (Attachment as an Excel)