San Luis Obispo County
Disaster Healthcare Coalition

Governance Structure

I. Purpose

The purpose of the San Luis Obispo County Disaster Healthcare Coalition (SLO-DHCC) is to collaboratively work together during emergency preparedness, response and recovery. SLO-DHCC serves San Luis Obispo County cities and rural communities by:

A. Promoting quality in the delivery of disaster patient/victim care services by assessing the level of healthcare preparedness and making recommendations on activities that should be implemented to address gaps.
B. Supporting the needs of healthcare organizations while ensuring the needs of the community are met.
C. Engaging and building partnerships that address the needs of communities most impacted by disasters.
D. Developing and implementing effective practices including planning, education, and evaluation as they relate to emergency preparedness.
E. Serving as an advisory function to the County Health Officer and Public Health Emergency Preparedness (PHEP) program by providing recommendations on county policies and procedures.
F. Promoting interaction and collaboration across all sectors of the healthcare community to ensure coordinated sharing of incident information and resources during disaster response and recovery.
G. Working in coordination with the National Response Framework Annex process: Emergency Support Function #8 (Public Health and Medical Services), the State of California Emergency Plan: Emergency Function 8 Public Health and Medical Annex and the California Department of Public Health Emergency Operations Manual process at the local level in accordance with NIMS and SEMS.

II. Membership

There are two types of membership in the SLO-DHCC: full and advisory.

Full membership on the coalition is extended to any healthcare entity in San Luis Obispo County and the healthcare associations representing various healthcare sectors, which include but are not limited to:

A. San Luis Obispo County Health Agency (including Behavioral Health, Health Equity, and local Emergency Medical Services Agency)
B. Hospitals
C. Clinics (Community Health Centers and Urgent Care Centers)
D. Skilled Nursing Facilities
E. Residential Care Facilities
F. Emergency Medical Services Providers
G. Ambulatory Surgery Centers
H. Dialysis Centers
I. Home Health Agencies
J. Hospice Agencies
K. Support Service Providers (Laboratories, Pharmacies)
L. Primary Care Providers

As full members, entities will sign a SLO-HCC Participation Agreement (Attachment D) every five years and submit a completed SLO-HCC Capabilities Worksheet (Attachment C). Roles and responsibilities of full members are outlined in Attachment A and the process for reimbursement of resources is outlined in Attachment B.

Advisory membership is extended to non-healthcare entities with a role in emergency management within San Luis Obispo County. As advisory members, entities will provide expertise on topics within their area of authority. Advisory member entities include but are not limited:

A. Office of Emergency Services
B. Public safety agencies
C. Special districts (APCD, Cambria Health District))
D. State and federal entities (CMC, Cal Poly, ASH, State Parks, FBI)
E. Non-profit organizations with a role in emergency management (American Red Cross, Long Term Care Ombudsman, Tri-Counties Regional Center, VOAD, etc.).

All organizations seeking membership, both full and advisory, in SLO-DHCC are asked to designate a primary and secondary representative from their organization to provide redundancy in communication with the group. These representatives will be asked to:

- Register for the California Health Alert Network (CAHAN) via the PHEP Program.
- Provide updated email and phone contact information as needed to update email and rapid fax lists for day-to-day committee business and emergency notification purposes.

This will allow member entities to coordinate resources and information with the Medical and Health Operational Area Coordinator (MHOAC), the County Health Agency Department Operation Center (CHADOC) and County Emergency Operation Center (EOC) in emergencies. It will also allow the Chair to communicate with member entities to conduct regular group communications.

III. Leadership and Coordination

The Public Health Emergency Preparedness (PHEP) Program is the convener of SLO-DHCC. The PHEP Program Manager serves as the Coalition Chair. The Chair shall:

A. Set meeting agendas
B. Coordinate meeting announcements
C. Preside over all meetings
D. Coordinate communications among the members and outside entities
E. Assure that this governance structure document is reviewed at least every other year by December by the membership. Proposed changes can be made during this review cycle.

In the absence of the PHEP Program Manager, the San Luis Obispo County Public Health Department EMS Division Manager (Medical and Health Operational Area Coordinator-MHOAC) will hold nominations and elections for the Coalition Chair position from the membership. At that time, the Coalition will amend this document to define Coalition Chair term length.

IV. Meetings

A. Regular meetings of SLO-DHCC shall be held at 10:30 a.m., on the first Thursday in the months of January, April, July and October, at a location designated by PHEP in advance of each meeting. Whenever possible, the quarterly meeting location will be designated at the beginning of each calendar year for the entire year. Additional meetings may be held as determined by the Chair and locations will be arranged by PHEP staff.
B. The Coalition shall review, evaluate and make recommendations on issues related to healthcare emergency management and the medical and health coordination system.
C. Recommendations will be made by agreement of the convened members.
D. PHEP staff will attend all SLO-DHCC meetings and maintain official minutes. Each meeting's minutes shall be distributed to all DHCC member entities via the representatives designated above in Section II prior to the next scheduled meeting.
E. Special subcommittees and/or workgroups may be occasionally appointed by the chairperson to address specific issues that are compatible with the purposes of the SLO-DHCC.

V. Goals

A. Short Term (one to two years):
   - Invite new healthcare entities to join SLO-DHCC.
   - Engage members in healthcare system preparedness, response and recovery activities.
   - Complete a health hazard vulnerability assessment every five years and review annually.
   - Assess healthcare resources and include the resources in the emergency resources inventory.
   - Train and test redundant communications systems and information sharing procedures.
   - Plan, conduct and evaluate exercises.
B. Long Term (three to five years):
   - Encourage members to sign Memorandum of Understandings (MOU)s with vendors.
   - Share emergency plan templates, including Continuity of Operations Plan (COOP), among members.
   - Identify and mitigate potential health and safety impacts, including behavioral health impacts, of member entity staff.

VI. Sustainability

HCC funding is awarded by the Administration for Strategic Preparedness and Response (ASPR) through the Hospital Preparedness Program (HPP) grant. This grant fully supports the HCC Readiness and Response Coordinator. In the absence of funding to support SLO-DHCC, the following strategies will be considered by SLO-DHCC membership:

A. Rotate Coalition Chair to maintain the Coalition's focus on collaborative communication.
   Generate funds internally by charging annual membership dues and/or charging fees for Continuing Education Units (CEUs) for training and exercises. Establish ListServ type platform to share information among members

Attachment A: Full Member Role and Responsibilities

I. Planning Roles

Planning Roles for Full Members:

During the planning phase, each healthcare entity participating in the SLO-DHCC agrees to do the following to the best of their ability:

- Establish and maintain relationships with healthcare partners and local emergency response partners
- Regularly share information with other SLO-DHCC members
- Participate in SLO-DHCC meetings
- Review plans, policies and procedures that are developed by SLO-DHCC members and provide feedback.
- Provide subject matter expertise on public health emergency preparedness matters
- Participate in training, drills and exercises
- Maintain emergency supplies for disaster response
- Develop organization disaster response, recovery and continuity of operations plans

II. Operational Roles

A. Healthcare Coalition Readiness and Response Coordinator (HCC RRC)

   a. The HCC RRC serves as the HCC's administrative and programmatic point of contact during everyday operations, including managing communications, systems, and coordination with the recipient. The RRC oversees HCC planning activities, including coordinating trainings, facilitating exercises, ensuring financial sustainability, and developing budgets. They lead three principal activities:

      i. Reviewing and activating the Readiness Plan
      ii. Supporting the HCC in steady state and in response
      iii. Leading engagement with non-clinical community partners

B. HCC Clinical Advisor

   a. The EMSA Medical Director acts as the HCC Clinical Advisor and gathers and provides clinical expertise to ensure that plans, exercises, and educational activities maintain clinical accuracy and relevance. Clinical Advisors act as the HCC's clinical point of contact with health care entities, EMS agencies, and external subject matter experts.

      i. The Clinical Advisor must be an active clinician who practices as a lead or co-lead for an HCC member health care organization.
      ii. To be funded under HPP, the Clinical Advisor must have a history of involvement in emergency services or response activities. They must be informed on medical surge issues and hold a basic familiarity with chemical, burn, radiological, nuclear, explosive (CBRNE), trauma, pediatric emergency response, and downtime emergency principles.

   b. HCCs may determine how best to fulfill their own needs for clinical advisement over the course of a budget period. In their annual workplan, HCCs will substantiate how their clinical advisement structure supports HCC plans.

III. Response Roles

A. Response Roles for Full Members:

Operational Responsibilities

The primary goal for healthcare entities following an event/emergency is to maintain operations and continue to provide care to their patients/clients/residents. If needed during an event/emergency, healthcare entities may be asked to expand operations. This may include activating their surge plans to create additional capacity within their facility and extending hours of operations

Communication/Information Sharing

Healthcare entities should notify the MHOAC if they have an emergency/event that impacts or threatens to impact their healthcare entity. Upon notification of an event/emergency, the MHOAC will ask healthcare entities for their status to determine impacts of the event/emergency on the medical and health system.

Healthcare entities should be prepared for communication failure during a disaster and have plans for alternate methods of communication with staff and the MHOAC. This includes using telephones (landlines/cellular), handheld portable radios, satellite phone, runners, pre-established reporting locations, or any other means.

All health care providers who maintain a state or federal license may also have an obligation to report any occurrence that threatens the welfare, safety, or health of patients/residents to the appropriate licensing entity. It is the responsibility of each partner to comply with these obligations.

Ordering Resources

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

Healthcare entities should be prepared to share information and available resources (personnel, equipment, supplies, pharmaceuticals) with other SLO-DHCC members to the best of their ability. The default process for reimbursement of utilized resources is in Attachment B. Any deviation from the default process must be agreed upon between the receiving and providing organizations in writing.

B. Response Role of the County of San Luis Obispo Health Agency

During a response to an event/emergency, the Health Agency will not direct the internal activities of any healthcare organization but will assess the status of affected healthcare entities. This assessment may result in requests for assistance such as evacuation of residents, sheltering of residents, or resources to successfully shelter in place or provide medical care. The goal of the Health Agency is to assure the safety and well-being of the community in a coordinated, resource-effective manner. These activities are conducted through the activation of the County Health Agency Department Operations Center (CHADOC) and the County Emergency Operations Center (EOC).

Operational Responsibilities

The Health Agency serves as the Medical and Health Operational Area Coordinator (MHOAC). During a disaster response the MHOAC reports to the Regional Disaster Medical Health Coordinator (RDMHC) Program and the California Department of Public Health on the status of medical and health entities within San Luis Obispo County. During a disaster the MHOAC will:

- Conduct an assessment poll of hospitals using ReddiNet™ to determine the impact on each facility and their ability to continue operations, and the estimated number of victims they could receive.
- Send messages via CAHAN, phone, email, ReddiNet or radio to request a status update from all potentially affected healthcare facilities/agencies and long term care providers to assure that all are aware of the event.
- Provide information to healthcare partners such as evacuation warnings/orders, the medical and health implications, the level of activation of CHADOC and contact information for reporting status/requesting resources.
- Determine which facilities/agencies can aid the affected agencies, populations, or facilities.
- Determine and request transport, such as ambulances or buses to evacuate facilities or affected individuals with medical or other need for specialized transport.
- Set up and operate in coordination with partners any necessary disaster field operations such as medical evacuations, field treatment sites, medical shelters or Government Authorized Alternate Care Sites.

Communication/Information Sharing

During a disaster the MHOAC will request information from healthcare entities regarding their status and the status of their clients. The MHOAC will provide this information to regional and state agencies. The MHOAC uses this information to determine the ability of the healthcare system to function after a disaster and the need to provide emergency medical and health services.

Ordering Resources

Medical and health resources needed during a disaster that cannot be obtained through vendors can be requested from the MHOAC. The process to request resources is detailed in the MHOAC SOP. If resources are needed from outside the county, the MHOAC will make requests via the Regional Disaster Medical Health Coordinator Program in compliance with the procedures outlined in the California Department of Public Health and Medical Emergency Operations Manual (EOM).

C. Response Role of Hospitals

Operational Responsibilities

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

During a response to an event/emergency hospitals will activate their surge plans to create additional capacity within their facility. Typically, they will activate their Hospital Command Center and work

collaboratively with the MHOAC to accept and treat persons that are ill or injured because of the event/emergency.

Communication/Information Sharing

Following an event/emergency, hospitals will respond to the ReddiNet polls sent out by the MHOAC. The initial poll will be tailored to the specific event and will be used to determine the number and category (red, yellow and green) of victims each hospital has the capacity to receive, the number and types of inpatient beds that are available in each hospital (Hospital Bed Availability), and any impact to the hospital's infrastructure depending on the event.

D. Response Role of Clinics/Outpatient Providers

Operational Responsibilities

The primary goal for clinics/outpatient providers following an event/emergency is to maintain operations and continue to provide care to their current patients. If needed during a disaster clinics/outpatient providers may be asked to expand operations. This includes extending hours of operation to accept the lower acuity patients, to relieve stress on acute care hospitals, or provide care for patients whose providers are not able to function.

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

E. Response Role of Ambulatory Surgery Centers

Operational Responsibilities

The primary goal for ambulatory surgery centers following an event/emergency is to maintain operations and continue to provide care to their current patients. If needed during a disaster, ambulatory surgery centers may be asked to expand operations. This includes extending hours of operation to accept the lower acuity patients to relieve stress on acute care hospitals or provide care for patients whose providers are not able to function.

F. Response Role of Skilled Nursing Facilities and Long Term Care Facilities

Operational Responsibilities

The primary goal for skilled nursing facilities (SNFs) and residential care facilities for elderly (RCFEs) following an event/emergency is to maintain operations and continue to provide care to their residents. SNF/RCFEss may need to activate their surge plans in order to accept patients from hospitals or other long term care facilities.

Communication/Information Sharing

When an emergency event impacts or is threatening to impact a SNF/RCFE, the facility must notify the Long Term Care Ombudsman (LTCO). In the event the LTCO cannot be reached, the facility must notify the MHOAC. Following an event/emergency, LTCO and/or MHOAC will ask SNF/RCFEs for their status. The MHOAC will coordinate with the LTCO to communicate and determine the status of SNF/RCFEs facilities and advise on any potential action in relationship to the event, receive SNF/RCFEs reports on plans to safeguard their residents, and resource requests.

G. Response Role of Intermediate Care Facilities and Developmentally Disabled Facilities

Operational Responsibilities

The primary goal for intermediate care facilities (ICFs) and adult residential care facilities (ARFs) serve clients with intellectual/developmental delay (I/DD) following an event/emergency is to maintain operations and continue to provide care to their residents.

Communication/Information Sharing

When an emergency event impacts or is threatening to impact an ICF/DD, the facility must notify the Tri County Regional Center (TCRC). In the event the TCRC cannot be reached, the facility must notify the MHOAC. Following an event/emergency, TCRC and/or MHOAC will ask ICF/DDs and ARFs for their status. The MHOAC will coordinate with the TCRC to communicate and determine the status of ICF/DDs a ARFs and advise on any potential action in relationship to the event, receive ICF/DD and ARF reports on plans to safeguard their residents, and resource requests.

H. Response Role of Dialysis Centers

Operational Responsibilities

The primary goal for dialysis centers following an event/emergency is to maintain operations and continue to provide dialysis treatments to its clients and support other dialysis centers that are impacted by the event/emergency by providing services to their clients.

An assessment of electrical and water utility availability and quality is necessary to determine the need for assistance. When an emergency event impacts or is threatening to impact a dialysis facility, the MHOAC should be notified. If the dialysis provider is experiencing difficulty in contacting their utility providers, then contact the MHOAC to facilitate communication.

I. Response Role of Home Health and Home Care Agencies

Operational Responsibilities

The primary goal for home health/home care agencies following an event/emergency is to maintain operations and continue to provide care to their residents. When an emergency event impacts or is threatening to impact a client’s residence, the agency should prepare the resident to shelter in place or evacuate. If there are clients who are in harm’s way and cannot be assisted by the agency, the agency calls 911. Evacuation destinations should be planned in advance. In addition, general population shelters

operated by the American Red Cross or medical shelters operated by the Health Agency may be available during disasters.

J. Response Role of Emergency Medical Services Provider Agencies

Operational Responsibilities

The primary goal for Emergency Medical Services Provider Agencies following an event/emergency is to maintain 9-1-1 response capabilities. In Multiple Casualty Incidents (MCI), Emergency Medical Services Providers will work closely with the MHOAC follow the established policies to triage and sort victims, provide pre-hospital treatment and transportation to the identified destination (usually acute care hospitals) for definitive medical care.

IV. Recovery Roles and Responsibilities for all Full Members

Once the immediate response is underway, healthcare entities must begin to address recovery planning. Recovery activities at healthcare facilities will be focused on financial recovery and documentation to support reimbursement for the services provided in support of the medical response. Healthcare entities should use appropriate ICS forms to document the event to enhance the potential to recover funding from FEMA. Recovery will also focus on resuming the day-to-day functions of the healthcare facility.

Short -Term Recovery
This process takes place at the end of the event and returns the facility to pre-event status as soon as feasible regarding staffing, supplies and equipment, communications, EMS services, facility use, medical records, standards of care and finance.

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

Lessons Learned / After-Action Reports
Once the situation is stable, affected entities should conduct an after action debrief. The Health Agency may conduct a county-wide medical and health system after action debrief. Following the debriefs, entities should develop an after action report that identifies strengths and areas of improvement from the response and recovery efforts. Entities should also develop an improvement plan to outline how the areas of improvement will be resolved.

Attachment B: Default Process for Reimbursement

Reimbursement
The process for reimbursement during times of disaster will be conducted as outlined below.

Loaned Equipment:
The receiving healthcare organization shall return to the providing organization any and all equipment borrowed during the time of a disaster. Equipment shall be returned to the providing organization in the same condition in which it was received, and in a timely manner. The receiving healthcare organization shall bear all of the costs associated with shipping and receiving the borrowed equipment.

Loaned Supplies, Materials or Pharmaceuticals (Consumables):
The receiving healthcare organization shall return to the providing organization as soon as feasibly possible an exact replacement inventory of borrowed consumables. It shall be the receiving healthcare organization's responsibility to pay for any costs related to shipping the consumables back to the providing organization. Alternatively, the receiving healthcare organization can reimbursement the providing organization for the costs of the consumables, including applicable shipping fees.

Loaned Personnel:
The receiving healthcare organization shall reimburse the providing organization compensation for all borrowed personnel during times of disasters. Reimbursement rates shall be based on the current compensation rate for personnel as provided by the providing organization. The receiving healthcare organization is only responsible to reimburse the providing organization for the cost of wages for personnel that are specifically requested. Responding personnel who have not been specifically requested shall be considered volunteers.

Attachment C: Resource Capabilities

Organization Name: ______________________________ ____________
Date: mm/dd/yyyy

Address: ______________________________

Main Phone Number: ______________________________

Overview of Services Provided

Please provide a brief description of the medical and health services your organization provides.

[ ]

Material Resources

Please check the box if your organization may be able to offer to the following types of material resources in times of disaster.

- ☐ Diagnostic Equipment
- ☐ Durable Medical Equipment
- ☐ Facilities-conference room
- ☐ Facilities-kitchen
- ☐ Home Medical Equipment
- ☐ Laboratory Equipment
- ☐ Life Support Equipment
- ☐ Medical Monitoring Equipment
- ☐ Personal Protective Equipment
- ☐ Pharmaceuticals
- ☐ Portable Generators
- ☐ Therapeutic Equipment
- ☐ Transportation Vehicles- buses or vans
- ☐ Treatment Equipment
- ☐ Other - Please Specify:

[ ]

Essential Elements of Information

This census information is a point in time and other information is a best estimate.

1. Total Number of Staffed Beds: ______ ____ *N/A*
2. Average Daily Census: ______ ____ *N/A*
3. Does your facility have backup power? ○ Yes ○ No

If YES:

3a. What type of fuel does your facility use for backup power? ____________ ____________
Gasoline, Diesel, Gasoline and Diesel, Unknown, Other (please describe)

3b. Number of gallons of fuel stored onsite:_________

3c. Number of hours this amount of fuel could power your facility's emergency loads:________

3d. Is your facility's HVAC system powered by the emergency generator? ○ Yes ○ No ○ Unsure

4. Describe which of the following ***functional*** communication equipment your facility has:

___Two-Way Radio ("Walkie-Talkie")
___Landline-Internet based (i.e. VOIP)
___Landline-Hard-wired (i.e. copper based)
___Cellular Phone(s)
___Satellite Phone(s)
___Internet
___Other (Explain) [ ]

5. Is this equipment tested on a regular basis (explain): [ ]

Staff Resources

Please list the number of applicable staff your organization would have available to help in times of disaster

_____ Administrative Staff
_____ Behavioral Health Professional
_____Bus/Truck Driver
_____ Case Manager
_____ Certified Nurse Assistant/Home Health Aide/Medical Asst
_____ Chaplain
_____ Child Care Worker
_____ Cook/Food Services Worker
_____ Dentist
_____ Diagnostic Radiologic Technician
_____ EMT/Paramedic
_____ GIS Specialist
_____ Hemodialysis Technician
_____ Information Technology staff
_____ Longterm Care Ombudsman Services
_____ Medical Records and Health Information Technologist
_____Midwife
_____Nuclear Medicine Technologist
_____Nurse Practitioner
_____Occupational Therapist/Physical Therapist
_____Optometrist/Ophthalmologist
_____Personal and Home Care Aide
_____Pharmacist
_____Phlebotomist
_____Physician
_____Physician Assistant
_____Psychiatric Technician
_____Psychologist
_____Radiation Therapist
_____Registered Dietitian
_____Registered Nurse/Licensed Vocational Nurse
_____Respiratory Therapist
_____Security Guard
_____Social Worker
_____Sonographer
_____Translator

Other: (Please specify)

Attachment D: Participation Agreement

Organization Name: ______________________________ ______________

Date: mm/ddy/yyyy

Organization Contact Information

Address: ______________________________

Website: ______________________________

Phone (include area code): ______________________________

Enter 10-digit phone number without dashes

24/7 Points of Contact

1) Name: ______________________________

Title: ______________________________

Office Phone: ______________________________

Enter 10-digit phone number without dashes

24X7 Phone: ______________________________

Enter 10-digit phone number without dashes

Email: ______________________________

2) Name: ______________________________

Title: ______________________________

Office Phone: ______________________________

Enter 10-digit phone number without dashes

24X7 Phone: ______________________________

Enter 10-digit phone number without dashes

Email: ______________________________

IN WITNESS WHEREOF, the undersigned agrees to participate in the San Luis Obispo County Disaster Healthcare Coalition as a full member:

______________________________ ______________

Authorized Signature *Date: mm/ddy/yyyy*

Printed Name: ______________________________

Title: ______________________________

COUNTY OF SAN LUIS OBISPO HEALTHY AGENCY

______________________________ ______________

Authorized Signature *Date: mm/ddy/yyyy*

Printed Name: ______________________________

Title: ______________________________

Acronyms

APCD	Air Pollution Control District
ARF	Adult Residential Care Facility
ASH	Atascadero State Hospital
ASPR	Administration for Strategic Preparedness and Response
CAHAN	California Health Alert Network
CBRNE	Chemical, burn, radiological, nuclear, explosive
CEU	Continuing Education Unit
CHADOC	County Health Agency Department Operations Center
CMC	California Mens Colony
COOP	Continuity of Operations Plan
DHCC	Disaster Healthcare Coalition
EMS	Emergency Medical Services
EMSA	Emergency Medical Services Agency
EMT	Emergency Medical Technician
EOC	Emergency Operations Center
EOM	Emergency Operations Manual
FBI	Federal Bureau of Investigation
FEMA	Federal Emergency Management Agency
GIS	Geographic Information System
HCC	Healthcare Coalition
HCC RRC	Healthcare Coalition Readiness and Response Coordinator
HPP	Hospital Preparedness Program
I/DD	Intellectual/Developmental Delay
ICF	Intermediate Care Facility
ICS	Incident Command System
LTCO	Long Term Care Ombudsman
MCI	Multiple Casualty Incident
MHOAC	Medical and Health Operational Area Coordinator
MOU	Memorandum of Understanding
NIMS	National Incident Management System
PHEP	Public Health Emergency Preparedness
RCFE	Residential Care Facility for Elderly
RDMHC	Regional Disaster Medical Health Coordinator
SEMS	Standardized Emergency Management System
SLO	San Luis Obispo
SNF	Skilled Nursing Facility
SOP	Standard Operating Procedure
TCRC	Tri County Regional Center
VOAD	Voluntary Organizations Active in Disaster
VOIP	Voice Over Internet Protocol