After-Action Report & Improvement Plan

Los Angeles County
Disaster Healthcare Volunteers
Full Scale Exercise

Exercise Dates: April 26, 2013

Version 4, June 27, 2013

For Official Use Only
After Action Report/Improvement Plan

Los Angeles County Disaster Healthcare Volunteers
Full-Scale Exercise

This exercise was funded by the Los Angeles County Emergency Medical Services Agency with funds from the FY 2012 Emergency System for the Advance Registration of Volunteer Health Professionals grant program, Department of Health and Human Services, Assistant Secretary for Preparedness and Response. (Grant number: ESREP100003-03-02)
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3. For more information about the exercise, please consult the following points of contact:

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EXECUTIVE SUMMARY

The Los Angeles County Disaster Healthcare Volunteers Full-Scale Exercise was designed to establish a learning environment for players to exercise Disaster Healthcare Volunteers deployment procedures and the overall management of volunteer health professionals at local healthcare facilities.

The Los Angeles County Disaster Healthcare Volunteers (DHV) Full-Scale Exercise was sponsored by the Los Angeles County (LAC) Emergency Medical Services (EMS) Agency with funding from the United States Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response through a three-year Emergency System for the Advance Registration of Volunteer Health Professional (ESAR-VHP) supplemental grant. This Exercise Plan was produced with input, advice, and assistance from the response partners, local healthcare facilities, and the Exercise Design Team.

The purpose of this report is to analyze exercise results, identify strengths to be maintained and built upon, identify potential areas for further improvement, and support development of corrective actions.

Major Strengths

The major strengths identified during this exercise are:

- Successful demonstration of the County EMS Agency’s ability to fully exercise the DHV system, from healthcare facility resource request to notification of volunteers to deployment and eventual release/demobilization of volunteers.
- Successful demonstration of the County’s ability to fully meet and exceed federal emergency preparedness capabilities, (i.e., Capability 15 – Volunteer Management). This includes functions to coordinate, notify, organize, assemble, and demobilize volunteers.
- The actual, “boots on the ground” deployment of 150+ volunteers to eight healthcare facilities throughout the county.
- Validation of the overall content, process, and procedures set forth in the Los Angeles County Deployment Operations Manual. While some revision is needed, the overall concept of operations and procedure structure was demonstrated to be sound.
- The ability, for the first time, of local healthcare facilities to exercise and explore issues related to receiving Disaster Healthcare Volunteers.
- The EMS Agency’s ability to staff six mobilization centers and process 150+ volunteers in a timely fashion according to existing procedures.
Primary Areas for Improvement

Throughout the exercise, several opportunities for improvement in Los Angeles County’s ability to manage DHV deployments were identified. The primary areas for improvement, including recommendations, are:

- Changes to the LAC Deployment Operations Manual, predominantly reminders and job aids to promote improved messaging and management of volunteers.
- Re-evaluation of the mobilization center process. This requires exploration via discussion and problem-solving exercises within the LAC EMS Agency, and should eventually be reflected in changes to the LAC Mobilization Center Operations Manual.
- Changes to the DHV system software (CORES), which Los Angeles will request of the State’s EMS Authority but which are out of the purview of the LAC EMS Agency.
- Exploration of issues of mutual aid, coordination, roles, and responsibilities among the various DHV units in Los Angeles County (including the surge unit and the MRC units).

Based on controller, evaluator, and participant feedback, the overall exercise was a resounding success. Subsequent exercises should focus on:

- Increasing the preparedness of local hospitals to receive and use DHVs,
- Refining and testing any revision to operation of mobilization centers,
- Including more healthcare facilities in the requesting and receiving of DHVs, and
- Evaluating the state of readiness among LAC DHV volunteers.
SECTION 1: EXERCISE OVERVIEW

Exercise Details

Exercise Name
Los Angeles County Disaster Healthcare Volunteers Full-Scale Exercise

Exercise Date
April 26, 2013

Duration
One day

Locations
• California Hospital Medical Center
• Henry Mayo Newhall Memorial Hospital
• Providence Little Company of Mary San Pedro
• PIH Health Hospital
• Northridge Hospital Medical Center
• Santa Monica - UCLA Medical Center
• Venice Family Clinic
• Eisner Pediatric Clinic

Sponsors
Los Angeles County Emergency Medical Services Agency with funding from the United States Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response through a three-year Emergency System for the Advance Registration of Volunteer Health Professional supplemental grant 6 ESREP100003-03-02..

Target Capabilities
• Capability 15: Volunteer Management
Scenario Type
Catastrophic earthquake

Exercise Planning Team Leadership

<table>
<thead>
<tr>
<th>Team Member</th>
<th>Organizational Affiliation</th>
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<tbody>
<tr>
<td>Sandra Shields</td>
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<td>LAC EMS Agency</td>
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<td>Terry Crammer</td>
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<tr>
<td>Carole Snyder</td>
<td>PIH Health Hospital</td>
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<td>Isabel Oropeza</td>
<td>PIH Health Hospital</td>
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<tr>
<td>Terry Stone</td>
<td>Henry Mayo Newhall Memorial Hospital</td>
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<tr>
<td>Chris Riccardi</td>
<td>Providence Little Company of Mary San Pedro</td>
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<td>Community Clinic Association of Los Angeles County</td>
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<td>Volunteer Los Angeles</td>
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<td>LAC Department of Public Health</td>
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<td>Ciraolo Consulting, LLC</td>
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<td>Ciraolo Consulting, LLC</td>
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Participating Organizations
Los Angeles County Emergency Medical Services Agency
Hospital Association of Southern California
Community Clinical Association of Los Angeles County
California Hospital Medical Center
Henry Mayo Newhall Memorial Hospital
Providence Little Company of Mary San Pedro
PIH Hospital
Northridge Hospital Medical Center
Santa Monica-UCLA Medical Center
Venice Family Clinic
Eisner Pediatric Clinic
California Emergency Medical Services Authority
Volunteer Los Angeles

Volunteer Units Participating in the Exercise
LA County Surge Unit
MRC Los Angeles
Beach Cities Health District MRC
Long Beach MRC

Number of Participants

- Total number of DHV volunteers: 159 (see breakdown, below)
- Controllers: 10
- Evaluators: 26
- Additional facilitators and management staff: 5
- Additional players at healthcare facilities: unknown, not tallied

<table>
<thead>
<tr>
<th></th>
<th>Total or overall</th>
<th>Surge Unit</th>
<th>MRC LA</th>
<th>Long Beach MRC</th>
<th>Beach Cities MRC</th>
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<tbody>
<tr>
<td>Total number of LAC DHV</td>
<td>199¹</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>requested by healthcare</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>facilities</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Assigned DHV volunteers</td>
<td>224</td>
<td>182</td>
<td>25</td>
<td>9</td>
<td>8</td>
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<tr>
<td>DHV volunteers actually</td>
<td>159</td>
<td>134</td>
<td>16</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>attending</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Attendance rate (attended /</td>
<td>71%</td>
<td>73.6%</td>
<td>64%</td>
<td>66.6%</td>
<td>37.5%</td>
</tr>
<tr>
<td>assigned)</td>
<td></td>
<td></td>
<td></td>
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</table>

¹ The number of assigned volunteers was higher than what was requested by the six hospitals and two clinics. The LAC Surge Unit leader decided to recruit and assign more volunteers to the exercise than was requested to accommodate an anticipated attrition rate of volunteers who would actually attend. This exercise artificiality ensured that there were enough volunteers for each facility to accomplish their exercise goals and would not be done during an actual disaster.
SECTION 2: EXERCISE DESIGN SUMMARY

Exercise Purpose and Design

The purpose of this exercise was to test plans and procedures for deployment of Los Angeles Disaster Healthcare Volunteers to local area hospitals and clinics.

The overarching goals of this exercise were to:

- Fully exercise the LAC Disaster Healthcare Volunteer (DHV) system using a scenario which deployed DHVs to local health care facilities, spanning the request for DHV assistance through DHV deployment to six area hospitals and two clinics, to release of volunteers.
- Evaluate incident command infrastructure, coordination, and communication between the Los Angeles County Emergency Medical Services Departmental Operating Center (DOC) and playing hospitals/clinics.
- Test the ESAR-VHP operational requirements and LAC DHV deployment process, from request for DHV assistance to release of volunteers.
- Exercise the playing hospitals’ and clinics’ ability to request, receive, check credentials of, assign, orient, and release from duty DHVs.
- Evaluate and refine the LAC Disaster Healthcare Volunteer Deployment Operations Manual and relevant training materials prior to rolling training out to all Los Angeles area hospitals.
- Improve the ability of non-playing Los Angeles area hospital staff to validate credentials, check the health status of, and utilize, request, and receive DHVs by including evaluators and observers from non-playing hospitals.

Exercise Objectives, Capabilities, and Activities

This exercise tested Capability 15: Volunteer Management, in both the U.S. Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response’s Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness and the U.S. Department of Health and Human Services Centers for Disease Control and Prevention’s Preparedness and Response’s Public Health Preparedness Capabilities: National Standards for State and Local Planning. The four functions of these target capabilities are identified in the table below.
Functions Mapping for Capability 15: Volunteer Management

| Function 1: Participate with volunteer planning processes to determine the need for volunteers in healthcare organizations | Function 1: Coordinate volunteers |
| Function 2: Volunteer notification for healthcare response needs | Function 2: Notify volunteers |
| Function 3: Organization and assignment of volunteers | Function 3: Organize, assemble, and dispatch volunteers |
| Function 4: Coordinate the demobilization of volunteers | Function 4: Demobilize volunteers |
| Source: U.S. Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response | Source: U.S. Department of Health and Human Services Centers for Disease Control and Prevention |

Scenario Summary

This exercise was driven by a major earthquake affecting the Los Angeles basin. The earthquake, and its associated aftershocks, produced extensive damage and caused healthcare facilities to request Disaster Healthcare Volunteer resources. Six area hospitals and two clinics requested volunteers who were expected to report for five or more days with each hospital providing lodging and meals. Key scenario facts were as follows:

- 1,800 fatalities
- 53,000 injured
- 300,000 buildings damaged
- 1,600 fires
- Lifelines disrupted (water, gas, electric)
- Communication systems overloaded
SECTION 3: ANALYSIS OF CAPABILITIES

This section reviews the performance of exercised capabilities, activities and tasks. Observations and analysis are organized according to the activities identified in the Exercise Evaluation Guides, which in turn correspond to procedures for deployment set forth in the Deployment Operations Manual and the Mobilization Center Operations Guide. This section focuses on the mobilization center and healthcare facility point of view; the next section focuses on the Medical Reserve Corps Unit Leaders’ point of view.

Activity 1: Evaluate the Mobilization Center Team’s ability to open Mobilization Centers for each of six hospitals.

Description: At the time of an incident, the county will activate and operate a mobilization center at each of the six participating hospitals.

Activity 1.1: A Mobilization Center was opened and operated at the deployment venue (hospital).
1.1.a. The Mobilization Center was appropriately staffed, per the Mobilization Center Operations Manual.
1.1.b. The Mobilization Center was appropriately equipped, per the Mobilization Center Operations Manual.

Overview: There was a broad consensus among evaluators that the process was adequate for set up and management. Most reported a “good flow” of volunteers despite some examples of bottleneck. All evaluators felt that this objective was met. There was some confusion at some mobilization centers—clarity at one. The use of checklists, group orientation/briefing at outset, and color coding of check-in forms resulted in the most efficient process.

Strengths:

• Most reported a smooth and efficient operation including a “good flow” of volunteers.
• Mobilization Center staff were generally thought to be knowledgeable and to make the process work well.
• Staff were seen to be “problem solvers.”
• Set up of mobilization center went smoothly and quickly.

Areas for Improvement:

• Better signage required to cut down on confusion.
• Not all mobilization centers used checklists for their staff which resulted in some confusion.
• The “health check” station was a bottleneck.
• Some confusion on the part of arriving volunteers regarding what to do,
what to expect.

- There were many complaints and concerns about parking at mobilization centers and the directions/information shared with volunteers by email.
- Some volunteers felt that they should be kept up to speed on the nature of the disaster scenario and would appreciate more information about the exercise/experience.
- Some mobilization staff were unable to answer questions and not as knowledgeable as they should be.

**Recommendations:**

- Ensure that a “group orientation” for all workers in the mobilization center is conducted at the outset. (Henry Mayo may be viewed as a best practice).
- Provide checklist/JAS to Mobilization Center workers to ensure that they know their duties.
- Ensure that Mobilization Center staff are easily identified. Consider providing vests to all staff.
- Provide better signage so that steps are clear.
- Ensure that pre-deployment communication with volunteers includes precise and correct information about parking at whatever facility is being used.
- Consider providing “barricades” for management of large flow of volunteers and to ensure that volunteers do not bypass stations.
- Consider increasing the staff and space available for health check in order to decrease the potential for bottleneck (and provide more privacy).
- Consider a brief orientation to arriving volunteers prior to check in to ensure that they understand the objectives of the exercise and the steps they will be asked to take in the Mobilization Center.
- Consider a brief “player handbook” for volunteers that would lay out expectations of the exercise.
- Add “disaster briefing/update” to mobilization center activities so that volunteers can be kept informed of the situation.
- Review Mobilization Center process and consider staffing only with county staff.

**Activity 2: Evaluate the Mobilization Center Team’s ability to check in/register disaster healthcare volunteers.**

**Description:** The Mobilization Center Team will check-in and register all DHVs deployed to a participating healthcare facility.

**Activity 2.1:** The Mobilization Center Team is able to check-in all DHVs deployed to a specific facility

2.1.a. All DHVs at a specific facility are checked in against the appropriate roster.
2.1.b. Spontaneous unaffiliated volunteers (SUVs) are not checked in.
2.1.c Deviations from the roster are communicated to the receiving healthcare facility.
2.1.d The licenses of all appropriate volunteers are checked prior to completing deployment rosters.

**Overview:** In general, evaluators and participants felt that the process of checking in volunteers and deploying to facilities was successful. Different locations reported different experiences with SUVs. Clarification is needed to ensure a uniform approach to the handling of SUVs.

**Strengths:**

- With some exceptions, SUVs were identified and not deployed to the healthcare facility.
- Rosters were available and checked at all mobilization centers.

**Areas for Improvement:**

- The “role assignment” station was not felt to be of value and in some circumstances was not utilized.
- There was variation among evaluators with regard to the identification and reporting of SUV. While generally a successful process, some more care should be given to ensure that SUVs are handled according to protocol.
- Some evaluators noted deficiencies in the rosters—e.g., no professional license information.
- Several evaluators reported that volunteers without appropriate licenses were allowed to go through the process.
- A number of questions were raised in the mobilization centers by volunteers about malpractice.

**Recommendations:**

- Consider renaming the “Role Assignment” station in the Operations Manual to be the “Facility Assignment” station and clarifying actions that will take place at this station.
- Ensure uniformity in mobilization center response to the identification of SUVs and the communications expected when they are identified.
- Review the output of the DHV system in terms of content required on rosters and ensure that rosters are produced appropriately.
- Consider providing arriving volunteers with a printed list of what they should do in the mobilization center in order to supplement verbal orientation. This may assist in decreasing confusion and frustration.
- Consider seeking a wider range of professions in future exercises, (reaching beyond RNs and MDs).
- Provide malpractice material—e.g., FAQ document/handout—at mobilization centers.
Activity 2.2: The Mobilization Center Team ensures Disaster Service Worker registration for each deployed volunteer.

**Overview:** This activity was noted as complete by all evaluators. Very few issues were identified for improvement. The issue of swearing in of non-citizens should be investigated and clarified.

**Strengths:**
- Brief orientation to the Disaster Service Worker (DSW) program was done well.
- In general, swearing in went smoothly.
- No complaints or concerns were raised about the DSW paperwork.

**Areas for Improvement:** Questions were raised about the propriety/legality of swearing in non-citizens.

**Recommendations:**
- Clarify issue of whether non-citizens can be sworn as DSW volunteers and update Operations Manual accordingly.
- To the extent possible, encourage enrollment/swearing of DSW at routine events such as trainings, etc. Greater numbers of volunteers who are already sworn may decrease the time and bottleneck associated with this process.

Activity 2.3: The Mobilization Center team ensures each volunteer is fit for duty.

2.3.a. A brief screening tool is available for volunteer screening.
2.3.b. Volunteers failing the screening are appropriately deferred from service.

**Overview:** While most of the volunteers who arrived for the exercise were fit for duty, several were not. Some volunteers expressed concern about their ability to stand for periods greater than one hour, walking short distances, and similar limitations. The general feeling of evaluators and coordinators was that communications with DHVs should be clearer as to what is expected as part of a hospital deployment in terms of physical exertion as well as the need to appear professionally attired.

**Strengths:** Despite confusion and some volunteers who were clearly not fit for duty, it was felt that the fitness screening process was successful in the Mobilization Center.

**Areas for Improvement:**
- Explore issues related to tuberculosis (TB) questions and responses: there was considerable confusion about what questions to ask and how to deal with specific situations—e.g., the PPD + volunteer without a chest X-ray within a year.
Unclear what to do if a volunteer “fails” health screening with symptoms of infectious disease.
Several volunteers arrived with concern about their ability to stand for extended periods.
Some volunteers arrived inappropriately attired for professional work.

**Recommendations:**

- Consider adopting a consistent set of questions related to TB that would be agreed to by all receiving institutions.
- Add protocol to Mobilization Center operations manual addressing the proper response to identifying a volunteer with a potentially contagious disease.
- Ensure that pre-deployment communications with volunteers include specifics related to physical demands and expectations and that clearly encourages volunteers who are not fit to not deploy.
- Ensure that pre-deployment communications include expectations about appropriate attire—e.g., closed-toe shoes.

**Activity 3: Evaluate the Mobilization Center Team’s ability to demobilize disaster healthcare volunteers.**

**Description:** The Mobilization Center Team will check-in and register all DHVs deployed to a participating healthcare facility.

**Activity 3.1:** The Mobilization Center Team tracks and records the demobilization of disaster healthcare volunteers.
3.1.a. The Mobilization Center Team gathers all DSW forms, check-in, and sign-out forms.
3.1.b The Mobilization Center Team completes any additional demobilization activities.

**Overview:** There was very little evaluation from the evaluators and controllers on this activity. Most simply noted that the task was “fully” completed.

**Strengths:**

- Management of documents was well done by both hospital labor pool and county employees.
- The DSW process well-handled and documentation properly transmitted.

**Areas for Improvement:**

- Several sites noted that those who left early had trouble coordinating with the mobilization center.
- It was felt that this exercise did not fully exercise the demobilization process.
- It was unclear how forms such as HICS 253 would or should be handled in...
a multi-day deployment.

**Recommendations:**

- Improve communication between receiving facility and the mobilization center with regard to demobilization. Ensure that receiving facility and deployed volunteers know how to contact the appropriate persons for demobilization.
- The demobilization process should be studied more, perhaps by further table top exercises. This exercise did not fully account for issues such as re-assignment during a deployment. Issues such as having one mobilization center or mobilization centers apart from the receiving hospitals should be looked at in more detail. Other issues that could be addressed include extending volunteer deployment at a facility.

**Activity 4: Participate with volunteer planning processes to determine the need for volunteers in healthcare organizations**

**Description:** Evaluate the facility’s ability to plan for the use of volunteer health professionals during a disaster.

**Activity 4.1:** The facility’s Incident Command (Hospital Command Center) staff is able to use pre-established triggers in the EOP plan to make a decision to request disaster healthcare volunteers.

4.1.a. The facility has pre-established triggers in the facility EOP to make a decision to request DHVs.

4.1.b. Triggers are clear and relevant to real-world scenarios.

**Activity 4.2:** The facility’s Incident Command staff are able to engage in planning discussions necessary to receive volunteers with the LAC EMS Agency DOC, before and during a deployment of volunteers.

4.2.a. Incident Command staff are able to resolve planning and logistics considerations necessary to receive volunteers.

**Overview:** Most of this process occurred before the day of the exercise and was not seen by the assigned evaluators. Consequently, the feedback provided by evaluators is limited. Exercise coordinators discussed some of these issues at length and noted that there needs to be a better ability to match actual hospital need with available specialties and competencies.

**Strengths:** In the exercise, most hospitals and clinics did receive the resources that they requested.

**Areas for Improvement:**

- Several facilities noted difficulty in assigning roles in the hospital due to a failure to match up a stated need with a volunteer’s skills or abilities. (For
example, one clinic requested 2 marriage and family therapists, and received 1 MFT and 1 RN. That facility does not use RN and, therefore, do not have specific assignments for RNs.)

- Hospitals need to know more about the specialties and capabilities of volunteers—they need to know what they are receiving. It was noted that the DHV system can capture this information but it is not verified in the way that hospital employment is.

**Recommendations:**
- The DHV system must identify volunteers’ area of clinical practice to ensure that volunteer deployed to the health facility meets the request.
- Consider having volunteers fill out a checklist of capabilities—perhaps as part of the mobilization process and ensure that this information is transported to the receiving facility along with the roster.

**Activity 5: Volunteer notification for healthcare response needs**

**Description:** The facility is able to place resource requests for, and receive rosters of, Disaster Healthcare Volunteers. The County is able to notify volunteers, confirm their assignments, communicate relevant deployment information, generate deployment rosters, and deliver those rosters to requesting facilities.

**Activity 5.1:** The facility’s Incident Command staff are able to place a resource request for disaster healthcare volunteers with the county.
- 5.1.a. The resource request is appropriately completed.
- 5.1.b The Incident Command staff receive confirmation that the request was received.

**Activity 5.2:** The Incident Command staff are able to receive a roster of available, licensed, and credentialed disaster healthcare volunteers prior to receiving those volunteers in person.
- 5.2.a. A complete roster is delivered in both hardcopy and electronic forms prior to the first volunteer’s arrival.
- 5.2.b The roster is complete and correct.

**Overview:** As with activity #4, most evaluators were unable to provide much feedback on 5.1 and 5.2 activities as much of it was not viewed directly.

**Strengths:**
- All facilities were able to receive a roster of volunteers in a timely fashion—either electronically, in hard copy, or both.
- Facilities were able to place a request in the period prior to exercise day and that request was processed effectively.

**Areas for Improvement:**
- Feedback about volunteers being added to roster without telling the county DOC was confusing and at times contradictory in the same facility.
Despite the contradictory evaluations, there was evidence that names of volunteers were added to the roster, perhaps without proper notification of the county DOC and/or receiving facility.

- Rosters were not complete in that they did not contain professional license numbers on the rosters.

**Recommendations:** Ensure that the content of rosters is complete and uniform. If necessary, address roster presentation with vendor. Rosters should include the professional license number and clinical area of practice.

**Activity 6: Organization and assignment of volunteers**

**Description:** The requesting healthcare facility receives, organizes, assigns, and manages volunteers during the course of their deployment in such manners as to ensure the verification of licensure to practice, and to provide oversight of the care, treatment, and services provided. The County is able to generate and maintain appropriate lists of deployment assignments, shifts, and related information for all volunteers.

**Activity 6.1:** The requesting facility is able to receive volunteers, check them in, validate credentials, brief them, and assign volunteers duties within the facility.

6.1.a. The healthcare facility checks in each volunteer against the County-provided roster.
6.1.b. The healthcare facility turns away any volunteer not on the County-provided roster.
6.1.c. The healthcare facility validates the identity and credentials of each volunteer.
6.1.d. The healthcare facility provides a pre-assignment medical screening to ensure the safety of the volunteers.
6.1.e. The healthcare facility provides a briefing to each volunteer.
6.1.f. The healthcare facility assigns each volunteer.

**Overview:** In general, the evaluator feedback suggests that this was a very successful exercise. Most of the facilities report a smooth process of receiving volunteers, checking them in, validating the credentials, and assigning duties. Widespread comments suggest a strong desire to ensure that volunteers are not required to do duplicate data entry on forms. Also, many volunteers expressed a desire for a more realistic, patient-focused exercise experience.

The exercise also tested, and discovered problems with, volunteers from multiple units (i.e., the LAC Surge Unit, as well as local Medical Reserve Corps). It was noted that the LAC Deployment Operations Manual (DOM) is not clear on the issue of when volunteers are “assigned” to a disaster operation and then come under the management of the receiving unit. In practice, conveying all messages, missions, and availabilities through each Unit Leader prior to and after assignments is most challenging. Such a process or requirement prevents the receiving Unit leader from effectively addressing pro-active assignments, re-assignments, providing unified reporting instructions, providing a unified rostering
process. It was noted that proactive communication among Unit Leaders did not happen effectively during the run up to the exercise. It was difficult to reach Unit Leaders by telephone and routine call-ins did not occur.

**Strengths:**

- Credentials were validated quickly and efficiently at facility.
- In some cases, volunteers who were found not to have valid licenses were appropriately assigned to non-clinical positions.
- Many felt the general orientation given volunteers to be excellent.
- Specific orientations to units were considered very good.

**Areas for Improvement:**

- Some volunteers arrived without proper copies of credentials.
- Volunteers found “double paperwork” to be frustrating. Look for ways to allow volunteers to fill out forms at mobilization center that can be used (copy/NCR form, etc.) at the receiving facility.
- Need signs at stations for clarity.
- Some felt the orientations to be overly long and redundant.
- Experience on the unit was varied among the facilities. Some felt that the floor personnel were not sufficiently informed or prepared to deal with volunteers.
- Some staff on the floor expressed desire to know more about the clinical expertise and experience of arriving volunteers.
- Some volunteers were expecting/hoping for more clinical training.
- Several volunteers had names on the roster that differed from those on their license (e.g., shortened name used on roster).
- Some security concerns were raised—e.g., volunteers with inappropriate access to parts of a facility.
- Staffing a drill or disaster requires “lean forward” proactive communication by the Unit Leaders. This did not fully occur. Failure of unit leaders to routinely engage in telephonic communication prior to the exercise is clearly problematic. Expectations regarding unit leader responsibilities, including availability and control of volunteers during deployment, should be explored.
- In an actual disaster – gathering an availability list once per Unit will not work. The Surge Unit continued to send availability notifications when it became clear that there were not enough of certain types of volunteers to ensure positions were staffed. This would be an ongoing requirement following a disaster.
- There is a lack of clarity in the DOM on when volunteers from other units are actually “assigned” to the disaster operation and come under the management of the receiving Unit. Though in theory conveying all messages/missions/availabilities through each Unit Leader prior and after assignment is in the DOM, in practice this presents multiple challenges to the Unit Leader who is coordinating the mission and prevents pro-active assignments, re-assignments, unified reporting instructions and “rostering”
of volunteers, etc. For a large disaster with multiple hospital sites, this method will not work. In addition to changes to the DOM, one thing that would have helped for the drill (and during a disaster)—there should be a Unit leader conference call to discuss mission manager procedures, clarify expectations, discuss communication requirements etc.

Recommendations:

- Ensure that pre-deployment communications state clearly what credentials volunteers are supposed to bring with them to the deployment (e.g., professional license, government issued ID, certifications, etc.).
- In communications, suggest to all volunteers to carry photocopy of all licenses and certifications.
- Look for ways to reduce paperwork including use of forms at mobilization center that can be copied and then used at receiving facility.
- Ensure that pre-deployment communications for future exercises state clearly what the volunteer can expect as regards clinical experience and/or training.
- Consider suggesting more focused orientations that clearly outline what is unique or different about a particular facility, including providing maps of the facility to volunteers. Add specific orientation to hospital codes (e.g., colors, etc.)
- Unit personnel—i.e., charge nurses and key staff—should be brought into the process, informed of what to expect from arriving personnel in terms of licensure and capabilities.
- Consider use of a self-report capabilities check list—perhaps completed at mobilization center—that can be sent to receiving facility.
- Name of volunteer on the roster should be full name used on professional license and not a shortened version. Consider sending communication to registered volunteers to ensure that their name in the DHV system is consistent with their license name.
- Routinely add security briefing to the facility orientation process.
- DOM changes include:
  - Clarify the process of “assignment” of volunteers and when volunteers come under the management of the requesting Unit.
  - Setting expectations for Unit Leader communication at the outset of the mutual aid request.
  - Ensuring that a Unit Leader conference call is regularly scheduled as part of the deployment process.
  - Ensuring that gathering availability lists is an ongoing process rather than a onetime occurrence.
  - Clarify mutual aid requesting process.

Activity 6.2: The requesting facility is able to educate deployed DHVs on personal resilience and communicate with the County regarding PsySTART issues that need follow-up post assignment. (Note: Not all healthcare facilities are providing PsySTART
6.2.a. Volunteers are educated on personal resilience as part of their deployment briefing.
6.2.b. The healthcare facility is able to identify PsySTART-related issues among deployed volunteers.

**Overview:** This activity received very little feedback. In fact, most evaluators did not include any comment or even checkmark on their evaluation form. Some simply provided a brochure to volunteers. Others were unclear on what to do or how to do it.

**Strengths:** Brochures about personnel coping were well received.

**Areas for Improvement:** Need to provide more clarity to facilities as to what is expected.

**Recommendations:**
- Consider distributing PsySTART information to volunteers at the Mobilization Center rather than relying on facilities.
- Seek common understanding from facilities as to what is the best approach to this issue.

**Activity 6.3:** The requesting facility is able to orient volunteers to, and evaluate their performance in, the appropriate department to which the volunteer is assigned.
6.3.a. Each volunteer is assigned to a specific unit.
6.3.b. Each volunteer receives an orientation to their assigned unit.
6.3.c. Each volunteer receives appropriate oversight on that unit.
6.3.d. Each unit to which a volunteer is assigned provides performance feedback on that volunteer.

**Overview:** Local (receiving healthcare facility) orientations were very positively received. The experience of assigning specific roles varied significantly among the different facilities. As with other areas of evaluation, it was felt that floor staff should be brought more up to speed with the expectations related to incoming volunteers. A major lesson learned concerned the notion of “hospital ready,” (e.g., Emergency Credential Level 1), and the related matching of DHV nurses with the hospital’s request at the level of specialty and clinical preparation for particular roles. As the DHV software (“CORES”) does not currently provide the level of specificity needed, this issue places a burden on hospitals to communicate the least specific request, while placing a burden on unit coordinators and volunteer managers to best understand the preparation of individual volunteers.

**Strengths:** Local orientations/tours were very well received.
Areas for Improvement:
- Assignments on the units were uneven. Some facilities had clear assignments, some had none.
- Need to better understand how volunteers can function with local technology. For example, how to deal with Pyxis and electronic medical record password issues.

Recommendations:
- Encourage facilities to include in their plan how to address password and other technology issues in order to permit volunteers to do assigned tasks.
- Work with receiving facilities as part of the requesting process to clarify what clinical role/assignments will be filled by volunteers.

Activity 6.4: The requesting facility is able to track each Disaster Healthcare Volunteer during the deployment.
6.4.a Each volunteer is tracked using the HICS 253 form (Volunteer Staff Registration).
6.4.b The facility is able to complete the necessary record keeping regarding the volunteers’ service, including producing ICS 226 forms if needed to report specific volunteer performance issues.

Overview: While little specific feedback was given on this activity, it was generally felt to be successful. The evidence suggests that most facilities completed a tracking form and that the forms were properly saved.

Strengths: Facilities were able to track volunteers during deployment.

Areas for Improvement: HICS form 253 could be more effective if it were electronic.

Recommendations: Consider exploring an electronic HICS 253 form that can sort volunteers by category.

Activity 6.5: The requesting facility is able to manage likely problems related to disaster healthcare volunteers’ deployments, (such as injury, spontaneous unaffiliated volunteers, lapsed licenses, and illness).
6.5.a Problems are quickly identified and appropriately managed, including illness and injury.
6.5.b The County is informed of any volunteer- or deployment-related problem.

Overview: The experiences of different facilities in response to the illness and needle stick injects was varied. Overall, most felt that it went well. The evaluations suggest that there needs to be somewhat more clarity with regard to whom should be notified about these issues.

Strengths: Responses handled appropriately—even after initial confusion.
**Areas for Improvement:** One facility did not have a process for dealing with injury for a volunteer. Attempt to contact Mobilization Center for guidance was unsuccessful.

**Recommendations:** Consider adding more specific guidance on response to volunteer injury/illness in the operations manual. Information should include specifically who to call in such a situation and perhaps a standard plan for management.

**Activity 6.6:** The requesting facility is able to provide accommodations for volunteers, including rest areas, hygiene facilities, communications, and food and hydration.

**Overview:** The responses to this section of the evaluation were uniformly positive. This appears to have been a very strong part of the exercise. Volunteers felt welcomed and cared for in the process.

**Strengths:** Rest areas, hygiene areas, food and water were available from beginning to end of exercise.

**Areas for Improvement:** The issue of sleeping accommodations not tested in this exercise. (However, it was discussed in the hot wash of at least one facility).

**Recommendations:** Future exercises may focus on providing accommodations for a longer term deployment of volunteers.

**Activity 7: Coordinate the demobilization of volunteers**

**Description:** The healthcare facility demobilizes and coordinates the release of volunteers.

**Activity 7.1:** The facility is able to demobilize and check out each volunteer.

7.1.a Each volunteer is checked out against the roster at the end of shift/service.
7.1.b The healthcare facility collects all appropriate forms (e.g., HICS 253, and as appropriate, ICS 226) and submits copies of those forms to the county.

**Overview:** Very little feedback given on this activity by evaluators. That which was given suggests that it was a generally positive response and that this activity was successfully accomplished.

**Strengths:** Check out was done and HICS forms used at most facilities.

**Areas for Improvement:** Those facilities that completed the exercise early were not able to communicate with Mobilization Center.

**Recommendations:** Consider developing protocol for demobilization directly from the facility and not requiring a return to Mobilization Center.
SECTION 4: ANALYSIS OF CAPABILITIES – UNIT LEADERS

This section reviews the performance of exercised capabilities from the perspective of DHV Collaborative Unit Leaders, who requested use of a separate evaluation process not based on the Deployment Operations Manual or Mobilization Center Operations Guide.

Description: LA County Surge and MRC Unit Leaders coordinate deployment of volunteers to multiple facilities.

Activity 1.1: Determine if volunteers are greeted by pre-identified hospital/clinic contact person upon arrival.

Overview: All reviewers indicated that this was fully completed. No specific comments made about strengths or areas for improvement. No other comments or recommendations were made.

Activity 1.2: Verify that Hospital/Clinic (HC) staff properly identify and credential licensure of volunteer.

Overview: While all reviewers considered this activity fully completed, some comments were made about failure to check license at check-in and an over-reliance on membership cards.

Strengths:
- Licenses properly verified at the healthcare facilities.
- One site unable to verify a phlebotomist license on line but properly assigned to a non-clinical assignment that did not require licensure.

Areas for Improvement: Failure to check professional license along with government issued ID at check-in.

Recommendation: Encourage facilities to have plan for use of volunteers whose licenses cannot be verified.

Activity 1.3: Healthcare staff/supervisor ensures appropriate break times for volunteers.

Overview: All reviewers indicated that this was fully completed. No specific comments made about strengths or areas for improvement. No recommendations made.

Activity 1.4: Provide facility orientation and relevant just-in-time-trainings to assigned volunteers.

Overview: Generally noted to be fully completed. However, one reviewer notes that this was not done.
Strengths:

- Excellent orientation included giving volunteers an emergency code word.
- One volunteer orientation was deemed “great” and included all issues specific to the facility, personal safety, emergency procedures, expectations, and where to eat and take break. Also, excellent handouts were provided to volunteers.

Areas for Improvement: None noted.

Recommendation: Review the orientation provided at Henry Mayo Newhall and consider sharing with other facilities as a best practice.

Activity 1.5: Just-in-time-training covered necessary information for volunteers to perform assigned roles in Hospital/Clinic.

Overview: Reviewers noted that this was either fully completed or partially completed (without specific comment). No other comments or recommendations were made.

Activity 1.6: Provide personal protective equipment for assigned volunteers, if necessary.

Overview: Reviewers all noted this was not applicable. No other comments or recommendations were made.

Activity 1.7: Demonstrate established communication processes between healthcare staff and volunteers.

Overview: Generally reviewed as completed. However, one reviewer suggested poor communication as evidenced by confusion at the beginning of the exercise.

Strengths: None noted.

Areas for Improvement: Volunteers should be given an agenda so that they know what to expect.

Recommendations: In future exercises ensure that both volunteers and healthcare facility staff have an agenda and know what to expect.

Activity 1.8: Examine communication exchanges and troubleshoot for shared language issues and areas of improvement.

Overview: Reviewers cited this as either “partially” completed or “not applicable.” No other comments or recommendations were made.
Activity 1.9: Observe healthcare protocol and planned course of action volunteer-related issues (i.e., volunteer injury, volunteer has emergency, volunteer conflict).

**Overview:** Most reviewers did not address this activity. However, one noted that it was addressed in briefing/orientation. No other comments or recommendations were made.

Activity 1.10: Directions provided volunteers were adequate and facility had clearly marked the check-in/out area at the hospital/clinic.

**Overview:** Reviewers found this to vary among sites. The biggest concern was the lack of clear signage directing volunteers.

**Strengths:** None noted.

**Areas for Improvement:** Need improved signage.

**Recommendations:** Ensure that recommendations for improved signage are included in operations manual.

Activity 1.11: Directions provided volunteers were adequate and facility had clearly marked check-in/out area at Mobilization Center.

**Overview:** Reviewers found this to vary among sites. The biggest concern was the lack of clear signage directing volunteers.

**Strengths:** None noted.

**Areas for Improvement:** Need improved signage.

**Recommendations:** Ensure that recommendations for improved signage are included in operations manual.

Activity 1.12: Mobilization Center staff properly checked-in/out volunteers and directed them to their assignment.

**Overview:** Reviewers either did not witness or marked this activity as fully completed without further comment. No other comments or recommendations were made.

Activity 1.13: Volunteers were treated appropriately and given assignment appropriate for their credential level.

**Overview:** Reviewers marked this as completed and commented positively on the experience. Comments were drawn from evaluator’s conversations with
deployed volunteers.

**Strengths:**
- Volunteers reported very positive feelings about the exercise.
- Volunteers reported a high comfort level in taking on assignments.

**Areas for Improvement:** None noted.

**Recommendations:** None noted.
SECTION 5: CONCLUSION

This exercise successfully demonstrated the County EMS Agency’s ability to fully exercise the DHV system, deploy volunteers throughout the county, and meet all of the federal Capability 15 – Volunteer Management. The exercise validated the overall content, process, and procedures in the Los Angeles County Deployment Operations Manual. Finally, this exercise culminated a multi-year training and exercise program designed to prepare hospitals and clinics throughout the county to request, receive, and utilize disaster healthcare volunteers.

Opportunities for improvement in Los Angeles County’s ability to manage DHV deployments were identified in the following areas, which are detailed in the Improvement Plan (Appendix A):

- Changes to the LAC DHV Deployment Operations Manual.
- Re-evaluation of the Mobilization Center process. This requires exploration via discussion and problem-solving exercises within the LAC EMS Agency, and should eventually be reflected in the LAC EMS Agency Mobilization Center Operations Manual.
- Changes to the DHV system software (CORES), which Los Angeles will request of the State’s EMS Authority but which are out of the purview of the LAC EMS Agency.
- Exploration of issues of mutual aid, coordination, roles, and responsibilities among the various DHV units in Los Angeles County (including the surge unit and the MRC units).
- A handful of miscellaneous issues which transcend the above categories.

Based on controller, evaluator, and participant feedback, the overall exercise was a resounding success. Subsequent exercises should focus on:

- Increasing the preparedness of local hospitals to receive and use DHVs,
- Refining and testing any revision to operation of Mobilization Centers,
- Expanding the number of healthcare facilities capable of requesting and receiving DHVs, and
- Continuing to maintain a state of readiness among local volunteers.
## APPENDIX A: IMPROVEMENT PLAN

These recommendations draw on Exercise Evaluation Guides, participant feedback, the After Action Report, and the Controller/Evaluator Debriefing Conference.

<table>
<thead>
<tr>
<th>Observation Title</th>
<th>Recommendation</th>
<th>Primary Responsible Agency</th>
<th>Agency Contact</th>
<th>Start Date</th>
<th>Target Completion Date</th>
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<tbody>
<tr>
<td>LAC Deployment Operations Manual revisions (Draft)</td>
<td>See revisions list, below</td>
<td>LAC EMS Agency</td>
<td>Sandra Shields</td>
<td>6/1/2013</td>
<td>6/30/2013</td>
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<td>LAC Deployment Operations Manual revisions (Final)</td>
<td>See revisions list, below</td>
<td>LAC EMS Agency</td>
<td>Sandra Shields</td>
<td>6/1/2013</td>
<td>6/30/2014</td>
</tr>
<tr>
<td>Mobilization Center process review</td>
<td>See list, below</td>
<td>LAC EMS Agency</td>
<td>Sandra Shields</td>
<td>7/1/2013</td>
<td>6/30/2014</td>
</tr>
<tr>
<td>Changes to CORES software</td>
<td>See list, below, to be forwarded to Patrick Lynch at California EMS Authority</td>
<td>LAC EMS Agency</td>
<td>Sandra Shields</td>
<td>7/1/2013</td>
<td>6/30/2014</td>
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<tr>
<td>LAC DHV unit collaboration</td>
<td>See list, below</td>
<td>LAC EMS Agency</td>
<td>Sandra Shields</td>
<td>7/1/2013</td>
<td>6/30/2014</td>
</tr>
<tr>
<td>Fitness for duty screening</td>
<td>Discuss through the Disaster Resource Centers, determine if emergency credentialing level 1 is sufficient coverage for TB testing.</td>
<td>LAC EMS Agency</td>
<td>Jacqui Rifenburg</td>
<td>7/1/2013</td>
<td>6/30/2014</td>
</tr>
<tr>
<td>Reassignment of DHVs</td>
<td>Managing the issue of reassigning DHVs. This touches on changes in the DOM, mobilization center process, and the DHV system software.</td>
<td>LAC EMS Agency</td>
<td>Sandra Shields</td>
<td>7/1/2013</td>
<td>6/30/2014</td>
</tr>
<tr>
<td>Review of the demobilization process</td>
<td>See below for summary of issues. Explore via discuss and/or</td>
<td>LAC EMS Agency</td>
<td>Sandra Shields</td>
<td>7/1/2013</td>
<td>6/30/2014</td>
</tr>
<tr>
<td>Observation Title</td>
<td>Recommendation</td>
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<tr>
<td>tabletop exercise</td>
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</tbody>
</table>

LAC Deployment Operations Manual revisions should address the following points:

- **Pre-deployment communications including the following:**
  - Ensure that pre-deployment communication with volunteers includes precise and correct information about parking at whatever facility is being used.
  - Appropriate attire—e.g., closed-toe shoes;
  - Fitness for duty (including expectations re standing, walking, etc.);
  - Release of personal contact information to the receiving facility (any receiving facility needs to have contact information for the deploying volunteer); and,
  - Bringing photocopies of ACLS, PALS, CPR, and other cards.
  - State clearly what credentials volunteers are supposed to bring with them to the deployment (e.g., professional license, government issued ID, certifications, etc.).
  - Ensure that pre-deployment communications for future exercises state clearly what the volunteer can expect as regards clinical experience and/or training.
  - Automatic reminder call or text might have worked to lower the amount of no-shows.

- Clarify issue of whether non-citizens can be sworn as DSW volunteers and update Operations Manual accordingly.
- Consider adopting a consistent set of questions related to TB that would be agreed to by all receiving institutions.
- Work with receiving facilities as part of the requesting process to clarify what clinical role/assignments will be filled by volunteers.
- Consider adding more specific guidance on response to volunteer injury/illness in the operations manual. Information should include specifically who to call in such a situation and perhaps a standard plan for management.
- Communication process between EMS Agency and unit coordinators in multi-unit deployments:
  - Clarify the process of “assignment” of volunteers and when volunteers come under the management of the requesting Unit.
  - Setting expectations for Unit Leader communication at the outset of the mutual aid request.
  - Ensuring that a Unit Leader conference call is regularly scheduled as part of the deployment process.
  - Ensuring that gathering availability lists is an ongoing process rather than a onetime occurrence.
  - The requesting unit/agency should have a conference call with EMSA just to review how request will be set up in Mission Manager.
  - Clearly define the requesting process for mutual aid.
Mobilization Center process review should address the following points:

- The LAC EMS Agency Mobilization Center process needs to be further discussed and explored via tabletop exercise. The following list represents the range of topics and feedback to be considered.

  - Presence, authority, and identification
    - Center staff need to establish more of a presence/authority, through uniforms, vests, aggressive greeting, etc. This intersects with the recommendation to consider all-county staffing of Mobilization Centers.
    - Communication between the receiving facility and the Mobilization Center must be addressed. Several healthcare facilities were unable to contact the Mobilization Centers.

- Process flow and operations at/through a Mobilization Center
  - Review entire Mobilization Center process, possibly through a tabletop exercise.
  - Consider staffing centers only with county staff.
  - Consider renaming the “Role Assignment” station in the Operations Manual to be the “Facility Assignment” station and clarifying actions that will take place at this station.
  - The centers should get a cleared health form first, before volunteers fill out any other paperwork: screen for health/fitness first.
  - Stations at the Mobilization Center should be numbered (1, 2, 3, 4…) and consolidated. There are too many stations and staff. There could be reception, check in/check out/role assignment, health check stations. There is no need for orientation “station”. After orientation, volunteers could return to check in/check out/role assignment table for final check. Final check should include all paperwork (all kept together) to ensure health check and DSW was completed. Check in station must also check professional licenses.
  - The “paperwork check” form at the Mobilization Center should call for initials instead of a checkbox.
  - Consider having volunteers fill out a checklist of capabilities—perhaps as part of the mobilization process and ensure that this information is transported to the receiving facility along with the roster.
  - Look for ways to reduce paperwork including use of forms at mobilization center that can be copied and then used at receiving facility.
  - Consider the use of triplicate (“NCR”) forms to reduce paperwork.
  - Provide better signage so that steps are clear, and ensure that recommendations for improved signage are included in operations manual. Signage needs to include the entire path of the volunteer, starting with parking.
  - Consider providing “barricades” for management of large flow of volunteers and to ensure that volunteers do not bypass stations.
  - Consider increasing the staff and space available for health check in order...
to decrease the potential for bottleneck (and provide more privacy).
  o Improve communication between receiving facility and the Mobilization Center with regard to demobilization. Ensure that receiving facility and deployed volunteers know how to contact the appropriate persons for demobilization.

- Information dissemination at the Mobilization Center
  o It would be nice to have a kiosk computer with a loop of information, for briefing volunteers.
  o Consider a brief orientation to arriving volunteers prior to check in to ensure that they understand the objectives of the exercise and the steps they will be asked to take in the Mobilization Center.
  o Ensure that a “group orientation” for all workers in the mobilization center is conducted at the outset.
  o Add “disaster briefing/update” to Mobilization Center activities so that volunteers can be kept informed of the situation.
  o Consider providing arriving volunteers with a printed list of what they should do in the Mobilization Center in order to supplement verbal orientation. This may assist in decreasing confusion and frustration.
  o Consider distributing PsySTART information to volunteers at the Mobilization Center rather than relying on facilities.
  o Provide malpractice material—e.g., FAQ document/handout—at Mobilization Centers.

- Exception handling at a Mobilization Center
  o Add protocol to Mobilization Center operations manual addressing the proper response to identifying a volunteer with a potentially contagious disease.
  o Ensure uniformity in Mobilization Center response to the identification of SUVs and the communications expected when they are identified.
  o Part of the Mobilization Center intake/screening process needs to include handling DHVs who are not properly attired for clinical work, fit for duty, or not arriving with their certifications and identification.

Changes to CORES software should address the following points:

- Review the output of the DHV system in terms of content required on rosters and ensure that rosters are produced appropriately.
- Consider options to encourage more entry of specialty information into the DHV system. Specialty and subspeciality for RNs and physicians/independent practitioners (NP/PA) in particular is needed.
- Ensure that the content of rosters is complete and uniform. If necessary, address roster presentation with vendor. Rosters should include the professional license number.
- Multiple difficulties were encountered with the mission manager in coordinating messaging and management of a multi-location event. These difficulties are being documented and will be sent/discussed with EMSA for further discussion with the vendor.
• Hospitals must have a specialty drop down menu. They need to know more about the specific experience and expertise of volunteers.
• Efforts should continue to press the California EMS Authority to be able to incorporate the volunteer application form into the application and make it printable to allow volunteers to bring the application with them to the hospital site rather than have to fill out applications multiple times.

LAC DHV unit collaboration action items include:
• Facilitated discussion to improve coordination of mutual aid between Surge and MRC units for specific DOM-related improvement items.
• EMS Agency will coordinate with the Department of Public Health using established Countywide procedures for mutual aid requests to refine DHV operations among the various units and MRCs. Consider using the HICS 253 Volunteer Roster or another ICS format.
• Consider exploring an electronic HICS 253 form that can sort volunteers by category.

Demobilization process:
• The demobilization process should be studied more, perhaps by further table top exercises. Specific issues are listed below.
  o This exercise did not fully account for issues such as re-assignment during a deployment.
  o Issues such as having one Mobilization Center or Mobilization Centers apart from the receiving hospitals should be looked at in more detail, to handle demobilization.
  o Other issues that could be addressed include extending volunteer deployment at a facility.
  o Consider developing protocol for demobilization directly from the facility and not requiring a volunteer to return to the Mobilization Center.
• Any changes to the demobilization process will eventually need to be reflected in both the DOM and the Mobilization Center Operations Manual.

Items for healthcare facilities:
• Consider suggesting more focused orientations that clearly outline what is unique or different about a particular facility, including providing maps of the facility to volunteers. Add specific orientation to hospital codes (e.g., colors, etc.)
• Unit personnel—i.e., charge nurses and key staff—should be brought into the process, informed of what to expect from arriving personnel in terms of licensure and capabilities.
• Consider use of a self-report capabilities check list—perhaps completed at Mobilization Center—that can be sent to receiving facility.
• Routinely add security briefing to the facility orientation process.
• Encourage facilities to include in their plan how to address password and other technology issues in order to permit volunteers to do assigned tasks.
• Hospitals need to get used to the idea of bringing in DHVs, including how to
receive and orient volunteers on the units, and identifying which tasks volunteers can do.

DHV Volunteer Management
• Name of volunteer on the roster should be full name used on professional license and not a shortened version. Consider sending communication to registered volunteers to ensure that their name in the DHV system is consistent with their license name.
• Some volunteers still do not have a Surge Unit membership card.
• To the extent possible, encourage enrollment/swearing of DSW at routine events such as trainings, etc. Greater numbers of volunteers who are already sworn may decrease the time and bottleneck associated with this process.
### APPENDIX B: PARTICIPANT FEEDBACK SUMMARY

**Participant Evaluation Forms**

The following feedback was gathered from the Participant Evaluation Form. The seven assessment factors were scored by participants using ratings from 1 to 5, with 1 representing Strongly Disagree and 5 representing Strongly Agree.

Feedback is presented in the table below. Note that although results are sorted by facility, evaluation factors do not necessarily correlate with performance at a given healthcare facility.

Total responses: 165

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<thead>
<tr>
<th>Factor Description</th>
<th>Exercise Overall</th>
<th>PIH</th>
<th>HMN</th>
<th>PLCMSP</th>
<th>CHMC</th>
<th>NH</th>
<th>UCLASM</th>
<th>VFC</th>
<th>EPC</th>
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</thead>
<tbody>
<tr>
<td>The exercise was well structured and organized.</td>
<td>4.13</td>
<td>4.56</td>
<td>4.26</td>
<td>3.57</td>
<td>4.18</td>
<td>4.07</td>
<td>3.25</td>
<td>4.25</td>
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<tr>
<td>The exercise scenario was plausible and realistic.</td>
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<td>4.56</td>
<td>4.26</td>
<td>3.54</td>
<td>4.14</td>
<td>4.14</td>
<td>2.40</td>
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<td>The facilitator(s) was knowledgeable about the material, kept the exercise on target, and was sensitive to group dynamics.</td>
<td>4.31</td>
<td>4.72</td>
<td>4.61</td>
<td>3.86</td>
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<td>3.60</td>
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<td>The Exercise Plan was a valuable tool throughout the exercise.</td>
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<td>4.49</td>
<td>4.26</td>
<td>3.18</td>
<td>4.07</td>
<td>4.40</td>
<td>2.86</td>
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<tr>
<td>The Controller/Evaluator Handbook was a valuable tool throughout the exercise.</td>
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<td>4.44</td>
<td>4.52</td>
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<td>4.12</td>
<td>3.77</td>
<td>2.73</td>
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<tr>
<td>Participation in the exercise was appropriate for someone in my position.</td>
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<td>4.51</td>
<td>4.57</td>
<td>3.93</td>
<td>4.29</td>
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<td>The participants included the right people in terms of level and mix of disciplines.</td>
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<td>4.67</td>
<td>4.35</td>
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</tbody>
</table>

PIH – PIH Health Hospital  (n=43)  
HMN - Henry Mayo Newhall Memorial Hospital  (n=23)  
PLCMSP - Providence Little Company of Mary San Pedro  (n=14)  
CHMC - California Hospital Medical Center  (n=29)  
NH - Northridge Hospital  (n=28)  
UCLASM - Santa Monica/UCLA Medical Center  (n=16)
DHV Survey (online)

All participating volunteers received a link to an online survey following the exercise, as part of a follow-up Thank You message. Of 159 volunteers attending the exercise, 19 responses were received (12%). Note that raw, unedited survey comments are included below.

The following table identifies which facility responding volunteers were deployed to:

<table>
<thead>
<tr>
<th>Facility</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>California Hospital Medical Center</td>
<td>3</td>
</tr>
<tr>
<td>Henry Mayo Newhall Memorial Hospital</td>
<td>5</td>
</tr>
<tr>
<td>Providence Little Company of Mary San Pedro</td>
<td>2</td>
</tr>
<tr>
<td>PIH Hospital</td>
<td>5</td>
</tr>
<tr>
<td>Northridge Hospital Medical Center</td>
<td>1</td>
</tr>
<tr>
<td>Santa Monica - UCLA Medical Center</td>
<td>2</td>
</tr>
<tr>
<td>Venice Family Clinic</td>
<td>1</td>
</tr>
<tr>
<td>Eisner Pediatric Clinic</td>
<td>0</td>
</tr>
<tr>
<td>One of the Mobilization Centers</td>
<td>0</td>
</tr>
</tbody>
</table>

Of those responding, eight were registered nurses, five non-clinical support, and one each physician, NP or PA, CNA, and RCP. Two respondents did not indicate a profession.

For twelve respondents, this was their first DHV activity (summit, exercise, or deployment). For six it was not. One respondent did not know.

Respondents were asked if they received appropriate and timely communication from the county regarding their assignments. Thirteen individuals said “Yes”; six said “No.” The following specific comments were received:

- After I signed up, confirmation of assignment took a long time. I didn’t know until a few days before if the hospital would be using me.
- Assignment was communicated once on site.
- More information regarding the type of disaster drill, scenario, detailed information, etc would be great prior to deployment.

Respondents were also asked “Did you receive appropriate and timely communication from the County regarding deployment and travel information?” Fourteen – nearly 75% – said “Yes.” Five said “No.” The following specific comments were received:

- Address on confirmation email was for Santa Monica/UCLA medical Center and not to the parking lot where the shuttle was waiting.
- Poor inaccurate directions, parking staff did not know where to send me, I was
sent me to the wrong place. I walked all over and took 20 minutes to get to the check in point.

Respondents were asked to rate their satisfaction with the following steps in the deployment process:

- Notification of the exercise
- Confirmation and reporting instructions (where, when to report at the exercise)
- Mobilization Center (check in, orientation, Disaster Service Worker swearing)
- Healthcare facility check in (license check, healthcare facility forms, etc.)
- Your experience at the healthcare facility during the exercise.
- Demobilization and check-out

Satisfaction ratings were “Very satisfied” or “Somewhat satisfied” in each category. Bold face text indicates highest score. Numbers in parentheses represent raw response counts.

<table>
<thead>
<tr>
<th>Step</th>
<th>Very dissatisfied</th>
<th>Somewhat dissatisfied</th>
<th>Neutral</th>
<th>Somewhat satisfied</th>
<th>Very satisfied</th>
<th>Not applicable</th>
<th>Rating Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification of the exercise</td>
<td>17.6% (3)</td>
<td>5.9% (1)</td>
<td>5.9% (1)</td>
<td>11.8% (2)</td>
<td>58.8% (10)</td>
<td>0.0% (0)</td>
<td>17</td>
</tr>
<tr>
<td>Confirmation and reporting instructions (where, when to report at the exercise)</td>
<td>33.3% (6)</td>
<td>5.6% (1)</td>
<td>5.6% (1)</td>
<td>5.6% (1)</td>
<td>50.0% (9)</td>
<td>0.0% (0)</td>
<td>18</td>
</tr>
<tr>
<td>Mobilization Center (check in, orientation, Disaster Service Worker swearing)</td>
<td>10.5% (2)</td>
<td>10.5% (2)</td>
<td>10.5% (2)</td>
<td>31.6% (6)</td>
<td>36.8% (7)</td>
<td>0.0% (0)</td>
<td>19</td>
</tr>
<tr>
<td>Healthcare facility check in (license check, healthcare facility forms, etc.)</td>
<td>16.7% (3)</td>
<td>0.0% (0)</td>
<td>11.1% (2)</td>
<td>38.9% (7)</td>
<td>22.2% (4)</td>
<td>11.1% (2)</td>
<td>18</td>
</tr>
<tr>
<td>Your experience at the healthcare facility during the exercise.</td>
<td>17.6% (3)</td>
<td>11.8% (2)</td>
<td>11.8% (2)</td>
<td>17.6% (3)</td>
<td>41.2% (7)</td>
<td>0.0% (0)</td>
<td>17</td>
</tr>
<tr>
<td>Demobilization and check-out</td>
<td>11.8% (2)</td>
<td>5.9% (1)</td>
<td>11.8% (2)</td>
<td>17.6% (3)</td>
<td>52.9% (9)</td>
<td>0.0% (0)</td>
<td>17</td>
</tr>
</tbody>
</table>

Asked to name the top three strengths observed at the exercise, respondents left these comments:

- Good variety of locations to deploy to. Good transportation services. Relative ease of check-in.
- Volunteers knew where to go with advance notice almost everyone showed up except for 2 people -The hospital assigned parking for the volunteers coming that
day, which points to the Hospital's readiness to engage volunteers and their commitment to make it a priority. -All stations were set up and for the most part worked properly.

- Venice Family Clinic was outstanding in welcoming us & orienting us to the facility. Everyone was most welcoming & informative. These people are really committed to what they do to help the underserved! Dr. Watson was very helpful & informative!

- Your staff learned to check in volunteers Lunch was provided -- I didn't expect it. Hospital staff were gracious and thankful volunteers attended. I thoroughly enjoyed talking with the CMO.

- Paperwork nicely organized. Knew what to expect/where to go from email Everyone pleasant, helpful.

- Organization , variety of healthcare professionals, supplies on hand.

- check in was organized for both County and hospital was organized about their trainings hospital was organized about sending us to the assignments.

- The PIH staff was very well-prepared & organized (Carol was a great MCI leader) The DHV staff was very eager to please and to do the right steps; although, we were all learning for the first experience, everyone was very adaptable/flexible and easy to work with. All county employees & volunteers were serious/hard working/engaged about the importance of this mission.

- Great organization at PIH Strong team at hospital level; it was good to actually be deployed to on-site location Good cooperation between volunteer staff at mobilization center - worked really well together.

- Dedicated and attentive staff. Overall planning was well coordinated Orientation and Debriefing was good.

- It was obvious that someone had done a great deal of preparation for the exercise. There were a few minor details that could use improvement, overall everything went quit well. Improved paperwork ease of check in support of staff.

- The preparedness of the hospital to accept and deploy staff. The efficiency and thorough way that the deployment opportunities are related to volunteers and how information is relayed via multiple mediums.

Asked to name the top three areas for improvement observed at the exercise, respondents left these comments:

- Check that the link for deployment location preferences works. Give the correct address for where to go if different from the healthcare facility. Try to provide license information to receiving facility so that they don't have to ask us again for the same information.

- Preparing the evaluators to know what should be happening and to help guide the volunteer staff not directly but at least answering questions in a constructive way. -Improved communication to make sure all supplies are in place, it is an all-day exercise. Hospital stated they did not receive the exact mix of volunteers they asked for by position.

- Providing a handout/with an agenda on the day of the exercise to volunteers to take advantage of the time while they are sitting around waiting for others to go through the process.
if you set up exclusions from duty, state that BEFORE the deployment! I was
told I didn't qualify because my CXR was from 2011 & not considered current (I'm
+ PPD x 30 years) 2. disorganized 'check in' at SMH-UCLA and too much
waiting!

This April 26th program was great to prepare for registration, the flow of
participants, exposure to chemical contamination procedures, evacuation
exercises. However there were no professional opportunities discussed or
demonstrated.

Improve organization, communication, and directions. 2. Provide training. There
was no training for physicians. 3. Prescreen volunteers. I believe the presence of
physician volunteers at this exercise with the obvious lack of clinical experience,
impaired mobility and cognition may damage DHV credibility. Clinical (RN, MD,
mid-level) providers should be coded as to: A.) current active practice, B.) current
non clinical practice but recent (within 3 years) clinical practice or, C. non clinical
/retired/administrative practice for three or more years.

Floor staff didn't know how to utilize volunteers I didn't know what I was allowed
to do, would be nice if told ahead of time like in the email Thought didn’t need
license if I had surge ID but I still had to go get license number from LA county to
give to Henry Mayo.

Time to activate drill to long, hot wash too short, facility layout was a maze

When we got to the floors there was little time and nothing for us to do. I would
have liked to be presented with some scenario having to do with the disaster.
The orientation info from the hospital might be OK if you were really deploying to
work there for 5 days, however most of that information, hand washing, HIPPA,
cover you sneeze is known to all health care providers and made for a
uninteresting morning. Have us gather in a different area and then get checked in
by the county. To wait in the room, to be told to leave the room to then come
back into the room (always with not enough seating) seemed silly.

More clarity about the mission beforehand (there were mixed messages that
came out in the debrief about what everyone expected). Many thought there
would be more hands on/injury/moulage when receiving the notification. DHV
and then PIH both had two separate packets of information to fill out? Can some
of this be done ahead of time and kept on file? Or can the duplicates be
minimized?

Hand-over from mobilization center to hospital was a little rough - likely because
the mobilization center was in the hospital. The volunteers were split into two
groups - that worked well, but those volunteers in the mobilization center were
sort "lost" - assigned sort of last minute to the hospital setting - likely because the
mobilization center was in the hospital.

Better communication for early arrivals regarding agenda time table. Reception
Area could be located in a more visible area to control traffic flow and answer
basic logistics questions. Emphasize upon arrival that identification will be
required.

Communication as to what to expect of exercise. For example: process of
deployment and check-in.

More information regarding specifics about the scenario prior to deployment so
that we can actually "act" out the exercise.

- Had I known that the intent was to take over Acute care for nurses who had been working for several days, I would have gone up to see my grandkids. That's why I distinctly mentioned that I do not do acute care. I expected to do triage (as a PHN and worker for several true incidents, that would be my expertise). I was shocked to find they had not prepared a triage; then again, I never received documentation telling me this was a 6-day exercise and we were supposedly coming in on the 3rd day.

Asking whether they would recommend the DHV program to colleagues and to provide any other input, respondents left these comments:

- Yes. Organize disaster drills that are more "hands-on". I was disappointed with the exercise at SM-UCLA since it was really just a mock check-in and unit orientation. I was expecting to go through a small scale emergency.
- Yes – I would recommend it to colleagues. I would recommend some snippet videos that give an overview of the program on the website. Some reference material, resources at the end of the exercise on what should have happened that day for each volunteer position, to compare to what actually happened, in order to improve.
- Yes, if the experience has more technical roles for a doctor of pharmacy.
- Please let us know whether the exercise provides any training or honestly portray that the participant is simply filling a seat so the health care facilities and mobilization center staff can experience the process. For this you could use high school kids as placeholders rather than experienced professionals.
- Yes, interesting.
- Yes, but I wonder how many people would be available in a real situation.
- NO- think most of my co-workers just assume they will be at the hospital that they work for in case of a disaster. Also the other branch -MRC- seems to be more active and do more. I wish we could join both. I am thinking of dropping DHV to become MRC.
- Yes. Ongoing training (like the June seminar last year at Long Beach Memorial) would be beneficial.
- Yes, but no one has taken my advice yet!
- Yes. Emphasize to potential volunteers that they will not be first responders but additional or replacement resources for organizations trying to recover from a longer term disaster.
- Yes, and have recommended. During the debriefing there was an disruptive DHV. I didn't agree with her approach nor did I agree with her complaints, but engaging her only wasted time. We are supposed to be professionals. Perhaps coming up with a process to deal with these distractions would be smart.
- Yes. This is a great program and I really appreciate the fact that we have colleagues ready to mobilize not only during the acute period of disasters but during the long haul to help staff with the aftermath and prolonged issues that remain in the recovery period. I am proud to be a member.
- Not without a bit more structure - also remembering this was a first of its kind. I would not be able to suggest this to my colleagues - there was no place for us.
One person mentioned that if we weren't acute care nurses, go someplace else. I would do that. My church is a "safe place" during disasters.
## APPENDIX C: EXERCISE EVENTS SUMMARY TABLE

<table>
<thead>
<tr>
<th>Event #</th>
<th>Event Time</th>
<th>Event Description</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>February 26</td>
<td>“Save the date” notice to relevant volunteers</td>
<td>Receive initial sense of how many volunteers are interested</td>
</tr>
<tr>
<td>2</td>
<td>March 19</td>
<td>Availability request to relevant volunteers; register to participate Ask unit leader to get avail rosters back by March 22 – to Slava and S3</td>
<td>Unit leaders should provide availability list to Slava and Sandra by March 22</td>
</tr>
<tr>
<td>3</td>
<td>March 22</td>
<td>Availability lists received</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>April 8, 8:00 a.m.- 12n</td>
<td><strong>EMS DOC Functional Exercise</strong> Following activities could be completed as part of Functional Exercise, or could occur separately:  - DOC simulates and acknowledges receipt of resource requests  - DOC notifies DHV unit coordinators, Mobilization Center staff, other  - Creation of mission and deployment groups in Mission Manager (DHV system)resources  - Notification of volunteers – polling for availability for Friday 4/26 deployment</td>
<td>These outcomes need to occur, whether as part of EMS DOC Functional Exercise or separately:  - Mission Manager contains relevant mission and deployment groups  - Volunteers receive request for Friday deployment</td>
</tr>
<tr>
<td>5</td>
<td>April 9 – April 11</td>
<td><strong>Volunteer response management</strong>  - Monitor volunteer responses; verify license and qualifications for each as they become available  - Respond to volunteers who become available with a confirmation-of-assignment email and “stand by” for more details  - Create rosters of available volunteers, for each deployment venue  - Confirm rostered volunteers; notify each of their assigned venue  - Send release-of-availability email to volunteers who are not rostered  - Compose and send instructions to rostered volunteers regarding deployment instructions  - Confirmatory phone call to each rostered volunteer</td>
<td>Growing pool of volunteers with appropriate credentials for resource request  - Rosters of available volunteers, one roster per deployment venue  - Confirmation email to each volunteer  - Email releasing those volunteers who responded but are not being deployed  - All volunteers to be deployed receive detailed instructions regarding where, when to report, and related details  - Each rostered volunteer receives automated confirmation call</td>
</tr>
<tr>
<td>6</td>
<td>April 9 – April 11</td>
<td><strong>Mobilization Center planning conference</strong></td>
<td>Completed planning for Mobilization Centers at each of 6 hospitals</td>
</tr>
<tr>
<td>7</td>
<td>April 15 – 18</td>
<td>Complete volunteer response management, detailed above</td>
<td>Completed rosters  - Confirmation and instructions to each rostered volunteer</td>
</tr>
<tr>
<td>Event #</td>
<td>Event Time</td>
<td>Event Description</td>
<td>Outcome</td>
</tr>
<tr>
<td>--------</td>
<td>------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>8</td>
<td>April 15</td>
<td>Healthcare facilities submit resource requests to county</td>
<td>Release of non-rostered volunteers</td>
</tr>
<tr>
<td>9</td>
<td>April 15</td>
<td>Check-in call with VLA regarding Mobilization Center staffing</td>
<td>Review of preparation to deploy six Mobilization Centers</td>
</tr>
<tr>
<td>10</td>
<td>April 22 - 24</td>
<td>Finalize rosters of available volunteers; calls to each volunteer</td>
<td>Final roster of volunteers for each venue</td>
</tr>
<tr>
<td>11</td>
<td>April 24</td>
<td>Send volunteer rosters to each receiving facility</td>
<td>Each receiving facility receives roster of expected volunteers</td>
</tr>
<tr>
<td>12</td>
<td>April 22, 10:00 am – 12n</td>
<td>C/E Briefing</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>April 23</td>
<td>Conference calls with all/each requesting facility to finalize logistics details (parking, point of contact, where to report, etc.)</td>
<td>Finalize all relevant logistics for Friday deployment</td>
</tr>
<tr>
<td>14</td>
<td>April 23</td>
<td>Check-in call with VLA regarding Mobilization Center staffing</td>
<td>Review of preparation to deploy six Mobilization Centers</td>
</tr>
<tr>
<td>15</td>
<td>April 23</td>
<td>Deployment instructions sent to all rostered volunteers</td>
<td>All rostered volunteers receive deployment instructions</td>
</tr>
<tr>
<td>16</td>
<td>April 24</td>
<td>Final QA check on Mobilization Center preparations</td>
<td>Mobilization Centers should have rosters in hardcopy and electronic (USB drive) form for each Center and venue</td>
</tr>
<tr>
<td>17</td>
<td>7:30 am</td>
<td>Controller and evaluator check-in</td>
<td>Check in at DOC and Mobilization Centers</td>
</tr>
<tr>
<td>18</td>
<td>7:30 am</td>
<td>Mobilization Centers set up</td>
<td>Mobilization Centers set up at each of 6 hospitals</td>
</tr>
<tr>
<td>19</td>
<td>7:45 am</td>
<td>Communication check (optional)</td>
<td>Ad hoc</td>
</tr>
<tr>
<td>20</td>
<td>9:00 am</td>
<td>Volunteers report for duty; commence Mobilization Center check-in process</td>
<td>Volunteer check-in at each Mobilization Center</td>
</tr>
<tr>
<td>21</td>
<td>10:00 am</td>
<td>Hand-off of volunteers from County (Mob Ctr) to receiving facilities</td>
<td>Volunteer check-in completed; volunteers sent to healthcare facilities for duty</td>
</tr>
<tr>
<td>22</td>
<td>10:00 am</td>
<td>Receiving facilities begin their volunteer intake process</td>
<td>Volunteer intake at each facility</td>
</tr>
<tr>
<td>23</td>
<td>10:11</td>
<td>Inject A: Volunteer fails medical screening</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>10:17</td>
<td>Inject B: Spontaneous unaffiliated volunteer shows up</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>10:33 am (approx.)</td>
<td>Inject C: Invalid RN license</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>10:00 – 10:30 am</td>
<td>Transport – from Mob Ctr to clinics</td>
<td>Volunteers serving at clinics need to get from Mob Ctr to clinic</td>
</tr>
<tr>
<td>27</td>
<td>11:00 am</td>
<td>Begin individual facility activities with volunteers</td>
<td>4 hours of planned activities with volunteers</td>
</tr>
<tr>
<td>28</td>
<td>1:17 pm</td>
<td>Inject D: Volunteer injured during deployment</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>2:00</td>
<td>Clinics will demob around 2pm; return to Mobilization Center</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>2:30</td>
<td>Notify local demob staff that demob is about to start</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>3:00 pm</td>
<td>Hot wash of volunteers</td>
<td>Hot wash for volunteers, with</td>
</tr>
<tr>
<td>Event #</td>
<td>Event Time</td>
<td>Event Description</td>
<td>Outcome</td>
</tr>
<tr>
<td>---------</td>
<td>------------</td>
<td>-------------------</td>
<td>---------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>healthcare facility staff in attendance</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>3:30 pm</td>
<td>Demobilization of volunteers (may occur earlier at some facilities)</td>
<td>Volunteers checked out at each facility, demobilization completed; collect evaluation forms; volunteers depart</td>
</tr>
<tr>
<td>33</td>
<td>4:00 pm</td>
<td>Hot wash of non-volunteer players</td>
<td>Hot wash for all non-volunteer players, including hospital preceptors/buddies</td>
</tr>
<tr>
<td>34</td>
<td>4:30</td>
<td>Tear-down Mobilization Centers</td>
<td>Collect EEGs and return to Sandra Shields</td>
</tr>
<tr>
<td>35</td>
<td>5:00</td>
<td>Report status to DOC/lead controller</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>May 6 1 – 3pm</td>
<td>Controller / Evaluator Debriefing</td>
<td>Controllers Evaluators Exercise Planning Team</td>
</tr>
</tbody>
</table>
# Appendix D: Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHV</td>
<td>Disaster Healthcare Volunteer system and registry</td>
</tr>
<tr>
<td>DHVs</td>
<td>Individual volunteers registered in the DHV system</td>
</tr>
<tr>
<td>DOC</td>
<td>Department Operations Center</td>
</tr>
<tr>
<td>DPH</td>
<td>Department of Public Health</td>
</tr>
<tr>
<td>DSW</td>
<td>Disaster Service Worker</td>
</tr>
<tr>
<td>ECL</td>
<td>Emergency Credential Level</td>
</tr>
<tr>
<td>EMS Agency</td>
<td>Emergency Medical Services Agency</td>
</tr>
<tr>
<td>ESAR-VHP</td>
<td>Emergency System for the Advanced Registration of Volunteer Health Professionals</td>
</tr>
<tr>
<td>FOUO</td>
<td>For Official Use Only</td>
</tr>
<tr>
<td>HICS</td>
<td>Hospital Incident Command System</td>
</tr>
<tr>
<td>ICS</td>
<td>Incident Command System</td>
</tr>
<tr>
<td>LAC</td>
<td>Los Angeles County</td>
</tr>
<tr>
<td>MHOAC</td>
<td>Medical Health Operational Area Coordinator</td>
</tr>
<tr>
<td>MRC</td>
<td>Medical Reserve Corps</td>
</tr>
<tr>
<td>PIH</td>
<td>PIH Health Hospital</td>
</tr>
<tr>
<td>SUV</td>
<td>Spontaneous Unaffiliated Volunteer</td>
</tr>
<tr>
<td>VLA</td>
<td>Volunteer Los Angeles</td>
</tr>
</tbody>
</table>