

Guidebook for 2009 Statewide Medical and Health Functional Exercise



California Emergency Medical Services Authority • California Primary Care Association
California Association of Health Facilities • California Hospital Association

Table of Contents

I	Planning the 2009 Statewide Medical and Health Functional Exercise	4
II	The Exercise Guidebook	5
III	Developing and Conducting the 2009 Statewide Medical and Health Functional Exercise	7
	▪ Coordinated Incident Action Planning	8
	▪ Assumptions in Exercise Planning and Conduct	10
IV	Exercise Objectives	13
	▪ Exercise Objectives by Discipline	
	○ Hospitals	13
	○ Local Health Departments	14
	○ Community Care Clinics	15
	○ Long Term Care Facilities	16
	○ Law Enforcement	16
	○ EMS Providers	17
	○ Local EMS Agencies	18
	○ Medical Examiners/Coroners	19
	○ Community Organizations	19
	○ Emergency Management	20
	▪ The Joint Commission: Emergency Management	20
	▪ NIMS Implementation Activities for Hospitals	24
V	Exercise Scenario	26
	▪ Pre-Event Information	26
	▪ Background: January to June 2009	26
	▪ Exercise Begins: June 18, 2009	31
	▪ Master Sequence of Events List (MSEL)	43

VI	Exercise Evaluation	57
	▪ Using the Exercise Evaluation Guides (EEG)	57
	▪ EEG: Communications	62
	▪ EEG: Intelligence/Information Sharing and Dissemination	72 79
	▪ EEG: Medical Surge	
VII	Appendices to the Guidebook	
	A Intent to Participate Form	91
	B Operational Area Participation Form	92
	C WHO and CDC Pandemic Phases	93
	D FAQ about Pandemic Influenza	95
	E Local Health Department Exercise Leads	97
	F Acronyms	103
	G Resources	105
VIII	Attachments *	
	1. CalEMA Daily Situation Report	
	2. Hospital Incident Action Plan	
	3. Risk Communication Tools	
	4. California Disaster Proclamation	

*** Attachments are contained in a separate file folder on the CD.**

I: Planning the 2009 Statewide Medical and Health Functional Exercise

Expanding the Continuum of Care during a Pandemic Influenza Surge

This guidebook provides guidance for local entities and communities participating in the 2009 Statewide Medical and Health functional exercise, which addresses expanding the continuum of care during a pandemic influenza.

This exercise has been developed by the California Department of Public Health (CDPH) in collaboration with the California Emergency Medical Services (EMS) Authority, the California Hospital Association, the California Primary Care Association, the California Association of Health Facilities and representatives from local health departments and healthcare, public safety and emergency management disciplines.

The exercise is the fourth and final phase of a year-long training and exercise program that focuses on communications, patient movement across the continuum of care, and identification and management of critical information and scarce resources during a pandemic influenza in California. The first three phases – the Satellite Broadcast, the Gap Analysis and the local facilitated Tabletop Exercises – were developed to identify issues in planning for and response to a pandemic influenza while providing the opportunity for coordination of response partners in each Operational Area (OA).

The 2009 Statewide Medical and Health functional exercise builds on the first three phases while establishing overarching objectives that are compliant with the federal Homeland Security Exercise and Evaluation Program (HSEEP). The exercise is based on three Homeland Security Target Capabilities that address the objectives for the exercise: Communications, Intelligence/Information Sharing and Dissemination, and Medical Surge. The exercise is designed to enhance coordination and provide opportunities for integrated planning among a variety of response partners at the OA level.

This Guidebook provides tools for planning and conducting the exercise according to HSEEP requirements in order to meet the goals, objectives, and Target Capabilities identified by each OA. The Guidebook addresses ten disciplines [local health departments, hospitals, long term care facilities, clinics, law enforcement, EMS providers, coroners/medical examiners, emergency management, community-based organizations, and local government] that would be affected by an influenza pandemic. Objectives for each discipline are grouped by the three Target Capabilities used in this exercise. Although the Guidebook provides a complete functional exercise, it also allows local flexibility in modifying the exercise conduct for level, length, and scope of participants.

II: The Exercise Guidebook

This Exercise Guidebook is divided into sections to provide easier access to the materials and direct planners to information appropriate to their individual needs.

Section I of the Guidebook offers a review to the phased approach to the development of the 2009 Statewide Medical and Health Functional Exercise and lays the foundation for the functional exercise.

Section II reviews the components of the Guidebook, while **Section III** provides recommendations and tips for planning and conducting the exercise, including issues related to collaborative planning. Also contained in **Section III** is a discussion of exercise artificialities consistent in exercise design, including simulated messaging and compression of the timeframe.

Section IV of the Guidebook identifies both general and discipline-specific objectives for this exercise. Individual agencies participating in the exercise may choose those objectives they wish to test. Discipline-specific objectives that reflect the three Target Capabilities of Communications, Intelligence/Information Sharing and Dissemination, and Medical Surge are noted. The Joint Commission (TJC) Accreditation Standards from the Emergency Management Chapter and the National Incident Management System (NIMS) implementation objectives for healthcare organizations are also described in this section.

Section V contains the exercise scenario. The background information covers the events as outlined in the tabletop exercise scenario and proceeds into scenario events from April 2009 to June 2009. The scenario is delineated both in a narrative and Master Sequence of Events Lists (MSEL) formats. The MSEL should be customized for local use to assist Controllers in tracking activities and ensuring the exercise play is on schedule. Additional tasks and activities can be added to the MSEL at the OA level, addressing the specific objectives to be tested and evaluated.

The exercise has been developed for conduct of play from 0800 – 1400 hours on June 18, 2009. OAs and their individual participating entities may decide to play longer or shorter within the exercise timeframe.

Section VI addresses the evaluation of the exercise. The Target Capabilities, activities and tasks are used to both develop and evaluate the exercise. Exercise Evaluation Guides (EEG), using the HSEEP format, reflect the three target capabilities with individual activities and tasks to assess compliance. The EEGs may be customized within the OA or by individual entities based on unique needs and depth of play. For example, if the OA chooses to activate local volunteer services to assist hospitals and other healthcare providers, this activity can be identified in the Medical Surge Target Capability.

Section VII contains the Appendices or documents that support the exercise development and conduct. These include the OA contacts for exercise planning, the *Intent to Participate* forms for agencies and organizations, an acronym list, resources used in the development of the exercise, and background information on Pandemic Influenza.

Attachments

Attachments to the Guidebook can be found on the CD-ROM as a separate folder. Planners are encouraged to use the attachments for both educational purposes and to heighten exercise play.

III. Developing and Conducting the 2009 Statewide Medical and Health Functional Exercise

The 2009 Statewide Medical and Health Functional Exercise is designed to include the many response partners and agencies necessary in the coordinated response to an influenza pandemic. These include, though are not limited, to:

- Hospitals
- Local Health Departments
- Long Term Care Facilities
- Clinics
- Law Enforcement
- EMS Providers
- Local EMS Agencies (LEMSA)
- Medical Examiner/Coroner
- Community-based Organizations
- Environmental Health Agencies
- Office of Emergency Management

Additional agencies and/or organizations that may be engaged in the development and execution of the exercise include private partners in business and service organizations; local government; 911 Dispatch Centers; information centers within the OA (e.g., 211 services); volunteer organizations; schools; and physician's offices.

The impact of an influenza pandemic will manifest across the entire healthcare and emergency response community. In some cases, exercises are developed and conducted with only a portion of the organization participating; in this scenario, all sections of the hospital, local health department, clinic or long term care facility will feel the impact of increased demand for services while there is a marked decrease in available personnel, supplies and equipment. For public safety agencies, the impact of decreased personnel will necessitate critical thinking for the continued provision of essential services. As first addressed in the gap analysis and discussed in the tabletop exercise, issues for discussion at individual agencies and facilities as well as within the community may include:

- What are the essential services of the facility / agency / organization?
- What services can be postponed or rescheduled? For how long?
- Can any services provided by the organization be assumed by a partner organization?
- How will the impact of personnel shortages at partner response organizations impact our services?
- Who is missing from the planning and conduct of the exercise that may have resources that can be used to support essential operations?

Within the exercise scenario, the opportunity to determine the impact of the pandemic on the OA is provided as two options (see page 30). In option 1, there is a large number of persons who have become ill and a large number of fatalities. In option 2, there is a significantly lesser

impact. Prior to the exercise, community-wide planning coordinated by the Local Exercise Lead should discuss the impact and determine the best scenario to be used in the exercise.

In Section IV, a comprehensive list of exercise objectives is provided for all participating disciplines. These objectives are sectioned to align with the three Target Capabilities identified for this exercise: Communications, Intelligence/Information Sharing and Dissemination, and Medical Surge. Participants may choose which objectives they will use to develop their individual exercise play and evaluation. For example, a community clinic may choose to assess their ability to expand patient capacity by utilizing non-traditional patient care areas within the facility (Objective J) but choose not to determine their ability to assist other clinics within the OA (Objective L).

The Emergency Management Standards within TJC 2009 accreditation guidance may also be used to develop and customize the exercise. Exercise planners should review the standards outlined in Section IV, and also the complete Emergency Management Chapter of the 2009 accreditation guidance for additional elements that can be addressed in the exercise planning and conduct, as well as elements needed to demonstrate compliance. For healthcare organizations tracking compliance with NIMS, the elements of compliance relative to this exercise can be found in Section IV.

Coordination of Incident Action Planning

In planning for the exercise, participants are encouraged to work with the local health department and emergency management officials to review roles and responsibilities in an influenza pandemic. Discussions may include how intelligence and information is shared, reporting guidelines, timelines and technology, and the activation and utilization of a Joint Information System (JIS)¹. The gathering and validation of information and intelligence is critical to Incident Action Planning; development of a coordinated Incident Action Plan (IAP) should be addressed in the exercise development stage. Organizations should determine:

- Who participates in the IAP development?
- How is it shared with response organizations?
- How are changes to the overall plan shared?
- Who sets the operational period?

The IAP lays the foundation for coordinated decision making; requesting and acquiring resources; and developing coordinated messages with subject matter experts as well as authorities.

An IAP template for hospitals, with the ability to customize the information with hospital and OA specific information and status, is included as Attachment 2.

¹ A Joint Information System (JIS) provides the mechanism to organize, integrate, and coordinate information to ensure timely, accurate, accessible, and consistent messaging across multiple jurisdictions and/or disciplines with nongovernmental organizations and the private sector. A JIS includes the plans, protocols, procedures, and structures used to provide public information

All messages should begin and end with “this is an exercise.” All forms, correspondence, messages, and any other documentation generated within the exercise planning and conduct should be clearly marked as exercise documents. At the conclusion of the exercise, all documentation should be collected for review and incorporation in the after action review (AAR) process.

Exercise safety should be considered at all times for agencies or facilities using volunteers or staff to simulate the role of patients. Simulators should be briefed on the exercise scenario, their individual roles, their contact(s) in case of questions or concerns and how to halt their participation in exercise play if necessary. As with all exercises, a Safety Officer should be designated to oversee operations. The Safety Officer has the ultimate approval of exercise conduct and operations and may temporarily suspend or halt exercise play for unsafe conditions.

The utilization of volunteers for this exercise is at the discretion of the participants within each OA. Volunteers may be used, for example, to simulate an influx of patients to the hospital or healthcare agency, as residents contacting the LHD or 211 information services, or as residents seeking antiviral medicines or flu shots.

A major component of the exercise is the continued provision of essential services. Activation of the Continuity of Operations Plan (COOP) within the OA, as well as the participant’s business continuity plan, should be considered in the exercise. The exercise provides the opportunity for sharing the components of the COOP, necessary to maintain services during a prolonged event.

Participating agencies should be active in planning the exercise, ensuring their individual needs, capabilities and resources are included and/or addressed. As previously mentioned the hours of exercise conduct are the decision of the agency or organization but should be considered as part of the entire exercise within the OA. Because the exercise scenario of influenza pandemic occurs over several months, participants may also elect to test or exercise components of their response system prior to June 18. Some examples of ways in which activities can be conducted prior to the exercise on June 18 are:

- test how health alerts are shared within the facility among employees and stakeholders,
- determination of the escalating impact of the pandemic as outlined in the scenario, and
- development of IAP for operational periods prior to June 18.

The 2009 Intent to Participate form will be disseminated by the Local Exercise Leads (see Appendix E) or may be downloaded as part of the Exercise Guidebook. Participating agencies and organizations shall complete and return the form to the OA contact no later than May 1, 2009. A summary of participants from each OA will then be sent to the CDPH Emergency Preparedness Office.

Attachments to this Guidebook may be used to augment play and promote realism in the scenario. These include:

Attachment 1: Cal EMA Situation Report

The California Emergency Management Agency (CalEMA) prepares and disseminates a daily report of critical actions, issues and directives for use by state, regional and local emergency management officials. The CalEMA report contained in the Guidebook serves as both a summary document of the scenario for this exercise and an educational tool for emergency planners across all levels of response.

Attachment 2: Hospital Incident Action Plan

Incident Action Planning at the hospital level is provided as an example in Attachment 2. The forms used are from the Hospital Incident Command System (HICS) tool kit. The objectives listed for the operational period are taken from the HICS Incident Response Guide (IRG) for Pandemic Influenza. A sample IAP is provided, along with blank forms that can be used by hospitals to develop and customize their own IAP for the exercise. All HICS forms and the IRG may also be downloaded from the California EMS Authority web site (see Appendix G: Resources).

Attachment 3: Risk Communications

CDPH has developed a risk communications plan for emergency response (see Appendix G: Resources), which can also be found in the CDPH Crisis and Emergency Risk Communications (CERC) Tool Kit. For this exercise, Attachment 3 contains the following communications-related materials: Key Messages, Questions and Answers, Fact Sheet and a Pocket Guide. In addition, video messages have been produced to augment exercise reality, including an interview with Dr. Mark Horton, State Health Officer.

Attachment 4: State of California Disaster Proclamation

Attachment 4 is a simulated Disaster Proclamation for this exercise.

Assumptions in Exercise Planning and Conduct

This exercise is based on the following assumptions:

1. Identification of Target Capabilities to guide exercise scenario development

In order to provide HSEEP compliance points and provide a standardized methodology and terminology for exercise design, development, conduct, evaluation, and improvement planning, the Exercise Workgroup identified three Target Capabilities to address and evaluate in this exercise. These are:

- Communications,
- Intelligence /Information Sharing and Dissemination, and
- Medical Surge

These three Target Capabilities provide a foundation for development of the scenario, first in the tabletop exercise then progressing into the functional exercise. It is acknowledged that the three Target Capabilities may not be applicable to all disciplines; for example, community based organizations may choose not to address the target

capability medical surge. Customization of the exercise at the OA and individual participant level may include the incorporation of additional Target Capabilities.

Each of the three Target Capabilities is further broken into Activities and Tasks, which serve two purposes: 1) planning the level of play and 2) evaluating the exercise. The Capability, Activity and Task (CAT) offer a list of action items that can be used in the exercise to stimulate play and discussion. The CAT format is identified in the EEG, providing a link to exercise play. The EEG is HSEEP compliant.

2. Identification of an exercise starting point that does not begin with the onset of an event

The exercise begins with the scenario timeline as laid out in the tabletop exercise. This allows for pre-exercise strategic planning at the OA level by identifying both strengths and gaps in response. Individual participants are given the opportunity to determine the level of impact resulting from an influenza pandemic. For example, an individual OA or participating agency may choose to simulate a 5% reduction in available workforce due to illness; or a 10% increase in patients seeking medical evaluation. These are highlighted as options in the exercise scenario. In planning the exercise, coordinated decisions within the OA should be made to determine the level (percentage) of impact that will best test the system and the participants.

The exercise scenario includes issues and discussion points allowing the participating agency or facility to conduct internal discussions on issues such as gathering situational information, impact on resources and shortages in resupply, medical guidance on patient care or laboratory testing. This is in contrast to past exercises which have required a more definitive action to an issue or “inject” into the scenario.

3. Compression of the exercise timeframe with pre-exercise actions, activities and decisions

The timeframe of the exercise will be compressed to allow for coordinated decision making, insertion of key issues, communication and messaging, and resource requesting within the exercise conduct timeframe. Due to the phased approach of this exercise, identification of impact (e.g., personnel shortages, patient numbers, availability of supplies and equipment among others) may be made prior to the start of the exercise, allowing this (simulated) information to be shared with response partners as well as regional and state authorities during the exercise. For example, an individual EMS provider may, for exercise play, determine that there is a 10% decrease of personnel or only a one day supply of N95 masks available. By determining these numbers prior to the exercise conduct on June 18, this information can be readily communicated to the Medical and Health Operational Area Coordinator (MHOAC).

4. Simulated risk communication messaging

CDPH has developed template risk communication messages for use by local health departments in a pandemic influenza which are available in Attachment 3. Additional messages may be developed and disseminated during the exercise. Exercise planners and participants are not required to use the templates; these are provided as tools to facilitate exercise conduct (see Attachment 3).

5. Designation of the 2009 Statewide Medical and Health Exercise as a functional exercise

There are seven types of exercises defined within HSEEP, each of which is either discussion based or operations based. Discussion based exercises familiarize participants with current plans, policies, agreements, and procedures or may be used in development. Discussion based exercises include seminars, workshops, tabletop exercises and games.

Operations based exercises validate plans, policies and agreements, clarify roles and responsibilities and identify resource gaps in an operational environment. These include drills, functional exercises, and full scale exercises. The 2009 Statewide Medical and Health Functional Exercise is developed as a functional exercise which examines and/or validates the coordination, command, and control between various multi-agency coordination centers but does not involve any “boots on the ground.” Further information on exercise design can be found in the HSEEP Toolkit at https://hseep/dhs.gov/support/HSEEP_101.pdf. Participants may also want to review the CDPH HSEEP Guidance document available on the Statewide Exercise page at <http://www.mycdlhn.com>.

NOTE: While the 2009 Statewide Medical and Health Functional Exercise has been developed based on the three Target Capabilities with a focus on coordinated response, individual participants are not precluded from “boots on the ground” exercise play. This level of play should be coordinated and developed at the OA level.

6. Exercise scenario development created for the disciplines targeted in the Gap Analysis

In the development of the Gap Analysis, core disciplines within the overall response structure were identified: hospitals, local health departments, clinics, long term care facilities, law enforcement, EMS Providers, Local EMS Agencies, Emergency Management, Medical Examiner/Coroner and Community Based Organizations. The development and conduct of the functional exercise is not restricted to those identified. While the Gap Analysis laid out discipline specific issues, the tabletop exercise provided the opportunity to identify other partners within the Operational Area who may play a role in the overall response. These agencies and organizations may include volunteer organizations, private businesses, government agencies and others.

IV. Exercise Objectives

The exercise objectives for each of the 10 disciplines identified as planning and response partners in the scenario are listed below. Individual OAs and participants may determine which objectives to use in exercise planning and conduct, based on level of preparedness, level and time of exercise play. Individual agencies/organizations may develop additional objectives.

Exercise Objectives by Discipline

When applicable, the objectives for each agency/organization are classified within the three Target Capabilities identified for this exercise.

1. Acute Care Facility/Hospital

Target Capability: Communications

- A. Assess the facility's ability to communicate with response partners including LHDs, other healthcare entities, law enforcement, EMS Providers, community organizations and emergency management.
- B. Test the plans and technology for gathering intelligence and sharing information with external response partners, such as LHD and emergency management authorities.

Target Capability: Intelligence/Information Sharing and Dissemination

- C. Test the plans and technology for gathering intelligence and sharing information with staff, patients and visitors.
- D. Develop IAPs within the incident management structure of the facility; coordinate with other healthcare and emergency management partners.
- E. Activate information management plans and develop public information messages in coordination with local authorities (JIS) and other healthcare providers in a rapid and timely manner for internal (current patients, staff, volunteers, physicians, visitors) and external (media, community) dissemination.
- F. Communicate facility needs to outside sources (e.g., vendors, suppliers, EMS, city / OA, corporate healthcare system) for essential supplies, services, and equipment to ensure integrity of resource supply chain. Note: the California Medical Mutual Aid Plan in accordance with the Standardized Emergency Management System requires resource requests that cannot be obtained through normal mechanisms to be submitted to the OA Emergency Operations Center.
- G. Provide situational status and projected impact on service provision with local authorities.

Target Capability: Medical Surge

- H. Activate the Emergency Operations Plan and Pandemic Influenza Plan, where developed.
- I. Assess the need to expand the hospital incident management team structure due to increased shortages of personnel and resources and patient surge.

- J. Activate and test facility surge plans to expand capacity and manage a large influx of patients in an infectious disease event.
- K. Test the ability to move patients across the continuum of care, including government-authorized alternate care sites, long term care facilities, and homes.
- L. Activate and test plans to respond to a fatality surge, integrating with OA resources from the Medical Examiner/Coroner coordinated through the OA Emergency Operations Center.
- M. Expand and augment personnel resources, including the use of volunteers and community resources, during a prolonged surge event between 96 hours and seven days.
- N. Prioritize, manage, and allocate resources, especially scarce resources (e.g., ventilators, isolation capacity, personal protective equipment, critical care beds, pharmaceuticals) during an infectious surge event.
- O. Test the ability of the facility to maintain security during patient surge events.

2. Local Health Departments

Target Capability: Communications

- A. Assess the ability to communicate with response partners including healthcare entities, law enforcement, community organizations and emergency management.
- B. Test the plans and technology for gathering intelligence and sharing information with external response partners, local health departments and emergency management authorities.
- C. Test the statewide Disaster Health Volunteer (DHV) two-way communication alert systems from JEOC to local DHV administrator (MHOAC).

Target Capability: Intelligence/Information Sharing and Dissemination

- D. Test the plans and technology for gathering intelligence and sharing information with employees.
- E. Participate in Incident Action Planning coordinated through the OA Emergency Operations Center, and/or Department Operations Center.
- F. Activate information management plans and develop public information messages in coordination with local authorities (OA JIS) as well as other healthcare providers in a rapid and timely manner for internal and external (e.g., media, community) dissemination.
- G. Provide situational status and projected impact on service provision with local authorities.

Target Capability: Medical Surge

- H. Activate the Emergency Operations Plan and Pandemic Influenza Plan, where developed.

- I. Assess the need for and activate expansion of the incident management team structure due to increase shortages of personnel and resources.
- J. Activate internal personnel surge plans to deal with increased need to respond to public health, laboratory, epidemiology and medical guidance issues.
- K. Request activations of government-authorized alternate care sites.

3. Community Care Clinic/Medical Clinic

Target Capability: Communications

- A. Assess the facility's ability to communicate with response partners including LHDs, other healthcare entities, law enforcement, community organizations and emergency management.
- B. Demonstrate the ability to communicate needs to outside sources (e.g., vendors, suppliers, EMS, city/OA stockpiles, corporate healthcare system) for essential supplies, services, and equipment to ensure integrity of resource supply chain.

Target Capability: Intelligence/Information Sharing and Dissemination

- C. Test the plans and technology for gathering intelligence and sharing information with external response partners including local health departments and emergency management authorities.
- D. Test the plans and technology for gathering intelligence and sharing information with employees, and patients.
- E. Develop IAPs within the incident management structure of the facility; coordinate with other healthcare and emergency management partners.
- F. Activate information management plans and develop public information messages in coordination with local authorities (OA JIS) and other healthcare providers in a rapid and timely manner for internal (current patients, staff, volunteers, physicians, visitors) and external (e.g., media, community) dissemination.
- G. Provide situational status and projected impact on service provision to local authorities.

Target Capability: Medical Surge

- H. Activate the Emergency Operations Plan and Pandemic Influenza Plan, where developed.
- I. Assess the need for and activate expansion of the incident management team structure due to increase shortages of personnel and resources and patient surge.
- J. Assess the ability of the clinic to expand patient capacity by utilizing non-traditional patient care areas within the facility (e.g., office space, conference rooms) for the triage and treatment of patients and/or acute care hospital transfers.
- K. Assess the ability to prioritize, manage and allocate resources, especially scarce resources (e.g., isolation capacity, personal protective equipment, pharmaceuticals) during an infectious surge event.

- L. Determine ability to assist other clinics and healthcare providers in the OA with personnel and equipment resources.
- M. Assess the ability to secure the facility and grounds to protect staff, volunteers, physicians, patients, visitors and assets, considering lockdown or closure of the facility.

4. Long Term Care Facilities

Target Capability: Communications

- A. Assess the facility's ability to communicate with response partners including local health departments, other healthcare entities, law enforcement, community organizations and emergency management.

Target Capability: Intelligence/Information Sharing and Dissemination

- B. Test the plans and technology for gathering intelligence and sharing information with external response partners, health department and emergency management authorities.
- C. Test the plans and technology for gathering intelligence and sharing information with employees, patients and visitors.
- D. Develop IAPs within the incident management structure of the facility and in coordination with other healthcare and emergency management partners.
- E. Activate information management plans and develop public information messages in coordination with local authorities (OA JIS) and other healthcare providers in a rapid and timely manner for internal (current patients, staff, volunteers, physicians, visitors) and external (media, others) dissemination.
- F. Provide situational status and projected impact on service provision with local authorities.

Target Capability: Medical Surge

- G. Activate the Emergency Operations Plan and Pandemic Influenza Plan, where developed.
- H. Determine the ability to expand the incident management team structure due to increase shortages of personnel and resources and patient surge.
- I. Test the ability to move patients across the continuum of care including government-authorized alternate care sites and homes.
- J. Test the ability to increase the level of patient care when movement to hospitals is delayed.
- K. Test the ability to restrict entry into the facility to prevent exposure and/or spread of influenza virus.

5. Law Enforcement

Target Capability: Communications

- A. Communicate with response partners including local health departments, EMS Providers, healthcare organizations, fire department and emergency management.
- B. Test the communication links to the law enforcement mutual aid coordinator for the OA.

Target Capability: Intelligence/Information Sharing and Dissemination

- C. Test the plans and technology for gathering intelligence and sharing information with external response partners including health department and emergency management authorities.
- D. Test the plans and technology for gathering intelligence and sharing information with employees.
- E. Develop IAPs within the incident management structure of the facility and in coordination with healthcare and emergency management authorities.
- F. Provide situational status and projected impact on service provision with local authorities.

Additional Objectives

- G. Activate the Emergency Operations Plan and Pandemic Influenza Plan, where developed.
- H. Identify services which can be postponed or suspended to increase public safety staff.
- I. Identify additional sources of manpower that can be activated to increase resources.

6. Emergency Medical Services Providers/Ambulance Providers

Target Capability: Communications

- A. Assess the provider's ability to communicate with response partners including local health departments, other EMS Providers, healthcare entities, law enforcement, community organizations and emergency management.
- B. Establish communications with the OA medical and health point of contact for guidance and protocols on response activities.

Target Capability: Intelligence/Information Sharing and Dissemination

- C. Test the plans and technology for gathering intelligence and sharing information with external response partners including local health departments and emergency management authorities.
- D. Test the plans and technology for gathering intelligence and sharing information with employees
- E. Participate in the development of IAPs within the incident management structure; coordinate with other healthcare and emergency management partners.
- F. Determine the ability to share resource capability and resource needs with the MHOAC.
- G. Provide situational status and projected impact on service provision with local authorities.

- H. Activate the Emergency Operations Plan and Pandemic Influenza Plan, where developed.
- I. Assess the ability to manage transportation of infectious patients, including infection control measures.
- J. Assess the ability to sustain, maximize, and augment EMS staffing during a surge event.
- K. Determine the ability to provide personnel and equipment to staff and support government-authorized alternate care sites.

7. Local EMS Agency

Target Capability: Communications

- A. Assess the LEMSA's ability to communicate with response partners including local health departments, EMS Providers, healthcare entities, law enforcement, community organizations and emergency management.
- B. Establish communications for EMS system management on response activities.
- C. Test the statewide Disaster Health Volunteer (DHV) two-way communication alert systems from JEOC to local DHV administrator (MHOAC)

Target Capability: Intelligence/Information Sharing and Dissemination

- D. Test the plans and technology for gathering intelligence and sharing information with external response partners including health department and emergency management authorities.
- E. Test the plans and technology for gathering intelligence and sharing information with staff.
- F. Participate in the development of IAPs within the incident management structure; coordinate with other healthcare and emergency management partners.
- G. Determine the ability to share resource capability and resource needs with the MHOAC.
- H. Provide situational status and projected impact on service provision with local authorities.

Target Capability: Medical Surge

- I. Activate the Emergency Operations Plan and Pandemic Influenza Plan, where developed.
- J. Assess the ability to manage transportation of infectious patients, including infection control measures.
- K. Assess the ability to sustain, maximize, and augment EMS staffing during a surge event.
- L. Determine the ability to provide personnel and equipment to staff and support government-authorized alternate care sites.

8. Medical Examiner/Coroner

Target Capability: Communications

- A. Assess the ability to communicate with response partners including local health departments, healthcare entities, law enforcement, and emergency management as well as private sector mortuary services
- B. Establish communications with the OA medical and health point of contact and OA law enforcement mutual aid coordinator.

Target Capability: Intelligence/Information Sharing and Dissemination

- C. Test the plans and technology for gathering intelligence and sharing information with external response partners including health department and emergency management authorities.
- D. Test the plans and technology for gathering intelligence and sharing information with staff.
- E. Develop IAPs within the incident management structure; coordinate with healthcare and emergency management partners.
- F. Provide situational status and projected impact on service provision with local authorities.

Additional Objectives

- G. Activate the Emergency Operations Plan and Pandemic Influenza Plan, where developed.
- H. Activate the mass fatality plan to respond to surge due to infectious disease and pandemic influenza.

9. Community Organizations

Target Capability: Communications

- A. Assess the organization's ability to communicate with response partners including LHDs, healthcare entities, law enforcement, other community organizations and emergency management.

Target Capability: Intelligence/Information Sharing and Dissemination

- B. Test the plans and technology for gathering intelligence and sharing information with external response partners including local health department and emergency management authorities.
- C. Test the plans and technology for gathering intelligence and sharing information with staff and clients.
- D. Provide situational status and projected impact on service provision with local authorities.

Additional Objectives

- E. Activate the Emergency Operations Plan and Pandemic Influenza Plan, where developed.
- F. Identify those services provided by the organization which can be postponed, consolidated or reassigned to partner organizations due to resources shortages (including organization and volunteer personnel).

10. Emergency Management

Target Capability: Communications

- A. Test the plans and technology for gathering intelligence and sharing information with external response partners, such as local health departments and emergency management authorities.
- B. Initiate JIS plans and technology for development and dissemination of coordinated messages to the media and public.

Target Capability: Intelligence/Information Sharing and Dissemination

- C. Assess the need to expand the incident management structure based on situation assessment, projected impact and anticipated length of activation.
- D. Initiate ongoing incident action planning with response partners, utilizing situational assessment and projected impact.
- E. Activate information gathering for entry into Response Information Management System (RIMS) and information sharing with Regional Emergency Operations Center.

Additional Objectives

- F. Activate the Emergency Operations Plan, and Pandemic Influenza Plan, where applicable.
- G. Assist in the procurement and allocation of scarce resources using the California Mutual Aid Plan.
- H. Assist in the identification of essential services for the OA, ensuring the sharing of information with response partners, local government and the public.
- I. Activate government-authorized alternate care sites according to the policy and plans of the OA.
- J. Activate mutual aid systems and resource requesting to support government authorities alternate care sites within the OA.
- K. Track and record all costs and expenditures related to the event, and project ongoing costs for the next 48, 72 and 96 hours.

The Joint Commission: Emergency Management

Beginning in 2009, TJC Accreditation Program for Hospitals includes a stand alone chapter on Emergency Management (EM). The Standards and Elements of Performance applicable to the

three core Target Capabilities: Communications, Intelligence/ Information Sharing and Dissemination and Medical Surge, are listed below. Individual hospitals wishing to demonstrate compliance with additional Standards and Elements of Performance (EP) may include these in their individual planning and customization of the exercise.

Standard EM 02.02.01

As part of its Emergency Operations Plan, the organization/hospital prepared for how it will communicate during emergencies.

Elements of Performance for EM.02.02.01. The Emergency Operations Plan describes the following:

EP1: How staff will be notified that emergency response procedures have been initiated.

EP2: How the hospital will communicate information and instructions to its staff and Licensed Independent Practitioners during an emergency.

EP3: How the hospital will notify external authorities that emergency response measures have been initiated.

EP4: How the hospital will communicate with external authorities during an emergency.

EP5: How the hospital will communicate with patients and their families, including how it will notify families when patients are relocated to alternate care sites.

EP6: How the hospital will communicate with the community or the media during an emergency.

EP7: How the hospital will communicate with purveyors of essential supplies, services, and equipment during an emergency.

EP8: How the hospital will communicate with other healthcare organizations in its contiguous geographic area regarding the essential elements of their respective command structures.

EP9: How the hospital will communicate with other healthcare organizations in its contiguous geographic area regarding the essential elements of their respective command centers.

EP10: How the hospital will communicate with other healthcare organization in its contiguous geographic area regarding the resources and assets that can be shared in an emergency response.

EP14: The hospital establishes backup systems and technologies for the communication activities identified in EM 02.02.01, EPs 1-9.

Standard EM.02.02.03

As part of its Emergency Operations Plan, the organization/hospital prepares for how it will manage resources and assets during an emergency.

Elements of Performance for EM.02.02.03. The Emergency Operations Plan describes the following:

EP2: How the hospital will obtain and replenish medical supplies that will be required throughout the response and recovery phases of an emergency, including personal protective equipment where required.

EP3: How the hospital will obtain and replenish non-medical supplies that will be required throughout the response and recovery phases of an emergency.

EP4: How the hospital will share resources and assets with other healthcare organization within the community if necessary.

EP5: How the hospital will share resources and assets with other healthcare organizations outside the community, if necessary, in the event of a regional or prolonged disaster.

EP6: How the hospital will monitor quantities of its resources and assets during an emergency.

Standard EM.02.02.05

As part of its Emergency Operations Plan, the organization/hospital prepares for how it will manage security and safety during an emergency.

Elements of Performance for EM.02.02.05. The Emergency Operations Plan describes the following:

EP1: The hospital's arrangements for internal security and safety.

EP2: The roles that community security agencies (for example, police, sheriff, National Guard) will have in the event of an emergency.

EP7: How the hospital will control entrance into and out of the healthcare facility during an emergency.

Standard EM.02.02.07

As part of its Emergency Operations Plan, the organization/hospital prepares for how it will manage staff during an emergency.

Elements of Performance for EM.02.02.07. The Emergency Operations Plan describes the following:

EP2: The roles and responsibilities of staff for communications, resources and assets, safety and security, utilities and patient management during an emergency.

EP3: The process for assigning staff to all essential staff functions.

EP4: The Emergency Operations Plan identifies the individual(s) to who staff report in the hospital's incident command structure.

Standard EM.02.02.11

As part of its Emergency Operations Plan, the organization/hospital prepared for how it will manage patients during emergencies.

Elements of Performance for EM.02.02.11. The Emergency Operations Plan describes the following:

EP4: How the hospital will manage a potential increase in demand for clinical services for vulnerable populations served by the hospital, such as patients who are pediatric, geriatric, disabled, or have serious chronic conditions or addictions.

EP7: How the hospital will manage mortuary services.

Standard EM.03.01.03

The organization/hospital evaluates the effectiveness of its Emergency Operations Plan.

Elements of Performance for EM.03.01.03

EP1: As an emergency response exercise, the hospital activated its Emergency Operations Plan twice a year at each site included in the plan.

EP2: For each site of the hospital that offers emergency services or is a community-designated disaster receiving station, at least one of the hospital's two emergency response exercises includes an influx of simulated patients.

EP3: For each site of the hospital that offers emergency services or is a community-designated disaster receiving station, at least one of the hospital's two emergency response exercises includes an escalating event in which the local community is unable to support the hospital.

EP4: For each site of the hospital with a defined role in its community's response plan, at least one of the two exercises includes participation in the community-wide exercise.

EP5: Emergency response exercises incorporate likely disaster scenarios that allow the hospital to evaluate its handling of communications, resources and assets, security, staff, utilities and patients.

EP6: The hospital designates an individual(s) whose sole responsibility during emergency exercises is to monitor performance and document opportunities for improvement.

EP7: During the emergency response exercises, the hospital monitors the effectiveness of internal communication and the effectiveness of communication with outside entities such as local government leadership, police, fire, public health officials, and other healthcare organizations.

EP8: During emergency response exercises, the hospital monitors resource mobilization and asset allocation, including equipment, supplies, personal protective equipment and transportation.

EP9: During emergency response exercises, the hospital monitors its management of the following: safety and security.

EP10: During emergency response exercises, the hospital monitors the following: staff roles and responsibilities.

EP14: The evaluation of all emergency response exercises and all response to actual emergencies includes the identification of deficiencies and opportunities for improvement. This evaluation is documented.

NIMS Implementation Objectives for Healthcare Organizations

In 2008, the Incident Management Systems Division of the Department of Homeland Security grouped the implementation objectives for healthcare organizations into five sections.

- Adoption
- Preparedness: Planning
- Preparedness: Training and Exercises
- Communications and Information Management
- Command and Management

Within these five sections, specific elements are identified to demonstrate compliance. For the Target Capabilities identified for this exercise, the NIMS elements within the five sections are identified.

Preparedness: Planning

Element 4: Participate in interagency mutual aid and/or assistance agreements, to include agreements with public and private sector and nongovernmental organizations.

Preparedness: Training and Exercises

Element 7: Promote NIMS concepts and principles into all organization related training and exercises; demonstrate the use of NIMS principles and ICS management structure in training and exercise.

Communications and Information Management

Element 9: Apply common and consistent terminology as promoted in NIMS, including the establishment of plain language communications standards.

Element 10: Utilize systems, tools and processes that facilitate the collection and distribution of consistent and accurate information during an incident or event.

Command and Management

Element 11: Manage all emergency incidents, exercises and preplanned (recurring or special events) in accordance with ICS organizational structures, doctrine and procedures as outlined in NIMS.

Element 12: ICS implementation must include the consistent application of Incident Action Planning and common communications plans as appropriate.

Element 13: Adopt the principle of Public Information, facilitated by the use of the JIS and Joint Information Center (JIC) during an incident or event.

Element 14: Ensure that public information procedures and processes gather, verify, coordinate, and disseminate information during an incident or event.

NIMS Implementation Objectives for Non-Healthcare Organizations

For non-healthcare or hospital participants in the exercise, the compliance elements for NIMS can be found at the web site

<http://www.fema.gov/emergency/nims/ImplementationGuidanceStakeholders.shtm>.

V. Exercise Scenario

Pre-Event Scenario

Background

The H5N2 avian influenza virus that has been circulating in Asia for some time continues to infect a few humans, some with very limited contact with wild fowl or infected domestic poultry. Recent unconfirmed media reports indicate higher human infection levels. Ministries of Health are reported to be increasing surveillance in target communities to verify reports.

January 2009

An outbreak of respiratory illness is reported in a Southeast Asian country. There are 159 reported cases in one town, affecting all age groups. 46 people have been hospitalized and 16 persons have died from severe pneumonia and respiratory failure.

The World Health Organization (WHO) confirms the outbreak and testing is pending. Surveillance in surrounding areas is increased and additional cases are identified throughout the country. A case definition is being developed by WHO.

January 16, 2009

Viral cultures from initial victims are positive for Type A influenza virus. WHO affirms the isolates are H5N2. Gene sequencing indicates the virus is avian in origin. Viral antigenic and sequence analysis show the virus is different than previously circulating in poultry that caused human infections.

January 30, 2009

Neighboring countries in Southeast Asia report outbreaks of respiratory illness. Once the virus epidemiology is available, WHO will update the public health guidelines. Meanwhile, national media report the novel virus, and it is the lead story on all major news networks and in newspapers. The WHO Declares Pandemic Phase 6 (see Appendix C).

February 15, 2009

Outbreaks appear in China, Singapore, the Republic of Korea and Japan. The WHO reports the following statistics:

- Cases occur in all age groups but young adults are most affected
- Case fatality rate is nearly 5%
- Transmission, epidemiology, and virology of the novel virus is being investigated

Public anxiety is high and international travel is rapidly decreasing. There is no vaccine currently available but production may begin within a month.

The Centers for Disease Control and Prevention is investigating a cluster of influenza-like-illness (ILI) in New Jersey. The index case is a 26 year old female who traveled to an affected country. She was admitted to a local hospital two days after the onset of symptoms, and died 7 days later due to pneumonia and severe respiratory failure.

Nine other potential cases identified in family members, neighbors and church members. All cases and contacts are treated with antiviral medication and are under self-isolation.

CDC confirms all cases with Type A influenza and subtyping confirms H5N2. The projected Case Fatality Ratio is 4-5%.

CDC releases a Health Alert and urges public health departments to:

- Increase surveillance for respiratory illness immediately
- Enhance public education and information
- Encourage medical and health providers to report cases and test suspicious cases
- Ensure strict isolation of laboratory confirmed infected persons
- Quarantine close contacts
- Educate the public on hand hygiene, respiratory hygiene, physical barriers, and other prevention measures to limit the exposure and risk of transmission
- Implement non-pharmaceutical community containment measures:
 - Increase social distancing by restricting public events and mass gatherings
 - Use of masks by the public when in high risk for exposure gatherings or settings

Media reports spur an increase in calls to local health authorities, advice hot lines, emergency departments and 911 Dispatch.

Emergency departments, urgent care centers and clinics report an increase in persons presenting with requests for “flu shots.” Patients are asking for prescriptions of antibiotics and antiviral medications “just in case” flu symptoms appear. Employees at some healthcare facilities and doctor’s offices are hoarding surgical masks and other personal protective equipment.

The California State Health Officer issues a Health Alert containing the following information:

- There are no confirmed cases of H5N2 currently in California
- Local public health, healthcare, and response partners should prepare for outbreaks in their communities
- CDC recommendations should be followed, including those for surveillance of possible cases, educational outreach, and reporting and testing of suspicious cases

Antiviral medications have been distributed to local health departments in California.

April 2009

CDC reports focal outbreaks of respiratory illness and deaths in several states including Florida, New York, Ohio and Texas. The media are overestimating numbers and severity of cases and public anxiety has risen to near-panic.

In California, healthcare providers are inundated with phone calls and people presenting to hospitals and clinics with demands for control measures and medications.

In communities across California, absenteeism has risen in schools, businesses, and community organizations that provide essential services. Attendance at public events, theaters and community gatherings has decreased.

In response to the increased demand for guidance on laboratory testing and the current increased surge in testing, the CDPH Viral and Rickettsial Disease Laboratory (VRDL) developed guidelines for local health departments.

The California State Health Officer has issued a Health Alert via CAHAN with the following guidance:

- For influenza A (H5) diagnostic testing, the preferred specimen requirements include:
 1. An oropharyngeal swab collected in 3 cc viral transport media (VTM), and
 2. A nasopharyngeal swab or wash or aspirate collected in 3 cc viral transport media (VTM), and
 3. Any specimen(s) from the lower respiratory tract (e.g., sputum, bronchoalveolar lavage, tracheal aspirate or pleural fluid tap).
 - Oropharyngeal swabs may have better yield than nasopharyngeal specimens. While both types of specimens should be collected, an oropharyngeal swab should be performed preferentially if only one sample can be taken.
 - In outpatient settings, it may be difficult to obtain samples from the lower respiratory tract in children. In these instances, two specimens from the upper respiratory tract (e.g. a nasopharyngeal wash and a throat swab) can be substituted.
- For local health departments that can test for influenza via PCR:
 - Screening for Influenza A and B is recommended.
 - Influenza A positive samples should then be tested for subtypes H1, H3, and H5. The first 2-3 positive specimens for influenza A (H5) should be forwarded to VRDL for confirmatory testing.
 - As resources allow at the local level, samples that are negative for Influenza A should be tested for other respiratory agents (e.g., using R-mix or other available testing).
 - As resources allow, VRDL will perform statewide surveillance of a small sampling of cases (25-50 positive samples per week) for antiviral resistance testing and genetic sequencing. Local health departments that wish to be included in this survey should send 1-2 positive RNA extracts weekly to VRDL.
- For local health departments which cannot test for influenza via PCR and are experiencing cases of high suspicion for influenza A (H5):
 - VRDL will provide testing as described above. Information on how to submit samples can be found in the VRDL Guidelines to Laboratory Services.

May 28, 2009

CDPH VRDL laboratory confirms the first case of H5N2 novel virus infection in California.

The State Health Officer is expected to issue orders for community mitigation strategies and measures to be implemented, including student dismissals and cancellation of large public gatherings.

Many Emergency Operations Centers and organization command centers are fully activated.

May 29, 2009

Local health departments received the small allocation of pre-pandemic vaccine (based on H5N1 strain) directly from Sanofi-Pasteur and implemented plans to provide the pre-pandemic vaccine to critical infrastructure, in accordance with federal guidelines and orders issued by the State Health Officer.

May 30, 2009

The State Health Officer orders student dismissals in K-12 grades and child care centers with six or more children effective today, approximately 2 weeks before the end of the school year, prompting parents to find alternate methods of child care earlier than expected and increasing work absenteeism due to lack of child care. Colleges and universities were advised to assess the need for student dismissals dependent upon the capability to implement effective social distancing and infection control measures. The State Health Officer issues a recommendation to local health departments to assess for and consider the cancellation of large public gatherings.

Panic buying increases in pharmacies and grocery stores as worried people start to hoard remedies for influenza and food.

June 1, 2009

There are laboratory confirmed clusters of H5N2 human cases in counties across California. The CDPH Joint Emergency Operations Center is activated on 24/7 status as are the majority of the OA Emergency Operations Centers.

Large public gatherings (e.g., concerts, conferences, sporting events) have been cancelled in many local health jurisdictions by the Local Health Officer, which will have a major impact on the local and state economy and social networking. The media is already beginning to forecast the worst case scenario.

CDC notifies all state and territorial public health departments that the H5N2 pandemic vaccine is in high production and shipments are expected to commence beginning July 20, 2009. The California State Health Officer notifies local health departments of the impending arrival of pandemic vaccine. California's portion of the national supply of vaccine has been allocated to each county on a population basis, and according to CDC procedures, pandemic vaccine will be shipped directly to each county's designated primary receiving site directly from the manufacturer, Sanofi Pasteur. Each county has notified CDPH of their primary receiving site(s) for vaccine and these will be the ship-to-sites. Local health department planning for receipt, storage, security, and distribution of the vaccine should begin immediately.

Clusters of severe influenza-like-illness and laboratory confirmed H5N2 cases are reported in multiple counties across California. The local public health and healthcare systems are heavily impacted with numbers of ill and worried well. Absenteeism rates of 25% are reported in agencies and businesses and are expected to climb.

June 2, 2009

Governor Schwarzenegger has proclaimed a State of Emergency in California. The event has been designated the *2009 Statewide Medical and Health Functional Exercise* in the proclamation, in all documents pertaining to the proclamation and in RIMS.

CDC projects Pandemic Severity Index of 5 (see Appendix D).

June 17, 2009 (one day prior to exercise)

CDC reports that all U.S. states and territories are now reporting outbreaks of laboratory-confirmed clusters of H5N2 with human-to-human transmission. CDC continues to project the Pandemic Severity Index at 5 with a national attack rate of 15%.

CDPH reports a statewide attack rate of 18%. Case fatality rates are at 15%. Hospitalizations have increased by 10-15%.

Note: Coordinated exercise planning at the OA should include review and choice of either of the following two options. OA planners may use the statewide rate or may determine a different percentage of impact for number of people who are ill, number of deaths and an overall percentage of impact within the county.

Option 1:

_____ (insert name) County is reporting a large number of laboratory-confirmed or suspect case clusters. There is approximately a ___% attack rate across the population of the county, with an estimate of _____ (insert number) persons with laboratory confirmed or suspect cases of H5N2, hospitals and clinics reporting census' at capacity or averaging XX% over normal census, and _____ (insert number) deaths. These numbers are projected to rise over the next several weeks.

Option 2:

_____ (insert name) County is reporting a small number of laboratory confirmed or suspect cases clusters. There is approximately a ___% (insert percentage of impact) attack rate across the population of the county, with an estimate of _____ (insert number) persons with laboratory confirmed or suspect cases of H5N2, hospitals and clinics reporting census' at capacity or averaging XX% over normal census, and _____ (insert number) deaths. While the number of confirmed cases is low at this time, it is projected that a surge of cases and influenza-like-illness will occur within 1-2 weeks. In addition, the county is beginning to see an influx of citizens/patients from surrounding highly impacted counties as their healthcare system becomes overwhelmed and people seek care in outside their county of residence.

Local hospitals, clinics and medical offices are reporting a significant increase in persons presenting with influenza-like-illness and asymptomatic persons requesting antiviral medicines and antibiotics.

Healthcare and public safety providers are experiencing a marked impact on staffing as personnel become ill, are absent to care for family, and/or are anxious about exposure and becoming ill if they present to work. The effect on staffing has a domino effect, as patient transfers from hospitals to long term care facilities are delayed, EMS providers have fewer personnel to accommodate routine transfers and clinics are cancelling and/or rescheduling appointments.

Exercise Begins

June 18, 2009 - 0800 hrs.

Command Centers and Emergency Operation Centers have been activated for at least three weeks.

The first activity in the functional exercise is to conduct a shift change and Command Center/Emergency Operations Center briefing.

Hospital and Clinic Command Centers may elect at this time to provide an IAP to oncoming Incident Management Team personnel. A template IAP can be found in Attachment 2.

Use of incident management software programs may be used to document the IAP, Hospital Command Center, Department Operating Center or Emergency Operations Center staffing, resource requesting and situational assessment. Access to applicable programs may be initiated and/or updated at this time.

The Daily Situation Report from CalEMA is released (Attachment 1). The report summarizes the impact of the influenza pandemic across the state as well as the actions currently underway or planned by state authorities.

Note: Participants are strongly encouraged to use the simulated CalEMA report (see Attachment 1) in the exercise conduct.

Issues for Discussion by All Participants

- ❑ *How would the CalEMA daily report be received by your agency? (Note: the CalEMA report would not normally be disseminated to healthcare facilities).*
- ❑ *How will the information be used in Command Centers?*
- ❑ *How will the information provided by CalEMA be shared with your staff? With your patients / clients?*
- ❑ *Who will develop messages for internal and external organizational communication?*
- ❑ *Who approves information and messages that is disseminated within and outside of your organization?*
- ❑ *How does your organization coordinate and interface with the OA Joint JIS and through the Joint Information Center (JIC)²? Which personnel are the designated point(s) of contact for the JIC?*

² JIC is a central location that facilitates operation of the JIS. The JIC is a location where personnel with public information responsibilities perform critical emergency information functions, crisis communications, and public affairs functions. JIC may be established at various levels of government or at incident sites, or can be components of Multiagency Coordination Systems.

- *Initiate accounting for costs incurred for incident response by individual facilities and at the OA Emergency Operations Centers, as well as an assessment of lost revenue.*

Reimbursable event costs incurred may include those related to personnel, including:

- *Overtime, call back pay and special pay incentives*
- *Use of temporary personnel*
- *Re-assignment of staff to positions or assignments not associated with daily activities*
- *“Just-in-time” training for use of personal protective equipment and/or fit testing*
- *Licensing and credentialing of medical and non-medical personnel, including volunteers*
- *Staffing of non-traditional patient care areas to support operations*

Reimbursable event costs incurred may include those related to supplies and equipment, including:

- *Ordering of additional supplies and equipment (including personal protective equipment) to increase on-hand caches*
- *Ordering of additional supplies and equipment (including personal protective equipment) to increase on-hand caches*
- *Ordering of additional pharmaceuticals to increase on-hand caches*
- *Logistical support for government-authorized alternate care sites*
- *Increased supplies of food and water to support expanded operations*
- *Purchase or rental of additional equipment to support government-authorized alternate care sites (e.g., lighting, heating, communications, sanitation, etc.)*
- *Purchase or rental of additional equipment to support operations (fuel, water)*

Lost revenue should be tracked, including projections based on the following:

- *Cancelled or postponed procedures*
- *Cancelled or postponed events*
- *Inability to receive or transfer patients*
- *Inability to provide day to day services, such as education and training*

Across California, 60% of local health departments report a high number of suspected or laboratory confirmed H5N2 cases and the healthcare system is highly impacted by high census and resource issues.

Issues for Discussion by All Participants

- ❑ *How will your agency or facility obtain critical information about the evolving situation, including:*
 - *Situation status of other healthcare providers at the community, local, and regional levels?*
 - *Situation status of local/community responders?*
 - *Updated epidemiology, transmission, and virology of the novel virus?*
 - *Location of and level of care provided in government-based alternate care sites?*
- ❑ *How will its impact on your agency/facility be evaluated?*
- ❑ *What is the supply and equipment status at your facility/agency?*
- ❑ *Can the growing impact on current supplies and supply use be projected?*

The governor has ordered all state agencies to evaluate essential and non-essential services and postpone or cancel any activities or operations that do not impact public safety.

Issues for Discussion by All Participants – Surge Capacity

- ❑ *What services, activities, or events provided by your agency or facility can be postponed or cancelled at this time?*
- ❑ *What is the decision making process and authority within your agency or facility to approve cancellation or postponement of services? Who has the ultimate authority for decision making?*
- ❑ *How can these now available resources augment personnel and other essential activities/functions (e.g., space, caregivers)?*
- ❑ *Will this increase your personnel or manpower pool?*
- ❑ *How will cancellation or rescheduling of services be tracked and monitored?*
- ❑ *Are there personnel that can be reassigned from their non-essential roles to provide essential services? How will this be tracked?*
- ❑ *Can essential services be maintained by augmenting staff with temporary personnel or use of volunteers?*
- ❑ *How are decisions shared with healthcare partners? With the local health department? What other organizations or agencies should have this information?*
- ❑ *How is the change in service delivery communicated to internal staff? To client patients and families?*

June 18, 2009 - 0830 hrs.

Local health departments, EMS Providers, and 911 Dispatch Centers are reporting a 50% increase in non-critical calls requesting advice on flu home care and protection measures, flu symptoms, locations outside hospitals that can provide medical treatment, lists of cancelled services and events within the local area, and non-emergency transport to hospitals and clinics.

Issues for Discussion by All Participants

- ❑ *From whom and how will your facility/organization receive information on infection control, social distancing, and care and treatment recommendations*
- ❑ *How will you share information on your operational status with your response partners?*
- ❑ *How will patients be transported to other levels of care now that EMS providers are impacted and unable to conduct non-critical and routine transport?*
- ❑ *How can calls for advice and guidance on available services be addressed? Can these calls be routed outside of your agency?*
- ❑ *How will your organization manage the volume of call coming in with requests for information, access to care and services and treatment for the flu?*

Community-based organizations that provide services to clients in their homes are greatly impacted. There are not enough drivers to deliver meals and supplies, incoming calls for new services have risen dramatically and volunteers are not reporting for shifts. These organizations are requesting help from local and OA emergency management to continue services.

Issues for Discussion by Community-Based Organizations

- ❑ *Are there services that can be cancelled or postponed so that essential services can be maintained? Are there services that a partner or sister agency can assume for you? Are there services that you can provide to a partner or sister agency so they may maintain essential services? Are Memoranda of Understanding in place to support essential services?*
- ❑ *What role(s) do volunteers play in your daily operations? Will increased numbers of volunteers help to support your services?*
- ❑ *How will interruptions in service delivery be communicated to clients receiving services? To clients contracting for services?*
- ❑ *How will situation status updates be shared with local/county emergency management and partner agencies?*
- ❑ *How does your agency / organization participate in development of the IAP?*

Due to absenteeism, non-emergency transportation services can handle only 50% of their normal volume. Medical transportation services that take clients from their homes to hospitals and clinics for chronic care appointments (dialysis, radiation therapy, etc.) are unable to meet the volume, causing some clients to call 911 for assistance.

Issues for Discussion by All Participants

- ❑ *Is your agency part of the 911 response system in your county?*
- ❑ *How does your agency identify essential versus non-essential services?*
- ❑ *How do you communicate your service disruptions with your clients?*
- ❑ *How do you work with your healthcare agency clients to triage or prioritize services?*
- ❑ *How do you track cancelled or postponed services?*
- ❑ *How do you recover or reschedule cancelled transports?*
- ❑ *How do you receive direction from EMS authorities / local health department authorities for alterations in service delivery?*

The California Department of Mental Health, local mental health departments and agencies/providers are reporting a major increase in the number of calls for information and assistance as public anxiety increases and media reports project large numbers of deaths in the next several weeks. Local providers are feeling the impact as calls increase and emergency room visits spike with worried well and anxious citizens.

Issues for Discussion by All Participants

- ❑ *Will this information impact your operations? Will your facility or agency be impacted by worried well or anxious citizens?*
- ❑ *What can be done to calm the public's fears? Does your agency play a role in calming fears?*
- ❑ *Are there private sector or community organizations that can assist with this issue?*

Long term care facilities are reporting a growing number of patients with influenza symptoms. Patients who would normally be transferred to hospitals must remain at long term care facilities.

Volunteers who normally assist at some facilities are not arriving for work. Long term care facilities are unable to accept hospital transfers. Several patients have died, and local mortuary, coroner and medical examiner services are overwhelmed due to increased volume as well as employee illness.

Issues for Discussion for All Participants

- ❑ *How do you communicate status information to local health department authorities, hospitals and other long term care facilities?*
- ❑ *How is facility status, including numbers of patients with flu symptoms, communicated to local health departments?*
- ❑ *Where will the facility store and secure bodies until officials can respond?*
- ❑ *How is the need for assistance communicated within the OA? To whom?*

- ❑ *Is there direct access to local health departments and OA emergency management or Emergency Operation Centers?*

The local health department is receiving calls from healthcare providers and residents, overwhelming the ability to respond. Persons are showing up at the local health department demanding flu shots. The local health department is also reporting a surge in routine laboratory testings, as hospital and free-standing labs can no longer handle the volume.

Issues for Discussion for Local Health Department

- ❑ *How are calls triaged for priority?*
- ❑ *How is this information then shared with healthcare organization, government agencies, public safety and the public?*
- ❑ *How does the local health department develop risk communication messages? How are they approved? How are they disseminated?*
- ❑ *What is the role of the local health department in the JIS?*
- ❑ *How can laboratory testing be prioritized?*
- ❑ *How will lab testing prioritization be communicated to hospitals and healthcare providers?*
- ❑ *How will a surge in laboratory testing impact routine tests?*
- ❑ *Is there any testing or reporting that can be suspended? How will this decision be shared within the healthcare community?*

Media continue to report on the state of the pandemic and now predict severe shortages of medicines and supplies. Media newscasts show long lines at pharmacies, grocery and convenience stores as people are buying over the counter cold and flu medicines, water and juice. Some news stations report looting of local pharmacies and grocery stores as fears of a shortage of over-the-counter medicines is anticipated.

Issues for Discussion for All Participants

- ❑ *How will these media reports impact your operations?*
- ❑ *Is there additional planning within your facility or agency to support your staff and their families based on this report?*
- ❑ *What is the mechanism within your facility/organization to receive accurate and up to date information?*
- ❑ *How will these reports impact your operations?*
- ❑ *How will this information be shared within your facility or organization?*

Public safety resources are strained. There is an increase of sick calls and absenteeism in law enforcement and fire services. Within each county, officials are beginning the cancellation of non-essential services and redistributing employees to public safety duties. Hospitals, clinics, long term care facilities, the local health department and pharmacies are also requesting the assistance of law enforcement to secure their facility and protect staff.

Issues for Discussion for All Participants

- ❑ *How can you control access to and control of critical supplies, equipment and pharmaceuticals in your facility?*
- ❑ *Do you have sufficient security staff to control access?*
- ❑ *Does your access control or lockdown plan require the use of local law enforcement services?*
- ❑ *How can you augment internal security if law enforcement is unable to provide resources?*
- ❑ *Are there non-essential services that can be cancelled or postponed to increase staffing and augment safety resources?*

Issues for Discussion for Public Safety

- ❑ *What non-essential services can be postponed or cancelled to augment essential public safety services?*
- ❑ *How will requests for services from private businesses, including healthcare organizations, be communicated to law enforcement? How will provision of services to these businesses be decided?*
- ❑ *How is situational information communicated to the OA Emergency Operations Center?*
- ❑ *How is the law enforcement mutual aid system accessed?*
- ❑ *How are situational status and the ability to provide services to support healthcare shared with health authorities?*

June 18, 2009 - 0900 hrs.

The Joint Emergency Operations Center (JEOC) supporting and coordinating medical operations requests a situational update from the Regional Emergency Operations Center and Regional Disaster Medical Health Coordinators (RDMHC) by 1200 hours. In turn, the RDMHC requests situational updates from the MHOAC by 1100 hours. Information includes patient census and bed availability, patients waiting to be seen, in-hospital deaths, employee illness and absenteeism and availability of supplies and equipment (including personal protective equipment and pharmaceuticals). Hospitals, clinics, long term care facilities and EMS Providers are instructed to provide information using the approved reporting system within the OA.

Note: MHOACs should ensure that participating hospitals and agencies have access to reporting forms using the system established within their OA.

Issues for Discussion for All Participants

- ❑ *How can this information be rapidly gathered within your agency or facility?*
- ❑ *How is this information documented?*
- ❑ *Who approves release of the information?*
- ❑ *Will this information affect your incident action planning?*

- ❑ *How is it communicated to the MHOAC?*

June 18, 2009 - 1000 hrs.

There are media reports that the supply of antiviral medicines will be exhausted in 72 hours and no further supply is anticipated. The media is reporting that a vaccine for the H5N2 virus is being mass produced in Canada and can be ordered on the internet.

Vendors supplying personal protective equipment are contacting their clients; they are requesting information on current supply levels as well as projected needs for the next week.

Issues for Discussion by All Participants

- ❑ *How will the determination of the impact of the pandemic as well as the projection for necessary supplies be made?*
- ❑ *How will additional supplies and equipment outside of vendor agreements be requested?*
- ❑ *When one vendor provides supplies and equipment to multiple facilities, who prioritizes deliveries?*

Issues for Discussion by Local Health Department

- ❑ *Are there any alternatives to traditional personal protective equipment used by healthcare providers? How can the current supply be augmented? How will this information be disseminated to healthcare providers?*

Hospitals are requesting the aid of the MHOAC to assist with patient discharges. Bed availability from long term care facilities as well as discharges to home are priorities for hospitals. Services provided by community organizations, including those that provide meals, transportation and in-home assistance, will be needed before patients can be safely discharged. Ambulance services are needed for patient transfers, but there is impact on service delivery due to employee illness.

Issues for Discussion by All Participants

- ❑ *How will patient care discharges and transfers be coordinated within the OA?*
- ❑ *Are there alternate methods available for patient movement?*
- ❑ *How can EMS be augmented to respond to the increased demand?*
- ❑ *How can the role of community organizations be enhanced to support hospital discharges?*
- ❑ *What services can your agency or facility provide to augment community resources?*

June 18, 2009 - 1100 hrs.

The MHOAC receives reports from hospitals, long term care facilities and clinics of shortages of personal protective equipment, especially N95 masks. Projections for staff shortages show a major impact in the next week due to cancellation of schools, and child and adult day care services.

Issues for Discussion for all Healthcare Organizations

- ❑ *What procedures are available to procure additional supplies to sustain operations? From vendors? Other facilities? Medical Mutual Aid system?*
- ❑ *Are vendor agreements and Memoranda of Understanding (MOUs) in place to procure additional supplies?*
- ❑ *How is the Medical Mutual Aid System accessed through the Standardized Emergency Management System (SEMS)?*
- ❑ *How are requests for supplies made? What essential information is needed when requesting supplies?*
- ❑ *Do local healthcare entities, local health departments and LEMSAs know how to access the California Disaster Healthcare Volunteer resources?*

Clinics report large numbers of persons presenting to and calling the clinic with requests for flu shots, cold medicine and antiviral medicines. Clinic staff are exhausted and some are now complaining of flu-like symptoms. Some patients are becoming angry with clinic staff. Clinics are instructing patients to go to hospital emergency rooms for evaluation.

Issues for Discussion for All Participants

- ❑ *How will this impact your operations?*
- ❑ *Can services be expanded based on these reports?*

Issues for Discussion for All Hospitals

- ❑ *Have you expanded operations within your facility to support patient care?*
- ❑ *What logistic needs do you have to support this expansion?*
- ❑ *Who will you share this information with: internally? Externally?*

The media are contacting local health departments, hospitals and OA Emergency Operation Centers to answer questions on the spread of the flu, projected impact, and length of the pandemic.

Issues for Discussion by Hospitals, Local Health Departments and County EOCs

- ❑ *How should this information be addressed and validated?*
- ❑ *Who is coordinating a response to this media report?*
- ❑ *What subject matter experts should be involved in developing a response?*

Participation in the JIS at the OA level may be exercised at this time.

June 18, 2009 - 1100 hrs.

Within the OA, government-authorized alternate care sites³ have been opened.

Note: Local planners developing the exercise should determine the locations of government-authorized alternate care sites within the OA. The current plans for these sites within the OA may be tested, addressing logistics, staffing, level of care, chain of command, etc.

The sites are located in the following locations:

1. _____
2. _____
3. _____
4. _____

Issues for Discussion by LHD, Hospitals, LEMSA and EMS Providers:

- How will you triage and refer patients away from facilities to government-authorized alternate care sites?*
- What are the criteria for referring patients from government-authorized alternate care sites to hospitals?*
- How do EMS Providers learn where to transport patients?*
- Who oversees the level of care provided at these sites?*
- How are healthcare organizations made aware of these services?*
- How are residents informed of the alternate care sites?*
- How will you identify staff who will be assigned to work at the government-authorized alternate care sites?*

June 18, 2009 - 1130 hrs.

The local health department is asking EMS Providers and 911 Dispatch Centers to aggregate the tracking of ILI patients transported and calls for ILI and respiratory distress by 1200.

³ In the *Standards and Guidelines for Healthcare Surge During Emergencies, Volume II: Government-Authorized Alternate Care Sites* published in February 2008, an Alternate Care Site is defined as “a location that is not currently providing healthcare services and will be converted to enable the provision of healthcare services to support, at a minimum, inpatient and/or outpatient care required after a declared catastrophic emergency.” CDPH adopted this operational definition distinguishing the government-authorized alternate care sites from the expansion of existing health care facilities given the differing laws and regulations under which each would operate. Additional information on the expansion of healthcare facilities and setup and operation of government-authorized alternate care sites can be found in the *Standards and Guidelines for Healthcare Delivery During Surge Emergencies* located at www.bepreparedcalifornia.ca.gov

Issues for Discussion for LEMSAs and EMS Providers

- ❑ *Is there a patient tracking and surveillance system already in use in your OA?*
- ❑ *Can it accommodate a spike in volume?*
- ❑ *How fast can the information be gathered, reviewed and provided to local health departments?*
- ❑ *Will the need for surveillance and tracking impact your operations?*
- ❑ *Are there any mechanisms that can enhance the data collection?*

Law enforcement agencies in the OA are impacted by sick calls from staff and absenteeism to care for family members. Media report looting and civil disobedience as law enforcement officers are unable to answer routine calls. Requests from hospitals, clinics and pharmacies for police support due to the high numbers of anxious patients are not able to be met.

Issues for Discussion by Healthcare Facilities

- ❑ *How will this impact security procedures at your facility?*
- ❑ *Will this impact staff morale?*
- ❑ *Will absenteeism increase?*
- ❑ *Can housing be provided for staff and families who are afraid to go home?*

The Medical Examiner/Coroner for the OA reports a major increase in calls from hospitals and long term care facilities. EMS Providers are responding to calls for severe respiratory distress resulting in cardiac arrest. Medical Examiner/Coroner services are unable to respond to homes and healthcare facilities; deceased bodies must be kept on site and/or in their homes.

Issues for Discussion by All Participants

- ❑ *How will these recommendations impact EMS Providers? The community?*
- ❑ *How will this information be disseminated to all healthcare partners?*
- ❑ *How will hospitals and long term care facilities increase, or in some cases, develop their morgue capacity?*
- ❑ *What roles does the local health officer play in this development?*
- ❑ *Are there issues of public health safety in this development?*
- ❑ *Will this impact public safety?*
- ❑ *Is there any issue of contagion with this recommendation?*
- ❑ *Are there sites within the community that can be used as temporary morgues?*
- ❑ *Are there federal assets that can be requested?*

June 18, 2009 - 1200 hrs.

The media reports that hospitals across the state have closed their doors to all new patients. This is raising the level of anxiety with calls from the public to elected officials to intervene.

Issues for Discussion by All Participants

- ❑ *How is this information validated?*
- ❑ *How is correct information disseminated to the public? To clients and patients? To staff?*

The OA Emergency Operations Center is asking for an update on current supplies of personal protective equipment from all healthcare, public safety and community organizations that utilize personal protective equipment. Resource caches in the area for terrorism response will be utilized as needed, but current supply levels are needed to triage distribution where it is most needed.

Issues for Discussion by All Participants

- ❑ *How can you rapidly assess your current supplies?*
- ❑ *How can you project your needs for the next 72 hours? The next 96 hours?*
- ❑ *How can you be a part of the decision making of allocation of critical supplies?*

June 18, 2009 - 1400 hrs.

The JEOC will release a situational update on the projected impact and spread of the influenza pandemic in California by 1800 today.

The Planning Section within Hospital Command Centers and Emergency Operations Centers are gathering information for development of the Incident Action Plan for the next operational period. They request information on operational status, availability of supplies and equipment, available staff and staff absenteeism, and cost expenditures to date.

The JEOC has requested a situation update from the REOC by 1600. The RDMHC is contacted and asked to gather and consolidate the information.

Master Sequence of Events List

The Master Sequence of Events List (MSEL) can be customized for local use to assist Controllers in tracking activities and ensuring the exercise play is on schedule. The MSEL and narrative together should be used to guide and evaluate the exercise.

Pre-Event Information: The H5N2 avian influenza virus that has been circulating in Asia for some time continues to infect a few humans, some of whom with very limited contact with wild fowl or infected domestic poultry. Recent unconfirmed media reports indicate higher human infection levels. Ministries of Health are reported to be increasing surveillance in target communities to verify reports.

Background: January 2009 – June 2009

Date	Time	Intended Recipients	Information	Actions / Issues
Jan 2009		All	Outbreak of respiratory illness is reported in a Southeast Asian country; 159 reported cases in one town, affecting all age groups. 46 people have been hospitalized and 16 persons have died from severe pneumonia and respiratory failure.	
Jan 16, 2009		All	Viral cultures from initial victims are positive for Type A influenza virus. The World Health Organization (WHO) affirms the isolates are H5N2 and are avian in origin.	
Jan 30, 2009		All	Neighboring countries in Southeast Asia report outbreaks of respiratory illness. WHO Declares Pandemic Phase 6.	
Feb 15, 2009		All	Outbreaks appear in China, Singapore, the Republic of Korea and Japan. WHO reports the following statistics: <ul style="list-style-type: none"> ▪ Cases occur in all age groups but young adults are most affected ▪ Case fatality rate is nearly 5% ▪ Transmission, epidemiology, and virology of the novel virus is being investigated There is no vaccine currently available but production may begin within a month.	
Feb 15, 2009		All	CDC is investigating a cluster of ILI in New Jersey. The index case is a 26 year old female who traveled to an affected country. She was admitted to a local hospital two days after the onset of symptoms, and died 7 days later due to pneumonia and severe respiratory failure. Nine other potential cases identified in family members, neighbors and church members. All cases and contacts are treated with antiviral medication and are under self-isolation.	
Feb 15, 2009	1000	All	CDC confirms all cases with Type A influenza and subtyping confirms H5N2. The projected Case Fatality Ratio is 4-5%.	
Feb15,	1200	Healthcare	CDC releases a health alert and urges public health departments to:	

2009			<ul style="list-style-type: none"> ▪ Increase surveillance for respiratory illness immediately ▪ Enhance public education and information ▪ Encourage medical and health providers to report cases and test suspicious cases ▪ Ensure strict isolation of laboratory confirmed infected persons ▪ Quarantine close contacts ▪ Educate the public on hand hygiene, respiratory hygiene, physical barriers, and other prevention measures to limit the exposure and risk of transmission ▪ Implement non-pharmaceutical community containment measures: <ul style="list-style-type: none"> ○ Increase social distancing by restricting public events and mass gatherings ○ Use of masks by the public when in high risk for exposure gatherings or settings 	
Feb 15, 2009		All	Media reports spur an increase in calls to local health department's advice hot lines, emergency departments and 911 Dispatch.	
Feb 15, 2009		Healthcare	Hospital emergency departments, urgent care centers and clinics report an increase in persons presenting with requests for "flu shots." Patients are asking for prescriptions of antibiotics and antiviral medications "just in case" flu symptoms appear. At some healthcare facilities and doctor's offices, staff are hoarding surgical masks and other personal protective equipment.	
Feb 15, 2009	1500	Healthcare	<p>The California State Health Officer from the California Department of Public Health issues a Health Alert containing the following information:</p> <ul style="list-style-type: none"> ▪ There are no confirmed cases of H5N2 currently in California ▪ Local public health, healthcare, and response partners should prepare for outbreaks in their communities ▪ CDC recommendations should be followed, including those for surveillance of possible cases, educational outreach, and reporting and testing of suspicious cases <p>Antiviral medications have been distributed to local health departments in California.</p>	
Apr 2009		All	CDC reports focal outbreaks of respiratory illness and deaths in several states including Florida, New York, Ohio and Texas. The media are overestimating numbers and severity of cases and public anxiety has risen to near-panic.	
Apr 5, 2009		Healthcare	Healthcare providers across California are inundated with phone calls and people presenting to hospitals and clinics with demands for control measures and medications.	
Apr 5, 2009	0800	LHD Healthcare	In response to the increased demand for guidance on laboratory testing and the current increased surge in testing, CDPH VRDL has developed guidelines for local health departments.	
Apr 5,	0900	LHD	The State Health Officer has issued a health alert with the following guidance:	

2009		Healthcare	<ul style="list-style-type: none"> ▪ For influenza A (H5) diagnostic testing, the preferred specimen requirements include: <ol style="list-style-type: none"> 1. An oropharyngeal swab collected in 3 cc viral transport media (VTM), and 2. A nasopharyngeal swab OR wash OR aspirate collected in 3 cc viral transport media (VTM), and 3. Any specimen(s) from the lower respiratory tract (e.g., sputum, bronchoalveolar lavage, tracheal aspirate or pleural fluid tap). <ul style="list-style-type: none"> ▪ Oropharyngeal swabs may have better yield than nasopharyngeal specimens. While both types of specimens should be collected, an oropharyngeal swab should be performed preferentially if only one sample can be taken. ▪ In outpatient settings, it may be difficult to obtain samples from the lower respiratory tract in children. In these instances, two specimens from the upper respiratory tract (e.g. a nasopharyngeal wash and a throat swab) can be substituted. • For local health departments that can test for influenza via PCR: <ul style="list-style-type: none"> ○ Screening for Influenza A and B is recommended. ○ Influenza A positive samples should then be tested for subtypes H1, H3, and H5. The first 2-3 positive specimens for influenza A (H5) should be forwarded to VRDL for confirmatory testing. ○ As resources allow at the local level, samples that are negative for Influenza A should be tested for other respiratory agents (e.g., using R-mix or other available testing). ○ As resources allow, VRDL will perform statewide surveillance of a small sampling of cases (25-50 positive samples per week) for antiviral resistance testing and genetic sequencing. To include your health jurisdiction in this survey, please send 1-2 of your positive RNA extracts weekly to VRDL. • For local health departments which cannot test for influenza via PCR and are experiencing cases of high suspicion for influenza A (H5): <ul style="list-style-type: none"> ○ VRDL will provide testing as described above. Information on how to submit samples can be found in the VRDL Guidelines to Laboratory Services. 	
Apr 6, 2009		All	Absenteeism has risen in schools, businesses, and community organizations that provide essential services.	
May 28, 2009	0930	All	CDPH VRDL confirms the first case of H5N2 novel virus infection in California. The State Health Officer issues orders for community mitigation strategies and measures to be implemented, including student dismissals and	

			cancellation of large public gatherings.	
May 28, 2009		All	Many Emergency Operations Centers, Hospital Command Centers and organization command centers are fully activated.	
May 29, 2009	0900-1800	LHD	Local health departments receive the small allocation of pre-pandemic vaccine (based on H5N1 strain) directly from Sanofi-Pasteur.	Activation of plans to provide the pre-pandemic vaccine to critical infrastructure in accordance with the federal guidelines and State Health Officer recommendations.
May 30, 2009	0800	All	The State Health Officer orders student dismissals in K-12 grades and child care centers with six or more children today, approximately 2 weeks before the end of the school year.	
May 30, 2009	0830	LHD	The State Health Officer issues a recommendation to local health departments to assess for and consider the cancellation of large public gatherings.	
May 30, 2009	1800	All	Evening newscasts report "panic buying" in pharmacies and grocery stores as worried people start to hoard remedies for influenza and food.	
June 1, 2009	0800	All	There are laboratory confirmed clusters of H5N2 human cases in counties across California.	
June 1, 2009	0800	All	JEOC is activated on 24/7 status as are the majority of the OA Emergency Operations Centers.	
June 1, 2009	1000	All	Large public gatherings (e.g., concerts, conferences, sporting events) have been cancelled in many local health jurisdictions by the local health officer.	
June 1, 2009	1000	LHD	CDC notifies CDPH (and all state departments of health) that the H5N2 pandemic vaccine is in high production and shipments will commence beginning July 20, 2009.	
June 1, 2009	1030	LHD	The State Health Officer notifies local health departments of the impending arrival of pandemic vaccine. As per CDC protocols, California's portion of the US vaccine has been allocated to each local health department according to population and will be shipped directly to local health departments from Sanofi Pasteur.	Planning for receipt and security of the vaccine should begin immediately.
June 1, 2009		All	Clusters of severe influenza-like-illness and laboratory confirmed H5N2 cases are reported in multiple counties across California.	
June 1, 2009		All	The public health and healthcare system is heavily impacted with numbers of ill and worried well.	
June 1, 2009		All	Absenteeism rates of 25% are reported in agencies and businesses and are expected to climb.	
June 2, 2009	0730	All	Governor Schwarzenegger proclaims a State of Emergency in California. The event has been designated the <u>2009 Statewide Medical and Health Functional Exercise</u> in the proclamation.	
	0800	LHD	CDC projects the Pandemic Severity Index of 5.	

June 17, 2009 (One Day Prior to Exercise)

Note: Coordinated exercise planning at the OA should include review and choice of either of the following two options. The OA should then determine the percentages of impact for number of persons ill, number of deaths and an overall percentage of impact within the county.

Prior to Exercise Start			<p>Option 1: _____ (insert name) County is reporting a large number of laboratory confirmed or suspect case clusters. There is approximately a ____% attack rate across the population of the county, with an estimate of _____ (insert number) persons with laboratory confirmed or suspect cases of H5N2, hospitals and clinics reporting census at capacity or averaging XX% over normal census, and _____ (insert number) deaths. These numbers are projected to rise over the next several weeks.</p> <p>Option 2: _____ (insert name) County is reporting a small number of laboratory confirmed or suspect cases clusters. There is approximately a ____% (insert percentage of impact) attack rate across the population of the county, with an estimate of _____ (insert number) persons with laboratory confirmed or suspect cases of H5N2, hospitals and clinics reporting census at capacity or averaging XX% over normal census, and ____ (insert number) deaths. While the number of confirmed cases is low at this time, it is projected that a surge of cases and influenza-like-illness will occur within 1-2 weeks. In addition, the county is beginning to see an influx of citizens/patients from surrounding highly impacted counties as their healthcare system becomes overwhelmed and people seek care outside their county of residence.</p>	
Date	Time	Intended Recipient	Information	Issues / Actions
June 17, 2009			CDC reports that all U.S. states and territories are now reporting outbreaks of laboratory confirmed clusters of H5N2 with human-to-human transmission.	
			CDC continues to project the Pandemic Severity Index at 5 with a national attack rate of 15%.	
			CDPH reports an attack rate of 18% across the state. Case fatality rates are at 15%. Hospitalizations have increased by 10-15%.	
			Local hospitals, clinics and medical offices are reporting a significant increase in persons presenting with influenza-like-illness and asymptomatic persons requesting antiviral medicines and antibiotics.	
			Healthcare and public safety providers are experiencing a marked impact on staffing due to illness or absenteeism.	
			Patient transfers from hospitals to long term care facilities are delayed as EMS Providers have fewer personnel to accommodate routine transfers.	
			Clinics are cancelling and/or rescheduling routine appointments.	

Exercise Begins: June 18, 2009

Command Centers and Emergency Operations Centers have been activated for at least three weeks.

Hospital and Clinic Command Centers may conduct a shift change and Command Center or Emergency Operations Center briefing.

Use of an IAP to facilitate the briefing is encouraged.

Date	Time	Intended Recipient	Information	Issues / Actions
June 18, 2009	0800	All	The daily report from CalEMA is released (see Attachment A)	<p><u>Issues for Discussion by All Participants</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> How would the CalEMA daily report be received by your agency? <input type="checkbox"/> How will the information be used in Command Centers? <input type="checkbox"/> How will the updated information provided by CalEMA be shared with your staff? With your patients / clients? <input type="checkbox"/> Who will develop messages for internal and external organizational communication? <input type="checkbox"/> Who approves information and messages that is disseminated within and outside of your organization? <input type="checkbox"/> How does your organization coordinate and interface with the OA Joint Information System (JIS) through the Joint Information Center? What personnel are the designated point(s) of contact for the Joint Information Center? <input type="checkbox"/> Accounting for costs incurred for incident response by individual healthcare facilities and at the OA Emergency Operations Center, as well as assessment of lost revenue should be initiated. <ul style="list-style-type: none"> Costs incurred may include those related to personnel, including: <ul style="list-style-type: none"> ▪ Overtime, call back pay and special pay incentives ▪ Use of temporary personnel ▪ Re-assignment of staff to positions or assignments not associated with daily activities ▪ "Just-in-time" training for use of personal protective equipment and/or fit testing ▪ Licensing and credentialing of medical and non-medical personnel, including volunteers ▪ Staffing of non-traditional patient care areas to support operations

				<p><i>Costs incurred may include those related to supplies and equipment, including:</i></p> <ul style="list-style-type: none"> ▪ <i>Ordering of additional supplies and equipment (including personal protective equipment) to increase on hand caches</i> ▪ <i>Ordering of additional pharmaceuticals to increase on hand caches</i> ▪ <i>Logistic support for government-authorized alternate care sites</i> ▪ <i>Increased supplies of food and water to support expanded operations</i> ▪ <i>Purchase or rental of additional equipment to support Alternate Care Sites (e.g., lighting, heating, communications, sanitation, etc.)</i> ▪ <i>Purchase or rental of additional equipment to support operations (e.g., fuel, water)</i> <p><i>Lost revenue should be tracked, including projections based on the following:</i></p> <ul style="list-style-type: none"> ▪ <i>Cancelled or postponed procedures</i> ▪ <i>Cancelled or postponed events</i> ▪ <i>Inability to receive or transfer patients</i> ▪ <i>Inability to provide day to day services</i>
0800	All	Across California, 60% of local health departments are reporting a high number of suspected or laboratory confirmed H5N2 cases and the healthcare system is highly impacted by high census and resource issues.		<p><u><i>Issues for Discussion by All Participants</i></u></p> <ul style="list-style-type: none"> ❑ <i>How will your agency or facility obtain critical information about the evolving situation, including:</i> <ul style="list-style-type: none"> ▪ <i>Situation status of other healthcare providers at the community, local, and regional levels?</i> ▪ <i>Situation status of local/community responders?</i> ▪ <i>Updated epidemiology, transmission, and virology of the novel virus?</i> ▪ <i>Location of and level of care provided in government-based alternate care sites?</i> ▪ <i>How will it its impact on your agency/facility be evaluated?</i> ▪ <i>What is the supply and equipment status at your facility/agency?</i> ▪ <i>Can the growing impact on current supplies and supply use be projected?</i>
0800	All	The Governor has approved use of overtime and special pay incentives for State personnel.		

0800	All	The Governor has ordered all state agencies to evaluate essential and non-essential services and postpone or cancel any activities or operations that do not impact public safety.	<p><u>Issues for Discussion by All Participants – Surge Capacity</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> What services, activities, or events provided by your agency or facility can be postponed or cancelled at this time? <input type="checkbox"/> What is the decision making process and authority within your agency or facility to approve cancellation or postponement of services? Who has the ultimate authority for decision making? <input type="checkbox"/> How can these now available resources augment personnel and other essential activities/functions (e.g., space, caregivers)? <input type="checkbox"/> Will this increase your personnel or staffing resources? <input type="checkbox"/> How will cancellation or rescheduling of services be tracked and monitored? <input type="checkbox"/> Are there personnel that can be reassigned from their non-essential roles to provide essential services? How will this be tracked? <input type="checkbox"/> Can essential services be maintained by augmenting staff with temporary personnel or use of volunteers? <input type="checkbox"/> How are these decisions shared with healthcare partners? With local health department? What other organizations or agencies should have this information? <input type="checkbox"/> How is the change in service delivery communicated to internal staff? To client patients and families?
0830	All	Local health departments, EMS Providers, and 911 Dispatch Centers are reporting a 50% increase in non-critical calls requesting advice on flu containment measures, flu symptoms, locations that can provide medical treatment outside hospitals, lists of cancelled services within the local area, and non-emergency transport to hospitals and clinics.	<p><u>Issues for Discussion by All Participants</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> From whom and how will your facility/organization receive information on infection control, social distancing, and care and treatment recommendations <input type="checkbox"/> How is your operational status shared with response partners? <input type="checkbox"/> How will patients be transported to other levels of care now that EMS providers are impacted and unable to conduct non-critical and routine transport? <input type="checkbox"/> How can calls for advice and guidance on available services be addressed? Can these calls be routed outside of your agency? <input type="checkbox"/> How will your organization manage the volume of call coming in with requests for information, access to care and services and treatment for the flu?
0830	Healthcare LHD Em. Mgmt	Community organizations that provide services to clients in their homes are greatly impacted. There are not enough drivers to deliver meals and supplies, incoming calls for new services have risen dramatically and volunteers are not reporting for shifts. These organizations are requesting help from local and OA emergency management to continue services.	<p><u>Issues for Discussion by CBOs</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Are there services that can be cancelled or postponed so that essential services can be maintained? Are there services that a partner or sister agency can assume for you? Are there services that you can provide to a partner or sister agency so they may maintain essential services? Are there Memoranda of Understanding in place to support essential services?

				<ul style="list-style-type: none"> <input type="checkbox"/> <i>What role(s) do volunteers play in your daily operations? Will increased numbers of volunteers help to support your services?</i> <input type="checkbox"/> <i>How will interruptions in service delivery be communicated to clients receiving services? To clients contracting for services?</i> <input type="checkbox"/> <i>How do you share situational status with local/county emergency management and partner agencies?</i> <input type="checkbox"/> <i>How does your agency/organization participate in OA Incident Action Planning?</i>
0830	LEMSA LHD Healthcare	Non-emergency transportation services can handle only 50% of their normal volume. Medical transportation services that take clients from their homes to hospitals and clinics for chronic care appointments (dialysis, radiation therapy, etc.) are unable to meet the volume causing some clients to call 911 for assistance.		<p><u>Issues for Discussion</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> <i>Is your agency part of the 911 response system in your county?</i> <input type="checkbox"/> <i>How does your agency identify essential vs. non-essential services?</i> <input type="checkbox"/> <i>How do you communicate your service disruptions with your clients?</i> <input type="checkbox"/> <i>How do you work with your healthcare clients to triage or prioritize services?</i> <input type="checkbox"/> <i>How do you track cancelled or postponed services?</i> <input type="checkbox"/> <i>How do you reschedule cancelled transports?</i> <input type="checkbox"/> <i>How do you receive direction from EMS authorities / local health authorities for alterations in service delivery?</i>
0830	All	The California Department of Mental Health is reporting a major increase in the number of calls for information and assistance as public anxiety increases and media reports project large numbers of deaths in the next several weeks. Local providers are feeling the impact as calls increase, emergency room visits spike with worried well and anxious citizens.		<p><u>Issues for Discussion</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> <i>Will this information impact your operations? Will your facility or agency be impacted by worried well or anxious citizens?</i> <input type="checkbox"/> <i>What can be done to calm the public's fears? Does your agency play a role in calming fears?</i> <input type="checkbox"/> <i>Are there private sector or community organizations that can assist with this issue?</i>
0830	Healthcare Emerg. Mgmt Coroner	<p>Long term care facilities report a growing number of patients with influenza symptoms. Patients who would normally be transferred to hospitals must remain at long term care facilities.</p> <p>Volunteers who normally assist at some facilities are not arriving for work. Long term care facilities are unable to accept hospital transfers. Several patients have died, and local mortuary, medical examiner and coroner services are overwhelmed due to increased volume as well as staff illness.</p>		<p><u>Issues for Discussion</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> <i>How do you communicate status information to local health authorities, hospitals and other long term care facilities?</i> <input type="checkbox"/> <i>How is facility status, including numbers of patients with flu symptoms, communicated to local health departments?</i> <input type="checkbox"/> <i>Where will the facility store and secure bodies until officials can respond?</i> <input type="checkbox"/> <i>How is the need for assistance communicated within the OA? To whom?</i> <input type="checkbox"/> <i>Is there direct access to local health departments and OA emergency management and emergency operations centers?</i>

0830	LHD Healthcare	The volume of calls from healthcare providers and citizens is overwhelming the ability of the local health department to respond. Persons are showing up at the health department, asking for flu shots. The local health department is also reporting a surge in routine laboratory testings, as hospital and free-standing labs can no longer handle the volume.	<u>Issues for Discussion for LHD</u> <ul style="list-style-type: none"> <input type="checkbox"/> How are calls triaged for priority? <input type="checkbox"/> How is this information shared with healthcare organizations, government agencies, public safety and the public? <input type="checkbox"/> How does the local health department develop risk communication messages? How are they approved? How are they disseminated? <input type="checkbox"/> What is the role of the local health department in the JIS? <input type="checkbox"/> How can laboratory testing be prioritized? <input type="checkbox"/> How will this be communicated to hospitals and healthcare providers? <input type="checkbox"/> How will a surge in laboratory testing impact routine tests? <input type="checkbox"/> Is there any testing or reporting that can be suspended? How will this decision be shared within the healthcare community?
0830	Public Safety Em. Mgmt LHD	Media continue to report on the state of the pandemic and now predict severe shortages of medicines and supplies. Media newscasts show long lines at pharmacies, grocery and convenience store as people are buying over the counter cold and flu medicines, water and fluids. News stations are reporting looting of local pharmacies and grocery stores as fears of supply shortages escalate.	<u>Issues for Discussion for all Participants</u> <ul style="list-style-type: none"> <input type="checkbox"/> How will these media reports impact your operations? <input type="checkbox"/> Is there additional planning within your facility or agency to support your staff and their families based on this report? <input type="checkbox"/> What is the mechanism within your facility/organization to receive accurate and up to date information? <input type="checkbox"/> How will these reports impact your operations? <input type="checkbox"/> How will this information be shared within your facility or organization?
0840	Law Enf.	Public safety resources are strained. There is an increase of sick calls and absenteeism in law enforcement and fire services. Within each county, officials are beginning the cancellation of non-essential services and redistributing employees to public safety duties.	<u>Issues for Discussion for Public Safety</u> <ul style="list-style-type: none"> <input type="checkbox"/> What non-essential services can be postponed or cancelled to augment essential, public safety services? <input type="checkbox"/> How will requests for services from private businesses, including healthcare organizations, be communicated to law enforcement? How will provision of services to these businesses be decided? <input type="checkbox"/> How is situational information communicated to the OA Emergency Operations Center? <input type="checkbox"/> How is the law enforcement mutual aid system accessed? <input type="checkbox"/> How are situational status and the ability to provide services to support healthcare shared with health authorities?
	Law Enf.	Hospitals, clinics, long term care facilities, the local health department and pharmacies are also requesting the assistance of law enforcement in anticipation of the media-reported potential for looting.	<u>Issues for Discussion for all Participants</u> <ul style="list-style-type: none"> <input type="checkbox"/> How can access to and control of critical supplies, equipment and pharmaceuticals be controlled? <input type="checkbox"/> Are there sufficient security staff to control access? <input type="checkbox"/> Does the access control or lockdown plan require the use of local law enforcement services?

			<ul style="list-style-type: none"> <input type="checkbox"/> How can internal security be augmented if law enforcement is unable to provide resources? <input type="checkbox"/> Are there non-essential services that can be cancelled or postponed to increase staffing and augment safety resources?
0900	RDMHC MHOAC	The JEOC overseeing medical operations requests a situational update from the RDMHC by 1200.	<p><u>Issues for Discussion for all Participants</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> How can this information be rapidly gathered within your agency or facility? <input type="checkbox"/> How is this information documented? <input type="checkbox"/> Who approves release of the information? <input type="checkbox"/> Will this information affect your incident action planning? <input type="checkbox"/> How is it communicated to the MHOAC? <p><i>Individual facilities and agencies must provide information through established technology and policy to the appropriate entity.</i></p>
0900	MHOAC LEMSA	RDMHC requests situational updates from the Medical and Health OA Coordinators by 1100. Information must include patient census and bed availability, patients waiting to be seen, in-hospital deaths, employee illness, and availability of supplies and equipment including personal protective equipment and pharmaceuticals.	
0900	Hospitals LHD LTC Clinics LEMSA	The MHOAC requests hospitals, clinics, long term care facilities and EMS Providers to provide information using the applicable format and information system by 1000.	
0900	All	There are reports that the statewide supply of antiviral medicines will last for less than 72 hours. The media is reporting that a vaccine for the H5N2 virus is being mass produced in Canada and can be ordered from the internet.	<p><u>Issues for Discussion by all Participants</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> How can you determine the impact of the pandemic as well as the projection for necessary supplies? <input type="checkbox"/> How do you request additional supplies and equipment outside of vendor agreements? <input type="checkbox"/> When one vendor provides supplies and equipment to multiple facilities, who prioritizes deliveries? <p><u>Issues for Discussion by Local Health Department</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Are there any alternatives to traditional personal protective equipment used by healthcare providers? How can the current supply be augmented? How will this information be disseminated to healthcare providers?
0930	All	Vendors supplying personal protective equipment are contacting their clients; they need information on current supply levels as well as projected needs for the next week.	
0930	MHOAC Hospitals	Hospitals are requesting the aid of the MHOAC to assist with patient discharges. Bed availability from long term care facilities as well as discharges to home are priorities for hospitals.	<p><u>Issues for Discussion</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> How will patient care discharges and transfers be coordinated within the OA? <input type="checkbox"/> Are there alternate methods available for patient movement? <input type="checkbox"/> How can EMS be augmented to respond to the increased demand? <input type="checkbox"/> How can the role of community organizations be enhanced to support hospital discharges?
0930	CBO Healthcare	Services provided by community-based organizations, including those that provide meals, transportation and in-home assistance, are needed before patients can be safely discharged home.	
0930	LEMSA	Ambulance services are needed for patient transfers, but there is impact on service delivery due to staff illness.	
1100	Healthcare LHD	Hospitals, long term care facilities and clinics have reported shortages of personal protective equipment, especially N95 masks.	<p><u>Issues for Discussion for all Healthcare Organizations</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> What procedures are available to procure additional supplies to sustain operations? From vendors? Other facilities? Medical Mutual Aid system?
1100	All	Projections for staff shortages show a major impact in the next week due to cancellation of schools, child and adult day care services.	

			<ul style="list-style-type: none"> <input type="checkbox"/> Are vendor agreements and MOUs in place to procure additional supplies? <input type="checkbox"/> How is the Medical Mutual Aid System accessed? <input type="checkbox"/> How are requests for supplies made? <input type="checkbox"/> What essential information is needed when requesting supplies? <input type="checkbox"/> Do local healthcare entities, local health departments and LEMSAs know how to access the California Disaster Healthcare Volunteer resources?
1100	Healthcare LHD	Clinics are reporting large numbers of persons presenting and calling the clinic with requests for flu shots, cold medicine and antiviral medicines. Clinics are having to turn away patients	<p><u>Issues for Discussion for all Participants</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> How will this impact your operations? <input type="checkbox"/> Can services be expanded based on these reports?
1100	All	Healthcare staff in clinics and hospitals are exhausted and some are now complaining of flu-like symptoms	<p><u>Issues for Discussion for all Hospitals</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Have you expanded operations within your facility to support patient care? <input type="checkbox"/> What are the logistic needs to support this expansion? <input type="checkbox"/> Who shares this information with internally? Externally?
1100	Healthcare LHD	Clinics are instructing patients to go to hospital emergency rooms for evaluation.	
1100	LHD Hospitals Em. Mgmt	The media are calling the local health department, hospitals and OA EOC with requests to answer questions on the spread of the flu, projected impact, and length of the pandemic.	<p><u>Issues for Discussion by Hospitals, LHD and County EOC</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> How should this information be addressed and validated? <input type="checkbox"/> Who is coordinating a response to this media report? <input type="checkbox"/> What subject matter experts should be involved in developing a response?
1100	All	The media report that local pharmacies cannot keep cold and flu medicine stocked on their shelves. There is also a significant increase in purchases of water, juices, electrolyte drinks and other fluids.	
1100	All	The manager of a local convenience store is interviewed on the news and stated the need the government to help with this crisis.	Participation in the JIS at the OA level may be exercised at this time.
1100	LHD Healthcare Law Enf. Em. Mgt LEMSA EMS Providers	<p>Within the OA, government-authorized alternate care sites have been opened, providing hospital based care.</p> <p>Note: Local Planners developing the exercise should determine the locations of these sites within the OA. The current plans for these sites within the OA may be tested, addressing logistics, staffing, level of care, chain of command, etc.</p> <p>The sites are located in the following locations:</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 	<p><u>Issues for Discussion by LHD, Hospitals, LEMSA and EMS Providers:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> How will you triage and refer patients away from facilities to government-authorized alternate care sites? <input type="checkbox"/> What are the criteria for referring patients from government-authorized alternate care sites to hospitals? <input type="checkbox"/> How do EMS providers learn where to transport patients? <input type="checkbox"/> Who oversees the level of care provided at these sites? <input type="checkbox"/> How are healthcare organizations made aware of these services? <input type="checkbox"/> How are residents informed of these sites? <input type="checkbox"/> How will you identify staff who will be assigned to work at the government-authorized alternate care sites?

1100	LEMSA LHD	The local health department is asking the LEMSA to aggregate data on 911 calls and EMS transports for influenza symptoms and respiratory distress by 1200.	<u>Issues for Discussion for LEMSAs and EMS Providers</u> <ul style="list-style-type: none"> <input type="checkbox"/> Is there a patient tracking and surveillance system already in use in your OA? <input type="checkbox"/> Can it accommodate a spike in volume? <input type="checkbox"/> How fast can the information be gathered, reviewed and provided to local health authorities? <input type="checkbox"/> Will the need for surveillance and tracking impact your operations? <input type="checkbox"/> Are there are mechanisms that can enhance the data collection?
1130	Law Enf. Em. Mgmt	Law enforcement agencies in the OA are impacted by sick calls among staff and absenteeism to care for family members. Media report that looting is imminent as law enforcement officers are unable to answer routine calls.	<u>Issues for Discussion by Healthcare</u> <ul style="list-style-type: none"> <input type="checkbox"/> How will this impact security procedures at your facility? <input type="checkbox"/> Will this impact staff morale? <input type="checkbox"/> Will absenteeism increase? <input type="checkbox"/> Can housing be provided for staff and families who are afraid to go home?
1130	All	Requests from hospitals, clinics and pharmacies for police support are not able to be met.	
	Healthcare LHD Coroner Em. Mgmt Law Enf.	The medical examiner/coroner for the OA reports a major increase in calls from hospitals and long term care facilities. EMS Providers are responding to calls for severe respiratory distress resulting in cardiac arrest. Medical examiner/coroner services are unable to respond to homes and healthcare facilities; deceased bodies must be kept on site and/or in their homes.	<u>Issues for Discussion</u> <ul style="list-style-type: none"> <input type="checkbox"/> How will these recommendations impact the EMS Providers? The community? <input type="checkbox"/> How will this information be disseminated to all healthcare partners? <input type="checkbox"/> How will hospitals and long term care facilities increase, or in some cases, develop their morgue capacity? <input type="checkbox"/> What roles does the local health officer play in this development? <input type="checkbox"/> Are their issues of public health safety in this development? <input type="checkbox"/> Will this impact public safety? <input type="checkbox"/> Is there any issue of contagion with this recommendation? <input type="checkbox"/> Are there alternate sites within the community that can be used as temporary morgues? <input type="checkbox"/> Are there federal assets that can be requested?
1130	All	All media are reporting that hospitals across the state have closed their doors to any new patients. This is raising the level of anxiety with calls from the public to elected officials to intervene.	<u>Issues for Discussion by all Participants</u> <ul style="list-style-type: none"> <input type="checkbox"/> How is this information validated? <input type="checkbox"/> How is correct information disseminated to the public? To clients and patients? To staff?
1200	All	The OA EOC is asking for an update on current supplies of personal protective equipment from all healthcare, public safety and community organizations that utilize personal protective equipment.. Resource caches in the area for terrorism response will be utilized as needed, but current supply levels are needed to triage distribution where it is most needed.	<u>Issues for Discussion by all Participants</u> <ul style="list-style-type: none"> <input type="checkbox"/> How can you rapidly assess your current supplies? <input type="checkbox"/> How can you project your needs for the next 72 hours? The next 96 hours? <input type="checkbox"/> How can you be a part of the decision making of allocation of critical supplies?

		All	JEOC releases a situational update on the projected impact and spread of the pandemic in California.
	1400	All	Hospital Command Centers and Emergency Operations Centers are gathering information for development of the IAP for the next operational period. They request information on operational status, availability of supplies and equipment, available staff and staff absenteeism, and cost expenditures to date.
	1400	HealthCare	The JEOC has requested a situation update from the RDMHCs by 1600.

VI. Exercise Evaluation

The 2009 Statewide Medical and Health Functional Exercise follows the principles of exercise design and execution as outlined in HSEEP. As previously discussed, the exercise has been designed based on three Target Capabilities:

- Communications
- Intelligence/Information Sharing and Dissemination
- Medical Surge

Each Target Capability is developed into an Exercise Evaluation Guide (EEG). Within each of the Target Capabilities are associated activities and tasks that gauge successful outcomes.

Using the Exercise Evaluation Guides

The purpose of HSEEP is to provide common exercise policy and program guidance that constitutes a national standard for exercises. EEGs assist in evaluation of the performance of the tasks, activities, and capabilities necessary exercise evaluation, improvement plans, and corrective actions, by providing evaluators with consistent standards and guidelines for observation, data collection, analysis, and report writing.

EEGs are the primary reference to ensure all jurisdictions/organizations evaluate exercises against the same measurable baseline. This method of evaluation helps to identify significant gaps in preparedness capabilities across the nation, and also serves as a tool to develop stronger and more consistent AAR/IPs. EEGs provide exercise evaluators with a manageable tool with which they can collect data during an exercise, in a format allowing the easy transfer of information to the AAR/IP.

The EEGs included in this guidebook can be customized with jurisdiction-specific tasks and performance measures that may be added to the list of Tasks and Performance Measures to be exercised.

Evaluators should familiarize themselves with the EEG, including the list of activities and tasks. During an exercise, the EEG is intended as a viewing guide, pointing evaluators in the direction of specific actions in order to assist their evaluation focus and support root-cause analysis and AAR development. While observing, the evaluator will be expected to:

1. Record the completion of tasks on the EEG

For each task, evaluators should check the box corresponding to the exercise participants' actions. Was the task "fully completed," "partially completed," "not completed," or "not applicable"? Most importantly, supplemental notes should be included to support the level of task completion identified. Each task line includes space to record at what time a task was completed. The checked boxes and timekeeping functions of the EEG format do not produce a report card or score sheet, but provides an objective record of task completion and support post-exercise analysis.

2. Record the demonstration of Performance Measures on the EEG itself

Performance measures are associated with many tasks and provide the evaluator the ability to record quantitative, observable indicators of performance. Each performance measure is followed by a target indicator as well as a location to input the actual, observed figure. For example, the Medical Surge Target Capability lists Activity 3: Increase Bed Surge Capacity. The associated task is: maximize utilization of available beds. The evaluator can record observations on the actions taken to maximize utilization of available beds.

3. Record supplemental notes on exercise events and observations

While the EEGs contain an extensive list of activities and tasks designed to help guide evaluators' observations, it is necessary that evaluators also record supplemental notes during exercise play. Notes might include observations on areas of strength and areas needing improvement area, times for completed actions and exercise events. Supplemental notes may also include initial analyses of root-causes for problems and recommendations for improvement.

4. Develop After Action Report

To maximize lessons learned from the experience, the evaluation materials should be used to draft an exercise AAR. Much of the information provided in the EEG Analysis Sheets will directly feed into the AAR.

The following structure is used to complete the Analysis Sheet:

Capability 1: Insert name of Target Capability i.e., Communication, Intelligence/Information Sharing and Dissemination or Medical Surge.

Capability Summary: Include a detailed overview of the capability, drawn from the Target Capability List capability description, and a description of how the capability was performed during the exercise.

Activity 1.1: Identify the activity from the EEG that is being observed.

Observation 1.1: First label as "Strength" or an "Area for Improvement." A strength is an observed action, behavior, procedure, and/or practice that is worthy of recognition and special notice. Areas for improvement are those areas in which the evaluator observed that a necessary task was not performed or that a task was performed with notable problems. Following this heading, insert a short, complete sentence that describes the general observation.

References: List relevant plans, policies, procedures, laws, and/or regulations, or sections of these plans, policies, procedures, laws, and/or regulations and Exercise Objective that the observation relates to.

Name of the task and the applicable plans, policies, procedures, laws, and/or regulations and 1-2 sentences describing their relation to the task

Analysis: Include a description of the behavior or actions at the core of the observation, as well as a brief description of what happened and the consequence(s) (positive or negative) of the action or behavior. If an action was performed successfully, include any relevant innovative approaches utilized by the exercise participants. If an action was not performed adequately, the root-causes contributing to the shortcoming must be identified.

Recommendations: Insert recommendations to address identified areas for improvement, based on the judgment and experience of the evaluation team. If the observation was identified as a strength, without corresponding recommendations, insert “none.”

1. Complete description of Recommendation #1
2. Complete description of Recommendation #2
3. Complete description of Recommendation #3

Provided below are examples for two exercise activities for Hospitals.

Activity 1: Pre-Event Mitigation and Preparedness

Observation: Strength. The hospital administrative team has adopted NIMS across the organization.

References: NIMS Compliance Elements for Hospitals

EEG, Task 1.2: Define incident management structure and methodology

Exercise Objective 1: Incident Command System (ICS)/Unified Command. Evaluate the local decision-making process, the capability to implement an onsite ICS structure, and the effective transition to a Unified Command in response to a local incident. Examine the response communities’ ability to employ pertinent ICS functions.

Analysis: Fictitious Healthcare Center has made NIMS integration a priority at the facility. They have incorporated NIMS principles into planning, and policy and procedure development. Education has been provided to staff including NIMS Federal Emergency Management Agency (FEMA) IS 100 Introduction to the Incident Command System, IS 200 Basic Incident Command System, IS 700 Introduction to the National Incident Management System, and IS 800 Introduction to the National Response Framework for all required administrative staff and IS 300 Intermediate Incident Command System, which is not yet a requirement. Plans are in place for providing IS 400 Advanced Incident Command System to hospital staff.

Recommendations:

1. Continue with NIMS compliance for hospitals, including newly hired staff

Activity 2: Incident Management

Observation: Area for Improvement. There was a lack of communication between individual hospital departments and the Hospital Command Center

References:

EEG, Task 2.1: Activate the health care organization's Emergency Operations Plan

Exercise Objective 1: Incident Command System. (ICS)

Evaluate the local decision-making process, the capability to implement an onsite ICS structure, and the effective transition to a Unified Command in response to a local incident. Examine the response community's ability to employ pertinent ICS functions.

Analysis: Fictitious Healthcare Center Emergency Management Plan is based on Incident Command System principles but the Hospital Command Center worked in virtual isolation. It was difficult for the Hospital Command Center to manage incident response with extremely limited information and situation reports from other departments. There was no common communication plan between individual departments and the Hospital Command Center.

An example of the lack of communication was that the Hospital Command Center remained unaware of patient arrival nearly an hour after ambulances delivered the first patient to the Emergency Department. Operations did not provide updates of patient care and the patient information received by the Hospital Command Center was minimal. Labor pool needs were not communicated to the Logistics Chief or the Hospital Command Center. The Incident Commander did not ask for briefings or situational reports from Command or General Staff. The Planning Chief did not receive adequate information for planning functions.

Recommendations:

1. Institute periodic Command and General Staff briefings by the Incident Commander
2. Ensure lines of communication with treatment areas requesting information and situational reports as needed
3. Utilize HICS Job Action Sheets as a guide for gathering information
4. Establish communication protocol with labor pool and Logistics Chief and Planning so that present and future needs for medical surge can be met
5. Activate the Hospital Command Center in future exercises to familiarize staff with communication between the Hospital Command Center and hospital departments

Customizing the EEG to local exercise play

Exercise planners and participants should use/customize the following EEG according to the Target Capabilities and activities that have been identified for the organization's exercise play.

Additional activities and tasks can be inserted into the EEG, based on these actions identified in the local planning. For example, if an individual organization chooses to use volunteers to support communications, an observed task may be inserted that measures the timely arrival of volunteers, sharing of accurate information and/or use of redundant communication technology.

**Exercise Evaluation Guide: 2009 Statewide Medical and Health Functional Exercise
Communications**

Capability Description:

Communications is the fundamental capability within disciplines and jurisdictions that response partners need to perform the most routine and basic elements of their job functions. Agencies must be operable, meaning they possess sufficient wireless communications capabilities to meet their daily internal and emergency communication requirements before they focus on interoperability.

Capability Outcome:

A continuous flow of critical information is maintained as needed among multi-jurisdictional and multi-disciplinary emergency responders, command posts, agencies, governmental officials, and healthcare entities for the duration of the emergency response operation in compliance with SEMS/NIMS. To accomplish this, the jurisdiction has a COOP for public safety communications to include the consideration of critical components, networks, support systems, personnel, and an appropriate level of redundant communications systems in the event of an emergency.

Jurisdiction or Organization:	Name of Exercise: 2009 Statewide Medical and Health Functional Exercise
Location:	Date: June 18, 2009
Evaluator:	Evaluator Contact Info:

Note to Exercise Evaluators: Not all activities and tasks are being evaluated at each location and for each entity. Activities and Tasks are customized for local exercise play and only those activities that have been identified for local exercise play should be reviewed.

Activity 1: Alert and Dispatch

Activity Description: In response to an incident alert, notify and provide communications management until the ICS or Emergency Operations Center is activated.

Tasks Observed (check those that were observed and provide comments)		
	Task /Observation Keys	Time of Observation/ Task Completion
1.1 (ComC 4.2)	Implement response communications interoperability plans and protocols. - Staff and management are informed of interoperable communications requirements - Interoperable communications equipment, channels and protocols are activated	Time: Task Completed? Fully [] Partially [] Not [] N/A []
1.2 (ComC 4.2.1)	Communicate incident response information per agency protocols. - Timely, accurate and clear incident information passed to dispatched response teams - Incident information relayed to pertinent incident management facilities (e.g., Incident Command Post , Emergency Operations Center/Multi Agency Coordination Center, Hospital Command Center, etc.) - Incident information relayed to response partners including local health departments, other acute care facilities, healthcare entities, law enforcement, community organizations and emergency management. (Exercise Objectives 1.C., 2.C., 3.C., 4.C., 5.B., 6.B., 7.B., 8.B.) - Incident information is gathered and shared with employees, patients and visitors as appropriate. (Exercise Objectives 1.E., 2.E., 3.E., 4.E, 5.D., 6.D., 7.D., 8.E.) - Incident information logged and disseminated to communications staff, as appropriate.	Time: Task Completed? Fully [] Partially [] Not [] N/A []
	Provide dispatch information to initial responders in an accurate and timely manner in conformity with: National Fire Protection Association 1221; Association of Public Communications Officials 25; and/or Communications Assistance for Law Enforcement Act standards	Yes [] No []
	Information is transmitted via secondary means when primary means are overloaded or fail (i.e., redundant systems and plans are activated to support primary communication systems)	TARGET Continuous
		ACTUAL
1.3 (ComC 4.2.1.1)	Use established common response communication language (i.e., plain English) to ensure information dissemination is timely, clear, acknowledged, and understood by all receivers.	Time: Task Completed? Fully [] Partially [] Not [] N/A []
	First responders acknowledge receipt and understanding of radio communications information	Yes [] No []

1.4 (ComC 3.5)	Initiate documentation process of required forms and follow-up notations. - Create logs of actions and messages sent and received - Forms, logs and reports are created in accordance with local requirements	Time: Task Completed? Fully [] Partially [] Not [] N/A []
1.5 (ComC 4.1.1)	Ensure that all critical communication networks are functioning. - Communications networks are continually checked for quality, degradation or failure - Maintenance and repair are conducted	Time: Task Completed? Fully [] Partially [] Not [] N/A []
	Alternate communications and/or dispatch centers are staffed in the event of a catastrophic loss of the primary site	Yes [] No []
	Equipment and personnel capabilities within communications and/or dispatch centers are available to process incoming calls with increased call volume, and/or loss of any one communication or dispatch center	Yes [] No []
1.6 (ComC 4.3)	Implement procedures to protect information facility and communication network systems. - Facility and physically secure - Communications equipment is sheltered from weather and physical damage - Communications equipment is monitored and protected from malicious attacks, including cyber attacks - An equipment accountability system is established	Time: Task Completed? Fully [] Partially [] Not [] N/A []

Activity 2: Provide Emergency Operations Center Communications Support

Activity Description: In response to notification of an incident, provide and receive interoperable voice, data, and video communications.

Tasks Observed (check those that were observed and provide comments)

	Task /Observation Keys	Time of Observation/ Task Completion
2.1 (ComC)	Implement incident communications interoperability plans and protocols. - Interoperable communications equipment, channels and protocols are activated and placed into service	Time:

4.2)		Task Completed? Fully [] Partially [] Not [] N/A []
2.2 (ComC 5.4.7)	Inform staff and management of interoperable communications requirements.	Time: Task Completed? Fully [] Partially [] Not [] N/A []
2.3 (ComC 4.2.1)	Establish communications with the OA medical and health point of contact for guidance and protocols on response activities. Communicate incident response information per agency protocols. (Exercise Objectives 6.F., 7.F.) - <i>Accurate and clear information passed to dispatched response teams</i> - <i>Incident information relayed to pertinent incident management facilities</i> - <i>Incident information logged and disseminated to communications staff as appropriate</i>	Time: Task Completed? Fully [] Partially [] Not [] N/A []
2.4 (ComC 4.2.1.1)	Use established common response communications language (i.e. plain English) to ensure information dissemination is timely, clear, acknowledged, and understood by all receivers. - <i>Dissemination is timely, clear, acknowledged, and understood by all receivers</i>	Time: Task Completed? Fully [] Partially [] Not [] N/A []
2.5 (ComC 4.2.2)	Coordinate incident site communications to be consistent with the SEMS/NIMS framework. - <i>A Communications Unit Leader is designated</i> - <i>An Incident Radio Communications Plan (ICS Form 205) is developed and maintained for complex incidents as a component of the Incident Action Plan</i>	Time: Task Completed? Fully [] Partially [] Not [] N/A []
2.6 (ComC 4.2.3)	Report and document the incident by completing and submitting required forms, reports, documentation, and follow-up notations. - <i>Create logs of actions and messages sent and received</i> - <i>Forms, logs and reports are created in accordance with local requirements</i>	Time: Task Completed? Fully [] Partially [] Not [] N/A []
2.7 (ComC 4.1.1)	Verify that all critical communication networks are functioning. - <i>Communication networks are continually checked for quality, degradation or failure</i> - <i>Maintenance and repair are conducted</i>	Time: Task Completed? Fully [] Partially [] Not [] N/A []

	Communications plan includes provision for back up if primary mode of communications overloads or fails	Yes [] No []
2.8 (ComC 4.1)	Establish and maintain response communications systems on-site. - <i>Interoperable communications equipment is available to responders</i> - <i>Communications systems operators and technical personnel are available</i>	Time: Task Completed? Fully [] Partially [] Not [] N/A []
	First responders are provided with command, tactical and support communications networks as requested by the Incident Commander	Yes [] No []
2.9 (ComC 4.3)	Implement information systems protection procedures. - <i>Communications equipment is sheltered from weather and physical damage</i> - <i>Communications equipment is monitored and protected from malicious attacks, including cyber attacks</i> - <i>An equipment accountability system is established</i>	Time: Task Completed? Fully [] Partially [] Not [] N/A []
	Communications plan accounts for known equipment incompatibility, and identifies strategies to overcome deficiencies	Yes [] No []
2.10 (ComC 5.2)	Establish and ensure connectivity to Emergency Operations Center /Multi-Agency Coordination Center.	Time: Task Completed? Fully [] Partially [] Not [] N/A []
2.11 (ComC 5.3.1.2)	Coordinate and provide telecommunications and information technology support to Federal, State, regional, tribal, local officials and non-governmental entities.	Time: Task Completed? Fully [] Partially [] Not [] N/A []

Activity 3: Return to Normal Operations		
Activity Description: Initiate incident-specific demobilization procedures for the interoperable communications system.		
Tasks Observed (check those that were observed and provide comments)		
	Task /Observation Keys	Time of Observation/ Task Completion
3.1 (ComC 7.1.1)	Develop communications section of the demobilization plan. <ul style="list-style-type: none"> - <i>Size of demobilization effort determined through review of incident records</i> - <i>Evaluate resources needed to support the demobilization effort</i> 	Time: Task Completed? Fully [] Partially [] Not [] N/A []
3.2 (ComC 7.1)	Initiate communications demobilization procedures. <ul style="list-style-type: none"> - <i>An updated demobilization plan is developed</i> - <i>Staff follow demobilization plan</i> - <i>Interoperable communications channels and equipment are successfully demobilized</i> - <i>Interoperable equipment returned</i> 	Time: Task Completed? Fully [] Partially [] Not [] N/A []
	Communications resources are returned to normal operations	Yes [] No []
3.3 (ComC 7.1.2)	Monitor communications demobilization. <ul style="list-style-type: none"> - <i>Demobilization plan distributed</i> - <i>Account for communications resources and return to normal operations</i> 	Time: Task Completed? Fully [] Partially [] Not [] N/A []
3.4 (ComC 4.2.3)	Report and document the incident by completing and submitting required forms, reports, documentation, and follow-up notations. <ul style="list-style-type: none"> - <i>Create logs of actions and messages sent and received</i> - <i>Forms, logs and reports are created in accordance with local requirements</i> 	Time: Task Completed? Fully [] Partially [] Not [] N/A []

Communications : EEG Analysis Sheets

The purpose of this section is to provide a narrative of what was observed by the evaluator/evaluation team for inclusion within the draft AAR/IP. This section includes a chronological summary of what occurred during the exercise for the observed activities. This section also requests the evaluator provide key observations (strengths or areas for improvement) to provide feedback to the exercise participants to support sharing of lessons learned and best practices as well as identification of corrective actions to improve overall preparedness.

Observations Summary

Write a general chronological narrative of responder actions based on your observations during the exercise. Provide an overview of what you witnessed and, specifically, discuss how this particular Target Capability was carried out during the exercise, referencing specific tasks where applicable. The narrative provided will be used in developing the exercise AAR/IP.

[Insert text electronically or on separate pages]

Evaluator Observations: Record your key observations using the structure provided below. Please try to provide a minimum of three observations for each section. There is no maximum (three templates are provided for each section; reproduce these as necessary for additional observations). Use these sections to discuss strengths and any areas requiring improvement. Please provide as much detail as possible, including references to specific Activities and/or Tasks. Document your observations with references to plans, procedures, exercise logs, and other resources. Describe and analyze what you observed and, if applicable, make specific recommendations. Please be thorough, clear, and comprehensive, as these sections will feed directly into drafting the AAR. Complete electronically if possible, or on separate pages if necessary.

Strengths

1. Observation Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ___ No ___

1) Analysis: (Include a **discussion** of what happened. When? Where? How? Who was involved? Also describe the **root cause** of the observation, including contributing factors and what led to the strength. Finally, if applicable, describe the positive **consequences** of the actions observed.)

2) References: (Include references to plans, policies, and procedures relevant to the observation)

3) Recommendation: (Even though you have identified this issue as a strength, please identify any recommendations you may have for enhancing performance further, or for how this strength may be institutionalized or shared with others.)

2. Observation Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ___ No ___

1) Analysis:

2) References:

3) Recommendation:

3. Observation Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ___ No ___

1) Analysis:

2) References:

3) Recommendation:

Areas for Improvement

1. Observation Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ___ No ___

1) Analysis: (Include a **discussion** of what happened. When? Where? How? Who was involved? Also describe the **root cause** of the observation, including contributing factors and what led to the strength. Finally, if applicable, describe the negative **consequences** of the actions observed.)

2) References: (Include references to plans, policies, and procedures relevant to the observation)

3) Recommendation: (Write a recommendation to address the root cause. Relate your recommendations to needed changes in plans, procedures, equipment, training, mutual aid support, management and leadership support.)

2. Observation Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ___ No ___

1) Analysis:

2) References:

3) Recommendation:

3. Observation Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ___ No ___

1) Analysis:

2) References:

3) Recommendation:

Exercise Evaluation Guide: 2009 Statewide Medical and Health Functional Exercise
Intelligence/Information Sharing and Dissemination

Capability Description: The Intelligence/Information Sharing and Dissemination capability is the multi-jurisdictional, multidisciplinary exchange and dissemination of information and intelligence among the Federal, State, local, and Tribal layers of government, healthcare entities, the private sector and residents. The goal of sharing and dissemination is to facilitate the distribution of relevant, actionable, timely information and/or intelligence that is updated frequently to the consumers who need it. More simply, the goal is to get the right information to the right people at the right time. An effective intelligence/information sharing and dissemination system will provide durable, reliable, and effective information exchanges between those responsible for gathering intelligence/information and information analysts. It will also allow for feedback and other necessary communications in addition to the regular flow of information and intelligence.	
Capability Outcome: Effective and timely sharing of information and intelligence occurs across Federal, State, local, Tribal, regional, and private sector entities to achieve coordinated awareness of, prevention of, protection against, and response to a threatened or actual, major disaster, or other emergency.	
Jurisdiction or Organization:	Name of Exercise: 2009 Statewide Medical and Health Functional Exercise
Location:	Date: June 18, 2009
Evaluator:	Evaluator Contact Info:
<i>Note to Exercise Evaluators: Activities and tasks are customized for local exercise play and only those activities that have been identified for your local exercise play should be reviewed.</i>	

Activity 1: Incorporate All Stakeholders Into Information Flow
Activity Description: All pertinent stakeholders across all disciplines are identified for inclusion in a clearly defined information sharing system.

Tasks Observed (check those that were observed and provide comments)		
	Task /Observation Keys	Time of Observation/ Task Completion
1.1 (Pre.A1d 1.1.2)	Identify relevant agencies, entities and officials to be included in the information sharing framework. <ul style="list-style-type: none"> - <i>All identified entities have readily available connectivity</i> - <i>Distribution lists are up-to-date with points of contact routinely verified on a periodic basis</i> - <i>Memoranda of understanding or similar agreements between appropriate entities exist and are on file</i> 	Time: Task Completed? Fully [] Partially [] Not [] N/A []
1.2 (Pre.A1d 3.1.2)	Comply with regulatory, statutory, privacy-related, and other issues that may govern the sharing of information. <ul style="list-style-type: none"> - <i>Operationally sound policies ensuring compliance have been implemented</i> - <i>Policies are followed by all personnel</i> 	Time: Task Completed? Fully [] Partially [] Not [] N/A []
1.3 (Pre.A1d 3.1.3)	Prevent, report, and/or address inappropriate disclosures of information and/or intelligence. <ul style="list-style-type: none"> - <i>Clearly defined process is implemented and followed</i> 	Time: Task Completed? Fully [] Partially [] Not [] N/A []

Activity 2: Conduct Horizontal Flow of Information		
Activity Description: Information flows across jurisdictions and across disciplines (among fire departments, EMS units, public works, the private sector, etc.) at all levels in a timely and efficient manner.		
Tasks Observed (check those that were observed and provide comments)		
	Task /Observation Keys	Time of Observation/ Task Completion
2.1 (Pre.A1d 5.1)	Horizontal coordination across jurisdictions including acute care facilities, clinics, long term care facilities, local health departments, community organizations, emergency management, and other healthcare entities is achieved at all levels through effective and timely information sharing. (Exercise Objectives 1.D., 2.D., 3.D., 4.D., 5.C., 6.C., 7.C., 8.D.)	Time: Task Completed?

	<ul style="list-style-type: none"> - Multi-jurisdictional lines of communication are established and used - An effective and technologically sufficient process for sharing information and/or intelligence is used - Receipt of information can be acknowledged - Alternative, supplemental, and backup mechanisms are available and routinely evaluated - Provide situational status and projected impact on service provision with local authorities (Exercise Objective 8.F.) 	<p>Fully [] Partially [] Not [] N/A []</p>
2.2 (Pre.A1d 5.1.1)	<p>Intelligence and/or information is shared across disciplines (i.e., Law Enforcement, Fire, EMS, local health department, healthcare entities, etc.) in a timely and effective manner.</p> <ul style="list-style-type: none"> - An effective and technologically sufficient process for sharing information and/or intelligence is used - Develop public information messages consistent with local authorities (OA JIS) and other healthcare providers for internal and external dissemination. (Exercise Objectives 1.G., 2.G., 3.G., 4.G.,) - Test the communication links to the law enforcement mutual aid coordinator for the OA. (Exercise Objective 5.F.) - Receipt of information can be acknowledged - Alternative, supplemental, and backup mechanisms are available and routinely evaluated 	<p>Time:</p> <p>Task Completed?</p> <p>Fully [] Partially [] Not [] N/A []</p>
2.3 (Pre.A1d 5.2)	<p>Dissemination and information sharing mechanisms are structured so that private sector entities receive accurate, timely, and unclassified information that is consistent with intelligence requirements.</p> <ul style="list-style-type: none"> - Information provided is updated frequently - Information provided is consistent with intelligence requirements - Effective mechanisms are used to provide feedback on information sent 	<p>Time:</p> <p>Task Completed?</p> <p>Fully [] Partially [] Not [] N/A []</p>

Intelligence/Information Sharing and Dissemination : EEG Analysis Sheets

The purpose of this section is to provide a narrative of what was observed by the evaluator/evaluation team for inclusion within the draft AAR/IP. This section includes a chronological summary of what occurred during the exercise for the observed activities. This section also requests the evaluator provide key observations (strengths or areas for improvement) to provide feedback to the exercise participants to support sharing of lessons learned and best practices as well as identification of corrective actions to improve overall preparedness.

Observations Summary

Write a general chronological narrative of responder actions based on your observations during the exercise. Provide an overview of what you witnessed and, specifically, discuss how this particular Target Capability was carried out during the exercise, referencing specific Tasks where applicable. The narrative provided will be used in developing the exercise AAR/IP.

[Insert text electronically or on separate pages]

Evaluator Observations: Record your key observations using the structure provided below. Please try to provide a minimum of three observations for each section. There is no maximum (three templates are provided for each section; reproduce these as necessary for additional observations). Use these sections to discuss strengths and any areas requiring improvement. Please provide as much detail as possible, including references to specific Activities and/or Tasks. Document your observations with references to plans, procedures, exercise logs, and other resources. Describe and analyze what you observed and, if applicable, make specific recommendations. Please be thorough, clear, and comprehensive, as these sections will feed directly into drafting the AAR. Complete electronically if possible, or on separate pages if necessary.

Strengths

1. Observation Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ___ No ___

1) Analysis: (Include a **discussion** of what happened. When? Where? How? Who was involved? Also describe the **root cause** of the observation, including contributing factors and what led to the strength. Finally, if applicable, describe the positive **consequences** of the actions observed.)

2) References: (Include references to plans, policies, and procedures relevant to the observation)

3) Recommendation: (Even though you have identified this issue as a strength, please identify any recommendations you may have for enhancing performance further, or for how this strength may be institutionalized or shared with others.)

2. Observation Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ___ No ___

1) Analysis:

2) References:

3) Recommendation:

3. Observation Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ___ No ___

1) Analysis:

2) References:

3) Recommendation:

Areas for Improvement

1. Observation Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ___ No ___

1) Analysis: (Include a **discussion** of what happened. When? Where? How? Who was involved? Also describe the **root cause** of the observation, including contributing factors and what led to the strength. Finally, if applicable, describe the negative **consequences** of the actions observed.)

2) References: (Include references to plans, policies, and procedures relevant to the observation)

3) Recommendation: (Write a recommendation to address the root cause. Relate your recommendations to needed changes in plans, procedures, equipment, training, mutual aid support, management and leadership support.)

2. Observation Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ___ No ___

1) Analysis:

2) References:

3) Recommendation:

3. Observation Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ___ No ___

1) Analysis:

2) References:

3) Recommendation:

Exercise Evaluation Guide: 2009 Statewide Medical and Health Functional Exercise Medical Surge

Capability Description: Medical Surge is proclaimed in a local jurisdiction when an authorized local official, such as a local health officer or other appropriate designee, using professional judgment determines, subsequent to a significant emergency or circumstances, that the healthcare delivery system has been impacted, resulting in an excess in demand over capacity in hospitals, long-term care facilities, community care clinics, public health departments, other primary and secondary care providers, resources and/or emergency medical services. The local health official uses the situation assessment information provided from the healthcare delivery system partners to determine overall local OA medical and health status.	
Capability Outcome: Those impacted by the event are rapidly and appropriately cared for. Continuity of care is maintained for non-incident related illness or injury.	
Jurisdiction or Organization:	Name of Exercise: 2009 Statewide Medical and Health Functional Exercise
Location:	Date: June 18, 2009
Evaluator:	Evaluator Contact Info:
<i>Note to Exercise Evaluators: Activities and tasks are customized for local exercise play and only those activities that have been identified for your local exercise play should be reviewed.</i>	

Activity 1: Pre-Event Mitigation and Preparedness
Activity Description: Conduct pre-event mitigation and preparedness plans, policies, and procedures prior to notification of medical surge incident.
Tasks Discussed (check those that were discussed and provide comments)

	Task /Observation Keys	Task Completion
1.1 (n/a)	<p>Define incident management structure and methodology.</p> <ul style="list-style-type: none"> - <i>Develop an incident management team chart for use in a pandemic event</i> - <i>Identify personnel to fill incident management team pandemic roles, including redundancies in the staffing</i> - <i>Identify medical / technical specialists to advise the incident management team in a pandemic event</i> - <i>Include identified pandemic medical / technical specialists in training and exercises</i> - <i>Identify the authority of the local health officer in a public health emergency in the local health department pandemic influenza plan</i> - <i>Develop a mass vaccination and distribution plan for antiviral medications</i> - <i>Include healthcare and public safety workers in public health mass vaccination and distribution plan</i> 	<p>Task Discussed/Met?</p> <p>Fully [] Partially [] Not [] N/A []</p>
1.2 (n/a)	<p>Develop protocols for increasing internal surge capacity.</p> <ul style="list-style-type: none"> -<i>Identify potential gaps in personnel, supplies, and equipment</i> -<i>Identify a comprehensive list of supplies and equipment needed to sustain operations in a pan flu event</i> -<i>Provide staff infection control measures training in response to influenza</i> -<i>Identify appropriate personal protective equipment for staff and establish baseline (par) level for on-site personnel with adaptation listed for surge event</i> -<i>Provide fit testing on a routine and emergency basis</i> -<i>Post proper infection control practices for containing the spread of influenza throughout the facility</i> -<i>Develop a laboratory-specific surge plan</i> -<i>Develop a mass fatality surge plan that addresses capacity, capability and infection control issues</i> 	<p>Task Discussed/Met?</p> <p>Fully [] Partially [] Not [] N/A []</p>
1.3 (n/a)	<p>Determine medical surge assistance requirements.</p> <ul style="list-style-type: none"> - <i>Coordinate with State, Tribal, and local medical, behavioral health, public health, and private sector entities to establish vendor agreements and Memoranda of Understanding in support of surge requirements</i> - <i>Develop policies and procedures to access additional supplies through the California Mutual Aid System</i> - <i>Test or exercise vendor agreements or Memoranda of Understanding to procure additional supplies</i> - <i>Coordinate mass fatality planning with coroners/medical examiners and healthcare facilities, local mortuary providers, and health authorities</i> 	<p>Task Discussed/Met?</p> <p>Fully [] Partially [] Not [] N/A []</p>

Activity 2: Incident Management		
Activity Description: In response to notification of an infectious surge event, activate the organization’s Emergency Operations Plan.		
Tasks Discussed (check those that were observed and provide comments)		
	Task /Observation Keys	Task Discussed/Met
2.1 (n/a)	Activate the organization’s Emergency Operations Plan . <ul style="list-style-type: none"> - <i>Implement notification procedures for incident management personnel and key administrative staff</i> - <i>Assign roles and responsibilities to the incident management team and general staff</i> - <i>Expand or deactivate members of the incident management team structure as needed. (Exercise Objectives 1. B. 2.B., 3.B., 4.B.)</i> - <i>Manage incident response in accordance with Incident Command System (ICS) organizational structures, doctrine, and procedures, as defined In SEMS/ NIMS</i> - <i>Establish a safety plan for facility patients and staff</i> - <i>Implement a common communications plan</i> 	Task Discussed/Met? Fully [] Partially [] Not [] N/A []
2.1.1	Activate the organization’s pandemic influenza plan (Exercise Objectives 1.A., 2.A., 3.A., 4.A., 5.A., 6.A., 7.A., 8.A.)	Task Discussed/Met? Fully [] Partially [] Not [] N/A []
2.2 (n/a)	Incident action planning. (Exercise Objectives 1.F., 2.F., 3.F., 4.F., 5.E., 6.E., 7.E.) <ul style="list-style-type: none"> - <i>Establish and document incident goals and objectives</i> - <i>Establish and document the strategy and general tactics to meet incident objectives</i> - <i>Develop and document support plans (e.g., safety plans, contingency plans)</i> - <i>Coordinate with other response entities, if appropriate, to define an operational period for response</i> - <i>Evaluate and revise objectives for each operational period</i> 	Task Discussed/Met? Fully [] Partially [] Not [] N/A []
2.3 (n/a)	Disseminate key components of incident action plan. <ul style="list-style-type: none"> - <i>Disseminate key components of the IAP with external response entities during each operational period</i> 	Task Discussed/Met? Fully [] Partially [] Not [] N/A []
2.4 (n/a)	Provide emergency operations support to incident management. <ul style="list-style-type: none"> - <i>Establish connectivity and coordinate requests for emergency operations support with multi-agency coordination centers (e.g., local or OA Emergency Operations Center), REOC, State Operations Center, , etc.)</i> 	Task Discussed/Met? Fully [] Partially [] Not [] N/A []

2.5 (n/a)	Provide facility security during surge event. (Exercise Objective 1.M.)	Task Discussed/Met? Fully [] Partially [] Not [] N/A []
2.6 (n/a)	Restrict long term care facility entry by visitors and others as determined by the facility, to prevent exposure and/or spread of infectious disease. (Exercise Objective 4.H.)	Task Discussed/Met? Fully [] Partially [] Not [] N/A []
2.7 (n/a)	Secure clinic facility and grounds to protect staff, volunteers, physicians, patients, visitors and assets, considering lockdown or closure of facility. (Exercise Objective 3.L)	Task Discussed/Met? Fully [] Partially [] Not [] N/A []
2.8 (n/a)	Identify law enforcement services that can be postponed or suspended to increase public safety manpower. (Exercise Objective 5.G.)	Task Discussed/Met? Fully [] Partially [] Not [] N/A []

Activity 3: Increase Bed Surge Capacity

Activity Description: Increase as many staffed and resourced healthcare beds as clinically appropriate.

Tasks Discussed (check those that were discussed and provide comments)

	Task /Observation Keys	Task Completion
3.1 (n/a)	Implement bed surge capacity plans, procedures, and protocols. (Exercise Objectives 1.H., 3.H.) <ul style="list-style-type: none"> - Activate government-authorized alternate care sites - Activate plans, procedures, and protocols to maximize bed surge capacity, including an influx of patients in an infectious disease event. (e.g., utilize non-traditional patient care spaces such as hallways, waiting areas, etc.) - Establish the capability and capacity to isolate patients - Establish the capability and capacity to isolate patients - Establish plans to for deferring routine, non-emergency services (if necessary) 	Task Discussed/Met? Fully [] Partially [] Not [] N/A []
	Maximize utilization of available beds. <ul style="list-style-type: none"> - Coordinate patient distribution with other health care facilities, EMS Providers and other services when 	Task Discussed/Met?

	<i>available</i>	Fully [] Partially [] Not [] N/A []
3.3 (n/a)	Initiate forward transport of less acutely ill patients. <ul style="list-style-type: none"> - <i>Activate MOUs with other health care organizations (if applicable) for transport and care of patients who are not stable enough to discharge home or to a government-authorized alternate care site.</i> - <i>Institute protocols to discharge stable inpatients to home or other health care facilities</i> - <i>Coordinate transport of inpatients with families and the incident management team</i> - <i>Implement transport procedures to pre-identified facilities based on level of care required</i> 	Time: Task Discussed/Met? Fully [] Partially [] Not [] N/A []
3.4 (n/a)	Provide medical surge capacity in government-authorized alternate care sites. <ul style="list-style-type: none"> - <i>Activate MOUs or agreements to open government-authorized alternate care sites.</i> - <i>Activate appropriate staffing (e.g., clinical security, administrative, etc.) and supply plans</i> 	Task Discussed/Met? Fully [] Partially [] Not [] N/A []
3.5 (n/a)	Existing clinics assist other clinics and healthcare providers in the OA with personnel and equipment resources. (Exercise Objective 3.J.)	Task Discussed/Met? Fully [] Partially [] Not [] N/A []

Activity 4: Medical Surge Staffing Procedure

Activity Description: Maximize staffing levels through recall of off-duty personnel, part-time staff, and retired clinical and non-clinical associates.

Tasks Discussed (check those that were discussed and provide comments)

	Task /Observation Keys	Task Completion
4.1 (n/a)	Recall clinical personnel in support of surge capacity requirements. (Exercise Objectives 1.H., 2.H.) <ul style="list-style-type: none"> - <i>Implement health care organization's staff call-back procedures (including "part-time" staff)</i> - <i>Activate procedures to receive, process, and manage staff throughout the incident</i> - <i>Develop plans and procedures to share information with staff and clients that is vetted through command staff, medical / technical specialist and coordinated with external response partners including local health departments.</i> - <i>Develop plan to monitor staff for signs or symptoms of influenza</i> - <i>Provide education and training on the pandemic influenza plan to all response partners, stakeholders and community organizations</i> 	Task Discussed/Met? Fully [] Partially [] Not [] N/A []
4.2 (n/a)	Augment clinical staffing. (Exercise Objectives 1.H, 1.J., 2.H.) <ul style="list-style-type: none"> - <i>Activate roster and initiate call-back procedures for qualified and licensed volunteer clinicians</i> 	Task Discussed/Met?

	<ul style="list-style-type: none"> - Implement strategies to integrate Federal clinical personnel (e.g., National Disaster Medical System and U.S. Public Health System Personnel) - Provide just-in-time training to clinical staff 	Fully [] Partially [] Not [] N/A []
4.3 (n/a)	<p>Augment non-clinical staffing. (Exercise Objectives 1.H, 1.J., 2.H)</p> <ul style="list-style-type: none"> - Activate MOUs for non-clinical staff (if applicable) - Activate processes to receive, process, and manage non-clinical staff throughout the incident 	<p>Task Discussed/Met?</p> <p>Fully [] Partially [] Not [] N/A []</p>
4.4 (n/a)	<p>Identify additional sources of manpower for law enforcement agency that can be activated to increase resources. (Exercise Objective 5.H.)</p>	<p>Task Discussed/Met?</p> <p>Fully [] Partially [] Not [] N/A []</p>
4.5 (n/a)	<p>Identify additional resources to sustain, maximize, and augment EMS staffing during a surge event. (Exercise Objective 6.H.)</p>	<p>Task Discussed/Met?</p> <p>Fully [] Partially [] Not [] N/A []</p>
4.6 (n/a)	<p>Identify community organization services which can be postponed, consolidated or reassigned to partner organizations due to resource shortages (including organization and volunteer personnel). (Exercise Objective 8.C.)</p>	<p>Task Discussed/Met?</p> <p>Fully [] Partially [] Not [] N/A []</p>

Activity 5: Receive, Evaluate, and Treat Surge Casualties

Activity Description: Receive mass casualties and provide appropriate evaluation and medical treatment.

Tasks Discussed (check those that were observed and provide comments)

	Task /Observation Keys	Task Completion
5.1 (n/a)	<p>Manage transportation of infectious patient, including infection control measures and personnel protection. (Exercise Objective 6.G.)</p>	<p>Task Discussed/Met?</p> <p>Fully [] Partially [] Not [] N/A []</p>
5.2 (n/a)	<p>Establish initial reception and triage site.</p> <ul style="list-style-type: none"> - Activate MOUs with other healthcare organizations or community assets (e.g., schools, conference centers) for initial patient triage 	<p>Task Discussed/Met?</p> <p>Fully [] Partially [] Not [] N/A []</p>

5.3 (n/a)	<p>Provide medical equipment and supplies in support of immediate medical response operations and for restocking supplies/equipment requested. (Exercise Objectives 1.H., 3.I.)</p> <ul style="list-style-type: none"> - <i>Identify additional medical equipment and supplies needed to meet surge capacity requirements</i> - <i>Implement restocking procedures for pre-hospital care providers</i> - <i>Request the assets from the Strategic National Stockpile through SEMS</i> 	<p>Task Discussed/Met?</p> <p>Fully [] Partially [] Not [] N/A []</p>
5.4 (n/a)	<p>Institute patient tracking.</p> <ul style="list-style-type: none"> - <i>Implement systems to track all patients in the(applicable) facility with capability to distinguish between incident-related and non-incident patients</i> 	<p>Task Discussed/Met?</p> <p>Fully [] Partially [] Not [] N/A []</p>
5.5 (n/a)	<p>Prioritize, manage, and allocate resources, especially scarce resources (ventilators, isolation capacity, personal protective equipment, critical care beds, and pharmaceuticals) during an infectious surge event, including executing medical mutual aid agreements. (Exercise Objectives 1.K., 3.I.)</p> <ul style="list-style-type: none"> - <i>Identify additional needed medical supplies, equipment, and other resources needed to meet surge requirements</i> - <i>Identify needed healthcare professionals</i> - <i>Coordinate and communicate requests for mutual aid support with local, regional, and State response agencies</i> - <i>Coordinate and communicate requests for support with outside sources (e.g., vendors, suppliers, EMS, city and OA stockpiles, corporate healthcare system) for essential supplies, services, and equipment. (Exercise Objective 1.L, 3.K.)</i> - <i>Share resource capability and resource needs with the MHOAC (Exercise Objective 6.I)</i> 	<p>Task Discussed/Met?</p> <p>Fully [] Partially [] Not [] N/A []</p>
5.6 (n/a)	<p>Activate Procedures for Crisis Care</p> <ul style="list-style-type: none"> - <i>Disseminate information on crisis care through established information management mechanisms within the organization and to external response entities</i> 	<p>Task Discussed/Met?</p> <p>Fully [] Partially [] Not [] N/A []</p>
5.7 (n/a)	<p>Activate mass fatality plans, integrating with operational resources from the medical examiner / coroner (Exercise Objective 1.I.)</p>	<p>Task Discussed/Met?</p> <p>Fully [] Partially [] Not [] N/A []</p>

Medical Surge: EEG Analysis Sheets

The purpose of this section is to provide a narrative of what was observed by the evaluator/evaluation team for inclusion within the draft AAR/IP. This section includes a chronological summary of what occurred during the exercise for the observed activities. This section also requests the evaluator provide key observations (strengths or areas for improvement) to provide feedback to the exercise participants to support sharing of lessons learned and best practices as well as identification of corrective actions to improve overall preparedness.

Observations Summary

Write a general chronological narrative of responder actions based on your observations during the exercise. Provide an overview of what you witnessed and, specifically, discuss how this particular Target Capability was carried out during the exercise, referencing specific Tasks where applicable. The narrative provided will be used in developing the exercise AAR/IP.

[Insert text electronically or on separate pages]

Evaluator Observations: Record your key observations using the structure provided below. Please try to provide a minimum of three observations for each section. There is no maximum (three templates are provided for each section; reproduce these as necessary for additional observations). Use these sections to discuss strengths and any areas requiring improvement. Please provide as much detail as possible, including references to specific Activities and/or Tasks. Document your observations with references to plans, procedures, exercise logs, and other resources. Describe and analyze what you observed and, if applicable, make specific recommendations. Please be thorough, clear, and comprehensive, as these sections will feed directly into drafting the AAR. Complete electronically if possible, or on separate pages if necessary.

Strengths

1. Observation Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ___ No ___

1) Analysis: (Include a **discussion** of what happened. When? Where? How? Who was involved? Also describe the **root cause** of the observation, including contributing factors and what led to the strength. Finally, if applicable, describe the positive **consequences** of the actions observed.)

2) References: (Include references to plans, policies, and procedures relevant to the observation)

3) Recommendation: (Even though you have identified this issue as a strength, please identify any recommendations you may have for enhancing performance further, or for how this strength may be institutionalized or shared with others.)

2. Observation Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ___ No ___

1) Analysis:

2) References:

3) Recommendation:

3. Observation Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ___ No ___

1) Analysis:

2) References:

3) Recommendation:

Areas for Improvement

1. Observation Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ___ No ___

1) Analysis: (Include a **discussion** of what happened. When? Where? How? Who was involved? Also describe the **root cause** of the observation, including contributing factors and what led to the strength. Finally, if applicable, describe the negative **consequences** of the actions observed.)

2) References: (Include references to plans, policies, and procedures relevant to the observation)

3) Recommendation: (Write a recommendation to address the root cause. Relate your recommendations to needed changes in plans, procedures, equipment, training, mutual aid support, management and leadership support.)

2. Observation Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ___ No ___

1) Analysis:

2) References:

3) Recommendation:

3. Observation Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ___ No ___

1) Analysis:

2) References:

3) Recommendation:

This page is intentionally left blank

Appendix A

INTENT TO PARTICIPATE

Please complete this form to indicate intent to participate in the exercise.
Forms should be submitted by no later than May 1, 2009

FAX THIS FORM TO THE OA EXERCISE CONTACT:

_____ at (_____) _____

✓ Type of Provider:

- | | | |
|---|---|--|
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Community Clinic | <input type="checkbox"/> Local Health Department |
| <input type="checkbox"/> Long Term Care Facility | <input type="checkbox"/> LEMSA | <input type="checkbox"/> EMS Provider |
| <input type="checkbox"/> Medical Examiner / Coroner | <input type="checkbox"/> Law Enforcement | <input type="checkbox"/> Community Organization |
| <input type="checkbox"/> Emergency Management | <input type="checkbox"/> Environmental Health | <input type="checkbox"/> Other _____ |

Name of Facility or Provider: _____

Address: _____

City _____ Zip _____

Exercise Coordinator or Contact: _____

Telephone #: _____ Fax #: _____

E-mail: _____

If you do not intend to participate in the 2009 Statewide Medical and Health Functional Exercise, please indicate by checking this box and submitting the form as indicated above.

No, my facility is not participating in this exercise.

The exercise is developed as a functional exercise in response to Pandemic Influenza. The exercise can be adapted be individual participants or within the OA. Please indicate the level of exercise play for your facility/agency:

- | | | |
|--|--|---|
| <input type="checkbox"/> Functional Exercise | <input type="checkbox"/> Full Scale Exercise | |
| <input type="checkbox"/> Tabletop Exercise | <input type="checkbox"/> Seminar / Workshop | <input type="checkbox"/> Communications |

The exercise is scripted for a start time of 0800 and an end time of 1400.
Please indicate the hours that your facility / provider will be participating in the exercise:

Time and Number of Hours of exercise play: Time: _____ to _____ # Hours: _____

Additional forms should be completed for each participating agency, organization or provider. If the organization represented on this form consists of more than one facility, an *Intent to Participate* form should be completed for each facility.

Appendix B

Operational Area Participation

The exercise contact identified for each Operational Area must complete this form and **return to the Emergency Preparedness Office of the California Department of Public Health** by May 15, 2009.

Please provide this information as a summary of those entities participating in the 2009 Statewide Medical and Health Functional Exercise for your OA.

Operational Area _____

Exercise Coordinator _____

Telephone # (____) _____ Fax # (____) _____

Email: _____

Agency / Organization Participation. Please indicate the type and number (where indicated) of exercise participants in the OA.

- | | |
|--|--|
| <input type="checkbox"/> Hospitals # _____ | <input type="checkbox"/> Community Clinics # _____ |
| <input type="checkbox"/> EMS Providers # _____ | <input type="checkbox"/> Long Term Care Facilities # _____ |
| <input type="checkbox"/> Local Health Department | <input type="checkbox"/> Medical Examiner / Coroner |
| <input type="checkbox"/> OA Emergency Management | <input type="checkbox"/> Law Enforcement Agency |
| <input type="checkbox"/> Environmental Health | <input type="checkbox"/> LEMSA |
| <input type="checkbox"/> Other _____ | |

Please note the number of hospitals NOT participating in this exercise:

The exercise is developed as a functional exercise in response to pandemic influenza. The exercise will be scripted for a start time of 0800 to be completed by 1400.

Please indicate the hours of exercise participation in your OA:

Time and Number of Hours of exercise play: Time: _____ to _____ # Hours: _____

Please send completed forms should be sent to CDPH EPO by May 15, 2009

Dianna Ziehm

Fax: 916-650-6420

Email: Dianna.Ziehm@cdph.ca.gov

Appendix C

World Health Organization and Centers for Disease Control Pandemic Phases

WHO identifies six phases of a pandemic with categorization into Inter-Pandemic Period, Pandemic Alert and a Pandemic Period.

CDC has identified six stages of a pandemic in the United States.

The WHO phases and U.S. stages are linked to the characteristics of a new influenza virus and its spread throughout the population.

The following chart identifies and compares the WHO phases and the U.S. Stages.

WHO Phases			U.S. Stages	
Inter-Pandemic Period (New virus in animals, no human cases)	Low risk of human cases	1	0	New domestic animal outbreak in at-risk country
	Higher risk of human cases	2		
Pandemic Alert (New virus causes human cases)	No or very limited human-human transmission	3	1	Suspected human outbreak overseas
	Evidence of increased human-human transmission	4	2	Confirmed human outbreak overseas
	Evidence of significant human-human transmission	5		
Pandemic Period	Efficient and sustained human-human transmission	6	3	Widespread human outbreaks in multiple locations overseas
			4	First human case in North America
			5	Spread throughout US
			6	Recovery and preparation for subsequent waves

Appendix D

Frequently Asked Questions (FAQs) about Pandemic Influenza

The official website for the distribution of information on pandemic influenza, www.pandemicflu.gov, which is managed by the U.S. Department of Health and Human Services, has prepared a series of answers to those questions most frequently asked in relation to pandemic influenza.

What is an influenza pandemic?

A pandemic is a global disease outbreak among humans. An influenza pandemic occurs when a new virus emerges for which there is little or no immunity in the human population, begins to cause serious illness, and then spreads easily person-to-person worldwide.

How do pandemic viruses occur?

New influenza viruses emerge as a result of a process called antigenic shift, which causes a sudden and major change in influenza A viruses. These changes occur when proteins on the surface of the virus combine in new ways as a result of mutation or exchange of genetic material between multiple influenza viruses. If such changes result in a new influenza A virus subtype that can infect humans and spread easily from person to person, an influenza pandemic can occur.

Will a pandemic influenza occur? If so, when will it happen?

Many scientists believe it is a matter of time until the next influenza pandemic occurs. However, the timing and severity of the next pandemic cannot be predicted. Influenza pandemics occurred three times in the past century: in 1918-19, 1957-58, and 1968-69.

Why are pandemics such dreaded events?

Influenza pandemics are remarkable events that can rapidly infect virtually all countries. Once international spread begins, pandemics are considered unstoppable, because the virus spreads very rapidly by coughing or sneezing. The fact that infected people can share the virus before symptoms appear adds to the risk of international spread via travelers.

The severity of disease and the number of deaths caused by a pandemic virus varies greatly, and cannot be known prior to the emergence of the virus. During past pandemics, attack rates reached 25-35% of the total population. Under the best circumstances, assuming that the new virus causes mild disease, the world could still experience an estimated 2 million to 7.4 million deaths (projected from data obtained during the 1957 pandemic). Projections for a more virulent virus are much higher. The 1918 pandemic, which was uniquely severe, killed at least 40 million people. In the U.S., the mortality rate of people infected with the virus during that pandemic was around 2.5%.

During a severe pandemic, such as the one that occurred in 1918, there would be large surges in the numbers of people requiring or seeking medical or hospital treatment, temporarily overwhelming health services. High rates of worker absenteeism could also interrupt other

essential services, such as law enforcement, transportation, and communications. Because populations will be fully susceptible to a pandemic virus, rates of illness could peak fairly rapidly within a given community. This means that local social and economic disruptions may be temporary. They may, however, be amplified in today's closely interrelated and interdependent systems of trade and commerce.

As all countries are likely to experience emergency conditions during a pandemic, opportunities for inter-country assistance, as seen during natural disasters or localized disease outbreaks, may be curtailed once international spread has begun and governments focus on protecting domestic populations.

What age groups are most likely to be affected during an influenza pandemic?

Although scientists cannot predict the specific consequences of an influenza pandemic, it is likely that many age groups would be seriously affected. The greatest risk of hospitalization and death – as seen during the last two pandemics in 1957 and 1968 and during annual influenza – will be infants, the elderly, and those with underlying health conditions. However, in the 1918 pandemic, most deaths occurred in young adults. Few if any people would have immunity to the virus.

Which groups will be especially vulnerable during an influenza pandemic?

Experts believe it highly unlikely that a pandemic influenza virus could be created by terrorists. Developing a pandemic influenza virus would require extraordinary scientific skill, as well as sophisticated scientific equipment and other resources.

Will the H5N1 bird flu virus cause the next influenza pandemic?

Scientists cannot predict whether an avian influenza (H5N1) virus will cause a pandemic. Today, H5N1 is a bird flu. There are no reported cases of sustained human-to-human passage of H5N1. However, as it mutates, it is possible the virus could become capable of passing human to human and then spread very quickly. That is why we are focusing on comprehensive public health efforts — increasing surveillance, monitoring for outbreaks, international cooperation, increasing antiviral stockpiles, and building more robust capacity for vaccine production — that will help protect us no matter what pandemic strain emerges or where.

Appendix E

Local Exercise Leads

The following is a list of the lead local exercise planners categorized within the six Mutual Aid Regions for California.

Region 1		
Long Beach	Nancy Lewis, PHN	2525 Grand Ave. Long Beach, CA 90815 562-570-4098 NancyLewis@longbeach.gov
Los Angeles	Brit Oiulfstad, DVM, MPH	600 S. Commonwealth Ave, 7th Floor Los Angeles, CA 90005 213-637-3600 213-381-0006 fax boiulfstad@ph.lacounty.gov
Orange	Keith Olenslager	405 W. 5th Street Santa Ana, CA 92701 714-667-8328 714-834-3125 fax kolenslager@ocha.com
Pasadena	Sandeep Mital	1845 N. Fair Oaks Ave Pasadena, CA 91103 626-744-6176 626-744-6182 fax smital@cityofpasadena.net
San Luis Obispo	Michelle Shoresman	2180 Johnson Ave San Luis Obispo CA 93401 805-788-2067 805-781-1372 fax mshoresman@co.slo.ca.us
Santa Barbara	Jan Koegler, MPH	300 San Antonio Road Santa Barbara, CA 93110 805-681-4913 805-681-8360 fax jan.koegler@sbcphd.org
Ventura	Barbara Spraktes-Wilkins	2240 E. Gonzales Road, Suite 220 Oxnard, CA 93036 805-981-5335 805-981-5294 fax Barbara.Spraktes-wilkins@ventura.org

Region 2		
Alameda	Muntu Davis, MD, MPH	1000 Broadway, 5th floor Oakland, CA 94607 510-267-3200 muntu.davis@acgov.org
	Jim Morrissey	1000 San Leandro Blvd San Leandro, CA 94577 510-618-2036 510-618-2099 fax jim.morrissey@acgov.org
Berkeley	Tanya Bustamante, MPH	1947 Center Street, 2nd Floor Berkeley, CA 94704 510-981-5342 tbustamante@ci.berkeley.ca.us
Contra Costa	Dan Guerra, REHS	1340 Arnold Drive, Suite 126 Martinez, CA 94553 925-313-9548 925-313-8385 fax dguerra@hsd.cccounty.us

Del Norte	Cindy Henderson	981 H Street Crescent City, CA 95531 707-465-0430 x376 707-465-1470 fax chenderson@co.del-norte.ca.us
Humboldt	Charlene Pellatz, RN, PHN, MS	529 I Street Eureka, CA 95501 707-268-2133 707-445-6097 fax cpellatz@co.humboldt.ca.us
Lake	Linda Fraser, BSHS, CHES	922 Bevins Ct Lakeport, CA 95453 707-263-1090 x 217 lindafr@co.lake.ca.us
Marin	Andrew Horvath, MPH	415-473-2979 415-473-2326 fax ahorvath@co.marin.ca.us
Mendocino	Anne Robinson	1120 S. Dora Street Ukiah, CA 95482 707-472-2750 707-472-2714 fax robinsoa@co.medocino.ca.us
Monterey	Jana Donckers	19065 Portola Dr., Suite I Salinas, CA 93908 831-755-5013 x34 831-393-1551 fax donckersjl@co.monterey.ca.us
Napa	Susan Tam	2344 Old Sonoma Rd., Bldg. G Napa, CA 94558 707-253-4199 707-253-4880 fax stam@co.napa.ca.us
San Benito	Samela Perez, MPH	1111 San Felipe Rd. Suite 102 Hollister, CA 952023 831-636-4011 831-636-4037 fax sam@sanbenitoco.org
San Francisco	Olivia Bruch Rebekah Varela	101 Grove Street Room 204 San Francisco, CA 94102 415-554-2740 415-554-2854 fax olivia.bruch@sfdph.org 101 Grove Street, Room 330 (415) 554-2894 415-554-2854 Rebekah.varelz@sfdph.org
San Mateo	Marian Bridges, PHN	225 37th Ave. San Mateo, CA 94403 650-573-2040 650-573-2363 fax mbridges@co.sanmateo.ca.us
Santa Clara	Rocio Luna, MPH	976 Lenzen Ave. San Jose, CA 96126 408-792-5078 408-792-5041 fax Rocio.Luna@hhs.sccgov.org
Santa Cruz	Lisa Angell	Watsonville Community Hospital c/o Emergency Department 75 Nielson Street Watsonville, CA 95076 831-761-5651 Lisa_Angell@chs.net langell@cruzio.com

Solano	Ted Selby	275 Beck Ave. MS 5-240 Fairfield, CA 94533 707-784-8608 707-421-6618 fax tselby@solanocounty.com
Sonoma	Kimberly Caldewey, PA, MPH	625 5th Street Santa Rosa, CA 95404 707-565-4582 kcaldewe@sonoma-county.org

Region 3		
Butte	Gene Azparren	202 Mira Loma Drive Oroville, CA 95965 530-538-7009 gazparren@buttecounty.net
Colusa	Bonnie Davies	251 E Webster St. Colusa, CA 95932 530-458-0266 bdavies@colusadhhs.org
Glenn	Grinnell Norton	240 N. Villa Ave Willows, CA 95988 (530) 934-6588 gnorton@glenncountyhealth.net
Lassen	Ruth Ann Nielson	1445 Paul Bunyan Road Susanville, CA 96130 (530) 251-8254 rneilson@co.lassen.ca.us
Modoc	Jennifer Slinkard	441 N. Main Street Alturas, CA 96101 (530) 233-6311 jenniferslinkard@co.modoc.ca.us
Plumas	Tina Venable	270 County Hospital Road, Suite 111 Quincy, CA 95971 (530)283-6330 tinavenable@countyofplumas.com
Shasta	John Duffy	2650 Breslauer Way Redding, CA 96001 (530) 229-8498 jduffy@co.shasta.ca.us
Sierra	Rhonda Grandi	P.O. Box 7 Loyalton, CA 96118 (530) 993-6737 rgrandi@sierracounty.ws
Siskiyou	Lynn Corliss	806 S. Main St Yreka, CA 96097 (530) 841-2130 lcorniss@co.siskiyou.ca.us
Sutter	Jennifer Broussard	1445 Veterans Memorial Circle Yuba City, CA 95993 (530) 822-7215 ext. 225 jbroussard@co.sutter.ca.us

Tehama	Amy Travis	P.O. Box 400 Red Bluff, CA 96080 (530) 527-6824 travisa@tcha.net
Trinity	Eilse Osvold-Doppelhauer	#51 Industrial Park Way Weaverville, CA 96093 (530) 623-8215 eosvolddoppelhauer@trinitycounty.org
Yuba	Cyndi Journagan	5730 Packard Avenue, Ste 100 Marysville, CA 95901 (530) 749-6279 cjournagan@co.yuba.ca.us
Region 4		
Alpine	Lynette Bennett	75-B Diamond Valley Road Markleeville, CA 96120 530-694-2146 x244 lbennett@hhs.alpinecountyca.gov
Amador	Lori Jagoda, PHN	10877 Conductor Blvd. Suite 400 Sutter Creek, CA 95685 209-223-6407 ljagoda@co.amador.ca.us
Calaveras	Fred Claridge	891 Mountain Ranch Road San Andreas, CA 95249 209-754-6460 Fclaridge@co.calaveras.ca.us
El Dorado	Patrick Klein	931 Spring Street Suite 7 Placerville, CA 95667 530-621-6241 Patrick.Klein@edcgov.us
Nevada	Patti Carter	500 Crown Point Circle Grass Valley, CA 95945 530-265-7174 Patti.Carter@co.nevada.ca.us
Placer	Lynette Goldstein	11484 B Ave. Auburn, CA 95603 530-889-7667 lgoldste@placer.ca.gov
Sacramento	Don Stangle	7001-A East Parkway, Suite 600 Sacramento, CA 95823 916-875-5881 Stangled@saccounty.net
San Joaquin	Judy Ward	P.O. Box 1020 Stockton, CA 95201 209-953-3701 jward@sjcphs.org
Stanislaus	Renee Cartier	830 Scenic Drive, Modesto, CA 95350 209-558-7035 rcartier@schsa.org
Tuolumne	Clarence Teem	20111 Cedar Road North Sonora, CA 95370 209-533-7460 cteem@co.tuolumne.ca.us

Yolo	Myrna R. Epstein, PHD, MPH, FPNP-RN	137 North Cottonwood St Suite 2100 Woodland, CA 95695 530-666-8553 myrna.epstein@yolocounty.org
------	-------------------------------------	---

Region 5		
Fresno	Rose Mary Garrone, RN, SPHN	1221 Fulton Mall Fresno, CA 93721 (559) 445-2709 (559) 445-3320 fax rgarrone@co.fresno.ca.us
Kern	Carolyn Forster	1800 Mt. Vernon Avenue Bakersfield, CA 93306 (661) 868-1209 (661) 868-1211 fax forsterca@co.kern.ca.us
King	Sabrina Bustamante	330 Campus Drive Hanford, CA 93230 (559) 584-1401 x 2618 sabrina.bustamante@co.kings.ca.us
Madera	Bernie Smith	14215 Rd. 28 Madera, CA 93638 (559) 675-7893 (559) 661-2854 fax bernie.smith@madera-county.com
Mariposa	Dana Tafoya	P.O. Box 5 Mariposa, CA 95338 (209) 966-3689 phepc@mariposacounty.org
Merced	Chuck Baucom	260 East 15th Street Merced, CA 95340 (209) 381-1255 (209) 381-1259 fax cbaucom@co.merced.ca.us
Tulare	Cynthia Coverston, PHN II	5957 S. Mooney Blvd. Visalia, CA 93277 (559) 737-46660 x2127 ccoversto@tularehhsa.org

Region 6		
Imperial	Ryan E Kelley	797 Main Street, Suite A El Centro, CA 92243 760-482-2974 ryankelley@co.imperial.ca.us
Inyo	Melissa Best-Baker	207A West South Street Bishop, CA 93514 760-872-3875 760-873-7800 (fax) mbestbaker@inyocounty.us
Mono	Debra Diaz	437 Old Mammoth Road #Q Mammoth Lakes, CA 93546 (760) 924-1829 (760) 924-4611 fax ddiaz@mono.ca.gov

Riverside	James Atkins	3900 Sherman Drive, Suite H Riverside, CA 92503 (951) 358-7184 (951) 358-7105 fax jatkins@co.riverside.ca.us
San Bernardino	Dori Baeza Melissa German	8088 Palm Lane San Bernardino, CA 92415 (909) 888-3982 dbaeza@dph.sbcounty.gov 8088 Palm Lane San Bernardino, CA 92415 (909) 884-0512 mgerman@dph.sbcounty.gov
San Diego	Jack Walsh	6555 Mission Gorge Road San Diego, CA 92120 (619) 285-6591 Jack.Walsh@sdcounty.ca.gov

Appendix F

Acronyms

ACS	Alternate Care Site(s)
CalEMA	California Emergency Management Agency
CBO	Community Based Organization
CDC	Centers for Disease Control
CDPH	California Department of Public Health
CHA	California Hospital Association
COG	Continuity of Government
COOP	Continuity of Operations
CPCA	California Primary Care Association
DOC	Department Operations Center
EEG	Exercise and Evaluation Guide
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
EM	Emergency Management
EMP	Emergency Management Program
EMS	Emergency Medical Service
EMSA	Emergency Medical Services Agency
FAQ	Frequently Asked Questions
HCC	Hospital Command Center
HICS	Hospital Incident Command System
HPP	Hospital Preparedness Program
HSEEP	Homeland Security Exercise and Evaluation Program
IAP	Incident Action Plan
ICS	Incident Command System
ILI	Influenza like Illness
IMT	Incident Management Team
IRG	Incident Response Guide
JEOC	Joint Emergency Operations Center
JIS	Joint Information System
LE	Law Enforcement
LEMSA	Local Emergency Medical Services Agency
LHD	Local Health Department
LIP	Licensed Independent Practitioner
LTC	Long Term Care
ME	Medical Examiner
MHOAC	Medical and Health Operational Area Coordinator
MOU	Memorandum of Understanding
MOA	Memorandum of Agreement
MSEL	Master Sequence of Events List
NIMS	National Incident Management System
OA	Operational Area
OES	Office of Emergency Services
POC	Point of Contact

PPE	Personal Protective Equipment
RDMHC	Regional Disaster Medical Health Coordinator
RIMS	Response Information Management System
SEMS	Standardized Emergency Management System
SOC	State Operations Center
TJC	The Joint Commission
VRDL	Viral and Rickettsial Disease Laboratory
WHO	World Health Organization

Appendix G

Resources

Resources used in the development of the Exercise and Exercise Guidebook include:

California Department of Public Health

State Pandemic Influenza Plan

Laboratory testing and sampling guidance

www.cdph.ca.gov

Medical Surge Standards during a Declared Disaster

www.bepreparedcalifornia.ca.gov

Centers for Disease Control

Pandemic Influenza planning guidance for professionals

www.cdc.gov

California Distance Learning Network

2009 Pandemic Influenza Gap Analysis

2009 Facilitated Tabletop Exercise

2009 Statewide Medical and Health Functional Exercise Guidebook

<http://63.64.44.135>

California Emergency Medical Services Authority

Hospital Incident Command System

Incident Action Planning Forms

Pandemic Influenza Incident Planning and Response Guides

www.emsa.ca.gov

Homeland Security Exercise and Evaluation Program

HSEEP Toolkit for Exercise Development

<https://hseep.dhs.gov>

NIMS Implementation and Compliance Elements

14 elements of implementation for hospitals and healthcare organizations

www.fema.gov/emergency/nims

For all stakeholders:

<http://www.fema.gov/emergency/nims/ImplementationGuidanceStakeholders.shtml>

The Joint Commission

Emergency Management Accreditation Standards

www.jointcommission.org

World Health Organization

Phases of Pandemic Influenza

www.who.int