

***Los Angeles County***

**Preface**

The 2014 Statewide Medical and Health Tabletop Exercise is sponsored by the California Department of Public Health (CDPH) and the Emergency Medical Services Authority (EMSA) in collaboration with the California Hospital Association (CHA), California Association of Health Facilities (CAHF), California Primary Care Association (CPCA) and the California Governor’s Office of Emergency Services (Cal OES) as well as response partners representing local health departments, public safety and healthcare facilities. This Situation Manual was produced with input, advice and assistance from the Statewide Medical and Health Design Workgroup, which followed guidance from the Homeland Security Exercise and Evaluation Program (HSEEP).

The 2014 Statewide Medical and Health Tabletop Exercise Situation Manual (SitMan) provides exercise participants with all the necessary tools for their roles in the exercise. It is tangible evidence of Los Angeles County’s commitment to ensure public safety through collaborative partnerships that will prepare them to respond to any emergency.

The 2014 Statewide Medical and Health Tabletop Exercise is an unclassified exercise. Control of exercise information is based on public sensitivity regarding the nature of the exercise rather than actual exercise content. Some exercise material is intended for the exclusive use of exercise planners, facilitators and evaluators, but players may view other materials that are necessary for their performance. All exercise participants may view the SitMan.

All exercise participants should use appropriate guidelines to ensure proper control of information within their areas of expertise and protect this material in accordance with current jurisdictional directives.

# Contents

**Preface............................................................................................................................i**

**Exercise Overview….……………………………………………………………..………. iii**

**General Information.................................................................................................... 1**

**Module 1: Communication and Medical Surge........................................................ 5**

**Module 2: Command Center Management and Incident Action Planning …..….. 7**

**Module 3: Public and Private Services and Resources........................................... 9**

**Addendum: Planning For the Functional Exercise….…….................................. A-1**

**Appendix A: Exercise Schedule............................................................................ A-3**

**Appendix B: Exercise Participants....................................................................... B-1**

**Appendix C: Participant Feed Back Form............................................................ C-1**

**Appendix D: Resources and References............................................................ D-1**

**Appendix E: Health Alert……............................................................................... E-1**

**Appendix F: Patient Evacuation Tracking Form................................................. F-1**

**Appendix G: Acronyms.......................................................................................... G-1**

# Exercise Overview

This SitMan provides exercise participants with all the necessary tools for their roles in the exercise. Some exercise material is intended for the exclusive use of exercise planners, facilitators, and evaluators, but players may view other materials that are necessary to their performance. All exercise participants may view the SitMan.

|  |  |
| --- | --- |
| **Exercise Name** | 2014 California Statewide Medical and Health Tabletop Exercise  |
| **Exercise Date** | [Agency insert date] |
| **Scope** | This exercise is a tabletop exercise planned for [Agency insert exercise date and time] at [exercise location]. The 2014 Statewide Medical and Health Exercise Program is a progressive exercise program in a series of exercises tied to a set of common program priorities. This year’s exercise is a multiphase program designed to be exercised between May and November 2014, culminating in the Functional Exercise on November 20th. Using this approach, each organization/jurisdiction can tailor the exercise to their specific needs. |
| **Mission Area(s)** | Response and Recovery |
| **Core Capabilities** | * Operational Communications (Formerly Communications)
* Public Health and Medical Services (Formerly Medical Surge and Epidemiological Surveillance and Investigation)
* Operational Coordination and On-Site Incident Management (Formerly Emergency Operations Center Management)
* Public and Private Services and Resources (Formerly Volunteer Management and Donations)
 |

|  |  |
| --- | --- |
| **Objectives****Objectives** | 1. Assess the communications process internally and externally, based on local policies and procedures.
2. Review redundant communication modalities within and across response partners.
3. Determine strengths and weaknesses in activation of medical and health partners surge plans. Identify critical issues and potential solutions.
4. Identify the process to activate the Incident Command System (ICS) in response to an emerging infectious disease. Determine specific levels necessary based on scenario and local policies and procedures.
5. Identify the steps in developing an Incident Action Plan (IAP) and conducting associated briefings.
6. Identify the processes for medical and health partners to provide current situational information to the Medical Health Operational Area Coordinator (MHOAC) Program.
7. Examine the MHOAC Program’s process to develop and submit a Medical Health Situation Reports consistent with the (EOM).
8. Identify the process for medical and health partners across the response system to request, distribute, track, and return medical countermeasure resources, including scarce resources, consistent with the EOM.
9. Validate the processes in place to activate the local disaster medical volunteer system.
10. Validate the process for epidemiological surveillance information communication and coordination among Medical Health partners, including CDPH, Local Health Department (LHD), Hospitals (specifically between infection prevention, and LHD personnel), and other healthcare facilities.
11. Identify steps to conduct surveillance and subsequent epidemiological investigations to identify potential exposure and disease.
12. Examine the process to implement necessary control measures to stop further cases of illness or disease in accordance with established policies.
13. Identify how the MHOAC Program consolidates and disseminates the epidemiological surveillance information received within the OA.
 |

|  |  |
| --- | --- |
| **Threat or Hazard** | Emerging Infectious Disease |
| **Scenario** | Influenza season has begun and hospitals and primary care see an increase in the number of influenza-like illness (ILI) cases presenting for care including a healthcare worker who returned from the Middle East with symptoms of ILI. The healthcare worker and one of his colleagues test positive for Middle East Respiratory Syndrome - Coronavirus (MERS-CoV). Emergency departments and community health centers see a surge in ILI cases presenting, and admissions increase over 10% with acute respiratory illnesses.  |
| **Sponsor** | The 2014 Statewide Medical and Health Tabletop Exercise is sponsored by CDPH and EMSA in collaboration with CHA, CAHF, CPCA and Cal OES, as well as response partners representing local health departments, public safety and healthcare facilities.  |

|  |  |
| --- | --- |
| **Participating Organizations** | This exercise is designed to include the following medical and health partners: acute care hospitals, local health departments, environmental health departments, community health centers, long term care facilities, ambulatory surgery centers, dialysis centers, emergency medical services, ambulance providers, law enforcement, fire service, community based organizations, emergency management, MHOAC Program, Regional Disaster Medical Health Coordination (RDMHC) program, private physicians, non-governmental organizations and other partners. Please see participating agencies in Appendix B (will be updated after exercise registration closes). |
| **Point of Contact** | **State point of contact:** Kristy Perez, Chief, Planning, Exercises and Training Section California Department of Public Health Emergency Preparedness Office 1615 Capitol Avenue MS 7002, Sacramento, CA 95814 Kristy.Perez@cdph.ca.gov Telephone: 916-650-6443**Los Angeles Exercise Co-Chairs:**

|  |  |
| --- | --- |
| Gary G. Chambers RN BSDisaster Program Manager/TLOLos Angeles County EMS Agency10100 Pioneer Blvd.Santa Fe Springs, CA 90670gchambers@dhs.lacounty.govOffice-562.347.1644Fax-562.944.6931 | Ryan Tuchmayer, MPH CEMDisaster ManagerCedars-Sinai Medical Center8700 Beverly Blvd., TSB 190Los Angeles, CA 90048ryan.tuchmayer@cshs.orgOffice-310.423.4336Fax-310.423.0143 |

 |

See Appendix G for a listing of agency/event acronyms.

# General Information

## Exercise Objectives and Core Capabilities

The following exercise objectives in Table 1 describe the expected outcomes for the exercise. The objectives are linked to core capabilities, which are distinct critical elements necessary to achieve the specific mission area(s). The objectives and aligned core capabilities are guided by elected and appointed officials and selected by the Exercise Planning Team.

| Exercise Objective | Core Capability |
| --- | --- |
| 1. Assess the communications process internally and externally, based on local policies and procedures.
 | Operational Communications |
| 1. Review redundant communication modalities within and across response partners.
 | Operational Communications |
| 1. Determine strengths and weaknesses in activation of medical and health partners surge plans. Identify critical issues and potential solutions.
 | Public Health and Medical Services |
| 1. Identify the process to activate the ICS in response to an emerging infectious disease. Determine specific levels necessary based on scenario and local policies and procedures.
 | Operational Coordination and On-Site Incident Management |
| 1. Identify the steps in developing an IAP and conducting associated briefings.
 | Operational Coordination and On-Site Incident Management |
| 1. Identify the processes for medical and health partners to provide current situational information to the MHOAC Program
 | Operational Coordination and On-Site Incident Management |
| 1. Examine the MHOAC Program’s process to develop and submit a Medical Health Situation Reports consistent with the EOM.
 | Operational Coordination and On-Site Incident Management |
| 1. Identify the process for medical and health partners across the response system to request, distribute, track, and return medical countermeasure resources, including scarce resources, consistent with the EOM.
 | Public and Private Services and Resources |
| 1. Validate the processes in place to activate the local disaster medical volunteer system.
 | Public and Private Services and Resources |
| 1. Validate the process for epidemiological surveillance information communication and coordination among Medical Health partners, including; CDPH, LHD, Hospitals (specifically between infection prevention, and LHD personnel), and other healthcare facilities.
 | Public Health and Medical Services |
| 1. Identify steps to conduct surveillance and subsequent epidemiological investigations to identify potential exposure and disease.
 | Public Health and Medical Services |
| 1. Examine the process to implement necessary control measures to stop further cases of illness or disease in accordance with established policies.
 | Public Health and Medical Services |
| 1. Identify how the MHOAC Program consolidates and disseminates the epidemiological surveillance information received within the OA.
 | Public Health and Medical Services |

Table 1. Exercise Objectives and Associated Core Capabilities

## Customizing the SitMan

The SitMan is a tool for use in planning and conducting the tabletop exercise (TTX). It is designed to be customized by exercise planners for each organization/jurisdiction’s needs. The TTX is discussion based and is divided into modules, each covering key information and questions that may be addressed during the exercise. Exercise planners are encouraged to expand both the scenario and the questions to better address each entity’s exercise objectives. Exercise planners may elect to use some or all of the modules based on time constraints, exercise participants and level of preparedness within the jurisdiction.

Throughout the SitMan, there are opportunities for customization by organization/jurisdiction planners. Exercise planners can input their customized language and then remove the highlight. Some areas may not apply to an organization/ jurisdiction and can be deleted. Additional information specific to the organization/ jurisdiction may be added by the exercise planner.

Each module section begins with a problem or issue derived from the scenario. The scenario is provided on page 14 of this document. Following the initial scenario, exercise planners may provide a more detailed discussion customized to their organization/jurisdiction’s needs. Exercise planners may delete the additional sections if they do not wish to create additional exercise discussion.

## Participant Roles and Responsibilities

The term *participant* encompasses many groups of people, not just those playing in the exercise. Groups of participants involved in the exercise, and their respective roles and responsibilities, are as follows:

* **Players.** Players are personnel who have an active role in discussing or performing their regular roles and responsibilities during the exercise. Players discuss or initiate actions in response to the simulated emergency. Players may include: Emergency Medical Services (EMS), hospitals, community health centers, skilled nursing care providers, the MHOAC Program, Public Health Departments, Regional Disaster Medical Health Specialists/Coordinators (RDMHS), Private Physicians, Regional Emergency Operations Centers (REOC), the Medical and Health Coordination Center (MHCC) and the State Operations Center (SOC).
* **Observers.** Observers do not directly participate in the exercise. However, they may support the development of player responses to the situation during the discussion by asking relevant questions or providing subject matter expertise.
* **Facilitators.** Facilitators provide situation updates and moderate discussions. They also provide additional information or resolve questions as required. Key Exercise Planning Team members also may assist with facilitation as subject matter experts during the exercise.
* **Evaluators.** Evaluators are assigned to observe and document certain objectives during the exercise. Their primary role is to document player discussions, including how and if those discussions conform to plans, polices, and procedures.

## Exercise Structure

This exercise will be a multimedia, facilitated exercise. Players will participate in the following three modules:

* Module 1: Communication and Medical Surge
* Module 2: Command Center Management and Incident Action Planning
* Module 3: Public and Private Services and Resources

Each module begins with a multimedia update that summarizes key events occurring within that time period. After the updates, participants review the situation and engage in group discussions of issues.

After these group discussions, participants will engage in a moderated plenary discussion in which a spokesperson from each group will present a synopsis of the group’s actions, based on the scenario.

The exercise facilitator is encouraged to invite subject matter experts to provide brief overviews of local/OA policies and procedures for emergency response as well as specific information related to the medical surge. The facilitator may also choose to use smaller functional or discipline specific groups to identify issues to present to the group.

## Exercise Guidelines

* This exercise will be held in an open, low-stress, no-fault environment. Varying viewpoints, even disagreements, are expected.
* Respond to the scenario using your knowledge of current plans and capabilities (i.e., you may use only existing assets) and insights derived from your training.
* Decisions are not precedent setting and may not reflect your organization’s final position on a given issue. This exercise is an opportunity to discuss and present multiple options and possible solutions.

Issue identification is not as valuable as suggestions and recommended actions that could improve mitigation, response, and recovery efforts. Problem-solving efforts should be the focus.

## Exercise Assumptions and Artificialities

In any exercise, assumptions and artificialities may be necessary to complete play in the time allotted and/or account for logistical limitations. Exercise participants should accept that assumptions and artificialities are inherent in any exercise, and should not allow these considerations to negatively impact their participation.

### *Assumptions*

Assumptions constitute the implied factual foundation for the exercise and, as such, are assumed to be present before the exercise starts. The following assumptions apply to the exercise:

* The exercise is conducted in a no-fault learning environment wherein capabilities, plans, systems, and processes will be evaluated.
* The exercise scenario is plausible, and events occur as they are presented.
* Exercise simulation contains sufficient detail to allow players to react to information and situations as they are presented as if the simulated incident were real.
* Participating agencies may need to balance exercise play with real-world emergencies. Real-world emergencies take priority.

### *Artificialities*

During this exercise, the following artificialities apply:

* [Include any additional simulations to be used in the exercise.]

## Exercise Evaluation

Evaluation of the exercise is based on the exercise objectives and aligned capabilities, capability targets, and critical tasks, which are documented in Exercise Evaluation Guides (EEGs). Evaluators have EEGs for each of their assigned areas. Additionally, players will be asked to complete participant feedback forms. These documents, coupled with facilitator observations and notes, will be used to evaluate the exercise and compile the After-Action Report.

# Module 1: Communication and Medical Surge

## Scenario

November 2014

Influenza season has begun and hospitals and primary care are already seeing an increase in the number of influenza-like illness (ILI) cases presenting for care.

On 11/14/14, a 62 year old male presents to the hospital emergency department (ED) complaining of fever of 102°F, cough, and moderate shortness of breath. During the history and physical, the ED physician obtains key information:

* On 11/12/14, he reported flying back to the California from Germany after a layover.
* On 11/11/14, he traveled by plane to Germany after having worked in Saudia Arabia for six months as a contract health care worker in a hospital located in Jedda. Five other colleagues who had worked with him returned with him on the same flights from Saudi Arabia to Germany and Germany to California.

He is admitted as a suspected MERS case and placed in airborne precautions due to his symptoms and travel history. The physician notifies the local health department (LHD) and specimens are collected for laboratory testing for possible Middle East Respiratory Syndrome – Coronavirus (MERS-CoV), in addition to routine respiratory pathogens, including influenza and other respiratory viruses.

## Key Issues

1. Internal and external communication between key response partners
2. Use of redundant communication modalities
3. How do you plan for an influx of patients?

## Questions

Based on the information provided, exercise players will participate in a discussion concerning the key issues raised above. Identify any additional requirements, critical issues, decisions, key participants or questions that should be addressed at this time.

The following questions are provided as suggested general subjects that exercise partners may wish to address as the discussion progresses. These questions are not meant to constitute a definitive list of concerns to be addressed nor is there a requirement to address every question.

The exercise facilitator should lead a discussion relating to the impact of a medical surge event due to emerging infectious disease to organizations/agencies and to the local community. (Consider breaking intodiscipline specific groups to identify the impact(s) and available resources).

Encourage participants to determine all possible impacts of an emerging infectious disease event. Review how the event will impact your response partners. Focus discussion on identifying gaps in planning as well as best practices that can be shared among response partners.

1. What is your process for receiving and disseminating critical information internally and externally with government and non-government partners?
2. What redundant communication systems are in place in case of system overload or failure and how are they tested?
3. How do you provide situation information with partners? What is the process and format for submitting situation reports from the field or local level to the MHOAC Program?
4. What format and process is used from the EOM in submitting your situation reports to the MHOAC Program?
5. How does your organization/jurisdiction participate in a Joint Information System?
6. How would you share your organization’s information with the Joint Information System? Who approves information to be shared?
7. How does your organization/agency use social media to disseminate information?
8. How do you plan for, and respond to, an influx of patients during a medical surge? What specific needs have you identified for surge events? (Staff/Equipment/Supplies/Medications, etc.)
9. How do non-hospital healthcare facilities, such as some long-term care facilities, assist the community’s and healthcare partner’s surge needs?

# Module 2: Command Center Management and Incident Action Planning

## Scenario Continued

On 11/15/14, two of his colleagues present to separate EDs in the area with worsening symptoms and developing pneumonias.

On 11/17/14, CDPH and CDC laboratories confirm MERS-CoV infection in the 62 year-old male along with one of his fellow healthcare colleagues.

With the confirmation of MERS-CoV, the relatively high incidence of death in other countries, and intense media coverage, people with ILI symptoms are flooding the healthcare system requesting testing and treatment for MERS-CoV.

EDs and clinics are seeing a definite rise in numbers of ILI cases presenting, and admissions have increased over 10% with acute respiratory illnesses.

On 11/20/14, a group of five people presents to the busy emergency department (ED), with symptoms of ILI. The group all report two days of fever of 101°F, cough, and increasing mild to moderate shortness of breath. They state they came to the ED because they recently travelled to Dubai and were concerned after seeing the news coverage of MERS-CoV. Two members of the group had been working as healthcare providers in a Dubai hospital.

## Key Issues

The issues below are suggested examples.

1. Response is coordinated through the use of ICS principles and Command Centers/Emergency Operation Centers (EOCs)
2. IAP are developed to guide and document the response and recovery phases
3. Situation reporting to the MHOAC Program utilizing the EOM format and process

## Questions

Based on the information provided, exercise partners are directed to participate in a discussion concerning the key issues raised above. Identify any additional requirements, critical issues, decisions, key participants or questions that should be addressed at this time.

The following questions are provided as suggested general subjects that exercise partners may wish to address as the discussion progresses. These questions are not meant to constitute a definitive list of concerns to be addressed, nor is there a requirement to address every question in this section.

1. How does your organization/jurisdiction implement ICS principles to organize and guide response and recovery operations in an emergency? Does the use of ICS principles address, when necessary, the application of unified command (UC)?
2. How is your Command Center/EOC activated to support ICS operations? Does the activation process utilize a written plan?
3. How are key partners notified of activation? What time frame is the notification communicated in?
4. How does your organization/jurisdiction communicate and share information with other members of the incident management team or Command Center/ EOC personnel? Is there a policy and procedure that covers this? If procedures are in place, is the process regularly tested?
5. What action planning procedures and forms are used to document and guide the response and recovery process? Is the IAP shared with response partners in the jurisdiction?
6. How are requests made or responded to for situational reporting utilizing the EOM?
7. What is the OA plan during a medical surge? How does the plan address mutual aid? How does the plan coordinate from OA to regional to State level?

This information should be clearly documented and may be further used in the development or customization of the local area exercise activities for the November 20, 2014, Functional Exercise objectives and scenario. Focus should be on the exercise area’s organization/jurisdiction’s specific needs and resources, including the dependency on partner organizations.

## Module 3: Public and Private Services and Resources

## Scenario Continued

Same as Module 2

## Key Issues

The issues below are suggested examples.

1. Identifying needs in a medical surge event
2. Requesting, distributing, tracking and returning materials and medical countermeasure resources
3. Activating local disaster medical volunteer systems

## Questions

Based on the information provided, participate in a discussion concerning the key issues raised above. Identify any additional requirements, critical issues, decisions, key participants or questions that should be addressed at this time.

The following questions are provided as suggested general subjects that exercise partners may wish to address as the discussion progresses. These questions are not meant to constitute a definitive list of concerns to be addressed, nor is there a requirement to address every question in this section.

1. How do you identify your human and material needs in a medical surge event?
2. How do you request, distribute, track and return medical countermeasure resources in accordance with the EOM, to include allocation of scarce resources?
3. What mutual aid agreements are in place?
4. How is the local disaster medical volunteer system activated? What are the triggers to activating the system?

## Conclusion of Discussion-Based Tabletop

There is a Participant Feedback Form (Appendix C), which the exercise facilitator may use to gather and record comments on the exercise and issues presented.

#  Addendum: Planning for the Functional Exercise

Exercise facilitators and planners may use the following to launch, or continue planning for the November 20, 2014 Functional Exercise objectives and activities.

Issues for discussion may include:

Exercise Levels

* What level of exercise play do the organizations/agencies represented today anticipate for the November 20, 2014 exercise? Examples include communications drill, functional and full scale exercises[[1]](#footnote-1); level of play may include use of simulated patients, movement of patients to healthcare facilities, perimeter lockdown, activation of the joint information center provision of mutual aid to affected areas, etc.
* Will your organization/agency activate its Command Center/EOC?
* Will your organization/agency exercise any of the additional LHD objectives (10-14)?

Exercise Times / Duration

* Exercise play is being developed to include a message to begin the exercise. Participants may begin exercise play at their discretion, but are strongly encouraged to collaborate with local/ OA partners and exercise planners.
* Participants may estimate their hours of exercise play at this time.
* Exercise planners should lead a discussion on exercise start and end times.

Scenario Development

Exercise planners should work with participants, especially public health authorities to customize the scenario of a medical surge due to an emerging infectious disease. The issues below may be used in support of the local scenario or, may be used in the development of a scenario customized for the organization/jurisdiction. Within OA, individual participants should determine the level of medical surge that will be simulated during the exercise.

Participation

Review the various organizations/agencies in attendance today. In the event of a medical surge due to an emerging infectious disease, are there additional organizations that would be impacted but not in attendance today? Are there additional organizations/agencies or departments that would be impacted at your facility? Are partners who do not provide hospital-based services but would be part of the response in off-loading adult patients to provide additional space for patients in attendance?

Testing of Plans and Procedures

Are there any plans, policies or procedures, which individual departments of agencies would like to test? Examples include: medical surge, infectious disease, volunteer management, etc.

Role of State Agencies (Pending Clarification from Cal OES)

* On November 20, 2014, CDPH and the EMSA will open the MHCC. The California Governor’s Office of Emergency Services is anticipated to participate by opening the SOC and REOC in support of local and regional exercise play. This will provide the opportunity for local participants to request additional resources, submit and receive situation status reports and respond to California Health Alert Network (or other notification systems) messages and receive further direction
* The exercise planner is encouraged to invite discussion on local and OA resource requesting and the projected level of requesting for November 20, 2014

# Appendix A: Exercise Schedule

**Note:** Jurisdictions/Agencies can fill in and adjust the following timeline, breaks, etc.

| Time | Activity |
| --- | --- |
| **[Month Day, 2014]** |
| 0000 | Registration |
| 0000 | Welcome and Opening Remarks |
| 0000 | Module 1: Operational Communication and Medical Surge Briefing, Caucus Discussion, and Brief-Back  |
| 0000 | Break  |
| 0000 | Module 2: Operational Coordination and On-Site Incident Management Briefing, Caucus Discussion, and Brief-Back  |
| 0000 | Lunch  |
| 0000 | Module 3: Public and Private Services and Resources Briefing, Caucus Discussion, and Brief-Back  |
| 0000 | Break |
| 0000 | Hot Wash |
| 0000 | Closing Comments |

# Appendix B: Exercise Participants

|  |
| --- |
| Participating Organizations |

**Los Angeles County**

Alhambra Hospital Medical Center

Antelope Valley Hospital

Barlow Respiratory Hospital

Beverly Hospital

California Hospital Medical Center

Catalina Island Medical Center

Cedars Sinai Medical Center

Centinela Hospital Medical Center

Children’s Hospital Los Angeles

Citrus Valley Foothill Presbyterian Hospital

Citrus Valley Medical Center Intercommunity

Citrus Valley Medical Center-Queen of the Valley

City of Hope

Coast Plaza Doctors Hospital

College Medical Center

Community Clinic Association

Community Hospital Long Beach

Community Hospital of Huntington Park

East Los Angeles Doctors Hospital

Encino Hospital Medical Center

Garfield Medical Center

Glendale Memorial Hospital and Health Center

Glendora Community Hospital

Good Samaritan Hospital

Greater El Monte Community Hospital

Henry Mayo Newhall Memorial Hospital

Hollywood Presbyterian Hospital

Huntington Memorial Hospital

Kaiser Foundation Hospital-Baldwin Park

Kaiser Foundation Hospital-Downey

Kaiser Foundation Hospital-Panorama City

Kaiser Foundation Hospital-South Bay

Kaiser Foundation Hospital-Sunset (LA)

Kaiser Foundation Hospital-W. Los Angeles

Kaiser Foundation Hospital-Woodland Hills

Keck Hospital of USC

LA Community Hospital

LA Community Hospital-Norwalk

LAC Harbor-UCLA Medical Center

LAC Olive View-UCLA Medical Center

LAC-USC Medical Center

Lakewood Regional Medical Center

Long Beach Memorial Medical Center

Marina Del Rey Hospital

Memorial Hospital of Gardena

Methodist Hospital of Southern California

Mission Community Hospital

Monterey Park Hospital

Northridge Hospital Medical Center

Olympia Medical Center

Pacific Alliance Hospital

Pacifica Hospital of the Valley

Palmdale Regional Hospital

PIH Health Downey Medical Center

Pomona Valley Hospital

Presbyterian Intercommunity Health

Providence Holy Cross Medical Center

Providence Little Company of Mary San Pedro

Providence Little Company of Mary Torrance

Providence St. Johns Hospital Health Center

Providence St. Joseph Medical Center

Providence Tarzana Medical Center

Rancho Los Amigos Hospital

San Dimas Community Hospital

San Gabriel Valley Medical Center

Sherman Oaks Hospital

Silver lake Medical Center

Southern California Hospital at Culver City

Southern California Hospital at Hollywood

St. Francis Medical Center

St. Mary’s Medical Center

St. Vincent Medical Center

Torrance Memorial Hospital

Tri-City Regional Medical center

UCLA Ronald Reagan Medical Center

UCLA Santa Monica Medical Center

USC Kenneth Norris Cancer Center

USC Verdugo Hills Hospital

Valley Presbyterian Hospital

West Hills regional Medical Center

Whittier Hospital

Los Angeles County Fire

Los Angeles County Department of Health

Los Angeles County Department of Mental Health

Los Angeles County Department of Public Health

Los Angeles City Fire

# Appendix C: Participant Feedback Form

Please enter your responses in the form field or check box after the appropriate selection.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Title:** |  |
| **Agency:** |  |  |  |  |
| **Role:**  | Player [ ]  | Facilitator *[ ]*  | Observer *[ ]*  | Evaluator *[ ]*  |

***Part I: Recommendations and Corrective Actions***

1. Based on the discussions today and the tasks identified, list the top three strengths and/or areas that need improvement.

|  |  |
| --- | --- |
| 1.
 |  |
|  |  |
|  |  |

1. Identify the action steps that should be taken to address the issues identified above. For each action step, indicate if it is a high, medium, or low priority.

| **Corrective Action** | **Priority** |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

1. Describe the corrective actions that relate to your area of responsibility. Who should be assigned responsibility for each corrective action?

| **Corrective Action** | **Recommended Assignment** |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |

1. List the policies, plans, and procedures that should be reviewed, revised, or developed. Indicate the priority level for each.

| **Item for Review** | **Priority** |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

***Part II: Assessment of Exercise Design and Conduct***

Please rate, on a scale of 1 to 5, your overall assessment of the exercise relative to the statements provided below, with 1 indicating strong disagreement with the statement and 5 indicating strong agreement.

| **Assessment Factor** | **Strongly****Disagree** | **Strongly Agree** |
| --- | --- | --- |
| The exercise was well structured and organized. | 1 | 2 | 3 | 4 | 5 |
| The exercise scenario was plausible and realistic. | 1 | 2 | 3 | 4 | 5 |
| The power point presentation helped the participants understand and become engaged in the scenario. | 1 | 2 | 3 | 4 | 5 |
| The facilitator(s) was knowledgeable about the material, kept the exercise on target, and was sensitive to group dynamics. | 1 | 2 | 3 | 4 | 5 |
| The Situation Manual was a valuable tool throughout the exercise. | 1 | 2 | 3 | 4 | 5 |
| Participation in the exercise was appropriate for someone in my position. | 1 | 2 | 3 | 4 | 5 |
| The participants included the right people in terms of level and mix of disciplines. | 1 | 2 | 3 | 4 | 5 |

***Part III: Participant Feedback***

What changes would you make to this exercise? Please provide any recommendations on how this exercise or future exercises could be improved or enhanced.

|  |
| --- |
|  |
|  |
|  |
|  |
|  |

# Appendix D: Resources and References

1. Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 PAHPRA Reauthorization Act at <http://www.phe.gov/Preparedness/planning/abc/Pages/webinar-resources-130620.aspx> and more resources at <http://www.phe.gov/Preparedness/planning/abc/Pages/default.aspx>

1. Federal Emergency Management Agency (FEMA) Ready.Gov Be informed: Learn what protective measures to take before, during, and after an emergency available at: <http://www.ready.gov/be-informed> **4/11/2014**

1. Capability 10: Medical Surge [www.cdc.gov/phpr/capabilities/capability10.pdf](http://www.cdc.gov/phpr/capabilities/capability10.pdf)

1. HSEEP 2013 home page: <https://www.llis.dhs.gov/hseep>
2. CHA Emergency Preparedness Website available at: <http://www.calhospitalprepare.org>

28. EOM <http://www.emsa.ca.gov/disaster/files/EOM712011.pdf>

# Appendix E: Health Alert

**Health Alert**

**This is an Exercise Inject for the November 2014 Statewide Medical and Health Exercise ONLY.**

**MIDDLE EAST RESPIRATORY SYNDROME CORONAVIRUS**

**Background**

In 2012, the World Health Organization (WHO) announced the discovery of a novel coronavirus, MERS-CoV, in Saudi Arabia. Though unrelated to Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV), MERS-CoV is most similar to coronaviruses found in bats.

In November, 2014, cases of MERS-CoV have been identified in counties within California *(This is only an Exercise)* and also in New York, Florida, and Illinois.

**Transmission**

The WHO and Centers for Disease Control and Prevention have confirmed that there is sustained, widespread human-to-human transmission of MERS-CoV, especially among close contacts (e.g., family members), children younger than 12 years of age, and healthcare workers exposed to cases.

**Morbidity and Mortality**

Most confirmed cases have had severe acute respiratory illness; some cases have also had gastrointestinal symptoms, including diarrhea.

Complications have included severe pneumonia, acute respiratory distress syndrome (ARDS) with multi-organ failure, renal failure requiring dialysis, consumptive coagulopathy and pericarditis.

The case fatality rate is 40%. There is no known treatment for MERS-CoV infection; management is supportive.

**MERS-CoV Infectious Period**

The infectious period for MERS-CoV is likely to extend from the onset of fever until 10-14 days after fever resolves.

**MERS-CoV Incubation Period**

Current data demonstrates that onset of symptoms has occurred up to 14 days after last exposure.

**MERS-CoV Case Definition**

**Patient Under Investigation (PUI)**

A person with the following characteristics should be considered aPUI:

1. Fever AND pneumonia or acute respiratory distress syndrome (based on clinical or radiological evidence) AND EITHER:
	* a history of travel from countries in or near the Arabian Peninsula1 within 14 days before symptom onset,

OR

* + close contact2 with a symptomatic traveler who developed fever and acute respiratory illness (not necessarily pneumonia) within 14 days after traveling from countries in or near the Arabian Peninsula1 OR
	+ a member of a cluster of patients with severe acute respiratory illness (e.g., fever and pneumonia requiring hospitalization) of unknown etiology in which MERS-CoV is being evaluated, in consultation with state and local health departments.

OR

Fever AND symptoms of respiratory illness (not necessarily pneumonia; e.g. cough, shortness of breath) AND being in a healthcare facility (as a patient, worker, or visitor) within 14 days before symptom onset in a country or territory in or near the Arabian Peninsula in which recent healthcare-associated cases of MERS have been identified3.

1. Countries considered in the Arabian Peninsula and neighboring include: Bahrain; Iraq; Iran; Israel, the West Bank, and Gaza; Jordan; Kuwait; Lebanon; Oman; Qatar; Saudi Arabia; Syria; the United Arab Emirates (UAE); and Yemen.
2. Close contact is defined as: a)being within approximately 6 feet (2 meters) or within the room or care area for a prolonged period of time (e.g., healthcare personnel, household members) while not wearing recommended personal protective equipment (i.e., gowns, gloves, respirator, eye protection– see [Infection Prevention and Control Recommendations](http://www.cdc.gov/coronavirus/mers/infection-prevention-control.html); or b) having direct contact with infectious secretions (e.g., being coughed on) while not wearing recommended personal protective equipment (i.e., gowns, gloves, respirator, eye protection – see [Infection Prevention and Control Recommendations](http://www.cdc.gov/coronavirus/mers/infection-prevention-control.html). Data to inform the definition of close contact are limited. At this time, brief interactions, such as walking by a person, are considered low risk and do not constitute close contact.
3. As of June 1, 2014, Jordan, Saudi Arabia, UAE; this may change as more information becomes available.

**Confirmed Case**

A confirmed case is a person with laboratory confirmation of MERS-CoV infection.

**Probable Case**

A probable case is a PUI with absent or inconclusive laboratory results for MERS-CoV infection who is a close contact of a laboratory-confirmed MERS-CoV case.

**MERS-CoV Case Reporting**

**Note:** California Reportable Disease Information Exchange (CalREDIE) will be used for case reporting during the exercise. The process for this is being developed. Additional information will be released prior to the exercise about entering cases.

**MERS-CoV Specimen Collection and Testing**

Polymerase chain reaction (PCR) testing for MERS-CoV is available at the CDPH Viral and Rickettsial Disease Laboratory (VRDL). *If this was a real event,* local health departments would contact VRDL to arrange shipping of specimens; however, because this is ONLY AN EXERCISE, do not contact VRDL.

**Specimen Collection Notes**

It is very important that an adequate volume of each specimen type is received by VRDL; without adequate specimen volume incomplete testing will occur and definitive results will be significantly delayed. For this reason, specimens will be prioritized by the local health department for MERS-CoV testing and multiple specimen types as outlined below should be submitted for testing:

* Lower respiratory tract specimens. Lower respiratory tract specimens typically have the highest yield, i.e., broncheoalveolar lavage, tracheal aspirate, pleural fluid and/or sputum, and should be collected whenever possible and sent in viral transport media (VTM) only; and
* Upper respiratory tract specimens, including nasopharyngeal and oropharyngeal (throat) swabs (nasal washes are not acceptable). Use only synthetic fiber swabs with plastic shafts. Do not use calcium alginate or wooden shaft swabs and send in VTM only; and
* Serum and stool specimens.

Complete the VRDL general purpose specimen submittal form with the specimen(s), available at: <http://cdph.ca.gov/programs/vrdl/Pages/CurrentVRDLSpecimenSubmittalforms.aspx>

Additional specimen collection information is available at:

<http://www.cdc.gov/coronavirus/mers/guidelines-clinical-specimens.html>

**Isolation Recommendations**

Community mitigation and infection control recommendations include isolation of confirmed, probable, or PUI cases.  At this time, quarantine of contacts to confirmed, probable, or PUI cases is not recommended.  However, each Local Health Officer may evaluate the need for quarantine on a case-by-case basis.

**Hospitalized Cases: Isolation**

Suspect or confirmed cases should be placed in an airborne infection (negative-pressure) isolation room with Airborne, Contact and Standard precautions, including eye protection for healthcare personnel. Isolation should continue until MERS-CoV infection has been ruled out (PCR testing is negative for suspected cases) or until 10 days after resolution of fever in laboratory-confirmed cases.

CDC infection control guidance for MERS-CoV is available at: <http://www.cdc.gov/coronavirus/mers/infection-prevention-control.html>

**Non-Hospitalized Cases: Home Isolation**

Symptomatic persons with suspect or confirmed MERS-CoV infection who are not ill enough to require hospitalization should remain at home ***in isolation*** until MERS-CoV infection has been ruled out (PCR testing is negative for suspected cases) or until 10 days after resolution of fever in laboratory-confirmed cases.

Home isolation recommendations include NO movement outside of the home (e.g., isolated person should not go to school, work, child care, community gatherings or other public areas) other than for medical care.

Assess whether the home is suitable and appropriate for isolating the ill person. You can conduct this assessment by phone or direct observation.

* The home should have a functioning bathroom that only the ill person and household members use. If there are multiple bathrooms, one should be designated solely for the ill person.
* The ill person should have his or her own bed and preferably a private room for sleeping.
* Basic amenities, such as heat, electricity, potable and hot water, sewer, and telephone access, should be available.
* If the home is in a multiple-family dwelling, such as an apartment building, the area in which the ill person will stay should use a separate air-ventilation system, if one is present.
* There should be a primary caregiver who can follow the healthcare provider’s instructions for medications and care. The caregiver should help the ill person with basic needs in the home and help with obtaining groceries, prescriptions, and other personal needs.

Additional home care guidelines can be found at <http://www.cdc.gov/coronavirus/MERS/hcp/home-care.html>.

Isolated persons who must travel outside the home (e.g., doctor visit) should wear a surgical mask and should not use public transportation. Healthcare providers should be notified of suspected or confirmed MERS-CoV infection before the isolated person enters the setting.

Other recommendations for isolated persons include frequent hand washing, covering the mouth and nose when sneezing or coughing, wearing a surgical mask when in the same room as an uninfected person. Isolated persons should not share eating or drinking utensils or towels or bedding with uninfected people.

Household disinfectant or diluted bleach solution *(give concentration/dilution instructions)* should be used to clean all surfaces contaminated with respiratory sections or other bodily fluids from an isolated person.

Additional information and guidance for community mitigation measures, isolation, and infection control, include:

* ***Interim Home Care and Isolation Guidance for MERS-CoV*** at <http://www.cdc.gov/coronavirus/MERS/hcp/home-care.html>; and
* *Interim Guidance for Preventing MERS-CoV from Spreading in Homes and Communities* at[*http://www.cdc.gov/coronavirus/MERS/hcp/home-care-patient.html*](http://www.cdc.gov/coronavirus/MERS/hcp/home-care-patient.html)

**Close Contacts: Self-Monitor**

Caregivers, household members, and other people who have had close contact with someone who is being evaluated for MERS-CoV infection should monitor their health for 14 days or until MERS-CoV infection has been ruled out in the contact, starting from the day they were last exposed to the ill person.

Symptom monitoring includes temperature checks twice daily and self-observation for the following respiratory and/or gastrointestinal symptoms:

* Fever (≥ 38°C , 100.4°F)
* Coughing
* Shortness of breath
* Any other symptoms such as chills, body aches, sore throat, headache, diarrhea, nausea/vomiting, and runny nose

If someone who has had close contact with a person being evaluated for MERS-CoV infection develops symptoms, they should alert their local health department immediately and the local health department should arrange for evaluation and testing in a healthcare setting that can provide appropriate isolation and infection control.

While being evaluated, symptomatic contacts should not go to school, work, child care, community gatherings or other public areas other than for medical care. They should also follow other recommendations for persons under home isolation, including wearing a surgical mask when in the same room as an uninfected person, covering the mouth and nose when sneezing or coughing, washing hands frequently, and avoiding sharing household items.

Additional information on MERS-CoV can be found on the CDPH website at <http://www.cdph.ca.gov/programs/cder/Pages/MERS-CoV.aspx> and the CDC website at <http://www.cdc.gov/coronavirus/mers/interim-guidance.html>.

Additional MERS-CoV resources can be found at:

* **Case Definitions for MERS-CoV**: <http://www.cdc.gov/coronavirus/mers/case-def.html>
* **Interim Guidelines for Specimen Collection and Testing for MERS-CoV**: <http://www.cdc.gov/coronavirus/mers/case-def.html>
* **Interim Infection Prevention and Control Recommendations for Hospitalized Patients with MERS-CoV**: <http://www.cdc.gov/coronavirus/mers/infection-prevention-control.html>
* **Interim Home Care and Isolation Guidance for MERS-CoV:** <http://www.cdc.gov/coronavirus/mers/hcp/home-care.html>
* **Frequently Asked Questions and Answers – MERS-CoV:** <http://www.cdc.gov/coronavirus/mers/faq.html>

**This is only an exercise.**

**November 2014**

**Appendix F: Patient Evacuation Tracking Form**



**Appendix G: Acronyms**

|  |  |
| --- | --- |
| AAM | After Action Meeting |
| AAP  | American Academy of Pediatrics |
| AAR | After Action Report |
| AAR/IP | After Action Report/Improvement Plan |
| ARI | Acute Respiratory Infection |
| AST | Ambulance Strike Team |
| ASTL | Ambulance Strike Team Leader |
| BHPP | Building Healthy Public Policy |
| C/E | Controller/Evaluator |
| CAHF | California Association Health Facilities |
| Cal OES | Governor's Office of Emergency Services |
| Cal OSHA | California Division of Occupational Safety and Health |
| CBO | Community Based Organizations |
| CCLHO | California Conference of Local Health Officers |
| CDC | Centers for Disease Control and Prevention |
| CDPH | California Department of Public Health |
| CE | Continuing Education |
| CHA | California Health Association |
| CID | Clinical Infectious Disease |
| CPCA | California Primary Care Association |
| DCDC | Division of Communicable Disease |
| DHS | Department of Homeland Security  |
| DOC | Department Operations Center |
| ED | Emergency Department |
| EEGs | Exercise Evaluation Guides |
| EMS | Emergency Medical Services |
| EMSA | Emergency Medical Services Authority |
| EMSC | Emergency Medical Services for Children |
| EOC | Emergency Operation Center |
| EOM | Emergency Operations Manual |
| EPO | Emergency Preparedness Office |
| ExPlan | Exercise Plan |
| FEMA  | Federal Emergency Management Agency |
| FTS | Field Treatment Sites |
| GETS | Government Emergency Telecommunications Service |
| HCC | Hospital Command Center |
| HICS | Hospital Incident Command System |
| HSEEP | Homeland Security Exercise and Evaluation Program |
| IAP | Incident Action Plan |
| ICS | Incident Command System |
| ICU | Intensive Care Unit |
| ILI | Influenza-like Illness |
| IP | Improvement Plan |
| JIC | Joint Information Center |
| JIS | Joint Information System |
| LEMSA | Local Emergency Medical Services Authority |
| LHD | Local Health Department |
| MERS-CoV | Middle East Respiratory Syndrome - Coronavirus  |
| MHCC | Medical and Health Coordination Center |
| MHOAC | Medical Health Operational Area Coordination Program  |
| MRC | Medical Reserve Corps |
| MSEL | Master Scenario Events List |
| NGO | Non-governmental organizations |
| NHICS | Nursing Home Incident Command System |
| NICU | Neonatal Intensive Care Unit |
| NIMS | National Incident Management System |
| OA | Operational Area |
| PAHPRA | Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 |
| POD | Point of Distribution |
| PPE  | Personal Protective Equipment |
| RDMHC | Regional Disaster Medical Health Coordination |
| REOC | Regional Emergency Operation Center |
| SEMS | Standardized Emergency Management System |
| SimCell | Simulation Cell |
| SitMan | Situation Manual |
| SME | Subject Matter Expert |
| SOC | State Operational Center |
| UC | Unified Command |
| VIP | Very Important Person |

1. HSEEP: <https://hseep.dhs.gov/hseep> [↑](#footnote-ref-1)