



2015
STATEWIDE MEDICAL AND HEALTH EXERCISE

EXERCISE PLAN

California Department of
Public Health



PREFACE

The 2015 California Statewide Medical and Health Exercise (SWMHE) is sponsored by the California Department of Public Health (CDPH) and the Emergency Medical Services Authority (EMSA). This Exercise Plan (ExPlan) was produced with input, advice, and assistance from the SWMHE Planning Team, comprised of representatives from:

- California Association of Health Facilities (CAHF)
- California Department of Public Health (CDPH)
- California Emergency Medical Services Authority (EMSA)
- California Hospital Association (CHA)
- California Primary Care Association (CPCA)
- County of San Mateo EMS Agency
- Emergency Medical Services Administrators Association of California (EMSAAC)
- Kaiser Permanente
- Los Angeles County Department of Public Health
- Orange County Health Care Agency
- Riverside County Department of Public Health
- San Joaquin County EMS Agency
- Sharp HealthCare
- Sutter County Public Health
- Watsonville Community Hospital

This ExPlan follows guidelines set forth by the U.S. Federal Emergency Management Agency (FEMA) Homeland Security Exercise and Evaluation Program (HSEEP).

The ExPlan gives participating organizations the information necessary to take part in an operations-based functional or full scale exercise.

This ExPlan is meant to aid healthcare entities and their partners in developing and executing a functional exercise as part of the broader SWMHE.

The Exercise Plan (ExPlan) gives elected and appointed officials, observers, media personnel, and players from participating organizations information they need to observe or participate in the exercise. Some exercise material is intended for the exclusive use of exercise planners, controllers, and evaluators, but players may view other materials that are necessary to their performance. All exercise participants may view the ExPlan.

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ADMINISTRATIVE HANDLING INSTRUCTIONS

1. The title of this document is the *California Statewide Medical and Health Exercise Plan (ExPlan)*.
 2. The information gathered in this ExPlan is designated as For Official Use Only (FOUO) and should be handled as sensitive information that is not to be disclosed. This document should be safeguarded, handled, transmitted, and stored in accordance with appropriate security directives. Reproduction of this document, in whole or in part, without prior approval from Alameda County Health Care Services Agency is prohibited.
 3. The ExPlan describes the roles and responsibilities of exercise participants, and the procedures they should follow.
 4. For more information about the exercise, please consult the following points of contact (POCs):
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EXERCISE OVERVIEW

Exercise Name	2015 California Statewide Medical and Health Exercise (SWMHE)
Exercise Date	October 8, 2015 - November 19, 2015
Scope	<p>This is an exercise planned for Alameda County Health Care Services Agency. The 2015 SWMHE Program is a progressive exercise program in a series of training exercises tied to a set of common program priorities. This year's exercise is a multiphase program designed to be conducted between May and November 2015, culminating on November 19th. The phases are listed below:</p> <p>Phase 1) Multimedia training, including:</p> <ul style="list-style-type: none"> • Disaster preparedness and response • Medical and health coordination • Requesting medical and health resources • California Public Health and Medical Emergency Operations Manual (EOM) training <p>Phase 2) Organization specific self-assessment tools to identify strengths and weaknesses</p> <p>Phase 3) A tabletop exercise to discuss current plans, policies and procedures</p> <p>Phase 4) A functional exercise to test current plans, policies and procedures</p>
Mission Area(s)	<ul style="list-style-type: none"> • Response
Core Capabilities	<ul style="list-style-type: none"> • Operational Communications • Public Health and Medical Services • Operational Coordination and On-Site Incident Management • Situational Awareness

Objectives

- Evaluate the internal and external information sharing.
- Evaluate tactical communication tools including DHV, CAHAN, ReddiNet, Conference Calls and Website.
- Evaluate the requesting process and management of medical countermeasures for closed PODS.
- Evaluate the capabilities and capacities to sustain a prolonged medical surge infectious disease event, through established plans for the county Health Care Service Agency, Hospitals, Clinics, Long Term Care Facilities, and Transport Providers to deal with a surge of pandemic influenza adult and pediatric patients.
- Evaluate the ability to respond to a prolonged infectious disease event.

Threat or Hazard

Pandemic Influenza

Scenarios

Novel Strain of Pandemic Influenza Virus (H5N1)

Sponsor

The 2015 SWMHE is sponsored by CDPH and EMSA in collaboration with response partners representing local health departments, public safety and healthcare facilities across California.

Participating Organizations

Alameda County Emergency Services (ASCO OES)

Alameda County EMS

Alameda County Healthcare Service Agency

Alameda County Public Health Department

Alameda Health System

Alta Bates Medical Center

Asian Community Mental Health Services

Asian Health Services

Axis Community Health

City of Berkeley Public Health Department

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- California Department of Public Health
- Camp Parks
- Chaparral House
- Community Health Center Network
- Eden Medical Center
- Hayward Healthcare & Wellness Center
- Hillside Senior Care
- Kaiser Permanente Oakland
- Kindred Hospital
- Lifelong Medical
- Mercy Retirement & Care Center
- Native American Health Center
- Paramedics Plus
- REACH Air Medical Services
- Rural/Metro Ambulance
- St. Rose Hospital
- Stanford Health Care – Valley Care
- UCSF Benioff Children’s Hospital
- United States Cost Guard
- Washington Hospital
- West Oakland Health Council

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Willow Rock Psychiatric Health Facility

GENERAL INFORMATION

INTRODUCTION

The California Department of Public Health (CDPH) and the Emergency Medical Services Authority (EMSA) lead California in an annual Statewide Medical and Health Exercise (SWMHE) Program. CDPH recognizes that being prepared for a threat to community health is of national concern in an era of possible bioterrorism, pandemic influenza, and emerging public health threats. This functional exercise has been developed to encourage all healthcare stakeholders and their partners to exercise their response to and recovery from unusual health events that may challenge their facilities and personnel.

This exercise is designed to establish a learning environment for players to exercise emergency response plans, policies, and procedures as they pertain to a public health emergency. To ensure an effective exercise, subject matter experts (SMEs) and local representatives from numerous agencies have taken part in the planning process.

The SWMHE Program has been developed with funding from the Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) grants.

EXERCISE OBJECTIVES & CORE CAPABILITIES

The following exercise objectives in Table 1 describe 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.

The objectives listed below are those tailored for this exercise. A set of example objectives tailored for different participating agencies and organizations (hospitals, community clinics, long-term care facilities, ambulance services, EMS services, offices of emergency management, departments of medical examiner/coroners, fire services, and law enforcement) is available at www.californiamedicalhealthexercise.com. According to FEMA’s Emergency Management Institute and general HSEEP guidelines, ten or fewer objectives are recommended for an exercise¹.

Exercise Objective	Core Capability
Evaluate the internal and external information sharing.	Operational Communications
Evaluate tactical communication tools including DHV, CAHAN, ReddiNet, Conference Calls and Website.	Operational Communications
Evaluate the requesting process and management of medical countermeasures for closed PODS.	Public Health and Medical Services
Evaluate the capabilities and capacities to sustain a prolonged medical surge infectious disease event, through established plans for the county Health Care Service	Public Health and Medical Services

¹ From FEMA’s Emergency Management Institute Exercise Design Guidelines, in “Unit 4: Exercise Design Steps.”

Exercise Objective	Core Capability
Agency, Hospitals, Clinics, Long Term Care Facilities, and Transport Providers to deal with a surge of pandemic influenza adult and pediatric patients.	
Evaluate the ability to respond to a prolonged infectious disease event.	Operational Coordination and On-Site Incident Management

Table 1. Exercise Objectives and Associated Core Capabilities

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 agency personnel who have an active role in public health emergency response and operations, and perform their regular roles and responsibilities during the exercise.
- **Exercise Director.** The Exercise Director is responsible for planning, coordinating, and overseeing all exercise functions. He or she manages exercise activities and maintains a close dialogue with the Controllers regarding the status of play and the achievement of the exercise design objectives.
- **Controllers.** Controllers assist in set-up and operate the exercise site, plan and manage exercise play, and act in the roles of response individuals and agencies that are not playing in the exercise. Controllers direct the pace of the exercise, provide key data to players, and may prompt or initiate certain player actions to ensure exercise continuity. In addition, they issue exercise materials to players as required, monitor the exercise timeline, and supervise the safety of all exercise participants. The SWMHE may utilize several Controllers on the day of the exercise, reporting to one Senior Controller.
- **Senior Controller.** The control staff is led by the Senior Controller, who is responsible for coordinating with the Exercise Director on exercise control and safety issues. The Senior Controller is responsible for monitoring activities throughout the exercise and tracking whether objectives have been met or require further attention. The Senior Controller will roam during exercise play, providing exercise control in any location required.
- **Simulators.** Simulators are control staff personnel who role-play non-participating organizations or individuals. They may operate out of the Simulation Cell (SimCell) or have face-to-face contact with players. Simulators act in accordance with instructions provided in the Master Scenario Events List (MSEL), and are ultimately accountable to the Exercise Director and Senior Controller.
- **Evaluators.** Evaluators evaluate and provide feedback on designated functional areas of the exercise. They are chosen on the basis of their expertise in the functional area(s) they have been assigned to review during the exercise and their familiarity with local emergency response procedures. Evaluators observe and document performance against established capabilities and tasks, in accordance with the EEGs.
- **Actors.** Actors are participants who may simulate patients or other members of the public who need healthcare or otherwise act to spur movement in the exercise.
- **Observers.** Observers visit or view selected segments of the exercise. Observers do not play in the exercise, nor do they perform any control or evaluation functions. Observers view the

exercise from a designated observation area and must remain within the observation area during the exercise. Very Important Persons (VIPs) are also observers, but they frequently are grouped separately.

- **Media Personnel.** Some media personnel may be present as observers, pending approval by the sponsor organization and the Exercise Planning Team.
- **VIPs.** VIPs visit or view selected segments of the exercise. VIPs do not play in the exercise, nor do they perform any control or evaluation functions. VIPs will view the exercise from a designated observation area and will remain within the observation area during the exercise. A dedicated group of exercise controllers will be assigned to manage this group.
- **Support Staff.** The exercise support staff includes individuals who are assigned administrative and logistical support tasks during the exercise (e.g. registration, catering).

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 constitute the implied factual foundation for the exercise and, as such, are assumed to be present before the exercise starts. Artificialities are exercise devices that are designed to enhance or improve exercise realism. The following assumptions and/or artificialities apply to the exercise:

- The exercise is conducted in a no fault learning environment wherein capabilities, plans, systems, and processes, NOT individuals, 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.
- All personnel participating in the exercise will operate in accordance with existing plans, procedures, and practices during the exercise.
- Exercise participants will react to the information and situations as they are presented, in the same manner as if this had been a real emergency incident.
- The influenza pandemic differs from seasonal influenza in frequency, scope, and severity. Pandemic influenza occurs when a novel strain of influenza is introduced into the global population that has no natural immunity, causing increased morbidity and mortality.

- New strains of influenza viruses are inevitable and can emerge unpredictably. They can spread rapidly and pervasively through susceptible populations. The sudden and unpredictable emergence of pandemic influenza can cause severe health and social consequences.
- A pandemic has the potential to result in large numbers of deaths, as well as large numbers of patients that require care at the same time. Medical and public health surge may quickly overwhelm the system's resources resulting in scarcity of medicine, equipment, personnel, and other healthcare resources.
- Hospitals are the optimal institutions to care for ill individuals, providing for medical surge through in-hospital alternative inpatient and outpatient areas. Primary care providers and other community healthcare groups will have a role in triaging patients to the most effective and available care entity. All non-hospital health care providers will coordinate locally with hospitals to acquire the most capacity possible to deal with the greatest number of ill individuals requiring care. Widespread illness in the community will also increase the likelihood of sudden and significant workforce shortages in critical community services in every sector, including critical infrastructure and public services.
- The pandemic event will seriously impact every healthcare, social, and economic organization on a global scale simultaneously. Resources and assistance from federal, state, and local governments will be severely limited.
- Certain antiviral medications are effective for treating the symptoms of this strain of influenza.
- The average incubation period of this strain is two to eight days.
- A significant number of people in the local area have been exposed, and there is a significant surge of H5N1 cases simultaneously presenting to hospitals and healthcare facilities on the morning of the exercise.
- Exercise communication and coordination is limited to participating exercise organizations, venues, and the SimCell (if one is used).
- Surrogates may be playing in place of some key decision makers. The surrogates will either be (a) junior to the principals they represent or (b) exercise controller simulating the actions of the participating representative.
- Some events may require time jumps or may be accelerated to meet exercise objectives.
- All exercise incidents and events will be based on a scripted MSEL.
- In some cases, actual distances may be condensed to accommodate the size of the play area, which may result in artificially located areas, such as staging areas.

EXERCISE TOOLS

In addition to this document, several tools have been developed by CDPH to aid healthcare entities and their partners in the development of their exercise. Other tools available on www.californiamedicalhealthexercise.com include:

- Save the Date Invitation Template
- EEG Template
- AAR Template
- Survivor Cards Template
- Extent of Play Planning Template
- Feedback Forms
- Waiver Forms
- Assessments
- Controller/Evaluator (C/E) Briefing Slide Deck Template
- C/E Handbook
- Debriefing Slide Deck Template
- Incident Planning Guide
- Incident Response Guide
- Objectives
- MSEL Template
- Certificate of Participation Template
- Additional Resources

HSEEP DOCTRINE

The Homeland Security Exercise Evaluation Program (HSEEP) serves as exercise and evaluation doctrine that is flexible, scalable, and adaptable to the needs of stakeholders across the whole community. Revised in 2013, the use of HSEEP, consistent with Presidential Policy Directive 8: the National Preparedness Goal, and the National Preparedness System, supports efforts to improve national capacity across the whole community to collectively build, sustain, and deliver core capabilities.

HSEEP encourages planners to identify exercise program objectives that are informed by strategy documents, threat, hazard, and capability assessments, and results from previous exercises. These program-wide objectives guide the design and development for individual exercises, as planners develop exercise-specific objectives and associated core capabilities for validation and assessment during exercise conduct. Exercise evaluation assesses exercise performance against exercise objectives — documenting strengths, areas for improvement, core capability levels and gaps, and corrective actions in an After Action Report/Improvement Plan (AAR/IP). Through improvement planning, exercise stakeholders prioritize, track, and analyze corrective actions, ensuring that the corrective actions inform future exercise program objectives.

EXERCISE LOGISTICS

SAFETY

Exercise participant safety takes priority over exercise events. The following general requirements apply to the exercise:

- A Safety Controller is responsible for participant safety; any safety concerns must be immediately reported to the Safety Controller. The Safety Controller and Exercise Director will determine if a real-world emergency warrants a pause in exercise play and when exercise play can be resumed.
- For an emergency that requires assistance, use the phrase **“real-world emergency.”** The following procedures should be used in case of a real emergency during the exercise:
- Anyone who observes a participant who is seriously ill or injured will immediately notify emergency services and the closest controller, and, within reason and training, render aid.
- The controller aware of a real emergency will initiate the [“real-world emergency”] broadcast and provide the Safety Controller, Senior Controller, and Exercise Director with the location of the emergency and resources needed, if any. The Senior Controller will notify the SimCell as soon as possible if a real emergency occurs.
- If the nature of the real emergency requires a suspension or termination of the exercise at the exercise site or for the exercise function, all exercise activities at that facility/area will immediately cease. Exercise play may resume once the real world emergency situation has been addressed. Exercise play at other sites and for other functions should not cease if one site/function has declared a real world emergency unless they are reliant on the affected venue. The decision to suspend or terminate exercise activity and notification will be made by the Exercise Director or Senior Controller.

Emergency Medical Services

The sponsor organization will coordinate with local emergency medical services in the event of a real-world emergency. Each venue or site is responsible for coordination with first responders during an emergency. Call 9-1-1 immediately followed by the Senior Controller or SimCell.

Security

If entry control is required for the exercise venue(s), the sponsor organization is responsible for arranging appropriate security measures. To prevent interruption of the exercise, access to exercise sites and the SimCell is limited to exercise participants. Players should advise their venue’s controller or evaluator of any unauthorized persons.

Media/Observer Coordination

Organizations with media personnel and/or observers attending the event should coordinate with the sponsor organization for access to the exercise site. Media/Observers are escorted to designated areas and accompanied by an exercise controller at all times. Sponsor organization representatives and/or the observer controller may be present to explain exercise conduct and answer questions. Exercise participants should be advised of media and/or observer presence.

Exercise Identification

Exercise staff may be identified by badges to clearly display exercise roles; additionally, uniform clothing may be worn to show agency affiliation. Table 2 describes these identification items.

Group	Vest Color
Exercise Director	Black
Evaluators	Black
Players, Uniformed	Red
Players, Civilian Clothes	Red
Incident Commander	White
Logistics Section	Yellow
Planning Section	Blue
Operations Section	Red

Table 2. Exercise Identification

PARKING AND TRANSPORTATION

Paid parking will be available at the exercise sites. Public transportation options are also available.

REGISTRATION/CHECK-IN

All participants should check in prior to the exercise, and receive instructions on facility characteristics.

LUNCH

Food and refreshments will be provided for all exercise participants.

CLEANUP AND RESTORATION

After the exercise, controllers, evaluators, and players will begin cleanup operations to restore the area to pre-exercise conditions.

POST-EXERCISE AND EVALUATION ACTIVITIES

For a full exercise schedule, including the time and location of all post-exercise meetings, please see Appendix A.

DEBRIEFINGS

Post-exercise debriefings aim to collect sufficient relevant data to support effective evaluation and improvement planning.

Hot Wash

At the conclusion of exercise play, controllers facilitate a Hot Wash to allow players to discuss strengths and areas for improvement, and to allow evaluators to seek clarification regarding player actions and decision-making processes. All participants may attend; however, observers are not encouraged to attend the meeting. The Hot Wash should not exceed 30 minutes.

Controller and Evaluator Debriefing

Controllers and evaluators (C/E) attend a facilitated C/E Debriefing immediately following the exercise. During this debriefing, controllers and evaluators provide an overview of their observed functional areas and discuss strengths and areas for improvement.

Participant Feedback Forms

Participant Feedback Forms provide players with the opportunity to comment candidly on exercise activities and exercise design. Participant Feedback Forms should be collected at the conclusion of the Hot Wash and returned to AAR Lead.

EVALUATION

Exercise Evaluation Guides

EEGs assist evaluators in collecting relevant exercise observations. EEGs document exercise objectives and aligned core capabilities, capability targets, and critical tasks. Each EEG provides evaluators with information on what they should expect to see demonstrated in their functional area. The EEGs, coupled with Participant Feedback Forms and Hot Wash notes, are used to evaluate the exercise and compile the AAR.

After Action Report

The AAR summarizes key information related to evaluation. The AAR primarily focuses on the analysis of core capabilities, including capability performance, strengths, and areas for improvement. AARs also include basic exercise information including the exercise name, type of exercise, dates, location, participating organizations, mission area(s), specific threat or hazard, a brief scenario description, and the name of the exercise sponsor and POC.

IMPROVEMENT PLANNING

Improvement planning is the process by which the observations recorded in the AAR are resolved through development of concrete corrective actions, which are prioritized and tracked as a part of a continuous corrective action program.

After Action Meeting

The After Action Meeting (AAM) is a meeting held among decision and policy-makers from the participating organizations, as well as the Lead Evaluator and members of the Exercise Planning Team, to debrief the exercise and review and refine the draft AAR and Improvement Plan (IP). The AAM should be an interactive session, providing attendees the opportunity to discuss and validate the observations and corrective actions in the draft AAR/IP.

Improvement Plan

The IP identifies specific corrective actions, assigns them to responsible parties, and establishes target dates for their completion. The IP is created by elected and appointed officials from the organizations participating in the exercise, and discussed and validated during the AAM.

PARTICIPANT INFORMATION AND GUIDANCE

EXERCISE RULES

The following general rules govern exercise play:

- Real-world emergency actions take priority over exercise actions.
 - Exercise players will comply with real-world emergency procedures, unless otherwise directed by the control staff.
 - All communications (including written, radio, telephone, and e-mail) during the exercise will begin and end with the statement “**This is an exercise.**”
 - Exercise players who place telephone calls or initiate radio communication with the SimCell must identify the organization or individual with whom they wish to speak.
 - Keep the exercise’s objectives in mind throughout the exercise.
-

PLAYER INSTRUCTIONS

Players should follow these guidelines before, during, and after the exercise to ensure a safe and effective exercise.

Before the Exercise

- Review appropriate organizational plans, procedures, and exercise support documents.
- Be at the appropriate site at least 30 minutes before the exercise starts. Wear the appropriate uniform and/or identification item(s).
- Sign in when you arrive.
- If you gain knowledge of the scenario before the exercise, notify a controller so that appropriate actions can be taken to ensure a valid evaluation.
- Review all player materials.

During the Exercise

- Respond to exercise events and information as if the emergency were real, unless otherwise directed by an exercise controller.
- Controllers will give you only information they are specifically directed to disseminate. You are expected to obtain other necessary information through existing emergency information channels.
- Do not engage in personal conversations with controllers, evaluators, observers, or media personnel. If you are asked an exercise-related question, give a short, concise answer. If you

are busy and cannot immediately respond, indicate that, but report back with an answer as soon as possible.

- If you do not understand the scope of the exercise, or if you are uncertain about an organization's participation in the exercise, ask a controller.
- Parts of the scenario may seem implausible. Recognize that the exercise has objectives to satisfy and may require incorporation of unrealistic aspects. Every effort has been made by the exercise's trusted agents to balance realism with safety and to create an effective learning and evaluation environment.
- All exercise communications will begin and end with the statement **"This is an exercise."** This precaution is taken so that anyone who overhears the conversation will not mistake exercise play for a real-world emergency.
- When you communicate with the SimCell, identify the organization or individual with whom you wish to speak.
- Describe critical actions by speaking out loud as you complete them. This procedure will ensure that evaluators are aware of critical actions as they occur.
- Maintain a log of your activities. Many times, this log may include documentation of activities that were missed by a controller or evaluator.
- Do not simulate additional events. Only play to those events and scenarios that are planned for the exercise.

After the Exercise

- Participate in the Hot Wash at your venue with controllers and evaluators.
- Complete the Participant Feedback Form. This form allows you to comment candidly on emergency response activities and exercise effectiveness. Provide the completed form to a controller or evaluator.
- Provide any notes or materials generated from the exercise to your controller or evaluator for review and inclusion in the AAR.

SIMULATION GUIDELINES

Because the exercise is of limited duration and scope, certain details will be simulated. The physical description of what would fully occur at the incident sites and surrounding areas will be relayed to players by simulators or controllers. A SimCell will simulate the roles and interactions of nonparticipating organizations or individuals. Simulated events will be based on the scripted MSEL.

APPENDIX A: EXERCISE SCHEDULE

Time	Personnel	Activity	Location
November 18, 2015			
TBD	Exercise Controllers, Evaluators, and Staff	Controller and Evaluator Orientation Briefing	TBD
As needed	Exercise Controllers and Staff	Set up Control Cell and Walk-through	HCSA-DOC
November 19, 2015			
0730	RSS Venue Controllers, Exercise Staff	Exercise Site Set Up/ Exercise Registration	Various Locations
0745	Controllers and Exercise Staff	Communications check	Various Locations
0745	Simulation Cell (SimCell)	Sim Cell Activated	Various Locations
0800	All	Exercise Registration	Various Locations
0815	Controllers	Conduct Player Briefing	Various Locations
0830	All	Exercise Starts	Various Locations
1200	All	Exercise Ends	Various Locations
1205	Controllers	Conduct Player Hotwash	Various Locations
0100	Controllers and Exercise Planning Team	Exercise Site Clean UP	Various Locations
TBD			
TBD	Exercise Planning Team	Exercise Debriefing	TBD
TBD	Controllers, Evaluators, and various officials	Controller and Evaluator After Action Review	TBD

APPENDIX B: Exercise Participants

Name	Organization
	Alameda County Emergency Services (ASCO OES)
	Alameda County EMS
	Alameda County Healthcare Service Agency
	Alameda County Public Health Department
	Alameda Health System
	Alta Bates Medical Center
	Asian Community Mental Health Services
	Asian Health Services
	Axis Community Health
	City of Berkeley Public Health Department
	California Department of Public Health
	Camp Parks
	Chaparral House
	Community Health Center Network
	Eden Medical Center
	Hayward Healthcare & Wellness Center
	Hillside Senior Care
	Kaiser Permanente Oakland
	Kindred Hospital
	Lifelong Medical
	Mercy Retirement & Care Center
	Native American Health Center
	Paramedics Plus
	REACH Air Medical Services
	Rural/Metro Ambulance
	St. Rose Hospital
	Stanford Health Care – Valley Care
	UCSF Benioff Children’s Hospital
	United States Coast Guard

STATEWIDE MEDICAL AND HEALTH EXERCISE
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	Washington Hospital
	West Oakland Health Council
	Willow Rock Psychiatric Health Facility

APPENDIX C: EXERCISE PERSONNEL ASSIGNMENTS

Name	Role	Position
Erica Pan, M.D.		Incident Commander
Sherri Willis		Public Information Officer
Preston Lam		Safety Officer
Rosanna Lee		Liaison Officer/DOC Manager
Zerlyn Ladua		Exercise Director
Darlene Fujii		DCDCP Continuity of Operations
Laurence Padua		Deputy Plans Section Chief
Aleta Rattanasith		Resource Status Unit
Laurence Padua		Documentation Unit
Beverly Chu		Situation Status Unit
Amy Pine		Operations Section Chief
Preston Lam		Inquiries Group
Carrie Joy		Inquiries Group
Mikael Wagner		Dissemination Group
Mark Pandori		Laboratory Group
Kate Holbrook		Disease Containment Branch Director
Fred Claridge		Medical Health Branch Director
Lee Siegel		EMS/Medical Transport Group
Michael Jacobs		Healthcare Facilities Group
Michelle Voos		Hospital Team
Adele Pagan		Community Clinic Team
Travis Kusman		
Wendy Georges		Deputy Logs Section Chief
Darlene Fujii		Personnel Unit
Rosanna Lee		Supplies Unit
Leo Halim		Communications Equip Unit
Ying Ling Wang		Informational Technology Unit
Arnie Spanjers		SimCell Controller
Jim Potts		SimCell Controller
Zachary Weiner		SimCell Controller
Catrina Christensen		SimCell Controller
Gary Oliver		SimCell Controller
Linda Cosgrove		Evaluator
Donata Nilsen		Plans Section Chief
Ron Seitz		Logistic Section Chief
Cynthia Frankel		Evaluator
Kevin Chao		Observer

STATEWIDE MEDICAL AND HEALTH EXERCISE
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Ronald Shuman	Observer
<ul style="list-style-type: none">Note : additional assignments will be made prior to the exercise .	

APPENDIX D: COMMUNICATIONS PLAN

All spoken and written communications will start and end with the statement ["THIS IS AN EXERCISE."]

PLAYER COMMUNICATIONS

Exercise communications do not interfere with real-world emergency communications. Players use routine organization communications systems. Additional communication assets may be made available as the exercise progresses. Each venue or organization coordinates its internal communication networks and channels.

CONTROLLER COMMUNICATIONS

The principal methods of information transfer for controllers during the exercise are face-to-face interaction. The controller communications network allows the Exercise Director or Senior Controller to make and announce universal changes in exercise documentation, such as changes to the MSEL.

The primary means of communication between the SimCell, controllers, and Players is landline telephone. A list of key telephone numbers will be available before the exercise starts.

COMMUNICATIONS CHECK

Before the exercise, the Controllers will conduct a communications check with all interfacing communications nodes to ensure redundancy and uninterrupted flow of control information.

PLAYER BRIEFING

Controllers may be required to provide scenario details to participants to begin exercise play. Technical handouts or other materials also may be provided to orient players with the exercise.

PUBLIC AFFAIRS

The sponsor organization and participating organizations are responsible for coordinating and disseminating public information before the exercise. Each venue should follow internal procedures.

2015 Statewide Medical and Health Communication Guide- Yellow Pages

Organization	Contact Name	Phone	Email	CAHAN	Reddinet	700/800MHz	Ham
Health Care Service Agency Department Operations Center (HCSA DOC)							
DOC Fax Number	Inbound:	(510) 268-7282					
	Outbound	(510) 268-7283					
Conference Calls	11am	(888) 808-6929 Access #: 9445482					
Plans Section		(510) 268-7281	Pheppsc@acgov.org				
Operations Section		(510) 268-7279	Pheposc@acgov.org				
Information & Guidance	Inquiries	(510) 268-7280					
	Inquiries	(510) 268-7284					
Medical Branch	Medical Health Branch Director	(510) 915-8728	Med1@acgov.org				
	EMS/Medical Transport Group	(510) 915-8612					
	Health Care Facilities Group	(510) 915-8618					
	Community Clinic Team	(510) 915-8388					
Logistics Section		(510) 268-7326	Pheplsc@acgov.org				
<u>Government Agencies</u>							
Alameda County Emergency Services (ACSO OES)	Paul Hess	FE: (510) 381-9203	FE: oes@acgov.org	Y	Y	Y	N
California Department of Public Health (CDPH)	Kevin Chao	FE: 510-377-3435	kevin.chao@cdph.ca.gov				
Camp Parks	Alan Brown	FE: (209) 765-4350 Office: (925) 875-4290	Alan.M.Brown10.civ@mail.mil	N	N	N	N
US Coast Guard	LCDR Zachary Woodward	FE: (407) 403-1018 Office: (510) 437-3602	Zachary.c.woodward@uscg.mil	N	N	N	N

STATEWIDE MEDICAL AND HEALTH EXERCISE
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Organization	Contact Name	Phone	Email	CAHAN	Reddnet	700/800MHz	Ham
Hospitals							
Alameda Health System	Sandra Williams	Office: (510) 535-7669 Cell: (510) 773-6824	swilliams@alamedahealthsystem.org	N	Y	Y	N
Alta Bates Medical Center	Rick Luna	FE: (510) 332-1415 Office: (510) 869-6734	lunar1@sutterhealth.org	Y	Y	Y	Y
UCSF Benioff Children's Hospital Oakland	Rob Newells	FE: (510) 428-3535 Office: (510) 428-8371 Cell: (510) 282-1532	hcc@mail.cho.org	Y	Y	N	Y
Eden Medical Center	Peggy Hatten	Office: (510) 727-8263 Cell: (510) 326-5720	hattenp@sutterhealth.org	Y	Y	Y	N
Kaiser Permanente Oakland	Zewdu Shibabaw	FE: (510) 915-0520 Office: (510) 752-5057	zewdu.y.shibabaw@kp.org	Y	Y	N	Y
	Jorge Palafox	Cell: (415) 533-4449	jorge.r.palafox@kp.org				
Kindred SFBA Hospital	Frank Gee	FE: (510) 418-2388 Office: (510) 357-8300	frank.gee@kindred.com	N	Y	N	Y
St. Rose Hospital	Ken Henkelman	FE: (925) 586-0159 HCC: (510) 264-2531 Office: (510) 264-4005	strose-emergency@srhca.org	Y	Y	N	Y
Stanford Health Care Valley Care	Caryn Thornburg	Office: (925) 373-4178 Cell: (925) 580-0152	cthornbu@valleycare.com	Y	Y	N	Y
Washington Hospital	Gus Arroyo	FE: (510) 818-6227 Office: (510) 818-7206 Cell: (510) 520-3501	Gus_arroyo@whhs.com	Y	Y	Y	Y
Willow Rock Psychiatric Health Facility for Adolescents	John Adam	FE: (510) 725-7040 Office: (510) 618-4716	jadam@telecarecorp.com	N	Y	N	N
Clinics							
Asian Community Mental Health Services	Catherine Powell	FE: (510) 869-6000 Office: (510) 869-6090 Cell: (510) 875-5317	catherinep@acmhs.org	Y	N	N	N
Asian Health Services	Dong Suh	FE: (510) 986-6836 Cell: (510) 290-3983	dsuh@ahschc.org	Y	Y	N	N
Axis Community Health	Aurora Bataclan	FE: (925) 201-6229	abataclan@axishealth.org	N	N	N	Y
Lifelong Medical	Jacquelin Poon	FE: (510) 981-4134	compliance@lifelongmedical.org	Y	Y	N	Y
Native American Health Center	Dawn Lulua-Claxton	FE: (510) 535-4471 Cell: (510) 418-5297	dawnl@nativehealth.org	N	Y	N	Y
West Oakland Health Council	Adrienne Beasley	FE: (510) 835-9610 Office: (510) 302-3729 Cell: (510) 508-7901	adrienneb@wohc.org	Y	N	N	N
Skilled Nursing Facilities							
Chaparral House	Kathy Smedley	FE: (510) 848-8774 Extension 104 Cell: (925) 408-4517	Ksmedley@chaparralhouse.org	Y	N	N	N
Hayward Healthcare & Wellness Center	Ada Lukban	FE: (510) 783-4811 Cell: (510) 386-3331	administrator@haywardhcc.com	Y	N	N	Y
Hillside Senior Care	Linda M. Joseph	Office: (510) 793-3000 Cell: (415) 235-3897	ljoseph97@gmail.com	N	N	N	N
Mercy Retirement & Care Center	Glen Goddard	FE: (510) 534-8540 Cell: (650) 773-6642	ggoddard@eldercarealliance.org	N	N	N	N

STATEWIDE MEDICAL AND HEALTH EXERCISE
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Organization	Contact Name	Phone	Email	CAHAN	Reddinet	700/800MHz	Ham
<u>Transport</u>							
Paramedic Plus	Frank intelisano	FE: (510) 746-5762	fintelisano@paramedicsplus.com				
Reach Air Medical Services	Kathie Dunn	FE: (707) 331-3068 Office: (800) 338-4045	Kathie.dunn@reachair.com	N	N	Y	N
Rural/Metro Ambulance	Peter Cordingley	Fe: (408) 655-4491	peter.cordingley@rmetro.com				
<u>Exercise Simulation Cell</u>							
City Of Berkeley SimCell		(510) 981-5324					
EMS, ALS, BLS		(510) 915-8392					
First Responders, Fire, Law		(510) 915-8227					
Hospitals, Clinics, Skilled Nursing Facilities and other Health Care Facilities		(510) 915-8616					
Government Agencies- Alameda County and CA		(510) 915-8352					
Other Agencies		(510) 915-8331					

APPENDIX E: 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
BAR	BioWatch Actionable Result
BHPP	Building Healthy Public Policy
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
C/E	Controller / Evaluator
CERT	Community Emergency Response Team
CHA	California Hospital Association
CID	Clinical Infectious Disease
C/ME	Coroner / Medical Examiner
CPCA	California Primary Care Association
DCDC	Division of Communicable Disease
DHS	Department of Homeland Security
DMORT	Disaster Mortuary Operational Response Team
DOC	Department Operations Center
ED	Emergency Department
EEG	Exercise Evaluation Guide
EHD	Environmental Health Department
EMS	Emergency Medical Services
EMSA	Emergency Medical Services Authority
EMSAAC	Emergency Medical Services Administrators Association of California
EMSC	Emergency Medical Services for Children
EOC	Emergency Operation Center
EOM	Emergency Operations Manual
EPO	Emergency Preparedness Office
ExPlan	Exercise Plan
FAC / FIC	Family Assistance Center / Family Information Center
FE	Functional Exercise

STATEWIDE MEDICAL AND HEALTH EXERCISE EXERCISE PLAN



FEMA	Federal Emergency Management Agency
FOUO	For Official Use Only
FSE	Full Scale Exercise
FTS	Field Treatment Site
GETS	Government Emergency Telecommunications Service
HCC	Hospital Command Center
HICS	Hospital Incident Command System
HIPAA	Health Insurance Portability and Accountability Act
HPP	Hospital Preparedness Program
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
MHCC	Medical and Health Coordination Center
MHOAC	Medical Health Operational Area Coordination Program
MOU	Memorandum of Understanding
MRC	Medical Reserve Corps
MSEL	Master Scenario Events List
NIAID	National Institute of Allergy and Infectious Diseases
NGO	Non-governmental organization
NHICS	Nursing Home Incident Command System
NICU	Neonatal Intensive Care Unit
NIMS	National Incident Management System
OA	Operational Area
OES	Governor's Office of Emergency Services
OEM	Office of Emergency Management
PAHPRA	Pandemic and All-Hazards Preparedness Reauthorization Act of 2013
PCR	Polymerase Chain Reaction
PHEP	Public Health Emergency Preparedness
POC	Point of Contact
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

STATEWIDE MEDICAL AND HEALTH EXERCISE EXERCISE PLAN



SME	Subject Matter Expert
SNS	Strategic National Stockpile
SOC	State Operations Center
SWMHE	Statewide Medical and Health Exercise
TTX	Tabletop Exercise
UC	Unified Command
VIP	Very Important Person
WHO	World Health Organization

APPENDIX F: H5N1 BRIEFING

WHAT IS H5N1?

H5N1 is a highly pathogenic viral subtype of the avian Influenza A virus that has been involved in outbreaks of poultry, especially in Asia and the Middle East. Avian influenzas are those that primarily affect poultry, however some viruses, such as H5N1, can infect humans, generally after contact with poultry, but usually do not spread between humans. Over time, some viruses may mutate and develop the ability to be transmitted efficiently between human beings.

The first recorded infection of humans by A (H5N1) influenza was in 1997 during a poultry outbreak in Hong Kong, China. Since its widespread re-emergence in 2003 and 2004, it has spread from Asia to Europe and Africa and has become entrenched in poultry in some countries, resulting in millions of poultry infections, several hundred human cases, and many human deaths. Outbreaks in poultry have seriously impacted livelihoods, economies, and international trade in affected countries.

SYMPTOMS

Initial symptoms of the A (H5N1) influenza are similar to a common seasonal influenza. The incubation period for A (H5N1) avian influenza may be longer than that for normal seasonal influenza, which is around 2 to 3 days. Current data for A (H5N1) influenza infection indicate an incubation period ranging from 2 to 8 days and possibly as long as 17 days.

A (H5N1) influenza symptoms can include:

- Fever greater than 100.4°F (38°C)
 - Cough
 - Diarrhea
 - Trouble breathing
 - Headache
 - General ill feeling (malaise)
 - Muscle aches
 - Runny nose
 - Sore throat
-

HOW DANGEROUS IS H5N1?

The case fatality rate for A (H5N1) influenza infection in people is much higher compared to that of seasonal influenza infections. More than 600 human A (H5N1) influenza cases have been reported to WHO from 15 countries in Asia, Africa, the Pacific, Europe and the Near East since November 2003. The

first report of a human infection with A (H5N1) influenza in the Americas was in Canada on January 8, 2014. Approximately 60% of the cases have died.

Currently, the A (H5N1) influenza virus does not transmit efficiently from person to person. Some cases of limited, non-sustained human-to-human transmission have likely occurred. There is always a concern that a mutation could occur that would enable the virus to pass easily among people, leading to a pandemic.

Currently, your risk of getting the A (H5N1) influenza virus is higher if:

- You work with poultry (such as farmers)
- You travel to countries where the virus is present
- You touch an infected bird
- You eat raw or undercooked poultry meat, eggs, or blood from infected birds

TREATMENT

Evidence suggests that some antiviral drugs, notably oseltamivir (Tamiflu) or zanamivir (Relenza) can reduce the duration of viral replication and improve prospects for survival.

In suspected cases, antivirals should be prescribed as soon as possible (ideally, within 48 hours following symptom onset) to maximize their therapeutic benefits. However, given the significant mortality currently associated with A (H5N1) infection and evidence of prolonged viral replication in this disease, administration of antivirals should also be considered in patients presenting later in the course of illness.

The virus that causes human A (H5N1) influenza is resistant to the antiviral medicines amantadine (Symmetrel) and rimantadine (Flumadine). These medicines should not be used in the case of an A (H5N1) influenza outbreak. The use of corticosteroids is not recommended.

SOURCES




"Avian Influenza." WHO, Mar. 2014. Web.
<http://www.who.int/mediacentre/factsheets/avian_influenza/en/>.

"Avian Influenza." The New York Times Health Guide, 3 Feb. 2013. Web.
<<http://www.nytimes.com/health/guides/disease/avian-influenza/overview.html>>.

"H5N1 Avian Flu (H5N1 Bird Flu)." *Flu.gov*. U.S. Department of Health and Human Services, n.d. Web.
<http://www.flu.gov/about_the_flu/h5n1/>.

APPENDIX G: COMMUNICATION & INFORMATION MANAGEMENT

Figure 1: Information Flow During Unusual Events

-  Information flow in compliance with regulatory, statutory and program requirements.
-  Information flow including notification and medical and health situation reporting.
-  Direct notification between entities and the CalOES State Warning Center in compliance with statutory and regulatory requirements (e.g., Hazmat spills and releases).

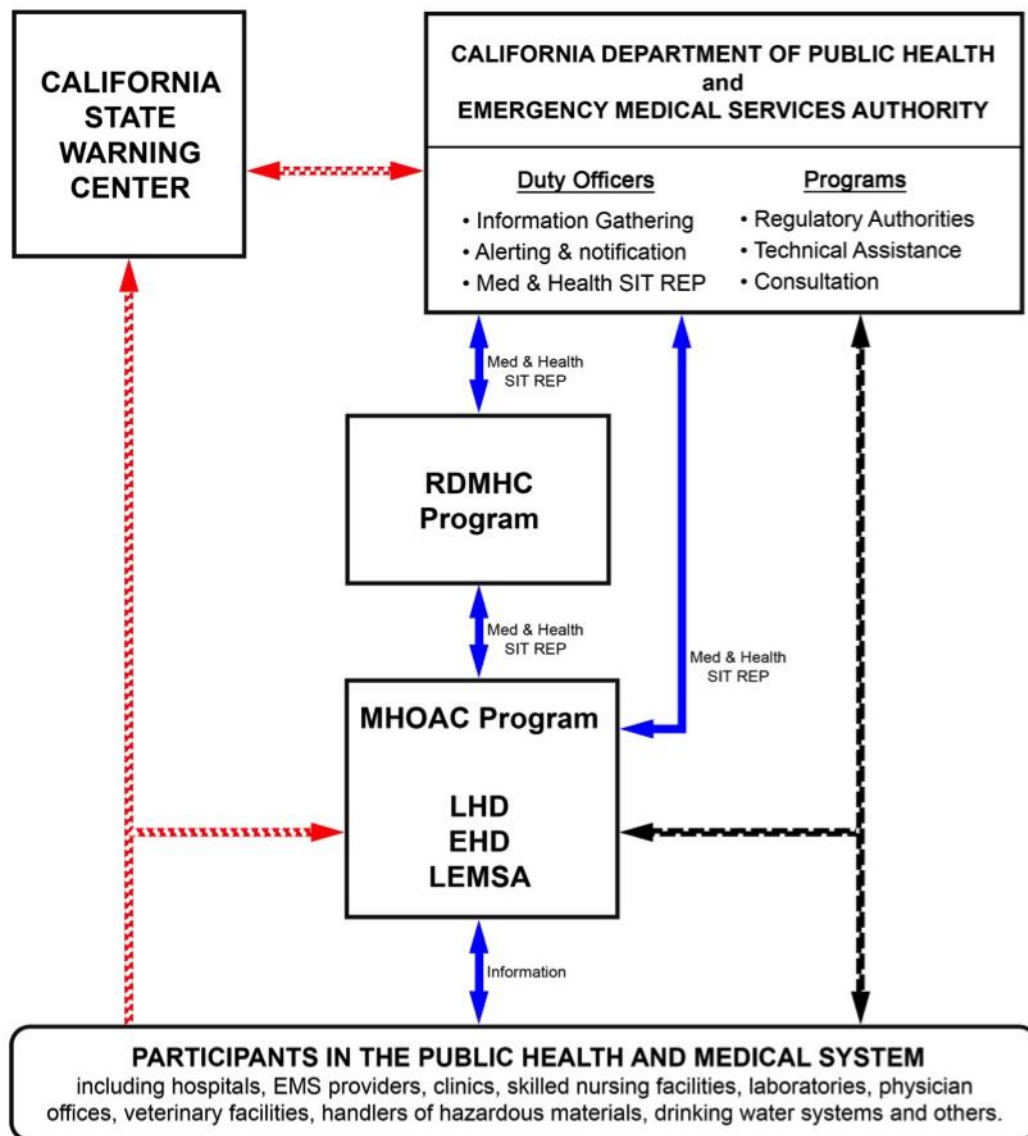





Figure 2: Information Flow During Emergency System Activation

-  Information flow in compliance with regulatory, statutory and program requirements.
-  Notification and health & medical situation reporting.
-  Emergency management incident reporting, inclusive of medical & health situation reporting.

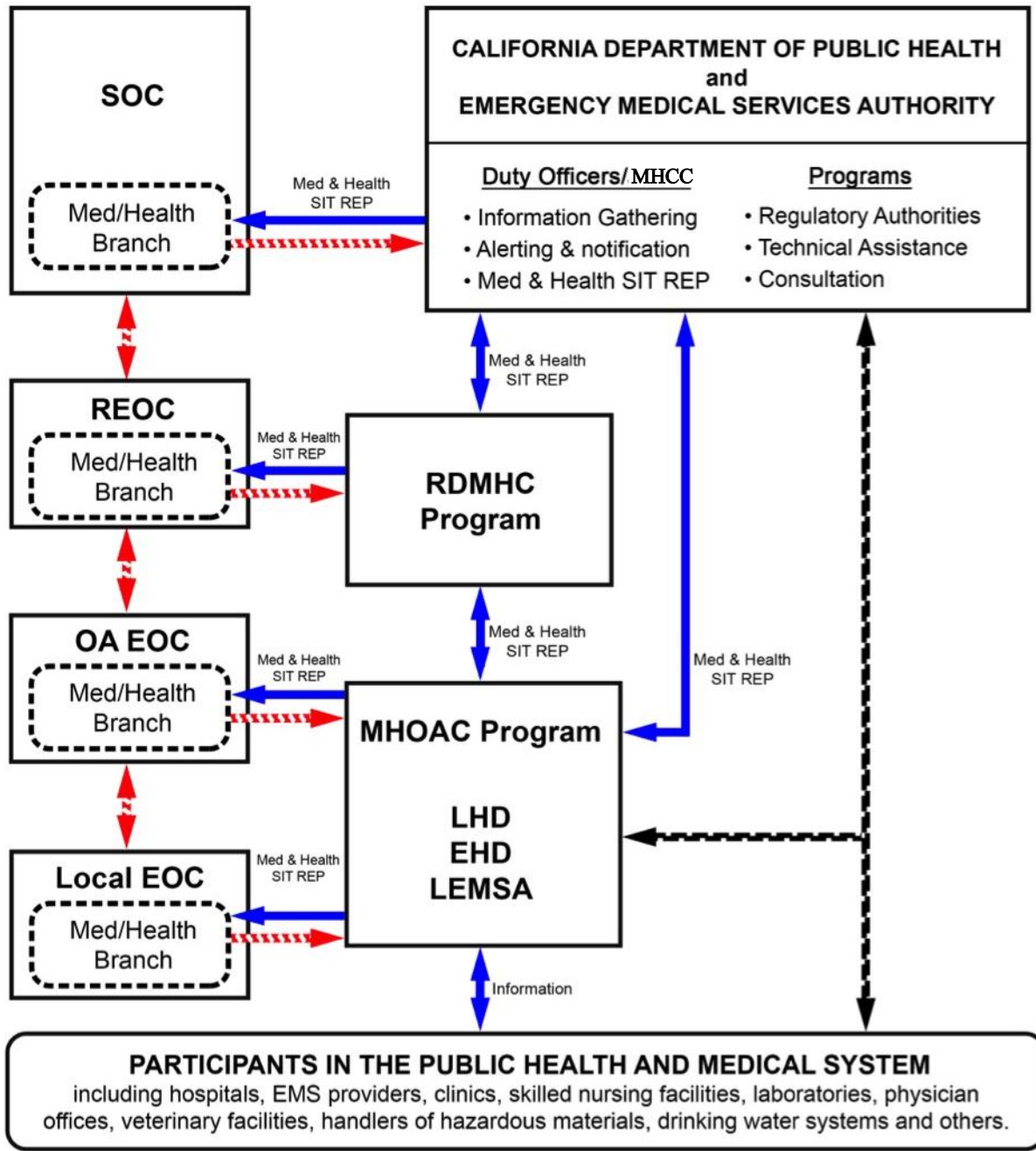


Table 4: Notification Process – Field to State²

NOTIFICATION PROCESS FOR UNUSUAL EVENTS AND EMERGENCY SYSTEM ACTIVATION – FIELD TO STATE		
SEMS LEVEL	ENTITY	INITIAL NOTIFICATION
Field	Field-Level Participants in the Public Health and Medical System, e.g., Hospitals EMS Providers Community Clinics Skilled Nursing Facilities Public Water Systems Public Health Laboratories	Notify local and State agencies in accordance with statutory and regulatory requirements and local policies and procedures.
Local Gov't	Public Health and Medical Agencies: LHD EHD LEMSA	Notify local and State agencies in accordance with statutory and regulatory requirements and local policies and procedures. Notify the MHOAC Program. LHD/EHD: Notify the CDPH Duty Officer Program (either directly or via the MHOAC Program) or Medical and Health Coordination Center (MHCC) if activated.
OA	MHOAC Program	Notify the RDMHC Program in affected region. Notify the local emergency management agency in accordance with local policies and procedures. Notify the CDPH and/or EMSA Duty Officer Programs (either directly or via the RDMHC Program).
Region	RDMHC Program	Notify the CDPH and/or EMSA Duty Officer Programs. Notify the local emergency management agency in accordance with local policies and procedures. Notify the MHOAC Program(s) in unaffected Operational Areas within the Mutual Aid Region to inform and provide advance warning if requests for assistance are anticipated.

² Source: CDPH EOM, July 2011.

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SEMS LEVEL	ENTITY	INITIAL NOTIFICATION
State	CDPH and EMSA Duty Officer Programs	Notify State agencies in accordance with policies and procedures. Notify the RDMHC Programs in other Mutual Aid Regions if assistance is required or anticipated.
	Cal OES State Warning Center	Notify State agencies, including Cal OES, in accordance with policies and procedures.

Table 5: Notification Process³ - State to Field

NOTIFICATION PROCESS FOR UNUSUAL EVENTS AND EMERGENCY SYSTEM ACTIVATION STATE TO FIELD		
SEMS LEVEL	ENTITY	INITIAL NOTIFICATION
State	Cal OES State Warning Center	Notify the CDPH and EMSA Duty Officer Programs.
	CDPH and EMSA Duty Officer Programs	<p>Notify State agencies in accordance with policies and procedures.</p> <p>Notify the RDMHC Program in accordance with policies and procedures: request acknowledgement of notification if a Medical and Health Situation Report is expected; escalate to the MHOAC Program if acknowledgement of notification is not received from the RDMHC Program within 15 minutes. Notify the RDMHC Program by email if no Medical and Health Situation Report is expected by CDPH and/or EMSA.</p> <p>Notify LHD/EHDs in accordance with policies and procedures and field-level entities in accordance with statutory and regulatory requirements for specific functions.</p>
Region	RDMHC Program	<p>Notify the MHOAC Program immediately if the State has requested a Medical and Health Situation Report. Otherwise, notify the MHOAC Program in accordance with policies and procedures.</p> <p>Notify emergency management agencies in accordance with policies and procedures, including the Cal OES Regional Duty Officer (or REOC if activated).</p>
OA	MHOAC Program	Notify local agencies (LHD, EHD, LEMSA, emergency management) in accordance with local policies and procedures.
Local Gov't	Public Health and Medical Agencies: LHD EHD LEMSA	Notify appropriate field-level entities in accordance with local policies and procedures.

³ Source: CDPH EOM, July 2011.

Table 6: Notification Process⁴ - Other

MEDICAL AND HEALTH SITUATION REPORT UNUSUAL EVENTS AND EMERGENCY SYSTEM ACTIVATION		
SEMS LEVEL	ENTITY	ACTIVITY
Field	Field-Level Participants in the Public Health and Medical System, e.g., Hospitals EMS Providers Community Clinics Skilled Nursing Facilities Public Water Systems Public Health Laboratories	Provide situational information to the appropriate local agency (e.g., LHD, EHD, LEMSA or MHOAC Program) in accordance with local policies and procedures.
Local Gov't	Public Health and Medical Agencies: LHD, EHD, LEMSA	Provide situational information to the MHOAC Program in accordance with local policies and procedures.
OA	MHOAC Program	Within two hours of incident recognition, prepare and submit initial Medical and Health Situation Report to: (1) RDMHC Program; (2) CDPH and/or EMSA Duty Officer Programs (or MHCC if activated); and (3) emergency management agency for the OA (or OA EOC if activated) in accordance with local policies and procedures. Under pressing circumstances, the initial Situation Report may be verbally delivered. Update as agreed or pursuant to change in status but no less than once per operational period.
Region	RDMHC Program	Confirm that the MHOAC Program submitted the Medical and Health Situation Report to CDPH and/or EMSA Duty Officer Programs and the emergency management agency for the OA (or OA EOC if activated) in accordance with policies and procedures. Confirm that the Cal OES Regional Duty Officer (or REOC if activated) received the information contained in the Medical and Health Situation Report in accordance with policies and procedures.
State	CDPH and EMSA Duty Officer Programs (or MHCC if activated)	Share information with State agencies in accordance with policies and procedures. Incorporate relevant information from Medical and Health Situation Reports into the statewide Public Health and Medical Daily Situation Report and share with CalOES, CHHS, RDMHC Programs, MHOAC Programs and other stakeholders at least once per operational period.

⁴ Source: CDPH EOM, July 2011.

Figure 3: Public Health and Medical System Status⁵

The designation of Public Health and Medical Incident Level 1, 2, or 3 describes the need for resources. It is also important to assess and report the operational status of the Public Health and Medical System within the Operational Area. Public Health and Medical System Status is assessed using a color-coded system that describes conditions along a continuum from normal daily operations to major disaster. This system is general modeled after the system developed to assess and report Health Care Surge Level described in CDPH’s Standards and Guidelines for Healthcare Surge During Emergencies.

PUBLIC HEALTH AND MEDICAL SYSTEM STATUS	
Color	Condition
Green	The Public Health and Medical System is in usual day-to-day status. Situation resolved; no assistance is required.
Yellow	The Public Health and Medical System is managing the incident using local resources or existing agreements. No assistance is required.
Orange	The Public Health and Medical System requires assistance from within the local jurisdiction/Operational Area.
Red	The Public Health and Medical System requires assistance from outside the local jurisdiction/Operational Area.
Black	The Public Health and Medical System requires significant assistance from outside the local jurisdiction/Operational Area.
Grey	Unknown.

⁵ Source: CDPH EOM, July 2011.



APPENDIX H: REPORTING FORMS⁶

State of California - Health and Human Services Agency

California Department of Public Health

LHJs should fax this form to (916) 440-5984

Novel Influenza Case History Form

(Please see page 3 for case definitions)

Patient information

CDPH Case ID #: _____

Last name _____ First name _____ DOB ____/____/____

Street address _____ City _____ Zip code _____

County of residence _____ Telephone numbers home _____ cell/other _____

Race: White Black Native-American Asian/PI Other Unknown

Ethnicity: Hispanic Non-Hispanic Sex: Female Male HCW: Yes No Unk

Reporting agency

Reporting LHJ _____

Name _____ Phone _____

Outcome status

Outpatient Date of first clinical evaluation: ____/____/____

Hospitalized ≥24 hrs

Hospital name _____

Admit date ____/____/____ Discharge date ____/____/____

Admitted to the ICU Yes No Unk

ICU admit date ____/____/____

Died Date of death: ____/____/____

Autopsy performed Yes No Unk

Location of autopsy: _____

Signs and symptoms

Date of onset of symptom(s) ____/____/____

Symptoms

Fever ≥37.8 Cough Sore throat

Nausea/vomiting Seizures Diarrhea

Shortness of breath Altered mental status

Headache _____ % O₂ sat on _____ % O₂

Other: _____

Significant past medical history

Cardiac disease Yes No Unk

Chronic pulmonary disorder Yes No Unk

Immunosuppression (e.g. cancer) Yes No Unk

Immunosuppressive meds (e.g. steroids) Yes No Unk

Metabolic disorder (e.g. DM, renal) Yes No Unk

Neuromuscular disorder (e.g. CP) Yes No Unk

Hemoglobinopathy (e.g. SCD) Yes No Unk

Genetic disorder (e.g. Downs) Yes No Unk

Pregnant Yes No Unk If yes, EDC: ____/____/____

Postpartum Yes No Unk If yes, delivery: ____/____/____

Weight: _____ kg lbs Height: _____ BMI: _____

Other conditions (e.g. hypertension) Yes No Unk

If YES for any of the above, please specify: _____

Vaccination status

Received flu vaccine for current season: Yes No Unk

Diagnostic/Laboratory studies

Influenza testing:

Date of specimen collection ____/____/____

Specimen type/s _____

Test/s performed and results

Rapid test Positive Negative

DFA Positive Negative

Culture Positive Negative

RT-PCR If PCR, specify test result (pls attach a

copy of the PCR test result): _____

Chest X-ray Positive Negative Not done

If positive, evidence of pneumonia Yes No Unk

If positive, evidence of ARDS Yes No Unk

Other abnormal results (LP, MRI/CT, LFTs, etc.) _____

2° bacterial infection Yes No Unk

If yes, community-acquired hospital-acquired

Specify pathogen _____

Specimen source _____

Date of specimen collection ____/____/____

Other micro results: _____

Clinical course

Antiviral treatment: Yes No Unk

_ Oseltamivir Dosage _____ Dates _____

_ Zanamivir Dosage _____ Dates _____

_ Other, Specify: _____

Intubated Yes No Unk

Complications

Pneumonia ARDS Sepsis Renal failure

Encephalitis/allopathy Pulmonary embolus

Other, specify: _____

CDPH 8658 (01/12)

The information requested on this form is required by the California Department of Public Health for purposes of identification and public health investigation

⁶ Influenza deaths in person 65+ years old are reportable in either the context of an outbreak or of a novel strain.

State of California - Health and Human Services Agency

California Department of Public Health

Novel Influenza Case History Form (p.2)

CDPH Case ID # _____

Risk factors (The following questions pertain to 10 days prior to symptom onset, unless otherwise specified)

History of travel

Yes No Unk

If yes, list all places visited and arrival and departure dates:

Location _____	Arrival date ____/____/____	Departure date ____/____/____
Location _____	Arrival date ____/____/____	Departure date ____/____/____
Location _____	Arrival date ____/____/____	Departure date ____/____/____

Close contact (within 3 ft) with a person who is a suspected, probable or confirmed novel human influenza A case

Yes No Unk

If yes, specify: _____

Touch (handle, slaughter, butcher, prepare for consumption) animals (including poultry, wild birds or swine) or their remains in an area where influenza infection in animals or novel influenza in humans has been suspected or confirmed in the last month

Yes No Unk

If yes, specify: _____

Exposure to animal (including poultry, wild birds or swine) remains in an area where influenza infection in animals or novel influenza in humans has been suspected or confirmed in the last month

Yes No Unk

If yes, specify: _____

Exposure to environments contaminated by animal feces (including poultry, wild birds or swine) in an area where influenza infection in animals or novel influenza in humans has been suspected or confirmed in the last month

Yes No Unk

If yes, specify: _____

Consumption of raw or undercooked animals (including poultry, wild birds or swine) in an area where influenza infections in animals or novel influenza in humans has been suspected or confirmed in the last month

Yes No Unk

If yes, specify: _____

Contact with any animals

Yes No Unk

If yes, specify contact with dogs, cats, horses, wild birds, poultry, swine: _____

Direct contact with pigs at an agricultural event, farm, petting zoo or place where pigs were exhibited (i.e. state or county fair) in the last month

Yes No Unk

If yes, specify event/location and date/s of contact: _____

Visit an agricultural event, farm, petting zoo or place where pigs live or were exhibited (i.e. state or county fair) in the last month

Yes No Unk

If yes, specify event/location and date/s of visit: _____

Epi-link to laboratory-confirmed or probable novel influenza A case

Yes No Unk

Visit or stay in the same household with anyone with pneumonia or severe influenza-like illness

Yes No Unk

Visit or stay in the same household with anyone who died following the visit

Yes No Unk

Handle samples (animal or human) suspected of containing influenza virus in a laboratory or other setting

Yes No Unk

Novel Influenza Case History Form (p.3)

Novel Influenza A Case Definition

Novel influenza A virus infections are all human infections with influenza A viruses that are different from currently circulating human influenza H1 and H3 viruses. These viruses include those that are subtyped as non-human in origin and those that are unsubtypeable with standard methods and reagents.

The clinical presentation of illness should be compatible with influenza virus infection.

Laboratory criteria for diagnosis

A specimen from a human that is reverse-transcriptase-polymerase chain reaction (RT-PCR) or culture-positive for influenza A and tests negative for currently circulating human H1 and H3 subtypes. Depending on the situation, a confirmatory reverse-transcriptase-polymerase chain reaction (RT-PCR) specific for the novel influenza virus of concern may or may not be available.

Specimens from cases with human infection with unsubtypeable influenza A viruses should be forwarded to the local public health laboratory or the California Department of Public Health Viral and Rickettsial Diseases Laboratory (CDPH-VRDL) for confirmation.

Case classification

Confirmed – A human case with illness consistent with a novel influenza A virus that has been confirmed by the public health laboratory, CDPH-VRDL or the Centers for Disease Control and Prevention (CDC). Depending on the situation, a confirmatory RT-PCR specific for the novel influenza virus of concern may or may not be available.

Probable – A human case with illness consistent with a novel influenza A virus infection that has been tested by the public health laboratory, CDPH-VRDL or CDC and were unsubtypeable with standard methods and reagents for circulating human influenza H1 and H3 viruses.

Suspect – A human case with illness consistent with a novel influenza A virus infection for which laboratory testing by a public health laboratory, CDPH-VRDL or CDC is pending, and is 1) epidemiologically linked to a confirmed case or 2) had exposure to a possible source of novel virus infection (e.g. swine, poultry, travel history, or laboratory exposure),

To report a case, please contact (*insert local county information here*) and fax this form to (*insert county fax information here*). Please forward any available medical records (e.g. H&P, micro reports, discharge summary, autopsy report, etc.). Please contact your local health department to report these cases as soon as possible so that we can assist with collection and shipment of specimens for further characterization.

ACUTE FEBRILE RESPIRATORY ILLNESS OUTBREAK REPORT FORM
COMMUNITY AND CONGREGATE SETTINGS

OUTBREAK INFORMATION			
Outbreak classification Confirmed Probable Suspect		Local outbreak tracking number	First onset date / /
			Last onset date / /
Pathogen/s identified? Yes No Unknown If yes, specify pathogen/s			
SETTING INFORMATION			
Setting type/s (check all settings where illnesses occurred) Specify setting type/s (e.g. skilled nursing, jail, school, etc)		Community/Non-congregate	Congregate/Institution
Location or facility name		Location or facility contact name	Facility contact number ()
If non-congregate setting: Total number of persons exposed: _____		If congregate/institutional setting: Total number of residents/students at time of outbreak: _____ Total number of staff at time of outbreak: _____	
CLINICAL INFORMATION			
Case definition used during the outbreak			
Predominant symptoms experienced by reported cases: Fever (100°F/37.8°C or greater) Cough Sore throat Shortness of breath Other If other, specify: _____			
Age range: _____ to _____ yrs.	Median age if available: _____	Number (%) Female: _____	
Number of cases with fever	Highest temperature recorded _____ °F _____ °C	Number with clinical diagnosis of pneumonia	Number with abnormal chest x-ray
Number hospitalized due to outbreak illness	Number admitted to the ICU due to outbreak illness	Number died due to outbreak illness	
Total number of cases that meet case definition _____ If congregate/institutional setting, number among residents/students _____ Number among staff members _____			
LABORATORY INFORMATION (Please attach copies of test results, if available)			
Total number of cases tested _____ If congregate/institution setting, number among residents/students _____ number among staff members _____		Total number of laboratory-confirmed cases _____ If congregate/institution setting, number among residents/students _____ number among staff members _____	
Type of specimens obtained and tested (e.g. NP swab, etc.)	Type of tests performed (e.g. rapid, PCR, etc)	Location where specimens were tested (e.g. local PHL, VRDL, etc.)	
Results			
Influenza A	Positive (# positive cases: _____)	Negative (# negative cases: _____)	
Influenza B	Positive (# positive cases: _____)	Negative (# negative cases: _____)	
Influenza type undetermined	Positive (# positive cases: _____)	Negative (# negative cases: _____)	
RSV	Positive (# positive cases: _____)	Negative (# negative cases: _____)	
Bordetella pertussis	Positive (# positive cases: _____)	Negative (# negative cases: _____)	
Legionella pneumophila	Positive (# positive cases: _____)	Negative (# negative cases: _____)	
Coccidioidomycosis (Valley fever)	Positive (# positive cases: _____)	Negative (# negative cases: _____)	
Other, specify: _____	Positive (# positive cases: _____)	Negative (# negative cases: _____)	
	Positive (# positive cases: _____)	Negative (# negative cases: _____)	
Laboratory information comments			
RISK FACTORS			
Check all risk factors that may have contributed to the outbreak.			
Close contact with a laboratory-confirmed case		Animal exposure Specify animal exposure: _____	
Other environmental exposure		Specify/describe other environmental exposure: _____	
Other risk factors		Specify other risk factors: _____	

SEVEN MINIMAL ELEMENTS CHECKLIST
<p><i>Below are the seven minimal elements for outbreak investigations as outlined in the CDC Public Health Emergency Preparedness (PHEP) Cooperative Agreement – Performance Measures Specifications and Implementation Guidance (pp. 56-60)</i></p> <p>All seven minimal elements included</p> <ul style="list-style-type: none"> Context/background (e.g. population affected, location, geographical area/s involved, etiology, etc.) Initiation of investigation (e.g. dates and times notification was received by the LHJ and initiation of investigation, etc.) Investigation methods (e.g. data collection and analyses methods, epi curve, case definition, exposure assessment and classification, etc.) Investigation findings/results (e.g. epi, lab and/or clinical results, other analytic findings, etc.) Discussion and/or conclusions Recommendations for controlling disease and/or preventing/mitigating exposure Key investigators and/or report authors
RESPIRATORY OUTBREAK DEFINITIONS
<p>INSTITUTIONS*</p> <p>A. For institutions associated with acute health care defined as general acute care hospital (GACH) or acute psychiatric hospital (APH):</p> <ul style="list-style-type: none"> • A sudden increase of acute febrile respiratory illness cases over the normal background rate; OR • One case of acute febrile respiratory illness that tests positive for influenza or other respiratory pathogen in the setting of a cluster (≥2 cases) of influenza-like illness (ILI); ILI is defined as fever (≥100°F or 37.8°C) plus cough and/or sore throat in the absence of a known cause other than influenza <p>B. For institutions associated with long term health care defined as skilled nursing facility (SNF), intermediate care facility (ICF), intermediate care facility-developmentally disabled (ICF-DD), intermediate care facility – developmentally disabled habilitative (ICF-DDH), intermediate care facility-developmentally disabled nursing (ICF-DDN), congregate living health facility (CLHF) and pediatric day health and respite care facility (PDHRCF):</p> <ul style="list-style-type: none"> • A sudden increase of acute febrile respiratory illness cases over the normal background rate; OR • At least one case of laboratory-confirmed influenza or other respiratory pathogen in the setting of a cluster of ILI within a 72-hour period (http://www.cdc.gov/flu/professionals/infectioncontrol/itc-facility-guidance.htm) <p>NOTE: Healthcare-associated institutional outbreaks are also reportable to the Hospital Acquired Infections (HAI) Unit of the California Department of Public Health</p> <p>C. Non healthcare-associated institutions defined as prison, jail, university dormitory and overnight camps:</p> <ul style="list-style-type: none"> • At least two cases of ILI within 48-72 hour period; OR • At least one case of ILI with laboratory confirmation for influenza or other respiratory pathogen in the setting of a cluster of ILI
<p>CONGREGATE SETTINGS – SCHOOLS AND DAY CAMPS*</p> <ul style="list-style-type: none"> • At least 10% of average daily attendance absent with ILI, sustained over a 3-day period; OR • 20% of an epidemiologically-linked group (such as single classroom, sports team or after-school group) ill with similar symptoms, with a minimum of 5 ill, sustained over a 3-day period
<p>ANY RESPIRATORY DISEASE CLUSTERS DUE TO A REPORTABLE DISEASE (TITLE 17, CCR 2500)*</p> <p><i>For the following diseases: plague, anthrax, Q-fever, hantavirus, brucellosis and psittacosis:</i></p> <ul style="list-style-type: none"> • Any respiratory disease cluster (defined as ≥2 cases of acute respiratory illness occurring within the incubation period of the disease in persons who are in proximity to the same infectious source) with laboratory confirmation in at least ONE case.
<p>COMMUNITY*</p> <ul style="list-style-type: none"> • Any respiratory disease cluster (defined as ≥2 cases of acute respiratory illness occurring within 48-72 hours in persons who are in close proximity to each other) assessed by the LHJ as having public health importance
<p>* PERTUSSIS</p> <p><i>Pertussis has a more specific definition for a respiratory outbreak, as outlined below:</i></p> <p>A. Institutions/Congregate setting (e.g. health care facility, school, day care)</p> <ul style="list-style-type: none"> • Two or more cases clustered in time and space (e.g. within 42 days of each other in one classroom) • Ideally, at least one case should be confirmed by culture <p>B. Community</p> <ul style="list-style-type: none"> • An increase in the number of cases in a given population during a defined time period, based on what is expected during a non-epidemic period

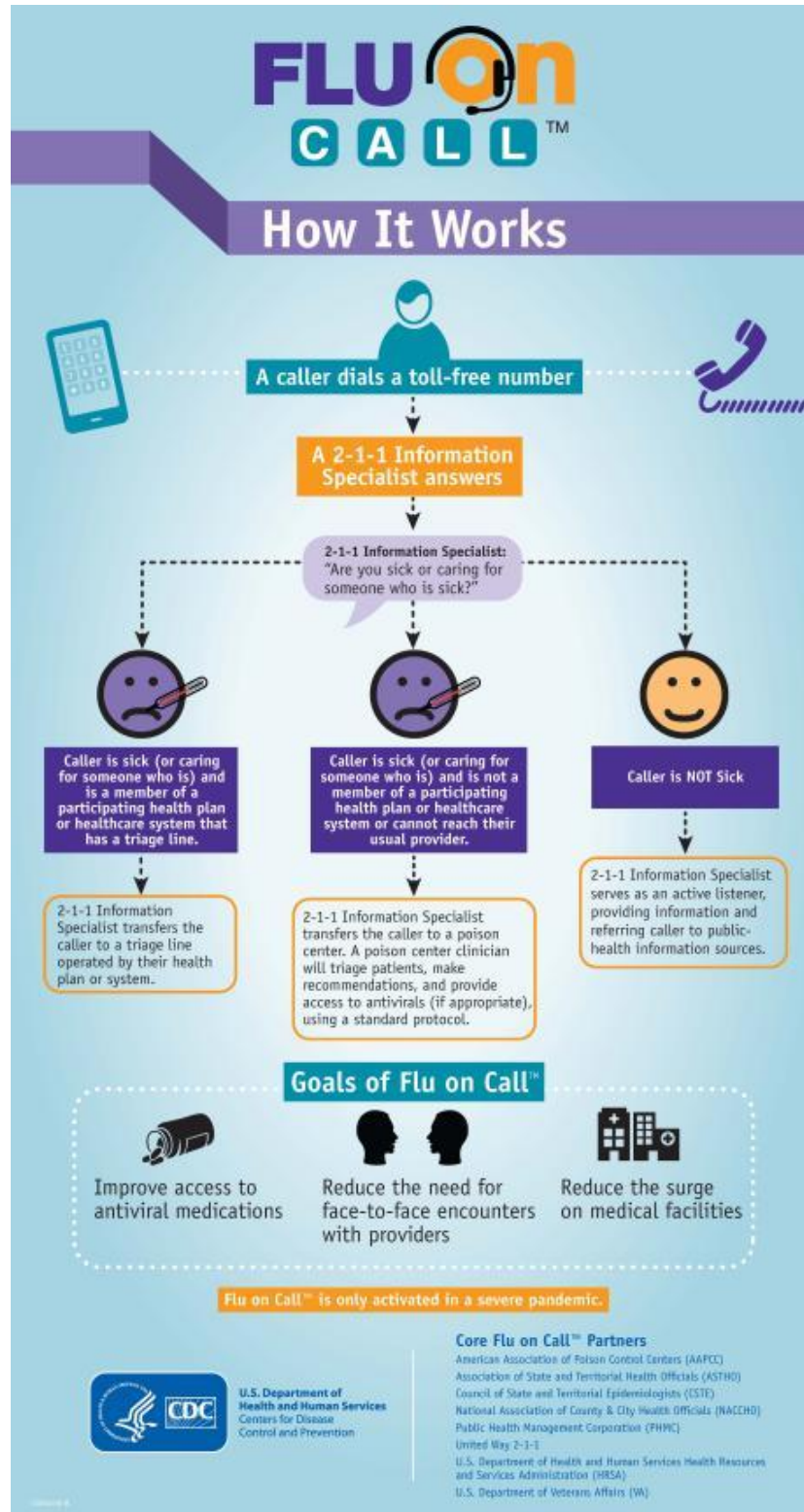
APPENDIX I: RESOURCE REQUEST MEDICAL AND HEALTH ⁷

Page 1 of _____

Resource Request: Medical and Health		Op Area (MHOAC) to Region/State		RR MH (5/2011)		
R E Q U E S T O R	1. Incident Name:		2a. DATE:	2b. TIME:		
	3. Requestor Name, Agency, Position, Phone / Email:		2c. Requestor Tracking #: <small>(Assigned by Requesting Entity)</small>			
	MISSION / TASK DESCRIPTION					
C O M P L E T E	5. ORDER SHEETS - USE ATTACHED		<input type="checkbox"/>	SUPPLIES/EQUIPMENT	<input type="checkbox"/>	PERSONNEL
			<input type="checkbox"/>	OTHER:		
M H O A C	7. Requesting entity must confirm that the verification questions in the PH&M EOM have been reviewed and answered.					
	<input type="checkbox"/> This request meet the criteria for submission based upon EOM guidelines.					
	<input type="checkbox"/> The creation of this request was in consultation with the RDMHC program					
8. MHOAC / EOC Review: (NAME, POSITION, AND SIGNATURE) (SIGNING INDICATES: 1) THE NEED HAS BEEN VERIFIED; 2) RESOURCES ARE NOT AVAILABLE AT THIS LEVEL; 3) THE REQUEST IS COMPLETE)			9. Describing the actions taken on this request so far.			
L O G I S T I C S	NOTE: To be completed by the Level/Entity that fills the request (OA EOC, Region, State).		12. Resource Tracking:			
	10. Additional Order Fulfillment Information:	11. Likely Supplier Name/Phone/Email:	<input type="checkbox"/> Entered into Resource Tracking System (Plans)			
			<input type="checkbox"/> Demob Expected:			
			<input type="checkbox"/> Demob Completed (if known):			
13. Notes:		14. ORDER FILLED AT (check box)				
		<input type="checkbox"/> Operational Area:				
		<input type="checkbox"/> OA within Mutual Aid Region:				
		<input type="checkbox"/> Outside of Region:				
F I N A N C E	15. Reply / Comments from Finance:		16. Finance Section Signature & Date/Time: <small>(Name, Position & Verification)</small>			

⁷ Source: CDPH EOM, July 2011.

APPENDIX J: FLU ON CALL™



Flu on Call™ Key Points
February 2015



What is Flu on Call™?

Flu on Call™ is a new CDC-led initiative to establish a national network of triage lines for use during a severe influenza pandemic.

Quick facts about Flu on Call™:

- The goals of Flu on Call™ include:
 - improving access to antiviral prescriptions for people who are sick;
 - providing an alternative to face-to-face provider encounters; and
 - reducing surge on medical facilities.
- Flu on Call™ is a network of triage lines staffed by information specialists and clinicians.
- People who contact Flu on Call™ and need information about pandemic influenza will be guided to appropriate information and resources.
- People who contact Flu on Call™ because they're sick (or caring for someone who is), will be able to talk to a clinician for medical advice.
- If the symptoms of the ill person meet the guidelines of the prescribing protocol, clinicians may be able to provide access to antiviral medications over the phone.
- Flu on Call™ is not meant to serve as a replacement for medical clinics or practices and the relationships that providers have with their patients. The system would only be activated during a severe pandemic when the medical care system is highly impacted.

Who is involved in Flu on Call™?

Flu on Call™ is a collaborative effort between CDC and several core partners including:

- The American Association of Poison Control Centers (AAPCC);
- The Association of State and Territorial Health Officials (ASTHO);
- The Council of State and Territorial Epidemiologists (CSTE);
- The National Association of County and City Health Officials (NACCHO);
- Public Health Management Corporation (PHMC);
- United Way Worldwide 2-1-1;
- The U.S. Department of Veterans Affairs;
- The U.S. Department of Health and Human Services Resources and Services Administration (HRSA).
- CDC is also engaging national health plans and large medical systems as a part of this effort.

What happens when someone calls Flu on Call™?

- Callers will dial a special toll-free number, which will be routed to a United Way Worldwide 2-1-1 call center. A trained Information Specialist will determine the caller's needs.
- If the caller is not sick and only needs information, the Information Specialist will provide the information needed or direct the caller to public health information sources.
- If the caller is affiliated with a participating health plan or healthcare system with a triage line, he or she will be transferred there.



Flu on Call™ Key Points
February 2015

- If the caller is not covered by a participating health plan/healthcare system or cannot reach his or her usual provider, the Information Specialist will transfer the caller to the poison center that serves his or her community.
- From there, a poison center clinician, working under a specific protocol, will triage the caller, provide advice and information, and provide access to antiviral medications over the phone, if it's appropriate.
- Callers who are severely ill, have certain underlying conditions, are calling on behalf of young children, or meet other criteria will be advised to seek face-to-face care.
- People who are uncertain about their symptoms or who are worried about exposure to pandemic influenza and need information can get it through **Flu on Call™**, avoiding unnecessary visits to emergency rooms or healthcare centers.
- **Flu on Call™** aims to leverage systems already in place, supporting local initiatives without placing additional demands on them.

When will Flu on Call™ be used?

- CDC envisions that **Flu on Call™** will be activated only during a severe influenza pandemic when large numbers of sick people are seeking care. **Flu on Call™** aims to reduce the need for face-to-face provider encounters only when medical facilities may have difficulty meeting demand. CDC and state and local public health authorities will coordinate activities so that **Flu on Call™** is launched at a time that will provide a benefit to the public and communities.

How do we know Flu on Call™ can work?

- **Flu on Call™** is modeled on successful statewide projects that were implemented during the 2009 H1N1 pandemic.
- For example, during the 2009 – 2010 H1N1 pandemic influenza response, Minnesota established the statewide Minnesota FluLine.
- Registered nurses staffed these telephone lines and triaged callers using a single, collaboratively developed protocol.
- For callers who met certain criteria, the Minnesota FluLine provided medical advice and access to prescriptions for antiviral medications for callers.
- The Minnesota FluLine fielded more than 27,000 calls between Oct. 29, 2009, and March 31, 2010.
- The Minnesota Department of Health estimates that the Minnesota FluLine may have prevented up to 11,000 in-person healthcare visits to emergency departments, clinics, and doctors' offices during the 2009 H1N1 influenza pandemic.
- **Flu on Call™** was inspired by the success of Minnesota's experience and that of several other state and local health departments.

For more information, please contact:

Lisa M. Koonin DrPH, MN, MPH

U.S. Centers for Disease Control and Prevention

Email: lkoonin@cdc.gov

APPENDIX K: PLAYER HANDOUT TEMPLATE

Player Handout
[Insert Date]

The Facility Exercise Director is:

Name
Title
Agency
Address
Phone Number
Email Address

EXERCISE PURPOSE

The [jurisdiction/organization/facility] is participating in the 2015 California Statewide Medical and Health Exercise (SWMHE) Program.

Today's exercise is a [full scale, functional, tabletop] exercise, which will help our State to be better prepared for emergencies and incidents of all types and sizes. This exercise will utilize all-hazards, multi-discipline objectives aligned with Homeland Security Exercise and Evaluation Program (HSEEP), Public Health Preparedness Program (PHEP), and Hospital Preparedness Program (HPP) guidelines and requirements. Players will test these objectives in response to a pandemic influenza scenario.

This SWMHE has been developed by the following participants: local, regional, and state agencies, including health departments, local emergency medical service agencies, environmental health departments, acute care hospital and facilities, emergency medical services, ambulance providers, long-term care facilities, community health centers and clinics, emergency management agencies, medical examiners/coroners, law enforcement, and fire services. The exercise is evidence of the growing public safety partnership between state and local jurisdictions regarding the response to the threat of public health emergencies that our Nation and communities face. More detailed information on the exercise can be found at www.californiamedicalhealthexercise.com.

EXERCISE OBJECTIVES

This exercise was designed to provide a forum to accomplish the objectives listed below and their associated capabilities. These exercise objectives and core capabilities were selected by our Exercise Planning Team by:

- Downloading the objectives and capabilities identified by the State
- Selecting and modifying the objectives and capabilities as needed for [jurisdiction/organization/facility] based on prior incidents, exercises, and requirements.

The selected capabilities are:

- [Insert capability here]
- [Insert capability here]
- [Insert capability here]

The selected objectives are:

- [Insert objective here]
- [Insert objective here]
- [Insert objective here]
- [Insert objective here]

SCOPE OF PLAY

This exercise is a functional exercise, planned for agencies and organizations throughout the state. The 2015 SMWHE Program is a progressive exercise program tied to a set of common program priorities.

PLAYER INSTRUCTIONS

Players should follow these guidelines before, during, and after the exercise to ensure a safe and effective exercise.

Before the Exercise

- Review appropriate organizational plans, procedures, and exercise support documents.
- Be at the appropriate site at least 30 minutes before the exercise starts. Wear the appropriate uniform and/or identification item(s).
- Sign in when you arrive.
- If you gain knowledge of the scenario before the exercise, notify a controller so that appropriate actions can be taken to ensure a valid evaluation.
- Review all player materials.

During the Exercise

- Respond to exercise events and information as if the emergency were real, unless otherwise directed by an exercise controller.
- Controllers will give you only information they are specifically directed to disseminate. You are expected to obtain other necessary information through existing emergency information channels.

- Do not engage in personal conversations with controllers, evaluators, observers, or media personnel. If you are asked an exercise-related question, give a short, concise answer. If you are busy and cannot immediately respond, indicate that, but report back with an answer as soon as possible.
- If you do not understand the scope of the exercise, or if you are uncertain about an organization's participation in the exercise, ask a controller.
- Parts of the scenario may seem implausible. Recognize that the exercise has objectives to satisfy and may require incorporation of unrealistic aspects. Every effort has been made by the exercise's trusted agents to balance realism with safety and to create an effective learning and evaluation environment.
- All exercise communications will begin and end with the statement **"This is an exercise."** This precaution is taken so that anyone who overhears the conversation will not mistake exercise play for a real-world emergency.
- When you communicate with the SimCell, identify the organization or individual with whom you wish to speak.
- Describe critical actions by speaking out loud as you complete them. This procedure will ensure that evaluators are aware of critical actions as they occur.
- Maintain a log of your activities. Many times, this log may include documentation of activities that were missed by a controller or evaluator.
- Do not simulate additional events. Only play to those events and scenarios that are planned for the exercise.

After the Exercise

- Participate in the Hot Wash at your venue with controllers and evaluators.
- Complete the Participant Feedback Form. This form allows you to comment candidly on emergency response activities and exercise effectiveness. Provide the completed form to a controller or evaluator.
- Provide any notes or materials generated from the exercise to your controller or evaluator for review and inclusion in the AAR.

Insert your jurisdiction/organization/facility's specific tasks here

EXERCISE CONTROL

The goal of the exercise control organization is to facilitate the exercise and ensure the timely movement of events and play. As such, controllers will be present to direct exercise activities such that evaluation objectives can be achieved, and exercise players feel they are in a supportive environment that encourages learning and personal and process improvement. Controllers will give you only information they are specifically directed to disseminate. You are expected to obtain other necessary information through existing emergency information channels.

A simulation cell (SimCell) will be used to simulate participants who are not present (e.g. Department Operations Center [DOC]) or to prompt players for target responses.

EXERCISE PARTICIPANTS

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 agency personnel who have an active role in public health emergency response and operations, and perform their regular roles and responsibilities during the exercise.
- **Exercise Director.** The Exercise Director is responsible for planning, coordinating, and overseeing all exercise functions. He or she manages exercise activities and maintains a close dialogue with the Controllers regarding the status of play and the achievement of the exercise design objectives.
- **Controllers.** Controllers assist in set-up and operate the exercise site, plan and manage exercise play, and act in the roles of response individuals and agencies that are not playing in the exercise. Controllers direct the pace of the exercise, provide key data to players, and may prompt or initiate certain player actions to ensure exercise continuity. In addition, they issue exercise materials to players as required, monitor the exercise timeline, and supervise the safety of all exercise participants. The SWMHE may utilize several Controllers on the day of the exercise, reporting to one Senior Controller.
- **Senior Controller.** The control staff is led by the Senior Controller, who is responsible for coordinating with the Exercise Director on exercise control and safety issues. The Senior Controller is responsible for monitoring activities throughout the exercise and tracking whether objectives have been met or require further attention. The Senior Controller will roam during exercise play, providing exercise control in any location required.
- **Simulators.** Simulators are control staff personnel who role-play nonparticipating organizations or individuals. They may operate out of the Simulation Cell or have face-to-face contact with players. Simulators act in accordance with instructions provided in the MSEL, and are ultimately accountable to the Exercise Director and Senior Controller.

- **Evaluators.** Evaluators evaluate and provide feedback on designated functional areas of the exercise. They are chosen on the basis of their expertise in the functional area(s) they have been assigned to review during the exercise and their familiarity with local emergency response procedures. Evaluators observe and document performance against the established capabilities and tasks, in accordance with the Exercise Evaluation Guides (EEGs).
- **Actors.** Actors are participants who may simulate patients or other members of the public who need healthcare or otherwise act to spur movement in the exercise.
- **Observers.** Observers visit or view selected segments of the exercise. Observers do not play in the exercise, nor do they perform any control or evaluation functions. Observers view the exercise from a designated observation area and must remain within the observation area during the exercise. Very Important Persons (VIPs) are also observers, but they frequently are grouped separately.
- **Media Personnel.** Some media personnel may be present as observers, pending approval by the sponsor organization and the Exercise Planning Team.
- **VIPs.** VIPs visit or view selected segments of the exercise. VIPs do not play in the exercise, nor do they perform any control or evaluation functions. VIPs will view the exercise from a designated observation area and will remain within the observation area during the exercise. A dedicated group of exercise controllers will be assigned to manage this group.
- **Support Staff.** The exercise support staff includes individuals who are assigned administrative and logistical support tasks during the exercise (e.g. registration, catering).

EXERCISE IDENTIFICATION

Exercise staff may be identified by badges and/or vests to clearly display exercise roles; additionally, uniform clothing may be worn to show agency affiliation. The table below can be used to describe these identification items.

Group	Color
Exercise Director	
Facilitator	
Controllers	
Evaluators	
Actors	
Support Staff	
Observers/VIPs	
Media Personnel	
Players, Uniformed	
Players, Civilian Clothes	

EXERCISE SCHEDULE

The exercise will begin at 0800 hours, and will continue until 1600 hours or when the Exercise Director ceases play. At the conclusion of the exercise, a hotwash will be facilitated to capture player first impressions. If you are unable to participate for the full length of time, including the hotwash, alert your Exercise Director.

Time	Personnel	Activity	Location
[Date Minus 1]			
[Time]	Exercise Controllers, Evaluators, and Staff	<ul style="list-style-type: none"> Controller and Evaluator Orientation Briefing 	[Location]
As needed	Exercise Controllers and Staff	<ul style="list-style-type: none"> Set up Control Cell and Walk-through 	[Location]
Player Briefing			
[Date]			
[Time]	Controllers and Exercise Staff	<ul style="list-style-type: none"> Check-in for Final Instructions and communications check 	[Location]
[Time]	Media	<ul style="list-style-type: none"> Media Briefing 	[Location]
[Time]	VIP & Selected Exercise Staff	<ul style="list-style-type: none"> VIP Controller Briefing 	[Location]
[Time]	Controllers and Evaluators	<ul style="list-style-type: none"> Controllers and Evaluators in Starting Positions 	[Location]
[Time]	All	<ul style="list-style-type: none"> Controllers give player briefs 	[Location]
[Time]	All	<ul style="list-style-type: none"> Exercise Starts 	[Location]
[Time]	All	<ul style="list-style-type: none"> Exercise Ends 	[Location]
Immediately Following the Exercise	All	<ul style="list-style-type: none"> Venue Hot Washes Turn in all Participant Feedback Forms 	[Location]
[Date Plus 1]			
Controllers, Evaluators, and various other officials	Controllers and Evaluators	<ul style="list-style-type: none"> Controllers and Evaluators After Action Report 	[Location]

EXERCISE TOOLS

Several tools will be available to support exercise players. These tools include:

- **ExPlan:** The ExPlan provides a “road map” to planning the exercise. The ExPlan contains information regarding the exercise objectives, schedule, evaluation strategy, history of the program, and the like. Intended readers of the ExPlan include the Exercise Planning Team, POD Command Staff and Section Chiefs.
- **Player Handout:** The Player Handout is provided to all POD staff on the day of the exercise and contains pertinent information about the exercise.

- Fact Sheets: Fact sheets provide pertinent information regarding the scenario.

Other tools developed for the exercise include:

- Master Scenario Events List (MSEL): The MSEL provides a chronological listing of all exercise events, to include those events that may be simulated or prompted. Intended readers of the MSEL include the Exercise Planning Team, controllers, and evaluators. Players will not be privy to information contained in the MSEL.
- Evaluation Evaluation Guides (EEG): EEGs have been developed following HSEEP and CDC guidelines. EEGs are tools that will be used by evaluators to perform quantitative and qualitative assessments of the exercise.
- Controller and Evaluator (C/E) Handbook: The C/E Handbook is designed to help exercise controllers and evaluators conduct and evaluate an effective exercise. This handbook also enables controllers and evaluators to understand their roles and responsibilities in exercise execution and evaluation. Should a player, observer, or media representative find an unattended handbook, it should be provided to the nearest controller or evaluator.

SAFETY REQUIREMENTS

Exercise participant safety takes a priority over exercise events. Although the organizations involved in this exercise come from various response agencies, they share the basic responsibility for ensuring a safe environment for all personnel involved in the exercise. The following general requirements apply to the exercise:

- Real-world emergency procedures will be followed during the exercise.
- All players and evaluators will serve as safety observers while the exercise activities are underway. Any safety concerns must be immediately reported.
- Participants will be responsible for their own and each other's safety during the exercise. It is the responsibility of all persons associated with the exercise to stop play if, in their opinion, a real safety problem exists. Once the problem is corrected, exercise play can be restarted.

All organizations will comply with their respective environmental, health, and safety plans and procedures, as well as the appropriate federal, state and local health and safety regulations.