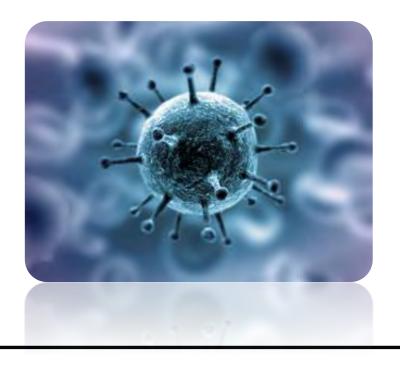


2018 California Statewide Medical Health Exercise







Alameda County Operational Area

High Consequence Infectious Disease Event





Welcome & Introductions

Overview of Participants

Overview of Exercise

Housekeeping

Agenda

8:30 AM	Welcome, Opening Remarks & Administrative Items
8:45 AM	Module 1 - Situation Briefing Facilitator: Dr. Erica Pan Initial Actions and Capabilities for Emerging High Consequence Infections Disease
10:00 AM	BREAK – Coffee/Refreshments
10:15 AM	Module 2 - Health Care Coalition Response & Coordination Facilitated Discussion
11:15 AM	Break – Move to Breakout Rooms
11:25 AM	Module 3 - Public Messaging, Patient Surge, Responder Safety Facilitated Breakout Discussions
12:05 PM	Lunch Pick Up – Reconvene to Plenary
12:15 PM	Working Lunch, Report Out & Hotwash Report Out from Breakout Groups on Key Actions, Strengths, Gaps
12:55 PM	Functional Exercise Preparation & Registration
1:10 PM	Closing Remarks & Participant Feedback
1:30 PM	Facilitator Debriefing, Planning Team Check In

Tabletop Exercise Purpose & Scope

Exercise Purpose

Provide an opportunity for public health and healthcare partners to address response functions for an emerging infectious disease, and to include coordinated command and control, pediatric medical surge, vulnerable populations, information sharing, and responder health and safety.

Scope

Discussion-based, scenario guided exercise to understand the individual and coordinated response roles of Alameda County Healthcare Coalition Partners as a novel, highly pathogenic disease significantly impacts the community.

Objectives

- Understand roles and responsibilities for an infectious disease response.
- Discuss healthcare system situational awareness in coordination with the MHOAC Program and Health Care Coalition Partners.
- Discuss infectious disease communication protocols to include internal/external reporting of infectious disease and healthcare worker/responder safety for transfer and receipt of infectious patients.
- 4. Discuss medical surge critical care bed expansion - with specific emphasis on pediatric surge - protocols for a significant infectious disease event.
- 5. Describe the receipt of information and guidance disseminated by Public Health in coordination with the Joint Information Center (JIC).

Capabilities Addressed:

- Health Care and Medical Response Coordination (HPP/HCPRC)
- Emergency Operations Coordination (PHEP)
- Medical Surge (PHEP/HPP/HCPRC)
- Medical Countermeasures
 Dispensing (PHEP)
- Surveillance and Epidemiologic Investigation (PHEP)
- Continuity of Health Care Service Delivery (HPP/HCPRC)
- Responder Safety & Health (PHEP)
- Information Sharing (PHEP)

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Assumptions & Artificialities

In any exercise, assumptions and artificialities may be necessary to complete the play in the time allotted.

During the exercise today, the following apply:

- Assume the scenario is real and may impact the jurisdiction.
- Events are plausible and occur as they are presented.
- Do not fight the scenario.
- There is no hidden agenda and there are no trick questions.
- All players receive information at the same time.





Exercise Ground Rules



Participate in a Collegial Manner



Share Policies and Practices that May Benefit Others



Turn off any Electronic Equipment and Participate Fully in Your Representative Role







Module 1

Initial Response Actions to Emerging High-Consequence Infectious Disease

(HCID)

HCSA DOC Activation for Infectious Disease Emergency Response (IDER)

- HCSA has been activated to manage information and provide guidance for the current novel virus threat.
- Review of IAP/Situation Status
- Health Alert Issuance in Progress



October 2018

There have been reports of illness and attributed deaths in small to medium size cities in Peru and Chile (South America).



gettyimages-677437956-800x533

Complaints begin with mild prodromal symptoms of cough & shortness of breath that rapidly progress to acute respiratory distress and pneumonia. Some patients present with severe headache, altered mental status, and in severe cases, encephalitis and death. The causative agent has not been identified.

Concerns are increasing as the illness has disproportionately affected children under the age of 14 and resulted in death for 60% of the suspected cases.

October 2018



There has not been much media attention in the United States; however the CDC has distributed awareness messages to public health departments nationwide.

Transmission: infectious respiratory droplets & direct contact.

Unknown virus has been termed "SoAm1018"

Recent HCID Events

- MERS-CoV
- Nipah Virus
- Ebola
- Pandemic H1N1 & Avian Influenza
- SARS

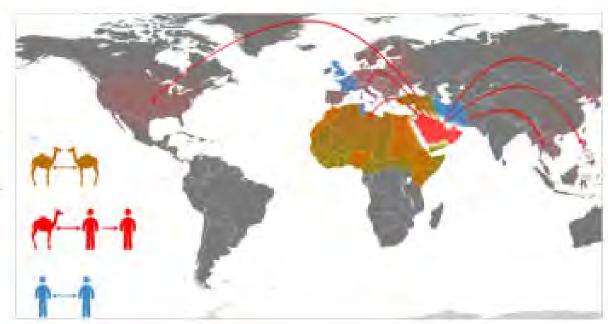


Middle East respiratory syndrome coronavirus (MERS-CoV)

Countries agree next steps to combat global health threat by MERS-CoV

27 September 2017 – Critical next steps to accelerate the response to the global public hearth threat posed by MERS-GoV have been agreed by representatives from the Ministries of Health and Ministries of Agriculture of affected and at risk countries, and experts. The virus, which circulates in dromedary carriels without pausing visible disease, can be fatal for humans.

Rand the story



2,249

Since September 2012, WHO has been notified of 2.229 laboratory-confirmed cases of infection with MERS-CoV.

For movie MERS Situation Lipidates





798

798 MERS-CoV associated deaths have occurred since September 2012.

For more: Coronavirus intestions move-

Technical Guidance



27

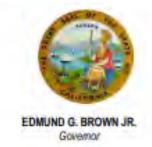
Since September 2012, 27 countries have reported cases of MERS-CoV

For more: Fact sheet on MERS-CoV.





State of California—Health and Human Services Agency California Department of Public Health



October 21, 2013

AFL 13-23

TO: All Health Facilities

SUBJECT: Health Alert Update - Middle East Respiratory Syndrome Coronavirus

The California Department of Public Health (CDPH) is dedicated to protecting the health and well-being of the people in California. This All Facilities Letter (AFL) is being issued to provide updated information regarding the novel coronavirus known as Middle East Respiratory Syndrome Coronavirus (MERS-CoV) and will replace the previously issued alert in AFL 13-13. CDPH is distributing the latest Centers for Disease Control and Prevention (CDC) information regarding MERS-CoV, which includes updates to the incubation period, heightened surveillance, patient evaluation, infection control, and laboratory precautions to prevent transmission of this novel virus.

In September 2012, the World Health Organization announced the discovery of MERS-CoV in a patient who died with an acute respiratory distress syndrome in Saudi Arabia. To date, MERS-CoV has been identified in 138 persons in eight countries (Saudi Arabia, Qatar, Jordan, Italy, the United Kingdom, the United Arab Emirates, France, and Tunisia). All cases have been directly or indirectly linked through travel to or residence in four countries: Saudi Arabia, Qatar, Jordan, and the United Arab Emirates. Symptoms include fever, cough and shortness of breath. Most patients have been severely ill and 60 (43 percent) have died. Although most reported cases involved severe respiratory illness requiring hospitalization, at least 27 (21 percent) involved mild or no symptoms.

Celebrating Healthy People in Healthy Communities

Health Alerts Programs & Services Communicable Disease Clinics Data & Reports About ACPHD Contact ACPHD

Communicable Disease > Disease Reporting and Control > Reportable Diseases & Conditions

Search

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Health Alerts

Search

Communicable Disease

List of Communicable Diseases

Disease Reporting and Control

Reportable Diseases & Conditions

Reporting Forms

Immunization & Disease Prevention Programs

Protect Yourself

Bay Area ID Conference 2018

Contact Information

Reportable Diseases & Conditions

Our Communicable Disease Team will investigate disease reports. In certain circumstances, testing at the Alameda County Public Health Lab will be arranged. The Communicable Disease Team provides guidelines for treatment, prophylaxis and infection control. Reporting of certain diseases may activate state and federal emergency response systems.

Start Here

Laboratory Reportable Diseases

California Code of Regulations, Title 17, Section 2505 requires laboratories to report laboratory testing results suggestive of diseases of public health importance to the local health department.

California Department of Public Health List of Laboratory Reportable Diseases

Healthcare Provider Reportable Diseases

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 requires that healthcare providers report known or suspected cases of disease or condition, listed below, to the jurisdiction in which the patient resides.

REPORT IMMEDIATELY BY PHONE

California Department of Public Health List of Healthcare Provider Reportable Diseases

During Business hours: (510) 267-3250 After hours: (925) 422-7595 Anthrax, human or Foodborne Disease animal (when two or more cases or suspected cases of Botulism (Infant, foodborne disease from Foodborne, Wound, separate households are Other)

- Brucellosis, human
- Cholera
- Ciguatera Fish Poisoning
- Dengue Virus Infection
- Diphtheria
- Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
- Escherichia coli: shiga toxin producing (STEC), including E. coli 0157:H7
- Flavivirus infection of

- suspected to have the same source of illness) Hemolytic Uremic
- Syndrome
- Influenza, novel strains (human)
- Measles (Rubeola)
- Meningococcal Infections
- Novel Virus with Pandemic Potential
- Paralytic Shellfish Poisoning
- Plague, Human or Animal

- Scombroid Fish Poisoning
- Shiga Toxin (detected in feces)
- Smallpox (Variola)
- Tularemia, human
- Viral Hemorrhagic Fevers, human or animal (Crimean-Congo, Ebola, Lassa and Marburg viruses)
- Yellow Fever
- Occurrence of any unusual disease
- Outbreak of any disease (including diseases not listed in §2500)

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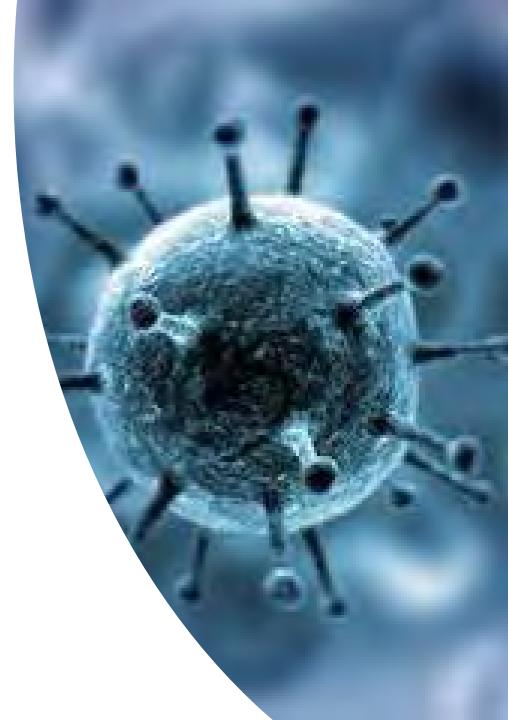
Communicable Disease Control & Prevention

- Treatment, Assessment and Frontline Hospitals
- General brief guidance for all healthcare facilities
- Senate Bill 432
- Infection Control Guidelines





Considerations for Containment



High Consequence Infectious Disease

- Causative pathogens: virus, bacteria, prions
- High-consequence pathogens have one or more of the following features:
 - potential to cause epidemics or pandemics
 - infect/affect many people
 - spread rapidly in a short time
 - infection results in high cost to society
 - infection results in high cost to the healthcare system
- Many factors contribute to new pathogens being discovered every day
 - Changes in population size
 - Geographic range
 - Increased interaction with possible vectors
 - Advances in travel modalities
 - Scientific advances

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Recent and Ongoing HCID Forecast

- MERS-CoV
- SARS
- Ebola
- Cholera
- Global emergence of antimicrobial resistance
 - Carbapenem resistant enterobacteriaceae
 - Multi drug resistant Candida auris
 - Bacteria containing *mcr-1* gene conferring resistance to Colistin

Early Recognition and Containment

- Risk assessment and implementation of infection control measures as needed based on preliminary assessment
 - Patient 1 walks into the ED and checks in with chief complaint of persistent cough for 3-5 days with runny nose and fever
 - Patient 2 walks into the ED and checks in with chief complaint of fever and generalized body rash
- Standardized triage questionnaire
 - For all patients at all levels of care (ED, outpatient clinics, specialty care centers etc.)
- Establish an algorithm/work flow
 - Assess and place in presumptive droplet precautions pending evaluation
 - Follow established guidelines for internal notification (ED provider, infection control, laboratory etc.)
 - Notify Alameda County Public Health Department

SoAm1018

■ Considerations for triage questionnaire

- Assess Symptoms
 - Cough, body ache, fatigue, shortness of breath, headache
 - Fever, respiratory distress, altered mental status
 - Rash, blisters or boils on the skin
- Travel to South America?
 - Travel to Peru or Chile?
- Contact with persons who've traveled to South America?
- Any other travel outside the county of residence or outside the country?
- Contact with persons with similar symptoms?

■ Infection Control

- Implement droplet and contact precautions
- Have PPE available: Mask, gown, glove, eye protection(goggles/face shield)
- Terminal cleaning upon discharge/transfer of patient
- Use infection control transfer form



Practices	Droplet Precautions	Contact Precautions
Place patient in a private room	Yes	Yes
Cohort suspect cases when private room is not available	Yes	Yes
Maintain spatial separation of 3ft between patients	Yes	Yes
Hand hygiene	Always!	
Wear surgical/procedural mask when working within 3ft of patient	Yes	Yes
Gloves when entering the room	No, except as it applies in standard precautions	Yes
Wear a gown if contact between the patient or patient's environment and the healthcare worker's clothing is anticipated	No, except as it applies in standard precautions	Yes
Remove gown and gloves upon exit; perform hand hygiene immediately after glove removal	Yes	Yes
Limit movement of patient to minimum necessary	Yes	Yes
Have patient wear a surgical/procedural mask to decrease contamination during movement/transfer	Yes	Yes
Minimize visitors	Yes	Yes
Dedicate Equipment	No	Yes
Disinfect non-dedicated equipment immediately after use	Yes	Yes
Increase frequency of cleaning and disinfection of high touch surfaces	Yes	Yes



Removing PPE

GLOVES

- Outside of gloves are contaminated!
- Grasp outside of glove with opposite gloved hand; peel off
- . Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist

GOGGLES/FACE SHIELD

- Outside of goggles or face shield are contaminated!
- To remove, handle by "clean" head band or ear pieces
- Place in designated receptacle for reprocessing or in waste container

GOWN

- Gown front and sleeves are contaminated!
- Unfasten neck, the waist ties.
- Remove gown using a peeling motion; pull gown from each shoulder toward the same hand
- Gown will turn inside out
- Hold removed gown away from body, roll into a bundle and discard into waste or linen receptacle

MASK OR RESPIRATOR

- Front of mask/respirator is contaminated – DO NOT TOUCH!
- Grasp bottom then top ties/elastics and remove

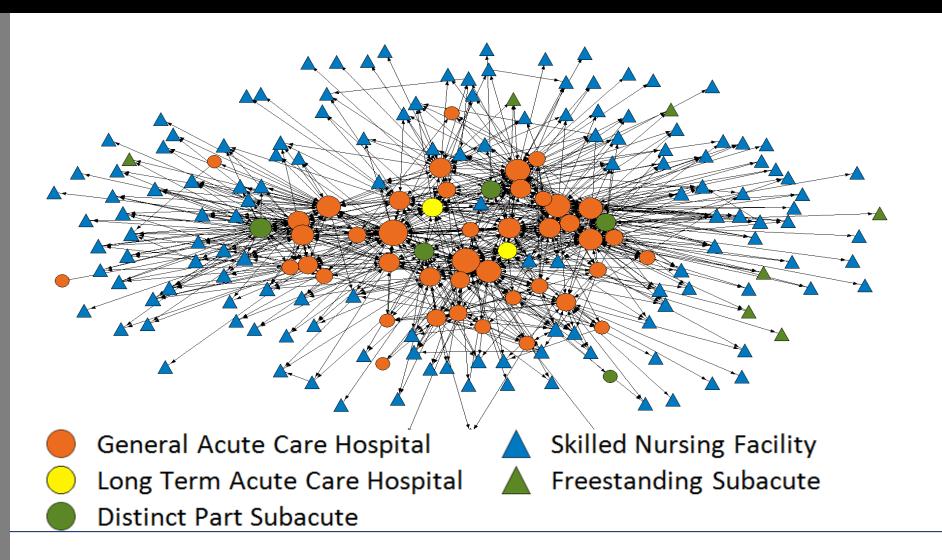






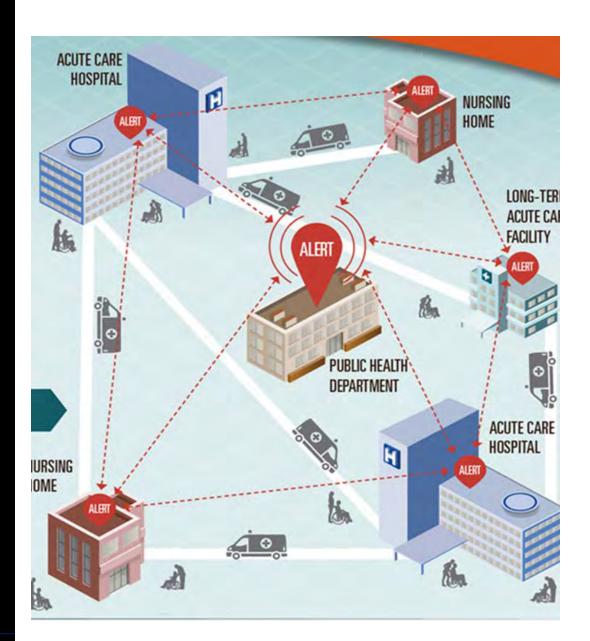


SF Bay Area Healthcare Facilities "Connectedness"





- Interfacility communication
- Notification of transport providers
- Notification of the Public Health department





Interfacility Transfer

- Notify receiving facility of infection control precautions
- Send copy of Transfer Form to the ACPHD-Acute Communicable Diseases Section
- Copy of Transfer Form is available on ACPHD website

http://www.acphd.org/media/500766/acphd-infection-control-transferform.pdf



INFECTION CONTROL TRANSFER FORM

This form should be sent with the patient/resident upon transfer. It is NOT meant to be used as criteria for admission, only to foster the continuum of care once admission has been accepted.

Affix patient label here

continuum of care once admissio					
	De	mographics			
Patient/Resident (Last Name, First N	lame):				
Date of Birth:		Transfer Date:			
Sending Facility Name:					
Contact Name:	Contact Phone:				
Receiving Facility Name:					
	Preca	utions and PPE			
	(V) 4 M M 1 · · ·)				
☐ No isolation precautions (currently) CHECK ALL PPE TO BE CO			CONSIDERED A	ONSIDERED AT RECEIVING FACILITY	
		Organisms .			
110 21 111	nce to infection of	A S. Committee of the C	e organism det	The state of the s	
Methicillin-resistant Staphylococcus aur		─ □ No known MDR organism or communicable diseases			
Vancomycin-resistant Enterococcus (VR					
MDR Acinetobacter species, resistant to carbapenem antibiotic(s) ‡					
MDR resistant to carbapenem antibiotic(s) without carbapenemase production (non-CP-CRE)‡					
Carbapenemase-producing resistant to carbapenem antibiotic(s) (CP-CRE)#					
Enterobacteriaceae† resistant to expanded-spectrum beta-lactam antibiotics (ESBL)‡					
Clostridium difficile (C. diff)					
Other lidentiful As			TI faciona		

Resources

- Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care (CDC Sept. 2016)
 - https://www.cdc.gov/infectioncontrol/pdf/outpatient/guide.pdf
- Guidelines, prevention tools and resources for Nursing Homes and Assisted Living(Long-Term Care Facilities[LTCFs])
 - https://www.cdc.gov/longtermcare/index.html
- Guidelines, tools and resources for Dialysis Centers
 - https://www.cdc.gov/dialysis/index.html





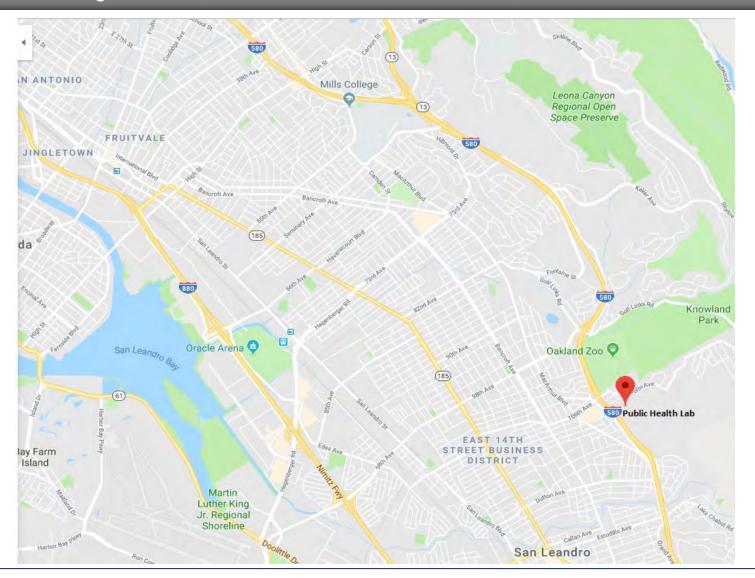


A. C. PUBLIC HEALTH LABORATORY 2901 Peralta Oaks Court, 2nd Floor Oakland, 94605





Location: Hwy 580, exit 106th Ave., near Zoo



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Current Laboratory Staff

- Director: Mark Pandori, PhD, HCLD (ABB), PHM
- Supervisor: Monica Bender, DVM, MT (ASCP), PHM
- ■PH Microbiologists (5)
- Research scientist (1)
- Lab technician (1)
- Lab Assistant (1)
- ■AA (1)
- Data clerk (1)(vacant)





Testing Capabilities

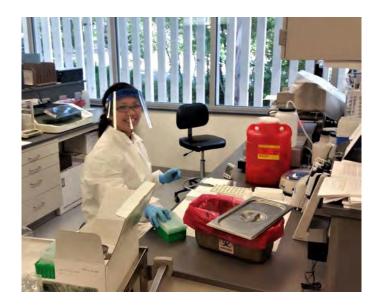
- ■Current volume ~20,000 tests per year
- Culture methods

(Bacteria, Mycololgy, and Mycobacteria)

- Surge capacity of 200 per week
- ■Whole genome sequencing

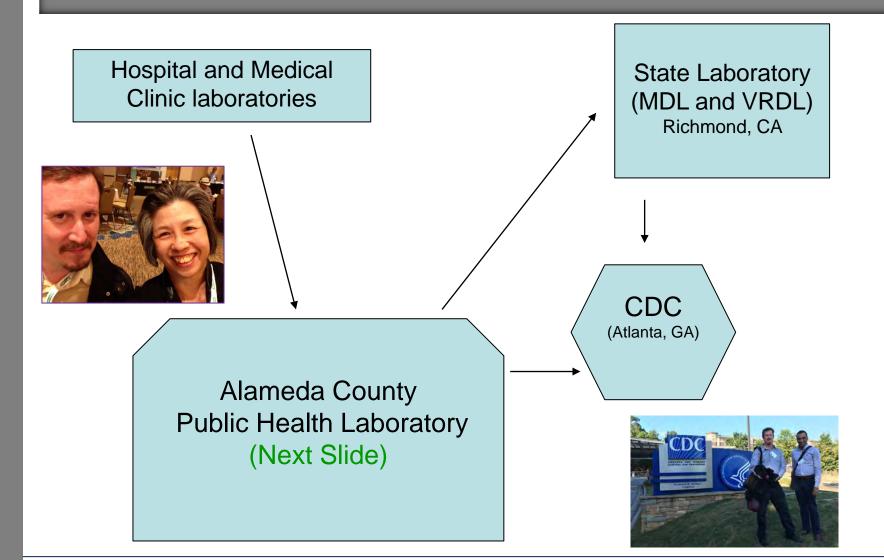
(Bacteria and Mycobacteria)

- Turnaround time (with culture): 4-6 days.
- ~50 per week if necessary
- ■PCR (bacteria and viruses)
 - Turnaround time for assay: ~6 hours





Public Health Laboratory Network





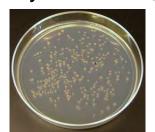


SWMHE current disease scenario: signs & symptoms (high fever respiratory distress rash encephalitis etc.)

(high fever, respiratory distress, rash, encephalitis, etc.)
possibly to due an infectious agent (bacteria, fungus, virus).

2-pronged approach (at ACPHL) to Identify Agent*:

■ Culture any body fluids (blood, urine, sputum, etc.) for bacteria, mycobacteria, fungi...

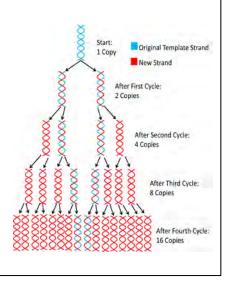




■ Whole Genome Sequence (bacteria and mycobacteria)



- Measles
- Enterorvirus
- Influenza
- RSV
- TB



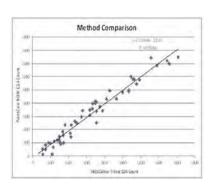
*In an outbreak, specimens likely would be sent to MDL, VRDL and/or CDC (e.g., Zika)





Streamline Data Management

- ACPHL has a database program (LIMS) able to manage high data volume of received specimens. It can generate specialized reports, including demographics, results, etc.
- Laboratory requisition slip:
 - Routine ACPHL form vs. a customized, Outbreak-specific form
 - PHL distributes to submitting labs
 - ACD distributes to *providers*
- All lab staff are trained in specimen data entry (patient/submitter/specimen info)
 - Into LIMS, and/or Outbreak-specific spreadsheet (stored on S:drive)
- Laboratory *results*
 - Microbiologists enter results into LIMS and/or spreadsheet
 - Positive results can be faxed asap to ACD (→ provider)
 - Public Health staff can have direct access to LIMS



Overview of Current Capabilities

- Alameda County Hospital Representatives
- Kaiser Permanente San Leandro
- UCSF Benioff Children's Hospital
- Kaiser Permanente Oakland





KAISER PERMANENTE San Leandro Medical Center 2500 Merced Street, San Leandro, CA 94577

2018 STATEWIDE MEDICAL & HEALTH EXERCISE
Alameda County Operational Area (OA)
Medical Surge Event: Infectious Disease
Table Top Exercise
10/2/2018

Jacqueline Francis MSN,RN,CIC- Infection Prevention Program Manager.



Capacity Overview

Bed Type	Number of Beds
Critical Care Monitored Beds	20 (with ability to convert 10 more beds over within 24 hours)
General Medical Surgical Beds	128
NICU Beds	20
Perinatal Beds	38
Pediatric Beds	N/A
Negative Pressure Rooms	14
Total Beds	216

Pediatric patients who require hospital admission will transfer to either Oakland or Santa Clara Kaiser Permanente Hospital.



Alternative Care Sites (ACS)

- Kaiser San Leandro does not have an in-patient Pediatrics department. Pediatric patients who present to the Emergency Department are treated, stabilized then transferred to another Kaiser Permanente Hospital or other contracted hospitals in which pediatric services are provided.
 - The Pediatric Hospital Based Specialist (HBS) or Pediatrician on-call review and coordinate appropriate care and transfer of care for each pediatric patient seen in the ED.
- The primary emergency alternative care facility for Kaiser San Leandro having the capabilities to meet the clinical needs of our inpatients and support similar treatment is Kaiser Oakland.
- The organization will also partner with the county public health to set-up and maintain alternative care sites during large community events.

9

Surge Capacity

■ The purpose of this plan is to support the provision of safe patient care during periods of limited bed capacity. The plan describes staffing options, accommodations potentially available for handling a large influx of patients at the Kaiser Permanente San Leandro Medical Center during a major mass causality incidents or disease outbreaks.





Emergency Management Plan

The purpose of this plan is to describe how to activate the Emergency Operations Plan (EOP) and the basic strategies and mechanisms the Kaiser Permanente San Leandro Medical Center will use to communicate to mobilize resources and conduct activities to support emergency management efforts.



Communication with Public Information Officer (PIO)

- The PIO will be in the Command Center and that is where IP/ID and PIO will determine what is to be communicated and how information is to be communicated for both internal and external audiences.
 - Each medical center has their own PIO onsite.
 - Information mush be accurate, consistent, timely and actionable communication which is enhanced by the use of plain language and accessible formats.



Who determines when screening procedures are implemented and how is this communicated to staff and established at the hospital?

- 1. Infectious Disease will determine when screening procedures are implemented.
- 2. The screening procedures will be communicated to the ED Director, Assistant Director and ED Charge nurse via phone call, email and inperson communication and as stated below. Huddle messages will be developed for change of shift huddles.
 - On-going communication systems include the following:
 - Internal telephone system
 - Two way radios
 - Pagers, email, satellite radio, public address systems, fax, cellular telephones, runners, and amateur radios may be used.
- 3. With the help of regional offices, scripts will be developed for all hospital and clinic points of entry, regarding screening procedure.





Surge Plan UCSF Benioff Children's Hospital Oakland

Amanda Lucas, MS RN CIC

Infection Preventionist

Manager, Infection Prevention & Control

UCSF Benioff Children's Hospital Oakland





Overview of Current Capacity

- Current license: 189 licensed beds
- Current ICU space: 61 beds (PICU 23 and NICU 38)
- Acute Care capacity: 128 beds
 - -Summit 20, 3 Surgical 9, 4 Med 33, 4 South 23, 5 Surgical 17, Hem/Onc 26 (11 beds are Bone Marrow Transplant)
- Ventilator inventory
 - -22 conventional vents
 - −6 Trilogy 'home style' vents
 - -7 Hfi Oss vents
 - −4 Jet Hfi vents
- Daily Leadership Operations Safety Briefing 0830 with a 1600 call added during surge
- Much of the surge comes from ambulatory patients overwhelming our ED



Surge Plan

STAGE	Alert	Phase 1	Phase 2	Phase 3
Variables Impacting Staging				
ED / 24 hours	140-178	179-210	211-247	>247
ED Admits / 24 hours	16-20	21-24	25-29	>29
DAILY TOTAL	156-198	199-234	235-276	>276
ED Left Without Being Seen (LWBS)	1-4	5-8	9-12	>12
Wait time 2ndary Triage	1 hour	2 hours	3 hours	4 hours
ED1 & ED2 pts. in lobby				
after triage in tracking.	ED1 = 8 ED2 = 10	ED1 = 12 ED2 = 15	ED1 = 20 ED2 = 20	ED1 = 25 ED2 = 30
Hospital Census*				
may not reflect ED volume	130	140	160	180
PICU Census	21	22 - 23	23 plus 1-3 Overflow	23 Plus >3 Overlow
Turnaways Yes / No	No	No	Yes 1-4	Yes >4
Action Plan:	 Hospital Yellow Alert Double Triage Seasonal Volume Staffing 	1. Hospital Red Alert 2. Triple Triage 3. Consider Hospital Command Center (HCC) Activation 4. Clinic "C" utilization 5. Additional ED Confi	1. Hospital Red Alert 2.HCC Activation 3. 4 Triage Areas 4. Pass thru Triage Tent* *for flu like symptoms 5. Treatment Tent on Dover	 Hospital Red Alert HCC Activation Alternative Sites: Garage, OPC, Claremont Labor Pool Staffing Disaster Tree
Note: These guidelines are meant as trigger points and are not to be used as snapshots. We will watch for sustained surge.		 5.Additional ED Staff 6. Triage pt.s to separate waiting areas flu like sx, acutely ill,injured. 7. Additional ancillary and support staff, i.e. registration, EVS, pharmacy 	6. Labor Pool Staff7. Limit Elective Surgeries	6. Cancel Non-Emergent surgeries





Note: These guidelines are meant as trigger points and are not to be used as snapshots. We will watch for sustained surge.	Hospital Yellow Alert Double Triage Seasonal Volume Staffing	1. Hospital Red Alert 2. Triple Triage 3. Consider Hospital Command Center (HCC) Activation 4. Clinic "C" utilization 5. Additional ED Staff 6. Triage pt.s to separate waiting areas flu like sx, acutely ill,injured. 7. Additional ancillary and support staff, i.e. registration, EVS, pharmacy	1. Hospital Red Alert 2.HCC Activation 3. 4 Triage Areas 4. Pass thru Triage Tent* *for flu like symptoms 5. Treatment Tent on Dover 6. Labor Pool Staff 7. Limit Elective Surgeries	Hospital Red Alert HCC Activation Alternative Sites: Garage, OPC, Claremont Labor Pool Staffing Disaster Tree Cancel Non-Emergent surgeries
Inpatient Response * Activated by the Nursing Supervisor in collaboration with ED and Inpatient Managers	1) Prioritize early discharges 2) Prioritize timely admission from ED 3) Ensure all "Summitable" patients are admitted and/or transferred to Summit 4) For Resident "bottlenecks" - page Chief Resident for resource redeployment to facilitate MD admit workflows	Implement all "Alert" Plans. In addition: 1) Implement "pull system" for acute care admissions whenever feasible 2) Consider "pull" to Critical Care (PICU and/or NICU) if appropriate based on acuity and type of personnel available for transport 3) Nursing Supervisor (in collaboration with the managers and CNs) to Identify and redeploy additional resources (ie., consider underutilized PACU staff).	Implement all "Alert" and	Implement all "Alert" and "Phase 1" and "Phase 2" action plans. In addition: Participate in HCC Activiation as requested





Ability to Exceed Capacity

- HICS command center—Code TRIAGE
- In order to allow for a 10% surge capability above capacity:
 - -Admit Holding Unit (8 beds appropriate for acute care patients)
 - −ED 2 Holding (4-8 beds appropriate for ICU level patients)
 - -PACU-Main Hospital (3-5 beds appropriate for ICU level patients)
 - -Outpatient Infusion unit (14beds appropriate for acute care patients)
 - -PACU OPC (7-10 beds appropriate for acute care patients)
- Limit/Cancel elective surgery
- PACU nurses convert to ICU nurses
- Re-assign licensed staff to appropriate roles
- Cohort patients by room/bay in NICU
 - −Bay A 9 beds
 - −Bay B 9 beds
 - −Bay C 20 beds

- Pandemic Plan
 - With order from Ala Co health, ability to open triage tent and dispensing/treatment tent
- -Visitor restrictions—Screening all who enter facility at front desk to keep ill visitors out of hospital
- No visitors under 18 during Pandemic conditions
- -Transfer out of non-ill patients at direction of County Health Officer
- -Vaccination clinics as needed



Concerns/Limitations for BCHO

- Morgue is tiny 2 adult limit
- What to do with deceased?
- Triage for this type of outbreak arrive to our facility with no hope for survival
- Supply of respiratory medications, e.g. albuterol, anti-virals
- Equipment for isolation: PPE (gowns, masks, gloves)
- Staffing to meet overflow surge e.g. Nurses, RTs, ICU docs



Will Hernandez

Safety Specialist – Emergency Management Emergency Management Peer Group, Co-Chair

Kaiser Permanente, Oakland



LEVERAGING SUSTAINABLE CAPABILITY & READINESS FOR CHILDREN UNDER ALL CONDITIONS

ALAMEDA COUNTY PEDIATRIC MEDICAL SURGE PLAN

DISASTER RESPONSE CONCEPT OF OPERATIONS

SCENARIO: NOVEL VIRUS DISPROPORTIONATELY AFFECTING CHILDREN <14







CYNTHIA FRANKEL, RN, MN

CO-CHAIR, CALIFORNIA NEONATAL/PEDIATRIC DISASTER COALITION ALAMEDA COUNTY EMERGENCY MEDICAL SERVICES

CYNTHIA.FRANKEL@AACGOV.ORG; (925) 285-2403

"ADULT & PEDIATRIC NEAR MISS" Surge Capacity & Capability Challenges

LESSONS LEARNED

H1N1 (2009) **

Potential Risk

- Hospital medical surge impact
- Limited ICUs, PICUs, EDs and beds
- Pandemic flu Virulent Virus





M. Sills et.al., Emerging Infections Diseases, Sept 2011 CDC MMWR Sept 16,2011

Inpatient Capacity at Children's Hospitals during Pandemic (H1N1) 2009 Outbreak, United States

Marion R. Sills, Matthew Hall, Evan S. Fieldston, Paul D. Hain, Harold K. Simon, Thomas V. Brogan,
Daniel B. Fagbuyi, Michael B. Mundorff, and Samir S. Shah

Less than one additional admission per ten inpatient beds would have caused ALL Children's hospitals to reach 100% capacity.

NOVEL VIRUS POTENTIALCHALLENGE



- AMBULANCE STACKING
 - 2 or more ambulances waiting for more than 30 minutes at single ED
- EDs OVERWHELMED
- HOSPITAL PROLONGED SURGE
 - PICUs/ ICUs filled to capacity





- MITIGATE AMBULANCE EXTENDED WAIT TIMES
 - ENSURE AMBULANCE RESOURCES AVAILABLE
 - FACILITATE HOSPITAL INTERNAL SURGE PLANNING
 - ALCO EMS SUPPORT HOSPITALS FOR SURGE
 - CONTINUOUS SYSTEM MONITORING

ALAMEDA COUNTY MEDICAL SURGE PLAN CRITICAL CARE EXPANSION MODELS — OPTIONS



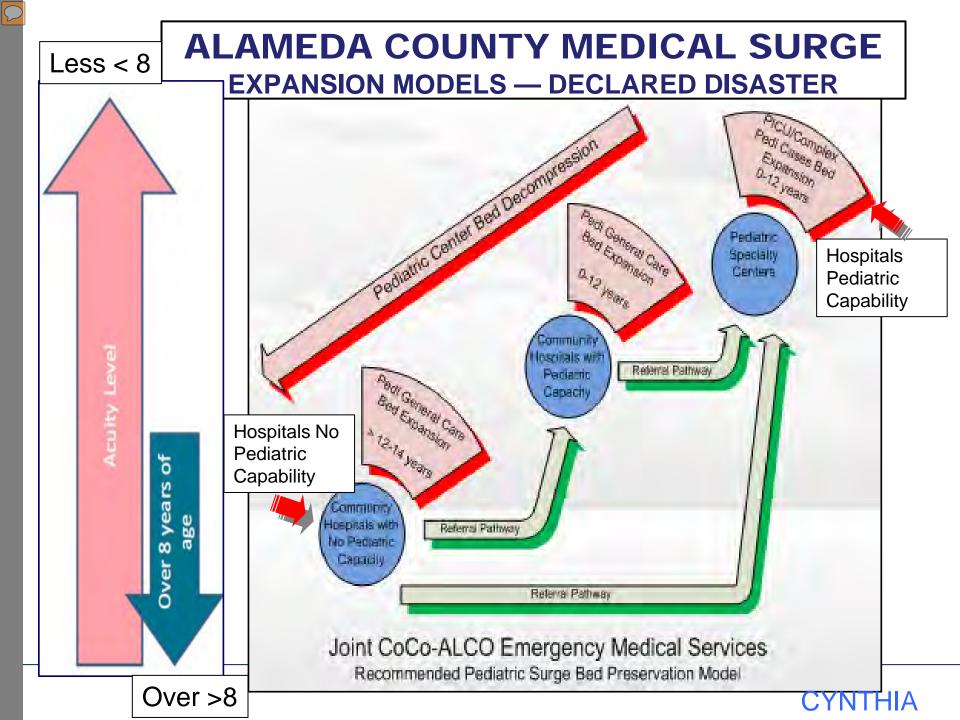


- Hospitals increase pediatric beds by <u>5%</u> above total licensed beds
- 2. Hospitals with ICU & PICU double numbers of staffed beds
- 3. Hospitals take <u>5 additional</u>
 <u>patients</u> in their ICU & PICU
- 4. Hospitals increase bed capacityby 10% above licensed beds

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ALAMEDA COUNTY MEDICAL SURGE PLAN CRITICAL CARE EXPANSION MODELS — OPTIONS

		Λ		HOSPITAL CAPABILITY (BASED ON LICENSED BEDS)	DESCRIPTION
		/ \		CRITICAL CARE FOR PEDIATRICS	
	4	ſ		- PICU (UCSF Benioff Children's Hospital; Kaiser Permanente Oakland)	PEDIATRIC PICU
	<8	3 ує	ears	- NICU	NICU
			•	- ICU	ICU
		ē	•	- TRAUMA CENTERS	ADULT & PEDIATRIC TRAUMA CENTERS
		ر ا	-	GENERAL MEDICAL/SURG CARE FOR PEDIATRICS	
		Acuit	of of	- GENERAL PEDIATRIC BEDS	PEDIATRIC ACUTE BEDS
		·	years o	- GENERAL MED/SURGE BEDS; NO LICENSED PEDIATIRC BEDS	
				NO INPATIENT IN-PATIENT PEDIATRIC BEDS	
>{	3 y	/eai	rs	- NO PEDIATRIC CRITICAL CARE; NO PEDIATRIC BEDS	
			Ÿ	- EMERGENCY ROOM ONLY	





Jim Morrissey- ALCO EMS Supervisor

Tactical Medical Program Director

FBI SWAT Tactical Medic (ret.)

Urban Shield EMS Branch Director

911 & Non-911 Transport Coordination

Michael Marsh, EMT-P, TEMS Specialist

Director of Operations

Paramedics Plus-Alameda County









Module 2

Health Care Coalition Response & Coordination

(Discussion)



Kaiser Oakland



- A family that resides in Alameda County just returned from a vacation to Peru.
- Several days after returning, the mother and two of her children become ill; symptoms rapidly worsen. In the early hours of September 28, the children are transported by ALS to CHO and are admitted with fevers (101°F, 103°F), shortness of breath and blisters on skin.
- The mother is transported and admitted to Kaiser Oakland the following afternoon as she is no longer able to breathe independently.
- The hospitals follow standard procedures for screening and isolating the patients upon arrival. The illness is reported to ACPHD on September 29 neither hospital has been able to definitively diagnose the illness and laboratory samples are taken for state or national level analysis.
- The situation in Peru and Chile is worsening; the virus has spread to the major cities of Lima (Peru), Valparaiso (Chile), and there is a report of a case in La Paz, Boliva. A strain has been isolated from the hospital in Lima.
- CDC has issued laboratory and screening guidance for healthcare systems in the United States.



Module 2 Discussion Questions

- What is the level (roles) of activation, internal communications, and key initial response actions at this time? At what point would you need some activation of your command centers?
- What are the triggers that would prompt the OA EOC Medical Health Branch to activate? Other Branches of the EOC? What would be the primary activities of the EOC?
- What type of information sharing or coordination would occur at the regional level?
- What resource/capability polling would be initiated? What role would the County have in assisting with vendor shortages or delayed delivery of supplies?

Communications:

- Alameda County: What type of guidance/messaging would be sent to the Coalition? Via what mechanisms? How is this coordinated within/across agencies?
- Healthcare Partners: What communications mechanisms would your organization rely upon to receive and share information with the County? What are the key pieces of information exchanged?
- What role are PIOs playing at this time?

■ Healthcare Partners:

- Would screening procedures be implemented at this time? If yes:
 - Describe what the process would be.
 - How is this communicated to staff? What other safety messages are communicated internally?
 - What resources would you leverage to develop screening protocols in this scenario?
 - How are you engaging infection control at this point?
- What internal resources would you assess given what you understand about the emerging disease? Do any raise
 concern as being in limited supply onsite? What actions would be taken if vendor shortages or delays are
 recognized?

Module 2 Epidemiology

- Late in the day on OCTOBER 1, the youngest child (age 3) dies from complications. The other child (age 8) and mother (age 37) are on supportive care.
- There are concerns about the sick children participating in daycare and elementary school on September 25 as well as a birthday party on September 24 that included up to 20 other children ranging in ages from 4-8 years old.
- A nurse working for a Home Health Agency recently returned from Peru. She has been experiencing mild flu-like symptoms, but continued to go to work and saw nearly a dozen home health patients from September 24-25. She also went to visit her father on September 24 at his nursing home.





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Module 2 Discussion Questions

ALAMEDA COUNTY:

- Describe surveillance activities given what you have learned from the BCHO and KP patients.
- What do you communicate to the Coalition based on this information?
 - Are 1 or 2 facilities designated for treatment or triage (rule in/out)?
 - What transport systems have the capability to transfer infectious patients?
- What is occurring with regards to public information and media messaging?

HOSPITALS:

- What are actions are being implemented for decompression/expansion in anticipation of many more patients arriving to the hospital (specifically for the receipt of patients with a novel virus with high infection rates)?
 - How would patients be triaged for care at hospitals other than BCHO?
 - In this scenario, what are the realistic capabilities and limitations for other hospitals to accept pediatrics?
- What questions would you have about laboratory specimen collection?



Module 2 Discussion Questions

NON-HOSPITAL HEALTHCARE PARTERS

- Do you have the ability to temporarily isolate those that are symptomatic/screen positive? If so, describe the procedure, location, length of time, and capacity.
- LTCFs: Do you have any capacity to accept pediatric patients (<u>not</u> infected with novel virus)?
- Clinics: What level of outpatient care can you provide to pediatric patients with less critical infection?
- Dialysis, home health and surgery centers, what kind of information do you share with your staff and the worried well who feel ILI? What do you do if one of you staff becomes infected?
- Transport Providers: Are there any changes in your transport plan?
- What notification of Transport Providers by Healthcare Facilities is provided?







Module 3

Public Messaging, Healthcare

Responder Safety, Patient Surge

(Breakout Groups)

Breakout Group Instructions

- Work with your group, discipline, facility type as assigned
- Answer questions on behalf of your facility
- Assign one person to serve as a scribe for your group
- Assign a spokesperson to serve as the reporter for your group during the debriefing
- Be prepared to provide a brief summary of key points from your breakout group



Breakout Assignments

Lake Merritt Room - City, County, State, Regional

Facilitator/Evaluator (Steve Mier, Zerlyn Ladua)

Uptown Room – Hospitals

Facilitator/Evaluator (Bethanne, Barbeau, Caryn Thornburg)

Eastmont Room – Dialysis, Home Health

Facilitator/Evaluator (Donata Nilsen, Michelle Leishman)

Laurel Room – Long Term Care, Residential Care

Facilitator/Evaluator (Curt Mueller, Ron Seitz)

Elmhurst Room – Clinics, Surgery Centers

Facilitator/Evaluator (Preston Lam, Louise Ainsley)

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Scenario - October 2, 2018



https://www.gettyimages.com



- Patient numbers have risen significantly throughout Alameda County during the past week. Total cases are estimated to be over 130, with 70 that have been hospitalized.
- Hospital critical care areas are full, including NICUs, PICUs, and ICUs.
- ALL hospitals have critical patients with the novel virus; half of ICU and PICU patients are suspected or confirmed to be suffering from this virulent virus. Hospitals are expected to expand critical care areas to receive an additional 2-8 patients in the critical care NICU, PICU, and ICUs. The pediatric medical surge plan is activated.
- There have been 3 additional deaths; a 4 year old, 16 year old, and a 23 year old day care provider associated with the initial cases.
- Staff across the healthcare delivery system have implemented infection control protocols and safety precautions when providing care; however, there are rising concerns about exposures and staff numbers reporting to work have declined.
- Media coverage across the Bay Area and the country has exploded and many facilities are receiving requests for statements or media showing up to their locations trying to get a story.

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Module 3 Injects

ALAMEDA COUNTY:

- Public health receives notification from CHO and KP about the potentially exposed transport providers of the index cases.
- EMS resources are stretched within the county.
- Laboratories are requesting guidance on sample collection and testing.

HOSPITALS:

- Critical care areas are beyond capacity and more patients are expected each day. There are significant staffing, bed, and resource strains particularly for pediatric care.
- An ambulance transport to your hospital has potentially exposed the EMTs to the disease.
- Two staff members (nurse and admissions) have reported that they are experiencing what they believe to be early symptoms of infection following exposure.
- KRON4 is outside your main entrance asking for a statement on the ill patients

Module 3 Injects

CLINICS:

- A number of patients have screened positive in the past several days, their severity of illness varies. However, one patient (5 years old) arrived this morning and is in severe respiratory distress, has a fever of 103°F, and displays several oozing blisters on the upper thighs.
- One of your staff members has not reported to work for the past 2 days and they have indicated that they may have been exposed at work.

LTCFs:

- One of your residents who was recently visited by their daughter starts complaining of difficulty breathing, seems confused, is dehydrated and feverish.
- Your staff attendance has declined by 30% since the outbreak was detected. Rumors and general distress has been overheard by management.
- A partnering hospital has requested that you accept as many of their low acuity patients as possible to assist with decompressing their beds.

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Module 3 Injects

DIALYSIS AND SURGICAL CENTERS:

- A patient has arrived for a procedure and screens positive for symptoms of the virus. They used the restroom and sat in the waiting area for a length of time with other patients and families.
- Patients have been calling asking if it is safe to come in for their procedures or whether you have had anyone ill come to the center. Staff also have concerns.

HOME HEALTH:

- You have been asked about the ability to accept low acuity patients (discharged to home) into your program as hospitals are decompressing beds.
- Many calls from your patients are coming in with concerns that they are sick; most are presumed to be worried well.

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Module 3 Discussion Questions

ALAMEDA COUNTY:

- What are the actions taken in response to the transport provider exposure?
 - TRANSPORT PROVIDERS: What are your internal processes to communicate with and monitor potentially exposed staff?
- What actions are taken by the Medical Health Branch with regards to transport assets?
- Describe laboratory guidance development, content, and dissemination. Would there be a point where laboratory testing of all patients would be curtailed?
- What guidance has been provided to handle infectious medical waste?
- What are the key actions and coordination with the County Coroner at this time?

HOSPITALS:

- What is your process upon recognition that transport providers may have been exposed?
- How are you coordinating internally, with the county, and other facilities to accommodate the increasing patient surge (especially given extended length of stay)? What are your biggest challenges?
- Describe healthcare worker monitoring protocols.
- How does your PIO coordinate with the County to develop messages? Who else must they coordinate with before a press release? What is the key content in messages?

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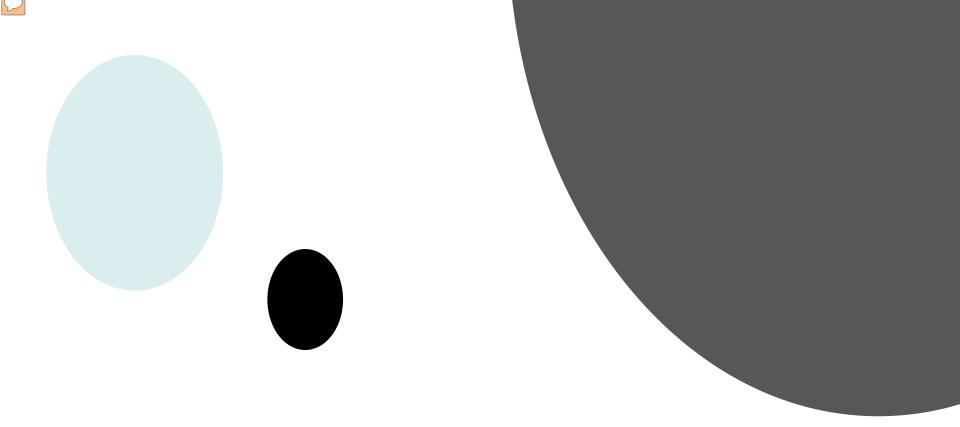
Module 3 Discussion Questions

NON-HOSPITAL HEALTHCARE PARTNERS:

- Describe actions/notifications after a patient/resident screens positive.
- Describe the process for coordinating transport to a hospital for a severely ill patient/resident (e.g., notifications, paperwork).
- Describe healthcare worker monitoring protocols.
- How are staff stress/mental health concerns addressed?
- How would patient inquiries about safety of visiting your facility or with worried well questions be handled?
- What is the process for releasing media statements if requested from your organization?

LTCFs/HHAs:

■ What would be your ability to accept discharged low acuity hospital patients? What are the limitations on the type of care that you could provide?



Lunch Pick Up Reconvene to Plenary for Debriefing/Hotwash





Debriefing/Report Backs



Hotwash

What were the primary strengths observed during today's exercise?

What were the key gaps or recognized areas for improvement?



Please complete the Participant Feedback Form to capture your candid feedback and ideas for the functional exercise.



2018 SWMH Functional Exercise Preparation

Michelle Leishman

- Functional Exercise Registration
- Webinar Registration
- AC Alert
- CAHAN

Cynthia Frankel

- ReddiNet
- Resource Requests
- Situation Status Reporting

This year's exercise may entail a variety of communication activities in the weeks leading up the week of November 12th.

Main Exercise Date: November 15, 2018

2018 SWMH Functional Exercise Preparation

ReddiNet HTML - New

- Ensure Training & Update HCC Contact Information
- Complete HAvBED & Customized Poll
- Disaster Forms (New EMS Website Link http://ems.acgov.org)
 - SitStat Reporting
 - Resource Requests

Disaster Email:

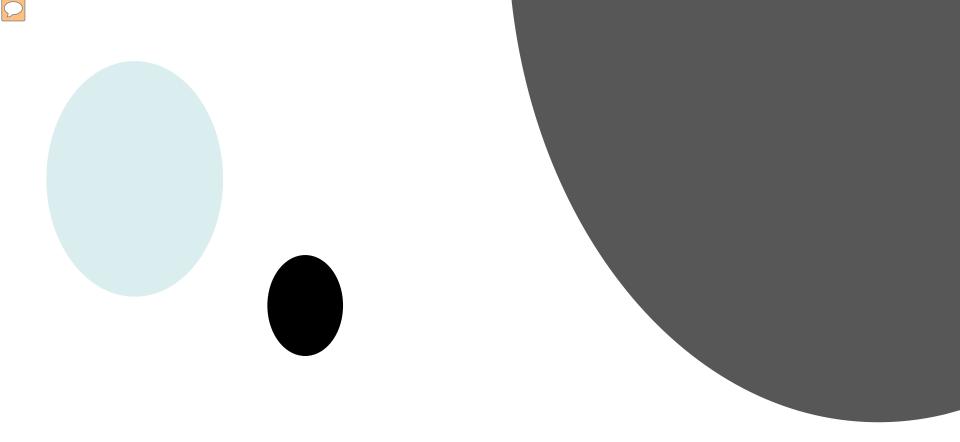
If you need resources, use Resource Request Form

- o Email to _____
- o Ensure name of organization on subject line

Situation Status & Resource Requests

Alameda County	Medical/Health Status R	eport Form Submittal Date: Time:	
) Event/Incident Title		Facility Name:	=
_		The second secon	=
3) Originator Name:		itle: 5) Department:	
6) Phone:	7) Em	ail:	
B) Hospital C	linic Other	9) EOC/HCC Phone #:	
a) Elioopitai	activated? Not Activated	Partially Activated Fully Activated	
iu) is your EOC/HCC	activated? Mot Activated	Partially Activated Pully Activated	
	ppropriate level of functionality		
Not Functional	Partially Functional	Fully Functional	
2) Provide facility in	frastructure status (damage, e	lectricity, water, internet, phones, etc):	
3) Can your facility p	provide essential Patient Care?	No Yes	
4) Estimated Casual	ties - How many patients do vo	ou have as a result of this event? (Based on STAR	T Tris
mmediate (Red)		Minor(Green) Deceased (Black)	
TALE GOVERNMENT			
5) Can your facility t		Yes. 16) If yes, number of patients	
7) Do you have STAI	FFED BEDS AVAILABLE (perso	onnel staffing with beds)? Based on HAVBED defin	ition
MED/SURG No	Yes # of Beds	OR No Yes # of Beds	
ICU No	Yes # of Beds	ISOLATION No Yes # of Beds	
PICU No	Yes # of Beds	OB/GYN No Yes # of Beds	- 1
NICU No	Yes # of Beds	TRAUMA No Yes # of Beds	
TELE No	Yes # of Beds	BURN No Yes # of Beds	
PSYCH No		OTHER No Yes # of Beds	
PEDS No	Yes # of Beds		
8) Can your Urgent (Care/Emergency Department to	ake more patients? No Yes	
9) If yes, number of	patients 20) Expli	ain any limitations:	
and the same of		State Charles and Charles and	
		not be addressed by your facility: nit a Medical/Health Request Form.	
if it you have any re	source needs, you most sub-	int a medical/riealth Request Form.	
This form is	to be contifuent ways Capilli	to the Operational Assa (County EOC)	
		ty to the Operational Area (County EOC) med1@acgov.org and will be received by EMS staff	
		er (925) 803-2720, or (925) 803-7872	
EOC	medical branch phone numbe	r (925) 803-7930 or (925) 803-7818	
If Reddine	t is available, please check regula	arly for updated messages and instructions.	

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Thank You! Questions?