Washington State Department of Health

Public Health
Seattle & King County

November 2008

Full-Scale Exercise After Action Report and Improvement Plan

Homeland Security Exercise and Evaluation Program

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CONTENTS

Administrative Handling Instructions i

Executive Summary v

Chapter 1: Exercise Overview 1
- Exercise Details 1
- Exercise Planning Team Leadership 2
- Participating Organizations 2

Chapter 2: Exercise Design Summary 5
- Exercise Purpose and Design 5
- Exercise Objectives, Capabilities, and Activities 5
- Scenario Summary 11

Chapter 3: Analysis of Capabilities 15
- Public Health - Seattle & King County Communicable Disease/Epidemiology ... 15
- Emergency Support Function-8 Area Command Center 21
- Emergency Support Function-8 Multi-Agency Coordination Group 32
- Public Health Information Center 34
- Washington State Department of Health Headquarters 39
- Washington State Department of Health Epi/CD 59
- Public Information Call Center 62
- Reception, Storage, and Staging Facility 66
- Alternate Care Facility 72
- Washington State Department of Health Laboratory 85

Chapter 4: Conclusion 87

Appendix A: Improvement Plan A-1

Appendix B: Acronym List B-1

Appendix C: King County Healthcare Coalition After Action Report C-1
(This report was provide under a separate cover after the main After Action Report was completed – normally it would have been incorporated into the main report)

EXECUTIVE SUMMARY

The Pandemonium 2008 Full Scale Exercise (FSE) was conducted to assess capabilities associated with a Pandemic Influenza response by Washington State Department of Health (DOH), the Public Health - Seattle & King County (PHSKC), local emergency response partners in King County, and King County hospitals. The exercise was developed to test PHSKC's abilities to coordinate local health and medical response efforts King County, and the State of Washington's abilities to coordinate response efforts at the State and Federal level during a Pandemic Influenza.

The exercise planning team was composed of numerous agencies, including PHSKC, King County/ Region 6 Hospitals, King County Healthcare Coalition, City of Seattle Office of Emergency Management, King County Office of Emergency Management, and DOH.

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

The major strengths identified during this exercise are as follows:

- ICS was successfully implemented as the primary management structure throughout all venues of the exercise.
- It was evident that all players in the PHSKC ESF 8 Area Command Center (ACC) led by PHSKC were given thorough training, and the shifts were seamless. Incident action plans (IAPs) were developed each day of play for the next operational period. Command and Staff briefings were delivered in a timely manner, with appropriate information gathered, analyzed, and delivered.
- After an initial delay in communications between (PHSKC) Communicable Disease (CD) Epidemiology (Epi) and the Area Command, a continuous flow of critical information was received and disseminated among the multi-jurisdictional and multi-disciplinary emergency responders, command posts, agencies, and governmental officials for the duration of the exercise in compliance with National Incident Management System (NIMS). The CD/Epi team identified a case definition of the disease and established the initial exposure site.
- Critical resources were readily identified and made available to PHSKC ESF 8 ACC staff. Situation Status/Reports were updated and posted in the PHSKC ESF 8 ACC displaying "real time" situation.
- Throughout the exercise play, the PHSKC ESF 8 ACC communications team, activated as Public Health Information Center (PHIC), effectively established timelines for media releases, gathered information and developed alerts and warnings that were distributed to public and private sectors and relevant government agencies. The team received and transmitted coordinated, prompt, useful, and reliable information regarding threats to health and safety.

- Upon ACC activation, an information release cycle was quickly established and maintained. Washington Tracking (WATrac), the information management system designed to support for health and medical response events in Washington, was established and used throughout the exercise; most staff agreed that it is an outstanding resource and communication tool if they are trained on its application.
- PHSKC ESF 8 established a Public Information Call Center (PICC) in order to receive and transmit coordinated, prompt, useful, and reliable information regarding a public health emergency. The information was updated regularly and outlined protective measures to be taken by individuals and their communities. Public information and warning messages were sent to appropriate response partners and community members via redundant avenues.
- The multi-agency coordination was managed through activation of local and State Emergency Operations Centers and Area Command Centers and in King County through activation of a Multi-Agency Coordinating Group (MAC). A MAC Group meeting was conducted in response to an escalating pandemic influenza in an appropriate time frame with the appropriate senior officials present based on the scenario provided.
- WA DOH successfully implemented its Continuity of Operations (COOP) Plan.
- DOH Division of Information Resource Management (DIRM) staff were able to set up and provided continuous support in the DOH EOC.
- The State public health laboratory worked in close partnership with public health epidemiology, hospitals and environmental health producing timely and accurate data to support ongoing public health investigations and the implementation of appropriate preventative or curative countermeasures. Lab specimens were ordered and sent to the State Public Health Lab in a timely manner. Suspected cases were investigated promptly; new suspect cases were identified and characterized based on case definitions; the source of exposure was determined to be a wedding; and, effective mitigation measures were communicated to the public, providers, and relevant agencies/departments. The Office of Shellfish and Water Protection (OSWP) appropriately responded to the exercise scenario even when the bio-toxin program staff all became ill.
- Information received from PHSKC CD/Epi regarding exposure and disease was confirmed rapidly by WA DOH CD/Epi. Confirmed cases were reported back to jurisdictional agencies. Suspected cases were investigated promptly, reported to relevant public health authorities, and accurately confirmed to ensure appropriate preventive or curative countermeasures are implemented. New suspect cases were identified and characterized based on case definitions on an ongoing basis; relevant clinical specimens were obtained, tested and results disseminated back to relevant agencies.
- Hospital use of WATrac was somewhat successful for requesting/tracking resources utilized or needed. Areas that did not have access to this system were still able to request and track resources
- Public Health – Seattle & King County established the alternate care facility (ACF) at the Seattle Center with effective security and crowd control; an organized, structured volunteer reception area and system to credential / accredit skilled volunteers; and

signage that met the needs of English speaking as well as those with limited English proficiency. The ACF incident scene was assessed and secured, access was controlled, and security support was provided to the ACF by Seattle Police Department. Emergency medical services (EMS) resources were effectively and appropriately dispatched and transported patients to the ACF. Flow of transport for EMS was efficient and effective.

- The ACF was set up to receive defined levels of triage and patient care. Continuity of care was maintained for patients and their families. Establishing the ACF was managed safely, effectively, and efficiently through the integration of the facility, resources (personnel, equipment, supplies, and communications), and procedures using ICS, Public Health Reserve Corp (PHRC) volunteers and PHSKC staff were identified, trained, and placed in appropriate response positions at the ACF.
- The Agency Duty Officer was used extensively to assist the Disaster Managing Executive and greatly facilitated communication and the exchange of information between the ART and the DOH Emergency Operations Center.
- Note taking during each of the ART meetings and distributing the notes shortly after the meetings proved very effective in documenting decisions and informing all about the activities of the ART.

Throughout the exercise, several opportunities for improvement in the State of Washington's ability to respond to the incident were identified. The primary areas for improvement are as follows:

- There was a delay in communicating initial surveillance and epidemiological information to health providers (via the Information and Alert Network [IAN]). Surveillance information was not communicated between CD Epi, Public Information Call Center (PICC), ACC, and other partners on a regular basis.
- WATrac was not available to non-hospital healthcare clinics/providers. There was a delay in getting access for on-coming shift Area Commander, limited staff that have been trained on the system and technical issues which hindered timely responses by staff.
- WATrac does not currently include a resource request and management module to assist with organizing and tracking health and medical resources. Adding this available module would greatly improve resource management for DOH, local public health, hospitals and other healthcare partners.
- Presently DOH does not have a method to determine the current staffing levels in the divisions or identify the staff working the incident.
- Incident action plans were not developed for the DOH EOC and staff did not actively seek guidance from leadership
- The PHRAT process proved to be cumbersome and difficult to use to gain consensus about social distancing measures during a pandemic. Discussions on antiviral use and alternate care facilities could not be completed due to lack of time.
- DOH Communicable Disease Epidemiology Section (CDES), as outlined in their response plan, are not task oriented, and proved difficult to assign roles and responsibilities to staff.

- DOH's SECURES did not have up-to-date contact information for all staff and messages were not always clearly written. DOH EOC Communications, including phone calls and situation reports, between and among the various venues was inconsistent during the exercise. There was no liaison between the DOH EOC and the DOH Communications Office.
- DOH EOC staff identified that the process, priorities, and procedures for dispensing antivirals during a pandemic are not clearly written, a plan for gathering information and disseminating it to the EOC staff, agency administration, or its partners is not apparent; and no internal task tracking system exists.
- The RSS Inventory Management Tracking System (RITS) took four personnel nearly six hours to input the data from the Managed Inventory that arrived at the RSS, causing a significant delay in distributing the resources. Critical medical supplies and equipment were received from the CDC, but several technical difficulties significantly delayed the repackaging and distribution of the SNS supplies. This component of the exercise failed, and as a result several hospitals were unable to exercise their plans to receive supplies from the RSS.
- The EMS and ACF staff did not utilize the established pre-hospital triage system and plans for alternate standards of care for the ACF.
- WAHVE volunteer application did not contain all required information fields and the WAHVE web-based application background check query was not configured properly to test at ACF.

CHAPTER 1: EXERCISE OVERVIEW

EXERCISE DETAILS

Exercise Name
Pandemonium 2008 Full Scale Exercise

Type of Exercise
Full Scale

Exercise Date
November 13, 14, 17, and 18, 2008

Duration
4 days

Location
Various venues in and around King County, Washington
Tumwater, Washington
Camp Murray, Washington

Sponsor / Point of Contact (POC)
Washington Department of Health
Public Health - Seattle & King County
Centers for Disease Control
U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness & Response

Program
Fiscal Year 2008 Department of Health and Human Services Grant Program
Centers for Disease Control and Prevention Cooperative Agreement of FY 2008
Assistant Secretary for Preparedness and Response (ASPR) Cooperative Agreement for FY2008

Mission
Response

Capabilities
- Communications
- Critical Resource Logistics and Distribution (non-medical)
- Emergency Public Information and Warning

- Emergency Public Safety and Security Response
- Emergency Triage and Pre-Hospital Treatment
- Emergency Operations Center Management
- Epidemiological Surveillance and Investigation
- Medical Supplies Management and Distribution
- Medical Surge
- On-site Incident Management
- Public Health Laboratory Testing
- Responder Safety and Health
- Volunteer and Donations Management

Scenario Type

Pandemic influenza

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PARTICIPATING ORGANIZATIONS

Federal

- Department of Health and Human Services
- Centers for Disease Control and Prevention

- U.S. Marshals Service
- Medical Reserve Corp

State

- Washington State Department of Health
- Washington Military Department, Emergency Management Division
- Washington State Patrol
- Washington State Department of General Administration
- Washington State Department of Social and Health Services

County and Local Agencies and Organizations

- Auburn Regional Medical Center
- Bellevue Fire Department
- City of Seattle Office of Emergency Management
- Enumclaw Regional Hospital
- Evergreen Hospital and Medical Center
- Fairfax Hospital
- Franciscan Health System
- Group Health Cooperative
- Harborview Medical Center
- Highline Medical Center
- Kindred Hospital
- King County Office of Emergency Management
- Navos
- Northwest Hospital
- Overlake Hospital and Medical Center
- Public Health – Seattle & King County
- Puget Sound Blood Center
- Seattle Cancer Care Alliance
- Seattle Center Emergency Services
- Seattle Children's Hospital
- Seattle Fire Department
- Seattle Police Department
- Snohomish Health District
- Snoqualmie Valley Hospital

- South King County Emergency Medical Services
- Stevens Hospital
- Swedish Medical Center
- Tacoma-Pierce County Public Health
- University of Washington Medical Center
- Valley Medical Center
- Veterans Administration Hospital and Clinics
- Virginia Mason Medical Center
- Vulnerable Populations Action Team (VPAT) Community Based Organizations enrolled in the Community Communications Network
- Washington Poison Center

Contract Support

- EG&G Division of URS Corp.

Number of Participants

- Players 718
- Controllers 21
- Evaluators 23
- Observers 350

Chapter 2: Exercise Design Summary

EXERCISE PURPOSE AND DESIGN

The Pandemonium 2008 Full-Scale Exercise (FSE) was conducted on November 13-14 and November 17-18, 2008, to give participants from the Washington State Department of Health (DOH) and the Public Health - Seattle & King County (PHSKC), local emergency response partners in King County and King County hospitals an opportunity to evaluate current concepts, plans, and capabilities for response issues pertaining to Pandemic Influenza.

The primary purpose of the Pandemonium 2008 FSE was to assess those elements of the Washington State Department of Health and Public Health Emergency Planning Region 6 that relate to the overall response and decision-making process, integration, and coordination with responding public health and safety agencies during a Pandemic Influenza in the State of Washington. DOH recognizes its responsibilities to protect the public from, and mitigate the consequences of, the hazards associated with naturally occurring events or acts of terrorism, including the necessity for a properly integrated response in the event of such an incident or naturally occurring events. With those responsibilities in mind, the State of Washington and Public Health - Seattle & King County have developed policies and procedures to respond to a pandemic event, such as the one depicted in the scenario for this exercise, and conduct associated exercises.

EXERCISE CAPABILITIES AND OBJECTIVES

Capabilities-based planning allows for exercise planning teams to develop exercise objectives and observe exercise outcomes through a framework of specific action items derived from the Target Capabilities List (TCL). The capabilities listed below form the foundation for the organization of all objectives and observations in this exercise. Additionally, each capability is linked to several objectives, also listed below, and corresponding activities and tasks.

Capability: Communications

Overarching Objective:

1. Demonstrate the ability to initiate and maintain communications between multiple venues during a pandemic in accordance with existing standard operating procedures (SOPs)

PHSKC Objectives:

1. PHSKC will demonstrate the ability to implement incident communications interoperability plans and protocols
2. PHSKC will demonstrate the ability to establish and maintain response communications systems on-site

WA DOH Objectives:

1. WA DOH will demonstrate the ability to initiate and maintain communications between multiple DOH venues
2. WA DOH will demonstrate the ability to use WebEOC at multiple venues to share information
3. WA DOH will demonstrate the ability of the DOH Communications Office and the DOH EOC to work together
4. WA DOH will demonstrate the ability to initiate and maintain communications between DOH EOC and other State exercise participants
5. WA DOH will demonstrate the ability to accomplish Secure Electronic Communication, Urgent Response and Exchange System (SECURES) notification procedures

Capability: Critical Resource Logistics and Distribution (non-medical)

PHSKC Objectives:

1. PHSKC will demonstrate the ability to provide logistical support for the operation and requests of the incident command and EOC
2. PHSKC will demonstrate the ability to coordinate distribution of stockpile assets
3. PHSKC will demonstrate the ability to request needed resources from EOC
4. PHSKC will demonstrate the ability to deploy and transport resources to appropriate, pre-determined locations
5. PHSKC will demonstrate the ability to track deployment, movement, and transportation of resources prior to and during an incident
6. PHSKC will demonstrate the ability to request State critical resources

Capability: Emergency Public Information and Warning

Overarching Objectives:

1. Demonstrate the ability to activate the Public Health Information Center (PHIC) and the Public Information Call Center (PICC) during a pandemic in accordance with existing SOPs
2. Demonstrate the ability to provide emergency public information to special, vulnerable, and at-risk populations during a pandemic in accordance with existing SOPs

PHSKC Objectives:

1. PHSKC will demonstrate the ability to activate plans, procedures, and policies for coordinating, managing, and disseminating public information and warnings
2. PHSKC will demonstrate the ability to implement government agency and non-governmental organization notification protocols and procedures

3. PHSKC will demonstrate the ability to activate and deploy public information/affairs personnel
4. PHSKC will demonstrate the ability to implement routing and approval protocols for release of information
5. PHSKC will demonstrate the ability to establish adequate numbers of trained personnel at dispatch or communication centers to process and disseminate information
6. PHSKC will demonstrate the ability to provide emergency information to special, vulnerable, and at-risk populations that are economically disadvantaged, have limited language proficiency, have disabilities (physical, mental, sensory, or cognitive limitations), experience cultural or geographic isolation, or are vulnerable due to age
7. PHSKC will demonstrate the ability to track media contacts and public inquiries, listing contact, date, time, query, and outcome
8. PHSKC will demonstrate the ability to establish frequently updated public information hotline

WA DOH Objectives:

1. WA DOH will demonstrate the ability to convene DOH Assessment Response Team (ART) and initiate response of appropriate DOH entities.
2. WA DOH will demonstrate the ability to provide, coordinate, and distribute public information messaging to all affected parties

Capability: Emergency Public Safety and Security Response

Seattle Police Department (SPD) Objectives:

1. SPD will demonstrate the ability to deploy appropriate personnel for public safety and security
2. SPD will demonstrate the ability to coordinate public safety and security operations with incident command / unified command
3. SPD will demonstrate the ability to provide and plan for access to the site for skilled support personnel
4. SPD will demonstrate the ability to control traffic and crowds
5. SPD will demonstrate the ability to maintain security operations

PHSKC Objectives:

1. PHSKC will demonstrate the ability to implement and maintain an on-scene personnel identity management system

Capability: Emergency Triage and Pre-Hospital Treatment

PHSKC Objectives:

1. PHSKC will demonstrate the ability to implement and coordinate effective, reliable interoperable communications between emergency management services (EMS), incident command, public health, and healthcare facilities
2. PHSKC will demonstrate the ability to implement and maintain accountability procedures for EMS personnel, equipment, and supplies

Capability: Emergency Operations Center Management

Overarching Objective:

1. Demonstrate the ability to activate the Emergency Operations Center during a pandemic in accordance with existing SOPs

PHSKC Objectives:

1. PHSKC will demonstrate the ability to activate the emergency operations center (EOC) and MAC Group in response to a pandemic influenza.
2. PHSKC will demonstrate the ability to coordinate with non-government agencies and/or private sector to collect/share data on incident situation
3. PHSKC will demonstrate the ability to collect, analyze, and disseminate information and intelligence and will develop, post, and distribute situation status updates for Emergency Support Function (ESF) 8 to response partners
4. PHSKC will demonstrate the ability to identify and coordinate needs/issues between Area Command, alternate care facility (ACF), and local emergency management to support logistical needs of field responders.
5. PHSKC will demonstrate the ability to provide direction, information, and/or support as appropriate to incident command and MAC
6. PHSKC will demonstrate the ability to coordinate resource logistics and distribution

WA DOH Objectives:

1. WA DOH will demonstrate the ability to establish and maintain channels of communication between DOH EOC, Shoreline incident command, and State EOC
2. WA DOH will demonstrate the ability to activate the DOH EOC in accordance with Department of Health Emergency Operations Plan
3. WA DOH will demonstrate the ability to meet resource requests
4. WA DOH will demonstrate the ability to mobilize the DOH RSS Task Force
5. WA DOH will demonstrate the ability to deploy and communicate with DOH liaison to local affected jurisdiction
6. WA DOH will demonstrate the ability to conduct a successful shift change
7. WA DOH will demonstrate the ability to coordinate and fill resource requests from the Divisions based on Pandemic Influenza Contingency Plans.

WA DOH Objectives for State EOC:

1. State EOC will demonstrate the ability to task and track assignments to the DOH EOC appropriately and timely
2. State EOC will demonstrate the ability to effectively operate the State ESF 8 desk by clearly defining roles and responsibilities of staff working at the desk.

Capability: Epidemiological Surveillance and Investigation

Overarching Objective:

1. Demonstrate the ability to conduct epidemiological investigations to identify potential exposure and disease during a pandemic in accordance with existing SOPs

PHSKC Objectives:

1. PHSKC will demonstrate the ability to facilitate reporting consistent with disease reporting laws and regulations
2. PHSKC will demonstrate the ability to compile surveillance data
3. PHSKC will demonstrate the ability to analyze surveillance data
4. PHSKC will demonstrate the ability to conduct epidemiological investigations to identify potential exposure and disease
5. PHSKC will demonstrate the ability to confirm the outbreak using lab data and disease tracking data
6. PHSKC will demonstrate the ability to define case characteristics
7. PHSKC will demonstrate the ability to recommend control measures for outbreak
8. PHSKC will demonstrate the ability to draft and disseminate initial report of epidemiological investigation

WA DOH Objectives:

1. WA DOH will coordinate and support an epidemiological emergency response
2. WA DOH will demonstrate the use of the NIMS ICS to respond to the emergency

Capability: Medical Supplies Management and Distribution

PHSKC Objectives:

1. PHSKC will demonstrate the ability to provide logistics support for medical supplies management and distribution
2. Seattle Police Department will demonstrate the ability to establish security checkpoints in vicinity of medical supplies warehouse, at staging areas, and facilities

WA DOH Objectives:

1. WA DOH will demonstrate the ability to request Strategic National Stockpile (SNS) resources
2. WA DOH will demonstrate the ability to mobilize and deploy the RSS staff
3. WA DOH will demonstrate the ability to activate the RSS within 6 hours of notification
4. WA DOH will demonstrate the ability to receive, stage, and inventory SNS resources
5. WA DOH will demonstrate the ability to deliver SNS resources to local distribution points within 12 hours of receipt
6. WA DOH will demonstrate the ability to mobilize staff to support RSS operations

Capability: Medical Surge

Overarching Objective:

1. Demonstrate the ability to activate alternative care sites and/or overflow emergency medical care facilities to manage hospital surge capacity during a pandemic in accordance with existing SOPs

PHSKC Objectives:

1. PHSKC will demonstrate the ability to implement incident response communications within the healthcare system
2. PHSKC will demonstrate the ability to consider the implementation of altered standards of care
3. PHSKC will demonstrate the ability to activate alternative care sites and/or overflow emergency medical care facilities to manage hospital surge capacity
4. PHSKC will demonstrate the ability to support medical surge capacity by using volunteer resources
5. PHSKC will demonstrate the ability to mobilize non-medical support personnel
6. PHSKC will demonstrate the ability to provide just-in-time training for staff performing non-standard duties
7. PHSKC will demonstrate the ability to coordinate and integrate with State ESF 8

Capability: On-Site Incident Management

Overarching Objective:

1. Demonstrate the ability to establish incident command during a pandemic in accordance with existing SOPs

PHSKC Objectives:

1. PHSKC will demonstrate the ability to direct and coordinate with arriving local and regional first responders
2. PHSKC will demonstrate the ability to establish incident command

Capability: Public Health Laboratory Testing

WA DOH Objectives:

1. WA DOH will demonstrate the ability to provide essential lab services when day-to-day capabilities are exceeded

Capability: Responder Safety and Health

PHSKC Objectives:

1. PHSKC will demonstrate the ability to designate a Safety Officer within the Incident Command System
2. PHSKC will demonstrate the ability to ensure ongoing safety and health assessments of response operations
3. PHSKC will demonstrate the ability to observe the scene and review/evaluate hazard and response information as it pertains to the safety of all persons at the location
4. PHSKC will demonstrate the ability to provide command structure with observation-based recommendations for the safety of on-site personnel

Capability: Volunteer and Donations Management

PHSKC Objectives:

1. PHSKC will demonstrate the ability to implement system to check credentialing of skilled volunteers if necessary

SCENARIO SUMMARY

The FSE was conducted over 4 days and included the simulation cell (SimCell) and numerous participating venues including but not limited to:: Control Cell, PHSKC Communicable Disease/Epidemiology, PHSKC ESF-8 Area Command Center, PHSKC Public Health Information Center (PHIC), Washington DOH Shoreline Facility, Washington DOH Emergency Operations Center, Washington State Emergency Operations Center, PHSKC Public Information Call Center (PICC), and an alternate care facility (ACF).

The Pandemonium 2008 FSE scenario begins with a woman and her father going to a central province in China to buy antiques for the father's antique exporting business in Beijing. Between November 4th and 6th the woman and her father go door to door in search of antiques with close contact with families. On November 4th both unknowingly become infected.

On November 6th the woman, her mother and father, and her best friend fly to Vancouver, British Columbia, where she is to be married to a King County, Washington resident. On November 7th the bride's father hosts a pre-wedding dinner party with wedding guests, 80 of whom have come

from King County. At that party 13 King County residents become infected after having close contact with both the bride and her father who are not yet symptomatic but have become contagious. The wedding is held on November 8th. On November 9th several out-of-town guests leave Vancouver. The bride and groom leave on a secret honeymoon to the Canadian Rockies.

On November 12th case number 5 (Lilly Yeng) becomes the first to become ill. She dies in the early morning hours of November 13th. Exercise Play begins on November 13th.

Major Events

Day One, November 13, 2008

- Media reports that World Health Organization declares Pandemic Phase 4 based on declaration of an outbreak in China. Declaration is confirmed by CDC.
- Public Health – Seattle & King County (PHSKC) Communicable Disease (CD) Epidemiology (Epi) Team responds to local health system increase in influenza cases
- PHSKC Preparedness activates ESF-8 Area Command Center to support CD Epi
- PHSKC Communications Team activates Public Health Information Center (PHIC)
- WaDOH CD-Epi and the Washington State Public Health Lab response to the event in support of PHSKC

Day Two, November 14, 2008

- Based on CD Epi response, PHSKC ESF-8 Area Command Center (ACC) activates ESF-8 Multi-Agency Coordination (MAC) Group setting up a meeting to review topics including health system status, decision making regarding changing protocol, and setting up an ACF
- PHSKC ESF-8 ACC remains activated
- PHIC remains activated
- PHSKC requests resource support, including Strategic National Stockpile (SNS) assets, from King County Office of Emergency Management
- Washington State DOH and State activate EOCs in response to events in King County that spreads to surrounding counties.
- Washington DOH coordinates SNS assets at reception, staging, and storage (RSS) location

November 15-16, Exercise Play On Hold

Day Three, November 17, 2008

- Due to increased calls to PHSKC, PHIC activates Public Information Call Center (PICC)

- Washington State DOH receives SNS assets at Reception Storage and Staging Facility, processes the material, and delivers assets to a limited number of King County hospitals, PHSKC distribution center, and PHSKC ACF.
- PHSKC ESF-8 ACC remains activated, monitors PICC operations, and SNS delivery
- Washington State and State DOH EOCs remain activated to support response activities.
- Washington State Department of Health conducts Continuity of Operations Exercise throughout the agency.

Day Four, November 18, 2008

- ACF Activation
- Washington State DOH EOC remains activated to support response activities as flu spreads throughout the state.

CHAPTER 3: ANALYSIS OF CAPABILITIES

This chapter of the report reviews the performance of the exercised capabilities, activities, and tasks. In this chapter, observations are organized by target capability for each organization. This chapter lists capabilities linked to Pandemonium 2008 Full Scale Exercise (FSE) objectives. Each activity is followed by related observations, which may include references, analyses, and recommendations.

Public Health - Seattle & King County Communicable Disease/Epidemiology

Demonstrated Targeted Capabilities:

Emergency Public Information and Warning
Epidemiological Surveillance and Investigation

CAPABILITY: EMERGENCY PUBLIC INFORMATION AND WARNING

Capability Summary: Develop, coordinate, and disseminate accurate alerts and emergency information to the media and the public prior to an impending emergency and activate warning systems to notify those most at-risk in the event of an emergency. By refining its ability to disseminate accurate, consistent, timely, and easy-to understand information about emergency response and recovery processes, a jurisdiction can contribute to the well-being of the community during and after an emergency.

Outcome: Public Health Seattle King County (PHSKC) Communicable Disease (CD) Epidemiology (Epi) took 3 hours, several phone calls, several situation briefings, and a personal visit from the PIO for lead members of the CD Epi staff to approve the initial message to the media/public regarding the situation. The staff made comments that they had a difficult time believing the artificialities in the exercise scenario, which may have influenced their level of play.

Activity 1: Manage Emergency Public Information and Warnings

Observation 1.1 (Area for Improvement): There was a delay in communicating initial surveillance and epidemiological information to health providers (via the Information and Alert Network [IAN]).

Reference(s):

1. Epidemiologic Response for Outbreaks and Investigations, Information Section (version 3)

Analysis: Sending an IAN Alert to local providers was discussed at the 0900 PHSKC ACC staff meeting. This initial notification was critical to establish a baseline to the evolving health crisis and to inform providers about treatment, testing protocols and criteria for personal protective equipment (PPE). The Communications Team immediately identified the need for getting the IAN message out to providers, but the delay led to confusion as providers saw an increasing number of affected patients without the situation awareness of PHSKC.

It took several phone calls and a personal visit from the public information officer (PIO) for lead members of the CD Epi staff to approve a message to the media/public regarding the situation. By that time, vital information had changed and was not included because of the new information had not been vetted and authorized by CD Epi. The Alert was sent out around noon but, by design, only went to participating hospitals (not to all local health providers). Initially, CD Epi and then later, the Area Command Center (ACC) received calls from providers, the public, and the media for over an hour before the IAN message was transmitted by email and fax (the initial faxed message did not have "*This is an Exercise*" clearly marked on it, which caused some initial confusion for the recipients of the faxed version). Responses to these calls were delayed, due to CD Epi's inability to authorize new situation status messages in a timely manner, causing frustration to providers. For PHSKC to be the lead in public health information during an event, staff must receive and transmit coordinated, prompt, useful, and reliable information regarding potential threats to their health and safety, through clear, consistent information delivery systems.

Recommendation(s):

1. Revise response plans to emphasize initial situation status with healthcare providers during an evolving situation
2. Stream line process to authorize IAN alerts and updates
3. Prioritize situational information to disseminate to appropriate agencies and include timeframe that further information will follow
4. Coordinate release of situational status with PIO and Washington (WA) State Department of Health (DOH)

Observation 1.2 (Area for Improvement): Surveillance information was not communicated between CD Epi, Public Health Information Call Center (PHIC), Area Command Center (ACC), and other partners on a regular basis.

Analysis: How to triage incoming calls/information, working with the PIO, and sending a Health Alert were all discussed at this initial meeting; however, a clear plan to communicate with the ACC and to put other areas of the health department on alert about the evolving situation was not articulated until the second staff meeting (9:52 am). This likely resulted in several outcomes: delays in identifying and receiving additional people for surge capacity and in coordinating efforts with the PIO. The CD/Epi liaison did feel he had good communication with the ACC, but noted a delay in the ACC-assigned surge capacity – reasons for this were not entirely clear, but may have been due to the delay in the request, the perceived unclear instructions for where

additional workers were to report, or the true lack of identified resources during the exercise (and possibly a real event). During the surge capacity training that occurred at 10:40am, only four CD/Epi personnel received training (no one from other divisions of the Health Department was trained). Uncoordinated and repetitive training sessions may be necessary and a true reality as the situation initially evolves, but will certainly deplete resources and decrease efficiency during this critical period. The delay in communication with the PIO also likely contributed to the length of time it took to issue the first press release – it reportedly took several hours for the PIO to receive CD/Epi's requested approval of the press release before being disseminated to the public.

CD Epi did not have awareness of a PICC resource, and spent time establishing a provider call center and a recorded information line for the general public.

In debrief, CD Epi staff members noted favorably the fact that public information staff were "kept away from them", referring to a sense of lack of designated reporting system in the past.

Recommendation(s):

1. Establish policy for timeline of initial CD/Epi message release
2. Designate CD/Epi liaison to physically sit in the ACC, to be available to the PIO, and joint information center (JIC) and to appreciate communication needs
3. Develop pre-canned message templates with CD Epi staff input
4. Train CD Epi staff on role in emergency public information and warning, message development and coordination, and available communication resources (PICC, Community Communications Network, WATrac)

Observation 1.3 (Strength): The alerting system and lists from CD/Epi worked well for most hospital systems.

Analysis: Some organizations need to update the contacts on their lists, a reality for any distribution list/notification system.

Recommendation(s):

1. Update contact list for distribution of alerts and warnings

Activity 2: Provide Rumor Control

Observation 2.1 (Area for Improvement): There was often confusion between ACC/WA DOH EOC/ PHSKC CD Epi about information regarding the number of patients involved and status of the investigation.

Analysis: It was difficult for the PHSKC PHIC to obtain status reports or updates from CD Epi. This impeded rumor control and caused incorrect information to be released several times.

Recommendation(s):

1. Activate JIC to monitor rumors/provide control
2. Establish policy for CD Epi situation status report development and dissemination
3. Consider integration of reporting system into WATrac to improve access to up-to-date information

CAPABILITY: EPIDEMIOLOGICAL SURVEILLANCE AND INVESTIGATION

Capability Summary: The Epidemiological Surveillance and Investigation capability is the capacity to rapidly conduct epidemiological investigations. It includes deliberate and naturally occurring exposure and disease detection, rapid implementation of active surveillance, maintenance of ongoing surveillance activities, epidemiological investigation, analysis, communicating with the public and providers about case definitions, disease risk, mitigation, and recommendations for the implementation of control measures.

Outcome: Potential exposure, case definition, and disease were identified rapidly by PHSKC CD Epi. Cases were reported immediately to all relevant public health agencies and healthcare providers. Lab specimens were ordered and sent to the State Public Health Lab in a timely manner. Suspected cases were investigated promptly; new suspect cases were identified and characterized based on case definitions; the source of exposure was determined to be a wedding; and, effective mitigation measures were communicated to the public, providers, and relevant agencies/departments.

Activity 1: Surveillance and Detection

Observation 1.1 (Strength): The CD Epi team did an excellent job of defining tasks to accomplish and assigning them to the various team members.

Analysis: CD Epi staff aggressively pursued case information despite challenges in doing so (were given less complete information on patients from health care sources than might be expected during a real event). They prioritized information-gathering – focused on dead or very ill patients once scope of scenario was evident. Roles were quickly delineated and assigned based on these identified tasks and individuals worked extremely well as a team.

The staff worked efficiently within the system to obtain labs quickly to help confirm the diagnosis (delay in having lab results from state lab was not due to delay in specimen collection and processing at PHSKC level). They identified wedding early in exercise as the common link.

Recommendation(s):

None

Observation 1.2 (Area for Improvement): There was difficulty with ongoing surveillance data management for rapidly evolving situation

Reference(s):

1. Outline for Epidemiologic Response for Outbreaks and Investigations (Incident Command System [ICS] format, version 3)
2. Discussion with data manager

Analysis: As information began coming in more quickly, it became clear that maintaining up-to-date CD Epi information on cases reported and under investigation was challenging. There was no coordinated system for recording case investigations. Most of the initial case recording was entered into the CD Epi database (this populates a comprehensive influenza database) by the administrative specialists. Some cases were entered by the CD Epi staff if the phone calls by-passed the administrative specialist. Not all information was entered into the CD Epi database in a timely manner. Surge staffing with just-in time training was needed after only a short time into the exercise.

The CD Epi liaison to the ACC noted that the information he was providing to the ACC was based on information shared at the three CD Epi staff meetings; however, at the times he met with ACC, that information may have been out of date. There was a continual delay in communicating situation status to ACC, DOH and hospitals, and no communication with ambulatory healthcare providers. DOH contacts were not receiving initial PHSKC CD Epi information, as they were not on the blast e-mail list that was used to disseminate information. The initial information about treatment guidelines and managing oseltamivir supply was not sent. Some of the hospitals requested this information. Using WATrac might allow real-time updating. However, having an official CD Epi situation update board which is kept current by the data manager and could be monitored by the ACC would be an improvement.

Recommendation(s):

1. Establish data management roles for surge issues
2. Data entry personnel to use separate room with laptops to enter data as it came
3. Train administrative staff on data entry using the pandemic influenza Microsoft Access database on the shared portal
4. Have a single data manager responsible for ensuring completed information is entered as rapidly as possible
5. Determine system to regularly share situation updates with ACC/Communication/DOH and appropriate healthcare agencies.
6. Have comprehensive blast fax list to include hospitals, healthcare providers, and appropriate state, local and federal agencies for disseminating public health information

Observation 1.3 (Area for Improvement): There was a lack of coordination and assistance between CD Epi, ACC, and other areas of PHSKC

Reference(s):

1. Outline for Epidemiologic Response for Outbreaks and Investigations, Liaison Section (ICS format, version 3)

Analysis: ICS structure within CD Epi was recognized and discussed in the first staff meeting at 0900 hours. There was some confusion about the need to establish ICS for this exercise, since CD/Epi has an operational mission, and that participants felt it was unrealistic to establish an ICS structure. This resulted in some initial distraction and discussion of how/when/in what order ICS is implemented. Without adhering to an ICS structure, the lines of communication between departments were not clear.

Recommendation(s):

1. Prepare written response plans to include early communication with the ACC (or if the ACC is not yet activated, notification of the Preparedness Division) of the need for surge personnel
2. Establish clear guidelines for an early alert notification to other areas of the Health Department, including Emergency Services, in the Response Plan

Emergency Support Function-8 Area Command Center

Demonstrated Targeted Capabilities:

Communications
Critical Resource Logistics and Distribution
Emergency Public Information and Warning
Emergency Operations Center Management

CAPABILITY: COMMUNICATIONS

Capability Summary: Communications is the fundamental capability within disciplines and jurisdictions that practitioners need to perform the most routine and basic elements of their job functions. Agencies must be operable, meaning they possess sufficient wireless communications capabilities to meet their daily internal and emergency communication requirements before they focus on interoperability, which means being able to work with other agencies.

Communications interoperability is the ability of public safety agencies (e.g. police, fire, emergency medical services (EMS)) and service agencies (e.g. public works, transportation, hospitals) to talk within and across agencies and jurisdictions when needed and authorized using various communications systems to exchange voice, data, and/or video with one another on demand or in real time. It is essential that public safety has the intra-agency operability it needs, and that it builds its systems toward interoperability.

Outcome: After an initial delay in communications between PHSKC Communicable Disease (CD) Epidemiology (Epi) and the Area Command Center (ACC), a continuous flow of critical information was received and disseminated among the multi-jurisdictional and multi-disciplinary emergency responders, command posts, agencies, and governmental officials for the duration of the exercise in compliance with National Incident Management System (NIMS). The PHSKC PHIC worked closely with the Command Staff, to include the consideration of critical components, networks, support systems, personnel, and an appropriate level of redundant communications systems that may be needed in response to a pandemic influenza scenario.

Activity 1: Provide Incident Command/First Responder/First Receiver/Interoperable Communications

Observation 1.1 (Area for Improvement): CD Epi staff need to better understand the urgency of disseminating the initial health alert to health providers via the Information and Alert Network (IAN).

Reference(s):

1. Outline for Epidemiologic Response for Outbreaks and Investigations, Information Section (ICS format, version 3)

Analysis: Sending a health alert to local providers was discussed at the first (0900 hrs) of three staff meetings during the exercise and is a component of the Response Plan under the "Information" heading. However, there was a delay in sending the information out until around noon and at that time it went, by design, only to hospitals (not to all local health providers). Calls from providers, the public, and the media were coming in for over an hour before the information was transmitted by email and fax (the faxed information did not have "Exercise" clearly marked on it, so caused some initial confusion for the recipients of the faxed version).

While the need for getting this information out was identified early on, there was delay in sending it that seemed to be caused by not recognizing the urgency of this communication in the context of the rapidly escalating situation. This led to confusion and possibly an increased sense of panic as providers saw an increasing number of affected patients without being aware of the situation and information as it was known by PHSKC at that time. It also could have resulted in misinformation and unnecessary provider and community anxiety depending on what information made it into the media at that point. This initial notification is critical in establishing that the health department and medical facilities are aware and in control of the situation to the extent possible as it develops and in informing providers about treatment and testing protocols and need for personal protective equipment (PPE). While it is necessary to have an appropriate approval chain for this information before it is widely disseminated (and becomes available to media), there must be a streamlined process in place and recognition that frequent updates may be necessary as the situation rapidly evolves. Basic situational information needs to be prioritized to get out to appropriate resources as quickly and accurately as possible and can and should include the statement that further information will follow (identifying the mechanism if possible) as it becomes available.

Recommendation(s):

1. Revise response plans to include emphasis on the importance of this initial communication with the healthcare system during an evolving situation; guidelines on target timeframes to disseminate information; and guidelines to expedite the approval process before dissemination
2. Revise communications plan to coordinate release of information with public information officer (PIO) activities including State Department of Health (DOH)

Observation 1.2 (Area for Improvement): Internal communications were not sufficient to keep staff informed during the initial response

Reference(s):

1. Communications Plan
2. Pan Flu Annex
3. Overarching Objectives: 1
4. PHSKC Objectives: 1, 2, 4, 8

Analysis: The initial focus of outreach was on getting information to the media. The end result was that communication to staff was lacking and only completed as the final component. This resulted in the front desk overwhelmed with calls and the staff being personally and professional concerned with the lack of internal information.

Messages are needed as soon as possible for front desk staff. Information for staff should be developed to reflect the key messages being given to the public.

Providing key messages to staff, in a manner that is personalized to them, allows them to assist on several levels:

- Staff is able to share a consistent message in a chaotic environment.
- Staff is aware of the scope of the response and can better recognize their own role and responsibility in the situation.
- Partners, such as communicable disease (CD) epidemiology (Epi), may provide better or faster response on message development to other partners/audiences.

Recommendation(s):

1. PHSKC Communications should develop a plan to prioritize internal communications in plans and pre-message development

Observation 1.3 (Area for Improvement): Several technical issues with WATrac hindered staff members' abilities to respond in a timely manner

Reference(s):

1. Communications Plan
2. Pan Flu Annex
3. Overarching Objectives: 1
4. PHSKC Objectives: 1, 2, 3, 4, 5, 6, 7, 8

Analysis: WATrac experienced a few technical issues that were corrected immediately, where possible.

- Command Center had difficulties posting certain document types and that was corrected when reported
- Some users did not have Adobe Flash Player 9 installed on their computers which made Command Center unusable.
- We learned that it is necessary to close the command center rooms at the end of each operational period to reduce the visual clutter seen by users.

Some users had difficulty remembering their username and password. This is a common issue for all password protected systems.

WADOH EOC staff had difficultly interpreting the information from the Regional Status Screen. This can easily be remedied with staff training which they are in the process of developing.

Computers being used for remote access cannot be used on site by available staff. Older laptops have difficulty with new web-based activities and delay activities.

Staff trained in WATrac and who had access to the appropriate rooms were able to consistently enter the system, and found it to be an outstanding method of coordination and communication. This was despite the fact that Public Health Information Center (PHIC) staff did not have access to where situation reports were posted - vital information for all players. WATrac's Knowledge Base was also despite the fact that the older laptops repeatedly locked up or functioned incredibly slowly, and some desk computers designated for exercise participation were not available because staff was signed in remotely.

The surge staff was frustrated by the delay in acquiring access to WATrac and in some instances could not enter the system, were initially put into incorrect information areas, or could not find needed information. On the final day of the exercise, the system was extremely slow for all players.

The communications surge team did not have timely access to many tools, such as WATrac or the internet. Several team members were not familiar with WATrac and could not utilize the system properly. Surge team members who do not use the system regularly could not remember how to utilize the software.

Employees not participating in the exercise were encouraged to telecommute so that their computers would be available to exercise players. However, the surge team discovered that if an employee logs into the system via remote access, the network is not available to someone else using their computer.

Access to computers in general was not consistent. Information technology (IT) staff resolved several access issues, but it took time and energy away from response activities.

Recommendation(s):

1. Continue to develop procedures and training with regard to technological issues
2. Identify what network/software access is needed for staff and where the information will be available
3. Provide access and training on necessary sites for core staff and any expected surge staff
4. Develop a streamlined, tested process for gaining access for anyone who may be involved in the response
5. Develop just-in-time training for WATrac
6. Obtain updated laptop availability for communications staff.

7. Work with Management Information Systems (MIS) to troubleshoot and resolve difficulties staff have when logging in on other employees' computers
8. Develop backup routes to access materials should technology fail

CAPABILITY: CRITICAL RESOURCE LOGISTICS AND DISTRIBUTION

Capability Summary: Critical Resource Logistics and Distribution is the capability to identify, dispatch, mobilize, and demobilize, as well as to accurately track and record available human and material critical resources throughout all incident management phases. Critical resources are those resources necessary to preserve life, property, safety, and security.

Outcome: Critical resources were readily identified and made available to PHSKC ESF 8 ACC staff. There were a few lessons learned about use and availability of WATrac. Incident Command and agency emergency responders received distribution of resources upon request. Situation Status/Reports were updated and posted in the ESF 8 ACC and they displayed "real time" situation.

Activity 1: Direct Critical Resource Logistics and Distribution Operations

Observation 1.1 (Area for Improvement): Non-hospitals (e.g., clinics) did not have access to WATrac; therefore, those facilities could not provide Strategic National Stockpile (SNS) receipt information through that system or receive SNS delivery updates

Reference(s):

1. EEG: Critical Resource Logistics and Distribution, Activity 3

Analysis: The use of WATrac for tracking SNS supplies was very innovative. One issue, though, was that hospitals had access to WATrac but non-hospitals did not. Hospitals could update their SNS resource receipt status on WATrac while clinics and other non-hospital facilities had to call Logistics to provide receipt status updates. Non-hospital facilities also could not access the WATrac chatroom that hospitals could access that provided real-time updates on SNS delivery times and other issues.

Recommendation(s):

1. Grant other health partners who may receive SNS supplies access to WATrac and provide training so that they can also use the system to update SNS receipt status

Observation 1.2 (Area for Improvement): The replacement Area Commander was not quickly granted access to the WATrac resource request tracking tool

Reference(s):

1. EEG: Critical Resource Logistics and Distribution, Activity 3

Analysis: At one point in the exercise, the Area Commander turned over his duties to a new Area Commander to simulate a shift change. The new Area Commander was not automatically granted access to the medical resource request tracking tool on WATrac. It was unclear whether the handover of the Area Commander duties was promptly communicated to all ACC staff – this may have been an attributing factor to his lack of access. It was also unclear whether WATrac had a streamlined or automatic approach for granting replacement Area Commanders the same access to documents and WATrac rooms that the previous Area Commanders had.

Recommendation(s):

1. Ensure that there is a protocol for granting access to appropriate WATrac documents and WATrac rooms for replacement staff during the turnover process

CAPABILITY: EMERGENCY PUBLIC INFORMATION AND WARNING

Capability Summary: Develop, coordinate, and disseminate accurate alerts and emergency information to the media and the public prior to an impending emergency and activate warning systems to notify those most at-risk in the event of an emergency. By refining its ability to disseminate accurate, consistent, timely, and easy-to understand information about emergency response and recovery processes, a jurisdiction can contribute to the well-being of the community during and after an emergency.

Outcome: Throughout the exercise play, the PHSKC Public Health Information Center (PHIC) effectively established timelines for media releases, gathered information and developed alerts and warnings that were distributed to public and private sectors and relevant government agencies. The team received and transmitted coordinated, prompt, useful, and reliable information regarding threats to health and safety.

Activity 1: Manage Emergency Public Information and Warnings

Observation 1.1 (Strength): The PHSKC Communications Team, activated as the PHIC, is well organized, prepared, and integrated

Reference(s):

1. Communications Plan
2. Pan Flu Annex
3. Overarching Objectives: 1 and 2
4. PHSKC: 1, 2, 3, 4, 5, 6, 7, 8A

Analysis: Throughout the exercise members of the PHIC expressed their professional views and worked through differences in opinion in wording, outreach techniques, and message emphasis. Staff encouraged each other to get materials approved and disseminated.

Different strengths in staff members are recognized and used appropriately. For example, some have a focus on detail; others have more knowledge of vulnerable populations. The skills are appreciated and sought out by others in the group.

Staff members took initiative to develop pre-written messages and templates. Staff members were always thinking about translation to reach varied audiences and how to reach community partners.

Recommendation(s):

1. Continue to provide training and exercise opportunities for the communications team

Observation 1.2 (Strength): The PHSKC Communications Surge Team was well prepared and integrated well despite technical issues.

Reference(s):

1. Communications Plan
2. Pan Flu Annex
3. Overarching Objectives: 1 and 2
4. PHSKC: 1, 2, 3, 4, 5, 6, 7, 8A

Analysis: Surge staff expressed confidence in their ability to contribute to the team, having received clear direction and support. Different surge staff joined the team on two different days. Each member quickly produced needed materials in a quality manner, reflecting appropriate training and information provided.

Recommendation(s):

1. Continue to provide training and exercise opportunities for the communications surge team

Activity 2: Activate Emergency Public Information, Alert/Warning, and Notification

Observation 2.1 (Area for Improvement): Production of press releases and media interaction drove public outreach.

Reference(s):

1. Communications Plan
2. Pan Flu Annex

3. Overarching Objectives: 2
4. PHSKC Objectives: 1, 2, 3, 4, 6, 7, 8

Analysis: On the first day of the event, various partners were requesting information. The team response was focused on the press releases. The structure of materials production was to produce a press release and then develop messaging for public health staff, partners, and general public from that source material. This structure led to a delay in outreach material development, as the press release was delayed in the approval process several times. The process improved over the three days.

In response plans, structure the response to begin with the development of key messages. These messages should then be posted in the ACC and distributed as appropriate. Assignments for materials development are then made and materials developed congruently. As the situation evolves, the key messages are revised, and the cycle of development and outreach continues. Given the nature of the pandemic influenza response, many of the key messages may be predetermined along with basic templates for associated materials to various audiences. This also allows for materials for vulnerable populations to be translated and vetted without time constraint.

Recommendation(s):

1. PHSKC PHIC should identify the development of key messages as a priority into the communications plan

CAPABILITY: EMERGENCY OPERATIONS CENTER MANAGEMENT

Capability Summary: Emergency Operations Center (EOC) management is the capability to provide multi-agency coordination (MAC) for incident management by activating and operating an EOC for a pre-planned or no-notice event. EOC management includes: EOC activation, notification, staffing, and deactivation; management, direction, control, and coordination of response and recovery activities; coordination of efforts among neighboring governments at each level and among local, regional, State, and Federal EOCs; coordination of public information and warning; and maintenance of the information and communication necessary for coordinating response and recovery activities. Similar entities may include the National (or Regional) Response Coordination Center (NRCC or RRCC), Joint Field Offices (JFO), National Operating Center (NOC), Joint Operations Center (JOC), Multi-Agency Coordination Center (MACC), Initial Operating Facility (IOF), etc.

Outcome: The response was effectively managed within the PHSKC ESF 8 ACC. Coordination between departments went smoothly for the most part, with a few problems getting timely information from PHSKC CD Epi on the first day of exercise play. Roles and responsibilities were identified by use of ICS. ICS positions were assigned, and throughout the exercise, roles were NIMS compliant. It was evident that all players in the PHSKC ESF 8 ACC

were given thorough training, and the shifts were seamless. Incident action plans (IAPs) were developed each day of play for the next operational period. Command and Staff briefings were delivered in a timely manner, with appropriate information gathered, analyzed, and delivered.

Activity 1: Activate EOC/ACC/MAC

Observation 1.1 (Area for Improvement): All ACC staff were not connected to a single chat/information room on WATrac

Analysis: The Planning Section maintained a log/chat room; however that information was not shared with the whole ACC. Having a room set up on WATrac where all ACC staff can post notes/documents, etc., would be beneficial so that everyone can maintain situational awareness.

Recommendation(s):

1. Consider creating a significant events log or some sort of document/information room for the ACC

Observation 1.2 (Area for Improvement): ACC staff identified the need for more templated forms and reports**.**

Analysis: ACC staff recommended having more templates available (ready to go before an exercise or real world event) to enable consistency in forms by all staff as well as so save time when writing up various documents.

Recommendation(s):

1. Identify and develop templates for frequently used forms and reports. Consider storing the templates in a file on WATrac

Observation 1.3 (Area for Improvement): The role of the PHSKC ESF 8 ACC Planning Section Operator was not clearly defined.

Reference(s):

1. EEG: Emergency Operations Center Management, Activity 2

Analysis: The operator in the PHSKC ESF 8 ACC Planning Section answered caller questions instead of forwarding the calls to a liaison officer, public information officer, or the joint information center (JIC). The role of the Planning Section is not to answer random public inquiries. It was also not clear if the operator was explaining the situation in a way that was consistent with the messaging of the PIO or Area Commander. The evaluator did not observe any briefings with the operator where messaging was discussed.

Recommendation(s):

1. If using an operator make sure that the operator is aware of the scope of the calls that position should answer according to ICS

Activity 2: Support and Coordinate Response

Observation 2.1 (Area for Improvement): The PHSKC ESF 8 ACC Planning Section did not demonstrate a clear information-sharing strategy with community partners

Reference(s):

1. EEG: Emergency Operations Center Management, Activity 2

Analysis: The evaluator did not observe any discussions on an information-sharing strategy with community-based organizations and private sector among the PHSKC ESF 8 ACC Planning Section members. The Planning Section did discuss possible insufficiency of messaging to community-based organizations, especially on the agency website. One gap mentioned was getting the message to faith-based groups.

The Planning Section sent out a situation snapshot to members of their Health ACC email address group (unclear on what organizations were included) and a press release and survey were emailed out to community groups that PHSKC had relationships with. Methods besides email were not employed in this exercise and there was no discussion on how community groups with no previous contact with PHSKC could be contacted for information. Other methods were simulated and identified throughout the exercise: conference calls at least daily with hospitals, local emergency management, businesses, neighboring counties, elected officials, and schools. Also, there were in-person briefings by the local health officer to the Board of Health and the county executive.

Recommendation(s):

1. Use multiple modes of communications (besides email) to share information, such as the situation snapshot
2. Identify an information-sharing strategy that includes groups that would be especially vulnerable or reluctant to work with Public Health during a pandemic

Observation 2.2 (Area for Improvement): There were gaps in the regional coordination and communication between the hospitals and healthcare system and Health and Medical Area Command.

Reference(s):

1. HSEEP Volume III: Exercise Evaluation and Improvement Planning

Analysis: The information received by the hospitals in regards to the ACF was good. There are concerns about how the ACF will handle behavioral health patients. A plan similar to how pediatrics are handled was suggested. A mission number for the event was not communicated to

the hospitals. The hospitals conference calls are a great way to communicate situation updates and get feedback on the healthcare system quickly. Hospitals need to review the conference call etiquette. A note taker should be assigned to future calls to capture minutes, or the call should be recorded. Hospitals prefer Health and Medical Area Command provide the administrative assistance on this call in the future.

Recommendation(s):

1. Regional team assist in exploring just in time training and fit testing for N95s and PAPRs
2. Health and Medical Area Command assign a note-taker to hospital conference calls, and/or record the calls
3. Health and Medical Area Command communicate the mission number of an event to hospitals once one is received/assigned
4. Behavioral Health plan be developed for the ACF, similar to the pediatrics plan

PHSKC Emergency Support Function-8 Multi-Agency Coordination Group

Demonstrated Targeted Capabilities:

Emergency Operations Center Management

CAPABILITY 1: EMERGENCY OPERATIONS CENTER MANAGEMENT

Capability Summary: Emergency Operations Center (EOC) management is the capability to provide multi-agency coordination (MAC) for incident management by activating and operating an EOC for a pre-planned or no-notice event. EOC management includes: EOC activation, notification, staffing, and deactivation; management, direction, control, and coordination of response and recovery activities; coordination of efforts among neighboring governments at each level and among local, regional, State, and Federal EOCs; coordination of public information and warning; and maintenance of the information and communication necessary for coordinating response and recovery activities. Similar entities may include the National (or Regional) Response Coordination Center (NRCC or RRCC), Joint Field Offices (JFO), National Operating Center (NOC), Joint Operations Center (JOC), Multi-Agency Coordination Center (MACC), Initial Operating Facility (IOF), etc.

Outcome: The multi-agency coordination was managed through a pandemic influenza scenario effectively through activation of local and State EOC/Area Command Center (ACC)/MAC. The participants on the MAC Group call November 14, 2008, were appropriate for the level of decision making abilities required for a public health emergency, but lacked training and resources to make this an efficient process.

Activity 1: Activate EOC/ACC/MAC

Observation 1.1 (Strength): The MAC Group meeting was coordinated in response to a pandemic influenza in an appropriate time frame with the appropriate senior officials present based on the scenario provided.

Reference(s):

1. Emergency medical services (EMS) Pan Flu Plan
2. PHSKC Emergency Support Function (ESF) 8 Area Command and MAC Standard Operating Procedure

Analysis: MAC Group meeting occurred November 14, 2008, at 1000 hours. Participants included the Local Health Officer (LHO), medical advisors from Public Health - Seattle & King County and Harborview Medical Center, King County EMS Medical Directors and EMS advisors, representatives from the Medical Examiners Office, members of the King County Healthcare Coalition Executive Council, PHSKC ESF 8 Area Commander and Public Health

Public Information Officer (PIO). The MAC meeting was facilitated by the MAC Coordinator (Chief Administrative Officer for Public Health – Seattle & King County).

Recommendation(s):

None

Activity 2: Support and Coordinate Response

Observation 2.1 (Area for Improvement): During the MAC meeting it was evident that factors influencing an efficient and effective policy decision making process were lacking.

Reference(s):

1. EMS Pan Flu Plan
2. PHSKC ESF 8 Area Command and MAC Standard Operating Procedure

Analysis: A summary of the situation status and policy issues that needed further discussion/advisement was provided to all participants two days before the meeting. At the beginning of the meeting a situation update was provided by the Area Commander and Chief of Communicable Disease and Epidemiology. EMS representatives provided a detailed summary of impacts faced by that healthcare sector, and a set of recommendations for consideration by the LHO to modify EMS response protocols countywide. The Area Commander highlighted the potential impacts that changes to EMS dispatch and response protocols would have on other healthcare sectors. This led to discussions involving multiple participants regarding the implications of modifying standards of care, available capacity, and service protocols on a countywide basis when only a select subset of healthcare organizations in the county have exceeded capacity. .

MAC participants did not use clear text when speaking – acronyms and medical codes were confusing to some of the participants. There was no policy book (briefing book) for MAC Group members that provided information regarding key policy issues and legal authorities. The Healthcare Coalition Executive Council needed advanced briefings on health and medical response plans, specifically EMS, since policy issues may arise regarding any component of the healthcare system during disasters. It was evident that the MAC Group clearly identify decision recommendations during the meeting, yet must also highlight any expected consequences those decisions would have on healthcare sectors.

Recommendation(s):

1. Develop MAC Group briefing book
2. Educate MAC Group members on response plans
3. Healthcare Coalition leadership to provide input on background information laid out in briefing book
4. Further clarify policy issues warranting input from MAC members

Public Health Information Center (PHIC)

Demonstrated Targeted Capabilities:
Emergency Public Information and Warning

CAPABILITY 1: EMERGENCY PUBLIC INFORMATION AND WARNING

Capability Summary: Develop, coordinate, and disseminate accurate alerts and emergency information to the media and the public prior to an impending emergency and activate warning systems to notify those most at-risk in the event of an emergency. By refining its ability to disseminate accurate, consistent, timely, and easy-to understand information about emergency response and recovery processes, a jurisdiction can contribute to the well-being of the community during and after an emergency.

Outcome: Upon ACC activation, an information release cycle was quickly established and maintained. WATrac was established and used throughout the exercise; most staff agreed that it is an outstanding resource and communication tool if they are trained on its application. SECURES was another site used, but since it is not available to all communications staff, its function was minimal. Computers being used for remote access couldn't be used on site by available staff. Older laptops had difficulty with new web-based activities and delay activities.

Activity1 Activate Emergency Public Information, Alert/Warning, and Notification Plans.

Observation 1.1 (Strength): PHIC members have a strong desire to support partners.

Reference(s):

1. Communications Plan
2. Pan Flu Annex
3. Overarching objectives: 2
4. PHSKC Objectives: 1, 2, 3, 4, 5, 6, 7, 8

Analysis: There were frequent discussions regarding how to work with internal and external partners and what resources and information they might need.

Upon ACC activation, an information release cycle was quickly established and maintained, and a staff member was "sent" to support an overwhelmed facility. An ad campaign was quickly envisioned, content determined, and contracting put in place.

Recommendation(s):

1. Incorporate the lessons learned and materials developed into plans.

2. Develop and/or identify materials for an ad campaign based on the key messages and potential flow of events

Observation 1.2 (Strength) PHIC members successfully managed the press briefing and media tour at the ACF.

Reference(s):

1. Communications Plan
2. Pan Flu Annex
3. PHSKC Objectives: 3, 5, 7

Analysis: A media briefing and tour were held at the ACF on Tuesday, November 18th. A press packet was given to each member of the media as they entered. They were taken through the badging process as if they were a volunteer or patient. They were then escorted to the area where a media briefing was to be held. A few of the media, who arrived early, wandered around the ACF and were difficult to find prior to the briefing. The briefing location allowed them to see the setup of the entire room from a raised angle. They were then given a tour of the facility, with mock patients being cared for and transported.

Materials were clear, speakers were appropriate and prepared. PHIC members completed various assignments in organizing and conducting the press briefing and media tour.

Having the JIC take press calls, release PHIC developed information and assist with press briefings allowed the PHIC to focus their efforts on the key messaging issues and make assignments to develop and release materials internally and to partners. There was some discussion of using public health communications partners to assist remotely. There was also a review of the different hotlines operated by PHSKC and a determination of which would be appropriate for using to disseminate information, how to get them updated, how often, etc.

Recommendation(s):

1. Designate a waiting area for media personnel, to prevent them wandering the ACF prior to briefings

Activity 2: Establish Joint Information System

Observation 2.1 (Area for Improvement): Although there were a few technical issues that were corrected immediately, staff who were trained in WATrac, had access to the appropriate rooms, and were able to consistently enter the system found it to be an outstanding method of coordination and communication.

Reference(s):

1. Communications Plan
2. Pan Flu Annex

3. Overarching Objectives: 1
4. PHSKC Objectives: 1,2,3,4,5,6,7,8

Analysis: WATrac experienced a few technical issues that were, where possible, corrected immediately.

- Command Center had difficulties posting certain document types and that was corrected when reported
- Some users did not have Flash 9 installed on their computers which made Command Center unusable.

PHIC staff did not have access to the knowledge board where situation reports were posted ~ vital information for all players. Older laptops repeatedly locked up or functioned incredibly slow, and some desk computers designated for exercise participation were not available because staff was signed in remotely.

PHSKC PHIC surge staff was frustrated by the delay in acquiring access to WATrac and in some instances could not enter the system, was initially put into incorrect information areas, or could not find needed information. On the final day of the exercise, the system was extremely slow for all players.

WA DOH EOC staff had difficultly interpreting the information from the Regional Status Screen. This can easily be remedied with staff training which they are in the process of developing.

It was clear that we need to develop just-in-time training materials for WATrac because there will be users have their first introduction to the system during a response.

Access to computers in general was uncertain. IT staff resolved several access issues, but it took time and energy away from response activities.

Recommendation(s):

1. Further develop procedures and training regarding technological issues
2. Determine what access is needed and where the information will be available
3. Obtain access and train core staff and any expected surge staff on necessary sites.
4. Develop a streamlined, tested process for gaining access for anyone who may be involved in the response
5. Develop just-in-time training for WATrac
6. Designate up-to-date laptop computers for communications staff to use during a response
7. Work with MIS to troubleshoot and resolve difficulties staff have when logging in on other employees' computers
8. Develop backup routes to access materials should technology fail

Observation 2.2 (Strength): PICC was activated and Just-in-Time-Training accomplished to begin operating the PICC

Reference(s):

1. Communications Plan
2. Joint Information Center Annex

Analysis: For some operators this exercise was their first exposure to a PICC. The Just-in-Time-Training (JITT) at the PICC provided important, yet specific, brief and accurate information for all Operators. The only negative aspect noticed by the Evaluator was the emphasis at the beginning of the training to begin each phone conversation with “This is a test”. The resulting interchange of this greeting with the greeting of “This is an Exercise” led to some minor and short term confusion that did not really effect the objectives of the training, but it does highlight the importance of accurate and uniform information at the JITT. Many operators appeared to have a hard time hearing callers due to the high level of background noise. Operators maintained a professional and calm attitude even when dealing with difficult callers and/or technical challenges. The materials provided to the operators including the binders and the use of the website for additional information were thorough. Operators were able to maintain a steady flow of calls for the hour allotted to the exercise without taking long breaks between calls.

Recommendation(s):

1. Provide dual ear headsets to cut down on background noise
2. Use a projector and screen for important information that must be posted

Observation 2.3 (Area for Improvement): Public outreach was initially driven by production of the press release and media interaction.

Reference(s):

1. Communications Plan
2. Pan Flu Annex
3. Overarching Objectives: 2
4. PHSKC Objectives: 1,2,3,4,6,7,8

Analysis: On the first day of the event, various partners were requesting information. The team response was focused on the press releases. The structure of materials production was to produce a press release and then develop messaging for public health staff, partners, and general public from that source material. This structure led to a delay in outreach material development, as the press release was delayed in the approval process several times. The process improved over the three days.

Recommendation(s):

1. Revise plans, checklists, and templates to ensure that key messages are developed, posted in the ACC and distributed as appropriate
2. Develop pre-determined key messages along with basic templates for associated materials to various audiences including translated materials

Activity 3: Issue Public Information, Alerts/Warnings, and Notifications

Observation 3.1 (Area for Improvement): Pre-messaging was needed for the time-period, in which surveillance was initiated, but a disease had not been identified nor victims confirmed.

Reference(s):

1. Communications Plan
2. Pan Flu Annex
3. Overarching Objectives: 1 and 2
4. PHSKC Objectives: 1,2,4,5,6,7,8

Analysis: A number of excellent outreach and information materials were developed in response to nuances of the exercise and should be incorporated into existing plans and support materials. Associated materials for the PICC, internal communication, and special/vulnerable populations were also developed and should be incorporated and enhanced.

Discussion ensued throughout the 3 days of exercise play on which components of the message should be emphasized and at what time should these be worked out in a non-event period. The components in question were home care (and how to perform it), seeing your personal healthcare provider, going to a pharmacy to obtain medical interventions (Tamiflu), calling a resource line, calling a medical information line, mask use, ACF messaging, calling 9-1-1 or going to the hospital only for life-threatening emergency care.

Recommendation(s):

1. Use materials developed in the exercise to enhance existing pre-developed messages and materials
2. Develop likely key messages and related outreach materials and incorporate into the existing plans
3. Revise plans to include new messaging technology and develop plans to monitor and respond to messaging in other venues such as blogs and texting
4. Incorporate PICC, internal communication, and special/vulnerable population needs and messaging in all outreach material development

Observation 3.2 (Strength and Area for Improvement): Translation and access to information for vulnerable populations was a constant consideration in message development.

Reference(s):

1. Communications Plan
2. Pan Flu Annex
3. Overarching objectives: 2
4. PHSKC objectives: 1, 2, 4, 5, 6, 7, 8

Analysis: Frequent discussion was held regarding the need for translation of materials, with the possible desire for additional languages, faster turn around, and concern about the actual quality of the messaging as supporting topics.

There is a high level of awareness of the needs and use of resources, the process to obtain translations, and what needs to be obtained. For example, one language has to be received as a pdf to ensure the integrity of the font is maintained.

Recommendation(s):

1. Continue discussion and research with community partners into the needs, desires, and usage of vulnerable populations to ensure that the translations done are the most effective
2. Train staff members in recording phone messages, answering PICC calls, and checking the accuracy of translated materials from other sources
3. Add additional resources for the deaf and visually impaired

Observation 3.3 (Area for Improvement): Accessing the language line was a lengthy and difficult process. The Limited English Proficiency (LEP) calls often were dropped while the operator was attempting to get the translator on the line.

Analysis: When attempting to access the language line, operators would lose the LEP caller who had been placed on hold due to interference from incoming calls. This issue led to many disconnects and frustration on the part of the operators and LEP callers. This is a technical issue that involves the phone system used. It is unknown if this issue is specific to the Language line or if it will also effect other attempted referrals. Operators left callers (LEP and English speakers) on hold for much longer than the 30 second guideline; some were left on hold for longer than 3 minutes. A number of operators lose callers (English speakers) while trying to place them on hold. Some Operators handled non-English speaking calls very proficiently, through to a successful conclusion of the call; other Operators experienced less-than-successful conclusions, and disconnections.

Operators varied in how they were able to handle non-English speaking calls.

Many of the calls, especially the calls from Chinese speakers were dropped at some point in the transfer, hold, or other place in the call. Some of these disconnects were caused by technological shortcomings, some by Operator error, some by not having sufficient numbers of Language Line

help and the call taking too long. The Operators seemed more able to handle the Spanish language calls than the Chinese language calls, but calls from both were lost throughout the exercise. It was obvious that once an Operator had successfully completed one non-English speaking call, they were much more proficient at completing successfully additional non-English speaking calls.

Reference(s):

1. Joint Information Center Plan
2. PICC Annex

Recommendation(s):

1. Provide operators with clocks that show the time spent on each call so that operators can better manage the call flow
2. Train the operators to end calls in a firm but polite manner
3. Provide a recording that says "please stay on the line" in several languages or has music playing for callers who are put on hold
4. PICC exercises and training for operators and technical specialist

Observation 3.4 (Area for Improvement): The system presented during the Just-in-Time-Training (use of flags for the Operators to call for designated types of assistance) was not consistent.

Reference(s):

1. Joint Information Center Plan
2. PICC Annex

Analysis: Some of the difficulty began during the Just-in-Time-Training when the technical advisors were not 100% certain how to place a call on hold. At first, they stated that to place a call on hold, Operators should just tap the "hang up" button once. Some Operators were unsure what the "hang up" button was. Some of the Operator's phones operated differently than other phones , for example, some would ring with an incoming call and other phones would just light up. A few calls were not picked up during the busy stages of PICC play because of this slight confusion. It was observed that some Operators would take the exact same steps as other Operators to place a call on hold and sometimes the call would be disconnected and other times, with the same actions taken, the call would hold or transfer properly.

At times, when the Operators would hold up a green or a red flag for the predetermined type of assistance they needed, any Technical Specialist would respond to the flag, but not always the Technical Specialist designated by the flag color. This led to the Operator sometimes asking the Technical Specialist for help that the Specialist could not always provide

The Operators were very skillful in the manner in which they fielded all calls, speaking of their professionalism, and their ability to properly disseminate accurate information to the caller. All Operators took their roles seriously, were efficient in the way they recorded all their calls, and treated all callers with respect. No Operator ever lost their cool or become frustrated, even with difficult or annoying callers. The Operators were also efficient at keeping informed about changes in the messages that they were to disseminate to callers. The system used to provide newly arriving information in large print on whiteboards or notepads at the front of the room is a great idea to continue to use to provide Operators with information.

Recommendation(s):

1. Standardize the phone system throughout the departments
2. Create written training aids for each phone system, to include how to place a call on "hold" or "mute" or to transfer a call or connect with another line
3. Create written instructions for a standardized Flag system
4. PICC training and drills for Operators and Technical Specialist

Washington State Department Of Health Headquarters

Demonstrated Targeted Capabilities:

- Communications
- Planning
- Critical Resource Logistics and Distribution
- Emergency Operations Center Management
- Emergency Public Information and Warning
- Emergency Public Safety and Security
- Responder Safety and Health

CAPABILITY: COMMUNICATIONS

Capability Summary: Communications is the fundamental capability within disciplines and jurisdictions that practitioners need to perform the most routine and basic elements of their job functions. Agencies must be operable, meaning they possess sufficient wireless communications capabilities to meet their daily internal and emergency communication requirements before they focus on interoperability, which means being able to work with other agencies.

Communications interoperability is the ability of public safety agencies (e.g. police, fire, emergency medical services (EMS)) and service agencies (e.g. public works, transportation, hospitals) to talk within and across agencies and jurisdictions when needed and authorized using various communications systems to exchange voice, data, and/or video with one another on demand or in real time. It is essential that public safety has the intra-agency operability it needs, and that it builds its systems toward interoperability.

Outcome: The DOH EOC demonstrated several strengths associated with set up and use of various communications systems. These included WebEOC; IT/Telecommunications, DIRM's ability to set-up the EOC 's call-center equipment in a timely manner and train staff as needed during the activation; effective cooperation and coordination to use and improve the SECURES messaging system; and using the Duty Officer as a liaison between the ART and the EOC. Major issues identified during this exercise were staff training (WebEOC, EOC roles and responsibilities), and the importance of department staff ensuring that up-to-date information is provided in SECURES. The use of a PHRAT call, although cumbersome during this exercise, showed that it was also a useful tool.

Activity 1: Provide Emergency Operations Center Communications Support

Observation 1.1 (Area for Improvement and Strength): DOH IT and DIRM staffs were present to assist with equipment use and training.

Reference(s):

1. EOC Job Action Sheet checklists
2. WebEOC User Guide

Analysis: During DOH EOC activation, Leadership change over, and shift change, Telecommunications and Division of Information Resource Management (DIRM) communicated clearly with staff on the use telephones, email, and WebEOC and encouraged EOC staff to ask questions and for assistance. EOC staff used the communication roster provided for the exercise within the EOC and also communicated with their respective DOH departments, as needed, to collect and communicate information.

Several EOC staff had not attended the WebEOC training that had been provided multiple times prior to exercise and, therefore, were not sure how to navigate WebEOC and communicate using the system. IT staff assisted and provided just-in-time training for those who needed assistance, and the EOC WebEOC user manual was a clear reference.

Recommendation(s):

1. All pre-identified EOC staff attends WebEOC training prior to exercise play which should ensure basic level of competency for a real event
2. Train Director and Section Leads to encourage staff to ask questions, clarify how to use communication tools, and monitor use

Activity 2: Alert and Dispatch

Observation 2.1 (Area for Improvement): Not all staff scheduled for the DOH EOC activation received the message sent on November 20th via SECURES and other staff were confused by the message content.

Reference(s):

1. DOH SECURES Policy
2. DOH Duty Officer Procedures
3. DOH Pan Flu Plan

Analysis: Several key players did not receive electronic messages to notify them of EOC activation and/or when to report for duty.

DOH EOC staff responsible for sending the secured electronic messages continuously troubleshot issues throughout the exercise to mitigate problems and prevent further confusion. The responsible staff coordinated with IT EOC staff, the EOC Director, and the DOH Duty Officer to try and ensure quality messages and to update distribution lists, as needed.

It was clear that some EOC staff had not updated their SECURES accounts so that they could receive the alerts in a timely manner and the exercise also emphasized the need for personal

accountability and for EOC staff to update their information so they are aware of when they are needed and events that are occurring. It was also noted that a cross-check system is needed to ensure that personnel who have not responded to the SECURES message are re-contacted.

Recommendation(s):

1. Establish a schedule to regularly test EOC staff with SECURES alerts to measure response and identify those who need to update information
2. Train Duty Officers to understand they can and should coordinate with EOC Section Leads to collect needed or requested information from policy leadership and in developing messages to be sent out over SECURES

Activity 3: Provide Incident Command/First Responder/First Receiver Interoperable Communications

Observation 3.1 (Area for Improvement): There appeared to be gaps in the radio communications available and/or limited staff who knew how to use the various systems.

Analysis: While 800 MHz communications and the IT set-up are solid and professionally staffed, there appears to be no VHF radio backup and Global Star satellite phone service is highly unreliable. It is common knowledge that Global Star satellites are failing. The failure of several systems (possibly due to power failures) could have serious negative impacts on DOH's ability to communicate, even within the building complex in Tumwater, WA.

Recommendation(s):

1. Replace Global Star Satellite phone with an alternate provider
2. Install a unit or docking station with a roof-mounted antenna for the satellite phone so that unit can be used indoors
3. Consider VHF radios and repeaters as backup to 800 MHz radios and phones

CAPABILITY: PLANNING

Capability Summary: Planning is the mechanism through which Federal, State, local and tribal governments, non-governmental organizations (NGOs), and the private sector develop, validate, and maintain plans, policies, and procedures describing how they will prioritize, coordinate, manage, and support personnel, information, equipment, and resources to prevent, protect and mitigate against, respond to, and recover from Catastrophic events. Preparedness plans are drafted by a litany of organizations, agencies, and/or departments at all levels of government and within the private sector. Preparedness plans are not limited to those plans drafted by emergency management planners. The planning capability sets forth many of the activities and tasks undertaken by an Emergency Management planner when drafting (or updating) emergency management (preparedness) plans.

Unlike the other target capabilities, the attributes of planning are difficult to quantify, as individual planners may have considerably varied education and experience and still produce plans that lead to the successful implementation of a target capability. The focus of the Planning Capability is on successful achievement of a plan's concept of operations using target capabilities and not the ability to plan as an end unto itself. Plans should be updated following major incidents and exercises to include lessons learned. The plans should form the basis of training and should be exercised periodically to ensure that responders are familiar with the plan and able to execute their assigned role. Thus, it is essential that plans reflect the preparedness cycle of plan, train, exercise, and incorporation of after action reviews and lessons learned.

Outcome: The DOH successfully demonstrated the understanding and use of the State pandemic influenza plan as well as many standard operating procedures. Issues in at least two divisions/offices were identified related to continuity of operations (COOP) plans.

Activity 1: Develop/Revise Operational Plans

Observation 1.1 (Area for Improvement/Strength): Community and Family Health (CFH) Chief Administrator instructed CFH extended leadership team to activate COOP plan.

Analysis: When the request was made by the CFH Chief Administration the Infectious Disease and Reproductive Health Office and Community Wellness and Prevention Office quickly initiated their continuity of operations plans. Maternal and Child Health did not respond until an EOC-CFH request prompted a second request. Parts of CFH do not have a COOP in place and/or did not clearly understand the request. The evaluator was unable to determine if Office of the Assistant Secretary activated its COOP plan or not.

Recommendation(s):

1. Maternal and Child Health Office needs to develop COOP for its area
2. Complete and test COOP plans within CFH

Observation 1.2 (Area for Improvement and Strength): The Office of Shellfish and Water Protection (OSWP) appropriately responded to the exercise scenario even when the bio-toxin program staff all became ill.

Analysis: During this exercise scenario there was a critical need for OSWP bio-toxin staff to be available to run the program during an emergency closure. All of the OSWP bio-toxin program became ill with the flu and were unable to perform job duties in support of the emergency closure. OSWP had procedures in place to address staff shortages and provide specific actions and activities that are essential to perform duties which ensure public health protection. OSWP acting management acted in a proactive manner to ensure that staffing levels were adequate for maintain program activities. Even though staff performed at an acceptable level, several areas for improvement were identified, especially the need for cross-training, a

plan to routinely review and update the procedures manuals, and the importance of participating in future exercises to assist in job performance during an emergency as well as improving office plans and procedures.

Recommendation(s):

1. Provide training for OSWP staff to become more familiar with the "How to procedures manuals" in order to provide for additional staff to act as backup in case the core team is out
2. Continue to develop, refine, and update the OSWP "how to procedures manuals"
3. Continue to participate in future exercises in order to test, learn, and improve on office plans and procedures

CAPABILITY: CRITICAL RESOURCE LOGISTICS AND DISTRIBUTION

Capability Summary: Critical Resource Logistics and Distribution is the capability to identify, dispatch, mobilize, and demobilize, as well as to accurately track and record available human and material critical resources throughout all incident management phases. Critical resources are those resources necessary to preserve life, property, safety, and security.

Outcome: Gaps were identified in Human Resource areas during this exercise. Personnel resources are critical during an emergency response, especially during a pandemic scenario with a potential absentee rate greater than 25%.

Activity 1: Develop and Maintain Plans, Procedures, Programs, and Systems

Observation 1.1 (Area for Improvement): Presently DOH does not have a method to determine the current staffing levels in the divisions or identify the staff working the incident.

Analysis: At this time none of the DOH divisions can provide information regarding the number of staff on duty (in the office or in the field) to assist in determining who is available for special assignment to the DOH EOC or to work from their desks on an incident. Without this information readily available phone calls, emails, and/or SECURES messaging must be used to staff the EOC.

When there is a DOH EOC activation the Administration/Finance Section is tasked with maintaining expenditure records associated with the incident (for possible reimbursement as well as normal recordkeeping). The section has access to DOH EOC sign-in sheets to identify those individuals working in the EOC, but does not have access to any records regarding those that are working from their desks. Without both sets of information accurate financial records and reports is impossible. Therefore, if the incident becomes a Federal declaration and reimbursement is

available, DOH will be incompletely reimbursed for the incident expenses, costing State taxpayers unnecessarily. An electronic recordkeeping system during activation or a phone-tree call-down (done every day) were two suggestions made during the exercise.

Recommendation(s):

1. Appoint a task force to study ways in which the current staffing status can easily be obtained.
2. Based on the task force findings, develop policies and/or procedures to have this information available 24/7.
3. Develop a system for staff to report hours worked from their desks on an incident.
4. Train staff regarding the new procedures.
5. Test the new procedures during an exercise.

Observation 1.2 (Area for Improvement): The process for ordering Federal assets, including Federal Medical Stations (FMS), is not well defined.

Analysis: Federal Medical Stations were first mentioned during the PHRAT call with the local officials. At that point several of them said order the assets for us without truly identifying the need. It was unclear whether the CDC and HHS representatives in the ART meeting could order this or it needed to go through the normal emergency management channels. Documentation to receive the FMSs could not be determined and there was confusion about what assets would come with them, especially staff. It was unclear how arriving staff teams would be processed and who would be responsible for their needed support such as housing.

Three Federal Medical Stations were ordered, one from Pierce County through the ESF-8 desk at the State EOC and two through the DOH EOC in Tumwater. No one in Tumwater passed these requests to the State EOC or even bothered to inform the State EOC that they had been ordered. The ESF-8 staff at the State EOC attempted repeatedly to get information regarding the sites requested for the two FMSs ordered in Tumwater. No information from Tumwater ever came regarding the requested locations. The State Health Officer recommended locations without consulting the locals who had ordered them. Finally, on the afternoon of November 17th, the State EOC ESF-8 desk contacted the Health Area Command Center directly and got the information. This action, had it occurred early on the 14th would have moved the process of ordering these Federal resources forward. The Health Area Command Center was able to define locations and wrap-around services for the two stations ordered from Tumwater. Why the DOH EOC could not have made the same call is a mystery. If DOH EOC is going to act as a resource management center, then it should be prepared to execute the request process fully. Even if DOH EOC is going to order those resources, it should notify the State EOC promptly to hasten planning for supporting resources,

There was confusion about staffing for the FMSs. The HHS liaison in the State EOC was extremely helpful in clarifying the ordering process and leaning forward to notify the HHS Secretary's Operations Center of the probable requests. However, the delay in getting requested

deployment times and locations would have lead to those resources being released to more prepared jurisdictions. Only the request from Pierce County, which went to the State EOC, went smoothly.

The process for requesting and receiving FMSs has not been documented in any existing Washington State or local plans. This procedure should make clear that these resources should be ordered from the State EOC through local EOCs or Health Coordination Centers. Such a procedure would allow local plans for deploying these resources to be followed and avoid a situation in which the State makes assumptions about the deployment of the assets that conflict with local plans.

Recommendations:

1. In cooperation with Federal and local officials establish a process for requesting and receiving FMS and other Federal assets.
2. Add the process(es) to the DOH CEMP.
3. Train staff in the process.
4. Incorporate FMS in exercises.

CAPABILITY: EMERGENCY OPERATIONS CENTER MANAGEMENT

Capability Summary: Emergency Operations Center (EOC) management is the capability to provide multi-agency coordination (MAC) for incident management by activating and operating an EOC for a pre-planned or no-notice event. EOC management includes: EOC activation, notification, staffing, and deactivation; management, direction, control, and coordination of response and recovery activities; coordination of efforts among neighboring governments at each level and among local, regional, State, and Federal EOCs; coordination of public information and warning; and maintenance of the information and communication necessary for coordinating response and recovery activities. Similar entities may include the National (or Regional) Response Coordination Center (NRCC or RRCC), Joint Field Offices (JFO), National Operating Center (NOC), Joint Operations Center (JOC), Multi-Agency Coordination Center (MACC), Initial Operating Facility (IOF), etc.

Outcome: The DOH EOC usually functioned well within a modified incident command system structure while it faced several challenges. The staff demonstrated the ability to problem solve or at least identify a tentative solution when an issue arose rather than setting it aside to be discussed later. This allowed tasks to be completed in a timely manner. Staff were supportive of each other—whether it was someone unfamiliar with a procedure, how to use a system, or knowing someone's name. The absence of a public information officer (PIO) or PIO liaison in the DOH EOC created gaps for the EOC staff regarding what public and DOH internal information had been released as well as what information was needed by the Communications Office. Communications with PHSKC was minimal, but the DOH EOC staff was able to obtain

needed information. WebEOC and other communications capabilities were effectively utilized to gather and disseminate information.

Activity 1: Develop and Maintain Plans, Procedures, Programs, and Systems

Observation 1.1 (Strength): DOH EOC functions under a modified ICS structure.

Reference(s):

1. EOC Job Action Sheet checklists

Analysis: The modified ICS structure under which the DOH EOC functions is confusing to outsiders who are familiar with a "normal" ICS structure. Operations and Logistics have been combined into one section. DOH made this change because there are few direct requests to DOH EOC for resources other than staff coordination and SNS antivirals and push pack requests. DOH has a strong SNS plan/procedure which is well-tested and functions almost independent of the EOC once it is requested from CDC and approved for shipment. Combining operations and logistics functions allows for a smoother flowing operation and less demands on agency staff. Staff assigned to be liaisons to the ESF-8 Desk at the State Emergency Management Division EOC at Camp Murray has a very good understanding of how the two EOCs coordinate activities to ensure that tasks are completed in a timely manner.

Administration/Finance works in conjunction with Operations/Logistics that ensure that orders for which the EOC is responsible are placed after approval for the purchase has been received and maintains accurate records regarding the purchases made so that proper accounting is completed.

DOH has given serious consideration to the structure of its EOC and proves that it functions well with this modified structure.

Recommendations:

None

Observation 1.2 (Area for Improvement): There are expectations that Human Resources "canned" communications can be prepared ahead of time and be ready for adjustments for the current situation and that communication from HR will happen more quickly.

Analysis: Some communications can be outlined in a template with options drafted ahead of time that are dependant on particular circumstances. This is difficult with HR issues since we will need to work with at least three different basic resources (the civil service rules for non-represented staff and the Washington Federation of State Employees and the Service Employees International Union 1199 NW Collective Bargaining Agreements). Also, what we can do depends on the extent of the emergency and whether or not it becomes a recognized or

Governor-designated emergency or even a Federal emergency. Employees, especially when under stress, expect immediate assistance with human resource type issues. By being better prepared HR can respond in a timelier manner.

Recommendation(s):

1. Work with the HR Operations and Labor Relations Managers to identify communications templates or draft language for future events

Observation1.3 (Area for Improvement): EOC set-up checklist did not include a microphone for use during briefings or instructions regarding the clearing out the EOC for easier room configuration.

Reference(s):

1. EOC Set-up Checklist 10 07

Analysis: Although a microphone was setup for this EOC activation due to someone remembering that it was requested at the last exercise, it was noted that it was not on the set-up checklist. Additionally, the microphone that did get set-up was on the podium in the corner of the room where the IT Support staff sits and this microphone only got used for exercise debriefing purposes. The EOC Director and Section Chiefs need a microphone to use for the briefings. They attempted to use one of the wireless microphones in the room but it only worked sporadically. There is a lot of activity in the EOC and some EOC directors and section chiefs have softer voices. It is important to make sure that all staff can hear what is being said.

The EOC room configuration was completed smoothly except for one issue. There were a lot of extra chairs that would get in the way of EOC staff. There was no location chosen ahead of time to store these extra chairs and a discussion started. The final decision was to put them in the Helpdesk storage room. This way the chairs were out of the room, but close enough so that if one was needed it could be obtained easily.

Recommendation(s):

1. Revise the EOC Set-up Checklist to include set-up and testing the wireless microphone
2. Revise the EOC Set-up Checklist to include instructions regarding storage of the chairs not used in establishing the EOC

Observation 1.4 (Area for Improvement): The process, priorities, and procedures for dispensing antivirals during a pandemic are not clear to everyone in the DOH EOC.

Reference(s):

1. Local pan flu plans
2. DOH CEMP (Pan Flu annex)
3. DOH SNS plan

Analysis: There remains much confusion about how and to whom antivirals will be dispensed during a pandemic. Federal policy on this has been conflicting and this is reflected in expectations at the State and local levels. The SNS policy is that antivirals are for treatment of the sick. However, some draft Federal documents allude to some limited prophylaxis under certain circumstances. In addition, some LHJs have local caches of antivirals that they can use in whatever manner they determine appropriate. This has created confusion at the Federal, State, and local levels. There are recommended priority groups established by the feds but it's unlikely that antivirals can be withheld from any ill individuals, if demand exceeds supply.

Recommendation(s):

1. Refine LHJ and State plans to outline how they will receive, store, stage, and dispense antivirals from the Federal government
2. Review and clarify LHJ plan for dispensing antivirals
3. Train staff to the revised plans
4. Conduct an exercise using the new plan to receive, stage, store, and dispense antivirals suing both local caches and Federal resources

Observation 1:5 (Area for Improvement): The process and timing of a Governor's Declaration of Emergency during a pandemic were not clear.

References

1. DOH CEMP (Pan Flu Annex)
2. ART checklist and procedures
3. Parallel State EMD procedures

Analysis: There is a need for an automatic trigger to begin the process of a Governor's declaration during a pandemic. This needs to happen in conjunction with State Emergency Management Division (EMD) as they prepare the actual language and submit to the Governor's office. This declaration enables rapid response and waives certain normal time restrictions. DOH and State EMD should agree to request a Governor's declaration when WHO Phase 4 is established. This is when antivirals will be sent from the feds to the State and mobilization will begin.

Recommendations:

1. State EMD and DOH work on pre-prepared draft language for a Governor's declaration during a pandemic.

Observation 1:6 (Area for Improvement): The process for a Department of Health/State Board of Health Emergency Order making influenza a notifiable condition needs to be better defined

References

1. DOH CEMP (Pan Flu Annex)
2. Epi Plans

Analysis: This topic was discussed during the exercise but the process apparently has not been documented in DOH emergency plans or tested. This would be critical to tracking an influenza pandemic as it spreads.

Recommendations:

1. Representatives from DOH and the Board of Health establish a process for making influenza a notifiable condition.
2. Add process to their respective plans.

Observation 1:7 (Area for Improvement): State Epidemiologist for Infectious Disease was tasked with giving situational updates over the phone to the ART when they met twice daily.

References:

1. ART procedures and checklists

Analysis: This requirement is time consuming when the State Epidemiologist needs to be focused on responding to the incident. It is not necessary that the participation be the State Epidemiologist, just that it be someone from the CD/Epi staff with up-to-date information and access to the State Epidemiologist if questions need immediate answers.

Recommendations:

1. Assign someone from CD/EPI other than the State Epidemiologist to provide the daily briefings to the ART so that he/she can focus on response activities.

Observation 1:8 (Area for Improvement): A significant success of the exercise was the use of checklists by the ART to make sure that they were able to quickly address critical issues that required immediate attention.

References:

1. ART Procedures and Checklists

Analysis: These checklists need to be as complete as possible and made a part of each ART member's emergency preparedness kit. Secretary Selecky has asked that staff review the existing ART emergency kits containing checklists and ART procedures to ensure that they are current and available to all ART members at all times.

Recommendations:

1. Staff review existing checklists and ART procedures and update as appropriate.
2. Distribute revised information to all ART members to ensure that it is available to them at all times.

Activity 2: Activate DOH EOC

Observation 2.1 (Area for Improvement): Reporting staff awaited arrival of designated EOC Director who did not arrive until 0845 due to problem with SECURES information.

Analysis: The SECURES message was not received by the designated EOC Director. Some one who had reported finally contacted her and she reported shortly thereafter. The issue regarding up-to-date contact information is discussed in another write-up. Staff should not have waited for this person to arrive. The ICS concept says that the first person to report is in charge until someone more appropriate arrive—the responding police officer is in charge until the fire department arrives at the fire or hazardous materials incident. As the response group increases in size and complexity the leadership role can change several times. Eventually The Operations/Logistics Section Assistant assumed leadership until the EOC Director arrived. Delaying the activation rather than progressing from open to fully operational can be detrimental to a response—no one is gathering information, preparing reports, identifying needs, communicating with other response agencies, etc. Time delays can be critical to a response and at least a partial activation at 0800 would have been beneficial.

Recommendation(s):

1. Review / update EOP section and position checklists to ensure clear leadership succession for all EOC positions
2. Train personnel to ensure that staff is prepared to assume the roles in which they are a successor.

Activity 3: Gather and Provide Information

Observation 3.1 (Area for Improvement): EOC staff did not initiate communications with other agencies.

Analysis: There seemed to be hesitation by staff within the EOC during the activation and shift change to initiate communication with and information collection from other agencies. DOH EOC staff needs to assert their roles and initiate communication with State, local, and other agencies to collect information. A delay in obtaining information could cause inappropriate decisions to be made by leadership or critical decisions might be delayer while waiting for information causing adverse consequences for the public. Multiple factors could have been involved in this, including lack of clear EOC shift objectives, lack of clear Section tasks to complete, and lack of confidence in EOC staff role and responsibility. Certain players within the EOC during each shift were strong leaders and obviously confident in the EOC's role and shared

that knowledge with other staff and encouraged others to initiate communication internally and externally via phone, email and WebEOC.

Recommendation(s):

1. Train EOC staff on EOC function/role during events and in initiating communication to collect situational awareness, collect routine data, and decrease delay in response and coordinate time
2. Ensure that Director/Lead briefings occur prior to activation and shift change so that objectives are set, tasks are assigned and schedules are set
3. Ensure EOC staff briefings include scenario overview, objectives, schedule, and assigned tasks so that staff is fully aware of situation, needs, and assignments

Observation 3.2 (Area for Improvement): There was limited information posted on the displays for easy access by EOC staff.

Analysis: Situation displays were comprised of an organization chart of the DOH EOC, a whiteboard listing of several key activated organizations and their numbers, large State maps without incident related annotations, and a continuously projected screens for WebEOC Activity Logs for the DOH EOC Director and the State ESF-8 Desk at the State EMD EOC, and a Significant Event Log. WebEOC appears to be the main tool for sharing information; and that information was log entries, viewable a few at a time. This is no substitute for analyzed, processed information displayed in ways that quickly convey important situation elements (about disease and response) and trends. This is key information to show the big picture in a way that is quickly grasped and that properly informs decision making. The DOH ART should work with PHEPR to envision displays and report formats that will assist the ART and the EOC to have key information readily available. WebEOC may be able to be formatted for key situation displays for easy sharing; however, manual methods should also be used so operations can continue if computer systems fail.

Recommendation(s):

1. Assign a Task Force to analyze how to improve information displays in the DOH EOC

Observation 3.3 (Area for Improvement): Incident action plans were not developed for the DOH EOC and staff did not actively seek guidance from leadership.

Reference(s):

1. DOH EOC activation checklists and Job Action Sheets
2. DOH Pan Flu Plan

Analysis: Throughout the exercise incident action plans (IAPs) would have assisted the DOH EOC staff in working together to obtain the information needed for decision making. However, not one IAP was completed. There was discussion among the various section chiefs and with the EOC Director, but a written plan was never completed. This lack of a plan created additional

challenges when the second shift reported for duty on Monday afternoon. They were not effectively briefed regarding the total situation, but were given a brief overview of the current status.

There were foreseen continuity of operations issues that could arise within DOH and Planning should have been addressing this in the IAP and, in coordination with the EOC Director and ART, how to address those issues prior to them eventually impacting the agency.

EOC staff also needs to engage with other EOC staff and seek clear guidance and objectives from leaders. If they do not ask questions leadership will assume that everything is fine. This could cause critical tasks to not be done in a timely manner—staff did not realize something that should be done and leadership had assumed that it was being completed because there was incomplete communication.

Recommendation(s):

1. Ensure that staff assigned to the DOH EOC Plans Section has been trained in developing IAPs
2. During an exercise Plans will develop IAPs in conjunction with other section chiefs and EOC Director

Observation 3.4 (Area for Improvement): The DOH EOC appeared disconnected from the State Laboratory in Shoreline, Public Health – Seattle & King County where the event was occurring, the DOH Communications Office, and the State EMD EOC.

Reference(s):

1. EOC Job Action Sheet checklists
2. EEG for Activating EOC/ACC/MAC Task- ResB1c4

Analysis: It appeared that the DOH EOC was not connecting to the Shoreline ICP other than receiving updated statistics when requested by the EHSPHL Liaison, Public Health Seattle/King County, the DOH Communications Office, and the State EOC. This was evident when the Federal Medical Stations (FMS) were requested and there was confusion about what decisions had to be made and who would make them—how many were being requested and by whom; where would they be placed; who provides the staffing for them—as well as the lack of information needed by the federal government to release the resources. Finally, there were several occasions when DOH Communications Office staff came into the DOH EOC and began creating work for different people. All of this indicated that the DOH EOC was largely operating in isolation from the main stakeholders in the exercise. It is imperative that the DOH EOC be involved in communications, decision making, and EOC staff assignments.

Recommendation(s):

1. Clarify the mission of the DOH EOC
2. Train EOC staff regarding the DOH EOC's mission during activations

3. Develop a clear set of procedures for the DOH EOC to coordinate with stakeholders

Observation 3.5 (Area for Improvement): There did not appear to be anyone from DOH assigned to the role of liaison to Public Health - Seattle & King County (PHSKC).

Reference(s):

1. EEG for Activating EOC/ACC/MAC Task- ResB1c4
2. Liaison Officer Job Action Sheet checklists

Analysis: In past exercises of this sort, DOH assigns someone to be a liaison with the affected local health jurisdiction. During this event, the position was discussed, but the local health jurisdiction did find it to be of value without further discussion of the role. The lack of this direct communications link with the local health jurisdiction created a gap in situational awareness and possibly some epidemiologic information. It would have been to DOH's and the LHJs' advantage to have this direct contact with someone at the PHSKC ESF-8 ACC.

Recommendation(s):

1. Work with all LHJs across the State to educate them on the benefits of a liaison and how they should incorporate them into their response plan.
2. If the plans of LHJ are for deploying a liaison, DOH needs to work out with the LHJ who will deploy the liaison.

Observation 3.6 (Strength): The EOC displayed WebEOC, map information related to the PODs, and case counts.

Analysis: The WebEOC screens that were posted were helpful to the DOH EOC staff, allowing them to see at least some of the information available to them. The GIS map showed the approximate location of all the PODs that would be used in this scenario. The map provided an excellent visual demonstration of some of the complexity for disbursement of the antivirals. If a staff member needed any information regarding the case counts it was readily available on the white board at the front of the room. The date and time of the posting were included in the information to assist staff in acknowledging how current the information was. These communication techniques helped to keep staff informed.

Recommendations:

None

Observation 3.7 (Area for Improvement): Situation reports provided limited information.

Analysis: Situation reports did not include information for the affected LHJs, the State Lab at Shoreline, hospitals' bed status (WATrac), the status of requested State and Federal resources, and information from the ART and/or PHRAT. In addition, the report did not include plans for

the upcoming operational period. No additional DOH actions were reported. It was not apparent in the documents that the ART or PHRAT had made any policy decisions. At a minimum this section could have indicated that no additional actions are occurring.

In addition to the situation reports, no briefing materials or other support materials were developed for the ART. If the mission of this organization is, in part, to support the ART, sufficient briefing materials were not developed and distributed to this group to support them.

Recommendation(s):

1. Develop job action check lists to include gathering developing and documenting situation and resource information so it can be analyzed and converted to situation reports and other documents (include all of the different DOH components to create a complete set of information)
2. Reformat DOH Situation report to better reflect the needs of

Observation 3.8 (Area for Improvement): It did not appear that the DOH EOC has a plan for gathering information and disseminating it to the EOC staff, agency administration, or its partners.

Analysis: The DOH EOC staff did not collect, analyze, and disseminate information or develop tools or displays for presenting information to the ART, their Federal Partners, the ESF-8 desk at the State EMD EOC, or LHJs. Although it is not necessary for an EOC to use ICS position titles, some of the ICS functions are applicable, including gathering pertinent information, analyzing the information, and using that information to develop incident action plans, situation reports, and material to assist the ART in performing its duties.

Recommendation(s):

1. Develop a structure with clear relationships and responsibilities for collecting, analyzing and sharing information with agency staff

Observation 3.9 (Area for Improvement): Washington Emergency Management Division (EMD) referred to the PIER website in one of the postings to WebEOC on Friday afternoon, November 14. However, no one in the DOH EOC knew what that website was or how to access it.

Analysis: If EMD expects personnel to use information that is posted to a website, EMD should ensure that everyone is aware of the site. Division of Information Resource Management (DIRM) staff in the DOH EOC at the time had never heard of PIER. No one in the DOH EOC contacted the ESF-8 desk at State EMD for assistance. Possibly someone from DOH Communications would have known the answer, but there was no one from DOH Communications in the DOH EOC. This left a hole in the information sharing continuum that could have been avoided.

Recommendation(s):

1. EMD should ensure that agencies are informed about PIER
2. DOH should consider having a PIO liaison in the EOC, even if that person is not from the DOH Communications Office, to provide better contact with the communications Office
3. DOH EOC staff should be trained to follow-up when additional information regarding communications is needed

Observation 3:10 (Area for Improvement): ART did not have access to WebEOC in the Executive Conference Room during the exercise.

References:

1. DOH EOC Emergency Operating Procedures

Analysis: Access to WebEOC would have facilitated situational awareness between the ART and the DOH and State EOCs. The capability exists but was not used due to a lack of knowledge by the ART about how to use the resource during an emergency.

Recommendations:

1. Train staff to bring up and use WebEOC at the ART during exercises or real events.

Activity 4: Identify and Address Issues

Observation 4.1 (Area for Improvement): There is not an effective system for tracking task assignments.

Analysis: The lack of a task assignment tracking system could cause some important / critical task to be overlooked. Task assignments were given verbally and/or via email. This inconsistent method can be disruptive and tasks could easily be overlooked. At least one EOC Director commented about her inability to easily determine if tasks were completed. Although the number of tasks for this exercise was not large, a system to which everyone is familiar should be in place because some situation in the future may have large numbers of tasks to be completed within the EOC or assigned through the EOC to division offices.

Recommendation(s):

1. Develop task assignment status tracking system
2. Train EOC staff on the use of the task tracking system
3. Use the system in an exercise to determine effectiveness and revise as necessary

Observation 4.2 (Area for Improvement): The PHRAT process (one of the major exercise objectives for the ART) proved to be cumbersome and difficult to use to come to consensus about social distancing measures during a pandemic. Discussions on antiviral use and alternate care facilities could not be completed due to lack of time.

Reference(s):

1. PHRAT procedures and checklists as updated for the exercise.

Analysis: The PHRAT call was initiated by the Secretary of Health and was designed to include all local health officers and administrators. It was simulated that all PHRAT members participated in the call rather than the small, previously identified group. It is not clear whether all local health officers and administrators are familiar with the process. Even with updated procedures and checklists the discussion was limited to school closures and even then there are not clear criteria for action. The open-ended discussion continued for some time and consensus was difficult to reach. It was not clear even when there was a consensus about closing schools exactly how this information would be transmitted to local school districts and the Office of the State Superintendent of Public Instruction. Also, the discussion focused on only one county, King, rather than hearing equally from all effected counties as to the impacts experienced and current response actions.

It is important for this body of professionals to share information regarding impacts, policy decisions made locally, current and future response actions, and actions that LHJs expect from the State. The ART, especially Secretary Selecky, is aware that the process needs improvement and is already considering changes in the process. The analysis should include an examination of who should be part of the process, what issues the group should consider, how the call is to be structured to be most efficient and effective in arriving at a consensus, how any decisions will be communicated and implemented, and how the State and local health jurisdictions can proceed if consensus cannot be reached. In order to increase the efficiency of the process one suggestion would be to have the ART develop a series of proposed options for consideration by the PHRAT prior to the call rather than having open-ended discussion. It is also recommended that the PHRAT discussion be limited to social distancing considerations such as school closures and closures of other large public gatherings. Some policy decisions regarding social distancing could be pre-established and data-driven, according to information about the local or regional situation gathered on the call (similar to the BioWatch Response Assessment Team criteria). Antiviral use and alternate care facilities can be more expeditiously addressed through other means.

Recommendation(s):

1. Assess and revise the PHRAT process
2. Test the revised process during an exercise

CAPABILITY: EMERGENCY PUBLIC INFORMATION AND WARNING

Capability Summary: Develop, coordinate, and disseminate accurate alerts and emergency information to the media and the public prior to an impending emergency and activate warning systems to notify those most at-risk in the event of an emergency. By refining

its ability to disseminate accurate, consistent, timely, and easy-to understand information about emergency response and recovery processes, a jurisdiction can contribute to the well-being of the community during and after an emergency.

Outcome: DOH EOC has an active roll in development, approval and dissemination of public information and warning. During this exercise, information was provided to the public by the Communications Office, but the DOH EOC was not actively involved in the process.

Activity 1: Activate Emergency Public Information, Alert / Warning, and Notification Plans

Observation 1.1 (Area for Improvement): A Communications Office representative was not assigned to work in the DOH EOC.

Reference(s):

1. DOH EOC Manual
2. DOH Pan Flu Plan

Analysis: Throughout the DOH EOC activation for the exercise, there was no Communications Office representative within the EOC, creating a huge void of communication between external partners and the EOC concerning public information issues, internal EOC communication issues, and coordination with the Communications Office. Although there was a work station established by DIRM and IT for the Communications Office representative in the EOC it was not readily apparent to at least some EOC staff. An apparently un-trained Communications Office staff person was sent to the DOH EOC on a daily basis to listen to the Director briefings, take notes, and return to the Communications Office, but never engaged in collecting information or asking about issues that Communications might need to address.

Different DOH EOC Sections were in need of a Communications Office representative during the exercise and there was no trained, consistent representative within the EOC for them to coordinate with. There should always be a Communications Office representative in the EOC to coordinate with other EOC Sections to address public information issues and then the Communications Office representative should take those issues from the EOC to the DOH Communications Office to coordinate response activities, collect information, and communicate back to the EOC, as needed.

Several different Communications Office staff came into the EOC at different times during the exercise to either observe and/or attend briefings, but none of the staff ever announced their presence, their purpose, or asked if there was a need to collect information and coordinate information between the EOC and Communications Office. The largest presence of Communications staff in the EOC was prior to the call-center being activated and it was purely regarding call-center activation.

There also seemed to be a need to have the Communications Office coordinate the public information issues coming out of DOH Epi/Lab Shoreline to ensure consistent messaging was used, coordinate when information would be sent out, and to ensure that the DOH EOC Communications Office representative could brief the EOC Director and/or Policy group (ART) when needed. This might need to be an additional PIO-trained staff person in a large incident.

The lack of a PIO Liaison working full-time in the EOC has the potential to cause innumerable problems with incomplete and inaccurate information being provided to the public as well as incomplete information being used in the EOC to make decisions. It is essential that the Communications Office and the EOC be consistently and constantly working together to ensure accuracy of all information used by everyone involved.

Recommendation(s):

1. Consider using public information-trained DOH staff from other agency divisions to assist the Communications Office by functioning as EOC Communications Office representative during activations, including exercises
2. All DOH Communications Office staff should attend DOH EOC training and WebEOC training to assist during EOC activation and that understand the need of coordination between EOC and the Communications Office
3. Train Communications Office staff regarding responsibilities during EOC activations to include using an ICS structure and assigning personnel to the DOH EOC, as well as in prioritizing current public information projects to ensure personnel are available
4. Train Communications Office staff to share information via telephone, email, and WebEOC so that DOH EOC staff can see what is happening regarding public information issues

CAPABILITY: EMERGENCY PUBLIC SAFETY AND SECURITY RESPONSE

Capability Summary: Public Safety and Security Response is the capability to reduce the impact and consequences of an incident or major event by securing the affected area, including crime/incident scene preservation issues as appropriate, safely diverting the public from hazards, providing security support to other response operations and properties, and sustaining operations from response through recovery. Public Safety and Security Response requires coordination among officials from law enforcement (LE), fire, and emergency medical services (EMS).

Outcome: The DOH EOC has a critical need for site security, which they addressed with contracted security agents. The just-in-time training for security personnel roles and responsibilities have been identified as a gap.

Activity 1: Plan for Public Safety and Security Response During Large-Scale, All-Hazards Events

Observation 1:1 (Area for Improvement): The process for requesting a declaration of a public health emergency by the Secretary of Health and Human Services (HHS) and what type of information would be required for a Stafford Act Declaration during a pandemic flu event are not well defined.

Analysis: The Federal government has not clarified the process for requesting an Emergency Declaration by the Secretary of HHS or the type of information that would be required for a Stafford Act declaration during a pandemic. The lack of a clear process could endanger thousands of lives in the United States and cause unnecessary financial burdens to State and local governments.

Recommendations:

1. DOH and State EMD should work with FEMA and HHS to determine the trigger points and process to request a public health emergency during a pandemic flu event.
2. DOH and State EMD should work with FEMA and HHS to determine the trigger points and process to request a Stafford Act declaration during a pandemic flu event.
3. Incorporate these processes into plans at the agency.

Activity 2: Control Traffic, Crowd, and Scene

Observation 2.1 (Area for Improvement): A contracted security guard stated that he did not know what role, if any, he would have during an actual incident that involved DOH Headquarters in Tumwater, Washington.

Analysis: Individuals that are tasked with ensuring that only authorized personnel enter a facility need to know their responsibilities for all situations. This individual was uncertain if he would have additional responsibilities, if the rules for admitting people to the building would change, if everything would be exactly like any other day of the week, if the rules would be different if the EOC is staffed 24/7,or if all non-DOH staff would need an escort.

Recommendation(s):

1. Develop written procedures for security personnel to follow during any EOC activation
2. Train security personnel regarding the procedures
3. If procedure variations for security personnel responsibilities exist, train the contracted security guards to these protocols

CAPABILITY: RESPONDER SAFETY AND HEALTH

Capability Summary: Responder Safety and Health is the capability that ensures adequate trained and equipped personnel and resources are available at the time of an incident to protect the safety and health of on-scene first responders, hospital/medical facility personnel (first receivers), skilled support personnel, and, if necessary, their families through the creation and maintenance of an effective safety and health program. This program needs to comply with the Occupational Safety and Health Administration (OSHA) and any other applicable Federal and State regulations and health and safety standards.

Outcome: The DOH EOC was challenged by staff questions regarding safe work place issues well as employee rights during a pandemic. It was recognized that during a real incident the advice from other offices/organizations would be available, but planning for these questions would allow for easier operations during a pandemic.

Activity 1: Develop and Maintain Plans, Procedures, Programs, and Systems

Observation (Area for Improvement): There were many issues regarding employee rights and staffing during a pandemic.

Analysis: The scenario presented several human resource (HR) issues as well as those identified by the staff working in the DOH EOC or from their work stations. HR recognized there was a critical exercise artificiality that impacted these issues—several pertinent agencies, offices, and organizations were not playing (e.g., Governor, Attorney General, and Labor Relations Office). Without these organizations involved, HR had to make decisions which they could not back up (the SimCell was not involved in these issues).

Someone refusing to leave work even though they are ill because they do not have any sick leave (what is management's authority in removing or isolating them); the need to either stay home or bring children to work (schools and day care are closed); and staff refusing to come to work (they might get exposed at work or they are caring for someone at home) were a few of the staffing questions that arose. Questions from staff included: guaranteeing staff safety if they come to work; overtime pay because I will probably have to work more than 40 hours; who is cleaning the cubicles and are they using more than water (something that will sanitize the surfaces); is DOH offering prophylaxis treatment for those who agree to work; does the heating/air conditioning/ventilation system "clean" the air of the germs; if you are operating 24/7, I do not have off-hours access; what does the union contract say about being "forced" to come to work; how will DOH keep sick people out of the buildings; and can you house me at DOH so I can avoid exposure at home.

Staff were uncertain what legal actions they could and could not take – sending someone home, allowing a modifications in the telecommunication rules (such as watching a child while working), and concern about various supervisors making different decisions related to the same issue.

Recommendation(s):

1. Training on policies to address HR needs created for those that will involved in these policy decisions.
2. Safety procedures (isolation, decontamination, etc.) need to be developed and practiced
3. If antivirals are going to be provided to DOH staff, need to have objective criteria and procedures in place
4. Training on all the above and should include Blood Borne Pathogen requirements

Activity 2: Activate Responder Safety and Health

Observation 2.1 (Area for Improvement): No one was assigned as the Safety Officer for the EOC.

Analysis: It was not apparent that there was a formal Safety Officer role in the EOC, which is very much needed and important for EOC staff safety and well being. It would be especially important with a pandemic event to be concerned about disease prevention and to have screening put into place for EOC staff. The lack of this role could inadvertently send a negative message to staff that agency administration is not concerned about their welfare which would be an inaccurate assessment.

Recommendation(s):

1. Add EOC Safety Officer as a new position or as an additional responsibility of a current position to address all health and safety issues for EOC staff
2. Add the assignment of this role is to the EOC Director's checklist—to make the assignment or ensure that someone has been appointed

Washington State Department Of Health Communicable Disease/Epidemiology (CD/Epi)

Demonstrated Targeted Capabilities:
Epidemiological Surveillance and Investigation

CAPABILITY: EPIDEMIOLOGICAL SURVEILLANCE AND INVESTIGATION

Capability Summary: The Epidemiological Surveillance and Investigation capability is the capacity to rapidly conduct epidemiological investigations. It includes deliberate and naturally occurring exposure and disease detection, rapid implementation of active surveillance, maintenance of ongoing surveillance activities, epidemiological investigation, analysis, communicating with the public and providers about case definitions, disease risk, mitigation, and recommendations for the implementation of control measures.

Outcome: Surveillance information received from PHSKC CD/Epi and other jurisdiction regarding exposure and disease was received by WA DOH CD/Epi. Surveillance summaries were reported back to jurisdictional agencies. Suspected cases were investigated promptly, reported to relevant public health authorities, and accurately confirmed to ensure appropriate preventive or curative countermeasures are implemented. New suspect cases were identified and characterized based on case definitions on an ongoing basis; relevant clinical specimens were obtained, tested and results disseminated back to relevant agencies.

Activity 1: Develop and Maintain Plans, Procedures, Programs, and Systems

Observation 1:1 (Area for Improvement): Lack of agreed upon and verifiable epidemiological data made policy decisions difficult for the ART.

References:

1. Pan Flu Appendix to DOH CEMP

Analysis: The ART was impeded in its ability to approve the request for Federal resources because the Federal data requirements were different than the data that DOH Epi staff was comfortable generating and reporting. CDC wanted case data to determine the severity of the outbreak and DOH Epi did not feel that they could reliably get this information, focusing instead on lab-confirmed cases of a novel flu virus which initially may not have initiated a Federal response.

Recommendations:

1. Develop different means to demonstrate to the Federal government the severity of the outbreak in order to obtain Federal assets.
2. Determine what epidemiological data is to be collected and reported, how it is to be reported, and when it is to be reported must be worked out between the Federal government and the States

Activity 2: Surveillance and Detection

Observation 2.1 (Area for Improvement): During the exercise, specimens were arriving at WA DOH Public Health Laboratory (PHL) without WA DOH Communicable Disease/Epidemiology Section (CDES) knowledge or triage.

Reference(s):

1. DOH CEMP, Appendix 1, Annex 3, Section VI (Laboratory Diagnostics)

Analysis: Under Annex 3 (DOH Pandemic Influenza Response Plan), all requests for novel or pandemic influenza should be referred to the DOH CDES which will screen requests for testing for novel and pandemic influenza to assure lab resources are used judiciously. This did not happen so criteria established by CDES for testing could not be followed. This could result in the lab being faced with accepting specimens arriving unannounced, and without direction from CDES on which to process, which could have resulted in sub-optimum use of lab time and reagents, and generation of information not useful for surveillance purposes.

Recommendation(s):

1. CDES, in coordination with PHL, will establish and exercise a policy for the triage, accepting, and processing of specimens during a pandemic influenza event

Observation 2.2 (Area for Improvement): Many written guidelines for CDES in the draft DOH Pan Flu Plan were not followed during this exercise.

Reference(s):

1. DOH CEMP, Appendix 1, Annex 3 (Pandemic Influenza Response Plan)

Analysis: There are many parts of the Annex 3 Pan Flu plan that identifies CDES in a leading or support role or in a decision-making capacity which were not followed by DOH EOC. This created gaps in understanding about roles and responsibilities of CDES. For example, CDES is directed by the plan to provide information to various stakeholders without specifying how this should proceed, or without reference to the need to run some/most of this for review and dissemination through the DOH EOC, which holds primary responsibility for coordinating communications within the agency during an emergency.

Recommendation(s):

1. CDES identify and operationalize roles and responsibilities under the plan

2. CDES in conjunction with appropriate DOH PHEPR staff, will develop and provide training and exercises for the CD/Epi response

Observation 2.3 (Area for Improvement): Shoreline epidemiologists were unaware of the activities of the DOH and State EOCs, or how their interaction with the DOH EOC was taking place. The DOH EOC Desktop did not serve its intended purpose.

References:

1. DOH CEMP

Analysis: There is a need to develop a methodology to provide periodic situation updates to the PHL. While in theory the DOH EOC Desktop could be utilized for communications and tracking to support coordination, it failed to provide any service for these purposes during the exercise, possibly because of unfamiliarity with its use presumably because of user inexperience. The only information received by CDES epidemiologists about activities of EOCs outside of PHL was gleaned during the DOH ART or PHRAT meetings.

Recommendations:

1. CDES in conjunction with appropriate DOH PHEPR staff will develop a system of communication to provide periodic and timely updates to PHL staff through the incident command system during an exercise or real event.
2. If the solution is use of the DOH EOC significant events log, then CDES in conjunction with appropriate DOH PHEPR staff will expand the list of users and provide required training and exercising to insure that its capabilities are being utilized.

Activity 3: Conduct Epidemiological Investigation

Observation 3.1 (Area for Improvement): Communication between the Shoreline Incident Command Post (SICP) and DOH EOC was inconsistent, with direct lines of communication between DOH EOC and SICP epidemiologists taking place outside of the ICS structure.

Reference(s):

1. DOH CEMP

Analysis: The DOH operates its incident command structure based in part on a DOH EOC in Tumwater and a Shoreline Incident Command Post based in the PHL. According to DOH ICS structures, communication should proceed through the Shoreline ICS to the EHSPHL representative in the DOH EOC, Tumwater. This was rarely the case. SICP epidemiologists were often uncertain about the roles of those in DOH EOC that they were speaking to and why communication was arriving outside of the ICS structure. Players would benefit by having visual access to the ICS structures of the various DOH entities during an exercise or real event.

Recommendation(s):

1. DOH should overhaul its ICS structure to eliminate the Shoreline ICP as a separate operations center, and include it as a component of the DOH EOC. This will require significant revision to existing DOH ICS planning documents and ICS structures
2. Once done, DOH should maintain ICS structure charts on a common-share drive (o:\drive) that identify ICS roles of each entity (e.g., Shoreline ICS structure, EHSPHL ICS structure in Tumwater, etc.) recognizing that roles may change during an actual event. During an event, DOH should periodically update each entity's ICS structure charts taking contingency considerations into account

Reception, Storage, And Staging (RSS) Facility

Demonstrated Targeted Capabilities:

Critical Resource Logistics and Distribution
Emergency Public Safety and Security
Medical Supplies Management and Distribution

CAPABILITY: CRITICAL RESOURCE LOGISTICS AND DISTRIBUTION

Capability Summary: Critical Resource Logistics and Distribution is the capability to identify, dispatch, mobilize, and demobilize, as well as to accurately track and record available human and material critical resources throughout all incident management phases. Critical resources are those resources necessary to preserve life, property, safety, and security.

Outcome: Hospital use of WATrac was very successful for requesting/tracking resources utilized or needed. Areas that did not have access to this system were still able to request and track resources, although a statewide system would have been less confusing to the ACC/EOCs.

Activity 1: Direct Critical Resource Logistics (CRL) and Distribution Operations

Observation 1.1 (Area for Improvement): Non-hospital healthcare clinics/providers did not have access to WATrac and therefore could not provide SNS receipt information through that system or receive SNS delivery updates.

Reference(s):

1. EEG: Critical Resource Logistics and Distribution, Activity 3

Analysis: The use of WATrac for tracking SNS supplies was very innovative. One issue that came up was that hospitals had access to WATrac but non-hospitals did not. Hospitals could update their SNS resource receipt status on WATrac while clinics and other non-hospital facilities had to call Logistics to provide receipt status updates. Non-hospital facilities also could not access the WATrac chatroom that hospitals could access that provided real-time updates on SNS delivery times and other issues.

Recommendation(s):

1. Grant other health partners who may receive SNS supplies access to WATrac and provide training so that they can also use the system to update SNS receipt status

Observation 1.2 (Area for Improvement): The replacement Area Commander was not quickly granted access to the WATrac resource request tracking tool

Reference(s):

1. EEG: Critical Resource Logistics and Distribution, Activity 3

Analysis: At noon, the Area Commander turned over his duties to a new Area Commander. The new Area Commander was not automatically granted access to the medical resource request tracking tool on WATrac. It was unclear whether the handover of the Area Commander duties was promptly communicated to all ACC staff – this may have been an attributing factor to his lack of access. It was also unclear whether WATrac had a streamlined or automatic approach for granting replacement Area Commanders the same access to documents and WATrac rooms that the previous Area Commanders had.

Recommendation(s):

1. Ensure that there is a protocol for granting access to appropriate WATrac documents and WATrac rooms for replacement staff during the turnover process

CAPABILITY: EMERGENCY PUBLIC SAFETY AND SECURITY RESPONSE

Capability Summary: Public Safety and Security Response is the capability to reduce the impact and consequences of an incident or major event by securing the affected area, including crime/incident scene preservation issues as appropriate, safely diverting the public from hazards, providing security support to other response operations and properties, and sustaining operations from response through recovery. Public Safety and Security Response requires coordination among officials from law enforcement (LE), fire, and emergency medical services (EMS).

Outcome: The RSS site did not have security set up prior to arrival of inventory. There was a delay in scene assessment and access control which could jeopardize the safety of first responders managing the SNS assets.

Activity 1: Establish Security

Observation 1.1 (Area for Improvement): Security at RSS was not readily available or present at arrival time of the Managed Inventory. After the Security Unit arrived, there was no authentication of RSS staff as per Entry Authorized Listing (EAL).

Reference(s):

1. DOH RSS Operating Procedures

Analysis: The lack of security control placed the RSS team and the delivery at risk. Due to the delay of security personnel arriving at the beginning of first shift, multiple RSS staff were not authenticated. The back doors to warehouse were locked but not directly linked to an active alarm, and there were no security staff assigned to that area. The sensitive content of the

Managed Inventory delivery is crucial for public assurance during a pandemic scenario. At no time during the first RSS team shift was there a check of staff on hand against the EAL.

Recommendation(s):

1. Ensure that RSS plan states that initial RSS staff and security personnel are to arrive at same time
2. Revise security checklist to include a full perimeter check of RSS site with situation reports to be done prior to activation and hourly
3. Ensure that RSS plan includes an initial check of RSS personnel against the EAL

CAPABILITY: MEDICAL SUPPLIES MANAGEMENT AND DISTRIBUTION

Capability Summary: Medical Supplies Management and Distribution is the capability to obtain and maintain medical supplies and pharmaceuticals prior to an incident and to transport, distribute, and track these materials during an incident.

Outcome: Critical medical supplies and equipment were received from the CDC, but several technical difficulties significantly delayed the repackaging and distribution of the SNS supplies. Site security was initially delayed, and there was limited communication between RSS site and EOC/ACC due to reallocation of human resources needed to manage inventory data.

Activity 1: Direct Medical Supplies Management and Distribution Tactical Operations

Observation 1.1 (Area for Improvement): Situational reports were minimal between RSS command center and RSS warehouse.

Analysis: Throughout both shifts, consistent and up to date information was lacking from the RSS warehouse. The DOH EOC did not have a clear situational awareness during the entire RSS drill. A "roll with the punches" mentality took place and eventually the RSS Lead Controller had to come to the warehouse and make sure everybody was on the same page. The lack of regular updates between the command center and the warehouse caused confusion and frustration to all players.

Recommendation(s):

1. Revise plan to include hourly situation reports between RSS and EOC

Observation 1.2 (Area for Improvement): The RSS Task Force Leader did not establish communications with the State EOC and the DOH EOC.

Reference(s):

1. DOH RSS Operating Procedures, Section IV, paragraph B, 2.
2. DOH EOC Emergency Operations Plan (EOP)

Analysis: Within the RSS command post, the RSS Task Force Leader has a desk, computer, and telephone. Command post phone numbers were not communicated to the EOCs with specific communications channels established. The RSS Task Force Leader spent very little time in the command post and therefore lost a valuable communications link. Additionally, the responsibility of who communicates with the RSS from the DOH EOC is not clear. DOH EOC procedures do not clearly delineate how this should happen.

Recommendation(s):

1. Establish RSS site communications with the EOCs
2. DOH EOC plan needs to clear delineate what positions are responsible for establishing and maintaining communications with the RSS during RSS activation.

Observation 1.3 (Strength)*:* ICS/NIMS used successfully for RSS during exercise

Reference(s):

1. DOH RSS Operating Procedures, Section VI, paragraph 1, b. and figure 2.

Analysis: During the exercise it was discovered that the Inventory Section did not have adequate staffing. The Inventory Management Lead expanded her staff from two to five specialists to complete data entry of incoming medical resources into the RITS system. The RITS system is an electronic tracking system for all medical resources that are received and distributed from the warehouse, and is critical for a successful operation. The expansion of the Inventory Section is an example of the use of the incident command system that should be copied in future endeavors..

Recommendation(s):

None

Activity 2: Repackage and Distribute

Observation 2.1 (Area for Improvement): Staging of inventoried pallets became more efficient as team became familiar with recourses on hand. Pallets were delivered in the wrong direction, which caused an initial delay in inventory.

Reference(s):

1. DOH RSS Operating Procedures

Analysis: inventoried managed inventory pallets began at 0948. By 1000 staging staff noticed pallets would be inaccessible should the need for an entire pallet arise. Inventory sheets were pulled from first 13 pallets by the staging lead which caused pallet shifting to be extremely

unorganized. The RSS Operations Chief assisted in the pallet shifting, bringing the number of staff moving the pallets to five, which cluttered the work space.

Recommendation(s):

1. Develop marking system for pallets and other assets during the staging procedures

Observation 2.2 (Area for Improvement): The RSS Inventory Management Tracking System (RITS) took four personnel nearly six hours to input the data from the Managed Inventory that arrived at the RSS, causing a significant delay in distributing the resources.

Reference(s):

1. DOH RSS Operating Procedures

Analysis: The inventory lead and two inventory specialist had to perform the data entry of items received in the RSS warehouse. This is a multi-step process in the RITS system to first enter the item by National Drug Code or stock number, receive the item, put the item away and then confirm the item is put away. With 63 pallets and 21 line items the process took six hours. The RITS system needs to be updated and the process simplified. Our Federal partners and the providers of RITS need to take steps to make the receiving of line items as easy, quick, and accurate as possible.

As a result, the delivery of SNS resources to King County medical facilities failed to occur. This caused several King County medical facilities to wait for many hours to receive resources so that they could effectively test their plans. Notification of the delays was never communicated through the system to the individual facilities.

Recommendation(s):

1. Work with the CDC, Division of Strategic National Stockpile, RITS project management to enhance the system with easier receiving capabilities and push to include bar code reading capabilities to streamline product entry into the inventory

Observation 2.3 (Strength): Three 53-foot tractor trailers arrived in the compound at 08:25 and were unloaded without delay, even though the main body of staff were still en route to the RSS.

Reference(s):

1. DOH RSS Operating Procedures, Section VI, paragraph 2, d.

Analysis: The use of partnerships between the Department of Health, General Administration, and the State Patrol is extremely valuable. The patrol continued to establish a security perimeter while the DOH Advance Team and the General Administration (GA) personnel unloaded the first trailer prior to the arrival of the RSS team's main group of personnel. A pause for briefing

and just-in-time training of the arriving staff and then work continued with all trucks being unloaded within forty minutes.

Recommendation(s):

None

Alternate Care Facility (ACF)

Demonstrated Targeted Capabilities:

Emergency Public Information and Warning
Emergency Public Safety and Security
Emergency Triage and Pre-hospital treatment
Medical Surge
Onsite Incident Management
Volunteer and Donations Management

CAPABILITY: EMERGENCY PUBLIC INFORMATION AND WARNING

Capability Summary: Develop, coordinate, and disseminate accurate alerts and emergency information to the media and the public prior to an impending emergency and activate warning systems to notify those most at-risk in the event of an emergency. By refining its ability to disseminate accurate, consistent, timely, and easy-to understand information about emergency response and recovery processes, a jurisdiction can contribute to the well-being of the community during and after an emergency.

Outcome: Press briefings were organized and well coordinated at the ACF. In a real event tours would not interfere with the operations of an ACF, but more depth for leads in Operations has been identified as a need.

Activity 1: Manage Emergency Public Information and Warnings

Observation 1.1 (Area for Improvement and Strength): Public Health Information Center (PHIC) members effectively managed the press briefing and media tour at the ACF.

Reference(s):

1. Communications Plan
2. Pan Flu Annex
3. PHSKC Objectives: 3, 5, 7
4. Alternate Care Facility Annex/Plan

Analysis: A media briefing and tour were held at the ACF on Tuesday, November 18th. A press packet was given to each member of the media as they entered. Materials were clear; speakers were appropriate and prepared. PHIC members completed various assignments in organizing and conducting the press briefing and media tour.

Because some media arrived early, they wished to wander the facility prior to the briefing rather than waiting for the tour. This caused more work for the PHIC members as they had to re-gather these individuals.

They were taken through the badging process as if they were a volunteer or patient and were then escorted to the media briefing area. The briefing location allowed them to see the entire room from a raised angle. They were then given a tour of the facility with mock patients being cared for and transported.

Recommendation(s):

1. Plans for media briefings need to include procedure for holding the media in a secured area until the briefing is held

CAPABILITY: EMERGENCY PUBLIC SAFETY AND SECURITY RESPONSE

Capability Summary: Public Safety and Security Response is the capability to reduce the impact and consequences of an incident or major event by securing the affected area, including crime/incident scene preservation issues as appropriate, safely diverting the public from hazards, providing security support to other response operations and properties, and sustaining operations from response through recovery. Public Safety and Security Response requires coordination among officials from law enforcement (LE), fire, and emergency medical services (EMS).

Outcome: The incident scene was assessed and secured, access was controlled, and security support was provided to the alternate care facility (ACF) by Seattle Police Department and Seattle Center Emergency Services.

Activity 1: Maintain Public Order

Observation 1.1 (Strength): The security plan was well executed and the performance of the security people was very good.

Reference(s):

1. Alternate Care Facility Annex/Plan

Analysis: There were Seattle Police and Seattle Center Emergency Services staff on site and the security personnel arrived early. They were stationed at the check-in counter and outside and inside the building at various locations including the pharmacy, the command post, the supplies section, and several other locations. Their presence was obvious and well planned.

The security team did a great job of making sure that the area was well policed and the presence was well planned. Seattle Center Emergency Services worked well in coordinating with the Seattle Police Department.

Recommendation(s):

None

Activity 2: Control Traffic, Crowd, and Scene

Observation 2.1 (Strength): There was good traffic and crowd control

Control traffic and crowds—most of issue was with tour groups! But well-organized by having free space around work areas so didn't interfere with patient care.

Reference(s):

1. Alternate Care Facility Annex/Plan

Analysis: ACF staff was very professional and continued with their work despite distraction of tour groups. In real event, depending on medical condition of patients, there would be no tour groups. This exercise allowed staff to exercise public relations effectively.

Recommendation(s):

None

CAPABILITY: EMERGENCY TRIAGE AND PRE-HOSPITAL TREATMENT

Capability Summary: Triage and Pre-Hospital Treatment is the capability to appropriately dispatch emergency medical services (EMS) resources; to provide feasible, suitable, and medically acceptable pre-hospital triage and treatment of patients; to provide transport as well as medical care en-route to an appropriate receiving facility; and to track patients to a treatment facility.

Outcome: Emergency medical services (EMS) resources were effectively and appropriately dispatched and transported patients to the ACF. There were a few patients that were sent to the ACF who were inappropriate placements for that setting, to assess the ACF ability to redirect these patients to a more appropriate facility. Flow of transport for EMS was efficient and effective.

Activity 1: Direct Triage and Pre-Hospital Treatment Tactical Operations

Observation 1.1 (Area for Improvement): The staff did not utilize the established pre-hospital triage system.

Reference(s):

1. Alternate Care Facility Annex/Plan

Analysis: Many patients arriving to the ACF were inappropriate for the facility and, if the current pre-hospital system were being utilized, would never have been sent to the ACF. The severely injured poly-trauma patient is an example. This patient was hit by a car and arrived intubated with multiple long bone fractures and was hemodynamically unstable. It is not clear why this patient would not have gone straight to the trauma center. With the current system, the medics would have called Harborview Medical Center (HMC) and the patient would have been transported to HMC. It is not clear why this system was not used. This patient utilized time and resources that could and should have been spent better elsewhere. If the trauma hospital is so overwhelmed it cannot take significant trauma, then our standards of care have to be significantly altered and, if this was the case, it was not communicated to any of the staff.

Recommendation(s):

1. Through training ensure staff is familiar with the existing pre-hospital evaluation system utilized by Seattle Medic One
2. Conduct an exercise to test staff knowledge and understanding of the pre-hospital evaluation system

Observation 1.2 (Area for Improvement): Alternate standards of care are not clear to pre-hospital providers.

Reference(s):

1. Alternate Care Facility Annex/Plan

Analysis: Patients arriving to the ACF were quite ill and, if we had full resources, should have gone to a hospital to be evaluated. Again, it was not clear what type of pre-hospital evaluation and triage was being done. An example was the 80-year-old nursing home patient (full code) with multiple strokes and a history of aspiration who presented to the ACF with decreased level of consciousness, hypotension, and respiratory distress. In a non-pandemic flu situation, this patient would have been evaluated by the paramedics, likely intubated, and taken to a hospital for treatment. One would surmise that given that the ACF is open and running, the hospitals are over-run. It was not clear whether this patient was transferred to the ACF for comfort/palliative care (which seems appropriate in a pandemic) or for treatment. If for treatment, it is not clear why our existing system was not being utilized. If for comfort, no one in the facility knew that standards had been changed. This patient was transferred in, intubated, stabilized, and then transferred to another hospital. If that was to be the plan, the patient should have gone to a hospital in the first place.

Recommendation(s):

1. Develop better communication regarding alternative standards of care and area hospital saturation to EMS providers as well as providers in the ACF

CAPABILITY: MEDICAL SURGE

Capability Summary: Medical Surge is the capability to rapidly expand the capacity of the existing healthcare system (long-term care facilities, community health agencies, acute care facilities, alternate care facilities and public health departments) in order to provide triage and subsequent medical care. This includes providing definitive care to individuals at the appropriate clinical level of care, within sufficient time to achieve recovery and minimize medical complications. The capability applies to an event resulting in a number or type of patients that overwhelm the day-to-day acute-care medical capacity. Medical Surge is defined as the rapid expansion of the capacity of the existing healthcare system in response to an event that results in increased need of personnel (clinical and non-clinical), support functions (laboratories and radiological), physical space (beds, alternate care facilities) and logistical support (clinical and non-clinical equipment and supplies).

Outcome: Regional coordination with the hospitals and healthcare system is a critical element to Health and Medical Area Command. Continuing to support the broad healthcare system is challenging and close coordination is necessary to be efficient in these efforts. The ACF was set up to receive all levels of triage and patient care. It is not set up to sustain high acuity of patient care, and would transfer higher levels of care to appropriate healthcare facilities. Continuity of care was maintained for patients and their families. Most of the evaluation for the ACF exercise was focused on correct/readable signage, and patient flow through the ACF.

Activity 1: Receive and Treat Surge Casualties

Observation 1.1 (Area for Improvement and Strength): Most signage was clear, readable, visible, with good use of color and clear icons, however, improvements are needed.

Reference(s):

1. Alternate Care Facility Annex/Plan

The colors for each area (e.g., ‘Start Here’, ‘Check In”, and “Check Out”) were very helpful.

It was great to have signs for each language indicating the availability of interpreters, but they were difficult to see because they were laying on the tables rather than being posted. Possibly the interpreter signs should be posted as well as being on the Check-In tables to ensure they are seen by the patients.

Also, the “No” signage with photographs such as cigarette, weapons, etc., were very good. However, there was no icon on the “Do not leave children unattended” sign. Several critical

signs did not have icons: “Please wait for staff,” “Medical Exam” and “Urgent Care,” which left the signs virtually non-understandable to someone who could not read the text.

There were no signs indicating the location of the restrooms.

Some of the signs outside were not easily seen (e.g., sign language interpreter). The “Entrance” sign in the front also said “Entrance” on the back side, so the information was not correct for someone who was facing the street and taking the sign very literally. There was a “health care facility” sign at the back of the building, but there were no icons or arrows pointing to the entrance.

There was confusion about the colored vests and what each color represented.

There was congestion in the Check-In area at the tables for information and check-in. The evaluator was uncertain if there was a difference in functions. This signs for the Medical/Urgent Care area were very clear, but one evaluator felt the pediatric signage should be posted higher. Check Out signage was not easily seen in Urgent Care (red/yellow) or Medical Care (green).

There was no disability exit signage in the Check Out area.

Recommendation(s):

1. Add the “family” picture to the “Do not leave children unattended” for people who are not proficient in English
2. Develop signs with arrows to direct people to the restrooms
3. Design icons/pictures for the “Please wait for staff,” “Medical Exam,” and “Urgent Care” signs
4. Modify the ACF set-up plan to place signs regarding the availability of language interpreters on posts or walls
5. Add a task to the ACF set-up tasks to ensure that signs, inside and outside, are visible – high enough, not lying down, located appropriately, etc.
6. Consider separate tables for Information and Check In
7. Ensure that enough Check Out signs, including disability exits signs, are available so they can be easily followed by patients

Observation 1.2 (Area for Improvement and Strength): Most signage is readable from a distance.

Reference(s):

1. Alternate Care Facility Annex/Plan

Analysis: All the signs, inside and outside, were readable from a distance. The size, font, color, and background color all contributed to readability. However, it is unknown if the Chinese

lettering was readable from a distance. Poor signage for the Chinese population would hinder appropriate treatment of these people.

Recommendation(s):

1. Evaluate Chinese signage to ensure that lettering is large enough to be readable from a distance

Observation 1.3 (Area for Improvement and Strength): Signs with green, red, and yellow arrows assisted patients through part of the process, but the signs at medical exam and urgent care did not these colored arrows causing confusion.

Reference(s):

1. Alternate Care Facility Annex/Plan

Analysis: It was easy to see where patients should go for registering, checking in, and waiting. The green, red, and yellow arrows helped with the flow. The absence of green, red, or yellow arrows by the "medical exam" and "urgent care" signs stopped the flow in the waiting room and caused confusion for some patients. There were no arrows directing patients to the exam room or Step 3, the Check Out. The "Step 3" sign was not visible from the treatment room. The arrow signs were included to show patients where to go; arrows are an easily understood icon. Perhaps no arrow signs were placed by the "medical exam" and "urgent care" signs because patients are supposed to wait until escorted by the medical staff instead of just following the arrows on their own. Patients might be confused or more stressed if they are unable to see via signage where their next steps will be.

Recommendation(s):

1. Evaluate the signage to be used in the "medical exam" and "urgent care" waiting area so patients can more easily understand that they are to wait to be called
2. Develop better, clearer signage system for the exit areas

Observation 1.4 (Area for Improvement): The staff were congregating around signs and covering them completely on many occasions.

Reference(s):

1. Alternate Care Facility Annex/Plan

Analysis: The sign at the entrance of the building, next to the road, the sign in the entrance, and the sign Step 1 were obstructed by police, EMS, security, and other people, equipment, and cars. It was hard to see them. It was hard to come near them to read. The number of police might discourage people from coming in or coming closer. The front door was also closed. Each factor by itself is not a major issue. But together they create a physical access problem to the Health Center.

Recommendation(s):

1. Revise plan to ensure that patient and emergency personnel entrances are separate and well marked
2. Ensure all signs are free from clutter or congregating groups of people

CAPABILITY: ON-SITE INCIDENT MANAGEMENT

Capability Summary: Onsite incident management is the capability to effectively direct and control incident management activities by using the Incident Command System (ICS) consistent with the National Incident Management System (NIMS).

Outcome: The set up and operation of the Alternative Care Facility was successfully accomplished. PHSKC staff and Public Health Reserve Corp (PHRC) volunteers reported to the ACF and received appropriate just-in-time training for their positions. Patients were transported and received appropriately. Establishing the ACF was managed safely, effectively, and efficiently through the integration of the facility, resources (personnel, equipment, supplies, and communications), and procedures using a common organizational structure that is ICS.

Activity 1: Establish full on-site Incident Command

Observation 1.1 (Strength): ICS was established at ACF

Reference(s):

1. Alternate Care Facility Annex/Plan

Analysis: The Operations Chief followed good ICS protocol by identifying the importance of all participants to report to their "Leads" and identifying who certain Leads were.

Recommendation(s):

None

Observation 1.2 (Area for Improvement): During the staff briefing it was very difficult to hear the Operations Chief.

Reference(s):

1. Alternate Care Facility Annex/Plan

Analysis: Operational leaders need to realize the critical nature of the Incident Briefing to eliminate as many potential problems as possible. The Incident Briefing involves many key people to run a successful ACF and attention to detail is absolutely necessary. This helps eliminate confusion and enhances the usefulness of "chain of command". During both parts of the briefing it was very difficult to hear the Operations Chief and Deputy. Many participants in the rear attempted to move closer to hear better and several commented more than once that they

could not hear. When nothing was done to correct this, many individuals lost interest in listening and began side conversations which only exacerbated the situation. As it was an exercise, many already knew their role; but in a real event, this briefing holds even more importance and needs to meet everyone's needs. By not recognizing and correcting the problem the staff were not as well informed as they should have been.

Recommendation(s):

1. Provide training to Operational Leaders and ICS Lead positions at ACF to ensure that everyone can hear and fully participate in all necessary briefings and meetings

Observation 1.3 (Area for Improvement): Several leaders missed training opportunities with critical involved community partners and volunteers because they were conducting tours.

Reference(s):

1. Alternate Care Facility Annex/Plan

Analysis: There were several VIP/media tours during the ACF exercise, and all were led by operational leads. This detracted from training the community and volunteer support personnel who arrived as surge staff. Many of the surge staff voiced a need for better training and explanation of their roles and responsibilities. All who participated in the ACF exercise commented positively, stating they considered this a great success, and that it was an exceptional undertaking.

Recommendation(s):

1. Plan for non-exercise personnel to lead VIP/media tours in future ACF exercises

Observation 1.4 (Strength): Set up of the ACF and the ability to support Medical surge capacity by using volunteer resources was successful.

Analysis: Overall the Logistics section team was able to set up the ACC before it was open to the public. The Logistics Section Chief was able to effectively utilize the volunteers on hand and both the Logistics Section Chief and Facilities Support Unit Leader effectively assigned responsibilities and established priorities. The logistics teams were familiar with cache contents and had the appropriate knowledge of setting up beds. The preposition of supplies was helpful to teams and facility maps included sections and beds layouts very handy. The check-in process went smoothly.

Recommendation(s):

1. Conduct a walk through of the facility with clinical staff and logistics teams prior to opening the ACF for operations.

2. Make available a signage board for the teams to post essential information, which could include the prepared Incident Action Plan, assign roles and priority task.
3. Urgent Care along with Communications Section should be the primary section to be completed before all other sections. A checklist prioritizing the order of sections to be set up would be helpful to have on hand.
4. Need heavy-duty cord mats to prevent tripping over cords and for heavy equipment to move over.
5. Have fork lift operators available to assist with moving caches or additional load that may come in

Observation 1.5 (Area for Improvement): Several logistics issues were identified regarding set up of the ACF.

Reference(s):

1. Alternate Care Facility Annex/Plan

Analysis: Throughout set-up and the operational period several logistics issues were identified at the ACF.

- The map that was provided did not match the layout that was used. This caused confusion to those who attempted to use the map.
- Power cords and hoses posed a tripping hazard in some locations. The safety of staff and patients is very important and a very busy ACF staff might not see the hazard.
- Having staff assigned to obtain supplies and to assist with mobility of some patients would be very helpful.
- Pack specialty supplies (e.g., pediatric- or gynecological-specific) in colored containers to distinguish them from routine adult supplies
- General supplies and medical supplies should be in separate storage areas with supply clerks assigned to each area. Medical supplies can be physically near the pharmacy for security but should be separately staffed and operated.
- There was no morgue or morgue staging area at the ACF. In a real event, this would be a needed function and would include special equipment and supplies, a secured space, and a plan for transporting the bodies.

Recommendation(s):

1. Consider having a “standard” ACF layout and modify it the day before or day of a set-up and distribute the revised map
2. Purchase some commercial products used to temporarily cover items on the floor to minimize tripping and allow for rolling of carts
3. Revise plan to assign staff for patient movement within the ACF
4. Develop simple request forms for areas to give to runners to obtain supplies (medical and other)

5. Establish a process for requesting wheelchair or other mobility assistance
6. Revise the plan to separate general supplies and medical supplies, establish supply clerk roles, and develop an inventory system to track receipts and withdrawals
7. Revise the plan to include a morgue/staging area, including a physical space and the specialized equipment and supplies that would be needed

Observation 1.6 (Area for Improvement): There was no formal Demobilization Plan

Reference(s):

2. Alternate Care Facility Annex/Plan

Analysis: Although the logistics teams demonstrated enthusiasm in breaking down the ACF, there was no written demobilization plan. This caused a lack of communication by Logistics Section Chief in explaining how Clinical and Logistics teams should assist with demobilization. The tear down appeared disorganized as the team concept broke down. The process for re-packing boxes and tracking boxes was not available, causing disorganized repackaging.

Recommendation(s):

1. Develop a demobilization plan and brief teams on actions items in the demobilization plan.
2. Establish process for restocking boxes which can include the following:
   - Provide a packing list needed in order to properly place the content into the box without damage the items, and also to keep track of items.
   - Take pictures of how to set up the items and how to store the items
   - Each piece of equipment should be coded w/each box
   - Each cache needs to be labeled with content inside
   - One lead packer should be assigned to track content of box as its being pack and make sure its being appropriately packed
   - Improve tracking of signage during breakdown

CAPABILITY: VOLUNTEER AND DONATIONS MANAGEMENT

Capability Summary: Volunteer and Donations Management is the capability to effectively coordinate the registration and management of unaffiliated volunteers and unsolicited donations in support of domestic incident management.

Outcome: Volunteers were identified, trained, and placed in appropriate response positions at the ACF.

Activity 1: Organize Volunteers and Assign Them to Disaster Relief Efforts

Observation 1.1 (Strength): Verification of skilled and non-skilled skilled volunteers occurred at check-in.

Reference(s):

1. Alternate Care Facility Annex/Plan

Analysis: King County ACF had a dedicated ACF personnel unit with an organized and structured staff and volunteer reception area and there is a system available for checking credentials / accreditation of skilled volunteers at the check-in desk.

Recommendation(s):

None

Observation 1.2 (Area for Improvement): Washington Health Volunteers in Emergencies (WAHVE) volunteer application did not contain all required information fields.

Reference(s):

1. Alternate Care Facility Annex/Plan
2. Public Health Reserve Corps Spontaneous Medical Volunteer Registration Form

Analysis: The WAHVE volunteer application did not contain all required information fields. It was missing date of birth and Social Security number. In addition, many volunteers did not provide all their information—most notably their medical license number. WAHVE is a portable web-based volunteer management application that can be utilized on any computer with internet capabilities to verify the information on spontaneous volunteers. WAHVE can be easily integrated into existing processes related to the check-in and verification of reporting volunteers.

To utilize the WAHVE web-based volunteer verification system in an efficient manner, volunteers need to fill out a volunteer application to gather all of their required background information including birth date and Social Security and medical license number.

DOH had a draft form developed to gather this information and the King County Public Health Reserve Corps had a similar form used for spontaneous volunteers. In an attempt to streamline paperwork for the volunteers, the forms were integrated at the last minute without a lot of time to thoroughly review the final product prior to the exercise date. In a real world event, this breakdown in the system would have caused unnecessary delays in granting authorized volunteer status to many individuals.

Recommendation(s):

1. Review the Spontaneous Medical Volunteer Registration Form to ensure that all required data fields are present
2. Share the revised form with other Medical Reserve Corps (MRC) programs that want to utilize WAHVE to verify medical credentials

3. Create list of required documentation to verify credentials of volunteers and share with Communications for use in releases to media and in PHSKC advisories when requesting or giving instructions to volunteers

Observation 1.3 (Area for Improvement): WAHVE web-based application background check query was not configured properly to test at ACF.

Reference(s):

1. WAHVE Web-Based Software Application Primary Source Verification Portal
2. Alternate Care Facility Annex/Plan

Analysis: The WAHVE web-based application serves as a tool to verify the credentials of medical professionals. It has the ability to query against several databases including the DOH state license, National Practitioner Data Bank (NPDB), American Board of Medical Specialties (ABMS), Office of Inspector General (OIG), Drug Enforcement Agency (DEA), National Criminal Background, and Social Security number check. In order for the system to work effectively, it is important to ensure that system in configured properly.

During the exercise, it was discovered that the background check portal was not configured properly in advance and, thus, was not working correctly. During the exercise, we were able to contact the vendor to fix the problem.

Recommendation(s):

1. Work with the WAHVE system vendor to ensure that all Primary Sources Queries are configured properly

Washington State Department Of Health Laboratory

Demonstrated Targeted Capabilities:
Laboratory Testing

CAPABILITY: LABORATORY TESTING

Capability Summary: The Laboratory Testing capability is the ongoing surveillance, rapid detection, confirmatory testing, data reporting, investigative support, and laboratory networking to address potential exposure, or known exposure, to all-hazards which include chemical, radiochemical, and biological agents in all matrices including clinical specimens, food and environmental samples, (e.g., water, air, soil). All-hazard threats include those deliberately released with criminal intent, as well as those that may be present as a result of unintentional or natural occurrences.

Outcome: The Washington State Public Health Laboratories' exercise goal was to determine the surge capacity of the laboratory and its ability to achieve testing capabilities for critical samples during a pandemic. The public health laboratory worked in close partnership with public health epidemiology, hospitals and environmental health producing timely and accurate data to support ongoing public health investigations and the implementation of appropriate preventative or curative countermeasures. They exercised a scenario to test ability to provide essential lab functions when both day-to-day capabilities were exceeded and critical staffing positions were unfilled.

Activity 1: Direct Public Health Laboratory Testing

Observation 1.1 (Area for Improvement): Public Health Laboratory response was taxed due to increased sick calls, leaving staff available who were not familiar with the test procedures and forcing prioritization of essential functions.

Reference(s):
1. Public Health Laboratory Testing WA DOH Objective 1

Analysis: The Microbiology laboratory had minor involvement on November 13 until the first sample arrived around noon. During that day, after receiving the WHO Phase 4 announcement, the Laboratory Director checked with microbiology supervisors to determine the flu testing capabilities. Staff planned how they would begin testing and, as part of the exercise, key staff members were taken out of play to see how the laboratory would adapt. Meetings were held and strategies were devised to determine how testing for large numbers of samples would be accomplished. Surge capacity was looked at in terms of instrumentation needed to perform the tests. It was determined that if sample requests increased greatly then instruments in Newborn Screening and the BioWatch labs would be used. Plans were made for running shifts if necessary. The laboratory received the first case for flu testing that afternoon.

On November 14 the lab discovered that the BioWatch instruments could not be used for testing unless they were calibrated for the test. BioWatch staff assisted the Microbiology staff to perform these calibrations. The laboratory received more samples and used the manual login system that had been developed for outbreaks. Dr. Gautom contacted partner labs on the 13th and the 14th to alert them of the status in Washington state and to determine if they could provide surge capacity if needed. Laboratories which were contacted were: Seattle King County, the FDA laboratory in Bothell, the Washington Animal Disease Diagnostic Laboratory, the University of Washington Virology Laboratory, the Montana Public Health Laboratory, and the British Columbia Center for Disease Control Laboratory. All the laboratories were willing to help in anyway that they could. On November 17, 2008, the exercise resumed after the weekend break. Dr. Gautom was taken out of play and Blaine Rhodes was made the Operations Chief for the Laboratories. By this point the microbiology lab's involvement in the exercise was minimal; however, the chemical response team was processing and testing samples for selenium.

Recommendation(s):

1. Provide cross-training between sections at the laboratory
2. Create just-in-time training for surge staff.
3. CD Epi and Microbiology to revise reporting methods for CD Epi during a huge outbreak
4. Determine how much testing would be necessary for each county and at what time to stop testing
5. Create message template for internal communication between departments
6. Consider HR policy changes to help keep critical staff at PHL

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CHAPTER 4: CONCLUSION

The Pandemonium 2008 Full-Scale Exercise (FSE) successfully achieved most of the objectives to assess and evaluate current concepts, plans, and capabilities for response issues pertaining to Pandemic Influenza.

Other findings are intended to provide the basis for continued development of planning guidelines, equipment selection, and responder training. Exercise participants identified several lessons learned. Major areas for improvement are as follows:

- Develop process for consistent, timely and accurate information sharing between departments, response partners, and government agencies.
- Develop and exercise security plans for all venues necessary to support a pandemic influenza response, to include EOC/ACC/RSS/ACF
- Develop and exercise COOP plans.
- Identify areas that will need surge staff, and develop just-in-time training for each function.

The State Department of Health identified the following major areas for improvement:

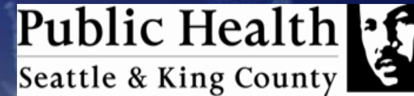
- Lack of agreed upon and verifiable epidemiological data during a flu made policy decisions difficult at multiple levels.
- Designating at DOH EOC position to be the liaison with the Strategic National Stockpile (SNS) Washington State Reception Storage and Staging (RSS) Facility would greatly improve the situational awareness at both locations
- The Public Health Response and Assessment Team process needs further analysis and updating. The current process proved cumbersome and is not well defined.
- The process for requesting and receiving certain federal medical surge support including the Federal Medical Stations is unclear and needs refinement
- Although the RSS has a well developed ability to receive and account for the SNS push packages, the ability to receive large scale managed inventory deliveries using the RITS inventory tracking system needs further development.
- DOH should continue to conduct progressively more robust tests of its' Continuity of Operations Plans.

This FSE clearly reflected many of the challenges facing the State of Washington and the Public Health Region 6 agencies. While the exercise scenario brings into question many concepts regarding response to an overwhelming public health emergency, such as a pandemic, the agencies demonstrated their credentials, dedication, and intent to support a coordinated effort. Follow-up exercises addressing critical components of the overall response should be pursued.

APPENDIX A: IMPROVEMENT PLAN

This Improvement Plan (IP) has been developed specifically for the Washington State Department of Health and Public Health - Seattle & King County as a result of the Pandemonium 2008 Full-Scale Exercise conducted November 13, 14, 17, and 18, 2008. The following table includes the key recommendations and corrective actions identified in *Chapter 3: Analysis of Capabilities*, the After Action Conference, and the Exercise Evaluation Guides (EEGs). The IP has been formatted to align with the *Corrective Action Program System*.

Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
Public Health – Seattle & King County Communicable Disease (CD)/Epidemiology (Epi)				
CAPABILITY: EMERGENCY PUBLIC INFORMATION AND WARNING				
1.1: There was a delay in communicating initial surveillance and epidemiological information to health providers (via the Information and Alert Network [IAN])	1.1.1: Revise response plans to emphasize initial situation status with healthcare providers during an evolving situation	1.1.1.1:		
		1.1.1.2:		
	1.1.2: Stream line process to authorize IAN alerts and updates	1.1.2.1:		
		1.1.2.2:		
	1.1.3: Prioritize situational information to disseminate to appropriate agencies and include timeframe that further information will follow	1.1.3.1:		
		1.1.3.2:		
	1.1.4: Coordinate release of situational status with PIO and Washington (WA) State Department of Health (DOH)	1.1.4.1:		
		1.1.4.2:		



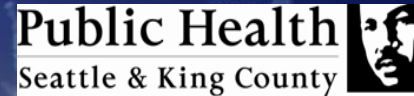
Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
1.2: Surveillance information was not communicated between CD Epi, Public Health Information Call Center (PHIC), Area Command Center (ACC), and other partners on a regular basis.	1.2.1: Establish policy for timeline of initial CD/Epi message release	1.2.1.1:		
		1.2.1.2:		
	1.2.2: Designate CD Epi liaison to physically sit in the ACC, to be available to the PIO, and joint information center (JIC) and to appreciate communication needs	1.2.2.1:		
		1.2.2.2:		
	1.2.3: Develop pre-canned message templates with CD Epi staff input	1.2.3.1:		
	1.2.4: Train CD Epi staff on role in emergency public information and warning, message development and coordination, and available communication resources (PICC, Community Communications Network, WATrac)	1.2.4.1:		
		1.2.4.2:		
1.3: The alerting system and lists from CD/Epi worked well for most hospital systems.	1.3.1: Update contact list for distribution of alerts and warnings	1.3.1.1:		
		1.3.1.2:		
2.1: There was often confusion between ACC/WA DOH EOC/PHSKC CD Epi about information regarding the number of patients	2.1.1: Activate JIC to monitor rumors/provide control	2.1.1.1:		
		2.1.1.2:		

Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
involved and status of the investigation.	2.1.2: Establish policy for CD Epi situation status report development and dissemination	2.1.2.1:		
		2.1.2.2:		
	2.1.3: Consider integration of reporting system into WATrac to improve access to up-to-date information	2.1.3.1:		
		2.1.3.2:		
CAPABILITY: EPIDEMIOLOGICAL SURVEILLANCE AND INVESTIGATION				
1.2: There was difficulty with ongoing surveillance data management for rapidly evolving situation	1.2.1: Establish data management roles for surge issues	1.2.1.1:		
		1.2.1.2:		
	1.2.2: Data entry personnel to use separate room with laptops to enter data as it came	1.2.2.1:		
		1.2.2.2:		
	1.2.3: Train administrative staff on data entry using the pandemic influenza Microsoft Access database on the shared portal	1.2.3.1:		
		1.2.3.2:		
	1.2.4: Have a single data manager responsible for ensuring completed information is entered as rapidly as possible	1.2.4.1:		
		1.2.4.2:		
	1.2.5: Determine system to regularly share situation updates with ACC/Communication/DOH and	1.2.5.1:		
		1.2.5.2:		

Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
	appropriate healthcare agencies.			
	1.2.6: Have comprehensive blast fax list to include hospitals, healthcare providers, and appropriate state, local and federal agencies for disseminating public health information	1.2.6.1:		
		1.2.6.2:		
1.3: There was a lack of coordination and assistance between CD/Epi, ACC, and other areas of PHSKC	1.3.1: Prepare written response plans to include early communication with the ACC (or if the ACC is not yet activated, notification of the Preparedness Division) of the need for surge personnel	1.3.1.1:		
		1.3.1.2:		
	1.3.2: Establish clear guidelines for an early alert notification to other areas of the Health Department, including Emergency Services, in the Response Plan	1.3.2.1:		
		1.3.2.2:		
Emergency Support Function-8 Area Command Center				
CAPABILITY: COMMUNICATIONS				
1.1: CD Epi staff need to better understand the urgency of disseminating the initial health alert to health providers via the Information and Alert Network (IAN)	1.1.1: Revise response plans to include emphasis on the importance of this initial communication with the healthcare system during an evolving situation; guidelines on target timeframes to disseminate information; and guidelines to expedite the approval process before dissemination	1.1.1.1:		
		1.1.1.2:		
	1.1.2: Revise communications plan to coordinate release of information with	1.1.2.1:		

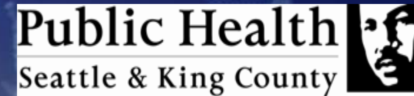
Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
	public information officer (PIO) activities including State Department of Health (DOH)	1.1.2.2:		
1.2: Internal communications were not sufficient to keep staff informed during the initial response	1.2.1: PHSKC Communications should develop a plan to prioritize internal communications in plans and pre-message development	1.2.1.1:		
		1.2.1.2:		
1.3: Several technical issues with WATrac hindered staff members' abilities to respond in a timely manner	1.3.1: Continue to develop procedures and training with regard to technological issues	1.3.1.1:		
		1.3.1.2:		
	1.3.2: Identify what network/software access is needed for staff and where the information will be available	1.3.2.1:		
		1.3.2.2:		
	1.3.3: Provide access and training on necessary sites for core staff and any expected surge staff	1.3.3.1:		
		1.3.3.2:		
	1.3.4: Develop a streamlined, tested process for gaining access for anyone who may be involved in the response	1.3.4.1:		
		1.3.4.2:		
	1.3.5: Develop just-in-time training for WATrac	1.3.5.1:		
		1.3.5.2:		

Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
	1.3.6: Obtain updated laptop availability for communications staff.	1.3.6.1:		
		1.3.6.2:		
	1.3.7: Work with Management Information Systems (MIS) to troubleshoot and resolve difficulties staff have when logging in on other employees' computers	1.3.7.1:		
		1.3.7.2:		
	1.3.8: Develop backup routes to access materials should technology fail	1.3.8.1:		
		1.3.8.2:		
CAPABILITY: CRITICAL RESOURCE LOGISTICS AND DISTRIBUTION				
1.1: Non-hospitals (e.g., clinics) did not have access to WATrac; therefore, those facilities could not provide Strategic National Stockpile (SNS) receipt information through that system or receive SNS delivery updates	1.1.1: Grant other health partners who may receive SNS supplies access to WATrac and provide training so that they can also use the system to update SNS receipt status	1.1.1.1:		
		1.1.1.2:		
1.2: The replacement Area Commander was not quickly	1.2.1: Ensure that there is a protocol for granting access to appropriate WATrac	1.2.1.1:		



Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
granted access to the WATrac resource request tracking tool	documents and WATrac rooms for replacement staff during the turnover process	1.2.1.2:		
CAPABILITY: EMERGENCY PUBLIC INFORMATION AND WARNING				
1.1: The PHSKC Communications Team, activated as the PHIC, is well organized, prepared, and integrated	1.1.1: Continue to provide training and exercise opportunities for the communications team	1.1.1.1:		
		1.1.1.2:		
1.2: The PHSKC Communications Surge Team was well prepared and integrated well despite technical issues.	1.2.1: Continue to provide training and exercise opportunities for the communications surge team	1.2.1.1:		
		1.2.1.2:		
2.1: Production of press releases and media interaction drove public outreach.	2.1.1: PHSKC PHIC should identify the development of key messages as a priority into the communications plan	2.1.1.1:		
		2.1.1.2:		
CAPABILITY: EMERGENCY OPERATIONS CENTER MANAGEMENT				
1.1: All ACC staff were not connected to a single chat/information room on WATrac	1.1.1: Consider creating a significant events log or some sort of document/information room for the ACC	1.1.1.1:		
		1.1.1.2:		
1.2: ACC staff identified the need for more template forms and reports.	1.2.1: Identify and develop templates for frequently used forms and reports. Consider storing the templates in a file on WATrac	1.2.1.1:		
		1.2.1.2:		

Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
1.3: The role of the PHSKC ESF 8 ACC Planning Section Operator was not clearly defined.	1.3.1: If using an operator make sure that the operator is aware of the scope of the calls that position should answer according to ICS	1.3.1.1:		
		1.3.1.2:		
2.1: The PHSKC ESF 8 ACC Planning Section did not demonstrate a clear information-sharing strategy with community partners	2.1.1: Use multiple modes of communications (besides email) to share information, such as the situation snapshot	2.1.1.1:		
		2.1.1.2:		
	2.1.2: Identify an information-sharing strategy that includes groups that would be especially vulnerable or reluctant to work with Public Health during a pandemic	2.1.2.1:		
		2.1.2.2:		
2.2: There were gaps in the regional coordination and communication between the hospitals and healthcare system and Health and Medical Area Command.	2.2.1: Regional team assist in exploring just in time training and fit testing for N95s and PAPRs	2.2.1.1:		
		2.2.1.2:		
	2.2.2: Health and Medical Area Command assign a note-taker to hospital conference calls, and/or record the calls	2.2.2.1:		
		2.2.2.2:		
	2.2.3: Health and Medical Area Command communicate the mission number of an event to hospitals once one is received/assigned	2.2.3.1:		
		2.2.3.2:		



Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
	2.2.4: Behavioral Health plan be developed for the ACF, similar to the pediatrics plan	2.2.4.1:		
		2.2.4.2:		
Emergency Support Function-8 Multi-Agency Coordination Group				
CAPABILITY: EMERGENCY OPERATIONS CENTER MANAGEMENT				
2.1: During the MAC meeting it was evident that factors influencing an efficient and effective policy decision making process were lacking.	2.1.1: Develop MAC Group briefing book	2.1.1.1:		
		2.1.1.2		
	2.1.2: Educate MAC Group members on response plans	2.1.2.1:		
		2.1.2.2:		
	2.1.3: Healthcare Coalition leadership to provide input on background information laid out in briefing book	2.1.3.1:		
		2.1.3.2:		
	2.1.4: Further clarify policy issues warranting input from MAC members	2.1.4.1:		
		2.1.4.2:		
Public Health Information Center (PHIC)				
CAPABILITY: EMERGENCY PUBLIC INFORMATION AND WARNING				
1.1: PHIC members have a	1.1.1: Incorporate the lessons learned	1.1.1.1:		

Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
strong desire to support partners.	and materials developed into plans.	1.1.1.2:		
	1.1.2: Develop and/or identify materials for an ad campaign based on the key messages and potential flow of events	1.1.2.1:		
		1.1.2.2:		
1.2: PHIC members successfully managed the press briefing and media tour at the ACF.	1.2.1: Designate a waiting area for media personnel, to prevent them wandering the ACF prior to briefings	1.2.1.1:		
		1.2.1.2:		
2.1: Although there were a few technical issues that were corrected immediately, staff who were trained in WATrac, had access to the appropriate rooms, and were able to consistently enter the system found it to be an outstanding method of coordination and communication.	2.1.1: Further develop procedures and training regarding technological issues	2.1.1.1:		
		2.1.1.2:		
	2.1.2: Determine what access is needed and where the information will be available	2.1.2.1:		
		2.1.2.2:		
	2.1.3: Obtain access and train core staff and any expected surge staff on necessary sites.	2.1.3.1:		
		2.1.3.2:		
	2.1.4: Develop a streamlined, tested	2.1.4.1:		

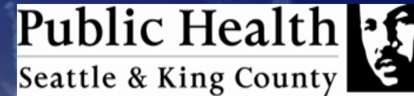
Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
	process for gaining access for anyone who may be involved in the response	2.1.4.2:		
	2.1.5: Develop just-in-time training for WATrac	2.1.5.1:		
		2.1.5.2:		
	2.1.6: Designate up-to-date laptop computers for communications staff to use during a response	2.1.6.1:		
		2.1.6.2:		
	2.1.7: Work with MIS to troubleshoot and resolve difficulties staff have when logging in on other employees' computers	2.1.7.1:		
		2.1.7.2:		
	2.1.8: Develop backup routes to access materials should technology fail	2.1.8.1:		
		2.1.8.2:		
2.2: PICC was activated and Just-in-Time-Training accomplished to begin operating the PICC	2.2.1: Provide dual ear headsets to cut down on background noise	2.2.1.1:		
		2.2.1.2:		
	2.2.2: Use a projector and screen for important information that must be	2.2.2.1:		

Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
	posted	2.2.2.2:		
2.3: Public outreach was initially driven by production of the press release and media interaction.	2.3.1: Revise plans, checklists, and templates to ensure that key messages are developed, posted in the ACC and distributed as appropriate	2.3.1.1:		
		2.3.1.2:		
	2.3.2: Develop pre-determined key messages along with basic templates for associated materials to various audiences including translated materials	2.3.2.1:		
		2.3.2.2:		
3.1: Pre-messaging was needed for the time-period, in which surveillance was initiated, but a disease had not been identified nor victims confirmed.	3.1.1: Use materials developed in the exercise to enhance existing pre-developed messages and materials	3.1.1.1:		
		3.1.1.2:		
	3.1.2: Develop likely key messages and related outreach materials and incorporate into the existing plans	3.1.2.1:		
		3.1.2.2:		
	3.1.3: Revise plans to include new messaging technology and develop plans to monitor and respond to messaging in other venues such as blogs and texting	3.1.3.1:		
		3.1.3.2:		

Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
	3.1.4: Incorporate PICC, internal communication, and special/vulnerable population needs and messaging in all outreach material development	3.1.4.1:		
		3.1.4.2:		
3.2: Translation and access to information for vulnerable populations was a constant consideration in message development.	3.2.1: Continue discussion and research with community partners into the needs, desires, and usage of vulnerable populations to ensure that the translations done are the most effective	3.2.1.1:		
		3.2.1.2:		
	3.2.2: Train staff members in recording phone messages, answering PICC calls, and checking the accuracy of translated materials from other sources	3.2.2.1:		
		3.2.2.2:		
	3.2.3: Add additional resources for the deaf and visually impaired	3.2.3.1:		
		3.2.3.2:		
3.3: Accessing the language line was a lengthy and difficult process. The Limited English Proficiency (LEP) calls often were dropped while the operator was attempting to get the translator on the line.	3.3.1: Provide operators with clocks that show the time spent on each call so that operators can better manage the call flow	3.3.1.1:		
		3.3.1.2:		
	3.3.2: Train the operators to end calls in a firm but polite manner	3.3.2.1:		
		3.3.2.2:		
	3.3.3: Provide a recording that says	3.3.3.1:		

Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
	"please stay on the line" in several languages or has music playing for callers who are put on hold	3.3.3.2:		
	3.3.4: PICC exercises and training for operators and technical specialist	3.3.4.1:		
		3.3.4.2:		
3.4: The system presented during the Just-in-Time-Training (use of flags for the Operators to call for designated types of assistance) was not consistent.	3.4.1: Standardize the phone system throughout the departments	3.4.1.1:		
		3.4.1.2:		
	3.4.2: Create written training aids for each phone system, to include how to place a call on "hold" or "mute" or to transfer a call or connect with another line	3.4.2.1:		
		3.4.2.2:		
	3.4.3: Create written instructions for a standardized Flag system	3.4.3.1:		
		3.4.3.2:		
	3.4.4: PICC training and drills for Operators and Technical Specialist	3.4.4.1:		
		3.4.4.2:		
Washington State Department of Health Headquarters				
CAPABILITY: COMMUNICATIONS				
1.1: DOH IT and DIRM staffs	1.1.1: All pre-identified EOC staff attends	1.1.1.1:		

Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
were present to assist with equipment use and training.	WebEOC training prior to exercise play which should ensure basic level of competency for a real event	1.1.1.2:		
	1.1.2: Train Director and Section Leads to encourage staff to ask questions, clarify how to use communication tools, and monitor use	1.1.2.1:		
		1.1.2.2:		
2.1: Not all staff scheduled for the DOH EOC activation received the message sent on November 20th via SECURES and other staff were confused by the message content.	2.1.1: Establish a schedule to regularly test EOC staff with SECURES alerts to measure response and identify those who need to update information	2.1.1.1:		
		2.1.1.2:		
	2.1.2: Train Duty Officers to understand they can and should coordinate with EOC Section Leads to collect needed or requested information from policy leadership and in developing messages to be sent out over SECURES	2.1.2.1:		
		2.1.2.2:		
3.1: There appeared to be gaps in the radio communications available and/or limited staff who knew how to use the various systems.	3.1.1: Replace Global Star Satellite phone with an alternate provider	3.1.1.1:		
		3.1.1.2:		
	3.1.2: Install a unit or docking station with a roof-mounted antenna for the satellite phone so that unit can be used indoors	3.1.2.1:		
		3.1.2.2:		

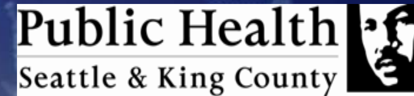


Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
	3.1.3: Consider VHF radios and repeaters as backup to 800 MHz radios phones	3.1.3.1:		
		3.1.3.2:		
CAPABILITY: PLANNING				
1.1: Community and Family Health (CFH) Chief Administrator instructed CFH extended leadership team to activate COOP plan.	1.1.1: Maternal and Child Health Office needs to develop COOP for its area	1.1.1.1:		
		1.1.1.2:		
	1.1.2: Complete and test COOP plans within CFH	1.1.2.1:		
		1.1.2.2:		
1.2: The Office of Shellfish and Water Protection (OSWP) appropriately responded to the exercise scenario even when the bio-toxin program staff all became ill.	1.2.1: Provide training for OSWP staff to become more familiar with the "How to procedures manuals" in order to provide for additional staff to act as backup in case the core team is out	1.2.1.1:		
		1.2.1.2:		
	1.2.2: Continue to develop, refine, and update the OSWP "how to procedures manuals"	1.2.2.1:		
		1.2.2.2:		
	1.2.3: Continue to participate in future exercises in order to test, learn, and improve on office plans and procedures	1.2.3.1:		
		1.2.3.2:		

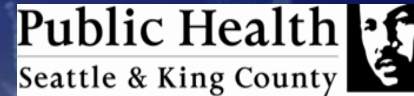
Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
CAPABILITY: CRITICAL RESOURCE LOGISTICS AND DISTRIBUTION				
1.1: Presently DOH does not have a method to determine the current staffing levels in the divisions or identify the staff working the incident	1.1.1: Appoint a task force to study ways in which the current staffing status can easily be obtained.	1.1.1.1:		
		1.1.1.2:		
	1.1.2: Based on the task force findings, develop policies and/or procedures to have this information available 24/7.	1.1.2.1:		
		1.1.2.2:		
	1.1.3: Develop a system for staff to report hours worked from their desks on an incident.	1.1.3.1:		
		1.1.3.2:		
	1.1.4: Train staff regarding the new procedures.	1.1.4.1:		
		1.1.4.2:		
	1.1.5: Test the new procedures during an exercise.	1.1.5.1:		
		1.1.5.2:		
1.2: The process for ordering Federal assets, including Federal Medical Stations (FMS), is not well defined.	1.2.1: In cooperation with Federal and local officials establish a process for requesting and receiving FMS and other Federal assets.	1.2.1.1:		
		1.2.1.2:		

Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
	1.2.2: Add the process(es) to the DOH CEMP.	1.2.2.1:		
		1.2.2.2:		
	1.2.3: Train staff in the process.	1.2.3.1:		
		1.2.3.2:		
	1.2.4: Incorporate FMS in exercises.	1.2.4.1:		
		1.2.4.2:		
CAPABILITY: EMERGENCY OPERATIONS CENTER MANAGEMENT				
1.2: There are expectations that Human Resources “canned” communications can be prepared ahead of time and be ready for adjustments for the current situation and that communication from HR will happen more quickly.	1.2.1: Work with the HR Operations and Labor Relations Managers to identify communications templates or draft language for future events	1.2.1.1:		
		1.2.1.2:		
1.3: EOC set-up checklist did not include a microphone	1.3.1: Revise the EOC Set-up Checklist to include set-up and testing the wireless	1.3.1.1:		

Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
for use during briefings or instructions regarding the clearing out the EOC for easier room configuration.	microphone	1.3.1.2:		
	1.3.2: Revise the EOC Set-up Checklist to include instructions regarding storage of the chairs not used in establishing the EOC	1.3.2.1:		
		1.3.2.2:		
1.4: The process, priorities, and procedures for dispensing antivirals during a pandemic are not clear to everyone in the DOH EOC.	1.4.1: Refine LHJ and State plans to outline how they will receive, store, stage, and dispense antivirals from the Federal government	1.4.1.1:		
		1.4.1.2:		
	1.4.2: Review and clarify LHJ plan for dispensing antivirals	1.4.2.1:		
		1.4.2.2:		
	1.4.3: Train staff to the revised plans	1.4.3.1:		
		1.4.3.2:		
	1.4.4: Conduct an exercise using the new plan to receive, stage, store, and dispense antivirals suing both local caches and Federal resources	1.4.4.1:		
		1.4.4.2:		
1.5: The process and timing of a Governor's Declaration	1.5.1: State EMD and DOH work on pre-prepared draft language for a Governor's	1.5.1.1:		



Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
of Emergency during a pandemic were not clear.	declaration during a pandemic.	1.5.1.2:		
1.6: The process for a Department of Health/State Board of Health Emergency Order making influenza a notifiable condition needs to be better defined	1.6.1: Representatives from DOH and the Board of Health establish a process for making influenza a notifiable condition.	1.6.1.1:		
		1.6.1.2:		
	1.6.2: Add process to their respective plans.	1.6.2.1:		
		1.6.2.2:		
1.7: State Epidemiologist for Infectious Disease was tasked with giving situational updates over the phone to the ART when they met twice daily.	1.7.1: Assign someone from CD/EPI other than the State Epidemiologist to provide the daily briefings to the ART so that he/she can focus on response activities.	1.7.1.1:		
		1.7.1.2:		
1.8: A significant success of the exercise was the use of checklists by the ART to make sure that they were able to quickly address critical issues that required immediate attention.	1.8.1: Staff review existing checklists and ART procedures and update as appropriate.	1.8.1.1:		
		1.8.1.2:		
	1.8.2: Distribute revised information to all ART members to ensure that it is available to them at all times.	1.8.2.1:		
		1.8.2.2:		
2.1: Reporting staff awaited arrival of designated EOC	2.1.1: Review / update EOP section and position checklists to ensure clear	2.1.1.1:		



Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
Director who did not arrive until 0845 due to problem with SECURES information.	leadership succession for all EOC positions	2.1.1.2:		
	2.1.2: Train personnel to ensure that staff is prepared to assume the roles in which they are a successor.	2.1.2.1:		
		2.1.2.2:		
3.1: EOC staff did not initiate communications with other agencies.	3.1.1: Train EOC staff on EOC function/role during events and in initiating communication to collect situational awareness, collect routine data, and decrease delay in response and coordinate time	3.1.1.1:		
		3.1.1.2:		
	3.1.2: Ensure that Director/Lead briefings occur prior to activation and shift change so that objectives are set, tasks are assigned and schedules are set	3.1.2.1:		
		3.1.2.2:		
	3.1.3: Ensure EOC staff briefings include scenario overview, objectives, schedule, and assigned tasks so that staff is fully aware of situation, needs, and assignments	3.1.3.1:		
		3.1.3.2:		
3.2: There was limited information posted on the displays for easy access by EOC staff.	3.2.1: Assign a Task Force to analyze how to improve information displays in the DOH EOC	3.2.1.1:		
		3.2.1.2:		
3.3: Incident action plans were not developed for the	3.3.1: Ensure that staff assigned to the DOH EOC Plans Section has been	3.3.1.1:		

Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
DOH EOC and staff did not actively seek guidance from leadership.	trained in developing IAPs	3.3.1.2:		
	3.3.2: During an exercise Plans will develop IAPs in conjunction with other section chiefs and EOC Director	3.3.2.1:		
		3.3.2.2:		
3.4: The DOH EOC appeared disconnected from the State Laboratory in Shoreline, Public Health – Seattle & King County where the event was occurring, the DOH Communications Office, and the State EMD EOC.	3.4.1: Clarify the mission of the DOH EOC	3.4.1.1:		
		3.4.1.2:		
	3.4.2: Train EOC staff regarding the DOH EOC's mission during activations	3.4.2.1:		
		3.4.2.2:		
	3.4.3: Develop a clear set of procedures for the DOH EOC to coordinate with stakeholders	3.4.3.1:		
		3.4.3.2:		
3.5: There did not appear to be anyone from DOH assigned to the role of liaison to Public Health - Seattle & King County (PHSKC).	3.5.1: Work with all LHJs across the State to educate them on the benefits of a liaison and how they should incorporate them into their response plan.	3.5.1.1:		
		3.5.1.2:		
	3.5.2: If the plans of LHJ are for deploying a liaison, DOH needs to work out with the LHJ who will deploy the liaison.	3.5.2.1:		
		3.5.2.2:		

Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
3.7: Situation reports provided limited information.	3.7.1: Develop job action check lists to include gathering developing and documenting situation and resource information so it can be analyzed and converted to situation reports and other documents (include all of the different DOH components to create a complete set of information)	3.7.1.1:		
		3.7.1.2		
3.8: It did not appear that the DOH EOC has a plan for gathering information and disseminating it to the EOC staff, agency administration, or its partners.	3.8.1: Develop a structure with clear relationships and responsibilities for collecting, analyzing and sharing information with agency staff	3.8.1.1:		
		3.8.1.2:		
3.9: Washington Emergency Management Division (EMD) referred to the PIER website in one of the postings to WebEOC on Friday afternoon, November 14. However, no one in the DOH EOC knew what that website was or how to access it.	3.9.1: EMD should ensure that agencies are informed about PIER	3.9.1.1:		
		3.9.1.2:		
	3.9.2: DOH should consider having a PIO liaison in the EOC, even if that person is not from the DOH Communications Office, to provide better contact with the communications Office	3.9.2.1:		
		3.9.2.2:		
	3.9.3: DOH EOC staff should be trained to follow-up when additional information regarding communications is needed	3.9.3.1:		
		3.9.3.2:		
3.10: ART did not have access to WebEOC in the	3.10.1: Train staff to bring up and use WebEOC at the ART during exercises or	3.10.1.1:		

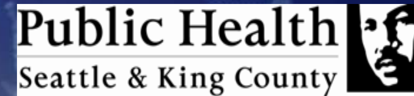
Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
Executive Conference Room during the exercise.	real events.	3.10.1.2:		
4.1: There is not an effective system for tracking task assignments.	4.1.1: Develop task assignment status tracking system	4.1.1.1:		
		4.1.1.2:		
	4.1.2: Train EOC staff on the use of the task tracking system	4.1.2.1:		
		4.1.2.2:		
	4.1.3: Use the system in an exercise to determine effectiveness and revise as necessary	4.1.3.1:		
		4.1.3.2:		
4.2: The PHRAT proved to be cumbersome and difficult to use to come to consensus about social distancing measures during a pandemic. Discussions on antiviral use and alternate care facilities could not be completed due to lack of time	4.2.1: Assess and revise the PHRAT process	4.2.1.1:		
		4.2.1.2:		
	4.2.2: Test the revised process during an exercise	4.2.2.1:		
		4.2.2.2:		
CAPABILITY: EMERGENCY PUBLIC INFORMATION AND WARNING				
1.1: A Communications	1.1.1: Consider using public information-	1.1.1.1:		

Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
Office representative was not assigned to work in the DOH EOC.	trained DOH staff from other agency divisions to assist the Communications Office by functioning as EOC Communications Office representative during activations, including exercises	1.1.1.2:		
	1.1.2: All DOH Communications Office staff should attend DOH EOC training and WebEOC training to assist during EOC activation and that understand the need of coordination between EOC and the Communications Office	1.1.2.1:		
		1.1.2.2:		
	1.1.3: Train Communications Office staff regarding responsibilities during EOC activations to include using an ICS structure and assigning personnel to the DOH EOC, as well as in prioritizing current public information projects to ensure personnel are available	1.1.3.1:		
		1.1.3.2:		
	1.1.4: Train Communications Office staff to share information via telephone, email, and WebEOC so that DOH EOC staff can see what is happening regarding public information issues	1.1.4.1:		
		1.1.4.2:		
CAPABILITY: EMERGENCY PUBLIC SAFETY AND SECURITY				
1.1: The process for requesting a declaration of a public health emergency by the Secretary of Health and Human Services (HHS) and	1.1.1: DOH and State EMD should work with FEMA and HHS to determine the trigger points and process to request a public health emergency during a pandemic flu event.	1.1.1.1:		
		1.1.1.2:		

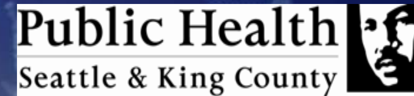
Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
what type of information would be required for a Stafford Act Declaration during a pandemic flu event are not well defined.	1.1.2: DOH and State EMD should work with FEMA and HHS to determine the trigger points and process to request a Stafford Act declaration during a pandemic flu event.	1.1.2.1:		
		1.1.2.2:		
	1.1.3: Incorporate these processes into plans at the agency.	1.1.3.2:		
		1.1.3.1:		
2.1: A contracted security guard stated that he did not know what role, if any, he would have during an actual incident that involved DOH Headquarters in Tumwater, Washington.	2.1.1: Develop written procedures for security personnel to follow during any EOC activation	2.1.1.1:		
		2.1.1.2:		
	2.1.2: Train security personnel regarding the procedures	2.1.2.1:		
		2.1.2.2:		
	2.1.3: If procedure variations for security personnel responsibilities exist, train the contracted security guards to these protocols	2.1.3.1:		
		2.1.3.2:		
CAPABILITY: RESPONDER SAFETY AND HEALTH				
1.1: There were many issues regarding employee rights and staffing during a pandemic.	1.1.1: Training on policies to address HR needs created for those that will be involved in these policy decisions.	1.1.1.1:		
		1.1.1.2:		
	1.1.2: Safety procedures (isolation, decontamination, etc.) need to be developed and practiced	1.1.2.1:		
		1.1.2.2:		

Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
	1.1.3: If antivirals are going to be provided to DOH staff, need to have objective criteria and procedures in place	1.1.3.1:		
		1.1.3.2:		
	1.1.4: Training on all the above and should include Blood Borne Pathogen requirements	1.1.4.1:		
		1.1.4.2		
2.1: No one was assigned as the Safety Officer for the EOC.	2.1.1: Add EOC Safety Officer as a new position or as an additional responsibility of a current position to address all health and safety issues for EOC staff	2.1.1.1:		
		2.1.1.2:		
	2.1.2: Add the assignment of this role is to the EOC Director's checklist—to make the assignment or ensure that someone has been appointed	2.1.2.1:		
		2.1.2.2:		
Washington State Department of Health CD/Epi				
CAPABILITY: EPIDEMIOLOGICAL SURVEILLANCE AND INVESTIGATION				
1.1: Lack of agreed upon and verifiable epidemiological data made policy decisions difficult for the ART.	1.1.1: Develop different means to demonstrate to the Federal government the severity of the outbreak in order to obtain Federal assets.	1.1.1.1:		
		1.1.1.2:		
	1.1.2: Determine what epidemiological	1.1.2.1:		

Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
	data is to be collected and reported, how it is to be reported, and when it is to be reported must be worked out between the Federal government and the States	1.1.2.2:		
2.1: During the exercise, specimens were arriving at WA DOH Public Health Laboratory (PHL) without WA DOH Communicable Disease/Epidemiology Section (CDES) knowledge or triage.	2.1.1: CDES, in coordination with PHL, will establish and exercise a policy for the triage, accepting, and processing of specimens during a pandemic influenza event	2.1.1.1:		
		2.1.1.2:		
2.2: Many written guidelines for CDES in the draft DOH Pan Flu Plan were not followed during this exercise.	2.2.1: CDES identify and operationalize roles and responsibilities under the plan	2.2.1.1:		
		2.2.1.2:		
	2.2.2: CDES in conjunction with appropriate DOH PHEPR staff, will develop and provide training and exercises for the CD/Epi response	2.2.2.1:		
		2.2.2.2:		
2.3: Shoreline epidemiologists were unaware of the activities of the DOH and State EOCs, or how their interaction with the DOH EOC was taking place. The DOH EOC Desktop did not serve its intended purpose.	2.3.1: CDES in conjunction with appropriate DOH PHEPR staff will develop a system of communication to provide periodic and timely updates to PHL staff through the incident command system during an exercise or real event.	2.3.1.1:		
		2.3.1.2:		
	2.3.2: If the solution is use of the DOH EOC significant events log, then CDES in conjunction with appropriate DOH PHEPR staff will expand the list of users and provide required training and	2.3.2.1:		
		2.3.2.2:		

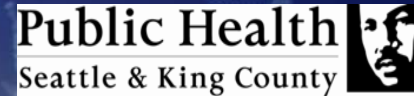


Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
	exercising to insure that its capabilities are being utilized.			
3.1: Communication between the Shoreline Incident Command Post (SICP) and DOH EOC was inconsistent, with direct lines of communication between DOH EOC and SICP epidemiologists taking place outside of the ICS structure.	3.1.1: DOH should overhaul its ICS structure to eliminate the Shoreline ICP as a separate operations center, and include it as a component of the DOH EOC. This will require significant revision to existing DOH ICS planning documents and ICS structures	3.1.1.1:		
		3.1.1.2:		
	2.1.2: Once done, DOH should maintain ICS structure charts on a common-share drive (o:\drive) that identify ICS roles of each entity (e.g., Shoreline ICS structure, EHSPHL ICS structure in Tumwater, etc.) recognizing that roles may change during an actual event. During an event, DOH should periodically update each entity's ICS structure charts taking contingency considerations into account	3.1.2.1:		
		3.1.2.2:		
Reception, Storage, and Staging (RSS) Facility				
CAPABILITY: CRITICAL RESOURCE LOGISTICS AND DISTRIBUTION				
1.1: Non-hospital healthcare clinics/providers did not have access to WATrac and therefore could not provide SNS receipt information through that system or receive SNS delivery	1.1.1: Grant other health partners who may receive SNS supplies access to WATrac and provide training so that they can also use the system to update SNS receipt status	1.1.1.1:		
		1.1.1.2:		



Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
updates.				
1.2: The replacement Area Commander was not quickly granted access to the WATrac resource request tracking tool	1.2.1: Ensure that there is a protocol for granting access to appropriate WATrac documents and WATrac rooms for replacement staff during the turnover process	1.2.1.1:		
		1.2.1.2:		
CAPABILITY: EMERGENCY PUBLIC SAFETY AND SECURITY				
1.1: Security at RSS was not readily available or present at arrival time of the Managed Inventory. After the Security Unit arrived, there was no authentication of RSS staff as per Entry Authorized Listing (EAL).	1.1.1: Ensure that RSS plan states that initial RSS staff and security personnel are to arrive at same time	1.1.1.1:		
		1.1.1.2:		
	1.1.2: Revise security checklist to include a full perimeter check of RSS site with situation reports to be done prior to activation and hourly	1.1.2.1:		
		1.1.2.2:		
	1.1.3: Ensure that RSS plan includes an initial check of RSS personnel against the EAL	1.1.3.1:		
		1.1.3.2:		
CAPABILITY: EMERGENCY MEDICAL SUPPLIES AND MANAGEMENT				
1.1: Situational reports were minimal between RSS command center and RSS warehouse.	1.1.1: Revise plan to include hourly situation reports between RSS and EOC	1.1.1.1:		
		1.1.1.2:		
1.2: The RSS Task Force	1.2.1: Establish RSS site	1.2.1.1:		

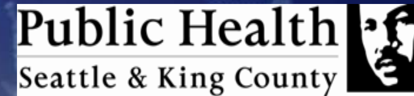
Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
Leader did not establish communications with the State EOC and the DOH EOC.	communications with the EOCs	1.2.1.2:		
	1.2.2: DOH EOC plan needs to clear delineate what positions are responsible for establishing and maintaining communications with the RSS during RSS activation.	1.2.2.1:		
		1.2.2.2:		
2.1: Staging of inventoried pallets became more efficient as team became familiar with recourses on hand. Pallets were delivered in the wrong direction, which caused an initial delay in inventory.	2.1.1: Develop marking system for pallets and other assets during the staging procedures	2.1.1.1:		
		2.1.1.2:		
2.2: The RSS Inventory Management Tracking System (RITS) took four personnel nearly six hours to input the data from the Managed Inventory that arrived at the RSS, causing a significant delay in distributing the resources.	2.2.1: Work with the CDC, Division of Strategic National Stockpile, RITS project management to enhance the system with easier receiving capabilities and push to include bar code reading capabilities to streamline product entry into the inventory	2.2.1.1:		
		2.2.1.2:		
Alternate Care Facility (ACF)				
CAPABILITY: EMERGENCY PUBLIC INFORMATION AND WARNING				
1.1: Public Health Information Center (PHIC) members effectively managed the press briefing	1.1.1: Plans for media briefings need to include procedure for holding the media in a secured area until the briefing is held	1.1.1.1:		
		1.1.1.2:		



Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
and media tour at the ACF.				
CAPABILITY: EMERGENCY TRIAGE AND PRE-HOSPITAL TREATMENT				
1.1: The staff did not utilize the established pre-hospital triage system.	1.1.1: Through training ensure staff is familiar with the existing pre-hospital evaluation system utilized by Seattle Medic One	1.1.1.1:		
		1.1.1.2:		
	1.1.2: Conduct an exercise to test staff knowledge and understanding of the pre-hospital evaluation system	1.1.2.1:		
		1.1.2.2:		
1.2: Alternate standards of care are not clear to pre-hospital providers.	1.2.1: Develop better communication regarding alternative standards of care and area hospital saturation to EMS providers as well as providers in the ACF	1.2.1.1:		
		1.2.1.2:		
CAPABILITY: MEDICAL SURGE				
1.1: Most signage was clear, readable, visible, with good use of color and clear icons, however, improvements are needed.	1.1.1: Add the “family” picture to the “Do not leave children unattended” for people who are not proficient in English	1.1.1.1:		
		1.1.1.2:		
	1.1.2: Develop signs with arrows to direct people to the restrooms	1.1.2.1:		
		1.1.2.2:		
	1.1.3: Design icons/pictures for the “Please wait for staff,” “Medical Exam,” and “Urgent Care” signs	1.1.3.1:		
		1.1.3.2:		
	1.1.4: Modify the ACF set-up plan to place signs regarding the availability of language interpreters on posts or walls	1.1.4.1:		
		1.1.4.2:		

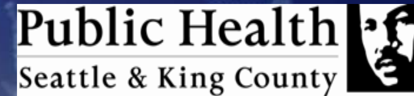
Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
	1.1.5: Add a task to the ACF set-up tasks to ensure that signs, inside and outside, are visible – high enough, not lying down, located appropriately, etc.	1.1.5.1:		
		1.1.5.2:		
	1.1.6: Consider separate tables for Information and Check In	1.1.6.1:		
		1.1.6.2:		
	1.1.7: Ensure that enough Check Out signs, including disability exits signs, are available so they can be easily followed by patients	1.1.7.1:		
		1.1.7.2:		
1.2: Most signage is readable from a distance.	1.2.1: Evaluate Chinese signage to ensure that lettering is large enough to be readable from a distance	1.2.1.1:		
		1.2.1.2:		
1.3: Signs with green, red, and yellow arrows assisted patients through part of the process, but the signs at medical exam and urgent care did not these colored arrows causing confusion.	1.3.1: Evaluate the signage to be used in the "medical exam" and "urgent care" waiting area so patients can more easily understand that they are to wait to be called	1.3.1.1:		
		1.3.1.2:		
	1.3.2: Develop better, clearer signage system for the exit areas	1.3.2.1:		
		1.3.2.2:		
1.4: The staff were congregating around signs and covering them completely on many occasions.	1.4.1: Revise plan to ensure that patient and emergency personnel entrances are separate and well marked	1.4.1.1:		
		1.4.1.2:		
	1.4.2: Ensure all signs are free from clutter or congregating groups of people	1.4.2.1:		
		1.4.2.2:		
CAPABILITY: ON-SITE INCIDENT MANAGEMENT				

Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
1.2: During the staff briefing it was very difficult to hear the Operations Chief.	1.2.1: Provide training to Operational Leaders and ICS Lead positions at ACF to ensure that everyone can hear and fully participate in all necessary briefings and meetings	1.2.1.1:		
		1.2.1.2:		
1.3: Several leaders missed training opportunities with critical involved community partners and volunteers because they were conducting tours.	1.3.1: Plan for non-exercise personnel to lead VIP/media tours in future ACF exercises	1.3.1.1:		
		1.3.1.2:		
1.4: Set up of the ACF and the ability to support Medical surge capacity by using volunteer resources was successful.	1.4.1: Conduct a walk through of the facility with clinical staff and logistics teams prior to opening the ACF for operations.	1.4.1.1:		
		1.4.1.2:		
	1.4.2: Make available a signage board for the teams to post essential information, which could include the prepared Incident Action Plan, assign roles and priority task.	1.4.2.1:		
		1.4.2.2:		
	1.4.3: Urgent Care along with Communications Section should be the primary section to be completed before all other sections. A checklist prioritizing the order of sections to be set up would be helpful to have on hand.	1.4.3.1:		
		1.4.3.2:		
	1.4.4: Need heavy-duty cord mats to prevent tripping over cords and for heavy equipment to move over.	1.4.4.1:		
		1.4.4.2:		
	1.4.5: Have fork lift operators available to	1.4.5.1:		



Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
	assist with moving caches or additional load that may come in	1.4.5.2:		
1.5: Several logistics issues were identified regarding set up of the ACF.	1.5.1: Consider having a "standard" ACF layout and modify it the day before or day of a set-up and distribute the revised map	1.5.1.1:		
		1.5.1.2:		
	1.5.2: Purchase some commercial products used to temporarily cover items on the floor to minimize tripping and allow for rolling of carts	1.5.2.1:		
		1.5.2.2:		
	1.5.3: Revise plan to assign staff for patient movement within the ACF	1.5.3.1:		
		1.5.2:		
	1.5.4: Develop simple request forms for areas to give to runners to obtain supplies (medical and other)	1.5.4.1:		
		1.5.4.2:		
	1.5.5: Establish a process for requesting wheelchair or other mobility assistance	1.5.5.1:		
		1.5.5.2:		
	1.5.6: Revise the plan to separate general supplies and medical supplies, establish supply clerk roles, and develop an inventory system to track receipts and withdrawals	1.5.6.1:		
		1.5.6.2:		
	1.5.7: Revise the plan to include a morgue/staging area, including a physical space and the specialized equipment and supplies that would be needed	1.5.7.1:		
		1.5.7.2:		
1.6: There was no formal	1.6.1: Develop a demobilization plan and	1.6.1.1:		

Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
Demobilization Plan	brief teams on actions items in the demobilization plan.	1.6.1.2:		
	1.6.2: Establish process for restocking boxes which can include the following: – Provide a packing list needed in order to properly place the content into the box without damage the items, and also to keep track of items. – Take pictures of how to set up the items and how to store the items – Each piece of equipment should be coded w/each box – Each cache needs to be labeled with content inside – Lead packer should be assigned to track content of box as its being pack and make sure its being appropriately packed – Improve tracking of signage during breakdown	1.6.2.1:		
		1.6.2.2:		
CAPABILITY: VOLUNTEER AND DONATIONS MANAGEMENT				
1.2: Washington Health Volunteers in Emergencies (WAHVE) volunteer application did not contain all required information fields.	1.2.1: Review the Spontaneous Medical Volunteer Registration Form to ensure that all required data fields are present	1.2.1.1:		
		1.2.1.2:		
	1.2.2: Share the revised form with other Medical Reserve Corps (MRC) programs that want to utilize WAHVE to verify medical credentials	1.2.2.1:		
		1.2.2.2:		



Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
	1.2.3: Create list of required documentation to verify credentials of volunteers and share with Communications for use in releases to media and in PHSKC advisories when requesting or giving instructions to volunteers	1.2.3.1:		
		1.2.3.2:		
1.3: WAHVE web-based application background check query was not configured properly to test at ACF.	1.3.1: Work with the WAHVE system vendor to ensure that all Primary Sources Queries are configured properly	1.3.1.1:		
		1.3.1.2:		
Washington State Department of Health laboratory				
CAPABILITY: Laboratory Testing				
1.1: Public Health Laboratory response was taxed due to increased sick calls, leaving staff available that were not familiar with the test procedures and forcing prioritization of essential functions.	1.1.1: Provide cross-training between sections at the laboratory	1.1.1.1:		
		1.1.1.2:		
	1.1.2: Create just-in-time training for surge staff.	1.1.2.1:		
		1.1.2.2:		
	1.1.3: CD Epi and Microbiology to revise reporting methods for CD Epi during a huge outbreak	1.1.3.1:		
		1.1.3.2:		

Observation	Recommendation	Corrective Action Description	Responsible Party/Agency	Completion Date
	1.1.4: Determine how much testing would be necessary for each county and at what time to stop testing	1.1.4.1:		
		1.1.4.2:		
	1.1.5: Create message template for internal communication between departments	1.1.5.1:		
		1.1.5.2:		
	1.1.6: Consider HR policy changes to help keep critical staff at PHL	1.1.6.1:		
		1.1.6.2:		

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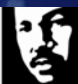
APPENDIX B: ACRONYM LIST

AAR	After Action Report
ACC	Area Command Center
ACF	Alternate Care Facility
ACGIH	American Conference of Government Industrial Hygienists
ART	Assessment Response Team
C/E	Controller and Evaluator
CBRNE	chemical, biological, radiological, nuclear and explosive
CD	communicable disease
CDC	Centers for Disease Control and Prevention
CDES	Communicable Disease Section
COOP Plan	continuity of operations plan
CSO	Customer Service Office
DEM	Department of Emergency Management
DHS	(U.S.) Department of Homeland Security
DMAT	Disaster Medical Assistance Team
DO	Duty Officer
DOA	dead on arrival
DOH	(Washington State) Department of Health
DOH-CFH	(DOH) Community and Family Health
DOH-DIRM	(DOH) Division of Information Resources Management
DOT	Department of Transportation
DPS	Department of Public Safety
DSHS-HRD	Department of Social and Health Services - Human Resource Division
DSHS-SAL	Department of Social and Health Services - State Agency Liaison
DTS	Department of Technology Services
EAL	entry authorized listing
EEG	exercise evaluation guide
EMD	(WA) Emergency Management Division
EMS	emergency medical services
EOC	Emergency Operations Center
Epi	Epidemiology
Epi/Imms Section	Epidemiology and Immunizations Section
ESF	Emergency Support Function
FBI	Federal Bureau of Investigation
FSE	full-scale exercise
HAN	Health Alert Network
HMC	Harborview Medical Center
HPF	Health Professions and Facilities
HR	human resources
HSEEP	Homeland Security Exercise and Evaluation Program
HSQA	Health System Quality Assurance
IAN	Information and Alert Network
IAP	incident action plan
ICS	Incident Command System
IP	improvement plan

IT	information technology
JIC	joint information center
JIS	joint information system
KC	King County
LEP	limited English proficiency
LHJ	local health jurisdiction
LHO	local health officer
LRN	Laboratory Response Network
MAC	multi-agency coordination
MACC	multi-agency coordination center
MIS	management information system
MRC	Medical Reserve Corps
NIMS	National Incident Management System
OSWP	Office of Shellfish and Water Protection
PHIC	Public Health Information Center
PHL	public health laboratory
PHSKC	Public Health - Seattle & King County
PICC	Public Information Call Center
PIO	public information officer
POC	point of contact
PPE	personal protective equipment
RSS	reception, storage and staging
SECURES	Secure Electronic Communication, Urgent Response and Exchange System
SimCell	simulation cell
SME	subject matter expert
SNS	Strategic National Stockpile
SOP	standard operation plan / procedure
SPD	Seattle Police Department
TARU	Technical Assistance Response Team
TCL	Target Capabilities List
USDHS	U.S. Department of Homeland Security
UTL	Universal Task List
UWMC	University of Washington Medical Center
VPAT	Vulnerable Populations Action Team
WA	Washington
WADDL	Washington Animal Disease Diagnostic Laboratory
WAHVE	Washington Health Volunteers in Emergencies
WATrac	Washington system for Tracking Resources, Alerts, and Communication (Washington’s hospital bed capacity website)
WHO	World Health Organization



APPENDIX C

PANDEMONIUM
November 13, 14, 17 & 18, 2008
Region 6 Hospitals After Action Report

Executive Summary

Each year the Washington State Department of Health chooses a Region in the State to hold their annual full scale exercise of the Centers for Disease Control Strategic National Stockpile activation. Region 6 (King County) was chosen for 2008. The scenario for this exercise was created jointly by the Washington State Department of Health, Public Health Seattle and King County (PHSKC) and others, including the King County Healthcare Coalition. The exercise was conducted over 4 days to test the many objectives at the State and local levels. The exercise was conducted as a combination of functional and full scale activities each day.

The Homeland Security Exercise and Evaluation Program (HSEEP) requires measures tested in exercises be linked to target capabilities; however current target capabilities have limited applicability to healthcare. Additionally, hospitals and healthcare are not yet required to follow HSEEP; therefore the report for healthcare exercise activities is included as an annex to the overall report. Hospitals and healthcare partners worked collaboratively to create their own objectives specific to healthcare delivery. These objectives helped meet Joint Commission Requirements as well as test current local planning issues. They were focused on regional capabilities and collaboration among healthcare providers.

Healthcare partners tested five key areas:

- Communications between their organizations, Public Health Seattle and King County, Health and Medical Area Command and local Emergency Management;
- EOC Operations;
- Delivery of the Strategic National Stockpile directly to hospitals;
- Information management and resource tracking via WATrac; and
- Coordination of media messaging

Objectives

Hospitals and other healthcare agencies used the pandemic influenza scenario to address the following Regional Objectives:

- Test ability of hospitals to respond to an influx of patients
- Evaluate ability of Area Command to communicate with healthcare organizations across the region
- Evaluate ability of healthcare facilities to communicate with outside agencies
- Provide healthcare organizations and partners with information regarding the Alternate Care Facility
- Provide healthcare partners with situational updates, including MAC group decisions/recommendations
- Coordinate public messaging with Public Health Communications via WATrac
- Evaluate ability of hospitals to track resources using WATrac

Healthcare organizations that are Joint Commission accredited were encouraged to also test the following elements:

- ✓ Communicating during emergency conditions.
- ✓ Managing resources and assets during emergency conditions.
- ✓ Managing safety and security during emergency conditions.
- ✓ Defining and managing staff roles and responsibilities during emergency conditions.
- ✓ Managing utilities during emergency conditions.
- ✓ Managing clinical activities during emergency conditions.

Major Strengths

- Communications of health alerts between PHSKC CD/Epidemiology and hospitals was successful
- WATrac worked well as a tool for coordinating with hospitals for exercise control and event management.
- The hospital conference call met stated objectives for communication and coordination about patient influx

Primary Areas for Improvement

- Some healthcare facilities identified additional training needs regarding WATrac
    - Identify training needs and provide training to healthcare partners
- Emergency Departments were not able to easily view alert messages on the live site in WATrac.
    - Modifications to WATrac to move messaging link to the left side banner on the screen would help information be more visible to Emergency Departments
- Some hospitals identified gaps in N95 and PAPR fit testing programs at their facilities.
    - Assess PPE fit testing needs for N95 masks and PAPRs.
    - Identify additional PPE supply needs.
- The Strategic National Stockpile (SNS) was not received by all hospitals due to a delay by Washington Department of Health and the CDC.
    - Retest SNS delivery to hospitals to test inventory, tracking, receipt and distribution of SNS

Exercise Overview

Timeline and Major Events

Day 1, Thursday, November 13, 2008

- PHSKC Communicable Disease and Epidemiology Team responds to local health system increase in influenza cases
- PHSKC Preparedness activates Health and Medical Area Command to support CD/Epidemiology

- PHSKC Communications Team activated the Public Health Information Center (PHIC)

Day 2,Friday, November 14, 2008

- Health and Medical Area Command Center activated ESF-8 Area Command MAC Group, setting up a meeting to review topics including health system status, decision making regarding changing protocol and setting up an alternate care facility
- Health and Medical Area Command continued activation and interaction with healthcare partners and community organizations
- PHSKC requests resource support from King County Office of Emergency Management
- WA State DOH coordinated Strategic National Stockpile (SNS) assets at Receipt, Staging and Storage (RSS) location
- PHSKC Public Information Officers coordinate with healthcare partner PIOs on media messaging

Day 3,Monday, November 17, 2008

- Due to increased calls to PHSKC, PHIC activated the Public Information Call Center
- WA State DOH coordinated delivery of SNS assets to King County hospitals and the PHSKC alternate care facility (ACF)
- Health and Medical Area Command remains on limited activation, monitors PICC operations and SNS delivery

Day 4, Tuesday, November 18, 2008

- Alternate Care Facility (ACF) activation, including tours for healthcare and community partners

Participants

Auburn Regional Medical Center	Overlake Hospital Medical Center
Children's Hospital	Puget Sound Blood Center
Enumclaw Regional Hospital	Regional Hospital
Evergreen Healthcare	St. Francis Hospital
Fairfax Hospital	Swedish Ballard
Group Health Central	Swedish Cherry Hill
Group Health East	Swedish First Hill
Harborview Medical Center	UW Medical Center

Highline Medical Center	Valley Medical Center
Kindred Hospital Seattle	VA Hospital
Navos	Virginia Mason Medical Center
Northwest Hospital	

Analysis of Capabilities

Issue	Analysis	References	Recommendations
Communication	Updated protocols and Job Action Sheets will assist with the facilitation of communicating with healthcare partners in future events	ESF-8 EOC Manual PHSKC CD/Epi Distribution and Blast Fax Notification Protocol	Create workgroup to re-visit distribution list recipients and maintenance of these lists for hospitals and ambulatory care
EOC Operations	Logistic requests for state or federal resources must be funneled through King County ECC or Seattle EOC	ESF-8 EOC Manual	Clarification of roles and responsibilities is needed with King County ECC on this issue
Direct Delivery of the Strategic National Stockpile to Hospitals	Delivery of the SNS to hospitals only occurred at 18% of the hospitals due to DOH and CDC coordination issues	SNS Plan	Re-testing of this capability will occur in October 2009
WATrac	Resource tracking functionality was not tested due to delay in SNS delivery	ESF-8 EOC Manual	Follow up exercise scheduled for October 2009 to re-test this process
Media Messaging	WATrac was used to coordinate with public information officers in healthcare facilities around media messaging and for posting of media releases	Communications Plan	Further training in WATrac is needed by some. Technological issues for utilizing WATrac need to be addressed internally at some organizations

Conclusion

Pandemonium offered the unique opportunity to test multiple areas of response, including engaging the Public Information Officers, testing various capabilities of WATrac, exploring patient influx and dispensing plan challenges internally at hospitals, practicing direct communication to healthcare partners on health alerts, evaluating the ability to do direct delivery of SNS to hospitals, activating the alternate care facility and testing patient throughput, and engaging the MAC Group for the first time. This exercise was an effective opportunity to test the healthcare system, Health and Medical Area Command and the interface with community partners over an extended of time. All healthcare participants were successful at maintaining their levels of play and communicating their statuses clearly. Health and Medical Area Command was consistent and punctual in delivering situation status updates and supporting the requests for resources and information that came through the Area Command Center.

Healthcare partners successfully coordinated these events and stayed in communication with each other to make them realistic and relevant to current planning and regional goals. The lessons learned were extremely valuable and reflect issues that will help us respond more efficiently in a real event.

Lessons Learned

- Blast fax from PHSKC CD/Epidemiology was received well
  - Distribution list contacts need to be updates
  - In future exercises, mock alerts should indicate "this is an exercise"
  - Most hospitals have requested a paging system for urgent health alerts
- Some hospitals reported short staff on Respiratory Therapists and PAPRs.
- Just in time training and fit testing need to be expanded for PAPRs
- WATrac interface for communicating with hospitals for exercise control and event management worked well
  - Some additional WATrac training needed for some organizations
  - Tested messaging on live site to test EDs. Moving link to left side banner on screen would be helpful
- Some hospitals reported the need for a more robust N95 fit testing program
- Receipt of the Strategic National Stockpile was delayed, or did not occur for most. For those facilities that received it, the quantities expected and quantities received did not match
  - DOH computer system was not in sync with the CDC system, which delayed delivery by a minimum of 6 hours
  - State DOH would like to test this portion of the exercise again in 2009 – currently scheduled tentatively for October 2009
  - Communication lines with DOH Logistics desk and PHSKC/Health and Medical Area Command were inconsistent
  - More training/education needed with local Emergency Management on their role in assisting the facilitation of logistics requests to the State, especially those directed at medical needs
- Hospital conference call went well. However, hospitals should remind their staff about conference call "etiquette" – too much background noise made parts of the call hard to hear, or distracting
  - Meeting minutes of these calls would be helpful
  - Health and Medical Area Command should coordinate with and Hospital Control about agenda prior to the call
- Many organizations tested on-site security with their dispensing plans. Most would be requesting assistance from local law enforcement in a real event.
- Mission number of the event, once declared an emergency, was not communicated to healthcare partners
- Inconsistent cross-county coordination, during exercise planning and throughout the exercise
- Need to address PIO engagement/interface with Command Center staff
- The ACF exercise was a valuable learning experience for healthcare partners
  - The oxygen capability is beneficial
  - Additional work needs to be done to identify strategy and protocol for integrating healthcare staff into ACF operations

Pandemonium Improvement Plan

Objective	*Observation*	*Recommendation*	*Corrective Action*	*Capability Element*	*Responsible Party*	*Expected Completion Date*	*Status*
Evaluate ability of Area Command to communicate with healthcare organizations across the region	Some hospital contacts used by CD/Epi for Communicable Disease Health Alerts were out of date	Update hospital distribution lists for communicable disease health alerts	Update the lists quarterly	Planning	Hospital Emergency Managers to coordinate with PHSKC CD/Epi Kay Koelemay, MD	February 2010	
Evaluate ability of Area Command to communicate with healthcare organizations across the region	Information for ambulatory care partners was likely out of date as well (see above)	Update healthcare partner contact information for CD/Epi in similar format as for hospital distribution lists (see above)	Convene workgroups with large ambulatory care providers to determine appropriate distribution lists	Planning	PHSKC CD/Epi Kay Koelemay, MD Sarah Magill	February 2010	
Evaluate ability of healthcare organizations to test managing resources and assets during emergency conditions	Some hospitals reported short staff on Respiratory Therapists and PAPRs	Increase supply of PAPRs throughout the region	Update the funding list to add PAPRs as appropriate	Equipment	PHSKC Preparedness/ Region 6 Hospital Committee Onora Lien/Cynthia Dold	August 2009	

Evaluate ability of Area Command to communicate with healthcare organizations across the region	Messaging in WATrac was tested in live site	Move alerting link on WATrac to left side banner	Make changes in WATrac, as recommended	Systems/ Equipment	WATrac Workgroup Allison Schletzbaum	June 2009	Been requested to State
PHSKC will demonstrate the ability to request needed resources from EOC	King County Emergency Management directed Health and Medical Area Command to request resources directly from the State EOC	Clarification with King County Emergency Management about responsibilities on assisting with/facilitating logistics requests	Clarify roles and expectations with King County Emergency Management	Plans/ Protocols	PHSKC Preparedness Section Michael Loehr	June 2009	
Evaluate ability of Area Command to communicate with healthcare organizations across the region	Hospital conference call went well, but meeting minutes would be helpful	Meeting minute support for hospital conference calls needed during events	Develop a protocol for meeting minutes and add to the appropriate Job Action Sheet within Planning Section in Health and Medical Area Command	Plans/ Protocols	Health and Medical Area Command Danica Mann Ali Jaffe-Doty	May 2009	
Evaluate ability of Area Command to communicate with healthcare	Hospital conference call could have been more efficient	Hospital Control and Health and Medical Area Command need to collaborate better on agendas for these	Develop a procedure and Job Action Sheet for the Health	Plans/ Protocols	Health and Medical Area Command Danica Mann Allison	May 2009	

organizations across the region		conference calls	and Medical Area Command staff to support this process		Schletzbaum		
Evaluate ability of Area Command to communicate with healthcare organizations across the region	Mission number of the event, once declared an emergency, was not communicated to healthcare partners	Situation Status report has a field for mission number. Further training of healthcare partners and Health and Medical Area Command staff is needed	Update situation status unit Job Action Sheet to cover this issue. Provide education to healthcare partners on use of situation status form information	Training/ Plans	Health and Medical Area Command Danica Mann	May 2009	
PHSKC will demonstrate the ability to activate alternative care sites and/or overflow emergency medical care facilities to manage hospital surge capacity	Donations of staff will be needed to operate the Alternate Care Facility (ACF)	Determine best way to incorporate healthcare staff into filling a staffing need at the Alternate Care Facility (ACF)	Develop strategy and protocol for integrating healthcare staff into Health and Medical field activities	Planning	PHSKC VMS Bryan Heartsfield	February 2010	