

INFECTIOUS DISEASE PLAN

Florida Region 3 Healthcare Coalition Alliance

DRAFT Version 2, April 2021

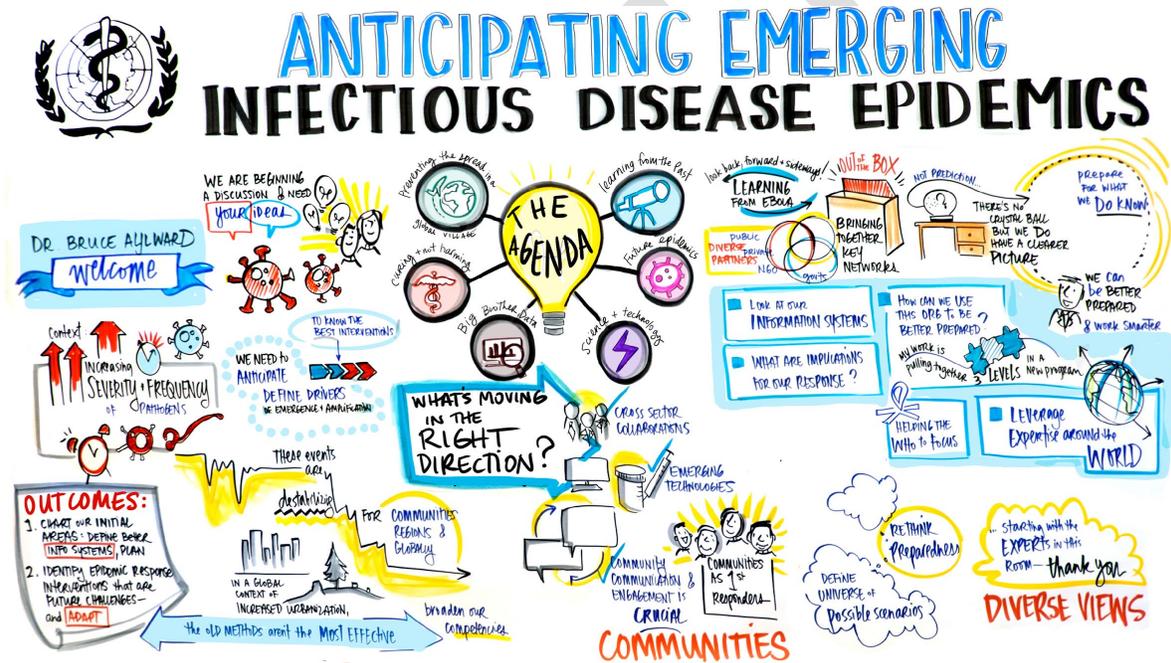


Table of Contents

Introduction.....2

Purpose.....2

Scope.....2

Overview of the Northeast Florida Regional Council.....3

Planning Assumptions.....3

Concept of Operations.....6

 A. Activation.....6

 B. Notifications.....7

 C. Roles and Responsibilities.....7

 D. Operational Mission Areas.....9

 1. Surveillance.....9

 2. Infection Control and Prevention.....10

 3. Non-Pharmaceutical Interventions.....12

 4. Patient Care and Management.....14

 5. Support Services.....15

 6. Surge Staffing.....19

 7. Supply Chain, Supplies, Personal Protective Equipment.....19

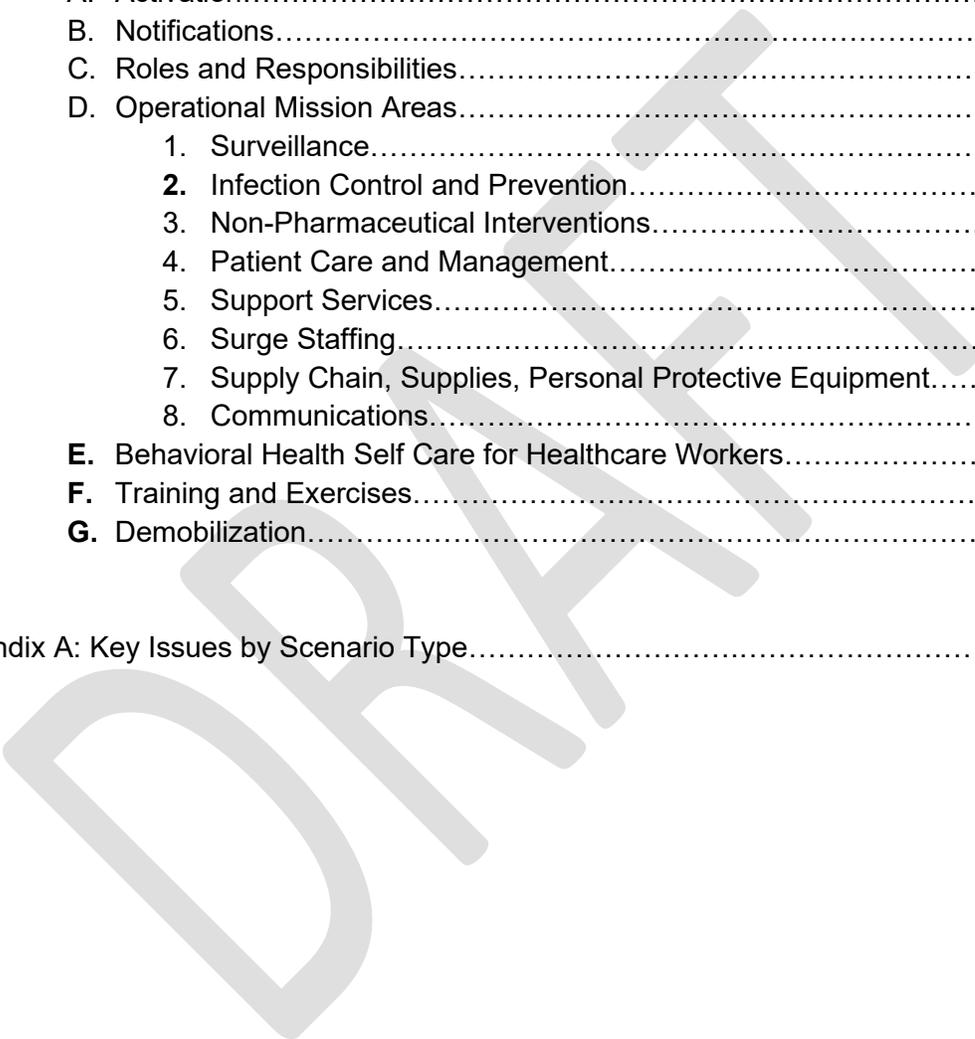
 8. Communications.....20

 E. Behavioral Health Self Care for Healthcare Workers.....20

 F. Training and Exercises.....21

 G. Demobilization.....22

Appendix A: Key Issues by Scenario Type.....24



Introduction

As demonstrated by epidemics over the past decade and the current COVID-19 pandemic, emerging infectious diseases pose a constant threat to the health and well-being of our society. Florida is a hub for international travel and tourism. This fact increases the risk that emerging infectious diseases will be introduced and potentially spread within our population. Northeast Florida is home to over 2.6 million persons and contains multiple international ports of entry. Therefore, the region is at risk for importation and spread of emerging infectious diseases.

This plan will focus on high consequence infectious diseases, which include new or existing pathogens that have the capacity to disrupt society as a result of the disease severity, potential widespread impact on the population, or complexity of the response needed to protect the public's health. As such, the response is expected to go beyond routine infectious disease investigation and prevention measures and will require multi-agency coordination to control the disease.

Purpose

The purpose of this document is to serve as the high consequence infectious disease-focused operational plan for the Florida Region 3 Healthcare Coalition Alliance (the "Alliance") to complement existing response plans for the three-healthcare coalition (HCC) included in the Alliance.

It serves as an infectious disease response guide for infectious disease emergencies that stress the healthcare systems supported by the Alliance. The document provides tools for HCC members to use to increase the efficiency and effectiveness of responses to highly infectious diseases. Included are recommendations for planning, equipping, training, and exercising responses to highly infectious diseases.

The plan is a high-level, incident specific response plan, which identifies the experts and specialized resources that are available to the HCCs. The plan provides guidance to support a coordinated healthcare response to a range of known and emerging infectious diseases and is adjustable to ensure a tailored activation and response to address varying infectious disease agent and severity scenarios.

Each agency or facility is encouraged to develop more detailed policies and procedures that support individual operations.

Scope

The Northeast Florida Regional Council Infectious Disease Surge Annex is a piece of the Regional Emergency Response Plan. It will serve as a regional planning document for 2021-2022 for the Alliance and the membership of the supported HCCs. This plan outlines the concept of coordination and operation for high consequence infectious disease incidents in the region that have increased complexity or duration that will require multi-agency coordination. The plan is not intended to guide the response to infectious diseases that are routinely detected and responded to in the region (i.e. salmonella, hepatitis, HIV, tuberculosis, foodborne illness,

sexually transmitted diseases, etc.) unless the situation requires an augmented response and coordination (e.g. community-based or complex outbreak response).

The information in this plan is applicable to the role and responsibilities of healthcare organizations (including hospitals, ambulatory care, long-term care, home healthcare, and other support services) and the relationship of these organizations with the Florida Department of Health and other emergency response partners.

Overview of the Northeast Florida Regional Council

The Northeast Florida Regional Council is contracted by the Florida Department of Health (DOH) and receives Hospital Preparedness Funding (HPP) funding to establish and maintain three healthcare coalitions that serve 18 counties in north Florida:

- **Northeast Florida Healthcare Coalition**, which supports partners in Baker, Clay, Duval, Flagler, Nassau, and St. Johns counties.
- **North Central Florida HealthCare Coalition**, which supports partners in Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, and Union counties.
- **Coalition for Health and Medical Preparedness, CHAMP**, which supports partners in Marion county.



These HCCs work as a collaborative network of healthcare organizations and their respective public and private sector response partners to collectively plan, organize, equip, train and exercise to build capabilities related to regional healthcare system preparedness, response and recovery.

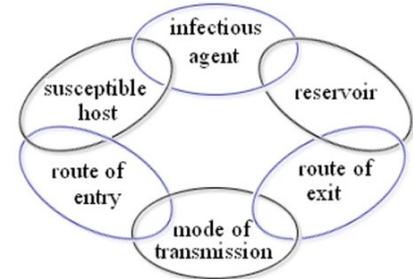
Planning Assumptions

- This plan is meant to provide an overview of the healthcare system response to high consequence infectious disease cases or outbreaks and will coordinate with other relevant state, regional, or local plans and partners.
- Understanding of novel pathogens/diseases, infection control, risk factors, clinical care, and patient outcomes will rapidly evolve, resulting in rapidly changing guidance and responses.
- There will be no known cure or vaccine for most emerging infectious diseases; treatment for patients consists mainly of supportive care. If vaccines or treatments are available, their allocation and distribution may involve significant logistics operations.
- High consequence infectious disease response may be longer and require more complex coordination than prior responses.
- High consequence infectious disease cases and outbreaks may be anticipated, providing an opportunity to plan, or there may be no advanced notice and require immediate response.
- All healthcare facilities must be able to maintain a base level of preparedness to safely screen, stabilize, isolate/implement other infection prevention precautions as

appropriate, arrange transport to a facility that can provide more advanced care as needed, and report the infection to the Florida Department of Health.

- Patients with a high consequence infectious disease could present to healthcare organizations in the region through multiple scenarios:
 - A symptomatic person without a known exposure or other risk factors that puts them at risk for the disease presents to a facility with no advanced notice.
 - A symptomatic person with a known exposure or other risk factors that puts them at risk for the disease presents to a facility with no advanced notice.
 - A person being monitored or treated for an exposure/disease is directed to a healthcare facility for medical evaluation or treatment.
- Not all healthcare facilities in the region may be able to care for patients with high consequence infectious disease.
- Patients with complex medical situations (i.e. pediatric, obstetric, severely ill) may present to any healthcare facility.
- Healthcare facilities should plan for integration or increased use of telemedicine consultations.
- Resources such as personnel, equipment, and personal protective equipment may be in short supply through region, state, or country depending on the scale of the response.
- Staffing at coalition facilities may be challenged by illness, fear of illness, or family obligations (e.g. child/family care if schools are out). Healthcare workers are a high-risk population during most infectious disease incidents; the implementation of effective infection prevention measures and associated training are necessary for workforce protection across the coalition.
- Healthcare facilities and vendors may become overwhelmed with the treatment and disposal of biohazard material; waste management guidance may be modified, as necessary, to support the health and medical system while maintaining safe handling and transport.
- Healthcare organizations throughout the region will commit their own resources to address internal challenges prior to providing resources to other healthcare organizations.
- Healthcare organizations will rely on existing contracts with medical suppliers and pharmaceutical vendors to the maximum extent possible.
- Healthcare systems, facilities, and providers have, or are in the process of completing, internal plans for high consequence infectious disease responses.
- Supply chain and delivery issues will occur and may have dramatic effects on clinical care.
- The Alliance or HCCs should plan to request, receive, and distribute Strategic National Stockpile (SNS) assets in accord with jurisdictional public health and emergency management processes, including personal protective equipment (PPE), ventilators, and medical treatment (e.g., antitoxin for select bioterrorism agents).
- Families of patients will place a strain on the healthcare system through information-seeking about loved ones or concerns about exposure/illness. Family members may have also been exposed and may pose a risk to healthcare workers and others in the community.

- Roles and responsibilities of agencies and organizations will change depending on the severity and spread of the infectious disease incident and the respective level of activation by impacted jurisdictions.
- Buildings and outdoor areas may become contaminated with infectious agents and may be closed until they are disinfected. Ensure signage is available for facility entrances advising of precautions and restrictions.
- Process for external communications (to include liaisons and spokespersons) and internal communications (to include a way for employees to obtain the most up-to-date information and to receive updates on the event/ incident). The media will play an integral role in the response based on the information they are sharing, the intensity of how it is shared, and where they are physically positioning themselves (i.e., media staging areas).
- Large-scale infectious disease outbreaks may require the recruitment of volunteers, retirees, and trainees to support and relieve healthcare workers.
- During some infectious disease incidents, individual healthcare facilities may face fatality management challenges that require support from other coalition members.
- Community-based interventions may require significant public health efforts (e.g., mask distribution, social distancing / isolation assistance).
- Health concerns, difficult work environments, and stresses of community mitigation measures may present behavioral health challenges among staff of coalition members and the general public.
- The objectives of public health and medical organization may differ during the response. Public health is primarily focused on preventing infectious disease spread throughout the community and medical facilities are focused on the care of patients that present to them. However, these objectives often work together to achieve mutual goals.
- Cases will require laboratory confirmation unless DOH no longer requires testing to meet the case definition.
- The Florida Department of Health has the overall responsibility for epidemiologic investigations, contact tracing, and the issue of any social distancing, isolation, and quarantine orders according to state laws, as well as for issuing overall guidance on infection prevention and control precautions.
- Comprehensive and well-coordinated public health control and community mitigation strategies (e.g., mask-wearing, contact tracing, individual vaccination, quarantine and/or isolation, community-wide cancellation of events, visitation policies) remain the primary methods for controlling and stopping the spread of infectious diseases.
- Large scale infectious disease responses will require coordination with other regional, state, and federal partners.
- County Health Officers have the authority to change or implement procedures to protect the public's health.
- Major public health emergencies will require federal Centers for Medicare and Medicaid Services (CMS) waivers, Food and Drug Administration (FDA)-issued Emergency Use



Authorization (EUA), and other authorities that may affect healthcare operations and affect coalition options.

- The plan is not intended to guide the response to infectious diseases that are routinely detected and responded to in the region (i.e. salmonella, hepatitis, HIV, tuberculosis, foodborne illness, sexually transmitted diseases, etc.) unless the situation requires an augmented response and coordination (e.g. community-based or complex outbreak response).
- The Florida Department of Health maintains plans for infectious disease responses (i.e. pandemic influenza, isolation & quarantine, Florida Infectious Disease Transportation Network Plan, etc.). This plan is meant to assist the Alliance and HCCs integrate with other planning efforts.

Concept of Operations

A. Activation

- This plan may be activated during any high consequence infectious disease response scenario that warrants coordination between healthcare organizations when the response exceeds, or is expected to exceed, their individual capacity or capability.
- This plan is intended to facilitate a quick response. Therefore, this plan can be activated by the County Health Officer or the Alliance. If time permits, HCC stakeholders and local/state emergency response partners should be notified prior to activation.
- If prior notification is not possible, following activation, impacted County Health Officers and members of the Alliance should notify each other.
- County Health Officers will in turn notify DOH County Health Systems, DOH Bureau of Epidemiology, DOH Bureau of Preparedness and Response, and County government stakeholders.
- If the activation is in one county, the Alliance and the County Health Officer may communicate with other stakeholders and County Health Departments, respectively, regarding the situation, potential impacts, and potential need for broader activation in the region.
- Activation Triggers
 - One or more suspected or laboratory confirmed high consequence infectious disease patients identified in the region.
 - Regional coordination required to assist with monitoring, laboratory testing, patient care, implementation of isolation or quarantine, or patient transport to another medical facility.
 - Multiple counties or facilities affected by a high consequence infectious disease requiring a coordinated response.
 - Regional coordination required for risk communication, public information, and/or media response.

B. Notifications

- All healthcare providers and laboratories are required to report [notifiable diseases and conditions](#) to the Florida Department of Health. This includes outbreaks of any disease, any case, cluster of cases, or exposure to an infectious or non-infectious disease, condition, or agent found in the general community or any defined setting (e.g., hospital, school, other institution) not listed that is of urgent public health significance.
- DOH Bureau of Epidemiology (850-245-4401) and all [county health departments](#) maintain 24/7 contact numbers for reporting notifiable diseases. County health departments are the front line of public health to investigate and respond to notifiable diseases, including high consequence infectious disease. If a high consequence infectious disease is suspected or confirmed in a patient presenting to a healthcare facility, the provider, laboratorian, or designee (e.g. infection control practitioner) should contact their county health department, who will contact the DOH Bureau of Epidemiology.
- Once the high consequence infectious disease is reported to DOH, healthcare providers may provide a situational awareness notification (without protected health information) to the Alliance representative(s). Additionally, CHD staff may also notify the Alliance representative(s) to begin a coordinated high consequence infectious disease response.
- Following initial notification, the Alliance and DOH (CHD, leadership, or subject matter experts) will identify the appropriate partners to further notify. Partners and Alliance members may include:
 - Nearby CHDs
 - Additional DOH staff (leadership, preparedness, etc)
 - Local healthcare organizations/providers
 - Local EMS
 - Centers for Disease Control and Prevention
 - Local government/emergency management
 - Other health partners

C. Roles and Responsibilities

There will be overlapping roles and responsibilities for high consequence infectious disease responses between DOH and CHDs, healthcare organizations, and Alliance members. It is recommended that all organizations use the Incident Command System (ICS) to coordinate responses.

Primary Agencies & Roles

1. Florida Region 3 Healthcare Coalition Alliance
 - Establish and maintain three healthcare coalitions that serve 18 counties in north Florida: the Northeast Florida Health Care Coalition, North Central Florida Health Care Coalition, and the Coalition for Health and Medical Preparedness.

- Collaborate with public health, emergency management, and regional healthcare partners in the response to high consequence infectious diseases in the region.
- Distribute situational awareness information to and from healthcare organizations and coalition members.
- Assist to coordinate medical and non-medical resource needs, as needed, for healthcare organizations.
- Provide communications materials and support for healthcare information and communications needs.

2. Florida Department of Health and County Health Department

- Coordinate multi-jurisdictional response to an acute infectious disease.
- Coordinate with federal and neighboring state partners if the response exceeds local and state resources.
- Provide support for medical and non-medical resource needs of local healthcare providers, including the coordination of local and national stockpiles of resources.
- Provide direction on legal and statutory regulations and modifications.
- Manage the communicable disease outbreak.
- Lead policy decision making for healthcare and public health response.
- Assess the public health threat, evaluate potential consequences based on established criteria, and determine whether isolation and/or quarantine other measures to protect the public are necessary in any given response situation.
- Monitor cases and contacts of cases of acute infectious disease.
- Coordinate services required for isolation and quarantine.
- Activate Public Health emergency response structure (e.g. ICS).
- Coordinate public information and media communications concerning a high consequence infectious disease response.
- Coordinate communications with healthcare providers concerning a high consequence infectious disease response.
- Coordinate EMS transportation needs for select high consequence infectious disease (i.e. Ebola virus disease) cases.
- Advise healthcare organizations on laboratory testing processes.
- Advise healthcare organizations and other public health partners on environmental cleaning and decontamination.
- Coordinate the transfer of select high consequence infectious disease (i.e. Ebola virus disease) patients to other facilities and appropriate partners.

3. Healthcare organizations

- Provide medical care for patients during an infectious disease response.
- Communicate with CHDs regarding patient placement, movement, and care for select high consequence infectious diseases.

- Communicate with the Alliance all medical and non-medical resource needs.
- Provide timely situational awareness information regarding the infectious disease response to the Alliance.
- Achieve a base level of preparedness to be able to appropriately screen, manage and/or transfer patients with acute infectious diseases.
- Provide assistance to other healthcare organizations during a response in line with signed mutual aid agreements.
- Coordinate EMS transportation needs for high consequence infectious disease cases.

D. Operational Mission Areas

1. Surveillance

Routine Surveillance Systems

Healthcare organizations and providers are the front line for infectious disease surveillance in our communities. DOH coordinates multiple surveillance systems across the state with a variety of different goals to monitor the epidemiology of diseases affecting the populations. These systems include notifiable disease surveillance, vital statistics, syndromic surveillance, laboratory-based surveillance, antimicrobial resistance surveillance, and sentinel surveillance. Healthcare partners are encouraged to participate in all public health surveillance systems that are available to their facilities.

Healthcare organizations should partner with relevant public health and healthcare delivery system informatics initiatives, including electronic laboratory reporting, electronic test ordering, electronic death reporting, and syndromic surveillance as it relates to the submission of emergency department or urgent care center visit data to DOH.

The Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) is a biosurveillance system that collects emergency department chief complaint data from participating hospitals and urgent care centers in Florida. The objective of this surveillance system is to provide DOH with the data sources and analytic tools needed to identify outbreaks or unusual trends more rapidly, leading to a more timely public health response. Healthcare facilities also gain access to analyze surveillance data they provide to the system using the ESSENCE-FL web interface. Facilities that are interested in learning more about ESSENCE-FL, can contact their CHD or the Bureau of Epidemiology.

Identify, Isolate, Inform

In an effort to identify suspected high consequence infectious diseases early in the course of receiving healthcare, to implement appropriate transmission-based precautions, facilities and providers should establish routine patient screening for high consequence infectious disease risk factors corresponding with their patient population.

For example, primary and acute care facilities and providers should screen for factors such as international travel in the prior 30 days, any close contact with animals or use of animal products, relevant vaccination history, contact with person(s) suspected or known to have an infectious disease, recent history of undergoing public health monitoring, and occupation (i.e. lab worker or researcher).

Additionally, long-term care facilities and providers should screen for factors such as a history of receiving healthcare internationally in the past six months, prior infection or colonization with an antimicrobial resistant pathogen, and contact with a person(s) suspected or known to have an infectious disease.

Collecting information on relevant infectious disease risk factors will better prepare clinicians to identify high consequence infectious diseases during the medical evaluation of their patients. Leading to more prompt isolation of patients thus reducing the risk of disease transmission among patients and staff at the facility.

Clinicians that identify a suspected or confirmed high consequence infectious disease should report the patient to the CHD immediately to initiate the necessary public health response to protect the community.

Public Health Surveillance Reports

DOH produces several routine and event specific public health surveillance reports and summaries, these products will benefit the Alliance and healthcare facilities/providers involved in infectious disease surveillance and response.

Routine surveillance summaries include:

- [COVID-19 Surveillance Summaries](#)
- [Florida Flu Review](#)
- [Florida Arbovirus Surveillance Report](#)
- [Hepatitis A Surveillance Report](#)
- [Vaccine Preventable Diseases Surveillance Report](#)
- [Weekly Morbidity Statistics Report](#)
- [Annual Morbidity Statistics Report](#)

2. Infection Control and Prevention

To ensure that infection control resources are available during both routine infectious disease and high consequence infectious disease responses, foundational infection control and prevention (IPC) expertise, planning, and training is recommended for some staff at all healthcare facilities and providers offices. It is recommended that facilities meet and exceed regulatory requirements to hire or train select staff to ensure on-site availability of personnel with professional training and experience in infection control.

Healthcare facilities may elect to have staff participate in regional Association for Professionals in Infection Prevention and Epidemiology (APIC) chapters to contribute to a network of IPC peer support, mentoring, and problem solving. The peer support will enhance any one facility's capabilities by enhancing staff knowledge and experience and providing a connection to a network of IPC expertise.



All healthcare facilities and providers will benefit from developing and maintaining an infection control plan and program. Ideally the plan should be developed by facility staff and tailored to create a program to meet the needs of patients and staff.

The basic elements of an infection prevention program are designed to prevent the spread of infection in healthcare settings. When these elements are present and practiced consistently, the risk of infection among patients and healthcare personnel is reduced.

The Infection Control Assessment Tools linked were developed by CDC to assist health departments in assessing infection prevention practices and guide quality improvement activities (e.g., by addressing identified gaps). These tools may also be used by healthcare facilities to conduct internal quality improvement audits.

CDC Infection control assessment tools can be found here:

<https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html>

On a broader scale, jurisdictional public health infection control and prevention programs (including healthcare associated infections [HAI] program staff) may participate in developing infectious disease response plans and include HCC members for management of individual cases and larger emerging infectious disease outbreaks.

Consider use of the National Institute for Occupational Safety and Health (NIOSH) Hierarchy of Controls to consider applicable interventions as appropriate to the pathogen and transmission routes.

Considerations include:

- Roles and resources for N95 respirator fit-testing,
- Guidelines for conservation and re-use or extended use of N95 respirators/ powered air purifying respirators (PAPRs),
- Workplace engineering and administrative controls,
- Training in PPE donning and doffing,
- Return to work post illness or exposure policy for healthcare workers consistent across the coalition,
- Contingency plan for at-risk staff,
- Meeting the need for family support to enable staff to work,
- Use of telehealth and phone triage lines,
- Dedicated care teams for the outbreak, and
- Decontamination of PPE and patient care areas.

To compile key references useful for all healthcare facilities and public health partners, the CDC has created an [Infection Control Guideline and Guidance Library](#).

Key selected resources include:

- [Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings](#)
- [Guideline for Disinfection and Sterilization in Healthcare Facilities](#)
- [Guidelines for Environmental Infection Control in Health Care Facilities](#)
- [Management of Multidrug-Resistant Organisms In Healthcare Settings](#)
- [Infection Control in Healthcare Personnel: Infrastructure and Routine Practices for Occupational Infection Prevention and Control Services](#)

3. Non-Pharmaceutical Interventions

The CDC published [guidelines](#) in 2017 that describe the use of Nonpharmaceutical interventions (NPIs). These guidelines provide rationale and recommendations describing the implementation of various NPIs to reduce disease transmission. NPIs are strategies for disease, injury, and exposure control. They include actions that persons and communities can take to help slow the spread of respiratory viruses (e.g., seasonal and pandemic influenza viruses).

These actions include personal protective measures for everyday use (e.g., staying home when ill, covering coughs and sneezes, and washing hands often) and communitywide measures reserved for pandemics and aimed at reducing opportunities for exposure (e.g., coordinated closures and dismissals of child care facilities and schools and cancelling mass gatherings). NPIs can be used in conjunction with available

pharmaceutical interventions (antiviral medications) to help slow its transmission in communities, especially when a vaccine is not yet widely available.

These measures include:

- Voluntary home isolation
- Respiratory etiquette
- Hand hygiene
- Voluntary home quarantine
- Use of facemasks in community settings
- School closures and dismissals
- Social distancing measures
- Environmental surface cleaning measures

Other measures include restrictions on facility visitors, including adaptations that allow for continuation of critical services such as emergency medical services (EMS) handoffs, supply deliveries, off-site laboratory processing, and waste management while protecting the facility.

When a multiagency high consequence infectious disease response is required, the Alliance will promote consistent response strategies and joint policy and strategy coordination during a protracted event/pandemic across its membership. This may include working with DOH and other key stakeholders on public communication and promotion of personal protective actions.

Monitoring, Isolation, and Quarantine

DOH maintains the authority for broader implementation of quarantine and isolation protocols to protect the public's health. DOH may engage with the Alliance and its members to discuss implementation of quarantine and isolation in healthcare facilities or implementation for healthcare staff. DOH routinely works with healthcare facilities to direct persons undergoing quarantine or isolation for medical evaluations, testing, or treatment. During this process, advanced notification of the receiving facility by DOH staff is the expected standard so that appropriate infection control practices can be implemented immediately upon patient arrival.

Monitoring of cases and contacts of cases during an acute infectious disease response will be led by CHDs in collaboration with healthcare organizations (e.g., infection control and/or occupational health professionals). Individuals will be monitored according to national, state, and/or local standardized procedures. Monitoring procedures and movement restrictions are situation and disease specific and could vary from one response to the next. CHDs may work with healthcare organizations to pre-identify healthcare facilities that monitored individuals should be directed to if they develop symptoms and are in need of medical evaluation.

For examples, refer to the DOH document: [Guidance for Monitoring of Persons Exposed to Communicable Infectious Diseases of Public Health Importance](#)

CHDs will typically rely on voluntary compliance by individuals who require monitoring. In the event that large scale isolation or quarantine is required for any of the cases or contacts of the high consequence infectious disease cases, DOH will activate its isolation and quarantine plans. CHDs are the lead agency for coordinating operations, resources, and services associated with the voluntary or involuntary isolation and/or quarantine of individuals. The Alliance membership will work with healthcare organizations to provide support to CHDs when necessary.

4. Patient Care and Management

Patient Triage

- EMS may provide additional phone screening for individuals before EMS arrival on the scene to ensure proper personal protective equipment and infection control steps are taken.
- Healthcare organizations should consider providing phone and/or in-person screening/triage during a high consequence infectious disease response.
- DOH or select tertiary care hospital partners will provide clinical guidance on infectious disease patient management and infection control measures when necessary.
- During an emergency, DOH (in coordination with other state agencies as appropriate) may activate a Public Information Contact/Call Center (PICC). If conditions warrant, the PICC will provide public information and medical triage by nurses or in coordination with external agency nurse lines. CHDs will work with specific external agencies to provide support on a case-by-case basis.

Local Hospitals

All local hospitals are expected to maintain baseline preparedness levels for early-encounter screening to identify, and isolate (when necessary), individuals suspected of having a high consequence infectious disease. This includes utilizing appropriate administrative, environmental and infection control measures, personal protective equipment, and staffing.

In the event patients with a high consequence infectious disease require a level of care that cannot be achieved at all hospitals, DOH will work to identify specific facilities that have appropriate capability and capacity (E.g., infection control practices, personal protective equipment, isolation units or patient care area, equipment and staffing). The Alliance will be responsible for engaging with regional healthcare executives/administrators in a multi-jurisdictional response.

Ambulatory Care

Ambulatory care organizations are expected to plan and provide baseline screening for infectious diseases as early as possible in the clinical encounter whether over the phone or in person, isolate the patients (if necessary) and when necessary, coordinate with CHDs, EMS, and other healthcare organizations to appropriately transfer the patient to a receiving facility for further screening, testing, and treatment.

Ambulatory care facilities are not expected to provide full testing and care for all acute infectious disease patients, but should maintain protocols to ensure the ability to promptly identify and safely evaluate, stabilize and isolate if necessary, suspected infectious disease patients and implement guidance for transfer of patients to designated facilities when indicated. Ambulatory care facilities should be able to decontaminate and identify exposed staff or patients, if a high consequence infectious disease patient were evaluated onsite. Ambulatory care will coordinate with the Alliance, CHDs, and other healthcare organizations for updated guidance during response.

Palliative Care and Behavioral Health

In coordination with direct medical care, palliative care may be necessary to support patients with a high consequence infectious disease. Plans should be enacted early in an infectious disease response to address and plan for palliative care needs as appropriate based on the pathogen. Additionally, due to the impact of being infected, exposed, or treating individuals with an acute infectious disease, plans may be required to support a surge in behavioral health needs of patients, family members, community members, healthcare staff and employees during an acute infectious disease incident. CHDs, healthcare organizations, and the Alliance should work together to facilitate information coordination and standardizations of resources provided to address palliative care and behavioral health concerns based on the incident. Palliative care and behavioral health response may need to continue long after an acute infectious disease response is demobilized.

5. Support Services

Support services may include any healthcare or non-healthcare staff or material resources required to support the care of acute infectious disease patients. This may include dialysis providers, blood banks/blood product providers, laboratory services, infection prevention/control, waste and material management, food and dietary services, and environmental services. Support service providers will work with healthcare facilities, the Alliance, and CHDs to prepare and respond by assisting healthcare organizations in the care of acute infectious disease patients.

a. Laboratory

DOH has identified which [diseases and conditions](#) require patient specimen submission to the DOH Bureau of Public Health Laboratories (BPHL) for

confirmation or additional testing. Facilities should plan that all instances of suspected or confirmed high consequence infectious disease will require specimen submission to DOH BPHL.

- Prior consultation with DOH is required before shipping specimens for testing for high consequence infectious disease. This consultation will determine the appropriate specimen type(s), specimen collection process, handling and shipping requirements, appropriate public health laboratory for submission, and the required documentation.
- Facilities will contact the CHD to arrange for specimen submission to the BPHL.
- The CHD will coordinate with subject matter experts within DOH.
- DOH routinely relies on the reporting healthcare facilities/providers to collect specimens from patients with high consequence infectious disease.
- Facilities are asked to not send patients with suspect infectious diseases to CHD locations, as the department does not routinely have appropriate staff to provide medical treatment.
- Facilities are asked to not send patients with suspected infectious diseases to outpatient laboratories for specimen collection.
- In some circumstances, DOH may be able to coordinate provision of appropriate specimen collection kits or coordination with other facilities with appropriate supplies.
- All specimens submitted to BPHL will require a clinical lab submission form [DH1847](#).
- Laboratory staff may also contact BPHL staff for peer-to-peer consultation and to discuss services provided.
 - BPHL Jacksonville: 904-791-1500
 - BPHL Miami: 305-324-2432
 - BPHL Tampa: 813-233-2203
- More information on BPHL can be found on their website: <http://www.floridahealth.gov/programs-and-services/public-health-laboratories/index.html>

The Bureau of Public Health Laboratories annually sponsors, through the CDC Cooperative Agreement Grant for Public Health Emergency Preparedness, Infectious Substances Packaging and Shipping Training for our Sentinel Laboratory partners, including hospital and county health department laboratory personnel and non-sentinel laboratory personnel if space is available. This training is open to personnel who are responsible for packaging and shipping infectious substances and diagnostic specimens. Participants will learn how to properly package and ship Category A and Category B infectious substances and other dangerous goods such as dry ice by air and ground in accordance with prescribed guidelines. Space is limited and advance registration is required.

Infectious Substances Packaging and Shipping Training is required every two years to maintain certification. Registration information can be found here: http://www.floridahealth.gov/programs-and-services/public-health-laboratories/educational-opportunities/documents/registering-for-2021-infectious-substances-ps-classes-in-train-03_21.pdf

b. Waste Management, Decontamination

Healthcare organizations will work through their normal vendors and channels to ensure all waste produced in the screening and care of high consequence infectious disease patients will be handled and disposed of appropriately. If needed, the Alliance will coordinate with DOH to provide guidance on waste handling and disposal. Where necessary, healthcare facilities or DOH may coordinate or contract with specific waste management contractors for the safe handling and removal of waste associated with healthcare for infectious disease patients as well as coordinating with the appropriate utilities as needed. Healthcare facilities and waste management agencies will maintain protocols for the handling of waste from infectious disease patients in accordance with existing guidelines:

- Centers for Disease Control and Prevention [Guidelines for Environmental Infection Control in Health Care Facilities](#)
- Centers for Disease Control and Prevention [Guideline for Disinfection and Sterilization in Healthcare Facilities](#)
- <https://www.epa.gov/pesticide-registration/list-k-epas-registered-antimicrobial-products-effective-against-clostridium>
- Association for Professionals in Infection Control and Epidemiology (APIC) [States Targeting Reduction in Infections via Engagement \(STRIVE\) program resources](#) - Environmental Services Training Modules and tools
- [EPA's Registered Antimicrobial Products Effective against Clostridium difficile Spores](#)
- [Interim Guidance for Environmental Infection Control in Hospitals for Ebola Virus](#)

c. Mortuary Services

A death due to a confirmed high consequence infectious disease is considered a natural death and does not fall under the jurisdiction of the Medical Examiner's Office, unless the death is in connection to an act of bioterrorism, or executive action has directed the Medical Examiners Commission have a role in documenting deaths due to the infectious disease. Healthcare organizations are therefore expected to work through their normal channels for the care of the deceased. CHDs, and the DOH will coordinate any changes in guidance or reporting associated with deaths due to a high consequence infectious disease. If

healthcare organizations need assistance in coordinating the care of the deceased, local officials will communicate with local mortuary services to provide guidance on protocols and handling. Local mortuary services have internal plans and protocols to handle the remains of infectious disease patients. For an example of guidelines for the handling of human remains, see the [CDC Ebola human remains guidelines](#).

d. Patient Transport

Local EMS agencies will have internal guidelines and protocols for responding to possible high consequence infectious disease within the community. This includes protocols for patients who have been identified as possibly exposed and are being monitored by CHDs as well as patients who have not been previously identified. As information is made available, EMS will incorporate and follow current Occupational Health and Safety Administration (OSHA) and Center for Disease Control and Prevention (CDC) guidelines for personal protective equipment and infection control associated with the current acute infectious disease response. EMS will maintain and update plans established to coordinate the identification, management, and cleaning of an appropriate transport vehicle for patient transport. If cross-jurisdictional support is required, EMS will work through existing memorandums of agreement/ understanding to address their needs. Transportation method/mode considerations must take into account the number of patients, acuity level, and confirmed or suspected infectious disease. For non-Ebola patients, healthcare organizations and public health agencies should use standard transport protocols and mechanisms and for arranging transport to appropriate facilities.

Florida Infectious Disease Transportation Network Plan (FIDTN)

The Florida DOH has developed the Florida Infectious Disease Transportation Network Plan to coordinate transport of patients with selected high consequence infectious diseases to treatment facilities with more specialized levels of care as needed.

Patients with severe, high consequence diseases, such as Ebola, MERS, SARS, and others, can present significant challenges to Florida's healthcare system. Due to these challenges, and the need for very specialized care, the best course of action may be the transfer of such patients to hospitals capable of treating patients with these types of disease. Such facilities may exist in the State of Florida, or, if not, patients may need to be transported to facilities designated by the U.S. Health and Human Services (HHS), Office of the Assistant Secretary for Preparedness and Response (ASPR) as special pathogen treatment centers or "Regional Treatment Centers" (RTC). The closest facility of this type to Florida is

Emory University Hospital in Atlanta, with Grady Memorial Hospital, also in Atlanta, serving as an alternative.

In the event that a transportation of a patient with a high consequence infectious disease is needed and a treatment hospital is found in Florida, the patient will be transferred from the facility to a more specialized treatment hospital. If, on the other hand, the RTC must be used, plans call for federally-contracted air medical transportation assets to be used. If these assets are not available due to being assigned to other missions or if weather minimums preclude transportation by air, ground transport must be made, in cooperation with the Georgia Department of Public Health (GDPH), to shuttle the patient to the RTC.

The Florida Department of Health (DOH) has the responsibility for coordinating these two types of transports. If needed, facilities should discuss the need to transfer high consequence infectious disease patients to CHD staff to specialized treatment facilities. In turn, CHD staff will communicate with DOH experts and leadership to initiate the FIDTN plan.

6. Surge Staffing

Healthcare facilities should develop, or augment, surge staffing plans to bolster future infectious disease responses. Based on lessons learned during prior responses, multiple approaches to surge staffing will be needed during a prolonged response.

These options may include:

- Cross training existing staff
- Staff pay enhancements
- Mutual aid agreements with partner facilities
- Contract agency staffing agreements
- Medical reserve corps
- Requesting support from state ESF8 during a response
- National Guard activation

Additionally, facilities will need to develop training for surge staff to successfully integrate staff into the response.

7. Supply Chain, Supplies, Personal Protective Equipment - Refer to Alliance Health Care Coalition Supply Chain Mitigation Strategy

HCCs play a key role in linking public sector response agencies, including emergency management agencies and public health departments, and private healthcare facilities that serve as points of service. HCCs are key stakeholders, and though not direct components of the supply chain, they may be able to act as a coordination point

between multiple vendors/suppliers and healthcare facilities to address supply disruptions. HCCs play an essential role in working with supply chain readiness and response planning members during normal operations.

By serving as a coordination and information-sharing hub, HCCs can: encourage best practices in communicating and engaging with supply chain components, standardize and provide guidance on activities that impact supply chain operations during emerging events, and provide opportunities for supply chain components and coalition members to train and exercise with one another. HCCs can also play a role in helping healthcare facilities share information and coordinate strategies in their area to cope with specific supply (medication, equipment, dialysis solutions) shortages affecting stakeholders.

HCCs serve as a unifier of the healthcare preparedness and response activities across a community, working to link the disaster preparedness and response plans to provide care and protect public health in their area. All HCCs should be able to act as information sharing hubs for distributors and providers and have the ability to share product and delivery information and strategy. For HCCs with a broader role in emergency response, primary activities may include tracking impediments to product delivery, resource request management and brokering, and monitoring healthcare facilities; operational status and needs within the HCC.

The “2021 Alliance Healthcare Coalition Supply Chain Mitigation Strategy Templates” provide an overview of the emergency planning and response considerations of healthcare supply chain owners, operators, and end-users, as well as insights for healthcare coalitions (HCCs) working with healthcare supply chain partners on preparedness, response, and recovery.

8. Communications

- DOH will coordinate public information and risk communications messaging and education. DOH, CHDs, and Alliance membership will coordinate to ensure consistency of messaging.
- DOH will lead in planning (including communications plan development) and providing risk communication and official guidance to all healthcare organizations. In accordance with their role within DOH, CHDs will often communicate with local healthcare partners.
- The Alliance will participate in any Joint Information System (JIS) established for the high consequence infectious disease incident.
- The Alliance will coordinate situational awareness information sharing with healthcare organizations and other local and state partners throughout the regions during an emergency response. As needed, The Alliance will work with the CHDs on communication to local partners.

E. Behavioral Health Self Care for Healthcare Workers

Healthcare facilities leadership and managers should review available [ASPR TRACIE resources](#) to prepare to develop programs, plans, and services that address employee behavioral health to help staff cope with prolonged high consequence infectious disease response. These plans and resources are designed to assist with issues related to disaster behavioral health, provider self-care, suicide prevention, and compassion fatigue. ASPR found that one continuous knowledge gap identified has been the need for information for front-line healthcare to use prior to a disaster to recognize and reduce their stress levels and maintain resilience during recovery.

ASPR TRACIE Self Care for Healthcare Workers Modules

Module 1: Compassion Fatigue and Secondary Traumatic Stress Identification for Healthcare Providers

Module 1 educates staff on the concept of traumatic stress. It identifies terms, risk factors, and symptoms associated with compassion fatigue, secondary traumatic stress, vicarious trauma, and burnout. The concept of self-care is introduced and participants learn about building skills that can improve resilience.

Module 2: Organizational Wellness From the Top: Stress Mitigation and Work Satisfaction for Healthcare Providers

Module 2 defines organizational wellness, causes of organizational “disease,” and how stress can negatively affect the work environment. Tips and tools for measuring wellness are included, as are suggestions for implementing wellness strategies. The module closes with stress reducing exercises for executives and an emphasis on the importance of physical activity and learning opportunities for leaders and staff.

Module 3: Cognitive Tools for Mitigating Compassion Fatigue and Secondary Traumatic Stress

Module 3 moves participants to a more comprehensive identification and understanding of the types of tools that can help to mitigate compassion fatigue and secondary traumatic stress. Cognitive strengthening is defined and tools for restructuring are provided. Participants learn about mindfulness, engaging with others, and how to manage triggers in stressful situations. This module has two longer webinars—the second webinar examines the fight, flee, or freeze reactions healthcare workers might experience and provides tools for identifying and managing these reactions before, during, and after traumatic experiences. The module takes participants through two scenarios—a mass shooting and an unknown infectious disease—and shares how they can prepare for these and other situations where there is a surge of patients and supplies and staff are limited.

F. Training and Exercises - Refer to the Alliance's Integrated Preparedness Plan (IPP), which follow the below concepts:

- Develop a coalition-wide training, exercise, and evaluation program to improve response capabilities in an infectious disease scenario. This may include PPE training, crisis standards of care training, community-based interventions, etc.
- Ensure ongoing training on appropriate use of PPE and management of suspect special pathogen or high consequence infectious disease cases in healthcare facilities and EMS.
- Includes infection prevention personnel at the health care facility and jurisdictional levels in planning, training, and exercises/drills.
- Develops and exercises plans to coordinate patient management and distribution for highly pathogenic respiratory viruses and other highly transmissible infections, including complicated and critically ill infectious disease patients, when tertiary care facilities or designated facilities are not available

G. Demobilization

When DOH in consultation with HCCs, Alliance, and local healthcare organizations determine that the need for advanced coordination with healthcare for the high consequence infectious disease response has passed, the decision will be made to demobilize and transfer any outstanding coordination back to normal operational channels.

Triggers and indicators for ending acute infectious disease response and monitoring:

- If the level of state or regional coordination necessary to manage existing patients is comparable to that of normal operating procedures.
- If the immediate danger has passed and there is no longer a threat.
- Completion of the monitoring period for all exposed persons.
- The passage of at least two incubation periods without reported cases.
- The healthcare system has sufficient resources and capacity to resume normal operations Healthcare emergency department volume decreases in general, or decreases to usual census levels (social and clinical measure of change)
- Syndromic surveillance markers indicate a return to baseline.
- Call center volume (911 and other call centers) return to normal threshold.
- EMS call reports (type and volume) return to normal threshold.
- Community and social media concerns decrease.
- Media requests for information decrease.

The Alliance, HCCs and the CHDs will lead in notifying staff and local partners of the demobilization. At that time:

- All activations are demobilized.
- Final situational awareness information is sent to all partners.
- All partners are notified of the demobilization.
- A debrief and after-action process is established for internal operations and all partners.
 - Document processes that should be sustained and identify areas for improvement.
 - Update plans, processes and procedures

The following activities should be considered:

- Return any borrowed assets
- Debrief local, regional, and/or state partners with after action report and improvement plan and coordinated approach to incorporating recommendations into future planning
- Communicate concerning payment and reimbursement for the response
- Communicate any screening or surveillance activities that need to be revised or maintained longer term.

Source Documents:

Healthcare Coalition Infectious Disease Surge Annex Template

[Healthcare Coalition Infectious Disease Surge Annex Template \(hhs.gov\)](https://www.hhs.gov)

Northwest Healthcare Response Network - Regional Acute Infectious Disease Response Plan

[Regional-Acute-Infectious-Disease-Response-Plan_08_2017_FINAL.pdf \(nwhrn.org\)](https://www.nwhrn.org)

Appendix A: Key Issues by Scenario Type



Bioterrorism

- Recognition of event / determination of potential impact
 - Defining the population at risk / implementing screening
 - Environmental assessment
 - Request for state/federal assets – PPE, ventilators, MCM / treatment, Federal Medical Station (FMS)
 - State / federal declarations of disaster
 - Risk communications
 - Behavioral health (community and responders)
 - Regional patient movement coordination / MOCC
 - Surge capacity (outpatient and inpatient) with an emphasis on critical care
 - Alternate care systems / sites
 - Incorporation of SNS, FMS, and other federal resources into response
 - MCM distribution – community
 - MCM distribution and use – healthcare
 - Pharmacy (e.g., distribution, receipt, handling, billing)
 - Clinical care (e.g., antitoxin)
 - Crisis Standards of Care (CSC) – roles and responsibilities, triage decision-making
 - Fatality management
 - Waste management and environmental protection of facilities
-

VHF/Ebola

- Recognition of case(s) / determination of potential impact
- Identify – isolate – inform
- Testing / sample coordination
- Risk communications
- Behavioral health (community and responders)
- Regional patient movement coordination / MOCC role / thresholds (i.e., when is a MOCC needed?)
- PPE support / coordination
- Engineering and administrative controls for infection prevention
- Public health investigation / isolation / quarantine
- Frontline / Assessment / Regional treatment resources and roles
 - Surge capacity plan in event of multiple cases
- EMS transport mechanisms / teams / process
- Waste management and environmental protection of facilities
- Fatality Management

Highly Pathogenic Respiratory Viral Infection

- Recognition of case(s) / determination of potential impact
- Identify – isolate – inform
- Regional patient movement coordination / MOCC role / threshold (i.e., when is a MOCC needed?)
- Testing / sample collection
- Risk communication
- Behavioral health (community and responders)
- PPE support / coordination
- Public health investigation / isolation / quarantine
- Engineering and administrative controls for infection prevention
- Frontline / Assessment / Regional treatment resources and roles (may be significantly different than VHF; regional facilities may not be used; and usual referral centers may provide care)
 - Surge capacity plan in event of multiple cases
- EMS transport mechanisms / teams / process as applicable

Pandemic

- Recognition of case(s) / determination of potential impact
- Identify – isolate – inform
- Coalition vs. state coordination / interface (how do coalitions interface with state response to prevent duplication of effort / maintain coalition operations that may be different in different areas)
- Request for state/federal assets – PPE, ventilators, MCM / treatment, Federal Medical Station (FMS)
- State / federal declarations of disaster
- Regional patient movement coordination / MOCC role and ‘level loading’ policies
- Risk communications
- Behavioral health (community and responders)
- PPE use recommendations, support for fit-testing, supply / cache support role
- Supply Chain
- Public health investigation / isolation / quarantine
- Surge capacity (outpatient and inpatient, especially ICU)
- CSC – indicators and triggers (e.g., cancelling elective surgery), roles and responsibilities, triage decision-making
- Testing strategy and roles/responsibilities
- MCM distribution – community
- MCM distribution and use – healthcare
 - Pharmacy (e.g., distribution, receipt, handling, billing)
 - Clinical care
- Long-term care facility support
- Homecare agency support
- Alternate care sites / systems
- Fatality management

Training Needs Assessment

Overview

At the direction of the Region 3 Healthcare Coalition Alliance (the Alliance), Critical Integrated Solutions (CIS), Inc., developed, deployed, and evaluated the results of two surveys aimed at determining the Alliance's training, logistics, and infectious disease planning needs. Those results were delivered to Alliance leadership on March 11, 2021. Following an analysis of those results, the CIS team presented an overview during two virtual sessions (with one additional planned) on March 17 and March 24, 2021.

In addition to the results from the two surveys, the CIS team also reviewed the results of several facilitated planning sessions from early 2020 (just as the pandemic started), CDC/HHS materials and templates, the current Region 3 Multi-Year Training and Exercise Plan (MYTEP), and other related materials. The CIS team has expertise in Florida infectious disease planning, logistics, operations, and training. There were 125 overall responses to the poll, however several of the subsections did not require all participants to respond. The majority of the respondents represented specialized nursing facilities, assisted-living facilities (33%) hospitals (20%), home health care (12%), or other healthcare facilities (12%).

Given the impact of COVID-19 on the global healthcare system during the past year, it was not surprising that the greatest training needs were in the areas of infectious diseases, hand hygiene, disinfection/decontamination, personal protective equipment (PPE), and other details associated with infection control, patient/resident care, and staff safety. The need for behavioral health support was also notable with all 125 respondents reporting some level of concern (Q35).

The responses to questions (Q23 and Q24) about Incident Command System (ICS) training indicated a 60/40 split between organizations that use some form of ICS and those that do not. ICS was identified as a potential training gap, specifically position-specific training. The extended pandemic response may have reinforced the value of Hospital ICS and Nursing Home ICS to those who have not previously used it.

The extensive training calendar for Region 3's current MYTEP includes numerous training opportunities during 2021-2023 to build on key skills (see Appendix A). Certainly, the offerings in position-specific ICS training, Hospital and Nursing Home ICS should go a long way to support those needs, assuming enough people take advantage of those offerings. Courses such as Personal Protective Measures for Biological Events (PER-320) cover significant elements of PPE and decontamination in an 8-hour course. The Hospital Emergency Response Team (AWR-900/901) training series, and the MGT courses, likewise appear to address some of the identified training needs.

The recommendations below build on the current MYTEP offerings and focus on bridging the gaps, particularly in infection control. Not all gaps can be bridged with training, so additionally we have some exercise recommendations to help develop more integrated capabilities across the region. While it wasn't identified as a training need, medical surge was identified in the survey as the biggest challenge in this past year full of challenges.

While training cannot fill that gap alone, and a pandemic stretches human and material resource needs for a longer duration than any other infectious disease, integrated training and

exercise can help build a better mutual support structure within the coalition. This shifting of resources within the coalition is more likely for shorter duration infectious disease events and may include shifting non-clinical staff to take on some tasks to reduce the impact on clinical staff. The members of the coalition have likely done some of this in previous response events and, when possible, provided support during the pandemic response.

Survey Results Breakdown

Top Overall Areas of Concern:

1. Staffing/personnel surge
2. Safety/security of residents/patients/staff
3. Personal protective equipment
4. Supply chain management
5. Communications

Top Identified Training Needs (Q 103, Page 153, 4.0+ score):

1. Infectious disease training (All Staff)
2. Hand hygiene training (All Staff)
3. Environmental cleaning/disinfection (Environmental Staff)
4. PPE—Universal Precautions
5. Communications (All Staff)
6. Safety (Facilities/Maintenance)

Potential Training Gaps (Q 104, Page 159, 3.5+score):

1. Rapid identification and isolation of Persons Under Investigation
2. Transmission-based precautions
3. Assessment, transport, and treatment of COVID-19 suspected or confirmed patients
4. PPE optimization protocols, extended use, and re-use
5. PPE donning and doffing procedures (e.g. universal masking etiquette)
6. Prioritized clinical interventions
7. Crisis standards of care/triage and infection control
8. Incident Command Position-Specific Training
9. Managing the care of COVID residents

Training Recommendations

1. Support members seeking either the Associate – Infection Prevention and Control (a-IPC) entry-level certification or the Certification in Infection Prevention and Control (CIC)
2. Infection Prevention and Control Training for Healthcare Professionals (Intermediate level)
3. Rapid Identification and isolation of a Person Under Investigation for infectious disease. (Overview level course - 1 to 2 hours of instruction)
4. Contact investigations/contact tracing and applications of quarantine and isolation (Overview level course - 1.5 hour to 3.0 hours of instruction)

5. Standardized PPE, decontamination, handwashing, skills-based training (donning/doffing, masking) for all levels of patient/resident care
6. Patient/resident care for infectious diseases for non-clinical staff
7. Develop seminar on legal, ethical, and policy issues associated with quarantine, disaster standards of care, triage, and crisis decision making
8. Continuity of Operations/Business Continuity training beyond the IS-1300 level

Other Training Considerations

1. Training focused on rural healthcare systems
2. Conduct review of current curriculum to see if any revisions need to be made based on COVID-19 response
 - a. Hospital Emergency Response Training
 - b. AWR, PER, and MGT series
 - c. Points of Dispensing Training
 - d. FAST series of trainings
3. Use HERT-trained staff to partner/mentor LTCF staff in smaller or geographically isolated areas.

Exercise Recommendations

While technically it is beyond the scope of this survey, training and exercises are integrated processes as reflected in the MYTEP. A number of the capabilities that we recommend to the Alliance can best be developed and observed among members through the exercise program. While the exercise program was not part of the current Region 3 MYTEP we reviewed, the CIS team includes the following for your consideration.

- Infectious disease discussion-based exercises (e.g. seminars on current infectious disease practices, medical ethics, disaster standards of care) can help elevate infectious disease understanding and practice across the coalition. They can be done virtually and continue the enhanced ability we all have gained with Zoom, MS Teams, etc. during this pandemic response.
- Infectious disease exercises can be scheduled for the January-March period following training sessions in late September-December (Hurricane Season dependent). This will provide an opportunity to refresh skills during the influenza/respiratory disease season (assuming COVID does not remain a year-round response).
- PPE donning and doffing skills drills should be considered to keep “muscle memory” from pandemic response as well as to ensure new employees, particularly non-clinical staff, learn and train on correct procedures.
- Logistic drills including supplier call downs can ensure that vendors are still in business, you have the latest contact name and number, and that any agreements/contracts are updated regularly.

- Integrate different infectious diseases into the 3-year exercise cycle for the Infectious Disease Plan and related plans.
- Medical surge exercises, more than training, is the best way to see if shifting resources, repurposing staff and/or facilities will work. Consider other infectious diseases since the surge challenge in a pandemic is nearly overwhelming.
- The pandemic has forced most of us to practice COOP and Business Continuity plans and take actions we probably would not have considered before. Use this experience to update COOP/Business Continuity Plans and consider a coalition-wide exercise in the future (a year or two after the pandemic ends).



Appendix A

Region 3 Multi-Year Training and Exercise Program (MYTEP)

Epi Response/PPE:

- iFirst training
- Isolation/Quarantine
- PER-320 Personal Protective Measures for Biological Events
- PER-321 Barrier Precautions and Controls for Highly Infectious Disease (HID)
- BPHL Infectious Substances Packaging and Shipping Training

Hospital/SNF/ALF:

- FRAME AWR-900 Framework for Healthcare Emergency Management
- HERT-B AWR-901-1 Hospital Emergency Response Training for Mass Casualty Incidents
- AWR-901
 - Update Hospital Emergency Response Team (HERT) Training for COVID?
 - Is there an equivalent for SNFs/ALFs? Is it linked to HERT?

Behavioral Health Other Health:

- Disaster Behavioral Health First Aid Specialist Training (BFAST)
- B Fast/C Fast/R Fast
- FDOH SpNS: Caring for those with memory impairment (“COVID Brain” impacts?)

ICS/ESF-8:

- G-775 Emergency Operations Center (EOC) Management and Operations
- L-952 All Hazards PIO
- L962 Planning Chief/All Hazards Planning Section Chief Training (L963)
- L958 Operations Section Chief
- FL-2355 LOG Management Course
- ESF-8 Training
- WebEOC Boot Camp
- FDOH CDC Public Information and Communication in a MCM Response
- IS 1300 Intro to Continuity of Operations Plans (COOP)
- Hospital Incident Command Systems (HICS)
- Nursing Home Incident Command Systems (NHICS)

Alternate Care/Points of Dispensing:

- MGT-319 Medical Countermeasures: Points of Dispensing (POD), Planning and Response
- Point of Dispensing (POD) Essentials Train-the-Trainer (MGT-442-1)
- MGT-341 Disaster Preparedness for Hospitals and Healthcare Organizations within the Community Infrastructure
 - LTCF support changes?
 - Any changes from COVID?
 - Can this support COVID-related gaps in training?



Florida Region 3 Healthcare Coalition Alliance

Integrated Preparedness Plan

April 26, 2021

INTEGRATED PREPAREDNESS PLANNING TEAM

[Training POC:]

[Name]
[Title]
[Agency]
[Street Address]
[City, State ZIP]
[xxx-xxx-xxxx (office)]
[xxx-xxx-xxxx (cell)]
[e-mail]

[Exercise POC:]

[Name]
[Title]
[Agency]
[Street Address]
[City, State ZIP]
[xxx-xxx-xxxx (office)]
[xxx-xxx-xxxx (cell)]
[e-mail]

[Budget POC:]

[Name]
[Title]
[Agency]
[Street Address]
[City, State ZIP]
[xxx-xxx-xxxx (office)]
[xxx-xxx-xxxx (cell)]
[e-mail]

[Planning POC:]

[Name]
[Title]
[Agency]
[Street Address]
[City, State ZIP]
[xxx-xxx-xxxx (office)]
[xxx-xxx-xxxx (cell)]
[e-mail]

[Recovery & Mitigation POC:]

[Name]
[Title]
[Agency]
[Street Address]
[City, State ZIP]
[xxx-xxx-xxxx (office)]
[xxx-xxx-xxxx (cell)]
[e-mail]

[Hazard Analysis/Risk Assessments POC:]

[Name]
[Title]
[Agency]
[Street Address]
[City, State ZIP]
[xxx-xxx-xxxx (office)]
[xxx-xxx-xxxx (cell)]
[e-mail]

PURPOSE

[Provide introductory language as necessary.]

Consider specifying or describing:

- The role of the Integrated Preparedness Plan (IPP);
- Which department(s) administer the IPP;
- Who is required to abide by the IPP;
- The years covered under the IPP; and
- The review and revision schedule

DRAFT

PREPAREDNESS ACTIVITY CONSIDERATIONS

The 2020-2021 COVID-19 Pandemic underlined a need to increase the Florida Region 3 Healthcare Coalition Alliance's (the Alliance) ability to respond to infectious disease outbreaks. Northeast Florida's capabilities had been stretched during previous infectious disease response activities such as Ebola, Zika Virus, and hepatitis A in recent years. In developing an infectious disease plan and supporting training and exercise schedule, The Alliance hopes to reduce morbidity and mortality associated with infectious disease outbreaks in the future. The training and exercises outlined below are focused on the Planning; Public Information and Warning; Operational Coordination; Logistics and Supply Chain Management; and Public Health, Healthcare, and Emergency Medical Services Core Capabilities.

The Alliance had begun planning for pandemics and vaccine-preventable disease outbreaks in 2019-2020. The information from those three (3) planning sessions was augmented by a detailed survey in March 2021. The survey covered logistics and supply chain, infectious disease planning, and training. Survey respondents were asked to consider lessons learned and improvements made during the COVID-19 Pandemic response. The recommended training and exercise program supports the Infectious Disease Response Plan.

Threats, Hazards, and Risks

Infectious diseases are a natural hazard that can affect a community at any time. SARS-CoV-2, a novel virus that causes COVID-19, has created a global pandemic that is still not ended after more than a year. There are a variety of other infectious diseases (e.g. Ebola, Zika, influenza, etc.) that can create a surge on healthcare systems.

Capability Assessments, Corrective Actions, and Improvement Plans

The COVID-19 Pandemic overwhelmed Logistics and Supply Chain Management and Public Health, Healthcare, and Emergency Medical Services Core Capabilities. Critical supplies such as personal protective equipment (PPE), COVID-19 test kits, and therapeutic treatments were in very short supply. The most critical logistical shortage was staff for healthcare facilities and health services, public health agencies, and Emergency Medical Services. The COVID-19 Pandemic also dramatically impacted Health and Social Services and Economic Recovery Core Capabilities, but these are beyond the scope of the Infectious Disease Response Plan.

External Sources and Requirements

The US Department of Health and Human Services (HHS) has required that states develop infectious disease, logistics and supply chain, and other plans in response to the COVID-19 Pandemic.

Accreditation Standards and Regulations

[Provide a brief description of the accreditation standards and regulations that informed the development of the preparedness priorities.]

DRAFT

PREPAREDNESS PRIORITIES

At the direction of the Alliance, Critical Integrated Solutions (CIS), Inc., developed, deployed, and evaluated the results of two surveys aimed at determining the Alliance's training, logistics, and infectious disease planning needs. Those results were delivered to Alliance leadership on March 11, 2021. Following an analysis of those results, the CIS team presented an overview during three virtual sessions on March 17, 24, and again on April 28, 2021.

In addition to the results from the two surveys, the CIS team also reviewed the results of several facilitated planning sessions from early 2020 (just as the pandemic started), CDC/HHS materials and templates, the current Multi-Year Training and Exercise Plan (MYTEP), and other related materials. The CIS team has expertise in Florida infectious disease planning, logistics, operations, and training. There were 125 overall responses to the poll, however several of the subsections did not require all participants to respond. The majority of the respondents represented specialized nursing facilities, assisted-living facilities (33%) hospitals (20%), home health care (12%), or other healthcare facilities (12%).

Given the impact of COVID-19 on the global healthcare system during the past year, it was not surprising that the greatest training needs were in the areas of infectious diseases, hand hygiene, disinfection/decontamination, personal protective equipment (PPE), and other details associated with infection control, patient/resident care, and staff safety. The need for behavioral health support was also notable with all 125 respondents reporting some level of concern.

The responses to questions about Incident Command System (ICS) training indicated a 60/40 split between organizations that use some form of ICS and those that do not. ICS was identified as a potential training gap, specifically position-specific training. The extended pandemic response may have reinforced the value of Hospital ICS and Nursing Home ICS to those who have not previously used it?

The extensive training calendar for the current MYTEP includes numerous training opportunities during 2021-2023 to build on key skills (see Appendix A). Certainly, the offerings in position-specific ICS training, Hospital and Nursing Home ICS, should go a long way to support those needs, assuming enough people can take advantage of those offerings. Courses such as Personal Protective Measures for Biological Events (PER-320) cover significant elements of PPE and decontamination in an 8-hour course. The Hospital Emergency Response Team (AWR-900/901) training series, and the MGT courses, likewise appear to address some of the identified training needs.

The recommendations below build on the current MYTEP offerings and focus on bridging the gaps, particularly in infection control. Not all gaps can be bridged with training, so additionally we have some exercise recommendations to help develop more integrated capabilities across the region. While it wasn't identified as a training need, medical surge was identified in the survey as the biggest challenge in this past year full of challenges.

While training cannot fill that gap alone, and a pandemic stretches human and material resource needs for a longer duration than any other infectious disease, **integrated training and exercise** can help build a better mutual support structure within the coalition. This shifting of resources within the coalition is more likely for shorter duration infectious disease events and may include shifting non-clinical staff to taking on some tasks to reduce the impact on clinical staff. The members of the coalitions in NE Florida have done some of

this in previous response events and, when possible, provided support during the pandemic response.

Based on the above-mentioned considerations, the IPPW participants determined the following priorities will be the focus for the multi-year cycle of preparedness:

Preparedness Priorities
<ul style="list-style-type: none"> • Staffing/personnel surge
<ul style="list-style-type: none"> • Safety/security of residents/patients/staff
<ul style="list-style-type: none"> • Personal protective equipment
<ul style="list-style-type: none"> • Supply chain management
<ul style="list-style-type: none"> • Communications
<ul style="list-style-type: none"> • Behavioral Health

Staffing/personnel surge

COVID-19 stretched the entire healthcare system close to a breaking point.

Corresponding Capabilities:

- Logistics and Supply Chain Management; and Public Health, Healthcare, and Emergency Medical Services

Rationale:

- Shortages of trained healthcare and public health personnel, PPE, and testing kits reduced the Alliance’s ability to respond to COVID-19 overtime. Other highly consequential infectious diseases have, and will, surge the healthcare and public health workforce. Infection control practices, including appropriate PPE, are the best mechanisms for reducing morbidity and mortality in an infectious disease outbreak/epidemic/pandemic response.
- Planning Factors: The Alliance’s Infectious Disease Surge Plan is premised on supporting personnel and equipment surges to support response to a variety of high consequence infectious diseases up to and including pandemics. Cross training healthcare and public health workers on infection control, PPE, disease investigation, contact tracing, non-clinical aspects of patient management, and incident management is a key element to provide surge capability. Points of Dispensing (PODS) and alternate care sites (ACS) can be used to reduce surge on healthcare facilities as well as providing medical countermeasures, etc.

Organization and Equipment Factors:

[Provide a brief description of organization and equipment factors applicable to this priority.]

Supporting Training Courses:

- Support members seeking either the Associate – Infection Prevention and Control (a-IPC) entry-level certification or the Certification in Infection Prevention and Control (CIC)

Infection Prevention and Control Training for Healthcare Professionals (Intermediate level)

- Rapid Identification and isolation of a Person Under Investigation for infectious disease. (Overview level course - 1 to 2 hours of instruction)
- Contact investigations/contact tracing and applications of quarantine and isolation (Overview level course - 1.5 hour to 3.0 hours of instruction)
- Seminar on legal, ethical, and policy issues associated with quarantine, disaster standards of care, and triage.
- Patient/resident care for infectious diseases for non-clinical staff
- FRAME AWR-900 Framework for Healthcare Emergency Management
- HERT-B AWR-901-1 Hospital Emergency Response Training for Mass Casualty Incidents

Defense of Facilities/Alternate Care Site strategies can assist with surge:

- MGT-319 Medical Countermeasures: Points of Dispensing (POD), Planning and Response
- Point of Dispensing (POD) Essentials Train-the-Trainer (MGT-442-1)

Supporting Exercises:

- Infectious disease discussion-based exercises (e.g., seminars on current infectious disease practices, medical ethics, disaster standards of care) can help elevate infectious disease understanding and practice across the coalition. They can be done virtually and continue the enhanced ability we all have gained with Zoom, MS Teams, etc. during this pandemic response.
- Infectious disease exercises can be scheduled for the January-March period following training sessions in late September-December (Hurricane Season dependent). This will provide an opportunity to refresh skills during the influenza/respiratory disease season (assuming COVID does not remain a year around response).

Safety/security of residents/patients/staff

COVID-19 revealed dramatic shortfalls in infection control, sanitation, decontamination, and other procedures designed to protect healthcare workers, patients, and nursing home residents. As the workforce is impacted by high turnover, it is important to keep a high level of competency with safety procedures. Training and exercises should be skills based and include non-clinical staff, particularly in small or geographically isolated facilities, home healthcare, in-home support for elders, etc.

Corresponding Capabilities:

- Public Health, Healthcare and Emergency Medical Services

Rationale:

- The better trained the healthcare and public health workforce is in safety procedures overall the less likely. As an adjunct to infection control practices, staff, patient, and resident safety procedures can limit the introduction or spread of an infectious disease. These procedures can be expanded using non-clinical staff.

Planning Factors:

- See the Alliance's Infectious Disease Surge Plan for details

Organization and Equipment Factors:

[Provide a brief description of organization and equipment factors applicable to this priority.]

Supporting Training Courses:

- PER-320 Personal Protective Measures for Biological Events
- PER-321 Barrier Precautions and Controls for Highly Infectious Disease (HID)
- MGT-341 Disaster Preparedness for Hospitals and Healthcare Organizations within the Community Infrastructure
- Training should include a variety of highly consequential infectious diseases as examples
- Isolation/Quarantine training

Supporting Exercises:

- Safety procedures should be integrated into regular internal drills for healthcare facilities
- The exercise cycle should include different infectious disease scenarios

Personal Protective Equipment

This was a key element of both staff and patient safety and was a critical shortfall during the initial COVID-19 response.

Corresponding Capabilities:

- Logistics and Supply Chain Management; and Public Health, Healthcare, and Emergency Medical Services

Rationale:

- Donning and doffing the appropriate PPE is a critical skill set for all public health, healthcare, and Emergency Medical Services workers (clinical and non-clinical) during an infectious disease response. The lack of appropriate PPE requires changes to strategy that can include alternate PPE, cleaning and reusing PPE, etc. that would not be optimal under normal circumstances.

Planning Factors:

- Ensuring PPE supply chain is intact and additional supplies can be obtained as needed. Plan for a variety of high consequence infectious diseases. As an example, the PPE requirement for Ebola can be different than that for a respiratory virus.

Organization and Equipment Factors:

[Provide a brief description of organization and equipment factors applicable to this priority.]

Supporting Training Courses:

- PER-320 Personal Protective Measures for Biological Events
- PER-321 Barrier Precautions and Controls for Highly Infectious Disease (HID)
- OSHA required training.

Supporting Exercises:

- PPE donning and doffing skills drills should be considered to keep “muscle memory” from pandemic response as well as to ensure new employees, particularly non-clinical staff, learn and train on correct procedures.
- Contacting PPE suppliers annually should be a standard logistics drill to ensure viability of supply chain.

Supply Chain Management

Equipment and supplies are critical to any infectious disease response. This can include items as ubiquitous as N-95 masks or as specialized as respirators have been during the COVID-19 response. Ensuring that any needed equipment and supplies can be acquired, maintained, and distributed during a surge event requires prior planning and ongoing training and exercises.

Corresponding Capabilities:

- Logistics and Supply Chain Management

Rationale:

- The inability to acquire and maintain critical healthcare resources during the COVID-19 response underlined the need to ensure logistical support for future infectious disease responses.

Planning Factors:

- See logistics and Supply Chain documents for details of assessment process.

Organization and Equipment Factors:

[Provide a brief description of organization and equipment factors applicable to this priority.]

Supporting Training Courses:

1. FL-2355 LOG Management Course
 2. L-967 NIMS ICS All-Hazards Logistics Section Chief (LSC)
 3. Optimizing Supply of PPE, Reutilization, and Other Equipment during Shortages
 - a. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>
 4. On-Line Supply Chain Management Training Options:
 - a. <https://www.edx.org/learn/supply-chain-management>
 5. PPE Donning/Doffing
 - a. Medical Evaluations and Fit Testing:
<https://www.oshatrain.org/courses/mods/756m4.html>
 - b. Medical PPE Donning and Doffing Training
 - i. Video: <https://youtu.be/H4jQUBAIBrI>
 - ii. PPE Fact Sheet: https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf
1. ESF-8 Training
 2. Web EOC Bootcamp

Supporting Exercises:

- Logistic drills including supplier call downs can ensure that vendors are still in business, you have the latest contact's name and number, and that any agreements/contracts are updated regularly. Strategic National Stockpile type

exercise where supplies are properly inventoried, stored, divided and re-distributed to PODS or like sites all with the appropriate personnel and equipment.

DRAFT

Communications

Internal and external communications issues were identified in communication among response structures (internal communications) as well as external communications (Public Information Officer, Joint Information System). Communicating with the public and other community stakeholders during an infectious disease response is critical and these challenges were some of the most consequential during the COVID-19 response. Poor external communications early on continue to make public compliance with public health measures difficult. The technical challenges of sharing disease-specific issues such as patient care, testing, vaccination, etc. with non-public health and medical response partners is similarly challenging and consequential.

Corresponding Capabilities:

- Public Information and Public Health, Healthcare, and Emergency Medical Services

Rationale:

- “Communication is never the second thing to go wrong in a disaster” is the old saw, but it is true that many of our largest challenges come from the lack of timely, accurate, and actionable communications both with the public and with internal stakeholders. Better training on the specifics of communicating about infectious disease not only helps those charged with supplying that information, but can help manage expectations for those who will be receiving this information from public health and medical subject matter experts and responders.

Planning Factors:

See NEFHC Infectious Disease Surge Plan for more detail

Organization and Equipment Factors:

[Provide a brief description of organization and equipment factors applicable to this priority.]

Supporting Training Courses:

- L-952 All Hazards PIO
- Hospital Incident Command Systems (HICS)
- Nursing Home Incident Command Systems (NHICS)
- CDC Crisis and Emergency Risk Communication on-line training
- ESF-8 Training

Supporting Exercises:

- Any infectious disease exercise should include at least a public health communication component. Effectively communicating the most accurate information and recommendations to the general public is the most important intervention in a widespread infectious disease response.

- Establishment of a Joint Information Center that includes internal and external stakeholders and leadership engagement in forming or approving messaging

DRAFT

Behavioral Health Self Care for Healthcare Workers

The mental health impacts of sustained COVID-19 response at work and at home highlight the need for behavioral health support for all responders. Even non-pandemic infectious disease responses can last for many months and compound the usual stress associated with emergency management, public health, healthcare, and Emergency Medical Services.

Corresponding Capabilities:

- Public Health, Healthcare, and Emergency Medical Services

Rationale:

- Mental and behavioral health issues degrade the ability for anyone to respond effectively. Longer term stressors lead to people leaving the workforce in larger numbers. To prevent stress-related poor health outcomes and other contributors to surge issues, behavioral health self-care is critical.

Planning Factors:

See the Alliance's Infectious Disease Surge Plan for more details.

Organization and Equipment Factors:

[Provide a brief description of organization and equipment factors applicable to this priority.]

Supporting Training Courses:

- ASPR TRACIE Self Care for Healthcare Workers Modules
 - Module 1: Compassion Fatigue and Secondary Traumatic Stress Identification for Healthcare Providers
 - Module 2: Organizational Wellness From the Top: Stress Mitigation and Work Satisfaction for Healthcare Providers
 - Module 3: Cognitive Tools for Mitigating Compassion Fatigue and Secondary Traumatic Stress
- Substance Abuse and Mental Health Services Administration (SAMHSA)
 - [Service to Self](#)
 - [Creating Safe Scenes](#)
- National Child Traumatic Stress Network Psychological First Aid (PFA)
<https://www.nctsn.org/resources/psychological-first-aid-pfa-online>

Supporting Exercises:

- While not HSEEP exercise per se, behavioral health recommendations should be built into staff activities. Incorporating psychological first aid or ASPR Self Care principles into exercises can help ensure these practices are incorporated into response activities.

PROGRAM REPORTING

[In this section, discuss the preparedness activities and how they are intended to influence capability improvement. Include the jurisdiction's/organization's methodology for prioritizing, assigning, monitoring, tracking, and reporting the progress made toward resolution of issues identified during exercises and real-world incidents as well as capability improvement projects and the overall impact these actions have on capabilities.]

By continuously monitoring improvement actions, jurisdictions/organizations can periodically examine capabilities to ensure they are sufficient, accurate, and effective to handle the threats, hazards, and risks facing the jurisdiction/organization and can inform future Integrated Preparedness Cycle activities.

Program reporting should address:

- Compiling and recording areas for improvement from exercises and real-world incidents;
- Determining actions and linking capabilities needed to address identified areas for improvement and associated corrective actions;
- Prioritizing, assigning, tracking, reporting, and updating corrective action progress; and
- Incorporating changes, completed corrective actions, identified potential best practices, and lessons learned into future iterations of the Integrated Preparedness Cycle and Integrated Preparedness Plan.

MULTI-YEAR SCHEDULE OF PREPAREDNESS ACTIVITIES

Exercise Recommendations

Training and exercises are integrated processes as reflected in the IPP. A number of the capabilities that can best be developed and observed among members through the exercise program. The following are baseline exercises that form the foundation for branch-out exercises.

- Infectious disease discussion-based exercises (e.g., seminars, tabletop exercises on current infectious disease practices, medical ethics, disaster standards of care) can help elevate infectious disease understanding and practice across the coalition. They can be done virtually and continue the enhanced ability we all have gained with Zoom, MS Teams, etc. during this pandemic response.
- Infectious disease exercises full scale exercises (boots on the ground) can be scheduled for the January-May period following training sessions in late September-December (Hurricane Season dependent). This will provide an opportunity to refresh skills during the influenza/respiratory disease season (assuming COVID does not remain a year around response).
- PPE donning and doffing skills drills should be considered to keep “muscle memory” from pandemic response as well as to ensure new employees, particularly non-clinical staff, learn and train on correct procedures.
- Logistic drills including supplier call downs can ensure that vendors are still in business, you have the latest contact name and number, and that any agreements/contracts are updated regularly.

Integrated Preparedness Schedule Q1 Y1 2021

This is an example of how Infectious Disease Surge Plan training and exercises might be integrated into the Alliance’s calendar. This is based on [using off-Hurricane Season months](#) to focus on infectious disease capabilities. This calendar starts in October 2021 and assumes that COVID-19 Pandemic response has ended or been reduced enough to consider a return to regular business (the “new normal”).

OCTOBER 2021

Activity	Staffing/Personnel Surge	Safety/Security of Residents/Patients/Staff	Supply Chain Management	Communications	Personal Protective Equipment	Behavioral Health Self Care for Healthcare Workers
Plan	Review Infectious Disease Surge Plan. Are there any current real-world threats to the Alliance? Select next disease to focus on.		Are there any special logistical issues with the current threat or new disease?	Review Comms Section of Plan. Does it need to be updated?	Any special PPE considerations for current threat or new disease?	Continue Psychological First Aid/Disaster Behavioral Health offerings (On-line for all members?)
Organize	Conduct Coalition Meeting—assess where coalition is in pandemic cycle.					Consider the Alliance-based DBH support teams?
Equip			Begin Supply Chain Gap Analysis		Inventory on-hand PPE	

Activity	Staffing/Personnel Surge	Safety/Security of Residents/Patients/Staff	Supply Chain Management	Communications	Personal Protective Equipment	Behavioral Health Self Care for Healthcare Workers
Train	–Infection Prevention and Control Training for Healthcare Professionals (Intermediate level). –FRAME AWR-900 Framework for Healthcare Emergency Management. –Contact investigations/contact tracing and applications of quarantine and isolation (Overview level course - 1.5 hour to 3.0 hours of instruction) – Infection Prevention and Control Training for Healthcare Professionals (Intermediate level)	PER-321 Barrier Precautions and Controls for Highly Infectious Disease (HID)	FL-2355 LOG Management Course	Crisis and Emergency Risk Communication	PPE Fit testing and Donning/Doffing skills-based training.	Psychological First Aid/Disaster Behavioral Health in-person classes at quarterly. On-line course ongoing. – ASPR TRACIE Self Care for Healthcare Workers Modules

Activity	Staffing/Personnel Surge	Safety/Security of Residents/Patients/Staff	Supply Chain Management	Communications	Personal Protective Equipment	Behavioral Health Self Care for Healthcare Workers
Exercise	Consider a discussion-based exercise on a highly impactful infectious disease, or close out with COVID-19 current science					

NOVEMBER 2021

Activity	Staffing/Personnel Surge	Safety/Security of Residents/Patients/Staff	Supply Chain Management	Communications	Personal Protective Equipment	Behavioral Health Self Care for Healthcare Workers
Plan						
Organize	Conduct Coalition Meeting			Conduct COVID Lessons Learned Meeting		
Equip						

Activity	Staffing/Personnel Surge	Safety/Security of Residents/Patients/Staff	Supply Chain Management	Communications	Personal Protective Equipment	Behavioral Health Self Care for Healthcare Workers
Train	<ul style="list-style-type: none"> - Infection Prevention and Control (a-IPC) entry-level certification or the Certification in Infection Prevention and Control (CIC). -Hospital Incident Command Systems (HICS) -Nursing Home Incident Command Systems (NHICS) 	PER-320 Personal Protective Measures for Biological Events	L-967 NIMS ICS All-Hazards Logistics Section Chief (LSC)		PPE Fit testing and Donning/Doffing skills-based training.	Psychological First Aid/Disaster Behavioral Health (prior to holidays). On-line course ongoing. - ASPR TRACIE Self Care for Healthcare Workers Modules
Exercise		Specific infectious disease-based seminar			Donning/Doffing drills to include any disease-specific issues	

DECEMBER 2021

Activity	Staffing/Personnel Surge	Safety/Security of Residents /Patients/Staff	Supply Chain Management	Communications	Personal Protective Equipment	Behavioral Health Self Care for Healthcare Workers
Plan	Year-end Infectious Disease Plan review. Any real-world (e.g., current influenza season) updates?					
Organize	Conduct Coalition Meeting					
Equip			Review Results of Gap Analysis			



Activity	Staffing/Personnel Surge	Safety/Security of Residents /Patients/Staff	Supply Chain Management	Communications	Personal Protective Equipment	Behavioral Health Self Care for Healthcare Workers
Train	–Rapid Identification and isolation of a Person Under Investigation for infectious disease. (Overview level course - 1 to 2 hours of instruction). –Support (a-IPC and CIC). – Infection Prevention and Control Training for Healthcare Professionals (Intermediate level) –Point of Dispensing (POD) Essentials Train-the-Trainer (MGT-442-1)	MGT-341 Disaster Preparedness for Hospitals and Healthcare Organizations within the Community Infrastructure	Optimizing Supply of PPE, Reutilization, and Other Equipment during Shortages	Crisis and Emergency Risk Communications	PPE Fit testing and Donning/Doffing skills-based training.	Scenario-based Train-the-trainer for peer counselors or the Alliance DBH professionals/team members. On-line course ongoing. – ASPR TRACIE Self Care for Healthcare Workers Modules
Exercise	Call down drills for ICS/EOC activation					

JANUARY 2022

Activity	Staffing/Personnel Surge	Safety/Security of Residents/Patients/Staff	Supply Chain Management	Communications	Personal Protective Equipment	Behavioral Health Self Care for Healthcare Workers
Plan	Based on COVID Plan Review that started in October, begin to update plans for alternate infectious disease	PER-321 Barrier Precautions and Controls for Highly Infectious Disease (HID)				
Organize	Conduct Coalition Meeting					
Equip						
Train	–Contact investigations/contact tracing and applications of quarantine and isolation (Overview level course - 1.5 hour to 3.0 hours of instruction). –Support (a-IPC and CIC).	Isolation and Quarantine	FL-2355 LOG Management Course		L-952 All Hazards PIO	Psychological First Aid/Disaster Behavioral Health (in-person). On-line course ongoing. – ASPR TRACIE Self Care for Healthcare Workers Modules
Exercise	Logistics call down of vendors for PPE and other critical supplies					

FEBRUARY 2022

Activity	Staffing/Personnel Surge	Safety/Security of Residents/Patients/Staff	Supply Chain Management	Communications	Personal Protective Equipment	Behavioral Health Self Care for Healthcare Workers
Plan						
Organize	Conduct Coalition Meeting					
Equip						
Train	Seminar on legal, ethical, and policy issues associated with quarantine, disaster standards of care, and triage. Support (a-IPC and CIC). –Hospital Incident Command Systems (HICS) –Nursing Home Incident Command Systems (NHICS) –Contact investigations/contact tracing and applications of quarantine and	PER-320 Personal Protective Measures for Biological Events	L-967 NIMS ICS All-Hazards Logistics Section Chief (LSC)	L-952 All Hazards PIO	PPE Fit testing and Donning/Doffing skills-based training.	Psychological First Aid/Disaster Behavioral Health (in-person). On-line course ongoing. – ASPR TRACIE Self Care for Healthcare Workers Modules

	<p>isolation (Overview level course - 1.5 hour to 3.0 hours of instruction) – Infection Prevention and Control Training for Healthcare Professionals (Intermediate level) –Point of Dispensing (POD) Essentials Train-the-Trainer (MGT-442-1)</p>					
Exercise	<p>Infectious disease-based POD/ACS exercises—set-up/tear down</p>	<p>Infectious disease-based COOP/Business Continuity Discussion-based Exercise</p>				

MARCH 2022

Activity	Staffing/Personnel Surge	Safety/Security of Residents/Patients/Staff	Supply Chain Management	Communications	Personal Protective Equipment	Behavioral Health Self Care for Healthcare Workers
Plan	Based on COVID Plan Review that started in October, finalize plans for alternate infectious disease	Based on COVID Plan Review that started in October, finalize plans for alternate infectious disease	Based on COVID Plan Review that started in October, finalize plans for alternate infectious disease	Based on COVID Plan Review that started in October, finalize plans for alternate infectious disease	Based on COVID Plan Review that started in October, finalize plans for alternate infectious disease	Based on COVID Plan Review that started in October, finalize plans for alternate infectious disease
Organize	Conduct Coalition Meeting					
Equip						

Activity	Staffing/Personnel Surge	Safety/Security of Residents/Patients/Staff	Supply Chain Management	Communications	Personal Protective Equipment	Behavioral Health Self Care for Healthcare Workers
Train	Patient/resident care for infectious diseases for non-clinical staff. –Support (a-IPC and CIC). –FRAME AWR-900 Framework for Healthcare Emergency Management — Infection Prevention and Control Training for Healthcare Professionals (Intermediate level)	MGT-341 Disaster Preparedness for Hospitals and Healthcare Organizations within the Community Infrastructure	–FL-2355 LOG Management Course. –Optimizing Supply of PPE, Reutilization, and Other Equipment during Shortages	Crisis and Emergency Risk Communications	PPE Fit testing and Donning/Doffing skills-based training.	Psychological First Aid/Disaster Behavioral Health (in-person). On-line course ongoing. – ASPR TRACIE Self Care for Healthcare Workers Modules
Exercise						

April 2022

Activity	Staffing/Personnel Surge	Safety/Security of Residents/Patients/Staff	Supply Chain Management	Communications	Personal Protective Equipment	Behavioral Health Self Care for Healthcare Workers
Plan	Update plan based on any real-world infectious disease response actions.	Review plan for next infectious disease to train/exercise to.				
Organize	Conduct Coalition Meeting					
Equip						
Train	<p>FRAME AWR-900 Framework for Healthcare Emergency Management. Support (a-IPC and CIC).</p> <p>– Contact investigations/contact tracing and applications of quarantine and isolation (Overview level course - 1.5 hour to 3.0 hours of instruction)</p>	PER-321 Barrier Precautions and Controls for Highly Infectious Disease (HID)		L-952 All Hazards PIO	PPE Fit testing and Donning/Doffing skills-based training.	<p>Psychological First Aid/Disaster Behavioral Health (in-person). On-line course ongoing.</p> <p>– ASPR TRACIE Self Care for Healthcare Workers Modules</p>

Activity	Staffing/Personnel Surge	Safety/Security of Residents/Patients/Staff	Supply Chain Management	Communications	Personal Protective Equipment	Behavioral Health Self Care for Healthcare Workers
Exercise						

DRAFT

May 2022
(Hurricane Season 1 June-30 November)

Activity	Staffing/Personnel Surge	Safety/Security of Residents/Patients/Staff	Supply Chain Management	Communications	Personal Protective Equipment	Behavioral Health Self Care for Healthcare Workers
Plan						
Organize	Conduct Coalition Meeting					
Equip						

DRAFT

<p>Train</p>	<p>HERT-B AWR-901-1 Hospital Emergency Response Training for Mass Casualty Incidents. Support (a-IPC and CIC). –Hospital Incident Command Systems (HICS) –Nursing Home Incident Command Systems (NHICS) –Rapid Identification and isolation of a Person Under Investigation for infectious disease. (Overview level course - 1 to 2 hours of instruction). – Infection Prevention and Control Training for Healthcare Professionals (Intermediate level)</p>	<p>PER-320 Personal Protective Measures for Biological Events</p>	<p>L-967 NIMS ICS All-Hazards Logistics Section Chief (LSC)</p>	<p>CDC Crisis and Emergency Risk Communications (on-line)</p>	<p>PPE Fit testing and Donning/Doffing skills-based training.</p>	<p>Psychological First Aid/Disaster Behavioral Health (in-person). On-line course ongoing. – ASPR TRACIE Self Care for Healthcare Workers Modules</p>
<p>Exercise</p>						

DECEMBER 2022
(Hurricane Season 1 June-30 November)

Activity	Staffing/Personnel Surge	Safety/Security of Residents/Patients/Staff	Supply Chain Management	Communications	Personal Protective Equipment	Behavioral Health Self Care for Healthcare Workers
Plan	Year-end Infectious Disease Plan review. Any real-world (e.g., current influenza season) updates?					
Organize	Conduct Coalition Meeting—close out year					
Equip						

Activity	Staffing/Personnel Surge	Safety/Security of Residents/Patients/Staff	Supply Chain Management	Communications	Personal Protective Equipment	Behavioral Health Self Care for Healthcare Workers
Train	MGT-319 Medical Countermeasures: Points of Dispensing (POD), Planning and Response. Support (a-IPC and CIC). – Infection Prevention and Control Training for Healthcare Professionals (Intermediate level) –Point of Dispensing (POD) Essentials Train-the-Trainer (MGT-442-1)	MGT-341 Disaster Preparedness for Hospitals and Healthcare Organizations within the Community Infrastructure	Optimizing Supply of PPE, Reutilization, and Other Equipment during Shortages	CDC Crisis and Emergency Risk Communications (on-line)	PPE Fit testing and Donning/Doffing skills-based training.	Psychological First Aid/Disaster Behavioral Health (in-person). On-line course ongoing. – ASPR TRACIE Self Care for Healthcare Workers Modules
Exercise	No exercise or drill during holidays					

JANUARY 2023

Activity	Staffing/Personnel Surge	Safety/Security of Residents/Patients/Staff	Supply Chain Management	Communications	Personal Protective Equipment	Behavioral Health Self Care for Healthcare Workers
Plan			Review Supply Chain Management documents to prepare for full-scale exercise	Review Communications Section of ID Plan. Include any ESF8 comms pieces	Identify any gaps in PPE for the exercise/New Year	
Organize	Conduct Council Meeting—Include any Alliance -based resources/teams.					
Equip						

Activity	Staffing/Personnel Surge	Safety/Security of Residents/Patients/Staff	Supply Chain Management	Communications	Personal Protective Equipment	Behavioral Health Self Care for Healthcare Workers
Train	Point of Dispensing (POD) Essentials Train-the-Trainer (MGT-442-1). Support (a-IPC and CIC). –Contact investigations/contact tracing and applications of quarantine and isolation (Overview level course - 1.5 hour to 3.0 hours of instruction)	PER-321 Barrier Precautions and Controls for Highly Infectious Disease (HID)		L-952 All Hazards PIO	PPE Fit testing and Donning/Doffing skills-based training.	Psychological First Aid/Disaster Behavioral Health (in-person). On-line course ongoing. – ASPR TRACIE Self Care for Healthcare Workers Modules
Exercise	Finalize full-scale exercise plan integrating POD/ACS activation.				Identify PPE required for ID full-scale exercise	Include behavioral health injects into exercise scenario

FEBRUARY 2023

Activity	Staffing/Personnel Surge	Safety/Security of Residents/Patients/Staff	Supply Chain Management	Communications	Personal Protective Equipment	Behavioral Health Self Care for Healthcare Workers
Plan						
Organize	Conduct Coalition Meeting—Final exercise meeting. Role of coalition in exercise.					
Equip						

DRAFT

Activity	Staffing/Personnel Surge	Safety/Security of Residents/Patients/Staff	Supply Chain Management	Communications	Personal Protective Equipment	Behavioral Health Self Care for Healthcare Workers
Train	–Hospital Incident Command Systems (HICS) –Nursing Home Incident Command Systems (NHICS) – Infection Prevention and Control Training for Healthcare Professionals (Intermediate level) –Rapid Identification and isolation of a Person Under Investigation for infectious disease. (Overview level course - 1 to 2 hours of instruction).	PER-320 Personal Protective Measures for Biological Events	FL-2355 LOG Management Course	Refresher training on PIO/JIC/JIS positions and responsibilities	PPE Fit testing and Donning/Doffing skills-based training.	Psychological First Aid/Disaster Behavioral Health (in-person). On-line course ongoing. – ASPR TRACIE Self Care for Healthcare Workers Modules
Exercise	Full-scale regional disease response exercise	HCFs exercise safety, Decon, patient care, etc. as part of regional infectious-disease response		Include JIC/JIS in exercise response structure		Integrate Psychological First Aid/Self-Care principles into Responder Safety and Health play in exercise

MARCH 2023

Activity	Staffing/Personnel Surge	Safety/Security of Residents/Patients/Staff	Supply Chain Management	Communications	Personal Protective Equipment	Behavioral Health Self Care for Healthcare Workers
Plan	Develop improvement plan with exercise hot wash/AAR documents.			Develop improvement plan with exercise hot wash/AAR documents.		
Organize	Conduct Coalition Meeting to assess exercise results					
Equip						
Train	--Present refresher training based on exercise hot wash/AAR needed improvements. --FRAME AWR-900 Framework for Healthcare Emergency Management	MGT-341 Disaster Preparedness for Hospitals and Healthcare Organizations within the Community Infrastructure	--Optimizing Supply of PPE, Reutilization, and Other Equipment during Shortages	CDC Crisis and Emergency Risk Communications (on-line)	PPE Fit testing and Donning/Doffing skills-based training.	Continue Disaster Behavioral Health training for shelter teams, ESF-8 responders. – ASPR TRACIE Self Care for Healthcare Workers Modules

Activity	Staffing/Personnel Surge	Safety/Security of Residents/Patients/Staff	Supply Chain Management	Communications	Personal Protective Equipment	Behavioral Health Self Care for Healthcare Workers
Exercise	Seminar based on exercise hot wash/AAR. This can also serve as a final step in the AAR process.					

DRAFT