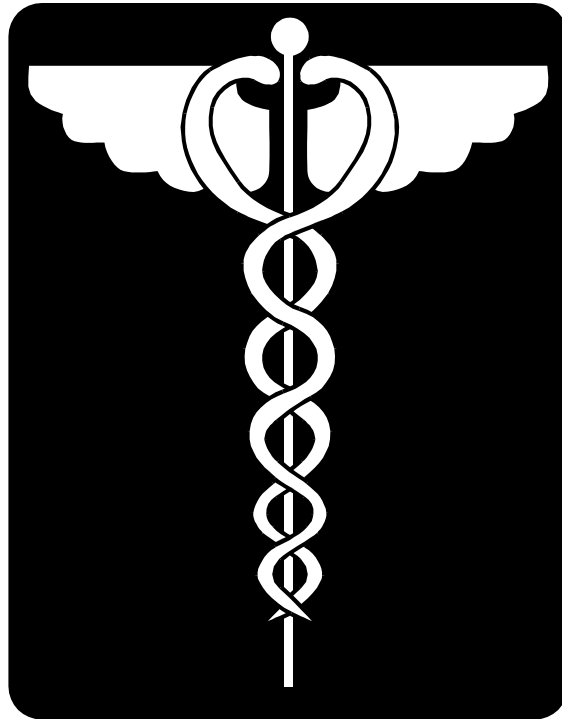


City and County of San Francisco
Medical and Health Disaster Exercise
May 13th, 2008

Healthcare Facilities Exercise Guidebook



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Executive Summary

April 25, 2008

The San Francisco Department of Public Health has been working in partnership with local healthcare facilities to increase our ability to respond to a surge event as a result of an influenza pandemic. These efforts include extensive plan writing, table top exercises and on May 13th, 2008, a functional exercise based on the logistical consideration of patient surge caused by an influenza pandemic.

The 2008 Medical Surge/Pandemic Influenza exercise is structured for the healthcare facilities for 3 hours, from 10:00 am to 1:00 pm. Hospitals will be expected to open their Incident Command Centers, and SFDPH will be activating the Department Operations Center. There are multiple objectives for this exercise, many of which are listed within this document. Each participant may add objectives that are specific to their facilities or adapt the scenario to exercise a particular piece of protocol or hospital function.

Each participant is responsible for creating evaluation materials and the After Action Report for their agency. An After Action Conference will be held on June 4th, 2008 immediately following the Hospital Council Disaster Response Planning meeting to evaluate and discuss the overall exercise and to give feed back on the exercise design and those objectives that involved inter-agency collaboration. The evaluation form is included in this guidance and is due to Rebekah Varela by June 13th, 2008. The location for this meeting will be announced as we get closer to the date.

Important Timelines and Deadlines

<u>May 2nd, 2008</u>	Deadline to: -Fax Intent to Participate form to the Rebekah Varela at (415) 554-2552.
<u>May 7th, 2008</u>	Hospital Council Tabletop exercise using Med Surge/Pan Flu Exercise scenario at 10AM. Location TBD.
<u>May 13th, 2008</u>	SFDPH will be activating from 10:00 am to 1:00 pm and will be able to interact with hospitals from 10:00 am and 1:00 pm. We recommend that hospitals activate before 10:00 am. While hospitals may conduct their exercise for any number of hours during the exercise play, the scenario will be most successful with facility exercise play from 10:00 am to 1:00pm.
<u>June 4th, 2008</u>	After Action Conference, 10AM. Location TBD.
<u>June 13th, 2008</u>	Deadline to complete and mail the appropriate exercise evaluations to Rebekah Varela at (415) 554-2552.

**Thank you for your commitment to disaster medical planning and preparedness.
We look forward to hearing about your successful exercise!**

**City and County of San Francisco
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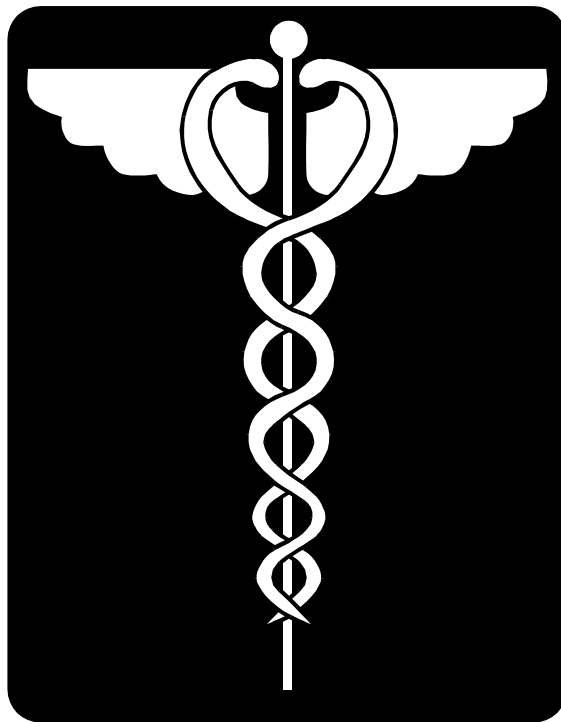
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Tips: How to Use the Guidebook



**City and County of San Francisco
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Tips: How to Use the Guidebook

This Disaster Exercise Guidebook is intended to provide participants with a scenario and tools to plan and conduct an exercise in their healthcare organization. The target audience for this exercise is acute care hospitals, community care clinics, public and private emergency medical services providers, and local health departments.

The San Francisco Department of Public Health Departmental Operations Center (DOC) will participate in the exercise by activating and providing coordination and allocation of resources and information-sharing. The exercise is scheduled for **10:00 AM to 1:00 PM**.

Reporting Intent to Participate

Participants should report their intent to participate to Rebekah Varela no later than May 2nd using the attached form. This will include information on the extent to which your facility would like to participate and the hours of your exercise.

Exercise Objectives

Some exercise objectives are provided for acute care hospitals, community clinics, EMS providers, and local public health departments. These may be edited to include the objectives put forth by your own planning groups. While there are multiple objectives for each, participants may use the objectives to exercise key components of the organization's emergency operations and surge plans, policies, and procedures or can exercise all objectives.

Pre-Exercise Health Alert

Pre-event Health Alerts are included in this Guidebook. To test the communication of Health Alert information to healthcare providers, the alerts contained in the Guidebook will also be distributed to participants before the exercise via this guidebook and posted on the SFDPH website (www.sfdph.org/healthalert).

The purpose of the Health Alerts is to exercise communication between SFDPH and hospital facilities, and for healthcare providers to test internal policies and procedures to manage Health Alerts within their organization, including to whom the information is given and what measures are implemented. Should the Health Alert not reach the participant during the exercise, the participant can use the Exercise Evaluation Form provided in the Guidebook.

Background for the Scenario

The exercise begins on Tuesday, May 13th at 9:00 am, but scenario background is provided to "set the stage" for the events leading up to the day of the exercise. The simulated background events begin prior to October 2007 through May 13th, 2008. The events occur Tuesday, May 13th.

Master Sequence of Events List

This year, the guidebook does not contain a master sequence of events list (MSEL). The MSEL will be sent out to facility exercise controllers only to maintain the level of participant play. The MSEL consists of the discussion and action points embedded in the scenario, listed by participant category. Participants can expand the MSEL by developing exercise injects and messages, customized to stimulate organizational play. This is suggested for each hospital facility to ensure individual objectives are met.

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Exercise Evaluation

Evaluating the exercise and creating an after-action report (AAR) and corrective action plan (CAP) can pose a challenge to planners. The Guidebook contains resources and references for exercise evaluation tools to assist the organization's exercise planner.

Participant Recognition and Certificates of Participation

After the exercise, Certificates of Participation will be issued to all exercise participants that complete and submit the Exercise Evaluation Sheet to the address below. The deadline to submit the Exercise Evaluation Sheet form is **June 13th, 2008**.

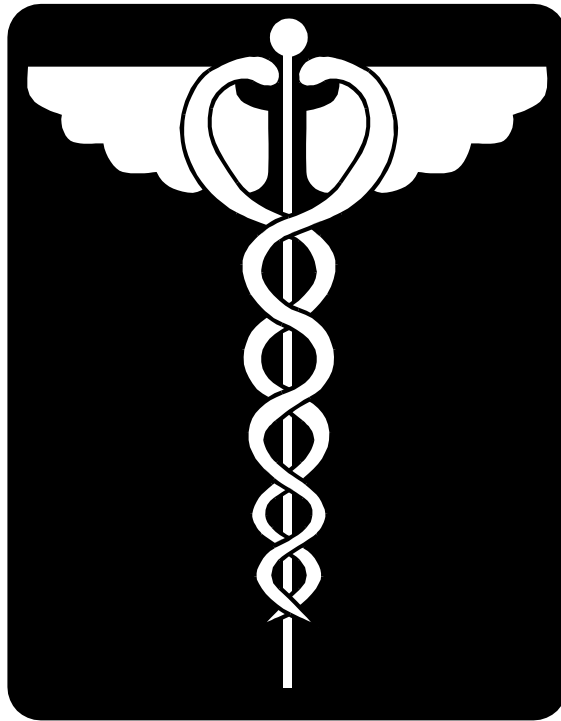
Exercise Evaluation Sheets should be mailed to:

Rebekah Varela
Office of Policy and Planning
Department of Public Health
101 Grove Street Room 330
San Francisco CA 94102

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Exercise Objectives



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ACUTE CARE FACILITY EXERCISE OBJECTIVES

Objective I: Pre-Exercise Event:

Assess the facility's integration and participation in community-wide emergency preparedness, planning and response. This integration includes area hospitals, community clinics, public health, other healthcare organizations (e.g., long-term care), public and private emergency medical services (EMS) providers, law enforcement, and emergency managers. As a result of this assessment, collaborate and build relationships with important providers to prepare for the exercise and any actual event.

Joint Commission 2008 Standards: E.C.4.11.3, E.C.4.11.4, E.C.4.11.6, E.C.4.11.7, E.C.4.12.1, E.C.4.12.2, E.C. 4.20.1, E.C.4.20.2, E.C.4.20.4

Objective II:

Exercise the ability to maintain reliable surveillance and communication capability to detect outbreaks of infectious disease and to communicate response efforts to staff, patients, their families and external agencies. Use appropriate forms and status reports.

Joint Commission 2008 Standards: E.C. 4.13.1, E.C.4.13.2, 4.13.3, E.C.4.13.4, 4.13.5, E.C.4.13.7

NIMS Implementation Activity for Hospitals and Healthcare Systems: Element 4

Objective III:

Assess the ability to prioritize, manage, and allocate resources, especially scarce resources (e.g., ventilators, negative-pressure isolation capacity, personal protective equipment, critical care beds, pharmaceuticals) during an infectious disease event.

Joint Commission 2008 Standards: E.C. 4.11.9, 4.11.10, E.C.4.14.

NIMS Implementation Activity for Hospitals and Healthcare Systems: Element 8, 15, 16

Objective IV:

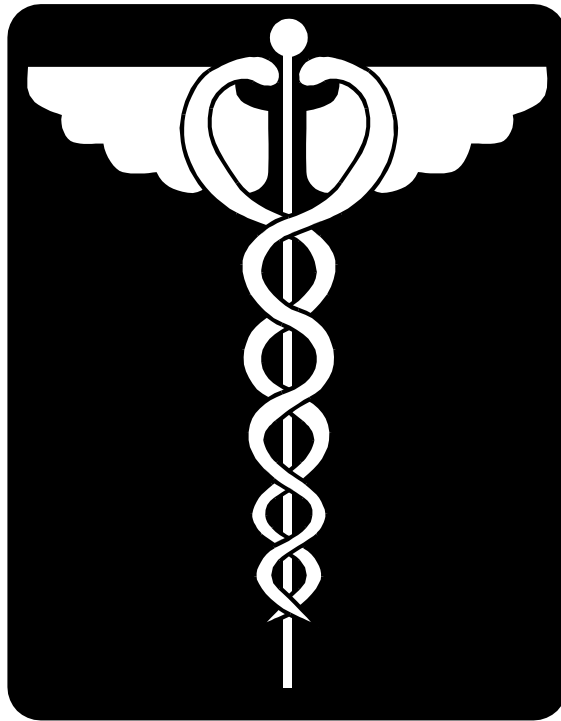
Demonstrate the ability to communicate facility needs to outside sources (e.g., vendors, suppliers, EMS, city/OA stockpiles, corporate healthcare system) for essential supplies, services, and equipment to ensure integrity of resource supply chain.

Joint Commission 2008 Standards: E.C. 4.14.

Objective V:

Provide feedback on resource request forms to SFDPH for adaptation for future use.

Exercise Scenario



**City and County of San Francisco
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BACKGROUND FOR THE SCENARIO

NOTE: The Medical and Health Disaster Exercise begins on May 13, 2008 at 10:00 am. This information is provided as scenario background to “set the stage” for the events leading up to the day of the exercise.

BACKGROUND

3/22/08 WHO reports evidence of increased human-to-human transmission of H5N1 avian influenza in Indonesia, Egypt, and Vietnam. Many cases have now been reported with no evidence of bird contact, and many cases are thought to be transmitted from person to person within households. Many of the case reports were delayed as the countries’ public health systems are overwhelmed by the numbers of avian and human flu cases. Cases have been reported in both rural and urban areas in all of these countries. No cases have been reported in the United States or North America. **All reported and confirmed cases demonstrated resistance to all antiviral treatments.**

WHO raises the alert level to Pandemic Alert Phase 5, the Centers for Disease Control & Prevention (CDC) to Federal Government Response Stage (FGRS) 2-3, (see attached “Federal Response Stages” for definitions).

The San Francisco Department of Public Health (SFDPH) participates in a Bay Area Health Departments conference call regarding the change in Pandemic Alert Phase and the need to increase preparation & response activities for pandemic influenza.

3/27/08 Ms. Tran, a 42 year old businesswoman was taken to your Hospital Emergency Department (ED) via ambulance with flu-like symptoms which started on October 23rd. She arrived home to San Francisco 5 days ago (Oct 20st) from Hanoi, Vietnam.

Your Hospital’s ED physician remembers to consider avian influenza in the differential diagnosis and calls the Infection Control Professional (ICP) at your Hospital, who then calls the SFDPH Communicable Disease Control Unit (CDCU) at 554-2830 and your hospital’s Emergency Preparedness Coordinator (EPC).

After consultation with the SFDPH CDCU staff and on-call physician, clinical specimens – nasopharyngeal and throat swabs – are sent to SF Public Health Laboratory and Ms. Tran is admitted to your Hospital. SFDPH issues an isolation order to Ms. Tran.

Your hospital is notified that preliminary results from the SFDPH lab are positive for H5N1 and that specimens forwarded to the state public health lab in Richmond for confirmation are positive for H5N1. The lab notifies the SFDPH CDCU on-call physician.

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SFDPH and the Mayor's office hold a press conference to announce the first human case of H5N1 in San Francisco.

3/28/08

WHO announces that they have lab confirmed more reported outbreaks in multiple countries and **HAVE RAISED THE PANDEMIC PHASE TO LEVEL 6**. The CDC escalates the Pandemic Flu Federal Government Response Stage to level 4.

SFDPH has activated emergency response plans. An Urgent Health Alert has been issued. Your Hospital has activated your HICS Command Center.

Mr. Tran (Mrs. Tran's husband) is taken to your hospital with similar symptoms and SFDPH lab and CDPH labs confirm H5N1. Once this was confirmed by the CDPH, the State Health Officer has ordered the dismissal of all schools, kindergarten through university level.

4/12/08

The CDC escalates the Pandemic Flu Federal Government Response Stage to level 5 (spread throughout the United States). Severity and "Category" level has not yet been declared, but media reports a high case fatality rate (5%). Dozens of additional suspected cases have been reported throughout the San Francisco Bay Area. SFDPH recommends that "Severe Pandemic Influenza Infection Control Recommendations for the Healthcare setting (including EMS)," as posted on www.sfdph.org/cdcp should be implemented. Initial cases were isolated and contacts were quarantined.

Due to the high severity of this pandemic flu strain, San Francisco Department of Public Health and neighboring bay area counties issue several health officer orders and guidance. All persons have been instructed to wear a mask covering nose and mouth when outside the home. Masks are required to board public transportation, and specific social distancing guidance has been issued to non-healthcare workplaces. Multiple press conferences to update the public on the situation and public health recommendations have occurred daily.

Businesses have been encouraged to request only essential employees to come to work in staggered shifts, and telecommuting has been supported for those who can do work from home. Public transportation is on holiday schedules, and large public gatherings have been cancelled.

SFDPH has requested vaccine via SEMS and was informed that initial allocations have already been made to other locations. As soon as additional vaccine is available, CDC & CDPH will notify SFDPH arrange for delivery. CDPH estimates that the soonest any additional vaccine will be available is 2-3 months from the point of request.

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5/12/08

Quarantine is no longer being implemented for contacts of cases as the presumption is that most of the population has been exposed. Because human-to-human transmission is now occurring in the general population in multiple countries, the WHO has raised the Pandemic Alert Level to Phase 6.

The surge of patients diagnosed with the flu has increased drastically across hospitals and clinics. Numbers being reported are showing a 100% increase in emergency department patients.

Census reports from hospitals have reached 150%. Overall staff shortage is reporting at 40%. Some clinics are reporting several staff members calling out of work, not wanting to be in a facility that is overloaded with influenza patients, while some report that they are experiencing symptoms of the virus and are incapable of performing their duties.

Antivirals are still presumed to be ineffective based on data from previous outbreaks in other countries. A vaccine is still unavailable.

All Healthcare facilities are experiencing equipment and operational staffing shortages, including the following:

- **All ventilators currently housed within acute care facilities are in use.**
- **N95 and surgical mask stock is at 25% of normal and distributors are only able to fill 10% of your facility's next requested order.**
- **Essential support and operational supplies are at minimal levels due to external staffing shortages including food service, laundry service and housekeeping services.**

EXERCISE BEGINS

5/13/08

Tuesday

9:00

As of 5pm 5/12/08, 10,125 San Francisco cases have been reported, and the initial 400 were lab confirmed (there are no reagents left to test for H5N1). 500 cases have died, and an additional 1000 have required ICU level care.

SFDPH has updated available Phase 6 Severe Pandemic Influenza infection control guidelines in the healthcare settings and Health Alert available to all hospitals via its website (<http://www.sfdcp.org/exercises.cfm>) & EMSsystem. It includes instructions and guidance for evaluating suspected cases for pandemic flu, case definitions, reporting instructions, infection control recommendations, and information for a citywide hospital conference call at 11:30am.

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Hospital discussion points

- What is your protocol for disseminating the Health Alert internally?
- How do you follow up to ensure key staffs have received the Health Alert?
- What are your challenges related to infection control recommendations while experiencing staffing and equipment shortages?

10am–12pm ACTION! Your hospital calls the SFPDPH DOC to request medical resources including PPE, staff and support services.

Hospital discussion points

- Who is in charge of collecting data on available resources within the hospital? What infrastructure must be intact to be able to accurately assess this information?
- What plans does your facility have to seek resources for your facility within your own networks or affiliates?
- Who is designated to request resources from the DOC?
- What plans does your hospital have to address shortage of staff in both clinical and non-clinical areas of operations?
- What plans does your hospital have to consider the use of volunteers in both clinical and non-clinical areas of operations?
- What other issues would arise for your facility with a shortage of staffing and PPE?

10am–1pm ACTION! Your hospital calls the SFPDPH CDCU 24/7 reporting line, (415) 554-2830, to report the total number of pandemic flu cases at your hospital for the last day/24hours.

Hospital discussion points

- Who is in charge of collecting this information, and how is it obtained?
- Who is designated to call the report into SFPDPH CDCU?

10am – 1pm ACTION! Your hospital calls the CDCU Disease Reporting Line, (415) 554-2830, at least once with infection control or clinician consultation question(s).

10:30am ACTION! Your hospital provides Incident Objectives and a Resource Status Update to the SFPDPH DOC.

11am SFPDPH issues an isolation order to isolate suspected and confirmed cases at your hospital and faxes it to your HICS Command Center and 24/7 number. Your hospital implements the isolation order.

Hospital discussion points

- Who at your hospital implements the isolation order(s)?
- Who at your hospital enforces the isolation order(s)?
- How will you implement the isolation order(s)?
- Does your hospital have the adequate resources to implement the isolation order(s)? If not, what do you need, and how will you request for them?

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11am – 12pm ACTION! Fax back the cover page of the isolation order with receipt information.

11:30am-12pm CONFERENCE CALL – SFDPH Clinician Consultation

To join the conference call dial: (877) 214-5637

A participant access code will be provided directly to participants.

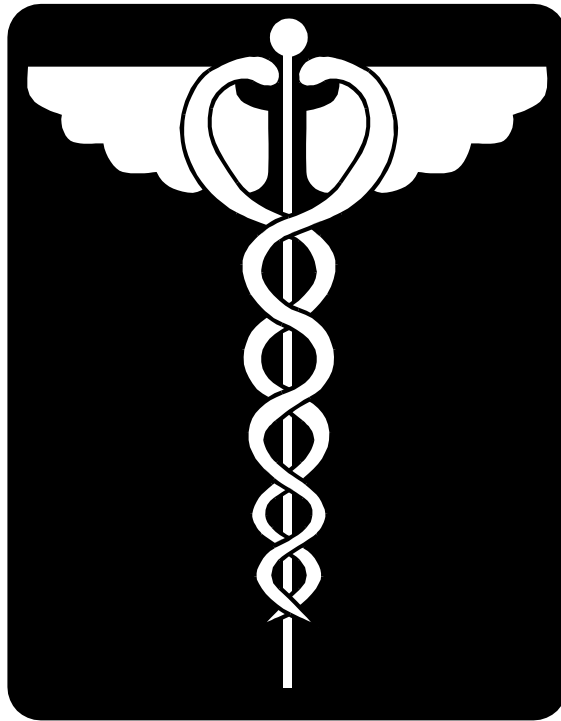
The tentative agenda is as follows. The agenda may change depending on evolving situational information:

- 1) Hospital and SFDPH situational update: number of cases and absent HCW, infection control supplies, etc.
- 2) Any questions on case definition or other clinical questions?
- 3) Any questions on infection control recommendations given shortage of supplies and staff?
- 4) Update on SFDPH response actions

EXERCISE ACTIVITY ENDS

1-2pm HOTWASH & DEBRIEFING PER INDIVIDUAL EXERCISE SITE

Conducting the Exercise



**City and County of San Francisco
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Pre-Exercise Activities

Preparing the Materials

Obtain the 2008 Medical Surge/Pandemic Influenza Exercise Guidebook for the May 13th, 2008 exercise from the Health Department's CDCP website (www.sfdph.org/cdcp) or Exercise Coordinator, Rebekah Varela at SFDPH, Rebekah.Varela@sfdph.org.

Notifying the Operational Area (OA) Exercise Coordinator of Intent to Participate

Exercise participants should report their intent to participate in the 2008 Medical Surge/Pandemic Influenza Exercise no later than May 2nd, 2008, using the included Intent to Participate form. The participant will fax or email the Intent form to the Rebekah Varela at Rebekah.Varela@sfdph.org or (415) 554-2552.

Exercise Planning in the OA

Each participant should prepare an exercise contact list for their organization for the OA Exercise Coordinator. Examples of numbers to provide include the Hospital Command Center (HCC), 24/7 hospital number, the facility exercise coordinator, the Incident Commander, and other key contacts.

Coordination with the Media

Media relations for the "real-life" (not the exercise simulation) should be coordinated through each facility Public Information Officers (PIO). If there is a question regarding real media relations, please contact Eileen Shields, PIO for SFDPH at 554-2507 or Eileen.Shields@sfdph.org.

Scheduling Personnel, Space, and Equipment

It is recommended that facility and organization staffs assigned to the exercise are notified well in advance to coordinate their schedules and plan for participation. For critical exercise positions or assignments, consider scheduling back-up staff that are also briefed and trained prior to the exercise.

- ❑ Announce the exercise date on local agencies/departments calendars, in-house publications or computer schedules so all involved personnel save the date when they are scheduling other activities.
- ❑ Identify and reserve the exercise location/space before the exercise.
- ❑ Assess the exercise area to make sure construction or other changes do not hinder the layout for performance of the exercise (e.g., removal of the phone lines from the room, or removal of chairs and tables.)
- ❑ Develop a checklist of equipment you will need to support the exercise.
- ❑ Check all equipment for proper functioning and operation before the exercise.

Developing Local Scenarios

The scenario in the 2008 Medical Surge/Pandemic Influenza Exercise Guidebook details a sequence of events to be used by participants. This sequence provides the overall anticipated schedule of activities that all participants will incorporate into the community exercise. The scenario is developed to allow customization at the hospital level in regards to meeting objectives, overall patient numbers and existing policies.

**City and County of San Francisco
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Exercise Day Activities

Pre-Exercise Survey of Resources

Changes often occur at the last minute and can interfere with a successful exercise. Organize a team of “checkers” who do nothing more than check facility readiness, materials, storage lockers, phones, fax machines and other communications systems the evening before and the morning of the exercise.

Briefing of Participants

Provide participating personnel with job action sheets, background information, organizational charts, pertinent policies and procedures, and role expectations before the exercise begins to increase participant comfort level and exercise success. At a minimum, the facility should be aware of the exercise in progress.

“This Is An Exercise!”

During the briefings, and throughout the exercise, it is very important to emphasize “this is an exercise” to all participants, agencies, and departments. Written materials and scripts should denote “Exercise only”, or “This is an Exercise”. Oral communications should be proceeded and end with “This is an exercise”.

Facility Signage

It is important to notify staff, patients, and visitors that an exercise is being conducted. Consider posting large signs at facility entrances and in key locations around the facility stating “*Disaster Exercise in Progress*” or similar language, to inform people of the event. Staff on-duty at the information desks in the entrance to the facility should also be given exercise information to inform visitors and others entering the facility about the exercise.

Exercise Safety

If exercise play within your facility includes volunteers or staff playing the role of casualties, you must activate an exercise safety officer to ensure safe conduct of the exercise. This should include a designated “code word” for the exercise volunteers to use in case of an unsafe or uncomfortable situation. The Exercise Safety Officer will notify the Lead Exercise Controller to temporarily suspend exercise play until the situation is resolved. In addition, volunteers should have proper identification and clear instructions on their role and scope of participation.

HICS Forms

If your facility has been trained in the use of the (new) HICS forms for incident action planning, stock these in your Hospital Command Center for use in the exercise. Forms are available on the EMSA web site at www.emsa.ca.gov/hics/hics.asp. These forms should be used in developing, documenting and communicating your Incident Action Plan for each operational period.

Terminating the Exercise for an Actual Emergency

Should there be a need to stop the exercise due to a real-time situation or event, the organization’s exercise controller will give a “**Terminate the Exercise**” order and all exercise should be immediately terminated until the situation can be addressed.

There may be situations where a real-time event, participant injury, or other situation may occur where the exercise should be stopped only in that area of play, but not necessarily the entire exercise. The exercise controller will announce a “**Pause the Exercise in [name of area or department]**” to pause the play until the situation can be addressed.

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May 13th, 2008**

**Conducting the 2008 Exercise
Tips for Hospitals**

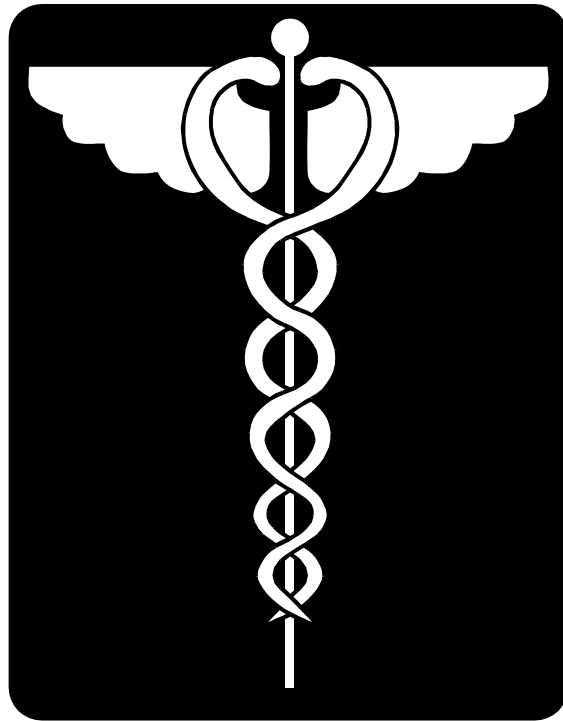
There are different types of exercises you can conduct, including tabletop, functional, and full scale (see glossary for definition of exercises). Each of these exercises can test your response and management of an infectious disease event.

The following are some ideas to achieve hospital-wide participation in the exercise:

- ❑ Activate the Emergency Operations Plan (EOP), the Hospital Command Center (HCC) and the Hospital Incident Command System (HICS) to manage the event and address the policy issues as described in the scenario. Incorporate into the activation personnel who may not have previously played a role in the HCC, such as infectious disease practitioners, epidemiologists, Infection Control staff, occupational health staff and others.
- ❑ Utilize the HICS Forms for development of your hospital incident action plan.
- ❑ Mobilize the infectious disease practitioners/infection control department to assist in determining facility priorities, patient care management, staff protection and reporting to local public health.
- ❑ Test the callback (staff notification) systems and lists, update lists and procedures as appropriate.
- ❑ Activate and practice “just-in-time” fit testing of N-95 masks and medical screening of employees to ensure employee protection in caring for infectious patients. The “fit testing” should include clinical and non-clinical support staff (e.g., housekeeping, dietary, engineering, security).
- ❑ Inventory all linen, nutritional supplies (food) and environmental services equipment and supplies to determine if additional quantities will be needed for the large patient influx and high patient census.
- ❑ Activate or assess internal and external security plans and institute traffic control measures, visitor access and set up perimeter barricades, etc.
- ❑ Prepare a plan to “lock down” the facility defining under what authority, when and how a “lock down” would occur and when the “lock down” would be discontinued. Review the ability to maintain ongoing ED services in the event of a lock-down and the ability to receive ambulance traffic and walk-in patients.
- ❑ Implement or assess hospital lab procedures to manage specimens from infectious patients in large numbers, including laboratory staffing, specimen prioritization and processing, and communication with local public health/Laboratory Response Network (LRN). Mock up the proper packaging and secure shipping of specimens to the local public health laboratory through the Laboratory Response Network.
- ❑ Activate your media relations or public information officer to respond to multiple media calls for information and/or convergence of media into your facility.
- ❑ Assess your capability to track patients throughout the hospital, including the hospital-based alternate care sites and to other patient care destinations, in accordance with applicable law and regulations.

These are only a few of the ideas to conduct a successful exercise to engage and involve multiple units/departments in a hospital. Use your imagination and be creative in your planning!

Intent to Participate



City and County of San Francisco
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May 13th, 2008

INTENT TO PARTICIPATE

Please complete this form to indicate your intent to participate in the exercise.

**FAX THIS FORM TO REBEKAH VARELA AT (415) 554-2552
BY Friday, May 2nd, 2008.**

Type of Provider: Hospital Community Clinic Ambulance
 Other: _____

Name of Facility or Provider: _____

Address: _____

City _____ Zip _____

County: _____

Exercise Coordinator Contact: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Exercise Command Center _____

Telephone #: _____ Fax #: _____

Infection Control Contact: _____

Telephone #: _____ Fax #: _____

E-mail: _____

24/7 Fax Number (this may be the number for your ED): _____

Check your facility's level of participation in the May 13th, 2008 exercise, including:

- Functional exercise *(See Glossary for exercise definitions)*
- Table top exercise
- Communications exercise
- Other (specify): _____

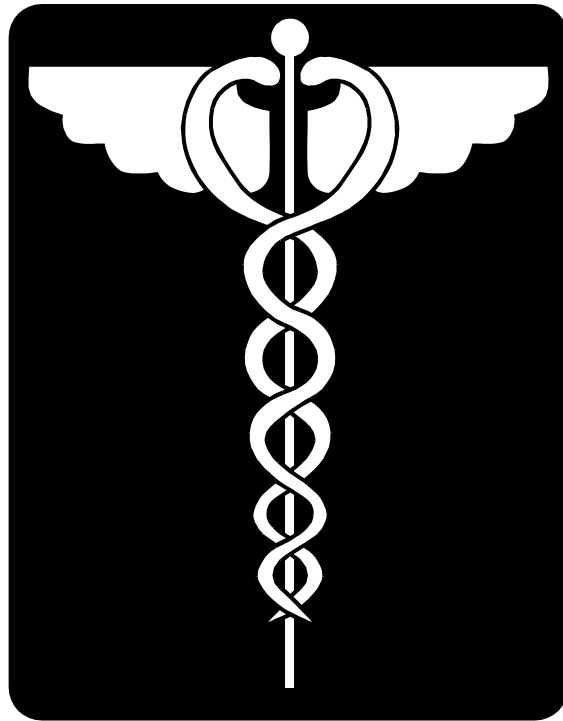
Estimated number of people participating: _____

Time and Number of Hours of exercise play: Time: # Hours:

Please complete this form for each healthcare facility, ambulance provider or entity participating in the exercise. If you are a multiple facility or multi-campus facility, complete **one "Intent to Participate" Form for each individual facility** participating.

The form may be duplicated for this purpose.

Status Update Forms



City and County of San Francisco
Medical & Health Disaster Exercise
May 13th, 2008

HOSPITAL STATUS REPORT FORM
Fax to DPH DOC at (415) 255-3567 (*exercise fax number*)

- 1) Complete page 1 within 1 (ONE) hour of event start.
- 2) Complete all pages within first 8 (eight) hours of event start.
- 3) Update at least once every 24 hours and fax to DPH DOC by 0600 hrs.
- 4) Update and fax as needed for significant changes.

Hospital Name: _____ Date/Time _____

Completed by (*name / title / call back phone#*): _____

1. FACILITY STATUS:

- Fully Functional
- Partially Functional due to:
 - Loss of Utilities (circle one): Power Water HVAC Communications
 - Partial structural damage
 - Other (describe) _____
- Not Functional due to:
 - Structural collapse
 - Other (describe) : _____
- Closed

- Partial Evacuation
- Full Evacuation

2. COMMAND CENTER STATUS:

Command Center Activated: Yes No

Primary phone: _____ Primary Fax: _____

3. EMERGENCY DEPARTMENT STATUS:

Total Patients from this event: _____ as of __:___ (time)

Triage Breakdown: Immediate _____ Delayed _____ Minor _____ Expired _____

Current ED Census: _____ (#) _____ (% of ED Beds / Space Filled)

4. IN- PATIENT STATUS:

Total Admitted Patients from this event: _____ as of __:___ (time)

Current Total Hosp Census: _____ (#) _____ (% of Beds/Space Filled)

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Hospital Name: _____ Date/Time _____

5. IN-PATIENT BED AVAILABILITY:

Area	Currently Available	Available in 12 Hrs	Available in 24 Hrs
ED			
Med-Surgical - Adult			
ICU - Adult			
Med-Surgical - Ped			
ICU - Ped			
OR			
Burn Capable			
Isolation / Neg Pres			
OB			
Neonatal			
Psych			
SNF			
Other			
TOTAL:			

6. BEDS NEEDED (Indicate Type + Quantity):

ED	
Med-Surgical - Adult	
ICU - Adult	
Med-Surgical - Ped	
ICU - Ped	
OR	
Burn Capable	
Isolation / Neg Press	
OB	
Neonatal	
Psych	
SNF	
Other	
TOTAL:	

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Hospital Name: _____ Date/Time _____

7. STAFFING STATUS:

Current Staffing Levels Adequate: <input type="checkbox"/> Yes <input type="checkbox"/> No	Staff Held Over: <input type="checkbox"/> Yes <input type="checkbox"/> No
Staff Call Back Plans Initiated: <input type="checkbox"/> Yes <input type="checkbox"/> No	

8. STAFF AVAILABLE TO OTHER AGENCIES:

1. I can provide staff to other agencies: Yes No
2. List available staff. Include number, discipline and duration.

Number	Discipline	Duration
example 2	Example Registered Nurses	Example 3 days

9. NEED STAFF FROM OTHER AGENCIES

1. I am requesting additional outside staff: Yes No
2. List needed staff. Include number, discipline, specialty, duration and personal supplies staff should bring. Prioritize requests (list most critical first.).

Number	Discipline	Specialty	Duration	Supplies Must Bring
example 1	example physician	example Emergency	example 2 days	Example stethoscope + scrubs

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Hospital Name: _____ Date/Time _____

10. OTHER ACTIONS TAKEN:

A. Security lockdown procedures initiated: Yes No

B. Elective surgery cancelled: Yes No

C. Clinic appointments cancelled: Yes No

D. Expediting patient discharge: Yes No

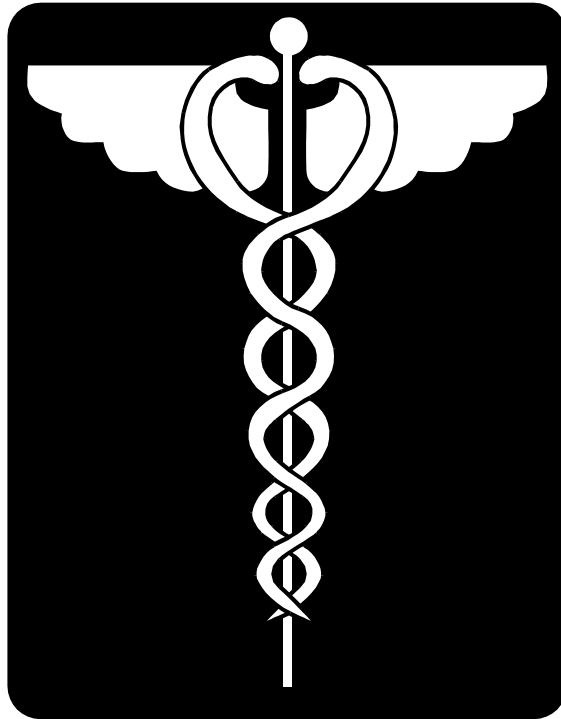
E. Alternate Triage Site if other than ED entrance: Yes No If yes,
location: _____

F. Alternate Care Site(s) activated Yes No If yes,
location(s) _____

List Other Actions Taken →

Use This Section To Add Further Requests Or Status Information →

Evaluating the Exercise



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Medical & Health Disaster Exercise
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Exercise Evaluation

Exercise Evaluation Tools

Exercises must be evaluated to measure performance and identify corrective actions. Exercises are critiqued to identify deficiencies and opportunities for improvement based upon monitoring activities and observations during the exercise (Joint Commission E.C. 4.20, B15.)

Using and/or adapting existing tools can facilitate exercise evaluation. Exercise evaluation can assist organizations to identify:

- Needed improvements in the Emergency Management Program, Emergency Operations Plan, procedures, or guidelines
- Enhanced collaboration and cooperative planning with community agencies (community-wide planning)
- Needed improvements in the emergency management system, including the incident command and control
- Training and staffing deficiencies
- Whether the exercise has achieved its objectives
- Needed equipment, supplies or services
- Needs for continued exercises on the plan or its functions

An evaluation tool to consider is the Homeland Security Exercise and Evaluation's *Exercise Evaluation Guides*. These guides are used nationally to evaluate exercises and several of the guides pertain to healthcare. Information about EEGs can be found at <https://hseep.dhs.gov/EEGsAbout.htm>, and a library of available EEGs at <https://hseep.dhs.gov/EEGSListings.htm>.

Conducting a Player Hotwash

(This information and the following form is from the Homeland Security Exercise and Evaluation Program, Volume III: Exercise Evaluation and Improvement Planning. The information can be found at <https://hseep.dhs.gov/>.)

Immediately after an exercise, evaluators (or team of evaluators and controllers) should debrief the players and controllers in his/her observed discipline, either separately or as a large group. This facilitated discussion, referred to as a *hotwash*, allows players to engage in a self-assessment of their exercise play and provides a general assessment of how the entity performed in the exercise. The hotwash also provides evaluators with the opportunity to clarify points or collect any missing information from players before they leave the exercise venue. The hotwash is conducted as soon as possible after the exercise, usually the same day. In exercises with several venues, separate hotwashes may take place at each location. A hotwash is led by an experienced facilitator who can ensure that the discussion remains brief and constructive, and who can focus conversation on strengths and areas for improvement.

During the hotwash, evaluators may distribute Participant Feedback Forms (see example on following pages to obtain information on perceptions of the exercise, how well each player thought his/her unit performed, and how well the unit integrated performance with other agencies and other exercise components. The questions on the Participant Feedback Form can also be used to conduct a verbal hotwash, rather than written.

The information can provide insight into why events happened the way they did or why some expected actions did not take place. Participant Feedback Forms are collected at the end of the hotwash and reviewed by the evaluation team to augment existing information. Participant Feedback Forms also serve to solicit general feedback on exercise quality, which can be

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provided to the exercise planning team to help implement improvements in future exercises. A summary of Participant Feedback Forms can be included as an optional appendix within an after-action report/corrective action plan.

Tips for Conducting a Successful Hotwash or Debriefing

- The hotwash should be conducted by an exercise controller or exercise planner who is well informed about the exercise scenario and objectives.
- A successful hotwash facilitator should stay within the time allotted for the debriefing, encourage participation from all members of the group, and be proficient in conflict resolution. Be prepared for negative comments about the exercise and the overall emergency management program. Exercises can be stressful for participants and they may share their concerns and frustrations. Be patient, non-judgmental, and listen with an open mind.
- Appoint a scribe: the hotwash facilitator should focus on that role and not on note taking.
- Keep a sign in sheet with name, department, area of assignment for the exercise and the role played (e.g., participant, controller, evaluator, victim).
- Set the tone for the hotwash/debriefing: make it positive and non-threatening. Many hotwashes focus on identifying “what worked, what did not work”. Begin by focusing on the positive: “what worked”. Ask participants to identify those areas they felt worked well, looking for innovative approaches in response and problem solving
- When participants get off track during the hotwash, refer to the objectives and the purpose of the debriefing. Acknowledge participants concerns, and refer them to the evaluation sheets as a method for voicing and documenting issues.
- Use humor to keep on time and on track.
- Keep on an eye on the audience: look for those individuals who are having difficulty finding an opportunity to speak.
- Use the objectives to move the discussion: refer to a specific objective and ask for input.
- When concluding the hotwash, identify the next steps to be taken
 - All verbal and written comments will be reviewed
 - Action items will be identified and an action plan developed
 - Educational issues will be identified and addressed

**City and County of San Francisco
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May 13th, 2008
Medical Surge/Pandemic Influenza Exercise
PARTICIPANT FEEDBACK FORM**

Please bring your completed evaluation form to the After Action Conference at the June 4, 2008 Hospital Council Meeting.

(If your agency is unable to send a representative to the After Action Conference, please arrange with Rebekah Varela to transmit your findings to DPH)

Exercise Name: 2008 Med Surge/Pan Flu Exercise (San Francisco)

Exercise Date: 05/13/2008

Participant Name: _____ **Title:** _____

Agency: _____ **Role:** Player Controller
 Evaluator Observer

Part I – Recommendations and Action Steps for your agency

1. Based on the exercise today and the tasks identified, list the top 3 issues and/or areas that need improvement in your organization.

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

3. Describe the action steps that should be taken in each area of responsibility. Who should be assigned responsibility for each action item?

4. List the equipment, training or plans/procedures that should be reviewed, revised, or developed. Indicate the priority level for each.

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Part II – Interaction with SF Department of Public Health

1. Please note approximately when and where the following were received during the exercise:

Mode	Date/Time Health Alert was read by key staff	Mode of receipt <i>(check all that apply)</i>	Title(s) of person(s) who read the Health Alert
SFDPH Health Alert & Infection Control Guidelines (WHO Phase 6)	<input type="checkbox"/> Did not receive	<input type="checkbox"/> SFDPH website <input type="checkbox"/> EMSystems alert <input type="checkbox"/> Other:	<input type="checkbox"/> Was not read
SFDPH Institutional Isolation order	<input type="checkbox"/> Did not receive	<input type="checkbox"/> Hospital 24/7 fax <input type="checkbox"/> Exercise day Command Center Fax <input type="checkbox"/> EMSystems alert <input type="checkbox"/> Other:	<input type="checkbox"/> Was not read

1a. Additional comments about health alert, infection control guidelines or I&Q order:

1b. Does your institution have a protocol for ensuring that health alerts, isolation orders and other SFDPH communications are delivered to the appropriate staff?

- Yes
- No
- Don't Know

1c. If yes, did staff follow the protocol during the exercise? How could it be improved?

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2. Did your organization call the 24/7 Disease Reporting Line (415-554-2830) to report at least one case of influenza during the exercise?

- Yes
- No
- Don't Know

2a. If yes, did you have problems getting through to speak with an SFDPH staff person in a timely manner?

- Yes → Please describe: _____
- No

3. Did your organization call the 24/7 Disease Reporting Line (415-554-2830) for clinical, infection control or other consultation at least once during the exercise?

- Yes
- No
- Don't Know

3a. If yes, did you receive the information that you needed?

- Yes
- No → Please describe: _____

4. Did your organization participate in the joint conference call with SFDPH that took place at 11:30am on the day of the exercise?

- Yes
- No
- Don't Know

4a. If yes, did you have problems getting through to the conference line?

- Yes → Please describe: _____
- No

4b. Who participated in the conference call? Were they the appropriate staff to include in this type of conference call?

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4c. How useful did your organization consider the conference call?

- Extremely useful Useful Neutral Not useful Extremely not useful

4d. What was the most useful part of the conference call?

4e. What was the least useful part of the conference call?

4f. Other feedback regarding the conference call (e.g. other information desired but not presented, length of call, number of participants, agenda items, etc.):

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Part III – Exercise Design and Conduct

1. What is your assessment of the exercise design and conduct?

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

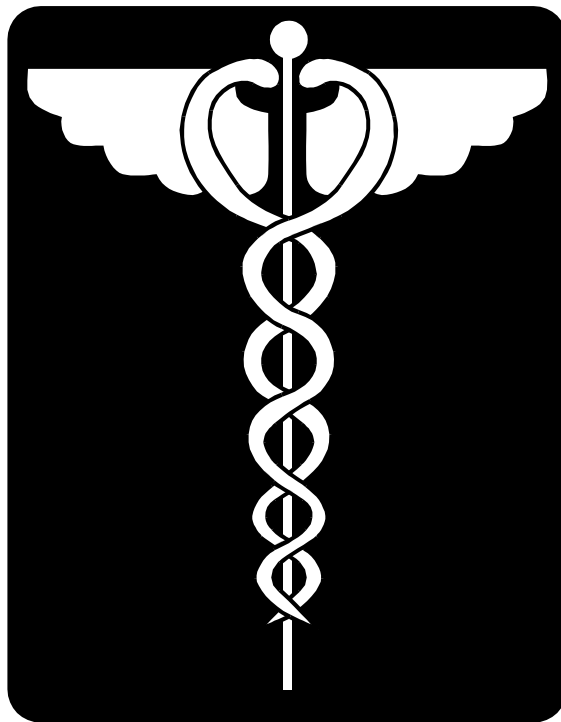
<u>Assessment Factor</u>	Rating of Satisfaction with Exercise				
	<i>Strongly Disagree</i>				<i>Strongly Agree</i>
a. The exercise was well structured and organized.	1	2	3	4	5
b. The exercise scenario was plausible and realistic.	1	2	3	4	5
c. The documentation used during the exercise was a valuable tool throughout the exercise.	1	2	3	4	5
d. Participation in the exercise was appropriate for someone in my position.	1	2	3	4	5
e. The participants included the right people in terms of level and mix of disciplines.	1	2	3	4	5

2. What changes would you make to improve this exercise?

Please provide any recommendations on how this exercise or future exercises could be improved or enhanced.

End of survey. Thank you for your feedback!

Glossary and Acronyms



**City and County of San Francisco
Medical & Health Disaster Exercise
May 13th, 2008
Glossary of Terms**

Avian influenza	Avian influenza, also referred to as bird flu, is a disease of birds (e.g. ducks, chickens). Between 2003 and 2006 the H5N1 avian influenza virus has infected millions of birds. Although it is primarily a disease of birds a small number of people have also been infected after having close contact with birds. Also see influenza, seasonal influenza, and pandemic influenza.
Contact	A contact is a term used to refer to someone who has been in close proximity with an individual who is, or is suspected of being, infected with an infectious disease like influenza.
H5N1	H5N1 is the latest avian influenza virus subtype of concern and there appears to be little human immunity to it. The predominant winter strain of human influenza is H3N2. Most adults have some partial immunity to this strain, which caused a pandemic in 1968 when it evolved from avian influenza.
Hand hygiene	Hand hygiene is a term that applies to the cleaning of ones hands. This is usually done with soap and water, hand sanitizer, or hand wipes. To kill an influenza virus hands must be washed with soap and water for 15 seconds and hand sanitizers or wipes must be used for 10 seconds and have an alcohol content of at least 60%.
Human-to-human transmission	Human-to-human transmission refers to the ability of an infectious diseases to be passed continuously from one person to another. Some viruses can be transmitted between animals (animal-to-animal), some can be transmitted from animal-to-human (and vice versa), and some can be transmitted from human-to-human.
Infection control	Infection control is broad term used to describe a number of measures designed to detect, prevent, and contain the spread of infectious disease. Some measures include hand washing, respiratory etiquette, use of personal protective equipment (PPE), prophylaxis, isolation, and quarantine.
Infectious disease	An infectious disease, or communicable disease, is caused by the entrance of organisms (e.g. viruses, bacteria, fungi) into the body which grow and multiply there to cause illness. Infectious diseases can be transmitted, or passed, by direct contact with an infected individual, their discharges (e.g. breath), or with an item touched by them.
Influenza	Influenza is a viral disease that causes high fever, sore through, cough, and muscle aches. It usually affects the respiratory system but sometimes affects other organs. It is spread by infectious droplets that are coughed or sneezed into the air. These droplets can land on the mucous membranes of the eyes or mouth or be inhaled into the lungs of another person. Infection can also occur from contact with surfaces contaminated with infectious droplets and respiratory secretions. Also see seasonal, avian, and pandemic influenza.
Isolation	Isolation is when sick people are asked to remain in one place (e.g. home, hospital), away from the public, until they are no longer infectious.

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Pandemic influenza	A pandemic influenza, or pandemic flu, occurs when a new subtype of influenza virus: 1) develops and there is little or no immunity (protection due to previous infection or vaccination) in the human population; 2) it is easily passed from human to human; 3) is found in many countries; and, 4) causes serious illness in humans. Also see influenza, seasonal influenza, and avian influenza.
Personal Protective Equipment (PPE)	PPE is specialized clothing or equipment worn to protect someone against a hazard including an infectious disease. It can range from a mask or a pair of gloves to a combination of gear that might cover some or all of the body.
Prophylaxis	Prophylaxis is an infection control measure whereby antimicrobial, including antiviral, medications are taken by a healthy individual (e.g. nurse, contact) to prevent illness before or after being exposed to an individual with an infectious disease (e.g. influenza).
Quarantine	A quarantine is when people who have been in close proximity to an infected person, but appear healthy, are asked to remain in one place, away from the general public, until it can be determined that they have not been infected.
Respiratory etiquette	Respiratory etiquette, or good coughing and sneezing manners, is one way of minimizing the spread of viruses which are passed from human-to-human in the tiny droplets of moisture that come out of the nose or mouth when coughing, sneezing, or talking. Healthy and sick people should cover their nose and mouth when sneezing, coughing, or blowing their nose and then put the used tissue in the trash to prevent the spread of germs.
Seasonal influenza	Seasonal influenza, commonly referred to as the flu, is an infectious disease. In the United States, flu season usually occurs between December and March. The influenza virus is one that has the ability to change easily; however, there is usually enough similarity in the virus from one year to the next that the general population is partially immune from previous infection or vaccination. Each year experts monitor the influenza virus and create a new vaccine to address changes in the virus. For this reason people are encouraged to get a flu shot each year. Also see influenza, avian influenza, and pandemic influenza.
Social distancing	Social distancing is an infection control strategy that includes methods of reducing the frequency and closeness of contact between people to limit the spread of infectious diseases. Generally, social distancing refers to the avoidance of gatherings with many people.

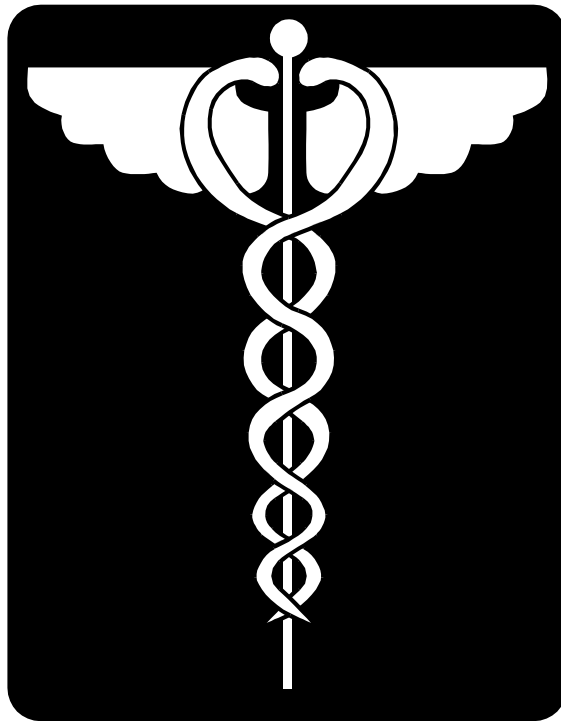
**City and County of San Francisco
 Medical & Health Disaster Exercise
 May 13th, 2008
 Acronyms**

AAR	After-Action Report
ACS	Alternate Care Sites
ACS	Auxiliary Communications Services
AEOC	Area Emergency Operations Center
ARC	American Red Cross
ASPR	Assistant Secretary of Preparedness and Response (Office of)
BVM	Bag-Valve-Mouth
CAHAN	California Health Alert Network
CAP	Corrective Action Plan (formerly known as Corrective Improvement Plan)
CERT	Community Emergency Response Team
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CDPH	California Department of Public Health (formerly known as the California Department of Health Services)
CHA	California Hospital Association
CIA	Central Intelligence Agency
CIP	Corrective Improvement Plan (Now known as Corrective Action Plan)
CISM	Critical Incident Stress Management
DHS	Department of Homeland Security
DOC	Departmental Operations Center
EC	Environment of Care
ED	Emergency Department
EMS	Emergency Medical Services
EMSA	Emergency Medical Services Authority
EOC	Emergency Operations Center
ETA	Estimated Time of Arrival
FBI	Federal Bureau of Investigation
FEMA	Federal Emergency Management Agency
HCC	Hospital Command Center
HEICS	Hospital Emergency Incident Command System (updated 9-06 and now known as HICS)
HEOC	Hospital Emergency Operations Center (now known as HCC)
HICS	Hospital Incident Command System
HRSA	Health Resources and Services Administration (now known as ASPR)
HSAS	Homeland Security Advisory System
HVAC	Heating, Ventilation and Air Conditioning
IAP	Incident Action Plan
IC	Incident Command or Incident Commander
ICS	Incident Command System
ILI	Influenza-like-illness
Joint Commission	Joint Commission on Accreditation of Healthcare Organizations
JEOC	Joint Emergency Operations Center
JIC	Joint Information Center
LEMSA	Local EMS Agency
MHOAC	Medical Health Operational Area Coordinator
MOB	Medical Office Building
MRC	Medical Reserve Corps

**City and County of San Francisco
Medical & Health Disaster Exercise
May 13th, 2008**

MSELS	Master Sequence of Events Listing
NDMS	National Disaster Medical System
NIMS	National Incident Management System
OA	Operational Area
OES	(California Governor's) Office of Emergency Services
OHS	(Governor's) Office of Homeland Security (State of California)
PIO	Public Information Officer
POC	Point of Contact
POD	Point of Dispensing
REOC	Regional Emergency Operations Center
RDMHC	Regional Disaster Medical Health Coordinator
RDMHS	Regional Disaster Medical Health Specialist
RIMS	Response Information Management System
RN	Registered Nurse
RTTAC	Regional Terrorism Threat Assessment Center
SEMS	Standardized Emergency Management System
SOC	State Operations Center
STTAC	State Terrorism Threat Assessment Center
TEW	Terrorism Early Warning
TEWG	Terrorism Early Warning Group
UA	Universal Adversary

Pan Flu Scenario Appendix





Gavin Newsom
Mayor

Communicable Disease Control & Prevention

101 Grove Street, Room 408

San Francisco, CA 94102

Tel: (415) 554-2830

Fax: (415) 554-2848

www.sfdph.org/cdcp

MOCK HEALTH ALERT
FOR MEDICAL & HEALTH DISASTER EXERCISE
MAY 13, 2008
SEVERE PANDEMIC INFLUENZA IN SAN FRANCISCO - UPDATE

As mentioned in previous health alerts, the WHO has declared pandemic phase to level 6, and the CDC escalated the Pandemic Flu Federal Government Response Stage to level 5 (spread throughout the United States) in April 2008. 10,125 San Francisco cases have been reported. SFDPH recommends that "Severe Pandemic Influenza Infection Control Recommendations for the Healthcare setting (including EMS)," as posted on www.sfdph.org/cdcp should be implemented. Pre-pandemic H5N1 Vaccine has been requested but is still unavailable for San Francisco. All reported and confirmed cases have demonstrated resistance to all antiviral treatments.

All Healthcare facilities are experiencing equipment and operational staffing shortages, including the following:

- All ventilators currently housed within acute care facilities are in use.
- N95 and surgical mask stock is at 25% of normal and distributors are only able to fill 10% of your facility's next requested order.
- Essential support and operational supplies are at minimal levels due to external staffing shortages including food service, laundry service and housekeeping services.

San Francisco Department of Public Health (SFDPH) requests that all hospitals be alert for cases of Pandemic influenza, inform SFDPH of aggregate cases daily, and implement appropriate infection control measures, as outlined below. This alert and additional information is posted on the SFDPH website: www.sfdph.org/cdcp. A conference call for San Francisco clinicians with questions will be held today from 11:30 am to 12 pm. Call (877) 214-5637; the pass code is 949772.

Actions requested of all clinicians

1. Be alert for cases of pandemic influenza.
2. Report aggregate cases of pandemic influenza that *meet the criteria* below to SFDPH Disease Control (554-2830).
3. Implement appropriate infection control measures and encourage respiratory etiquette among your staff and patients. See guidance below.

SURVEILLANCE/REPORTING

Suspect pandemic flu cases:

Report total number of suspect cases daily (today between 10a-12pm) to SFDPH Disease Control (554-2830) that meet the following criteria:

- A patient who has a respiratory illness with onset of illness after April 2008 that meets criteria 1, 2, 3 & 4:
1. Requires hospitalization or is fatal; AND
 2. Has or had a documented temperature of $\geq 38^{\circ}$ C (100.4 $^{\circ}$ F); AND
 3. Has radiographically confirmed pneumonia, acute respiratory distress syndrome (ARDS), or other severe respiratory illness **for which an alternate diagnosis has not been established**; AND

4. Has an epidemiologic link to a case of pandemic influenza.

For reference materials see: www.sfdph.org/cdcp.

INFECTION CONTROL

- For suspect and confirmed cases of Pandemic influenza: standard, contact, airborne, and eye protection precautions are recommended. Hospitalized patients should be managed with these infection control precautions until the infectious period has passed (i.e., 14 days after onset of symptoms) unless an alternate diagnosis is established or infection with influenza is excluded. Consider extending these precautions to 21 days or longer in pediatric or immune-compromised persons with Pandemic influenza infection.
- Consider doing refresher training for your key staff on appropriate use of PPE.
- Legal isolation orders for cases will be issued to each hospital.
- Restrict from work and monitor for 10 days after their last symptoms hospital staff who are suspect cases as defined previously. Include suspected or confirmed health care worker cases in daily line lists of cases to SFDPH Disease Control (Fax: 554-2848).
- For all patients & staff, encourage good respiratory etiquette/cough hygiene and hand hygiene. This includes:
 1. Not coughing or sneezing into hands but covering the mouth and nose with a tissue instead;
 2. Encouraging all people to wear a surgical mask;
 3. Performing hand hygiene after any contact with respiratory secretions or contaminated objects.
- Prioritize respiratory protection for staff caring for cases. When adequate supplies are available, consider N95 respirator or mask use during care for coughing or sneezing patients unable to contain their secretions.
- Restrict from work and monitor for 10 days after their last exposure hospital staff who are contacts to a case or suspect case as defined below. If this is absolutely not possible due to staffing availability and needs, only allow healthcare contacts and previously ill staff to take care of suspected pandemic flu cases.
 - **Hospital contacts to a case or suspect case:**
 - Healthcare workers and others (e.g., housekeeping staff) who were exposed to respiratory, oral or nasal secretions from a symptomatic case during the infectious period (i.e., 14 days after onset of symptoms) AND who *did not wear appropriate personal protective equipment* (e.g., N95 mask, gloves, goggles, etc.) during the exposure;
 - Laboratorians and others with *unprotected* exposure to laboratory specimens from a case.

Download specific guidelines, patient materials and a monitoring log sheets for health care workers from our website: <http://www.sfdcp.org/pandemicfluexercise.cfm> Updates will be added periodically.

PANDEMIC INFLUENZA GENERAL RESPONSE

SFDPH is monitoring the situation which includes surveillance at hospitals to identify cases. We are working closely with hospitals to ensure that appropriate infection control measures are implemented and coordinating with our public health partners within the Bay Area, the State and CDC. We are no longer processing specimens specifically for the pandemic influenza strain. For more information, visit our website. Additional information will be disseminated via press conferences to major local media outlets.

INFORMATION FOR PATIENTS

Pandemic Flu Frequently Asked Questions can be downloaded at www.sfdph.org/cdcp

ADDITIONAL INFORMATION

SFDPH website: www.sfdph.org/cdcp - click on pandemic influenza link

California Department of Public Health website: www.cdph.ca.gov

Centers for Disease Control: www.cdc.gov/flu

Department of Health & Human Services website: www.pandemicflu.gov

Reportable Diseases & Conditions

The Communicable Disease Control Unit physicians and public health staff at the San Francisco Department of Public Health work around the clock to receive and respond to communicable disease reports. Physicians and health care providers, per [Title 17 of the California Code of Regulations](#) are legally required to report suspected, lab-confirmed, and/or clinical diagnoses of specific [diseases and conditions](#) within specified time frames to the San Francisco Department of Public Health.

To download a copy of the recently updated list go to: www.sfcdcp.org/index.cfm?id=86

REPORTABLE DISEASES AND CONDITIONS		
City and County of San Francisco San Francisco Department of Public Health		
Title 17, California Code of Regulations (CCR) §§1016, §1018, §1019-§1023 and §1026-§1031 §10300. Every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or conditions listed below, must report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.		
WHO TO REPORT TO		
REPORT OUTBREAKS, DISEASES, AND CONDITIONS TO COMMUNICABLE DISEASE CONTROL UNIT UNLESS OTHERWISE INDICATED		
COMMUNICABLE DISEASE CONTROL UNIT PHONE: (415) 554-2830 FAX: (415) 554-2848 847 SASH ST SF For report requests after hours, follow the prompts to page the on-call MD	AIDS OFFICE PHONE: (415) 554-4650 STD CLINIC PHONE: (415) 487-6555 FAX: (415) 431-4620	TUBERCULOSIS CLINIC PHONE: (415) 299-8524 FAX: (415) 568-8369 ANIMAL BITES (mammals only) PHONE: (415) 254-6422 FAX: (415) 864-2900
DISEASE OR CONDITION / URGENCY REPORTING REQUIREMENTS		
URGENCY REPORTING KEY: <input type="checkbox"/> Report immediately by telephone <input type="checkbox"/> Report within one working day of identification <input type="checkbox"/> Report within seven calendar days by FAX, phone or mail		
<input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS) to AIDS Office <input type="checkbox"/> Alzheimer's Disease and Related Conditions <input type="checkbox"/> Anemia <input type="checkbox"/> Animal bites (mammals only) to Animal Care and Control <input type="checkbox"/> Anthrax* <input type="checkbox"/> Arsenic <input type="checkbox"/> Botulism* (Infant, Foodborne, Wound) <input type="checkbox"/> Brucellosis* <input type="checkbox"/> Campylobacteriosis <input type="checkbox"/> Cancer (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in situ and CIN II of the cervix) <input type="checkbox"/> Chancroid to STD Clinic <input type="checkbox"/> Chikungunya (only hospitalization and death) <input type="checkbox"/> Chlamydial infections to STD Clinic <input type="checkbox"/> Cholera <input type="checkbox"/> Ciguatera Fish Poisoning <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Colorado Tick Fever <input type="checkbox"/> Congenital, Acute Infection of the Newborn (specify etiology) <input type="checkbox"/> Cryptosporidiosis <input type="checkbox"/> Cryptococcosis <input type="checkbox"/> Dengue <input type="checkbox"/> Diarrhea of the Newborn, outbreaks <input type="checkbox"/> Diphtheria <input type="checkbox"/> Disorders Characterized by Lesions of Orosclerosis <input type="checkbox"/> Dracoid Acid poisoning (Venereal Swallow Poisoning) <input type="checkbox"/> Ehrlichiosis <input type="checkbox"/> Encephalitis, Infectious (specify etiology) <input type="checkbox"/> Escherichia coli shiga toxin producing (STEC) including E. coli O157 <input type="checkbox"/> Foodborne illness (2 or more cases from different households)	<input type="checkbox"/> Giardiasis <input type="checkbox"/> Gonococcal infections to STD Clinic <input type="checkbox"/> Hemorrhagic Infections Invasive diseases (less than 15 years of age) <input type="checkbox"/> Herpesvirus infections <input type="checkbox"/> Herpesvirus Latent Syndrome <input type="checkbox"/> Hepatitis, Viral <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B (specify acute case or chronic) <input type="checkbox"/> Hepatitis C (specify acute case or chronic) <input type="checkbox"/> Hepatitis D (Delta) <input type="checkbox"/> Hepatitis, other acute <input type="checkbox"/> Human Immunodeficiency Virus (HIV) to AIDS Office <input type="checkbox"/> Influenza deaths (less than 16 years of age only) <input type="checkbox"/> Kawasaki Syndrome (Maculatoxous Lymph Node Syndrome) <input type="checkbox"/> Legionellosis <input type="checkbox"/> Leprosy (Hansen Disease) <input type="checkbox"/> Leptospirosis <input type="checkbox"/> Listeriosis <input type="checkbox"/> Lyme Disease <input type="checkbox"/> Lymphogranuloma Venereum (LGV) to STD Clinic <input type="checkbox"/> Malaria <input type="checkbox"/> Measles (Rubella) <input type="checkbox"/> Meningitis (specify etiology) <input type="checkbox"/> Meningococcal infections <input type="checkbox"/> Mumps <input type="checkbox"/> Paralytic Shellfish Poisoning <input type="checkbox"/> Parvovirus Infection (PFD) to STD Clinic <input type="checkbox"/> Pertussis (Whooping Cough) <input type="checkbox"/> Plague (Human or Animal)* <input type="checkbox"/> Poliovirus <input type="checkbox"/> Rabies <input type="checkbox"/> Q Fever	<input type="checkbox"/> Rabies (Human or Animal) <input type="checkbox"/> Relapsing Fever <input type="checkbox"/> Rheumatic Fever, Acute <input type="checkbox"/> Rocky Mountain Spotted Fever <input type="checkbox"/> Rubella (German Measles) <input type="checkbox"/> Rubella Congenital Syndrome <input type="checkbox"/> Salmonellosis (other than Typhoid fever) <input type="checkbox"/> Severe Acute Respiratory Syndrome (SARS) <input type="checkbox"/> Scorpionfish Fish Poisoning <input type="checkbox"/> Shiga toxin producing Escherichia coli (STEC) including E. coli O157 <input type="checkbox"/> Shigellosis <input type="checkbox"/> Smallpox (Variola)* <input type="checkbox"/> Streptococcal infections, outbreaks of any type and individual cases in food handlers and dairy workers only <input type="checkbox"/> Syphilis to STD Clinic <input type="checkbox"/> Tetanus <input type="checkbox"/> Tetanus <input type="checkbox"/> Toxic Shock Syndrome <input type="checkbox"/> Toxoplasmosis <input type="checkbox"/> Transmissible Spongiform Encephalopathies (TSE) <input type="checkbox"/> Trichinosis <input type="checkbox"/> Tuberculosis to Tuberculosis Clinic <input type="checkbox"/> Tuberculosis* <input type="checkbox"/> Typhoid fever (cases and carriers) <input type="checkbox"/> Typhus fever <input type="checkbox"/> Vibrio infections <input type="checkbox"/> Viral Hemorrhagic Fevers* (e.g. Crimean-Congo, Ebola, Lassa and Marburg viruses) <input type="checkbox"/> Water-Associated Disease (e.g. Salmonella, E. coli, Shigella, Vibrio) <input type="checkbox"/> West Nile Virus <input type="checkbox"/> Yellow Fever <input type="checkbox"/> Yersiniosis <input type="checkbox"/> ANY UNUSUAL DISEASES <input type="checkbox"/> NEW DISEASE OR SYNDROME NOT PREVIOUSLY RECOGNIZED <input type="checkbox"/> OUTBREAKS OF ANY DISEASE
*Potential Bioterrorism Agents June 2005		

Severe Pandemic Influenza Infection Control Draft Recommendations
For the
Healthcare Setting including Emergency Medical Situations

San Francisco Department of Public Health

Updated May 12, 2008

Note: The yellow highlighted areas in the Infection Control Guidelines document are the areas that have the most potential to change during an actual pandemic depending on what we know then about the specific influenza strain and other extenuating circumstances.

The recommendations contained in this document comprise one component of an overall set of infection control recommendations developed by the San Francisco Department of Public Health to be used only for a severe influenza pandemic (Pandemic Severity Index 4 or greater). The Healthcare Setting recommendations are intended to guide infection control professionals and healthcare workers in healthcare settings. For the purposes of this document, the healthcare setting is broadly defined as a setting whose primary purpose is to attend to the needs of those requiring medical attention where patients suspected or confirmed with pandemic influenza will seek care, or will be provided care. This may include an acute care hospital, a sub-acute care facility, a long term or rehabilitation facility, an urgent care center, an ambulatory clinic, a physician office, and/or an Emergency Medical Service such as ambulance. The San Francisco Department of Public Health has developed separate infection control recommendations for other settings whose primary purpose is not the provision of medical care, such as homes, correctional facilities, and other workplace settings and for other groups, such as the general public. When not at work, the SFDPH Severe Pandemic Influenza Infection Control Recommendations for the General Public in Public Settings should be followed. These healthcare infection control recommendations do not supersede guidance from OSHA, JCAHO or other regulatory bodies, such as the OSHA Guidance on Preparing Workplaces for an Influenza Pandemic.

At any time in a severe pandemic situation, there is the assumption that there may be staff and equipment shortages, so this document presents the ideal infection control methods to limit transmission of influenza in healthcare settings during a severe pandemic with the recognition that global and location situations at the time of a pandemic may limit the ability of healthcare workers to implement them. For this reason, the document also includes recommended strategies to maintain the best possible infection control practices when the implementation of any of the recommendations is not feasible due to the lack of staffing, equipment or supplies. It is expected that each healthcare facility or setting has its own specific pandemic influenza plan and will use these recommendations to guide modifications to those plans. Health care workers should be familiar with their facility's pandemic influenza plan and should also have a personal/family pandemic influenza preparedness plan.

At the beginning of a severe influenza pandemic the exact modes of transmission may not be know, therefore these recommendations are based on providing a maximal level of protection, which may be decreased if further evidence at the time of the pandemic indicates that certain precautions or procedures are not necessary to reduce transmission. In healthcare settings, persons suspected or confirmed to have a novel influenza strain during a severe pandemic should be cared for using Standard, **Airborne**, Contact precautions, and Eye Protection as long as resources allow. Hand Hygiene and Respiratory Hygiene/Cough Etiquette strategies should be implemented as well. Those in the healthcare setting should maintain infection control standards and practices as much as possible in a severe pandemic situation for as long as feasible.

Patients who have pandemic influenza infections requiring hospitalization or on-going medical care for medical reasons should be managed with these infection control precautions for at least **14*** days (*Duration of infectiousness, incubation and isolation period will be determined at the time based on available epidemiology) after onset of symptoms with clinical improvement unless an alternative diagnosis is established or infection with a novel influenza strain has been excluded. These infection control precautions may be extended for longer period if there is no clinical improvement, or for pediatric or immune-compromised persons suspected or confirmed to have a novel influenza strain.

During a severe influenza pandemic, the general public may be instructed to wear a face mask when outside the home. A face mask refers to a surgical type of mask that covers the nose and mouth and either ties at the back or has loops around the ears. In addition to the use of face masks, the SFDPH will be recommending the strategies outlined in the next paragraph for the entire public; these strategies form the basic foundation for all of the components in the set of infection control recommendations for severe pandemic influenza. Consult the Severe Pandemic Influenza Infection Control Recommendations for the General Public document for further specific details. Healthcare-specific strategies are discussed in detail in the remainder of this document.

While Personal Protective Equipment (PPE), appropriately selected and worn correctly, provides some protection for the wearer from contact with pandemic influenza virus, the use of PPE is only a component of the basic strategies a person can take to decrease disease transmission. These strategies include:

- A. **Do not go to work when ill.**
- B. **Minimize contact with sick persons**, to decrease the amount of exposure to the virus.
- C. **Keep hands clean** - influenza virus is primarily a respiratory droplet transmissible disease, and cleaning hands with soap and water or an alcohol-based sanitizer as often as possible decreases the potential of contaminating objects and surfaces, as well as removing virus from hands after potential contact with viruses that have settled onto surfaces.
- D. **Avoid touching eyes, nose and mouth** with un-washed hands – hands that have not been washed can bring the virus into contact with the mucous membranes.
- E. **Wear a mask to cover nose and mouth** to limit transmission of the influenza virus.

- F. **Ask every unmasked person to wear a mask**, as tolerated. If mask cannot be tolerated, use tissue or cloth to cover the nose and mouth, especially when coughing or sneezing.

Because these recommendations have been developed in advance, the SFDPH will update the recommendations at the time of a pandemic based on the best epidemiologic information available at that time, and specifically will update any sections that are highlighted in yellow.

A. Identify and Isolate Confirmed or Suspected Cases

To reduce the transmission of any respiratory infections, including influenza, in healthcare settings, visual alerts (in appropriate languages) should be posted at entrances instructing patients and persons who accompany them to inform healthcare personnel of symptoms of a respiratory infection when they register for care.

1. Triage/Initial Assessment

- 1.1 Health care workers should don respiratory protection (an N95 or higher) mask prior to coming in close contact with symptomatic persons.
- 1.2 Offer a face mask to all symptomatic (fever, coughing and/or sneezing) persons including but not limited to patients, household members, visitors, etc. to wear if it can be tolerated. Otherwise, instruct the person to cover the mouth and nose with a tissue or cloth, especially when coughing and sneezing.
- 1.3 Place the symptomatic person in a single room or away from others if possible.
- 1.4 Otherwise, separate the symptomatic person at least 3 - 6 feet from others.
- 1.5 Hands must be washed or sanitized before and after caring for the patient.

2. Transporting Patient to an Acute Care Facility

- 2.1 Healthcare settings that do not provide in-patient care may need to transport the suspected or confirmed pandemic flu patient to an acute care facility.
- 2.2 The acute care facility should be notified prior to transfer of the patient so proper precautions can be taken at the receiving area of the acute care facility, **when feasible (this recommendation may change later in the course of a pandemic).**
- 2.3 Instruct the patient to wear a mask if tolerated. If not, ask the patient to cover the nose and mouth with a tissue during transport.
- 2.4 Unless medically indicated, do not remain in the same transport compartment with the patient. If the health care worker must stay with the patient, the

healthcare worker should don respiratory protection (of an N95 level of mask or higher) during transport.

- 2.5 Advise the patient's family members to ride in a separate vehicle if possible. Family members should ride in the same transport vehicle only for the health and well being of the patient (e.g. a dependent) and should don a mask when riding in the same vehicle.
- 2.6 If the vehicle doesn't have a separate ventilation system or separate compartments, turn up the ventilation system to the maximum in the transport vehicle.
- 2.7 Provide tissues for the coughing/sneezing patient to use, and a trash bag for disposal of tissues.
- 2.8 Instruct the patient to clean hands using hand sanitizer after coughing, sneezing or blowing the nose.
- 2.9 Transport vehicles that are soiled with respiratory secretion should be cleaned according to protocol prior to next use. Use diluted bleach or other disinfectant according to manufacturer's recommendation.
- 2.10 All trash can be discarded in the regular waste stream.
- 2.11 Healthcare workers hands must be cleaned at the end of the transport.

3. Patient Placement or Isolation

- 3.1 All persons suspected or confirmed to have pandemic influenza should not remain in a waiting room but should be taken immediately to an airborne isolation room if available. An airborne isolation room is a private room that at a minimum has: 1) monitored negative air pressure in relation to the surrounding areas; 2) 6 to 12 air changes per hour; and 3) appropriate discharge of air to the outdoors or monitored high-efficiency filtration of room air before the air is circulated to other areas in the hospital. Keep the door closed and place a sign on the door warning persons to check with staff prior to entering.
- 3.2 If an airborne isolation room is not available, place the patient in a private room with High Efficiency Particulate Air (HEPA) filtration unit. Keep the door closed and place a sign on the door warning persons to check with staff prior to entering.
- 3.3 If a private room with HEPA filtration is not available, place the patient in a private room at the end of the ventilation circuit. Keep the door closed and place a sign on the door warning persons to check with staff prior to entering.

- 3.4 If a private room at the end of the ventilation circuit is not available, place the patient in a private room. Keep the door closed and place a sign on the door warning persons to check with staff prior to entering.
- 3.5 If no private room is available, direct all persons suspected or confirmed to have pandemic influenza to sit as far away as possible (at least 3 - 6 feet) from others while wearing a mask. If masks are not available or are not able to be used, the person suspected or confirmed to have pandemic influenza should cover their mouth and nose with a tissue or other cloth as much as possible, especially when coughing or sneezing.
- 3.6 When resources are limited, consider re-prioritizing patients with other types of infectious diseases requiring a negative pressure airborne isolation room, consider converting a unit to "isolate" all the patients with a novel influenza strain where HVAC can be adjusted as needed, consider isolating one wing/ward, if available, to cohort these patients.

B. Control and Prevent Transmission

1. Hand Hygiene/Handwashing

- 1.1 At entrance points, post signs and instructions for everyone entering the facility to sanitize hands using alcohol based hand sanitizer. Ensure there are adequate numbers of hand sanitizer stations for the number of employees and visitors to the facility, and replace empty bottles as needed. For example, if the hand sanitizer bottles need to be replaced during a shift, more bottles may be needed.
- 1.2 Hand sanitizer should have at least 60% alcohol content in order to be effective.
- 1.3 Wash hands with soap and water or use hand sanitizer if hands are not visibly soiled after contact with persons suspected or confirmed to have pandemic influenza and/or environmental surfaces close to the person suspected or confirmed to have pandemic influenza. Ensure that adequate hand washing and/or alcohol hand sanitizer supplies are available throughout the facility.
- 1.4 Instruct those in contact with the person suspected or confirmed to have pandemic influenza not to touch the mucous membranes of their own nose, eyes, or mouth with potentially contaminated hands.
- 1.5 Wash or sanitize hands **before**:
 - i) Having direct contact with patients
 - ii) Donning sterile gloves before sterile procedures
 - iii) Moving from a contaminated-body site (e.g. open wound, mucus membranes, or a body site with blood or body fluids on it) to a clean-body site during patient care
 - iv) Moving from one patient to another
 - v) Eating

- 1.6 Wash or sanitize hands **after**:
- i) Contact with the patient's blood, body fluids, secretions or excretions, mucous membranes, skin, wound dressings
 - ii) Removing gloves
 - iii) Removing other Personal Protective Equipment such as masks, gowns, etc.
 - iv) Using a restroom or assisting a person using the restroom or diapering
- 1.7 When resources are limited, consider allowing staff to bring in their own cloth towels and soap or providing personal bar soap and personal cloth towels for hand drying. Or, staff may carry a bottle of hand sanitizer for personal use.

2. Masks

- 2.1 Healthcare workers should wear an N95 mask or higher level of respiratory protection when entering the room and caring for a person suspected or confirmed to have pandemic influenza.
- 2.2 Asymptomatic visitors must wear a face mask while in the healthcare facility. Visitors must be kept to a minimum and be allowed only for the health or well-being of the patient. Symptomatic visitors who do not require healthcare services should not be allowed in the facility unless authorized by the healthcare team. Symptomatic visitors who are allowed in the facility must wear a face mask at all times.
- 2.3 For aerosol generating procedures such as intubation and bronchoscopy, use of a powered air purifying respirator (PAPR) is recommended if available, if such procedures cannot be avoided or postponed. All visitors and non-essential personnel must leave the room during the performance of aerosol generating procedure. PAPR must be cleaned and disinfected after use according to the manufacturer's recommendation. When a PAPR is not available, then respiratory protection of at least N95 level should be used.
- 2.4 When resources are limited, consider extending use of N95 masks where feasible, or use a shield over the mask to minimize splattering or splashing of fluids so the mask may be re-used.

3. Respiratory Hygiene/Cough Etiquette

- 3.1 Post visual alerts in appropriate languages at the entrance to healthcare facilities (e.g. emergency departments, physician's offices, outpatient clinics) instructing all patients and the persons accompanying them to inform healthcare personnel when they first register for care about symptoms of a respiratory infection (fever, cough, sore throat or shortness of breath).

- 3.2 If not already done, instruct those suspected or confirmed to have pandemic influenza, and their companions, to wear a face mask over their nose and mouth at all times while in a healthcare setting if the person is able to tolerate wearing a mask, or until the person is placed in an airborne isolation room (if possible), and told by the staff that it is safe to remove the mask.
- 3.3 Instruct persons with cough to use tissues to contain respiratory secretions and discard them in the nearest lined waste receptacle if they cannot tolerate a mask. Persons should sneeze into a tissue and then discard and clean hands.
- 3.4 Patients and/or healthcare workers should wash or sanitize hands after having contact with respiratory secretions and contaminated objects/materials.
- 3.5 Provide no-touch trash containers to dispose of items contaminated with respiratory secretions such as tissues or used masks.
- 3.6 When resources are limited, consider using tissue or a cotton cloth such as a handkerchief to cover patient's/visitor's mouth and nose. The number of healthcare workers required to have contact with the patient should be kept to a minimum. Refer to Pandemic Flu PPE Options document on suggestions on re-using and/or extending the use of masks, or the **Improvised Masks document (not yet available)** during shortages.

4. Gloves

- 4.1 Wear disposable gloves (clean, non-sterile gloves are adequate) when entering the room of persons suspected or confirmed to have pandemic influenza.
- 4.2 Instruct individuals in contact with persons suspected or confirmed to have pandemic influenza not to touch the mucous membranes of their own nose, eye or mouth with potentially contaminated hands.
- 4.3 Change gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms.
- 4.4 When wearing gloves and working on multiple sites on the same patient, start work with the least contaminated or soiled areas first. Then work toward the most contaminated areas last while changing gloves and washing hands with soap and water in between each area. Hand sanitizer may be used, if hands are not visibly soiled.
- 4.5 Wear gloves when handling waste, soiled linen and laundry (e.g., bedding, towels, personal clothing).
- 4.6 If a gown is worn, gloves should cover the cuffs.

- 4.7 Remove gloves and clean hands before touching non-contaminated items and surfaces.
- 4.8 Remove gloves and wash hands with soap and water or use hand sanitizer if hands are not visibly soiled before leaving the room. Or, clean hands after leaving the room if sink/sanitizer is available immediately outside room.
- 4.9 After glove removal and hand washing, ensure that hands do not touch potentially contaminated environmental surfaces or items in the patient's room to avoid transfer of microorganisms to other patients or environment.
- 4.10 When resources are limited, consider using other means to create a barrier/protection for the hands, for example, using plastic bags, minimizing the use of gloves when there is no direct contact with blood or body fluids and washing hands immediately after contact, or using the same pair of gloves on the same patient working in order from clean to contaminated to dirty areas.

5. Eye Protection/Face Shield

- 5.1 Eye protection (face shields or goggles) should be worn when in direct face to face contact with a person suspected or confirmed to have pandemic influenza or their environment to protect mucous membranes of the eyes from direct transmission of the virus onto the eye or from indirect transmission from a contaminated hand touching the eye.
- 5.2 If goggles are used, they should fit snugly (but comfortably) around the eyes.
- 5.3 For aerosol-generating procedures (e.g. nebulizer treatments, intubation), a face shield may be worn over goggles and N95 to protect exposed areas of the face but should not be worn as a primary form of eye protection for these procedures. When PAPRs are available, it is assumed that a face shield is part of the design.
- 5.4 When resources are limited, consider assigning each health care worker needing eye protection one eye protection/face shield, consider postponing non-emergency procedures where the use of eye protection is necessary.

6. Gowns and Protective Apparel

- 6.1 Wear a gown (a clean, non-sterile, disposable gown that fully covers the front torso and arms and ties in the back is adequate) when entering the room if contact with the patient, environmental surfaces, or items in the patient's room is anticipated.
- 6.2 Select a gown that is appropriate for the activity and amount of fluid anticipated.
- 6.3 Remove the gown and wash hands with soap and water or use hand sanitizer if hands are not visibly soiled before leaving the patient's environment.

- 6.4 After gown removal, ensure that clothing does not contact potentially contaminated environmental surfaces to avoid transfer of microorganisms to other patients or environment.
 - 6.5 When resources are limited, consider using plastic coverings such as garbage bags to protect clothing from gross contamination by blood and body fluids. Discard in trash followed by hand hygiene.
 - 6.6 When resources are limited, consider re-using gown by leaving the used gown inside the patient room. Gown should be hung with the inside surface away from the patient. Avoid touching the inside surface with un-cleaned hands.
- 7. Cleaning and Disinfection of the Environment**
- 7.1 Environmental services personnel should wear N95 or above level of respiratory protection, gloves, gown and eye protection as indicated in this document when within 6 feet of by patients with a confirmed or suspected pandemic flu cases while cleaning rooms. (See Attachment A for sequence of donning PPE.)
 - 7.2 Keep cleaning supplies outside the patient's room and bring only what is needed for the task.
 - 7.3 Consider using a checklist (see sample Attachment C) to promote accountability for the thoroughness of cleaning.
 - 7.4 Clean and disinfect patients' rooms at least daily and more often when visible soiling or visible amounts of respiratory sections are seen, or when gross contamination occurs.
 - 7.5 Give special attention to frequently touched surfaces (e.g., bedrails, bedside and over-bed tables, TV control, call button, telephone, lavatory surfaces including safety/pull-up bars, doorknobs, commodes, ventilator surfaces) and equipment in the immediate vicinity of the patient, in addition to floors and other horizontal surfaces.
 - 7.6 Environmental services personnel should perform all routine and additional cleaning with an EPA-approved disinfectant. Alternatively when an EPA-approved disinfectant is unavailable, use regular bleach by adding 1 part of bleach to 9 parts of water, made up fresh daily or before use.
 - 7.7 If use of carpeted rooms cannot be avoided, steam cleaning should be done on a routine basis and when the carpet becomes soiled. Cleaning personnel should wear the recommended Personal Protective Equipment (PPE) that was noted for other healthcare personnel in this section. When steam cleaning carpet, it is preferred that the room is empty, remove as much furniture as possible, do it at

the end of the shift and allow sufficient time for the carpet to dry before resuming use.

- 7.8 Remove trash from the room at the end of cleaning. See section on Trash/Waste Disposal.
- 7.9 Remove and discard mask, gloves, gown and eye protection (if disposable) upon leaving the patient's environment in the order noted in Attachment B – Removing of PPE. Wash hands with soap and water.
- 7.10 Environmental services personnel should be trained in proper procedures for the use and removal of PPE and on the importance of hand hygiene. See Appendices A and B for the donning and removing of PPE.

8. Patient-care Equipment and Personal Articles

- 8.1 When possible, dedicate the use of non-critical patient-care equipment (such as stethoscopes, disposable blood pressure cuff, thermometers, etc.) to a single person suspected or confirmed to have pandemic influenza to avoid sharing between patients.
- 8.2 If use of common equipment or items is unavoidable, then adequately clean and disinfect them according to the manufacturer's recommendation before use on another patient (e.g. use alcohol pad to wipe the diaphragm of the stethoscope after use on one patient and before using it on another patient).
- 8.3 Keep areas around the patient free of unnecessary supplies and equipment to facilitate cleaning.
- 8.4 Patient-care equipment such as IV poles, walkers, etc. should be cleaned, disinfected and/or sterilized after use as per the manufacturer's recommendations.

9. Patient Dishes, Glasses, Cups & Eating Utensils

- 9.1 Wear disposable gloves (clean, non-sterile gloves are adequate) when handling used patients' trays, dishes, and utensils.
- 9.2 Wash reusable dishes and utensils in dishwasher with recommended water temperature and detergent.
- 9.3 Use of disposable plates and cups is not necessary.
- 9.4 When gloves are in limited supply, wear reusable utility gloves to pick up used food trays

10. Patient Laundry and Linen

- 10.1 Bring only as much clean linen into the room as needed for use for the shift.
- 10.2 Wear mask, gloves, and gown as needed, when directly handling soiled linen and laundry (e.g., bedding, towels, personal clothing).
- 10.3 Do not shake or otherwise agitate soiled linen and laundry in a manner that might aerosolize infectious particles.
- 10.4 Wash and heat dry laundry in the usual manner according to protocol.
- 10.5 Wash hands with soap and water or use hand sanitizer if hands are not visibly soiled after removing gloves that have been in contact with soiled linen and laundry.

11. Patient Trash/Waste Disposal

- 11.1 Wear N95, disposable gloves, gown, and eye protection when removing waste from the patient's environment. Remove and discard (if disposable) PPE upon leaving the patient's room in the order noted in Attachment B – Removing of PPE.
- 11.2 Wear disposable gloves when handling waste.
- 11.3 Dispose of trash in the usual manner according to protocol.
- 11.4 Wash hands with soap and water or use hand sanitizer if hands are not visibly soiled after removal of gloves.

12. Patient Transport within the Healthcare Facility

- 12.1 Limit the movement and transport of the person suspected or confirmed to have pandemic influenza outside the isolation room for medically necessary purposes only.
- 12.2 If transport or movement is necessary, ensure that the person suspected or confirmed to have pandemic influenza wears a face mask, puts on a clean patient gown, and washes hands with soap and water or uses hand sanitizer if hands are not visibly soiled before leaving the room and has tissues available for respiratory secretion containment during transport.
- 12.3 If a mask cannot be tolerated (e.g., due to the patient's age or deteriorating respiratory status), apply the most practical measures to contain respiratory secretions such as covering the mouth and nose with tissues or cloth.

Transporters of patients suspected or confirmed to have pandemic influenza should wear an N95 mask.

- 12.4 Inform the receiving area of the patient's isolation status and the estimated arrival time in advance if possible.
- 12.5 Limit contact between persons suspected or confirmed to have pandemic influenza and others by using less traveled hallways and elevators when possible. Exclude non-essential personnel/visitors from riding in the same elevator.

13. Visitors

- 13.1 Restrict asymptomatic visitors to a minimum except for the health and well being of the patient. Symptomatic visitors should not be allowed to visit unless authorized by the healthcare team.
- 13.2 Instruct all visitors about Hand Hygiene strategies, Respiratory Hygiene/Cough Etiquette, Standard, Contact, and Airborne precautions, and Eye Protection, and on the use of Personal Protective Equipment as detailed in this section and on the proper donning and removal of PPE. See Appendices A and B for the donning and removing of PPE.
- 13.3 Visitors who are the main care givers of the patient should be offered **FDA approved N95 (for use by the general population)** if available at all times while remaining in the patients' room. If N95s are not available, patients should wear a surgical mask if tolerated, and visitors should be also wear a surgical or procedure mask. Care givers should be instructed by hospital personnel to wear a surgical mask to contain their own secretions to limit asymptomatic spread of infection while in the healthcare setting, as all members of the public will be instructed to do the same when outside the home. The number of main care givers should be kept to a minimum and there should only be one designated caregiver at any given time. Care givers are those people who are expected to stay with the patient for prolong periods of time, most often with dependent persons, such as a child who needs a parent present or an adult who requires assistance with activities of daily living. When there are shortages of PPE, they should be prioritized for caregivers over other types of visitors.
- 13.4 Instruct all visitors to wear disposable gloves (clean, non-sterile gloves are adequate) when entering the room of persons suspected or confirmed to have pandemic influenza.
- 13.5 Instruct all visitors to remove gloves and wash hands with soap and water or use hand sanitizer if hands are not visibly soiled before leaving the room or immediately after leaving the room if an anteroom with sink is available.

- 13.6 Instruct visitors in contact with persons suspected or confirmed to have pandemic influenza not to touch the mucous membranes of their own nose, eye or mouth with potentially un-cleaned hands or gloved hands.
- 13.7 Ensure other visitors who are not main caregiver to wear a face mask when entering the room of a person suspected or confirmed to have pandemic influenza and to ensure that the mask covers the nose and mouth. Other visitors should stay 6 feet away from the patient, and the patient should wear a surgical mask if tolerated. **Consult SFDPH on latest information/guidance on respiratory protection for visitors other than main care giver.**
- 13.8 Instruct all visitors to wear a gown (a clean, non-sterile gown that fully covers the front torso and arms and ties in the back is adequate) when entering the room.
- 13.9 Instruct all visitors to remove the gown and wash hands with soap and water or use hand sanitizer if hands are not visibly soiled before leaving the patient's environment.
- 13.10 After gown removal, instruct all visitors to ensure that clothing does not contact potentially contaminated environmental surfaces to avoid transfer of microorganisms to other patients or environments.
- 13.11 Instruct all visitors to wear eye protectors (face shields or goggles) when in direct face to face contact with a person suspected or confirmed to have pandemic influenza or their environment to protect mucous membranes of the eyes from direct transmission of the virus onto the eye or from indirect transmission from a contaminated hand touching the eye.
- 13.12 If goggles are used, they should fit snugly (but comfortably) around the eyes.
- 13.13 For aerosol-generating procedures (e.g. nebulizer treatments, intubation), all visitors and caregivers should be instructed to leave the room and to remove their PPE in accordance with Appendices A and B. Visitors who are later allowed to re-enter the room after the aerosol-generating procedure is completed should be instructed to put on a new set of PPE as noted in this section when supplies allow or to re-don PPE that is in short supply as per Attachment C.

14. Vaccination of Healthcare Workers against Seasonal Influenza

- 14.1 Healthcare Workers should be vaccinated with the most recent seasonal human influenza vaccine annually. This measure will reduce the likelihood of a healthcare worker being potentially co-infected with seasonal and pandemic strains, and may also prevent the healthcare worker from spreading the seasonal strain to patients. (See Prevention and Control of Influenza, MMWR July 13, 2007/56 (RR06); 1-54.)

15. Vaccination of Healthcare Workers against Pandemic Influenza


16. Surveillance and Monitoring of Health Care Workers

- 16.1 Health care workers with symptoms of influenza should stay home and follow SFDPH Public Health Severe Pandemic Influenza Infection Control Recommendations for Caring for Pandemic Influenza Infected Persons in the Home Setting, unless an alternative diagnosis is established or diagnostic tests are negative for novel influenza.
- 16.2 Unprotected health care workers who had significant exposure without the use of PPE to anyone ill with or suspected to have a novel influenza strain may be asked to stay home and follow SFDPH Public Health Severe Pandemic Influenza Recommendations for Care of Exposed Persons in the Home Setting (up to 2 incubation periods) early in the course of a pandemic, or may be asked to work in cohorted groups with other exposed workers.
- 16.3 Instruct health care workers to be vigilant for the development of fever (i.e., measure temperature daily and as needed before reporting to work) or other respiratory symptoms for 10 days after the last exposure to a suspected or confirmed pandemic influenza patient. Attachment D is a sample of a monitoring tool.
- 16.4 Health care workers who become ill outside of work should follow SFDPH instructions on how to seek medical care if their condition deteriorates and notify their health care provider that they may have been exposed to pandemic influenza prior to being evaluated. In addition, employees should notify Occupational Health and Infection Control Personnel, and/or other appropriate departments at their facility.
- 16.5 Healthcare workers who become ill at work should notify their supervisor immediately and follow hospital procedure to be evaluated by the occupational health service (OHS). Inform the OHS prior to arrival of any contacts with patients with pandemic influenza. OHS may do telephone triage and send the HCW home accordingly.

16. Hygiene for Health Care Workers (to be added later)

ATTACHMENT A





Sequence for Donning Personal Protective Equipment

SEQUENCE FOR DONNING PERSONAL PROTECTIVE EQUIPMENT (PPE)	SECUENCIA PARA PONERSE EL EQUIPO DE PROTECCIÓN PERSONAL (PPE)
<p>The type of PPE used will vary based on the level of precautions required; e.g., Standard and Contact, Droplet or Airborne Infection Isolation.</p> <p>1. GOWN</p> <ul style="list-style-type: none"> Fully cover torso (gown neck to knees, arms to end of wrists, and wrap around the back) Fasten in back of neck and waist <p>2. MASK OR RESPIRATOR</p> <ul style="list-style-type: none"> Secure ties or elastic bands at middle of head and neck Fit flexible band to nose bridge Fit snug to face and below chin Fit checked respirator <p>3. GOGGLES OR FACE SHIELD</p> <ul style="list-style-type: none"> Place over face and eyes and adjust to fit <p>4. GLOVES</p> <ul style="list-style-type: none"> Extend to cover wrist of isolation gown 	<p>El tipo de PPE que se debe utilizar depende del nivel de precaución que sea necesario; por ejemplo, equipo estándar y de Contacto o de Aislamiento de Infecciones Invasoras por Gota o por Aire.</p> <p>1. BATA</p> <ul style="list-style-type: none"> Cubra con la bata todo el torso desde el cuello hasta las rodillas, los brazos hasta la muñeca y débale alrededor de la espalda Alinee por detrás a la altura del cuello y la cintura <p>2. MÁSCARA O RESPIRADOR</p> <ul style="list-style-type: none"> Asegure los cordones o la banda alta en la mitad de la cabeza y en el cuello Ajuste la banda flexible en el puente de la nariz Acomódela en la cara y por debajo del mentón Verifique el ajuste del respirador <p>3. GAFAS PROTECTORAS O ORBITAS</p> <ul style="list-style-type: none"> Colóquelas sobre la cara y los ojos y ajústelas <p>4. GUANTES</p> <ul style="list-style-type: none"> Extienda los guantes para que cubran la parte del puño en la bata de aislamiento
<p>USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION</p> <ul style="list-style-type: none"> Keep hands away from face Limit surface touched Change gloves when torn or heavily contaminated Perform hand hygiene 	<p>UTILICE PRÁCTICAS DE TRABAJO SEGURAS PARA PROTEGERSE A SÍ MISMO Y LIMITAR LA PROPAGACIÓN DE LA CONTAMINACIÓN</p> <ul style="list-style-type: none"> Mantenga las manos alejadas de la cara Limite el contacto con superficies Cambie los guantes si se rompen o están demasiado contaminados Realice la higiene de las manos

<http://www.cdc.gov/ncidod/sars/pdf/ppeposter148.pdf>

ATTACHMENT B

Sequence for Removing Personal Protective Equipment

SEQUENCE FOR REMOVING PERSONAL PROTECTIVE EQUIPMENT (PPE)	SECUENCIA PARA QUITARSE EL EQUIPO DE PROTECCIÓN PERSONAL (PPE)
<p>Except for respirator, remove PPE at doorway or in anteroom. Remove respirator after leaving room with nose and closing door.</p> <p>1. GLOVES</p> <ul style="list-style-type: none"> Outside of gloves is contaminated Grasp outside of glove with opposite gloved hand; peel off Hold removed glove in gloved hand Slit de fingers of ungloved hand under remaining glove at wrist Peel glove off over first glove Discard gloves in waste container  <p>2. GOGGLES OR FACE SHIELD</p> <ul style="list-style-type: none"> Outside of goggles or face shield is contaminated To remove, handle by head band or ear pieces Place in designated receptacle for reprocessing or in waste container  <p>3. GOWN</p> <ul style="list-style-type: none"> Gown front and sleeves are contaminated Unfasten ties Roll away from neck and shoulders, touching inside of gown only Turn gown inside out Fold or roll into a bundle and discard  <p>4. MASK OR RESPIRATOR</p> <ul style="list-style-type: none"> Front of mask/respirator is contaminated — DO NOT TOUCH! Grasp bottom, free top ties or elastic and remove Discard in waste container 	<p>Con la excepción del respirador, quítete el PPE en la entrada de la puerta o en la antecámara. Quítate el respirador después de salir de la habitación de pacientes y de cerrar la puerta.</p> <p>1. GUANTES</p> <ul style="list-style-type: none"> El exterior de los guantes está contaminado! Agarre la parte exterior del guante con la mano opuesta en la que todavía tiene puesto el guante y quítelo Sostenga el guante que se quitó con la mano enguantada Deslice los dedos de la mano sin guante por debajo del otro guante que no se ha quitado todavía a la altura de la muñeca Quítelo el guante de manera que acabe cubriendo al primer guante Arroje los guantes en el recipiente de desechos <p>2. GAFAS PROTECTORAS O OJERA</p> <ul style="list-style-type: none"> El exterior de las gafas protectoras o de la ojera está contaminado! Para quitarlas, tómelas por la parte de la banda de la cabeza o de las piezas de las orejas Colóquelas en el recipiente designado para reprocessar materiales o de materiales de desecho <p>3. BATA</p> <ul style="list-style-type: none"> La parte delantera de la bata y las mangas están contaminadas! Desate los cordones Si puedes, sujétate el interior de la bata, pásala por encima del cuello y de los hombros Volvete la bata al revés Dóblala o enróllala y deséchala <p>4. MÁSCARA O RESPIRADOR</p> <ul style="list-style-type: none"> La parte delantera de la máscara o respirador está contaminada — ¡NO LA TOQUE! Primero agarre la parte de abajo, luego los cordones o banda elástica de arriba y por último quítete la máscara o respirador Arrojela en el recipiente de desechos
PERFORM HAND HYGIENE IMMEDIATELY AFTER REMOVING ALL PPE	EFECTÚE LA HIGIENE DE LAS MANOS INMEDIATAMENTE DESPUÉS DE QUITARSE CUALQUIER EQUIPO DE PROTECCIÓN PERSONAL

<http://www.cdc.gov/ncidod/sars/pdf/ppeposter148.pdf>

ATTACHMENT C

Sample Checklist for Cleaning Patient Room

- Gather all supplies, make sure disinfectant is of proper dilution
- Don PPE prior to entering the patient's room
- Leave a "Caution – wet floor" sign by the door
- Check all hand washing sinks to ensure there is at least ¼ bottle of soap and fill up paper towel dispenser
- Check hand sanitizer dispenser to ensure there is at least ¼ bottle remaining
- Perform high dusting (if patient is not in the room) using a damp cloth with disinfectant,
 - TV if it is hanging from the ceiling,
 - Over the bed light fixture,
 - Other overhead items
- Wipe all horizontal and/or high-touch surfaces using a damp cloth with disinfectant
 - Side table
 - Bedside table, can swing over the bed
 - IV pole
 - Bed rails
 - Door knobs
 - TV remote control
 - Call button
 - Telephone
 - Bedside commode handrails
 - Walker handrails
 - Patient-controlled analgesia IV device
- Clean the hand washing sink
 - Discard any paper towels that are not in the dispenser
- Clean the bathroom using damp cloth with disinfectant
 - Discard any toilet papers that is not in the dispenser
 - Restock toilet paper
 - Wipe safety/pull up bar
 - Wipe doorknobs
 - Wipe down the side rail by the toilet
 - Wipe down the toilet seat
 - Clean the toilet bowl
 - Wipe the sink hot and cold water tap handles
 - Wipe the light switch
- Sweep the floor
 - Bathroom floor
 - Patient area
- Remove all garbage and leave by the door
 - From bathroom and reline trash can

- From patient area and reline trash can
- Wet mop the floor and let it air dry
 - Bathroom floor
 - Patient area
- Bring all supplies and garbage outside of patient's room
- Remove all PPE
- Wash hands

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2. If you develop any of the above symptoms while not working, contact your medical provider and call the 24 Hour Contact Number to report symptoms. Do NOT report to work until cleared by your medical provider.
3. If no symptoms develop by the last day of monitoring, please return this sheet to your Supervisor.
4. This form may be reproduced or it can be downloaded at: <http://www.sfcdep.org/pandemicflu.cfm>

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Pandemic Influenza FAQ



SAN FRANCISCO CITY & COUNTY PREPAREDNESS

1. What is San Francisco doing to prepare for pandemic influenza?

San Francisco agencies are closely monitoring avian influenza and preparing for a pandemic in our region. A San Francisco City Department Avian/Pandemic Influenza Task Force is coordinating planning to ensure a multi-disciplined approach to continuity of operations. The health department is also reaching out to hospitals and clinicians, front line workers, businesses, organizations that meet the needs of special populations, and the general public. See our website for more information: www.sfdph.org/cdcp

2. Why is San Francisco preparing for pandemic influenza?

An influenza pandemic is a unique type of emergency. A pandemic has the potential to cause illness in a very large number of people which could overwhelm the health care system and cause high levels of absenteeism in every workforce including community services. A pandemic, could last from several months to two years with periods of illnesses increasing and decreasing sporadically.

3. Is San Francisco prepared to deal with the first human case?

Yes. City Departments are developing coordinated pandemic influenza plans to respond to one or many human cases. Health advisories with instructions for diagnosing, reporting, and treating patients have been sent to San Francisco clinicians, the health department's disease control team has been trained to evaluate suspect cases, and our public health lab is prepared to do initial testing for avian influenza.

4. Is the San Francisco Health Department's pandemic flu plan available to the public?

The Health Department is in the process of finalizing an existing pandemic flu plan which will be followed by a review process. The plan should be available to the general public by Fall 2007.

5. Who has the authority to declare a public health emergency?

The local health officer has broad powers to address a pandemic influenza emergency. Under California law, a local health officer who believes a contagious, infectious or communicable disease exists within the territory under his or her jurisdiction "shall take measures as may be necessary to prevent the spread of the disease or occurrence of additional cases" and to protect the public's health (California Health and Safety Code Section 120175).

6. Will bay area public health department responses be coordinated?

San Francisco is part of the Bay Area Regional Emergency Planning Project, bringing together 10 counties and 3 major cities to coordinate planning and response efforts for a variety of hazards. In addition, California uses the Standardized Emergency Management System (SEMS) for disaster preparedness and response. The California Office of Emergency Services uses SEMS to facilitate mutual aid among cities and counties by defining a standard approach to requesting and sharing resources among jurisdictions.

7. How will the city share real time information?

During a pandemic real time information will be made available through press conferences, press releases to newspapers, TV stations, and radio, on our website (www.sfdph.org/cdcp), and through an information line (415-554-2905). Hospitals, clinics, and clinicians will receive Health Alerts with diagnosis, reporting, and treatment guidelines through emergency systems (e.g. EM System, Blast Fax, CAHAN). Information for the public will be coordinated through the Joint Information Center.

8. Will a quarantine be declared or isolation required?

A quarantine is when healthy people who have been around an infected person are asked to stay in one place. During the early stages of a pandemic, when there are just a few clusters of disease, some exposed people may be asked to remain in home quarantine for the time period required for symptoms to develop. The Health Department will most likely request that sick people remain in home isolation until they are symptom free. Sick people who must leave their home to visit a doctor will be asked to wear a mask.

9. Will public gatherings be canceled?

Some public gatherings may be postponed during a pandemic.

10. Will San Francisco public schools be closed during a pandemic?

Schools may close for short periods of time to slow the spread disease.

11. Will City Departments (e.g. transportation, police, and fire) be providing services during a pandemic?

Maintaining San Francisco city services is a priority during a pandemic. However, city departments may experience employee shortages due to ill staff. If so, city departments will operationalize emergency plans and prioritize essential services first. Standard services may be less regular than usual. Every effort will be made to notify the public of service changes.

12. Will hospitals be able to provide care for sick patients during a pandemic?

All San Francisco hospitals have surge capacity plans to deal with patient overflows. However, during a pandemic the Health Department may ask that non-essential health procedures be postponed and that individuals with mild illness recuperate at home. Family and community members may need to provide help to sick individuals if hospital bed space is limited.

13. Does San Francisco have a stockpile of masks or other protective equipment?

All San Francisco hospitals have stockpiles of masks and other personal protective equipment for health care practitioners. San Francisco has a stockpile of masks for emergency responders who would be in direct contact with sick or exposed people.

14. What can I do now?

Learn more about avian and pandemic influenza, how to prevent the spread of disease, and what to prepare for an emergency. Consider keeping a home supply of hand sanitizer and surgical masks. For details see: www.sfdph.org/cdcp and www.72hours.org.

This fact sheet will be updated as additional information is available.

Avian Influenza (Bird Flu)



FREQUENTLY ASKED QUESTIONS

What is the current avian influenza situation?

At this time avian influenza (H5N1), also known as bird flu, is a disease of wild birds and domesticated poultry like farm chickens, ducks, and turkeys. Although millions of birds have been infected, only a very small number of people have been infected (see www.sfdph.org/cdcp for exact numbers). Because all influenza viruses have the ability to change there is concern that the H5N1 virus could mutate and be spread easily and widely by humans. If that happens, it is possible that a pandemic or widespread outbreak of disease could occur. World health organizations and the San Francisco Department of Public Health are monitoring the situation and making plans to control avian influenza.

What is the difference between avian influenza and pandemic influenza?

A pandemic influenza occurs when a new influenza virus: 1) develops and there is little or no immunity (protection due to previous infection or vaccination) in the human population; 2) it is easily passed from human to human; 3) is found in many countries; and, 4) causes serious illness in humans. Presently avian influenza (H5N1) is not a pandemic influenza because it is mostly a disease of birds and is not easily passed between humans.

Is there avian influenza in the U.S. now?

No. Avian influenza has not been found in wild birds, domestic poultry, or humans in the United States.

How can a person get avian influenza?

Avian influenza is not easily passed from birds to humans. People may get avian influenza by touching an infected bird, fluid or surfaces contaminated with fluids from infected birds and then touching their eyes, nose, or mouth. People who could be at risk in the US are those who travel to countries with outbreaks of avian influenza and have close contact with live or improperly cooked poultry while there.

Can I get avian influenza from eating chicken or other poultry?

Thoroughly cooked poultry cannot infect someone with the virus. Avoid eating uncooked pink chicken or runny yolks. The U.S. does not import poultry except for a small amount from Canada. When cooking it's always good practice to wash your hands, surfaces, and cutlery after handling raw poultry products, including eggs to kill germs.

What can I do to prevent catching avian influenza?

When traveling to areas reporting avian flu outbreaks avoid direct contact with poultry, wild birds, farms, and live-animal markets. Avoid touching surfaces contaminated with poultry feces (droppings) or secretions and only eat well-cooked poultry. Wash your hands regularly and avoid touching your eyes, nose, and mouth.

What are the symptoms?

Individuals with avian influenza (H5N1) usually develop symptoms within 10 days of contact with infected birds, became very ill, and required hospitalization. Symptoms are usually severe and include high fever, muscle aches, cough, mucus production and shortness of breath. Abdominal pain and diarrhea can also occur.

Is it safe to travel to countries where avian influenza has been detected?

Yes. Follow the safety measures above. If you have contact with birds and develop symptoms within 10 days of close contact, call your doctor and let him/her know about your travels and contact with birds.

Is there an avian influenza vaccine?

No. A vaccine for humans is being developed. It is expected that if avian influenza becomes easily passed between humans a vaccine could be available within 4-6 months. There is now a vaccine for birds which is being used on domestic poultry in areas that have infected birds.

Is there a treatment?

No. There is no known treatment right now. Research is being done to identify the effectiveness of medications like oseltamavir (Tamiflu) and zanamavir (Relenza). If an outbreak occurs in our region, treatment recommendations will be made based on the most current information. Local and national stockpiles will be used to get the right medications, as available, to infected people and their close contacts.

Should I avoid chickens and other birds in San Francisco?

No. Birds are not a risk to people in San Francisco at this time. There is no avian influenza in chicken flocks, other domesticated birds, and wild birds in the U.S. If avian influenza is found in the U.S. additional guidance will be posted.

What should I do if I see a dead bird?

Avoid touching dead birds with your bare hands. Use gloves or an inverted plastic bag to place the dead bird in a garbage bag. Throw it away with your regular garbage. (To report a dead bird for West Nile Virus testing in California call: 1-877-WNV-Bird).

What is San Francisco doing to prepare for avian influenza?

The San Francisco Department of Public Health has created an Avian/Pandemic Flu Task Force for all city agencies. This group works to ensure that all city departments and agencies have well-developed and coordinated plans to address a pandemic influenza situation. We are working to ensure that our hospitals and clinicians are educated about pandemic flu and know how to care for infected patients. We also provide information on our website www.sfdph.org/cdcp and our avian influenza information line (415) 554-2905.

This fact sheet will be updated as the situation changes and additional information is available.

Updated October 19, 2006

WHAT HAPPENS WHEN YOU REPORT A DISEASE

The Communicable Disease Control Unit maintains a reporting telephone line to respond to clinician infectious disease reports 24 hours a day, 7 days a week. There are over 80 legally reportable diseases and conditions in San Francisco. Certain critical diseases must be reported within one hour to the Department of Public Health while others require same day notification or notification within one week. See the list of legally reportable diseases in the “What to Report” section.

After we receive an infectious disease report we immediately take action to protect the health of San Franciscans and our visitors.

HOW WE RESPOND TO

INFECTIOUS DISEASE REPORTS....

**COMMUNICABLE DISEASE
REPORTING**

Urgent Reports 24/7

☎ (415) 554-2830

After hours, follow prompts to page the on-call physician

Non-Urgent Reports

☎ (415) 554-2830
☎ (415) 554-2848 fax
✉ cdcontrol@sfdph.org
📍 101 Grove Street, Room 408
San Francisco, CA 94102

✓ INVESTIGATION

- **Case Investigation.** Interview cases and clinicians to identify risk factors and other potential contacts. Evaluate patients/contacts in sensitive occupations or settings that may pose a public health concern (e.g. food handlers, daycare attendees, health care workers or employees of group residential facilities).
- **Source Investigation.** Conduct an epidemiologic investigation to identify the source of infection and how it is being spread.
- **Lab Testing.** Provide guidance on obtaining lab tests to confirm diagnosis. Facilitate approvals for obtaining specialized tests performed at city, state, or federal public health labs.

✓ INFECTION CONTROL

- **Recommendations.** Work with infection control practitioners to recommend measures to control and prevent the spread of disease in health care settings.
- **Information & Education.** Provide information to cases, contacts, and the general public to prevent and control the spread of disease in community settings. In the event of an infectious disease emergency provide continued infection control guidance and recommendations.
- **State & National Notification.** Coordinate notification of state and national health officials and law enforcement, as necessary.

✓ TREATMENT RECOMMENDATIONS

- **Post-exposure & Preventive Treatment.** Assess the need for and recommend preventive treatments such as antibiotics and vaccines. In case of mass exposure to a treatable infectious agent, activate the local system for providing mass

✓ COMMUNICATION WITH CLINICIANS

- **Health Alerts.** Send Health Alerts, Advisories, and Updates to clinicians regarding infectious disease situations of public health concern.
- **Analysis of Surveillance Data.** Analyze and disseminate public health surveillance data to

treatment and/or prophylaxis.

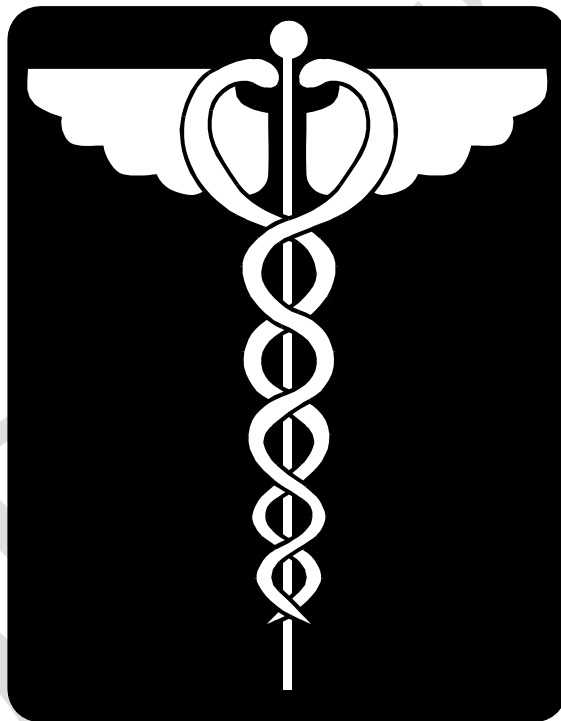
clinicians and the general public.

Federal Response Stages

Below is a table that maps the World Health Organization (WHO) pandemic phases to the U.S. federal response stages. For more detailed information for each of the federal response stages, including goals, actions, and policy decisions based on the outbreak situation and the risk posed to the U.S., see <http://www.pandemicflu.gov/plan/federal/fedresponsestages.html>

WHO Phases		Federal Government Response Stages	
INTER-PANDEMIC PERIOD			
1	No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk of human disease is considered to be low.	0	New domestic animal outbreak in at-risk country
2	No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human disease.		
PANDEMIC ALERT PERIOD			
3	Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.	0	New domestic animal outbreak in at-risk country
		1	Suspected human outbreak overseas
4	Small cluster(s) with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans.	2	Confirmed human outbreak overseas
5	Larger cluster(s) but human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible (substantial pandemic risk).		
PANDEMIC PERIOD			
6	Pandemic phase: increased and sustained transmission in general population.	3	Widespread human outbreaks in multiple locations overseas
		4	First human case in North America
		5	Spread throughout United States
		6	Recovery and preparation for subsequent waves

Exercise Contacts



**Day of Exercise Command Contacts
Not for Emergency Use**

Chinese Hospital
Exercise Coordinator: Stuart Fong
Command Center: Library
Exercise Phone: 677-2473
Exercise Fax: 217-4174

Kaiser Medical Center
Exercise Coordinator: Beverly Seyfert
Command Center: L140-2425 Geary Blvd
Exercise Phone: 833-9032
Exercise Fax: 833-3063

San Francisco General Hospital
Exercise Coordinator: Lann Wilder
Command Center: Conf Room 2A6
Exercise Phone: TBD
Exercise Fax: TBD

UCSF Medical Center
Exercise Coordinator: Robert Hunn
Command Center: 505 Parnassus – Rm M-169
Exercise Phone: 353-8666
Exercise Fax: 353-4221

Veteran's Affairs
Exercise Coordinator: Joe Johnson
Command Center: San Francisco VA Medical Center
Exercise Phone: 415-740-5255
Exercise Fax: 415-750-6686

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