

Glenn County Special Pathogens

Infectious Disease Emergency Response Plan (SPIDER)

Disease Detection, Investigation, and Mitigation

April 2017

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Record of Plan Approval & Update

Glenn County Public Health

Special Pathogens Infectious Disease Emergency Response Plan

The following signatories have agreed to the terms and conditions of this plan, which is subject to revision annually or more frequently as needed. This plan supersedes all previous plans.

Grinnell Norton, PHN, GCHHSA
Deputy Director, Public Health

Date

Jenifer Norris, PHN, GCHHSA-Public Health
Emergency Preparedness Program

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Amy Travis, MHOAC, Glenn County Sheriff's Office
Deputy Director, Office of Emergency Services


Date

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Glenn County Public Health


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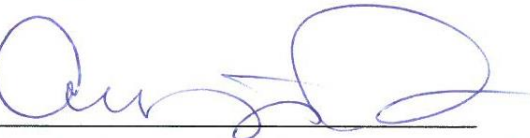
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4-10-2017
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4-10-2017
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Handling Information

The title of this document is the *Glenn County Special Pathogens Infectious Disease Emergency Response Plan (SPIDER)*. This Plan is an annex to the *Glenn County Public Health & Medical Emergency Operations Plan*.

1. The information gathered in this plan is classified as For Official Use Only (FOUO) and should be handled as sensitive information not to be disclosed. Reproduction of this document, in whole or in part, without prior approval from the Glenn County Health Department is prohibited.
2. This plan will be maintained and updated by Glenn County Medical-Health Emergency Preparedness (EP) Program staff. This plan will be maintained by EP program staff through annual reviews.
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Thank you to San Francisco Department of Public Health, the Bay Area Advanced Practice Center, Napa County HHS Division of Public Health, Kansas Department of Health & Environment, and Seattle-King County Public Health. This Plan is based on their research and templates provided to assist the greater community in preparedness.

Record of Changes

Date	Change #	Subject of Change	Initials
5-6-19	1-9	1. Added a "Record of Changes" page (pg.7) 2. Added Initial Threat Assessment Meeting (ITAM) as Appendix E 3. Added Glossary- as Section 9 4. Removed website links. 5. Clarified Epidemiologist's investigation tasks (pg.61) 6. Added a reference to Appendix B (pg. 67) 7. Added to the Community Containment Strategies (p.84) 8. Added reference to Appendix D (pg. 101) 9. Made Health Officer's name generic in Appendix B & C	L. Medina

Emergency Response Actions

Highly Infectious Disease

- Do you suspect that excess cases of naturally-occurring highly infectious disease, an unusual disease, or an intentional (e.g. bioterror) event may have occurred or may be occurring in your county?
 - **If yes, conduct an Initial Threat Assessment Meeting (ITAM) (Appendix E) and proceed with emergency response activities below**
- Determine the likelihood that the event was intentional (e.g. criminal/terror act)
 - **If intentional (BT) is suspected, contact Glenn County Sheriff's Office and FBI and activate at Level 3**
- Upon notification of suspect highly infectious disease, confirm that patient meets case criteria of including but not limited to symptomology, travel history, labs etc.
- If the case(s) is at a HCF, ensure the facility can:
 - Isolate the patient
 - Has access to and is using proper PPE
 - Sanitize all areas the patient had access to during visit
 - Complete lab draws on patient
 - Properly store lab specimens until PH Lab can pickup
- Immediate Notifications:**
 - Health Officer, HHS Director, PH Director, *(MHOAC, if not the activator)*
 - Regional Epidemiologist
 - Shasta County LRN Lab - *Request assistance with lab specimens when applicable*
 - LEMSA
 - RDMHS
 - CDPH DCDC Duty Officer
 - CDPH Duty Officer
 - EMSA Duty Officer:
 - MHCC (activated business hours)
 - Submit a Med-Health Situational Report (SITREP) to CDPH, EMSA & RDMHS within 2 hours
 - Glenn County Sheriff/OES
 - Cal-OES
- Activate and follow response guidance in the PH & Medical EOP**
 - *Refer to PH & Med EOP Sect. 4: Concept of Operations for response procedures*

Activate the Health DOC to manage operations

- Determine what PH staff should be immediately notified and deployed for assignment
 - Determine what PH staff can be notified & assigned the following business day
- Develop an ICS 201 Situation Briefing document
 - Begin ICS documentation on a 214 Unit Activity Log
 - Use ICS 211 form to check in response staff
- Staff DOC Manager, PIO, Safety Officer
- Staff sections:
 - Operations Chief: staff Epi & Surveillance Unit, Mass Prophylaxis Unit, Environmental Health Unit, Mental Health Unit
 - Plans Chief: incident action plans and situation reports for each operational period as well as maintain documentation
 - Logistics Chief: medical-health resource orders/needs
- Schedule a DOC staff briefing
 - Review current situation, IAP, job assignments and safety/PPE

Management/Command – Organize and manage response

- Coordinate with appropriate response partners
- Determine response organization
- Determine initial objectives
- Identify and recommend any control measures (isolation/quarantine, social distancing, etc.)
- If mass prophylaxis will be necessary, activate the SNS/Medical Countermeasures & Mass Prophylaxis Plan
- Identify any medical-health resource needs and request according to procedure
 - *See PH & Medical EOP Section 6: Resource Management*

PIO - Activate the CERC Plan and develop a media management plan

- Contact local law enforcement to notify of possible large media presence, request law enforcement on standby for assistance at hospital and health department
- Contact CDPH Public Affairs Office

MHOAC - Contact HCFs and EMS providers. Coordinate response.

- Contact HCFs and request a situation report (can be verbal)
- Identify needs of HCF based on current conditions & incident synopsis
- Ensure inpatient facilities have enough resources to maintain patient care for identified agent
- Identify any patient surge situations

Operations Section – CD & Epi Unit:

- Activate and follow the CD response procedures detailed in this Plan and JERP Plan
- Conduct case investigation and contact tracing

- ❑ **Operations Section – Environmental Health Unit**
 - Identify if any locations need to be contained and whether decontamination is necessary
 - If food-borne or environmentally caused, join Epi and Surveillance Unit
- ❑ **Operations – Mental Health Unit:**
 - Crisis counsellors available to assist family of patient, contacts in quarantine, response staff, and assist PIO with any mental health messaging
- ❑ **Operations – Care & Shelter Unit:**
 - When necessary, activate to assist with services to people in quarantine
- ❑ **Health Officer - Identify and recommend any control measures (isolation/quarantine)**
 - Employ Health Officer Authorities
- ❑ **Notify partners of plan activation, emergency operation center activations, and current situation via CAHAN or other approved method**
 - Local HCFs, Local responders, Region III Public Health Departments

SECTION 1: INTRODUCTION

Special Pathogens are highly infectious biological agents, including organisms such as bacteria, viruses or toxins, with the potential to cause significant illness or death in the population. The introduction of a special pathogen into population with little or no immunity would lead to an infectious disease emergency.

Infectious disease emergencies may include naturally occurring outbreaks (e.g., measles, mumps, meningococcal disease), emerging infectious diseases (e.g., SARS, avian influenza), and bioterrorism. The circumstances of infectious disease emergencies may vary by multiple factors, including type of biological agent, scale of exposure, mode of transmission and whether it was intentionally introduced (bioterrorism), and many others. Public health measures to contain such outbreaks are critical for diseases with high morbidity or mortality and limited medical prophylaxis and/or treatment.

Purpose

The purpose of the Special Pathogens Infectious Disease Emergency Response (SPIDER) Plan is to provide procedures for the identification, response, and containment of an infectious disease emergency in Glenn County.

Scope

This Plan outlines the procedure for a coordinated response to a highly infectious disease emergency. An infectious disease emergency will be urgent and may lead to an extensive public health and medical response that will exceed the Operational Area's normal disease control capacity. This plan does not include procedures for routine public health case management of communicable diseases.

This Plan is intended to be utilized during any infectious disease emergency that requires response that exceeds the department's normal disease control capacity. Some outbreaks or situations will require limited response activities while other situations will require large-scale operations and may expand to involve the region.

This Plan is an Annex to the Glenn County Public Health and Medical Emergency Operations Plan (EOP). It is to be utilized in conjunction with this overarching Plan as well as with other Glenn County and Region III response plans to include but not limited to:

- Public Health & Medical EOP
- N-E CA Joint Epidemiology Emergency Response Plan (JERP)
- Pandemic Influenza Emergency Response Plan

- Ebola Response Plan
- Smallpox Response Plan
- Medical Countermeasures and Mass Prophylaxis Plan (MCM/MP)
- Crisis Emergency Risk Communications Plan (CERC)
- Healthcare Surge Plan
- Mass Fatality Plan
- Operational Area Emergency Operations Plan (OA EOP)

Special Pathogens

Special pathogens represents diseases of high consequence; both high mortality and morbidity. They are highly infectious diseases and are often also highly contagious. Special Pathogens include but are not limited to the following:

- Category A Biological Agents
 - Anthrax (*Bacillus anthracis*)
 - Botulism (*Clostridium botulinum* toxin)
 - Plague (*Yersinia pestis*)
 - Smallpox (*Variola virus*)
 - Tularemia (*Franciscella tularensis*)
 - Viral Hemorrhagic Fever (Arenaviruses, Bunyaviruses, Ebola)
- Emerging infectious diseases
 - Severe Acute Respiratory Syndrome (SARS)
 - Middle East Respiratory Syndrome (MERS)
- Novel Influenza

In addition to special pathogens, large outbreaks of highly infectious disease in the community may lead to activation of this plan. Examples could include measles, meningitis, pertussis, etc.

Plan Organization

This Plan is organized to facilitate the development of an Incident Action Plan and assignment of tasks. It should efficiently transition into a plan for your response operations.

Response Activities, listed below, provide sequential steps to take in a response to highly infectious disease.

- Response Activities include detailed information critical to the response.
- Each Response Activity includes objectives that should be completed in your response.
- Detailed **Strategies and Tactics** to complete identified Objectives are included for critical Response Activities such as Detection- Surveillance and Investigation.
- **Tactics** should be provided to your CD & Epi Unit to act as a road map for completing critical tasks.

 *TIP – Use the Objectives and Strategies to write your Incident Action Plan.*

 *TIP - Use the Tactics as Job Aids for your staff in the field. Tactics are on blue paper.*

 *TIP – Activation pages are color coded.*

- *Use Green for Level 1 response*
- *Use Yellow for Level 2 response*
- *Use Pink for Level 3 response*

Response Activities

The Epidemiologic Response includes the following (often simultaneous) activities:

1. Initial Threat Assessment
2. Consultation & Confirmation
3. Activation
4. Notification
5. Response Organization
6. Detection - Surveillance
7. Investigation
8. Mitigation
9. Recovery and Demobilization

SECTION 2: ASSESSMENT & ACTIVATION

Initial Threat Assessment

An Initial Threat Assessment Meeting (ITAM) should be conducted to assess the situation and determine whether to activate and at what level. (See Appendix E)

This meeting can be used to lead into an Incident Action Planning meeting, if the event has predetermined that it is necessary to activate this Plan and/or the DOC

The objective of the ITAM is to:

- Inform/update key staff about a developing situation
- Assess incident impact/potential impact using the ITAM Guide for Assessment checklist
- Decide immediate action steps:
 - Alerting/notifications, activation of DOC, etc.
 - Schedule a follow up meeting to review additional info

Expected ITAM Outcomes include:

- Documentation of situation
- Assessment of current & potential impact
- Decision on action to be taken
- Decision on whether to activate the DOC & move to ICS structure
- Assignment of responsibility for immediate action steps (actions/steps required in 2-4 hrs.)
- Identify additional staff needed at next scheduled meeting &/or to fill DOC-ICS assignments
- Assign someone to notify staff
- Assign someone to notify necessary partners
- Schedule follow-up meeting, location, time, participants, etc.

Consultation and Confirmation

The Health Officer or designees (i.e. Deputy Director, MHOAC, Epidemiologist, Public Health Nurse) **will:**

- Consult with local and state disease experts to reach consensus that bioterrorism or other unusual event is suspected:
 - CDPH DCDC Duty Officer (The Duty Officer is on-call 24 hours a day and is responsible for responding to all calls involving infectious disease emergencies)
- Ensure Lab specimens are *in route* to the Laboratory Response Network (LRN)
 - Local Public Health LRN Laboratory:
 - Shasta County LRN Lab
 - State Public Health Laboratories:
 - CDPH Microbial Disease Laboratory (MDL) or Viral-Rickettsial Disease Laboratory (VRDL)
- Guide health care providers in specimen collection, handling, storage and transport in consultation with the Shasta County Public Health Laboratory
- Ensure that the diagnosis has been verified through appropriate laboratory tests and/or clinical history
- Establish the case definition that will be used in the initial outbreak investigation (including confirmed, probable and suspect cases), using available guidance from CDPH or CDC when possible

Activation

This Plan is to be activated when one or more of the following occur:

- A suspect or confirmed case of a disease categorized as a Special Pathogen
- A suspect or confirmed bioterrorism event
- Large outbreak of infectious disease requiring more than routine resources
- Waterborne outbreak or threat

This Response Plan should be activated in conjunction with the Glenn County Public Health & Medical Emergency Operations Plan (EOP).

Authority to Activate

The following staff are authorized to activate this Plan:

- Medical Health Operational Area Coordinator (MHOAC)
- HHS Deputy Director – Public Health
- Health Officer
- Public Health Program Manager

Activation Based on Scale & Scope

The scale and scope of the response will be dependent on the traits of the disease, the number of cases, and expected duration of the activation.

The following are key factors to consider that may increase the scale and scope of the response:

- Multiple modes of transmission (contact, airborne, and/or droplet)
- The disease is infectious before symptom onset
- A high basic reproduction number (mean number of secondary cases caused by a typical case)
- Minimal or no existing immunity in the population either due to previous infection or vaccination
- Minimal or no availability of effective post exposure prophylaxis and/or treatment
- Minimal or no availability of appropriate personal protective equipment
- Significant morbidity and/or mortality
- Minimal or no availability of regional, state, or federal mutual aid

This Response Plan should be activated at a level consistent with the situation, and should be evaluated and modified by the DOC Manager throughout the course of the activation. Levels of activation in this Plan are consistent with the levels of Health Department Operations Center (DOC). ***Refer to the Glenn County Public Health & Medical Emergency Operations Plan (EOP) for activation procedures.***

Health DOC Activation

The DOC is activated for a response to an Infectious Disease to:

- Coordinate continued outbreak investigation and case monitoring in the community and at hospitals
- Determine appropriate outbreak interventions and prepare Health Officer Orders
- Provide guidance to physicians, health care providers, and contact persons at hospitals, skilled nursing facilities and other congregate care settings
- Coordinate the use of hospital resources and activate Alternate Care Sites (ACS), if necessary (Health DOC Operations Section, Medical- Health Unit)
- Coordinate support services to home isolation and quarantine individuals/families.
- Coordinate with Emergency Medical Services (EMS) for patient transport
- Coordinate resources needed to support outbreak interventions including community containment, mass prophylaxis, and isolation and quarantine
- Provide risk communication to the public.
- Coordinate public health staffing and medical volunteers

The Operational Area EOC may be activated to:

- Manage proclamations, declarations
- Issue Emergency Alert System broadcasts
- Coordinate mutual aid, including medical mutual aid by the Medical Health Operational Area Coordinator (MHOAC)
- Coordinate law enforcement support
- Obtain additional resources to support outbreak interventions (Logistics Section)
- Coordinate transportation:
 - Mass dispensing site worker transport
 - Mass dispensing shuttle buses to sites
 - Secure transport of SNS pharmaceuticals and supplies

Level of Activation

There are three levels of activation: Level 1 – minimum, Level 2 – moderate, and Level 3 – Maximum. Each level provides a description of what is activated at that level and what type of scenario or event would typically result in that level of activation.

DOC Manager and/or MHOAC should determine the level of activation for the initial response using the guidelines provided below. *After determining the level of activation, go to Section 3: Notifications & Operations for a full description of activities to complete for the activation.*

Activation Level 1 – Minimum:

Level 1 Activation Description:

- Health and medical response for a serious, but manageable event that poses a **low** threat
- **At this level, the DOC is only active during normal business hours**, then go to Duty Officer/MHOAC On-Call status after hours
- Typically this level will only involve Command Staff & selected General Staff (ICS positions)—Key personnel (Director, supervisors, EP staff, CD staff)

Activate at Level 1 for response to the following Infectious Disease Events:

- *Initial activation until assessment can be completed*
- *Monitoring or movement restrictions are warranted for contacts of a Special Pathogen such as Ebola*
- *Non-special pathogen, infectious disease outbreak that requires additional management and resources*
 - *Examples: Measles, meningitis, pertussis*

Activation Level 2 – Medium:

Level 2 Activation Description:

- Major response required but the response is related to control of health or disease issues or healthcare system
- Necessary increase from level 1 Activation, determined by the Initial Threat Assessment meeting
- Need for increase staff to respond to the event
- Physical DOC is setup

- **DOC operation can remain during business hours, extended daytime hours, or the DOC Manager can assign after hours staff to work or activate Duty Officer/MHOAC On Call**

Activate at Level 2 for response to the following Infectious Disease Events:

- *An unconfirmed or suspect/probable case of highly infectious disease categorized as a Special Pathogen*
- *Emerging infectious disease without known disease traits*
- *Prophylaxis of a large number of contacts is required*
- *Mitigation measures include quarantine of multiple people*
- *Examples of disease typically falling in this category: Novel Influenza (H1N1 like)*

Activation Level 3 – Maximum:

Level 3 Activation Description:

- Full multi-agency response is essential
- Incident draws heavy media attention
- Health DOC will operate 24/7, with established operational periods
- OA EOC may also be activated

Activate at Level 3 for response to the following Infectious Disease Event:

- *Bio-terrorism incident is suspected or known*
- *Large outbreak*
- *Significant morbidity and mortality is anticipated or occurring*
- *A case of highly contagious special pathogen with limited immunity and limited prophylaxis available*
 - *Examples include: Smallpox, SARS, MERS, Ebola*
- *Disease that requires the activation and dispensing of Medical Countermeasures (SNS/MCM)*

SECTION 3: NOTIFICATIONS & OPERATIONS

Response Organization & Assignment

Health Department Operations Center organization and assignment to staff will be dependent on the level of the infectious disease event and the level of activation. Guidance for organization and assignment consistent with the level of activation and event is provided below.

Sections and units to consider activating for assignment:

- **Command & Management Section**
- **Operations' Section**
 - Medical-Health Branch
 - CD/Epi Unit
 - Environmental Health Unit
 - Mental Health Unit
 - Medical-Health Unit
 - Mass Care Unit
- **Planning Section**
- **Logistics Section**
- **Finance Section**

Level 1 Event Response Notification, Organization, & Assignment

Potential Level 1 Scenarios:

- *Initial activation until assessment can be completed*
- *Monitoring or movement restrictions are warranted for contacts of a Special Pathogen such as Ebola*
- *Non-special pathogen, infectious disease outbreak that requires additional management and resources*
 - *Examples: Measles, meningitis, pertussis*

Level 1 Event Notifications:

The following notifications should be conducted immediately:

(Can be completed during business hours)

- Health Officer, HHS Director, PH Director, MHOAC
- Regional Epidemiologist
- LEMSA
- Submit a Med-Health Situational Report (SITREP) to CDPH, EMSA, LEMSA & RDMHS for unusual event/advisory only situation

Following assessment of the situation and the case or contact, **consider alerting the following:**

- Glenn County Sheriff/OES
- Healthcare facilities
- Region 3 Health Departments

Level 1 Response Organization

The following response organization should be utilized during a Level 1 Infectious Disease Event:

- Operational Period should be 0800-1700 hours
- After-hours on-call should follow normal protocol (MHOAC)

Health DOC should include the following staff and organization:

- DOC Manager:
 - Staff who can fill this role:
 - PH Deputy Director, MHOAC, HHS Director, PH Program Manager- PHN
- PIO:
 - Staff who can fill this role:
 - MHOAC, HHS Director, Deputy Director PH, other trained PIO staff
- Medical Technical Specialist:
 - Health Officer, MHOAC – MD, LEMSA MD
- Operations Section Chief:
 - Staff who can fill this role:
 - PH Program Manager, Senior PHN, MHOAC, or anyone qualified to fill DOC Manager role
 - Operations section staff including CD/Epi unit:
 - PHNs, RNs, REHS
- Plans Section Chief:
 - Staff who can fill this role:
 - MHOAC, Emergency Preparedness program staff, staff with IAP/SITREP experience

Level 1 Event Response Initial Actions and Briefing:

- Activate appropriate DOC staff
- Conduct appropriate Level 1 notifications
- Conduct an initial briefing with DOC staff – utilize an ICS 201 form
- Assess current situation, level of risk exposure of client
- Establish Operational Period
- Set initial objectives and draft initial IAP. (*refer to PH & Medical EOP for Planning Process*)

Initial objectives could include:

- Identify cases and contacts for investigation
 - Develop case definition
 - Establish mode of transmission
 - Determine surveillance strategy
 - Identify containment measures
 - Determine need for Health Officer Order
 - Identify need for patient transport & assessment plan (Ebola and other highly pathogenic diseases)
- Make staff assignments (see next section for guidance on assignments)
 - Set briefing schedule
 - Distribute critical ICS documentation forms: 213, 214, 211 – for sign in
 - Plans section – document meeting
 - Determine additional response plans that should be activated and consulted:
 - GC OA Public Health & Medical EOP
 - JERP
 - CERC
 - Ebola Response Plan

Level 1 Event Response Assignments

Additional assignments should be made by DOC Manager as necessary for the event.

DOC Manager:

- Oversee event response and command/management and section chief staff
- Activation, immediate notifications, set operational period and briefing schedule, set initial objectives, make staff assignments
- Coordinate activities of Command and General Staff.
- Meet at least once per operational period with Command and General Staff Section Chiefs (meetings to be scheduled by the Plans Section.)
- Oversee functions of the Information Officer, Safety Officer, & Liaison Officer
- Review and approve objectives, Incident Action Plans, and public information
- Approve requests for additional resources (e.g., supplies, staff).
- Consult with Health Officer for medical evaluations and determination and issuance of Health Orders such as for isolation and quarantine
- Develop the patient transport and assessment plan (*for highly infectious diseases such as Ebola*) in coordination with LEMSA, RDMHS, CDPH & EMSA
- If quarantine or isolation is required, coordinate with Red Cross to assist with logistical needs
- Activate additional response plans as necessary for the response
 - Public Health & Medical EOP, JERP, CERC

PIO:

- Reports to: DOC Manager
- Activate the CERC Plan when deemed necessary
- Develop and issue public information as appropriate for the current situation
- Answer any media inquiries or requests for interviews
- Monitor media for rumor control
- Notify DOC Manager and local law enforcement if media attention is expected to grow and management/control may become an issue
- Coordinate with any agencies currently involved in the response to ensure joint messaging

Operations Chief:

- Reports to: DOC Manager
- Appoint additional CD/PHN staff to CD/Epi Unit to assist with operational assignments as necessary to the response
 - Provide staff with **Tactics (Blue Pages)** from Section 4 & 5 to use as Job Aids
- Establish strategies and tactics for achieving operational period objectives – **refer to Section 4 and 5 for strategies and tactics related to surveillance and investigation**
- Conduct Operations Briefing each operational period (*refer to Planning P & Briefings in the PH& Medical EOP*)
- Determine the need for disease control mitigation strategies - **Refer to Section 6 Mitigation**
 - Monitoring, movement restrictions, isolation, quarantine
 - Notify DOC Manager immediately if a Health Officer Order is required
- Issue guidance to healthcare providers
- Assist in the development of the Incident Action Plan (response goals, operational objectives, and support activities).
 - Implement the Incident Action Plan.
- Meet with Unit Leads at least once per operational period and address implementation issues as necessary.
- Oversee the provision of event and disease-related information to clinicians, responders, the public, special populations, and other stakeholders.
- Oversee the implementation of public health strategies to contain the infectious disease.
- Oversee the coordination of jurisdiction-wide issues of medical care and treatment.
- Oversee the implementation of case/contact investigation and surveillance.
- Oversee the provision of descriptive analysis of the incident (e.g., number of cases/contacts, demographic information).

CD/Epi Unit of Operations:

- Reports to: Operations Section Chief
- Communicate with Regional Epidemiologist
- Review Sections 3 (Surveillance) and 4 (Investigation)
- Conduct surveillance – **refer to section 4 Surveillance Tactics (Blue Pages)**
- Conduct epi investigation including case and contact investigations
 - **Refer to Section 5 Investigation for Tactics to achieve this assignment (Blue Pages)**
- Develop hypothesis, identify disease, develop case definition, recommend disease control measures
- Provide client education on disease and any restricted movement/quarantine issuance
- Conduct on-going monitoring and case management

Plans Chief:

- Reports to: DOC Manager
- Complete and maintain event documentation
- Print and distribute ICS forms as needed, to include at a minimum:
 - ICS 214 Unit Activity Log
 - ICS 211 for all DOC briefings/meetings
- Complete an initial Med-Health Situation Report as an advisory/alert and submit within 2 hours of event
- Assemble and submit an update Med-Health Situation Report every operational period, preferably every afternoon prior to the end of the operational period
 - SITREP is to be submitted to:
 - Shasta County – Regional Epidemiologist
 - LRN Lab
 - RDMHS
 - CDPH
 - EMSA
 - LEMSA
 - GC SO/OES
 - Healthcare partners as directed by DOC Manager
- Write the Incident Action Plan for the Operational Period
 - Write IAP for next op period, submit to DOC Manager for review and approval
 - IAP to be distributed at Operational Period Briefing

Level 2 Event Response Notification, Organization, & Assignment

Potential Level 2 Scenarios:

- *An unconfirmed or suspect/probable case of highly infectious disease categorized as a Special Pathogen*
- *Emerging infectious disease without known disease traits*
- *Prophylaxis of a large number of contacts is required*
- *Mitigation measures include quarantine of multiple people*
- *Examples of disease typically falling in this category: Novel Influenza*

Level 2 Event Notifications:

The following notifications should be conducted immediately:

- Health Officer, HHS Director, PH Director, MHOAC
- Regional Epidemiologist
- Shasta County LRN Lab - Request assistance with lab specimens when applicable
- LEMSA
- RDMHS
- CDPH DCDC Duty Officer:
 - Submit a Med-Health Situational Report (SITREP) to CDPH, EMSA , LEMSA & RDMHS within 2 hours
- Glenn County Sheriff/OES

Following assessment of the situation, alert the following:

- Local partners including healthcare facilities and first responder agencies
- Region 3 Health Departments

Level 2 Response Organization

The following response organization should be utilized during a Level 2 Infectious Disease Event:

- Operational Period should be 0800-1700 hours – DOC Manager determine need for additional hours
- After-hours on-call should follow normal protocol (MHOAC)

Health DOC should include the following staff and organization:

- DOC Manager:
 - Staff who can fill this role:
 - PH Deputy Director, MHOAC, HHS Director, PH Program Manager-PHN
- PIO:
 - Staff who can fill this role:
 - MHOAC, HHS Director, Deputy Director PH, other trained PIO staff
- Medical Technical Specialist:
 - Health Officer
 - MHOAC - MD
 - LEMSA Medical Director
- Operations Section Chief:
 - Staff who can fill this role:
 - PH Program Manager, Senior PHN, MHOAC, or anyone qualified to fill DOC Manager role
 - Operations section staff including CD/Epi unit, Medical-Health Unit:
 - PHNs, RNs, any additional staff with ICS 200 or higher training
- Plans Section Chief:
 - Staff who can fill this role:
 - MHOAC, Emergency Preparedness program staff, staff with IAP/SITREP experience
- Logistics Chief:
 - Staff who can fill this role:
 - MHOAC, Emergency Preparedness program staff

Level 2 Event Response Initial Actions and Briefing:

- For initial case activation:
 - Receive full briefing from EMS or HCF that treated PUI or confirmed case
 - Confirm suspect case
 - Confirm patient has been properly isolated
 - Personnel utilized and continue to utilize appropriate PPE
 - Appropriately sanitized area/equipment exposed to patient
 - Lab draws are underway
 - Confirm HCF has everything they need to appropriately isolate and treat the patient for next 24-72 hours
 - Provide HCF with best contact for next 24 hours
- Activate appropriate DOC staff
- Conduct appropriate Level 2 notifications

- Conduct an initial briefing with DOC staff – utilize an ICS 201 form
- Assess current situation, level of risk exposure and symptoms of patient
- Establish Operational Period
- Set initial objectives & draft initial IAP (refer to PH & Medical EOP for Planning Process)
 - Epi investigation including case and contact investigation
 - Case Management
 - Labs
 - PPE/safety
 - Patient transfer plan (if required)
 - Media management
 - Disease control/mitigation measures
 - Mass prophylaxis or mass care
- Make staff assignments (see next section for guidance on assignments)
- Set briefing schedule for DOC staff and briefing schedule with external partners:
 - Any impacted healthcare facilities
 - CDPH/EMSA
 - LEMSA
 - GC SO/OES
 - RDMHS
- Distribute critical ICS documentation forms: 213, 214, 211 – for sign in
- Plans section – document meeting
- Determine additional response plans that should be activated and consulted:
 - GC OA Public Health & Medical EOP
 - JERP
 - CERC
 - Ebola Response Plan
 - Pandemic Influenza Emergency Response Plan
 - Specimen Packaging and Transport Plan (SPAT)
 - Region III Infectious Disease Patient Transport Plan

Level 2 Event Response Assignments

Additional assignments should be made by DOC Manager as necessary for the event.

DOC Manager:

- Oversee event response and command/management and section chief staff
- Activation, immediate notifications, set operational period and briefing schedule, set initial objectives, make staff assignments
- Coordinate activities of Command and General Staff.
- Oversee functions of the Information Officer, Safety Officer, and Liaison Officer
- Meet at least once per operational period with Command and General Staff Section Chiefs (meetings to be scheduled by the Plans Section.)
- Review and approve objectives, Incident Action Plans, and public information
- Approve requests for additional resources (e.g., supplies, staff).
- Determine disease control/mitigation measures
- Consult with Health Officer for medical evaluations and determination and issuance of Health Orders such as for isolation and quarantine
- Develop patient transfer and transport plan. (if relevant)
- Activate additional response plans as necessary
 - GC OA Public Health & Medical EOP, JERP, CERC, Ebola Response Plan, Pandemic Influenza Emergency Response Plan, Specimen Packaging and Transport Plan (SPAT), Region III Infectious Disease Patient Transport Plan

PIO:

- Reports to: DOC Manager
- Activate the CERC Plan – review disease specific and response specific information templates
- Develop and issue public information as appropriate for the current situation
- Answer any media inquiries or requests for interviews
- Create a media management plan
- Monitor media for rumor control
- Notify DOC Manager and local law enforcement if media attention is expected to grow and management/control may become an issue
- Coordinate with any agencies currently involved in the response to ensure joint messaging

Operations Chief:

- Reports to: DOC Manager
- Appoint additional staff to assist with operational assignments as necessary to the response
 - CD/Epi Unit
 - Provide **Tactics (Blue Pages)** to use as Job Aids
 - Medical-Health Unit
- Conduct Operations Briefing each operational period (*refer to Planning P & Briefings in the PH& Medical EOP*)
- Establish strategies and tactics for achieving operational period objectives – **refer to Section 4 and 5 for strategies and tactics related to surveillance and investigation Tactics (Blue Pages)**
- Determine the need for disease control mitigation strategies – **Refer to Section 6 Mitigation**
 - Monitoring, movement restrictions, isolation, quarantine
 - Notify DOC Manager immediately if a Health Officer Order is required
- Issue guidance to healthcare providers
- Assist in the development of the Incident Action Plan (response goals, operational objectives, and support activities).
 - Implement the Incident Action Plan.
- Meet with Unit Leads at least once per operational period and address implementation issues as necessary.
- Oversee the provision of event and disease-related information to clinicians, responders, the public, special populations, and other stakeholders.
- Oversee the implementation of public health strategies to contain the infectious disease.
- Oversee the coordination of jurisdiction-wide issues of medical care and treatment.
- Oversee the implementation of case/contact investigation and surveillance.
- Oversee the provision of descriptive analysis of the incident (e.g., number of cases/contacts, demographic information).

CD/Epi Unit of Operations:

- Reports to Operations Section Chief
- Communicate with Regional Epidemiologist
- Review Sections 3 (Surveillance) and 4 (Investigation)
- Conduct surveillance – **refer to section 4 Surveillance Tactics (Blue Pages)**
- Conduct epi investigation including case and contact investigations
 - **Refer to Section 5 Investigation for tactics to achieve this assignment (Blue Pages)**
- Develop hypothesis, identify disease, develop case definition, recommend disease control measures
- Provide client education on disease and any restricted movement/quarantine issuance
- Conduct on-going monitoring and case management

Medical-Health Unit of Operations:

- *Activated only when required for the response*
- Reports to Operations Section Chief, unless otherwise defined by the DOC Manager
 - In small activations, this function will be completed by the **MHOAC**
- Act as a liaison for healthcare partners
- Issue guidance to healthcare providers
- Provides coordination and communication with healthcare facilities
- Collects and analyzes situational awareness from entire medical system
 - Coordinate information with Planning Section
- Determine overall healthcare system status
- Identify the need for implementing surge plans and coordinate with MHOAC and DOC Manager if activation is in effect or impending
- Ensure adequate PPE is available and in use by healthcare partners
- Receive resource requests from healthcare partners and coordinate requests with Logistics
- Identify scarce resources that may require MHOAC and DOC Manager to *deconflict* or prioritize (which facility or agency receives the scarce resource)

Mental Health Unit of Operations:

- *Activated only when required for the response*
- Reports to: Operations Section Chief
- Coordinate with CD/Epi Unit to identify clients or families in isolation or quarantine who may need assistance
- Assist PIO with public messaging to ensure messages regarding behavioral health and services are provided
- Operations Chief may assign Mental Health staff to assist at healthcare facilities, Points of Dispensing Sites (PODS) or other mass care/community sites.
- Provide guidance, support, and information to responders and health personnel

Environmental Health Unit of Operations:

- Activated only when required for the response
- Reports to: Operations Section Chief
- Address medical waste management and any sanitary issues resulting from the infected patient (i.e. housing, transportation or other facilities the patient may have contaminated during the infectious period)
- Assist in epi investigation in cases involving environmental hazards, foodborne, or waterborne disease or illness

Plans Chief:

- Reports to: DOC Manager
- Completes and maintains event documentation
- Print and distribute ICS forms as needed, to include at a minimum:
 - ICS 214 Unit Activity Log
 - ICS 211 for all DOC briefings/meetings
- Complete an initial Med-Health Situation Report as an advisory/alert and submit within 2 hours of event
- Assemble and submit a Update Med-Health Situation Report at least every operational period, preferably every afternoon prior to the end of the operational period
 - SITREP is to be submitted to:
 - RDMHS
 - CDPH
 - EMSA
 - LEMSA
 - GC SO/OES
 - Healthcare partners as directed by DOC Manager
- Write the Incident Action Plan for the Operational Period
 - Write IAP for next operational period, submit to DOC Manager for review and approval
 - IAP to be distributed at Operational Period Briefing

Logistics Chief:

- *Activated only when required for the response*
- Reports to: DOC Manager
- Ensure the logistical needs of operations section are met
- Coordinate with impacted EMS/HCFs to ensure adequate PPE is available
- Maintain inventory of OA med-health emergency supplies
 - Check out supplies as appropriate
- Write med-health resource requests for any additional resource needs
 - DOC Manager should review and approve all resource requests
- Order, receive, inventory, and track any emergency medical supplies including medical countermeasures

Level 3 Event Response Notification, Organization, & Assignment

Potential Level 3 Scenarios:

- *Bio-terrorism incident is suspected or known*
- *Large outbreak*
- *Significant morbidity and mortality is anticipated or occurring*
- *A case of highly contagious special pathogen with limited immunity and limited prophylaxis available*
 - *Examples include: Smallpox, SARS, MERS, Ebola*
- *A disease that requires the activation and dispensing of Medical Countermeasures (SNS/MCM)*

Level 3 Notifications

The following notifications should be conducted immediately:

- Health Officer, HHS Director, PH Director, MHOAC
- Regional Epidemiologist
- Shasta County LRN Lab - Request assistance with lab specimens
- LEMSA - advise local EMS
- RDMHS
- CDPH DCDC Duty Officer:
 - Submit a Med-Health Situational Report (SITREP) to CDPH, EMSA, LEMSA & RDMHS within 2 hours
 - ***Request immediate assistance for transport and placement of patient to a State identified treatment hospital when applicable (Ebola)***
- Glenn County Sheriff/OES
 - Advise to notify local law and fire
 - California OES State Warning Center
 - FBI if Bio-terrorism is possible.

After completion of immediate notifications, alert the following via CAHAN:

- Healthcare partners
- Region 3 Health Departments

Level 3 Event Response Organization

The following response organization should be utilized during a Level 3 Infectious Disease Event:

- Full activation of the Health DOC
 - Recommend activation of the OA EOC (when applicable)
- Operational Period should be determined by DOC Manager
- Any hours that the DOC is closed, ensure assignment of after-hours On-Call and notify all relevant partners of the appointed on-call contact

Health DOC should include the following staff and organization:

- DOC Manager:
 - Staff who can fill this role:
 - PH Deputy Director, MHOAC, HHSa Director, PH Program Manager-PHN
- PIO:
 - Staff who can fill this role:
 - MHOAC, HHSa Director, Deputy Director PH, other trained PIO staff
- Medical Technical Specialist:
 - Health Officer
 - MHOCA - MD
 - LEMSA Medical Director
- Operations Section Chief:
 - Staff who can fill this role:
 - PH Program Manager, Senior PHN, MHOAC, or anyone qualified to fill DOC Manager role
 - Operations section staff including CD/Epi unit, EH Unit, Mental Health Unit:
 - Any qualified staff
- Plans Section Chief:
 - Staff who can fill this role:
 - MHOAC, Emergency Preparedness program staff, staff with IAP/SITREP experience, any staff with ICS 300 and above
- Logistics Chief:
 - Staff who can fill this role:
 - MHOAC, Emergency Preparedness program staff, any staff with ICS 200 or above and experience with inventory management
- Finance Chief:
 - Staff who can fill this role:
 - HHSa Fiscal Program Manager, HHSa Deputy Director of Administration, Fiscal Admin Analyst

Level 3 Event Response Initial Actions and Briefing:

- For initial case activation: Receive full briefing from HCF that treated patient with identified disease
 - Confirm case and labs
 - Confirm patient has been properly isolated
 - Personnel utilized and continue to utilize appropriate PPE
 - Appropriately sanitized area/equipment exposed to patient
 - Confirm HCF has everything they need to appropriately isolate and treat the patient for next 24-72 hours
 - Provide HCF with best contact for next 24 hours
 - As required, prepare patient for transfer to a State identified treatment hospital or other specialty hospital
 - Coordinate Patient Transfer Plan with HCFs, LEMSA, RDMHS and State
- Activate appropriate DOC staff
- Conduct appropriate Level 3 notifications
- Conduct an initial briefing with DOC staff – utilize an ICS 201 or 202 form
- Assess current situation, patient status, and patient contacts
- Establish Operational Period
- Set initial objectives & draft initial IAP(*refer to PH & Medical EOP for Planning Process*)
 - Epi investigation including case and contact investigation
 - Case Management
 - Labs
 - PPE/safety
 - Patient transfer plan (if required)
 - Media management
 - Disease control/mitigation measures
 - Suspect or confirmed BT event:
 - Coordinate investigation with law enforcement and FBI
- Make staff assignments (see next section for guidance on assignments)
- Set briefing schedule for DOC staff and briefing schedule with external partners:
 - Healthcare facilities
 - CDPH/EMSA
 - LEMSA
 - GC SO/OES and Cal-OES
 - RDMHS
 - Regional Epidemiologist
- Distribute critical ICS documentation forms: 213, 214, 211 – for sign in
- Plans section – document meeting

- ❑ Activate and consult the following plans (as relevant to the response):
 - GC OA Public Health & Medical EOP
 - CERC
 - JERP
 - Ebola Response Plan
 - Pandemic Influenza Emergency Response Plan
 - Smallpox Plan
 - Healthcare Surge Plan
 - Mass Fatality Management Plan
 - SNS/Medical Countermeasure and Mass Prophylaxis Plan
 - Specimen Packaging and Transport Plan (SPAT)
 - Region III Infectious Disease Patient Transport Plan

Level 3 Event Response Assignments

Additional assignments should be made by DOC Manager as necessary for the event.

DOC Manager:

- Oversee event response and command/management and section chief staff
- Activation, immediate notifications, set operational period and briefing schedule, set initial objectives, make staff assignments
- Review and approve objectives, Incident Action Plans, and public information
- Approve requests for additional resources (e.g., supplies, staff).
- Coordinate activities of Command and General Staff.
- Meet at least once per operational period with Command and General Staff Section Chiefs (meetings to be scheduled by the Plans Section.)
- Oversee functions of the Information Officer, Safety Officer, & Liaison Officer
- Determine disease control/mitigation measures
- Consult with Health Officer for medical evaluations and determination and issuance of Health Orders such as for isolation and quarantine
- Develop patient transfer and transport plan. (if relevant)
- Determine if crisis care may be required for overburden medical system. Coordinate with Health Officer.
- Activate additional response plans as necessary
 - GC OA Public Health & Medical EOP, JERP, CERC, Ebola Response Plan, Pandemic Influenza Emergency Response Plan, Healthcare Surge Plan, SNS/Medical Countermeasures and Mass Prophylaxis Plan, Mass Fatality Plan, Smallpox Plan, Specimen Packaging and Transport Plan (SPAT), Region III Infectious Disease Patient Transport Plan
- If Bio-terrorism event:
 - Coordinate with law enforcement and FBI

- Establish joint investigation
- Appoint staff for positions in OA EOC or Federal Joint Field Office (JFO)

PIO:

- Reports to: DOC Manager
- Activate the CERC Plan – review disease specific and response specific information templates
- Create a media management plan
- Coordinate with local law enforcement for security/media management at health department and HCF
- Activate JIS/JIC for coordinated messaging among involved agencies
- Notify and coordinate with CDPH Public Affairs Office
- Coordinate a multi-agency press conference address the current situation and patient management and transfer plan
 - Ensure coordination with CDPH and EMSA, hospitals, and LEMSA
- Develop and issue public information
- Answer any media inquiries or requests for interviews
- Monitor media for rumor control

Operations Chief:

- Reports to: DOC Manager
- Appoint additional staff to assist with operational assignments as necessary to the response
 - CD/Epi Unit
 - Provide **Tactics (Blue Pages)** to be used as Job Aids
 - Medical-Health Unit
 - Mental Health Unit
 - Environmental Health Unit
- Conduct Operations Briefing each operational period (*refer to Planning P & Briefings in the PH& Medical EOP*)
- Establish strategies and tactics for achieving operational period objectives – **refer to Section 4 and 5 for strategies and tactics related to surveillance and investigation**
- Determine the need for disease control mitigation strategies – **Refer to Section 6 Mitigation**
 - Monitoring, movement restrictions, isolation, quarantine
 - Notify DOC Manager immediately if a Health Officer Order is required
- Ensure investigation coordination with law enforcement/FBI if BT event
- Issue guidance to healthcare providers
- Assist in the development of the Incident Action Plan (response goals, operational objectives, and support activities).
 - Implement the Incident Action Plan.

- Meet with Unit Leads at least once per operational period and address implementation issues as necessary.
- Oversee the provision of event and disease-related information to clinicians, responders, the public, special populations, and other stakeholders.
- Oversee the implementation of public health strategies to contain the infectious disease.
- Oversee the coordination of jurisdiction-wide issues of medical care and treatment.
- Oversee the implementation of case/contact investigation and surveillance.
- Oversee the provision of descriptive analysis of the incident (e.g., number of cases/contacts, demographic information).

CD/Epi Unit of Operations:

- Reports to Operations Section Chief
- Communicate and coordinate with Regional Epidemiologist
- Coordinate investigation with law enforcement, FBI, and/or Environmental Health as necessary
- Review Sections 4 (Surveillance) and 5 (Investigation)
- Conduct surveillance – *refer to section 4 Surveillance Tactics (Blue Pages)*
- Conduct epi investigation including case and contact investigations
 - *Refer to Section 5 Investigation for tactics to achieve this assignment (Blue Pages)*
- Develop hypothesis, identify disease, develop case definition, recommend disease control measures
- Provide client education on disease and any restricted movement/quarantine issuance
- Conduct on-going monitoring and case management

Medical-Health Unit of Operations:

- Reports to Operations Section Chief, unless otherwise defined by the DOC Manager
 - In small activations, this function will be completed by the **MHOAC**
- Act as a liaison for healthcare partners
- Provides coordination and communication with healthcare facilities
- Issue guidance to healthcare providers
- Collects and analyzes situational awareness from entire medical system
 - Coordinate information with Planning Section
- Determine overall healthcare system status
- Identify the need for implementing surge plans and coordinate with MHOAC and DOC Manager if activation is in effect or impending.
 - Identify whether Alternate Care Sites (ACS) may be needed to manage future surge.
- Ensure adequate PPE is available and in use by healthcare partners
- Receive resource requests from healthcare partners and coordinate requests with Logistics

- Identify scarce resources that may require MHOAC and DOC Manager to *deconflict* or prioritize (which facility or agency receives the scarce resource)
- Coordinate delivery of prophylaxis to 1st responders and healthcare partners
 - Activate PUSH Partner Plans for closed PODS for medical-health mass prophylaxis
- Identify need for crisis care. If crisis care may be required, notify Operations Section Chief or DOC Manager

Mass Care Unit of Operations:

- *Activated only when required for response*
- Reports to: Operations Section Chief
- Coordinates the provision of necessary healthcare services to public
- Medical Countermeasures event:
 - Coordinate the establishment of PODS in accordance with Medical Countermeasure/Mass Prophylaxis Plan
- Alternate Care Site event:
 - Coordinate the establishment of an alternate care site in accordance with the Pandemic Influenza Emergency Response Plan and Alternate Care Site Plan
- Mass Quarantine Site event:
 - Coordinate the establishment of a mass quarantine site
- Refer to the identified Plans for detailed response procedures

Mental Health Unit

- Reports to: Operations Section Chief
- Coordinate with CD/Epi Unit to identify clients or families in isolation or quarantine who may need assistance
- Assist PIO with public messaging to ensure messages regarding behavioral health and services are provided
- Operations Chief may assign Mental Health staff to assist at healthcare facilities, alternate care sites, Points of Dispensing Sites (PODS) or other mass care/community sites.
- Provide guidance, support, and information to responders and health personnel

Environmental Health Unit

- Reports to: Operations Section Chief
- Address medical waste management and any sanitary issues resulting from the infected patient (i.e. housing, transportation or other facilities the patient may have contaminated during the infectious period)
- Assist in epi investigation in cases involving environmental hazards or food

Plans Chief:

- Reports to: DOC Manager
- Completes and maintains event documentation
- Print and distribute ICS forms as needed, to include at a minimum:
 - ICS 214 Unit Activity Log
 - ICS 211 for all DOC briefings/meetings
- Complete an initial Med-Health Situation Report as an Immediate Action Required and submit within 2 hours of event
- Assemble and submit an update Med-Health Situation Report at least every operational period, preferably every afternoon prior to the end of the operational period
 - SITREP is to be submitted to:
 - RDMHS
 - CDPH & EMSA
 - LEMSA
 - GC SO/OES
 - Healthcare partners as directed by DOC Manager
- Write the Incident Action Plan for the Operational Period
 - Write IAP for next operational period, submit to DOC Manager for review & approval
 - IAP to be distributed at Operational Period Briefing

Logistics Chief:

- Reports to: DOC Manager
- Ensure the logistical needs of operations section are met
- Coordinate with impacted EMS/HCF to ensure adequate PPE is available
- Order, receive, inventory, and track any emergency medical supplies including medical countermeasures
- Maintain inventory of OA med-health emergency supplies
 - Check out supplies as appropriate
- Write med-health resource requests for any additional resource needs
 - DOC Manager should review and approve all resource requests

Finance Chief:

- Reports to: DOC Manager
- Ensures financial documentation of the incident is maintained
- Establish an incident specific billing code
- Executes purchases, contracts, and MOUs to support incident response

Incident Action Plan

The Incident Action Plan (IAP) allows incident response leaders to work together to develop objectives, set priorities, and communicate these objectives and priorities to all personnel involved in incident response and management.

Who participates in developing the IAP:

- Command/Management
- General Staff (Section Chiefs)

The phases of the Incident Action Planning process include:

- Understand the situation
- Establish incident objectives
- Develop the plan
- Prepare and disseminate the plan
- Execute, evaluate, and revise the plan

WHY AN IAP?

- Common operating picture
- Clear objectives
- Organizes personnel and response
- Tool for staff
- Synchronize efforts
- Quick reference for key information

All of these phases, and the **Planning P process**, result in a comprehensive Incident Action Plan. Incident Action Plans serve as the “blueprint” for the next operational period. While the planning process contributes to sound decision making, situational awareness, and a streamlined incident response, the IAP itself allows new operational periods to begin their shifts with succinct yet comprehensive information with which to work with, allowing them to begin responding that much faster. The IAP includes information not only on the current situation, but also on response organization, assignments, resources committed, actions taken in the last operational period, and safety messaging.

Objectives, Strategies, & Tactics

A common set of **objectives** is established and approved by the DOC Manager. Objectives are key to a successful response and a critical element of the IAP. Objectives are the “What”, as in what will be accomplished.

Strategies are the methods and general plan (roadmap) for how objectives will be accomplished. Strategies are developed by the Operations Section Chief and approved by the DOC Manager. Strategies are the “How”, as in how the objectives will be accomplished.

Tactics are the detailed plans that specify how the strategies will be executed. Tactics are established and approved by the Operations Section Chief. Tactics are the step-by-step instructions to achieving the objectives.



For additional instructions on the Planning P Process and steps to writing an IAP, refer to the Public Health & Medical EOP.

HICS IAP Form - Example - Ebola

1. Incident Name <div style="background-color: yellow; padding: 2px;">2014 Ebola Exercise</div>	2. Operational Period (# 1) DATE: FROM: _11/20/14_____ TO: 11/20/14_____ TIME: FROM: ____0800_____ TO: 1700_____
3. Situation Summary — HICS 201 — <div style="background-color: yellow; padding: 2px;">This is an exercise!</div> <p>Glenn County was notified of 2 return travelers from Liberia which require monitoring and possible movement restrictions. Case 1 is considered a low risk exposure and requires primarily monitoring. Case 2 is considered a high risk exposure and will require monitoring and movement restrictions. Follow up with the case will determine the level of movement restrictions.</p>	
4. Current Health Incident Management Team (fill in additional positions as appropriate) — HICS 201, 203 —	
<pre> graph TD IC["Incident Commander/DOC Manager Grinnell"] PIO["Public Information Officer Amy"] LO["Liaison Officer Amy"] SO["Safety Officer Jenifer"] MTS["Medical-Technical Specialists Dr. Rudnick"] OSC["Operations Section Chief Mary Lou"] PSC["Planning Section Chief Carolyn"] LSC["Logistics Section Chief Susan"] FASC["Finance / Administration Section Chief None"] IC --- PIO IC --- LO IC --- SO LO -.- MTS IC --- OSC IC --- PSC IC --- LSC IC --- FASC </pre>	

5. Health and Safety Briefing Identify potential incident health and safety hazards and develop necessary measures (remove hazard, provide personal protective equipment, warn people of the hazard) to protect responders from those hazards. — HICS 202, 215A —

Exercise

- Wear appropriate PPE for your assignment.
- Be aware of stress and fatigue in yourself and your co-workers.
- Report any safety issues to the Incident Commander.
- Watch for trip hazards in the DOC.

6. Incident Objectives — HICS 202, 204 —

6a. OBJECTIVES	6b. STRATEGIES / TACTICS	6c. RESOURCES REQUIRED	6d. ASSIGNED TO
Make contact with each case.	Case history Symptom review Demographics Contact Information Schedule for monitoring	PHN Forms IT equipment Medical equipment	Marcy M.
Notify critical partners	CAHAN Phone Email	IT Phone Fax	Amy
HO Order for quarantine	HO will prepare the quarantine order & complete legal steps	CDPH quarantine order, HO Quarantine Order template	Dr. Rudnick
Prepare appropriate risk communications	Research material; prepare press releases and fact sheets. Disseminate information as needed through approved channels.	Educational information, CERC Plan, computer	Amy

Refer to Public Health & Medical EOP for more information on Incident Action Planning.

SECTION 4: DETECTION

Surveillance

Surveillance of disease is defined as: The routine review of occurrence and spread of a disease that are pertinent to effective control. Included are the systematic collection and evaluation of morbidity and mortality reports, special reports of field investigations of epidemics and of individual cases, and other epidemiologic data.

Glenn County Public Health conducts constant, systematic disease data surveillance on conditions mandated by the California Codes and Regulations (CCR) as well as data on some non-required conditions through voluntary reporting as partnerships and infrastructure allow. This includes ongoing systematic collection and analysis of data and the provision of data which may lead to action being taken to prevent and control disease, usually of an infectious nature. By observing trends in time, place, and persons, changes can be observed or anticipated and appropriate action, including investigative or control measures, can be taken.

Legal Framework for Disease Surveillance

Glenn County Public Health receives communicable disease surveillance data under the authority of California Code of Regulations (CCR) Title 17, Section 2500. This directive requires health care providers to notify the local health authority (Glenn County) of reportable communicable disease incidence.

Cases/diseases/conditions are reported to the Center for Disease Control and Prevention (CDC) and/or the California Department of Public Health (CDPH) as required. CCR Title 17 section 2500(h)(i),(j)(1) provides instruction concerning methods and timeline of communication of reportable communicable disease incident. The Public Health Nurses enter morbidity data into the CalREDIE system making it available to CDPH however, for many reportable diseases including Special Pathogens; Title 17 requires additional notification measures to be taken.

The CDPH and CDC may provide additional surveillance guidance and provide infectious disease-related resources.

Communicable Disease Reporting

Healthcare providers are provided the CCR Title 17, Section 2500, reportable disease list. It is the duty of any healthcare provider knowing of or in attendance on a case or suspected case of a reportable disease or condition to report to the local health department for where the patient resides.

Healthcare providers may contact the main line at the Health Department for reporting. After hours, a message is received directing the caller to contact Sheriff's Office Dispatch. Glenn County maintains an

up-to-date list of staff in the MHOAC program who may be contacted 24/7 for infectious disease reporting and emergencies.

Surveillance Objectives

The purpose of the Surveillance is to identify, as rapidly as possible, cases and clusters of the infectious disease.

The Surveillance objectives are to:

- Develop, refine, and disseminate case definitions.
- Develop a case-finding strategy.
- Verify the accuracy and completeness of surveillance data.
- Identify cases for further detailed investigation.
- In selected situations, conduct syndromic surveillance to detect additional potential disease outbreaks occurring concurrently.

Surveillance Strategies

Strategies are the methods and general plan for how objectives will be accomplished. Depending on the disease, information needs, and/or resources, the following strategies may be used to achieve objectives:

Passive surveillance: The collection of data from existing unsolicited reports of the diseases(s). This data may be received from the local clinician community, hospitals and laboratories. This data is transmitted to the health department as required by Title 17. This data is used to identify cases and to determine the magnitude of the outbreak.

Enhanced passive surveillance: Employs a mix of active techniques in addition to the passive surveillance described above; for example, sending a health alert that highlights a specific disease or syndrome to clinical providers. This would stimulate clinician and/or laboratory reporting.

Active surveillance: Involves actively finding cases of the disease; for example, calling medical facilities (e.g., laboratories or emergency departments) or sending CD nurses to hospitals to extract information from hospital records.

Surveillance of Healthcare Workers: Surveillance to detect exposure or infection in healthcare workers so that they can be separated from uninfected patients to prevent further transmission of disease.

Syndromic surveillance: The collection and analysis of non-specific data from multiple data sources to detect a possible change or trend in the health of a population. Traditionally, syndromic surveillance has referred to the collection and analysis of syndrome-related data, but has expanded to include almost any non-specific data from multiple sources that may indicate a potential biologic event has occurred.

Syndromic surveillance data sources may include: data from hospital emergency departments or other emergency encounters, physician office visits, over-the-counter pharmaceutical sales, and school absenteeism records.

Surveillance Tactics

Tactics are the detailed plans that specify how the strategies will be executed. The following tactics will be employed to accomplish surveillance objectives:

1. Refine the case definition for surveillance needs:

- When the disease is known, see existing disease-specific case definitions. When pathogen or disease is unknown (e.g., an emerging disease) or laboratory testing is not readily available (e.g., SARS), the case definition should be based on the clinical presentation.
- If a point source outbreak is suspected, the exposure and symptom onset should be a part of the case definition.
 - *This is less likely for a respiratory aerosol transmissible disease, but would more likely occur during a bioterrorism event.*
- When the prevalence of disease is low, a more specific case definition should be used (e.g., incorporating laboratory confirmation).

2. Develop a surveillance strategy. Possible surveillance strategies include:

- **Enhanced Passive Disease Surveillance.** Enhanced passive surveillance will be conducted in most infectious disease emergencies. The primary tactics will include
 - Send out a Health Alert, requesting local providers to report suspected cases
 - Implement an EMResource surveillance alert for hospital ED reporting
- **Active Disease Surveillance.** Active surveillance will be used when it is critical to identify as many cases as possible.
 - This tactic should be employed for:
 - short-term intensive investigation,
 - as part of an analytic study, and
 - when failure to detect a case could result in severe morbidity or mortality.
 - Potential reporting sources include emergency room department data, hospital admission data, and sentinel outpatient care providers.
 - Consider deploying teams to conduct surveillance when surveillance cannot be adequately performed through other means of communication. If field investigation is required, the MHOAC or DOC Manager should request assistance from the Region.

- **Active Death Surveillance.** To capture as many cases as possible, consider conducting active surveillance for deaths related to the infectious disease (as defined by the case definition) and/or deaths due to unknown causes when relatively few cases have been identified. Potential reporting sources include the Sheriff-Coroner and Clerk Recorder's Office.
 - **Aggregate or Batch Surveillance.** Use aggregate surveillance to monitor the impact on the health care system and community. Consider using if a naturally-occurring disease is widespread in the community (e.g., pandemic influenza).
 - Potential reporting sources include hospitals, largest providers of outpatient care, major triage points (for example, emergency room department logs), and/or schools.
 - Potential information to collect includes demographics (age and sex), admitting or preliminary diagnosis, and number of deaths. Reporting sources will need help determining methods for de-duplicating numbers.
 - If field investigation is required, the MHOAC or DOC Manager should request assistance from the Region.
 - **Non-traditional Surveillance.** Additional non-healthcare setting surveillance may be considered if the healthcare system is overwhelmed and cases are potentially cared for outside traditional healthcare settings and in homes.
3. **If field surveillance is required to conduct the surveillance strategy, the MHOAC or DOC Manager should request assistance from the Region.**
 4. **Work collaboratively with the Regional Epidemiologist to develop the surveillance and investigation strategies and required forms, surveys, and questionnaires. Provide guidance to teams regarding the use of these documents.**
 5. **Ensure that identified cases, contacts, and surveillance data is shared with the Regional Epidemiologist. Identified data and information collected and received will be used only for public health purposes and will be kept confidential to the extent provided by law.**

Bio-Terrorism

Bio-terrorism agents are pathogens with high risk for use as a weapon, intentionally spread to a population, resulting in high morbidity and mortality.

CDC Category A Agents

Category A represent the highest priority agents. Organisms that pose a risk to national security because they can be easily disseminated or transmitted from person to person; that result in high mortality rates and have the potential for major public health impact; that might cause public panic and social disruption; and that require special action for public health preparedness.

- Anthrax (*Bacillus anthracis*)
- Botulism (*Clostridium botulinum* toxin)
- Plague (*Yersinia pestis*)
- Smallpox (*Variola virus*)
- Tularemia (*Franciscella tularensis*)
- Viral Hemorrhagic Fever (Arenaviruses, Bunyaviruses)

CDC Category B Agents

Category B agents represent the second highest priority agents. Organisms that are moderately easy to disseminate; that result in moderate morbidity rates and low mortality rates; and that require enhanced diagnostic capacity and disease surveillance.

- Brucellosis (*Brucella* species)
- Cholera (*Vibrio cholerae*)
- Cryptosporidiosis (*Cryptosporidium parvum*)
- Epsilon toxin of *Clostridium perfringens*
- Food safety threats (*Salmonella* species, *Escherichia coli* O157:H7, *Shigella*)
- Glanders (*Burkholderia mallei*)
- Melioidosis (*Burkholderia pseudomallei*)
- Psittacosis (*Chlamydia psittaci*)
- Q fever (*Coxiella burnetii*)
- Ricin toxin from *Ricinus communis* (castor beans)
- Staphylococcal enterotoxin B
- Typhus fever (*Rickettsia prowazekii*)
- Viral encephalitis (e.g. venezuelan equine encephalitis, eastern equine encephalitis, western equine encephalitis)

Detecting Bio-Terrorism

Characteristics suggestive of bioterrorism

Any disease, syndrome, or outbreak with one or more of the following:

- Large number of ill persons with similar disease or syndrome
- Large number of unexplained disease, syndrome or death
- Unusual illness in a population
- An unusual temporal or geographic clustering of illness
- An unusual age distribution for common diseases
- Higher than expected morbidity or mortality with a common disease or syndrome
- The disease or symptoms seems to be spreading quickly/very contagious
- Failure of a common disease to respond to usual therapy
- Multiple unusual or unexplained diseases in the same patient without other explanation
- Disease with unusual geographic, seasonal or demographic distribution
- Multiple atypical presentations of disease agents
- Similar genetic type among agents from temporally or spatially distinct sources
- Unusual, atypical, genetically engineered, or antiquated strain of agent
- Endemic disease with unexplained increase in incidence
- Simultaneous clusters of similar illness in non-contiguous areas
- Situation is preceded by an explosion or other type of airborne substance release (sprays, clouds, mists)
- A large number of cases of acute flaccid paralysis with prominent bulbar palsies, suggestive of a release of *botulinum toxin*.
- Atypical aerosol, food ,or water transmission
- Deaths or illness among animals that precedes or accompanies illness or death in humans
- Declaration of pandemic or pandemic believed to be imminent

For more information on biological agents visit the CDC website.

SECTION 5: INVESTIGATION

Investigation Purpose

An epidemiological investigation is conducted to determine the cause, source, mode of transmission, risk factors, exposures, and any other factors that may be associated with the disease. Case and contact investigations may be conducted.

Investigation Coordination

An epidemiological investigation will be led by the Glenn County Communicable Disease Team in coordination with the N-E CA Regional Epidemiologist located in Shasta County. If the outbreak investigation exceeds the capacity of Glenn County or involves multiple counties within the region, the Joint Epidemiology Response Plan (JERP) should be consulted for activation of coordinated response procedures.

CDPH and CDC may provide additional investigation guidance and resources.

Investigation Objectives

The overarching objectives of the investigative response include:

- Select appropriate investigation strategies for the response.
- Conduct case investigation and contact investigation.
- Collect information about suspected cases, possible contacts, disease characteristics, clinical characteristics, and possible disease exposures in a methodologically appropriate and efficient manner.
- Obtain, prioritize, and submit specimens for laboratory testing.
- Determine if epidemiologic study is needed and, if so, design and implement it with the assistance of the Data Branch.

Investigation Strategies

Strategies are the methods and general plan for how objectives will be accomplished. Strategies employed will depend on the disease, information needs, and/or resources associated with the emergency event.

The following strategies may be used to achieve investigation objectives:

- 1. Case Investigation**
- 2. Epidemiological study**
- 3. Contact Investigation**
- 4. Symptom Monitoring**

1. Case Investigation

Case investigation is employed to:

- Identify cases of an infectious disease
- Evaluate cases for possible risk factors
- Identify exposures
- Assess case characteristics
- Provide approved recommendations to cases and/or their medical provider
- Identify possible contacts to the case
- Collect, manage and/or track laboratory specimens
- Provide recommendations to help interrupt the transmission of disease.

Case investigation can be important throughout an event but is particularly important during the initial stages of an infectious disease emergency response. Investigations may be conducted over the telephone or in person, depending on the nature of the outbreak and available resources. Go-kits are available for staff conducting field investigations.

2. Epidemiologic study

May be employed to Understand and discover:

- Source of disease
- Mode of transmission

- Exposures
- Risk factors

For example, in an outbreak suspected to have originated from one source (“point source”) this may mean identifying a specific food item, activity, location, animal(s), or other exposure that was the source of infection. Study results and analysis enables responders to create targeted public health interventions to remove the source of disease.

Two commonly used epidemiological study types are cohort studies and case control studies.

- **Cohort studies:** The frequency of disease (or other outcome) is compared between exposed persons and unexposed persons.
- **Case-control studies:** The frequency of exposure is compared between those who are ill (or other outcome) and those who are well (or other outcome). Both study types can be prospective or retrospective, and both types involve surveying both ill and well persons. A cohort study may be used if the exposed population is readily defined. A case-control study may be used when the exposed population is not easily defined, when multiple exposures need to be examined, and/or when the disease occurrence is rare.

For more information and steps to a Epidemiological Investigation, refer to Appendix A

3. Contact investigation:

Contact Investigation is used to identify contacts to an infectious case, evaluate contacts for infection/disease, recommend strategies to treat and/or prevent infection/disease in the individual contact and/or interrupt the transmission of disease.

Determine if a contact investigation is warranted

When Contact Investigation is a Priority

- There are low numbers of cases, or
- Controlling the spread of novel (e.g., SARS) or re-emerging infections, or
- Chemoprophylaxis or vaccine is available (e.g., pneumonic plague, smallpox), or
- Ring vaccination is possible (Ring vaccination: the vaccination of all susceptible individuals in a prescribed area around an outbreak of an infectious disease. Ring vaccination controls an outbreak by vaccinating and monitoring a ring of people around each infected individual – used in the past to control smallpox outbreaks.)

When Contact Investigation is Not a Priority

- The prevalence of infection in the population is high (e.g., pandemic influenza in the mid to later stages), or
- Disease occurs in high-risk groups with many possible transmission routes and a high incidence of infection, or
- The contact investigation process is slower than the infection process (the incubation period is short or the basic reproductive ratio is high or a combination of both), making it difficult to keep pace with disease transmission. Consider:
 - Prioritizing contacts to be investigated and monitored, or
 - Contacting investigation a secondary activity, or
- Cases are infectious before they become symptomatic (e.g., influenza); however, note that contact investigation may be a priority when there are low numbers of cases.

Individual contact investigation may be more effective in controlling the spread of disease when:

- there are low numbers of cases,
- when prophylaxis or vaccination is available and can be promptly administered to the contact on initial investigation, and/or
- when no prophylaxis is available but quarantine can be promptly implemented.

Individual contact investigation may NOT be feasible or an effective use of scarce personnel resources when:

- The prevalence/incidence of infection is high (e.g., pandemic influenza),
- when many transmission routes exist,
- when the contact tracing process is slower than the infection process (the incubation period is short, or the basic reproductive ratio is high or a combination of both), and/or
- when a disease has airborne transmission (e.g., smallpox).

4. Symptom monitoring

Symptom monitoring involves monitoring either cases or contacts of a case for new signs and symptoms of disease. There are two types of monitoring: active and passive.

Active Monitoring:

- A healthcare or public health worker evaluates a case or contact on a regular basis by phone, video call, and/or in person for signs and symptoms suggestive of disease.

Passive monitoring

- A case or contact is asked to perform regular self-assessment and to contact the health department immediately if specific signs or symptoms develop.

Selecting active versus passive monitoring will depend on available resources and the disease. To reduce workload in active symptom monitoring, consider conducting symptom checks once per day for low suspect cases.

Survey development

Questionnaires or survey forms will be needed for case investigations, contact investigations, epidemiologic studies and symptom monitoring. Many template surveys have been pre-developed; see Appendices. Questionnaires and surveys can be administered via the telephone, in-person, or through a computer, depending on the population being targeted (cognitive skills, education level, access to a telephone or computer, etc.) and available resources.

Coordinate survey and assessment development with the Regional Epidemiologist.

Please note: many online tools have been created to help users create web-based surveys quickly and easily. Many of these cannot be used when collecting health information, because privacy of information cannot be ensured.

Considerations for Conducting an Investigation

When a point source exposure is suspected:

To generate a hypothesis about possible exposures:

- Review cases' residence, work addresses, and travel history for common location or exposure.
- During exploratory interviews, consider activities or sites where exposures may occur (e.g., health care settings, animal processing, animal fecal aerosolization, outdoor venues, community events, large social events.)

To test a hypothesis about possible exposures:

- **Conduct an analytic study** to identify the source or vehicle of the pathogen to control or eliminate the source of disease to prevent further primary cases.
- **Conduct an environmental study** and/or collect environmental samples (request assistance from Environmental Health via the DOC.) Feasibility depends on the persistence of the pathogen in the environment and the suspected setting/source. It may be useful to define the population at risk from the initial point source exposure.

When the disease is naturally-occurring and spread person-to-person

- **Once the pathogen is characterized and the number of cases increase**, case investigation and lab confirmation may not be necessary or can be scaled back (e.g., pandemic influenza – as the pandemic reaches mid to later stages).
- **When widespread community transmission is occurring**, contact investigation activities may be scaled back due to lack of resources (e.g., extensive smallpox, pneumonic plague, SARS).
- **If surveillance suggests a change in clinical presentation** (e.g., the fatality rate increases dramatically) or the epidemiology of disease (e.g., certain populations are more severely affected), then more thorough or different case investigation strategy may be necessary.

For more information and steps to an Epidemiological Investigation, refer to Appendix A

Investigation Tactics

Tactics are the detailed plans that specify how the strategies will be executed. **The following tactics will be employed to accomplish investigation objectives.** (*Tactics will appear on blue paper in print versions*)

Investigation tactics will include the following:

- **Case Investigation**
- **Contact Investigation**

Tactical Steps to a Case Investigation

Case investigation involves the interview and research related to cases of infectious disease. Case investigation is required (case investigation may already be in process prior to activation); AND consider an epidemiologic study may be needed.

Steps for Case Investigation:

1. **Receive information from the Operations Chief regarding the event, investigation strategy, and cases to interview.**
2. **Refine the case definition for investigation purposes.**
3. **Develop method, timeline, and protocols for contacting and interviewing cases.**
4. **Identify cases to investigate.** Cases may be identified through the following sources:
 - a. Surveillance may identify cases as providers report.
 - b. Identify symptomatic contacts or contacts that know of other suspect cases.
 - c. Coordinate with the Laboratory to identify new cases through laboratory test reports.
 - d. Identify any individuals in quarantine who develop symptoms.
 - e. If Mass Prophylaxis dispensing is activated, identify cases during screening activities at the PODs.
5. **Interview the case(s)**
 - a. Review case medical and lab reports
 - b. Interview of case(s) should include:
 - i. Demographics
 - ii. Illness information including symptoms, critical dates (onset, treatment, resolve, etc.), treatment, etc.
 - iii. Travel history

- iv. Food history (when relevant)
 - v. Contact listing
 - c. Fill out any forms, surveys, or questionnaires appropriate for the disease (if known), provided by Regional Epidemiologist/JERP, CDPH/CDC, or developed by the CD team.
- 6. Determine if suspected case meets current case definition.**
- 7. Educate cases about disease and disease control measures as appropriate.**
- 8. If potential contacts are identified during the investigation,** notate information for follow up under the Contact Investigation activities.
- 9. If case(s) work in sensitive occupations or work/live in sensitive situations, forward information to Operations Chief.**
- 10. If case(s) should be isolated, forward information to Operations Chief.**
- 11. Maintain all case data and forms.**
 - a. Use paper forms for recording information until otherwise instructed by Regional Epidemiologist or Operations Chief.
- 12. Epidemiologist to collate data from case investigations and orient in terms of time, place, and person.**
 - a. Develop a line list or epi curve
 - b. Develop a hypotheses
 - c. Evaluate and refine the hypotheses
- 13. Modify investigation, control and treatment based on the conclusion drawn by the investigation.**
- 14. Further investigate geographically defined clusters of suspected or probable cases and suspected community transmission**

CDPH and CDC may provide additional case investigation guidance and resources.

Tactical Steps to a Contact Investigation

Contact investigation is utilized to identify contacts of a case of infectious disease.

The main objective is to identify and locate persons who may have been exposed to a case, which may result in monitoring for evidence of illness or referral for treatment or prophylaxis. Contact investigation activities include locating, notifying, and interviewing contacts and symptom monitoring (active and/or passive).

Steps for Contact Investigation:

- 1. Receive information and briefing from Operations Chief regarding the event, investigation strategy, and contacts to interview.**
- 2. Refine the contact definition for investigation purposes.**
- 3. Develop method, timeline, and protocols for contacting and interviewing contacts.**
 - a. Select active versus passive monitoring and frequency of symptom monitoring (e.g., once/twice daily) will depend on available resources, disease progression and clinical characteristics.
- 4. Identify contacts.**
 - The Case investigation will result in the primary source of contacts to investigate.
 - Surveillance may identify contacts to cases.
 - Public phone calls into Health Department of hotline (if established) may identify contacts.
 - 1st responders and healthcare personnel may report who have been in contact with cases.
- 5. Prioritize which contacts are investigated and monitored.**
 - First priority should be on identifying:
 - Contacts that were exposed to the infectious disease event/cases; and
 - Contacts who are at highest risk for developing the infectious disease (disease morbidity/mortality is higher in certain groups of contacts, e.g., children, pregnant women, immunocompromised)
 - Other factors to help prioritize contacts include:
 - Whether the case was suspected or confirmed
 - Case symptom onset date and the infectious period
 - Type of contact/exposure
 - Length of exposure in hours
 - Dates of first and last exposure

6. Interview contacts

- a. Interview of contacts should include:
 - i. Demographics
 - ii. Confirm exposure
 - iii. Document absence or presence of symptoms
 - iv. Travel history
 - v. Food history (when relevant)
 - vi. Any additional contacts to the case
- b. Fill out any forms, surveys, or questionnaires appropriate for the disease (if known), provided by Regional Epidemiologist/JERP, CDPH/CDC, or developed by the CD team.

7. Determine if interviewee meets the current contact definition.

8. Educate contacts about symptoms and home care/infection control if appropriate.

- a. Refer ill contacts for medical care.

9. Develop method, time-line, and protocol for monitoring contacts (e.g., how frequently contacts are monitored, duration of contact surveillance).

- a. Reference, refine, or develop protocols.
- b. Conduct contact symptom monitoring

10. If appropriate, refer contacts for post-exposure prophylaxis.

11. If potential cases are identified during the investigation, report to Operations Chief for follow-up under Case Investigations.

12. If contacts work in sensitive occupations or work/live in sensitive situations, report to Operations Chief.

13. If contacts should be quarantined, report to Operations Chief for determination.

14. Maintain all contact data and forms.

- a. Use paper forms for recording information until otherwise instructed by Regional Epidemiologist or Operations Chief.

15. Epidemiologist to collate data from case investigations and orient in terms of time, place, and person.

- a. Develop a line list or epi curve
- b. Develop a hypotheses
- c. Evaluate and refine the hypotheses

16. Modify investigation, control and treatment based on the conclusion drawn by the investigation.

17. Contact tracing activities continue until widespread community outbreak

CDPH and CDC may provide additional contact investigation guidance and resources. This includes information found on their websites:

SECTION 6: MITIGATION

Purpose

The purpose of Disease Mitigation is to implement measures to minimize the spread of infectious disease in the community.

Health Officer Authority

General Information

The local Health Officer is authorized by local, State, and Federal laws to prevent and control the spread of disease within their jurisdiction. The local Health Officer is statutorily mandated to take all necessary measures to prevent the transmission of disease. Both the Health Officer and Local Law Enforcement have specific legal authority for controlling the movement of individuals to protect the health and safety of the public.

The Health Officer is authorized to monitor, evaluate, and restrict movement to control the spread of disease, however, the Health Officer's exercise of authority may impact, curtail or impair an individual's protected rights and liberties, therefore, constitutional considerations may arise and a balanced approach should be sought.

Health Officer Authorities

The Health Officer has the authority to invoke the following orders:

- **Individual Containment:**
 - Isolation
 - Quarantine
 - Involuntary Decontamination, disinfection, & treatment
- **Community Containment:**
 - Closure of public gatherings, venues, etc.
 - Dismissal of schools
 - Area Closure/Evacuation
 - Curfew

REFER TO APPENDIX C: HEALTH OFFICER ORDERS for template orders and additional information.

Federal Authority

The Public Health Service Act grants authority to the Secretary of Health and Human Services to make and enforce regulations “necessary to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the States or possessions, or from one State or possession into any other State or possession”¹. The law includes limitations on authority for apprehension, detention, or conditional release of individuals, requiring Executive orders of the President. The federal government can also implement quarantine under the Stafford Act, which triggers the United States Government Interagency Domestic Terrorism Concept of Operations Plan.²

State and Local Authority

The primary authority for isolation and quarantine resides at the state level as an exercise of state’s police power.³ The California Department of Public Health (CDPH) has the authority to quarantine, isolate, inspect, and disinfect persons, animals, houses, rooms or other property, places cities, or localities, whenever it deems it necessary to protect or preserve the public health⁴. Furthermore, CDPH promulgates general and specific rules regarding quarantine and disinfection of persons and property and may require the local Health Officer to enforce its regulations⁵.

A state’s authority to compel isolation and quarantine within its borders is derived from its inherent “police power”—the authority of a state government to enact laws and promote regulations to safeguard the health, safety, and welfare of its citizens. California law expressly authorizes compelled isolation and quarantine.

The role of CDPH in emergencies and disasters is further described as follows: “CDPH may take any necessary action to protect and preserve the public health....The department may also advise local

¹ 42 U.S.C. 264

² 42 U.S.C. § 5121 et seq.

³ Gibbon v. Ogden 22 U.S.1(1824) and Jacobson v. Massachusettes,197 U.S.11(1905)

⁴ CA HSC § 120145

⁵ CA HSC § 120210

health authorities, and, if the department determines that public health is menaced, it shall control and regulate the actions of the local health authorities".⁶

The director of the Department of Food and Agriculture may also impose quarantine measures.⁷

Under California Health and Safety Code, the local Health Officer (HO) is granted authority for ordering and ensuring measures related to isolation and quarantine both before and following a declaration of emergency.

The county Health Officer's authority includes:

1. Orders and ordinances of the board of supervisors pertaining to public health and sanitary matters;
2. Orders including quarantine and other regulations prescribed by the California Department of Public Health ; and
3. Statutes related to public health.⁸

Health Officer Authority and Native American Tribes

Native American tribes have the right to make and be governed by their own laws. However, this does not exclude all state regulatory authority on the reservation. State sovereignty does not end at a reservation's border.

Disease Outbreak That Threatens To Spread Beyond Tribal Lands

When state interests outside the reservation are implicated, states may regulate the activities even of tribe members on tribal land. Thus, if an outbreak of disease within the borders of a reservation threatens to spread beyond its borders, a Health Officer may be able to enforce orders within those borders.

⁶ CA HSC § 100180; Abbott, D. and McGurk, J. (1998). *Authority and Responsibility of Local Health Officers in Emergencies and Disasters*. California Department of Health Services.

⁷ CA Food and Agriculture Code 5763, 5301, 9568, 9569(a)

⁸ CA HSC § 101030

Validity and Enforcement of Health Officer Orders Issued While Individual is Outside the Reservation

It is also well established that states have criminal jurisdiction over reservation Indians for crimes committed off the reservation. Thus, if a tribal member is subjected to an order of isolation outside the reservation, then violates that order and returns to the reservation, the state would have criminal jurisdiction over that individual.

Health Officer and Declaration of Emergencies

In 2007, Section 56.10 of the Civil Code was amended; Sections 101080 and 101085 of the Health and Safety Code were amended; and Sections 101080.2 and 120176 were added to the Health and Safety Code, relating to public health.

The Local Pandemic and Emergency Health Preparedness Act of 2006 amended Section 101080 to the Health and Safety Code. The amendment added Health Officer authority to declare a local health emergency in situations of imminent and proximate threat of the introduction of any contagious, infectious, or communicable disease, chemical agent, non-communicable biologic agent, toxin, or radioactive agent.

The amended section states:

101080. Whenever a release, spill, escape, or entry of waste occurs as described in paragraph (2) of subdivision (b) of Section 101075 and the director or the local health officer reasonably determines that the waste is a hazardous waste or medical waste, or that it may become a hazardous waste or medical waste because of a combination or reaction with other substances or materials, and the director or local health officer reasonably determines that the release or escape is an immediate threat to the public health, or whenever there is an imminent and proximate threat of the introduction of any contagious, infectious, or communicable disease, chemical agent, noncommunicable biologic agent, toxin, or radioactive agent, the director may declare a health emergency and the local health officer may declare a local health emergency in the jurisdiction or any area thereof affected by the threat to the public health.

Whenever a local health emergency is declared by a local health officer pursuant to this section, the local health emergency shall not remain in effect for a period in excess of seven days unless it has been ratified by the board of supervisors. The board of supervisors shall review, at least every 14 days until the local health emergency is terminated, the need for continuing the local health emergency and shall proclaim the termination of the local health emergency at the earliest possible date that conditions warrant the termination.

For more information and procedures on Health Emergency Declarations, refer to Appendix B

Health Officer Authority for Isolation and Quarantine

The Health Officer (HO) has legal authority to issue individual or mass isolation and quarantine orders to protect the public's health.⁹ The HO may issue isolation/quarantine orders any time the HO has reasonable grounds to believe the order is necessary to prevent the spread of disease.¹⁰ The Isolation/Quarantine order may be "strict" or "modified"¹¹

According to California Code of Regulations, isolation and quarantine are defined as follows:

- **Isolation:** "Isolation is defined as separation of infected persons from other persons for the period of communicability in such places and under such conditions as will prevent the transmission of the infectious agent."
- **Quarantine:** "Quarantine is defined as the limitation of freedom of movement of persons or animals that have been or may have been exposed to a communicable disease for a period of time equal to the longest usual incubation period of the disease, in such manner as to prevent effective contact with those not so exposed."

Additionally, isolation can be either strict or modified:

⁹ CA HSC § 120130, 120175

¹⁰ In Re Application of Arata (1921) 52 Cal. App. 380

¹¹ CA HSC § 120130

Strict Isolation¹²: If the disease requires strict isolation, the Health Officer shall ensure that instructions are given to the patient and members of the household, defining the area within which the patient is to be isolated and stating the measures to be taken to prevent the spread of disease.

Modified Isolation: If the disease is one in which only a modified isolation is required, the local Health Officer shall issue appropriate instructions, prescribing the isolation technique to be followed. The isolation technique will depend upon the disease.

Public Health Orders for First Responder to Isolate

In 2007, Section 56.10 of the Civil Code was amended; Sections 101080 and 101085 of the Health and Safety Code were amended; and Sections 101080.2 and 120176 were added to the Health and Safety Code, relating to public health.

The Local Pandemic and Emergency Health Preparedness Act of 2006 added Section 101080.2 to the Health and Safety Code. This section states:

(a) The local health officer may issue, and first responders may execute, an order authorizing first responders to immediately isolate exposed individuals that may have been exposed to biological, chemical, toxic, or radiological agents that may spread to others. An order issued pursuant to this section shall not be in effect for a period longer than two hours and shall only be issued if the means are both necessary and the least restrictive possible to prevent human exposure.

Use of Public Health Orders

Equitable and ethical use of public health orders includes supporting and compensating persons who make sacrifices in their individual liberties and freedoms for public good. Specifically, considerations must be in place to provide shelter, food and lost wage compensation, and to protect the dignity and

¹² Title 17 CCR § 2516; 2518

privacy of the individual. Persons under public health orders should be treated with respect and dignity. Considerable thoughtful planning is needed to implement public health orders properly.

Obligations of the People under Public Health Orders

Once the Health Officer issues an order, patients have the duty to obey the orders. It is a misdemeanor to disobey the Health Officer order.¹³ The Health Officer Order should provide a method by which the person may register objections to the order. The Order should contain justification for the action and the process to contest or object to the order. Judicial relief under California Penal Code 1473 can be pursued by the person or their legal representative by filing an application with the Court.

Enforcement of Public Health Orders

Pursuant to Section 11158 of the Government Health & Safety Code, the sheriff of each county, or city and county, may enforce within the county, or the city and county, all orders of the Department of Public Health issued for the purpose of preventing the spread of any contagious, infectious, or communicable disease. Every peace officer of every political subdivision of the county, or city and county, may enforce within the area subject to his or her jurisdiction all orders of the Department of Public Health issued for the purpose of preventing the spread of any contagious, infectious, or communicable disease. This section is not a limitation on the authority of peace officers or public officers to enforce orders of the Department of Public Health. When deciding whether to request this assistance in enforcement of its orders, the Department of Public Health may consider whether it would be necessary to advise the enforcement agency of any measures that should be taken to prevent infection of the enforcement officers.

It is a misdemeanor to disobey a Health Officer order.¹⁴ Law enforcement has the authority to detain any individual who refuses to comply with a Health Officer order or a court order.¹⁵ Standard law enforcement protocols for use of force in the case of a misdemeanor apply in compelling compliance with isolation and quarantine.

¹³ CA HSC § 120275

¹⁴ CA HSC § 120275

¹⁵ SB 104: Government Code § 26602,41601, CA HSC § 100106

Compliance with State and Federal Privacy Laws

The Health Information and Portability and Accountability Act of 1996 (“HIPAA”) permits public health agencies to use protected health information for public health activities that include but are not limited to: preventing or controlling disease, injury or disability, reporting disease, reporting injuries, reporting vital events, the conduct of public health surveillance, the conduct of public health investigations, or the conduct of public health interventions.¹⁶ HIPAA allows the release of information, when authorized by law, to persons who may be at risk of contracting or spreading a disease.¹⁷ When using, disclosing or requesting protected health information, public health agencies are required to limit the use, disclosure or request to the minimum necessary.¹⁸ HIPAA does not define what constitutes the “minimum necessary”. That is a determination that must be made on a case by case basis.

¹⁶ 45 C.F.R. section 164.512(b)(1)(i)

¹⁷ 45 C.F.R. section 164.512(b)(1)(iv)

¹⁸ 45 C.F.R. section 164.502(b)

Legal Authority for Community Containment

Controlling Movement of People and Property

Both the Health Officer and Local Law Enforcement have specific legal authority for controlling the movement of individuals to protect the health and safety of the public.

Community containment measures may be used to prevent the spread of a communicable disease as part of an overall disease mitigation strategy. Community containment (social distance) refers to focused measures and/or community-wide measures to increase social distance between individuals who are well and unexposed from individuals who have been exposed to or infected by a communicable disease. Social distancing is sometimes used interchangeably with community containment within the isolation and quarantine literature and field.

There are several techniques that the Health Officer can use to curb the spread of disease in the community, some require legal orders, and some are guidance. This section will address the community containment strategies that may require legal orders.

Area Closures and/or Evacuations

The Health Officer may find it necessary for the protection of public health and safety to order immediate movement of individuals away from a particular building or geographic area.

The Health Officer may close an area “under immediate menace to the public health or safety” “created by a calamity including a flood, storm, fire earthquake, explosion, accident or other disaster,” Penal Code §409.5. The Health Officer can also order persons within the affected area to leave. The general powers of the Health Officer to control the spread of disease are also applicable in an evacuation event. H&S §120175.

Constitutional considerations

Evacuation orders cannot be “arbitrary, oppressive and unreasonable,” and must be narrowly drawn to be clear and specific to the situation. These orders must have documentation that factually supports the justification for the proposed evacuation. The process for issuing and enforcing the orders should adhere to applicable procedural protections

Highway Closures

An area closure may require highway closure. **To address a highway closure, coordinate the order with the following partner agencies:**

- Department of Transportation has the authority to restrict traffic or close state highway for the protection of the public.¹⁹
- CA Highway Patrol, police departments, and Office of Sheriff may close highway if there is a threat to public health or safety caused by dangerous substances.²⁰
- Health Officer has the authority to close the area where the menace exists where the menace was created by an avalanche.²¹
- Sheriff and Chief of Police....responsibility for closing areas to the public and consequently to order an evacuation whenever a menace to the public health or safety is created by a calamity.²²
- Law enforcement officers have the authority to close or restrict access to an area whenever a menace to the public health or safety is created by a calamity.²³

¹⁹ CA Street and Highways Code §124

²⁰ CA Vehicle Code § 2812

²¹ CA Penal Code § 409.6

²² CA Penal Code § 409.5

²³ CA Penal Code § 409.5

Public Assembly/Venues Closures

Closure of public gatherings may be very effective in a highly communicable disease that is transmitted by air or close contact. The Health Officer has the authority to close public gatherings and venues should it be deemed necessary to protect the public's health and control the spread of communicable disease.²⁴

The Health Officer may close an area where an immediate menace to the public's health exists and may also temporarily close public gatherings. If the closures involve multiple venues and appear likely to exceed several days, the Health Officer should consult with local officials as to whether a local emergency should be declared. Where a venue is subject to a permitting process, the permitting agency may be consulted for possible immediate suspension of the permit.

Closures of public gatherings raise issues regarding freedom of assembly, and freedom of speech, due process and equal protection rights.

Curfews

Prevention and control of highly communicable disease that threaten public health may require the use of a curfew, such as a means to limit density of groups of people at shopping venues when schools are closed.

Curfews may only be imposed under the conditions of Government Code §8634 and §8630(a):

- In a non-emergency situation by a local ordinance
- During a local emergency the local government may impose a curfew to preserve the public order and safety. Curfews can be proclaimed by Board of Supervisors, official designated by the Board of Supervisors (BOS) (through a county ordinance), or the Governor.²⁵

School Closures

The Health Officer has the authority to close schools should it be deemed necessary to protect the public's health and control the spread of communicable disease.²⁶

²⁴ CA HSC § 101000, 101025, 101030, 101040, 101475, 120175

²⁵ CA Government Code § 8634

Additionally, the Health Officer has the authority to exclude from schools certain persons who are under strict isolation/quarantine orders.²⁷

Health Officer Authority to Conduct Involuntary Decontamination, Disinfection, & Treatment

Health Officers may issue orders for decontamination, disinfection and/or treatment, if necessary to control or prevent the spread of the disease, condition or outbreak. The type of treatment, like the type of examination, is left to the Health Officer's discretion as is necessary and appropriate to address the circumstances of the presented situation. In addition, CDPH may request the Health Officer to assist with and perform such functions as disinfection, treatment and decontamination.

- The same principles discussed above apply to mass involuntary decontamination, disinfection and treatment.

Court Order Required For Non-cooperation

Although, Health Officers may have the power to order decontamination, disinfection and or treatment, they cannot enforce such orders without either (1) the subject's consent or (2) obtaining a court order. If the subject refuses to comply with the court's order, the Health Officer may implement isolation and quarantine and/or institute a contempt of court proceeding.

The least restrictive and least invasive principles described in "Constitutional Limitations Impacting Authority of the Health Officer," should also be considered in this context. Any intrusion must be limited to only such time as needed to complete the examination and/or determine that the person no longer poses a menace to the health of society.

Failing voluntary cooperation or consent to treatment by the infected person subject to the issued orders, the Health Officer may be statutorily authorized to isolate and quarantine such individuals. This authority extends to the temporary detention of an individual believed to have been exposed to biological agents or other contaminants in order to verify exposure and carry out decontamination procedures, provided that such actions are reasonably necessary to protect the public health.

²⁶ CA HSC § 101000, 101025, 101030, 101040, 101475, 120175

²⁷ CA HSC §120230

Mitigation & Containment Objectives

Disease mitigation may occur at the community or individual level. **General objectives for disease mitigation include:**

- Reduce the overall risk of transmission of a communicable disease by limiting social interactions and preventing inadvertent exposures
- Reduce the risk of exposure by separating and/or restricting the movement of persons suspected to have or with confirmed communicable disease that poses a significant public health threat to the community
- Reduce the risk of transmission of a communicable disease by restricting the movement of persons who may have been exposed to an infectious disease, but are not yet ill
- Identify the least restrictive strategy for limiting disease transmission
- Provide disease-specific infection control guidance to healthcare community

Mitigation & Containment Strategies

Mitigation strategies provide the modes for disease containment. Containment strategies include:

- Non-Pharmaceutical Interventions (NPIs)
- Medical Countermeasures – Prophylaxis

Non-Pharmaceutical Interventions

Non-Pharmaceutical Interventions (NPIs) include community and individual level social distancing measures to limit the spread of communicable disease. NPIs may be implemented to contain a person who is ill with the disease (isolation), who may have been exposed to the illness but are not ill (quarantine, movement restrictions), or a community where the need is identified to decrease the spread of disease (social distancing, travel restrictions, other precautionary behaviors). NPIs protect the public while preserving, to the extent possible, daily activities.

NPIs include:

- **Community containment**
 - Social Distancing
 - Closure of public gatherings
 - Dismissal of schools
 - Movement restrictions, area closures, and travel warnings
- **Individual containment**
 - Monitoring
 - Quarantine
 - Isolation
 - Decontamination

Rationale for the Use of NPIs

- To delay disease transmission and outbreak peak, to buy time for vaccine production.
- To decompress the epidemic peak and reduce the burdens on health care infrastructure.
- To diminish the total number of cases and to reduce morbidity and mortality.

Community Mitigation & Containment Strategies

Community mitigation strategies are used when it is determined that group-level activities should be altered to reduce the spread of disease.

Community mitigation strategies may target specific populations like students/teachers, workplace employees and clients, public transportation riders, attendees at large public gatherings (e.g., concert, sporting events, religious services), and other groups.

Strategies to reduce the transmission of disease during group activities include non-pharmaceutical interventions such as social distancing, healthy habits, workplace modifications, school dismissal or modification, cancellation of events/locals, closure of public gatherings etc.

Strategies for implementation of community mitigation include, but are not limited to:

- **Social distancing**
 - Measures to decrease the congregation of groups and/or encourage people to keep their physical distance from one another during outbreaks of disease that are easily transmissible, to slow the spread of infection.
- **School dismissal/modification**
 - Dismissal: The release of students from school primarily to reduce the congregation of many young people and the spread of disease.
 - Modification: Reduced class size, class mixing at break times, and/or use of enhanced healthy habits may be utilized before school dismissal.
 - *Note that schools may remain open to provide meals to children in need, distance education, and/or as facilities for other emergency operations.*
- **Closure of public gatherings**
 - Closure or postponement of any mass gathering that bring many people together in close proximity to reduce the potential for disease transmission.
 - Mass gatherings including mass transit, religious services, and other group settings.

- Postponement and/or cancelling of events such as parades, sporting events, fairs, or concerts
- **Workplace modifications**
 - Work settings and/or practices may be modified to reduce close contact among employees and clients.
 - Examples include elimination of face to face meetings (telephone conversations or teleconferences used instead), reconfiguration of desks to increase the distance between workers, installation of glass barriers between clients and employees at service desks, closure of lunch/break rooms, staggered shifts, telecommuting, etc.
- **Restriction and Exclusion**
 - Restriction and exclusion limit the spread of disease by decreasing transmission of an infectious disease from exposed persons in sensitive occupations or situations to vulnerable susceptible populations.
 - This strategy applies when there are actions that promote transmission and/or when there are environments in which identified vulnerable susceptible populations may become infected. Examples:
 - Require N-95 respirators, other PPE or workplace exclusion of healthcare workers who are not vaccinated for flu
 - Exclusion of unvaccinated children from school
- **Area closure and/or evacuation**
 - Maybe used when the environment has become hazardous such as a chemical spill, radiological materials release, water/sanitation outage, etc.
- **Travel restrictions**
 - Limit/restrict travel to countries with a known outbreak of highly infectious disease

Isolation & Quarantine Mitigation Strategies

Isolation and quarantine may be imposed to stop or slow the spread of communicable disease. They may be applied to individuals and to groups, on a voluntary or involuntary basis.

Isolation and Quarantine Definitions

- **Isolation** is the separation of infected persons from others for the period of communicability in order to prevent the transmission of the agent.
- **Quarantine** is the limitation of freedom of movement of persons who may have been exposed to a communicable disease, in order to prevent contact with unexposed persons. The quarantine period is equal to the longest usual incubation period (time from exposure to development of symptoms).

These strategies apply to person-to-person transmitted diseases in which it is possible to distinguish whether an individual is infected, exposed, uninfected, and/or unexposed and it is possible to implement the separation of these groups before transmission occurs.

Continuum of Isolation & Quarantine

1. **Passive monitoring:** The subject performs self-assessments based on the etiology of the disease and is directed to contact Public Health immediately if symptoms occur. Individuals in this category do not require separation from others or restriction of movement within the community.
2. **Active monitoring with activity restriction:** A PHN evaluates the subject on a daily basis (or more often if needed) by phone, Skype/FaceTime, or in person for signs and symptoms based on the etiology of the disease. Activity restrictions to be determined by Public Health and may include any or all of the following:
 - a. No travel on any public conveyance
 - b. Exclusion from work and/or school (telework is permitted)

- c. Exclusion from public places (shopping malls, movie theaters) and congregate gatherings.
 - d. Non-congregate public activities may be permitted when a minimum 3-foot distance from others (i.e. jogging at a park) and will be determined applicable based on the specific disease and disease traits.
 - e. Federal public health travel restrictions apply
3. **Quarantine:** The subject is separated from others throughout the duration of the defined incubation period for the suspected highly infectious disease from the date of last exposure. The subject is restricted voluntarily or involuntarily, in their home or another appropriate facility. A PHN will provide monitoring during that time on a daily basis.
4. **Working quarantine:** This restriction applies to healthcare workers or other essential personnel who have been exposed to patients of a highly infectious disease but need to continue working. Such personnel will be quarantined at home during off duty hours but permitted to work at their designated facility, with appropriate PPE, pending approval from their facility and Public Health.
5. **Widespread community quarantine, including “Cordon Sanitaire”:** This is a legally enforceable quarantine of a large area.
6. **Modified Isolation:** Dependent on the disease, the Health Officer may recommend or order modified isolation. The Health Officer shall issue appropriate instructions prescribing the technique to be followed (example: in-home isolation of ill in a segregated bedroom).
7. **Strict Isolation:** Requires the isolation of a person ill with a highly contagious disease. Strict isolation may be in a home or a medical facility. Additional instructions will be issued by Public Health stating isolation requirements (may include use of designated isolation room, reverse air, PPE, decontamination, etc.)

Medical Countermeasures - Prophylaxis

Medical countermeasures are the use of medications as prophylaxis to prevent the contraction and spread of the disease. They also include the use of medications for post-exposure prophylaxis. Medical countermeasures may be provided to an isolated group such as close contacts to a case of infectious disease or to the whole community following a bio-terrorism incident. Medical countermeasures, on grand scale may include the use of the Strategic National Stockpile (SNS).

For more information on Medical Countermeasures, SNS, and Mass Prophylaxis, refer to the Glenn County Medical Countermeasures and Mass Prophylaxis Plan.

Mass Prophylaxis

Mass prophylaxis is a public health strategy to dispense pharmaceuticals and/or administer vaccine to potentially exposed populations and/or those at risk of exposure in order to prevent infection.

Examples include:

- Mass dispensing of antibiotics to a community following an act of bio-terrorism such as the dispersal of plague or anthrax.
- Mass vaccination during a pandemic of influenza

Post Exposure Prophylaxis (PEP)

PEP is a medication or vaccine given to prevent exposed persons from developing disease and thereby reducing transmission.

Examples include:

- Providing antibiotics to exposed close contacts to a case of bacterial meningitis

Determining What Mitigation Strategy to Employ

The Health Officer should consider a multitude of variables when determining which mitigation strategy(s) to enact. When applicable, consultation with subject matter experts and community partners should be sought to assure consideration for all impacts of the mitigation strategy are weighed and support is available to ensure the mitigation measure is effectively employed.

Considerations for Determining Mitigation Strategy

- **Identify the least restrictive strategy that can effectively mitigate the spread of disease**
- **Consider the etiology of the disease including the mode of transmission, incubation period, level of communicability, mortality and morbidity rate, prophylactic medications, and treatments.**
 - Is there a vaccine available? Is it widely used in prevention?
 - Is the community level of vaccination rates enough to slow the disease?
 - Consider a tiered and targeted mitigation strategy such as individual isolation, social distancing of those who are not vaccinated, and offering vaccination and prophylaxis to close contacts
 - Example: Measles
 - Is it airborne, highly infective, and low community immunity rate?
 - Consider employing a higher level mitigation strategy to prevent significant spread and illness
 - Example: SARS, MERS, Smallpox
- **Is their current community spread of the disease?**
 - Consider social distancing, school closures, closure of public gatherings etc.
 - Consider working quarantine for healthcare personnel exposed but who can safely prevent potential further exposure/infection through use of PPE
 - Example: Pandemic influenza
- **Is the disease foreign and imported by travel to the region?**
 - Consider travel warnings, travel restrictions, and individual containment for those exposed by travel
 - Example: Ebola, MERS
- **Have certain individuals or groups had exposure to an infectious disease?**
 - Consider individual mitigation measures appropriate to the disease etiology and level of exposure including monitoring, activity restriction, and quarantine
 - Example: Exposure to Ebola can be at varying levels thus risk level varies and coordinating mitigation strategy. Refer to Ebola Response Plan for detailed levels of risk and coordinating level of mitigation.
- **Has there been a targeted exposure, Bio-terrorism or other event? Can it be effectively contained?**
 - Consider area closures and decontamination for chemical or radiological incidents

- Consider community quarantine – Cordon Sanitaire
- Is there an effective medical countermeasure available – consider medical countermeasures distribution
- **Do you have an infected/ill person?**
 - **Consider the etiology of the disease including the mode of transmission, incubation period, level of communicability, mortality and morbidity rate, prophylactic medications, and treatments.**
 - Is there a vaccine available? Is it widely used in prevention?
 - Example: Measles
 - Is it airborne, highly infective, and low community immunity rate?
 - Example: SARS, MERS, Smallpox
 - Is there an effective treatment available?
 - Example: Tuberculosis
 - Determine whether isolation will be necessary, modified or strict, and whether a HO order is necessary to ensure compliance
- **Quarantine or monitoring with activity restrictions? Consider the following:**
 - **What level of quarantine:** working quarantine, activity restriction with monitoring, or complete quarantine?
 - How is the disease spread? Can the person safely be in a park or other non-confined area without potential for further spread?
 - Consider monitoring with activity restrictions
 - Example: exposure to Ebola or other contact spread disease
 - If the disease is airborne or droplet, consider the period of infectivity? Is the person communicable before onset of symptoms?
 - If yes, quarantine
 - If no, consider monitoring with or without activity restrictions
 - **Consider your resources and compliance**
 - Can the person be reasonably trusted to follow instructions without a court order? If yes, monitor with activity restrictions
 - If non-compliance is likely or has occurred, HO order for quarantine
 - Consider civil liberties
 - Is law enforcement available and willing to enforce the order?
 - Consider how logistical needs will be met if a HO order for quarantine is issued
 - How will the person's needs be met including income, food, housing, medical care, etc.?
 - Provide access to behavioral and spiritual health services to ensure needs are met and compliance can be maintained.

Refer to the Matrix below for additional considerations in determining which Mitigation Strategy to sanction.

Matrix of Non-Pharmaceutical Interventions for Mitigation & Containment

This matrix is intended to assist in the decision of which Non-Pharmaceutical Intervention(s) to consider for the mitigation and containment of the spread of the disease. The least restrictive appropriate strategy should be utilized.

Community Containment Strategies

Strategy	Target Population	Reason & Use	Voluntary or Involuntary	Level of Effectiveness	Pros	Cons	Disease Type
Social Distancing	Whole community or targeted sector of population	Decrease number of contacts, increase distance between persons, modify or postpone public gatherings, modify workplace practices	Voluntary	Limited	Least restrictive means. Limited impact on community. Does not require a HO Order.	Limited effectiveness, workplace – commuter disruption	Airborne Droplet Contact
Dismissal of Schools & Childcare	Children	Decreases spread of disease in children. Limits number of contacts.	Both. Consultation with the schools should be sought before a decision is made to dismiss children, however, HO can order closure with Emergency Declaration	Somewhat effective	Decreases the congregation of children – social distancing	Economic impact for schools (loss of ADA funds). Impacts workforce due to childcare issues. Nutritional impact on children in school meal programs.	Airborne Droplet
Closure of public gatherings	Whole Community	Decreases spread of disease. Social distancing	Involuntary ordered by HO.	Effective	Decrease congregate settings that promote spread of disease	Difficult to enforce. Can lead to community unrest. Takes away civil liberties.	Airborne Droplet
Travel warnings	Travelers	Warns residents of disease epidemics in other locations to which they may travel.	Voluntary	Somewhat effective	Least restrictive method. Allows for informed decision to travel.	Economic impact on the community for which travel is not advised.	Airborne Droplet Vector Contact

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Travel restrictions	Travelers	Restricts travel to disease impacted region or country	Involuntary ordered by HO.	Somewhat effective	Limits importation of the disease	Difficult to enforce.	Airborne Droplet Vector Contact
Area Closures	People in that area of the community	Limits people from traveling into and out of an area that was exposed to a disease causing agent	Involuntary ordered by HO.	Very effective	Removes people from a contaminated area. Decreases further contamination or spread of disease	Requires multiagency coordination to evacuate and enforce closure.	Bio-terrorism or Other (chemical or radiology incident)
Community Quarantine “Cordon Sanitaire”	Whole community		Involuntary. Requires PH Emergency Declaration	Effective		Difficult to enforce. Can lead to community unrest. Takes away civil liberties. Requires multi-agency coordination to enforce. Would require state assistance.	Airborne Bio-terrorism or Other (chemical or radiology incident)

Individual Containment Strategies

Strategy	Exposed (non-symptomatic) or infected (ill)	Reason	Voluntary or Involuntary	Level of Effectiveness	Pros	Cons	Disease Type
Monitoring Only	Exposed	Symptom monitoring alone is effective in limiting spread of disease.	Voluntary	Somewhat effective	Least restrictive means, limited impact on individual	May become ill and infect someone else.	Contact Vector
Monitoring with activity restrictions	Exposed	Moderate activity restrictions and monitoring are sufficient to lower threat of spread of disease	Either. Involuntary only when compliance may be an issue.	Somewhat effective	Less restrictive, can be voluntary, restricts only activities that may lead to spread of disease	May become ill and infect someone else. May require HO if uncompliant.	Contact Droplet
Quarantine	Exposed	Person must be contained to eliminate threat to community	Involuntary, requires a HO Order	Effective	Eliminates the potential for spread of the disease.	Difficult to enforce. Can lead to unrest. Takes away civil liberties. Requires multi-agency coordination to enforce.	Airborne Droplet
Working Quarantine	Exposed	Person fills a critical job role and needs to continue working and can continue with use of appropriate PPE. (i.e. healthcare provider) (Rare)	Voluntary but requires a HO Order	Somewhat effective	Permits continued work, less restrictive	Requires the use of PPE. May become ill and infect someone else. Maybe ineffective in prohibiting after work activities. Must be coordinated with workplace.	Airborne Droplet
Modified Isolation	Infected	Ill person requires limited isolation (in-home, cohort or in HC facility)	Voluntary	Somewhat effective	Less restrictive	Could lead to unintentional infection of a caregiver or contact	Contact Droplet Vector

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Strict Isolation	Infected	Ill person with a highly infectious disease is isolated preferably in a healthcare facility	Involuntary. May require HO Order.	Effective	Ill person is isolated and contacts and caregivers are required to take steps to prevent spread of disease	Uses a lot of medical resources	Airborne Droplet Contact
Decontamination	Both	Person(s) have been exposed to hazardous material (biological, chemical, or radiological)	Both. Involuntary may require a HO Order	Effectiveness is dependent on the contaminate.	Removal of clothing and decontamination for chemical and radiological removes the majority of the illness causing contaminate	Less effective for biological hazards. Uses a lot of resources. Requires multi-agency coordination. Decontamination is most effective if done immediately but delays medical interventions.	Contact Bio-terrorism or Other (chemical or radiology incident)

Mitigation & Containment Tactics

Tactics are the detailed plans that specify how the strategies will be executed. **The following tactics will be employed to accomplish mitigation & containment objectives.** (*Tactics will appear on blue paper in print versions*)

Mitigation & containment tactics will include the following:

- **Community containment**
 - Social Distancing
 - Closure of public gatherings
 - Dismissal of schools
 - Movement restrictions
 - Area closures/evacuations
 - Mass prophylaxis
 - Community Quarantine

- **Individual containment**
 - Monitoring
 - Quarantine
 - Isolation
 - Decontamination
 - Medical countermeasures

Tactical Steps for Social Distancing

Social distancing measures are utilized to decrease the congregation of groups and encourage people to keep their physical distance from one another during outbreaks of disease that are easily transmissible, to slow the spread of infection.

Social distancing, as a whole, is a recommendation not an order. The focus will be on community education of communication.

To effectively implement social distancing measures in the community, complete the following:

Tasks for Implementing Social Distancing

1. **PH DOC Manager and Operations Chief, meet and consult with Health Officer and other subject matter experts** (local, state, federal) to determine whether social distancing measures should be put in effect
2. **PH DOC Manager, MHOAC or Operations Chief will meet with partners** who have confined populations (jails, schools, residential facilities) to provide guidance on implementation of social distancing in their facilities
3. **PH DOC Manager will brief PIO.** PIO will be tasked to develop a plan for public communication of the social distancing measures
 - a. Information Plan should include the use of the following dissemination channels:
 - i. Use of local media channels
 - ii. Use of social media
 - iii. Dissemination through partner agencies including:
 1. Schools
 2. Agencies serving access and functional needs populations
 3. Local government agencies
 4. Healthcare partners
 - iv. Community postings – flyers etc.
4. **Operations Chief will brief DOC Manager on surveillance and disease impacts**
 - a. Epi and CD staff will conduct disease surveillance
5. **Plans Chief will monitor the situation and brief DOC Manager**
 - a. Situation reports as well as epi data, from Operations, on the spread of the disease (case counts, school surveillance reports, etc.) will be analyzed to determine whether the social distancing measures are effective and should continue to be in effect
6. **DOC Manager will consult with Health Officer and other subject matter experts** to determine whether social distancing measures should remain in effect, whether additional mitigation measures should be considered, or when discontinuation is desired

Tactical Steps for Closure of Schools and Daycare

Schools and daycare may be modified or closed to decrease congregation of children who are substantial incubators of disease. This can be utilized in addition to social distancing to further decrease the spread of disease in the community.

- **Modifications** such as reduced class size, class mixing at break times, and use of enhanced hygiene may be issued as a **recommendation**, however,
- **Dismissal of students** must be issued as a **Public Health Order** to ensure education regulations are addressed

Tasks for Implementing Modification or Closure of Schools

1. **PH DOC Manager and Operations Chief, meet and consult with Health Officer, School Officials and other subject matter experts** (local, state, federal) to determine whether modifications or closure of schools and daycare should be put in effect. *If the Operational Area EOC is activated, medical/health branch should meet with education branch to develop the following plans.*
 - a. Discuss all options and select least restrictive action that can be effective
 - b. Determine how impacts of school modification or closure will be addressed including:
 - i. Use of e-learning (distance learning) techniques to allow for continued delivery of curriculum
 - ii. Continued delivery of school nutritional program for children enrolled in school meal program
 - iii. Recovery of school funding from ADA
2. **PH DOC Manager will brief PIO.** PIO will be tasked to develop a plan for Joint Information with school/Office of Education PIO(s). *If OA EOC is activated, this function will be performed by EOC PIO.*
 - a. Joint Information Plan should include the following:
 - i. Joint press releases
 - ii. Schedule for media briefings or press conference(s)

- iii. Channels for release of information including: media, social media, school modes, etc.
 - b. Key topics to be addressed include:
 - i. Reason for closure
 - 1. Disease specifics
 - ii. Anticipated duration
 - iii. Any continuation of services (nutritional programs, school curriculum, etc.)
 - iv. Additional social distancing techniques
 - 1. Discourage out of school mixing (social events, in-home daycare etc.)
- 3. Command and Management with the assistance of the Health Officer (Technical Specialist) will complete Public Health Order for closure of school(s)**
- a. Declare a local health emergency if no emergency proclamations are currently in place
 - i. Meet and consult with County Counsel to ensure legal authority is met in the issuance
 - ii. Meet with/ coordinate proclamation and/or order for closure with Board of Supervisors
 - b. Provide a copy of the official Order for School Closure to all involved parties including schools, local law enforcement, etc.
- 4. Operations Chief will brief DOC Manager on surveillance and disease impacts**
- a. Epi and CD staff will conduct disease surveillance
- 5. Plans Chief will monitor the situation and brief DOC Manager**
- c. Situation reports as well as epi data on the spread of the disease (case counts, school surveillance reports, etc.) will be analyzed to determine whether the social distancing including school closure are effective and whether they should continue to be in effect
- 6. DOC Manager will consult with Health Officer, school officials, and other subject matter experts to determine whether school closures should remain in effect, whether additional mitigation measures should be considered, or when discontinuation and repatriation is desired**

Steps for Issuance of School Closure Order

1. The Health Officer, in coordination with school officials, issues order for school closure to protect the public's health and control the spread of communicable disease.²⁸
2. Coordinate Joint Information System to ensure a unified message is released to the community
3. School Officials should do the following to recoup lost ADA:
 - a. When a school is closed or when there is a material decrease in ADA due to an emergency, school districts should file a J-13A waiver with the California Department of Education (CDE) (ref. Education Code Sections [E.C.] 41422 and 46390 et seq., and California Code of Regulations, Title 5, Section 425). Approval of the waiver allows the school agency to get credit for the lost ADA for the day of the closure, as well as for the missed instructional time.

Reopening Schools

When school closure is a result of an epidemic, schools will be advised to reopen by public health authorities. The process for reopening a school after an epidemic is similar to processes already established for reopening after summer and other breaks. Depending upon the severity of the epidemic, procedure for reopening may require attention to special considerations.

A disease epidemic can result in a change in student enrollment and staffing due to illness and/or death and can significantly affect a school's ability to reopen. Prior to reopening a school, changes in student enrollment and staffing should be assessed to determine which schools can reopen and when. This may require additional assessment of essential functions, skills, and reassignment of staff responsibilities to accommodate lack of staffing in any particular area.

Prior to reopening, in addition to routine maintenance, Public Health will recommend that hard surfaces are cleaned, especially those that are frequently touched such as door knobs and telephones. Common disinfectants can be used; no extraordinary measures are required. A list of antimicrobial products registered for use against the influenza A viruses can be found on the US Environmental Protection Agency website. Consult local district policy prior to use of any of these products.

Returning staff and students are likely to be impacted in some way by the epidemic (e.g., loss of a loved one, hospitalization, economic loss). It is important, to the extent possible, to assess the personal impact of the epidemic on staff, students, and their families prior to reopening in order to obtain the resources needed for recovery.

It is recommended that schools:

- Debrief students and staff in order to re-establish normalcy and an environment conducive to learning.
- Address the mental health needs of students and staff resulting from the stress of the epidemic.

²⁸ CA HSC § 101000, 101025, 101030, 101040, 101475, 120175

It is recommended that schools continue with prevention and mitigation strategies for staff, students, and parents until epidemic is clearly over. Communication between Public Health and school officials will remain an important component of ongoing recovery.

Tactical Steps for Closure of Public Gatherings

Closure of public gatherings may be very effective in a highly communicable disease that is transmitted by air or close contact.

The Health Officer may order the closure of an area where an immediate menace to the public health exists and may also temporarily close public gatherings. If the closures involve multiple venues and appear likely to exceed several days, the Health Officer should consult with local officials as to whether a local emergency should be declared. Where a venue is subject to a permitting process, the permitting agency may be consulted for possible immediate suspension of the permit.

Constitutional considerations

Closures of public gatherings raise issues regarding freedom of assembly, freedom of speech, due process and equal protection rights. Before proceeding with an order for involuntary isolation or quarantine, the following must be considered:

- Provision for due process of law and fundamental fairness principles
- Ensure that there is adequate justification that is clearly stated in plain language; the order cannot be “arbitrary, oppressive and unreasonable”
- Reasonable grounds for the proposed action.
- Order should be narrowly drawn and the process must provide for the constitutional safeguards of **notice** and an **opportunity to be heard**, e.g., pre- or post-confinement hearing.
- The Health Officer Order serves as “notice”. The Order may be initially oral, but should be confirmed in writing at the earliest possible opportunity.
- The procedures made available for subjects of the order will depend on the scale of the event (numbers of people subject to the order) and the degree to which individual liberties are restricted. Examples of available procedures:
 - Phone number where a person can register their objection
 - Pre- or post-confinement hearing

Tasks for Implementing Closure of Public Gatherings

1. **PH DOC Manager and Operations Chief meet and consult with Health Officer, local law enforcement and other subject matter experts** (local, state, federal) to determine whether closure of public gatherings should be implemented. *If the Operational Area EOC is activated, medical/health branch should meet with law branch to develop the following plans.*
 - a. Discuss all options and select least restrictive action that may be effective

- i. Selected/singular site, certain type of gathering, or all areas of public gathering
 - b. Consider impacts of closure of the venue(s) and review constitutional considerations
 - c. Determine how enforcement will be handled
 - d. Discuss whether an emergency proclamation is necessary
- 2. **PH DOC Manager will brief PIO.** PIO will be tasked to develop a plan for Joint Information with city(s)/county and/or law enforcement agencies. *If OA EOC is activated, this function will be performed by EOC PIO.*
 - a. Joint Information Plan should include the following:
 - i. Joint press releases
 - ii. Schedule for media briefings or press conference(s)
 - iii. Channels for release of information including: media, social media, school modes, etc.
 - b. Key topics to be addressed include:
 - iv. Reason for closure
 - 1. Disease specifics
 - v. Anticipated duration
 - vi. Additional social distancing techniques
- 3. **Command and Management with the assistance of the Health Officer (Technical Specialist) will complete Public Health Order for Closure of Public Gatherings**
 - a. Utilize Procedure for Order for Closure of Public Gatherings to ensure all aspects necessary in the Order are addressed (included in this section)
 - i. Meet and consult with County Counsel to ensure legal authority is met in the issuance
 - ii. Meet and consult with Board of Supervisors and/or City Council to ensure support for the order.
 - b. Provide a copy of the official Order for Closure of Public Gatherings to all involved parties including venues, local law enforcement, cities etc.
- 4. **Operations Chief will brief DOC Manager on surveillance and disease impacts**
 - a. Epi and CD staff will conduct disease surveillance

5. Plans Chief will monitor the situation and brief DOC Manager

- a. Situation reports as well as epi data on the spread of the disease (case counts, school surveillance reports, etc.) will be analyzed to determine whether the social distancing including closures are effective and whether they should continue to be in effect

6. DOC Manager will consult with Health Officer, city/county officials, and other subject matter experts to determine whether closures should remain in effect, whether additional mitigation measures should be considered, or when discontinuation and repatriation is desired

Procedure for Issuance of Order for the Closure of Public Gatherings

1) The Order for a Closure of Public Gathering may initially be oral, but should be followed by an order written and signed by the Health Officer. A checklist of potential items to consider, but not necessarily include in closure orders:

- Subject of the Order: Target population/geographic area described as specifically and narrowly as possible
- The specific directives that the individuals must follow
- Right to representation, if any, for the subject of the order
- Parameters and conditions of the order
- Duration of the order-both beginning and end dates and times
- Potential penalty for a violation
- Supporting facts
- Statutory authority and any other legal basis to support the order
- Method and opportunity to challenge the order
- Any additional information specific to the event triggering the need for the order
- Languages of the individuals
- Signature and title of Health Officer
- Method(s) of informing the individuals subject to the order as discussed below
- The content and appropriate procedures for closure orders are fact dependent and must be determined by the particular circumstances.

2) Service of the order

The method(s) of communicating the closure order will vary, depending on the nature of the incident, potential number of individuals affected as well as the geographic area concerned. Personal service, mail, media, posting of the venue, site, or place in question, or combination of these and other methods can be used to communicate the directives to the target group or area.

The Health Officer may want to employ multiple communication methods. The orders need to be narrowly drawn and the Health Officer should describe specifically the activities being modified or curtailed, the reason for the action, and the length of time the closure or restriction will occur.

3) Enforcement authority for Order for Closure of Public Gatherings

Requirement to comply with a Health Officer Order for Closure of:

- H&S §120220 requires that all persons shall obey the Health Officer's rules, orders, and regulations for isolation or quarantine.

Penalty for violation of a Health Officer Order for Closure of a Public Gatherings

- H&S §120275 stipulates that violation of a Health Officer Order for measures necessary to protect the public health is a misdemeanor.

4) Challenges to Orders for Closure of Public Gatherings

An opportunity to consult should be given before the effective date of the order unless the situation is suddenly grave, but an opportunity for the event sponsor or venue owner to object should be accorded as soon afterward as it may safely be conducted.

Extension or Termination of the Order for the Closure of Public Gatherings

The Order should be written for a specific period of time under most circumstances according to the known characteristics of the outbreak.

If no specific termination time is written in the Order, then a specific time for review of the Order shall be written in the Order; the review shall determine whether to terminate the Order or to extend the Order with appropriate justification for extension. A notification should be written and served to the subject of the Order for termination or extension; for an extension, supporting facts for the extension, any changes in instructions, and a new review date should be specified.

Tactical Steps for Area Closures & Evacuation

Closure and evacuation of contaminated areas is a very effective means to limit exposure to a contaminate whether it be chemical, biological, radiological, or nuclear. The Health Officer may find it necessary for the protection of public health and safety to order immediate movement of individuals away from a particular building or geographic area.

The Health Officer may close an area “under immediate menace to the public health or safety” “created by a calamity including a flood, storm, fire earthquake, explosion, accident or other disaster,” Penal Code §409.5. The Health Officer can also order persons within the affected area to leave. The general powers of the Health Officer to control the spread of disease are also applicable in an evacuation event. H&S §120175.

An event with the magnitude to require evacuation and area closure would likely require a declaration of a local emergency or public health emergency.

Constitutional considerations

Evacuation orders cannot be “arbitrary, oppressive and unreasonable,” and must be narrowly drawn to be clear and specific to the situation. These orders must have documentation that factually supports the justification for the proposed evacuation. The process for issuing and enforcing the orders should adhere to applicable procedural protections (see Orders for Closure of Public Gatherings).

Form of Evacuation Orders

There is no express content or method of service mandated for evacuation orders. In general, evacuation orders should be in writing and posted on the subject area or site. However, facts and circumstance may dictate the use of an initial oral order, which will be confirmed in writing at the earliest possible opportunity. As with any other Health Officer order the content and appropriate procedure for closure are fact dependent and must be determined by the particular circumstances. Evacuation Orders should be developed in coordination with local law enforcement.

Tasks for Implementing Evacuations and Area Closure

1. **PH DOC Manager and Operations Chief meet and consult with Health Officer, local law enforcement and other subject matter experts** (local, state, federal) to determine whether evacuation and area closure should be implemented. *If the Operational Area EOC is not activated, recommend activation to handle the complex issues of this situation. **Once activated, Medical/health branch should meet with law branch to develop the following plans.***

- a. Discuss all options and select least restrictive action that may be effective
 - b. Consider impacts of evacuation and area closure
 - i. Shelters will be required for displaced individuals
 - c. Review constitutional considerations
 - d. Determine how enforcement will be handled
 - e. Discuss proclamation of a local emergency or a public health emergency
2. **Brief PIO.** PIO will be tasked to develop a plan for Joint Information with city(s)/county and/or law enforcement agencies. *If OA EOC is activated, this function will be performed by EOC PIO.*
- a. Joint Information Plan should include the following:
 - i. Joint press releases
 - ii. Schedule for media briefings or press conference(s)
 - iii. Channels for release of information including: media, social media, school modes, etc.
 - b. Key topics to be addressed include:
 - i. Reason for evacuation and area closure
 1. Contaminate specifics (Chemical, Biological, Radiological, Nuclear)
 - ii. Anticipated duration
 - iii. Shelters for displaced residents
 - iv. Additional social distancing techniques
3. **Command and Management with the assistance of the Health Officer (Technical Specialist) will complete Public Health Order for Evacuation and Area Closure**
- a. Utilize Procedure for Order for Closure of Public Gatherings as a template for area closure. Law enforcement can provide evacuation order.
 - i. Meet and consult with County Counsel to ensure legal authority is met in the issuance
 - ii. Meet and consult with Board of Supervisors and/or City Council to ensure support for the order.
 - b. Provide a copy of the official Order for Area closure to all involved parties including venues, local law enforcement, cities etc.

4. Operations Section

- a. Med-Health Branch will provide epi and surveillance data on the spread of the disease/contaminate. Coordinate with medical facilities and EMS for surge. Coordinate behavioral health services for impacted persons. Analyze data to determine whether the social distancing, evacuation, and closures are effective and whether they should continue to be in effect.
- b. Care and Shelter Branch will provide data on shelters activated to house those impacted by the evacuation and closure. Care and Shelter will work with Logistics to ensure all logistical needs of the displaced are addressed.
- c. Law branch will monitor evacuation, area closure, scene security, and on-going investigation

5. Plans Section

- a. Situation reports, data collection, long term planning, as well as demobilization planning

6. **DOC/EOC Manager will consult with Health Officer, law enforcement, city/county officials, and other subject matter experts** to determine whether closures should remain in effect, whether additional mitigation measures should be considered, or when discontinuation and repatriation is desired

Refer to Procedure for an Order for Closure of Public Gatherings for development of area closure. Law enforcement should lead evacuation orders.

Tactical Steps for Isolation & Quarantine

Isolation and/or quarantine may be imposed to stop or slow the spread of communicable disease. Isolation and quarantine may be applied to individuals and to groups, on a voluntary or involuntary basis.

Quarantine is the limitation of freedom of movement of persons who may have been exposed to a communicable disease, in order to prevent contact with unexposed persons. The quarantine period is equal to the longest usual incubation period (time from exposure to development of symptoms).

Isolation is the separation of infected persons from others for the period of communicability in order to prevent the transmission of the agent.

Isolation and quarantine is an effective means of limiting transmission of a communicable disease. Quarantine can be issued at different levels including individual, community, or the least restrictive working quarantine. This section will provide Tactical tasks for implementing isolation and/or quarantine on an individual or group. Isolation and quarantine will be based on the least restrictive option feasible and will be based on risk level. Voluntary compliance will be sought whenever feasible.

Community level quarantine is not directly addressed in this section. Community level quarantine would require assistance and direction from State and/or Federal government. Although the Local Health Officer is authorized to institute community level quarantine, Cordon Sanitaire, there are many implications and State assistance and guidance would be sought.

REFER TO APPENDIX D: ISOLATION & QUARANTINE TOOLS for templates and additional information.

Constitutional considerations

Limitation of movement and confinement raises issues regarding freedom of assembly, freedom of speech, due process and equal protection rights. Before proceeding with an order for involuntary isolation or quarantine, the following must be considered:

- Provision for due process of law and fundamental fairness principles
- Ensure that there is adequate justification that is clearly stated in plain language; the order cannot be “arbitrary, oppressive and unreasonable”
- Reasonable grounds for the proposed action.
- Order should be narrowly drawn and the process must provide for the constitutional safeguards of **notice** and an **opportunity to be heard**, e.g., pre- or post-confinement hearing.
- The Health Officer Order serves as “notice”. The Order may be initially oral, but should be confirmed in writing within 12 hours.
- The procedures made available for subjects of the order will depend on the scale of the event (numbers of people subject to the order) and the degree to which individual liberties are restricted. Examples of available procedures:
 - Phone number where a person can register their objection
 - Pre- or post-confinement hearing

Tasks for Implementing Isolation and/or Quarantine

1. **PH DOC Manager and Operations Chief meet and consult with Health Officer, local law enforcement and other subject matter experts** (local, state, federal) to determine whether isolation and/or quarantine should be implemented and determine level. *If the Operational Area EOC is activated, utilize the medical-health branch to coordinate these tasks within the EOC.*
 - a. Discuss all options and select least restrictive action that may be effective
 - i. Voluntary vs involuntary isolation/quarantine, working quarantine
 - b. Consider impacts of order
 - i. Consider how logistical needs of isolated/quarantined will be addressed including loss of income, housing, food, social/behavioral health impacts, separation and care of animals (when the disease is zoonotic) and special needs of those with access and functional needs
 1. Quarantine may require housing locations or shelters for community quarantine
 - ii. Working quarantine allows healthcare workers to continue serving the community
 - iii. Quarantine may lead to issues of civil unrest especially if mass or community quarantine is ordered
 - iv. Mass or community quarantine would require vast resources and State assistance
 - c. Review constitutional considerations
 - d. Determine how enforcement will be handled
 - e. Discuss declaration of a local emergency or a public health emergency
 - f. *If considering community level quarantine, the OA EOC must be activated and a Public Health Emergency must be declared. Community level quarantine will require State and potentially Federal assistance. Contact CDPH and request advisement from the State Health Officer.*

2. **PH DOC Manager will brief PIO.** PIO will be tasked to develop a plan for Joint Information with stakeholders including Behavioral Health, law enforcement agencies, and impacted healthcare facilities. *If OA EOC is activated, this function will be performed by EOC PIO.*
 - a. Joint Information Plan should include the following:
 - i. Joint press releases
 - ii. Schedule for media briefings or press conference(s)
 - iii. Channels for release of information including: media, social media, school modes, etc.
 - b. Key topics to be addressed include:
 - i. Reason for isolation/quarantine
 1. Disease specifics
 2. Compliance
 - ii. Services and assistance available
 - iii. Anticipated duration
 - iv. Additional social distancing techniques
 - v. Rumor control and addressing social stigma
 - vi. Behavioral health tips for coping with isolation, social stigma, disease and death
3. **Plans Chief will monitor the situation and brief DOC Manager**
 - a. Situation reports as well as epi data on the spread of the disease (case counts, school surveillance reports, etc.) will be analyzed to determine whether the social distancing and orders for isolation and quarantine are effective and whether they should continue to be in effect
4. **Logistics Chief will receive, review, and identify resources to fulfil requests for services to people in isolation and quarantine as well as to support on-going public health operations**
 - a. Facilities and housing for isolated/quarantined
 - b. Food, medications, and other resources for isolated/quarantined

5. Operations Section

- a. **Epi and CD Unit** will conduct disease surveillance, contact tracing , and monitoring
 - i. *Detailed tasks for monitoring in the next section: Tactical Steps for Monitoring & Movement*
 - ii. *Detailed tasks for Surveillance and Investigation are included in sections 4 & 5*
 - b. **Behavioral Health Unit** will identify and deliver services to isolated persons via approved methods (by phone, Skype, FaceTime, telemedicine, or in person with appropriate PPE)
 - c. **Care and Shelter Unit** will coordinate with Red Cross and other non-governmental organizations to ensure people have resources required to remain in isolation/quarantine
 - i. Provision of services for isolated and quarantined including shelters, temporary housing, food, medications, money to pay bills etc.
6. **DOC Manager will consult with Health Officer, city/county officials, and other subject matter experts** to determine whether quarantine/isolation should remain in effect, whether additional mitigation measures should be considered, or when discontinuation and repatriation is desired

Procedure for an Order for Isolation or Quarantine

1) The Order for Isolation or Quarantine is written and signed by the Health Officer and contains the following:

- Subject of the order
- Individual Orders: Identity and address of the person when known, or if unknown, as detailed a description of the subject as available
- Mass Orders: Target population/geographic area, described as specifically and narrowly as possible
- The specific directive that the individual(s) must follow
- Duration of the order and date of release
- Potential penalty for a violation
- Supporting facts
- Statutory authority and any other legal basis to support the order
- Method and opportunity to challenge the order
- Location of the isolation or health facility or home and the reason for any out-of-home isolation
- Any additional information specific to the event triggering the need for the order
- Information regarding support services for isolation or quarantine and how to obtain them, if needed, including contact information (may be an attachment to the order itself)
- Language of the individual
- Whether the patient is a minor
- Mental capacity of the individual
- Signature and title of Health Officer
- Signature of the patient acknowledging the receipt of order (see discussion below)
- Right to representation, if any, for the subject of the order
- Method(s) of informing the individuals subject to the order

2) Service of the order

- Orders directed to individuals
 - A verbal order from the Health Officer is sufficient for initiating isolation or quarantine
 - The date and time that the individual was given the order should be documented as well as who handed the order to the individual. This method of service does not require the signature of the subject of the order to be effective
 - Within 12 hours, follow with a written Order for isolation or quarantine

- The Order should provide a method by which the person may register objections to the order. The Order should contain justification for the action and the process to contest or object to the order. Judicial relief under California Penal Code 1473 can be pursued by the person or their legal representative by filing an application with the Court.
 - It is a misdemeanor to disobey a Health Officer order. Law enforcement has the authority to detain any individual who refuses to comply with a Health Officer order or a court order. Standard law enforcement protocols for use of force in the case of a misdemeanor apply in compelling compliance with isolation and quarantine.
- Orders directed to a mass
 - Personal service, mail, media, posting of the venue, site, or place in question, or combination of these and other methods can be used to communicate the directive to the target group or area. To ensure reaching the broadest population in the most effective manner and to ensure successful enforcement, Health Officer may want to employ multiple communication methods.

3) Enforcement authority for isolation and quarantine and penalties

- Requirement to comply with a Health Officer Order for Isolation or Quarantine
 - H&S §120220 requires that all persons shall obey the Health Officer's rules, orders, and regulations for isolation or quarantine.
- Penalty for violation of a Health Officer Order for Isolation or Quarantine
 - H&S §120275 stipulates that violation of a Health Officer Order for Isolation or Quarantine is a misdemeanor.

Extension or Termination of the Order for Isolation or Quarantine

The Order should be written for a specific period of time under most circumstances according to the known characteristics of the outbreak. The Order may expire in accordance with the date or the Health Officer may rescind a prior order in writing.

If no specific termination time is written in the Order, then a specific time for review of the Order shall be written in the Order; the review shall determine whether to terminate the Order or to extend the Order with appropriate justification for extension. A notification should be written and served to the subject of the Order for termination or extension; for an extension, supporting facts for the extension, any changes in instructions, and a new review date should be specified.

Tactical Steps for Monitoring & Movement Restrictions

Restriction of movement orders will be based on each individual case and will be consistent with CDC and CDPH issued guidance or orders related to the identified highly infectious disease.

Movement restrictions, isolation, and quarantine will be based on the least restrictive option feasible and will be based on individual risk level. Voluntary compliance will be sought whenever feasible.

Isolation Tactics

- **Symptomatic Individuals who meet the symptom criteria for a highly infectious disease will be Isolated:**
 - Will undergo medical evaluation with appropriate infection control precautions
 - If medical evaluation results in individuals' being discharged with a diagnosis other than the highly infectious disease, conditions as outlined for asymptomatic individuals in the relevant exposure category will apply throughout the duration of the defined incubation period for the suspected highly infectious disease from the date of last exposure.
 - Issue an Order for Isolation if deemed necessary to ensure compliance.
 - Isolation will likely be in a healthcare facility except during pandemic or other surge situations
 - Public Health will provide infection control measures to healthcare partners
 - Patients isolated in a home setting:
 - Evaluate the suitability of patient's housing and care
 - Clear written Instructions will be provided by Public Health on infection control, waste disposal, how to notify and seek healthcare should it be required
 - Transportation to healthcare & healthcare destination should be coordinated by Public Health (may vary by disease)
 - Refer to the Region 3 Infectious Disease Transportation Plan
 - Provide active monitoring in-person or through other approved method (video, phone, etc.)
 - Provide access/assistance to services to remain in isolation (such as food, medications, paying bills, psychological support, etc.)

- Requests for assistance will be communicated to Operations Chief and forwarded to appropriate unit (care & shelter, behavioral health) or section (logistics)
 - All requests will be documented including resource requested/assigned (in-house or partner organization)
- Ensure any special needs (access and functional needs) of the patient are reviewed and addressed
- Enter information of isolated individual into the Isolation and Quarantine Database (Shasta Regional Epi Project software)
- Non-compliance will result in an order for strict isolation in a designated facility

Movement Restrictions and Modified Quarantine Tactics

Exposed but asymptomatic individuals: Determine level of movement restriction/quarantine based on disease traits, exposure risk, and current level of spread within the community.

- **Low Risk Category and Asymptomatic individuals may be assessed and monitored:**
 - Direct active monitoring throughout the duration of the defined incubation period for the suspected highly infectious disease from the date of last exposure.
 - Determine whether restrictions on travel, work, public conveyance, or congregate gatherings are is advised and/or required

- **Some Risk Category and asymptomatic individuals may be placed into modified quarantine or monitoring with activity restrictions:**
 - Provide direct active monitoring throughout the duration of the defined incubation period for the suspected highly infectious disease from the date of last exposure.
 - Individual assessment for additional restrictions:
 - Based on:
 - Level of exposure;
 - compliance with direct active monitoring;
 - the individual’s ability to immediately recognize and report symptom onset, self-isolate, and seek medical care; and
 - The probability that the proposed activity would result in exposure to others prior to effective isolation.
 - Determine level of Public Health Order for controlled movement/modified quarantine (voluntary when feasible), select level of limitation based on the specific disease and disease traits:
 - Exclusion from travel on any public conveyance
 - Exclusion from work and/or school (telework is permitted)
 - Working quarantine would allow physical work with proper use of PPE (typically for healthcare workers)
 - Exclusion from public places (shopping malls, movie theaters) and congregate gatherings.

- Can non-congregate public activities be permitted when a minimum 3-foot distance from others (i.e. jogging at a park) is maintained?
- Do Federal public health travel restrictions apply?
 - If travel is allowed:
 - Individual is subject to controlled movement, coordinated with public health authorities and monitoring is maintained
 - Travel is by non-commercial conveyance
 - Ensure client has resources required to remain in modified quarantine
 - Evaluate the suitability of patient's housing
 - Clear written Instructions will be provided by Public Health on how to report development of symptoms and how to seek healthcare should it be required
 - Transportation to healthcare & healthcare destination should be coordinated by Public Health (may vary by disease)
 - Refer to the Region 3 Infectious Disease Transportation Plan
 - Provide access/assistance to services to remain in isolation (such as food, medications, paying bills, psychological support, etc.)
 - Requests for assistance will be communicated to Operations Chief and forwarded to appropriate unit (care & shelter, behavioral health) or section (logistics)
 - All requests will be documented including resource requested/assigned (in-house or partner organization)
 - Ensure any special needs (access and functional needs) of the patient are reviewed and addressed
 - Enter information of individual into the Isolation and Quarantine Database (Shasta Regional Epi Project software)
 - Non-compliance may result in an order for quarantine

Quarantine Tactics

Exposed but asymptomatic individuals at high risk for the disease or the disease is a significant risk for rapid transmission to the community.

- **Restrict movement within the community or confine to a designated property/location**
- Community restrictions may include:
 - No travel on any public conveyance
 - Exclusion from work and/or school (telework is permitted)
 - Working quarantine would allow physical work with proper use of PPE (typically for healthcare workers)
 - Exclusion from public places (shopping malls, movie theaters) and congregate gatherings.
 - Can non-congregate public activities be permitted when a minimum 3-foot distance from others (i.e. jogging at a park) is maintained?
 - Travel restrictions apply
- Issue a Public Health Order for quarantine, if a voluntary order is not feasible
- Provide direct active monitoring throughout the duration of the defined incubation period for the suspected highly infectious disease from the date of last exposure.
- Ensure client has resources required to remain in quarantine
 - Evaluate the suitability of patient's housing
 - If patient does not have suitable housing (homeless, visitor, etc.), identify and provide housing through local means (designated shelter, hotel, etc.)
 - Clear written Instructions will be provided by Public Health on how to report development of symptoms and how to seek healthcare should it be required
 - Transportation to healthcare & healthcare destination should be coordinated by Public Health (may vary by disease)
 - Refer to the Region 3 Infectious Disease Transportation Plan
 - Provide access/assistance to services to remain in isolation (such as food, medications, paying bills, psychological support, etc.)

- Requests for assistance will be communicated to Operations Chief and forwarded to appropriate unit (care & shelter, behavioral health) or section (logistics)
 - All requests will be documented including resource requested/assigned (in-house or partner organization)
 - Ensure any special needs (access and functional needs) of the patient are reviewed and addressed
 - Enter information of individual into the Isolation and Quarantine Database (Shasta Regional Epi Project software)
 - Non-compliance may result in legal action or detainment
 - Notify the patient when quarantine has ended, unless Health Officer provides written justification for extension

Monitor, Evaluate, & De-escalation

Public Health will monitor the situation throughout the duration of the incident. Mitigation and containment strategies will continually be evaluated for effectiveness utilizing surveillance, disease traits, exposure risk, current level of circulation, civil obedience, and State and Federal guidance. Mitigation strategies may be escalated, de-escalated, or terminated.

- The DOC Manager, Health Officer, and Operations Section Chief should meet routinely to determine need to escalate and/or de-escalate mitigation and containment strategies.
 - If law enforcement is involved, routinely meet to determine civil obedience, identify compliance issues, and receive guidance on enforcement related to changes in mitigation and containment strategies.
- A change in the level of mitigation and containment strategy in use should be clearly communicated to all staff and stakeholders.
- The Public Information Officer (PIO) should be informed of the change in strategy and any relevant details to be disclosed to the public.
- CD & Epi Unit should determine impact of changes in mitigation and containment strategy on those who they are monitoring. Prepare for implementation.
- Health Officer Orders should be evaluated for potential changes including rescinding or extending based on the new defined containment and mitigation strategy.

SECTION 7: DEMOBILIZATION & RECOVERY

Demobilization

Purpose

The purpose of demobilization from a response or activation is to plan for a smooth transition of the emergency response back to normal daily operations and document and analyze actions that took place during the response.

The demobilization process is important not only to ensure documentation of the response, but also to justify financial expenditures (especially staff time), request additional grant funding, meet current grant deliverables, and incorporate lessons learned into emergency plans and future emergency responses.

Goals for collecting and collating information from this demobilization process are the following:

- Create a comprehensive and accurate After Action Report and Improvement Plan
- Recreate a timeline of key activities that occurred during the response
- Document when resources were needed most and when we had an abundance of resources (note: resources can mean people, things and information)
- Track when key decisions were made

This information will help us improve and update Emergency Plans as well as improve any future responses. For example, if we see through our collection of Personnel Request Forms that some branches needed a lot of staff during one period but not during another, we can anticipate this need and ensure we can fill it more readily in future events.

The Plans Section will provide all responders with information about their activation dates and what paperwork is incomplete or missing and what needs to be filled out.

Refer to Public Health & Medical EOP for complete Recovery and Demobilization procedures.

Demobilization Objectives

The purpose of the Demobilization Unit is to plan for a smooth transition of the emergency response back to normal operations and to analyze the response.

Demobilization objectives include:

- Develop and share the demobilization plan with Command/Management and General Staff.
- Ensure that all personnel are debriefed following demobilization and supervisor is notified of return to routine job duties.
- Ensure that equipment and materials are released and returned to controlling agencies.
- Develop the After Action Report for the response (or, work closely with person(s) developing the After Action Report to ensure they have the necessary information to complete the report.)

Demobilization Strategies

Methods utilized to achieve demobilization objectives include:

- **Demobilization Plan:**
 - Describes how personnel and activities of the infectious disease emergency event are to be reduced and/or closed out as the event abates.
 - Demobilization planning early on ensures a more orderly and appropriately phased conclusion of response activities. It also identifies items requiring follow-up and the parties responsible.
- **Demobilization Checklist:**
 - All responders closing out positions and/or modules will be required to complete specific tasks to ensure that materials are complete, organized, and easily accessible; timesheets are complete; pending tasks are transferred appropriately; etc.
- **After Action Report and Improvement Plan:**
 - After each activation an evaluation of the response must be completed.
 - A hotwash or debrief should be conducted with response staff.
 - The Improvement Plan will provide guidance on modifications that should be made to the plan.
 - HSEEP will be utilized for AAR and IP
 - MHOAC/EP program will lead the after action report process, as they are HSEEP trained.

- Please utilize the HSEEP AAR/IP template available on the HSEEP website.
- MHOAC maintains a Corrective Action Plan tracking log to ensure implementation of identified corrective actions.

Demobilization Tactics

The Demobilization Unit of Planning Section will:

- Review the Incident Action Plan and Resource Status Unit records to determine the size and extent of the demobilization effort.
- Coordinate demobilization with Command/Management and General Staff
- Identify surplus resources and probable release time in coordination with the Logistics Section.
- Identify logistic (including transportation) needs to support demobilization.
- Develop a Demobilization Plan and checklist that includes specific instructions for all personnel and resources that will require demobilization.
 - Incident Demobilization Plan that clearly states the timeline for demobilization, staff procedures for demobilization, procedures for turning in resources, and who will develop the After Action Report and Corrective Action Plan.
- On large scale incidents, demobilization can be complex requiring extensive planning activities.
- Brief Plans Section Chief on demobilization progress.
- Hold a debrief session to gather feedback from staff activated for the response
- Gather feedback via interviews, questionnaires, and other methods.
- Analyze the effectiveness of the response
- Write the After Action Report and Improvement Plan.

The Demobilization Unit is responsible for producing the following:

- Demobilization Plan
- Demobilization Check-out Procedure
- Module Objectives and Update, ICS Form 202b (for each Operational Period)
- After Action Report
- Corrective Action Plan

Recovery

Public Health Department Recovery Priorities

- Transition to recovery operations. Demobilize all appropriate personnel including Disaster Healthcare Volunteers
- Deactivate temporary healthcare facilities and shelters
 - Facilitate the discharge or transfer of patients to permanent healthcare facilities
- Recover unused emergency medical-health supplies from healthcare partners
 - Maintain and replenish medical health emergency supply caches
- Identify post-incident community health issues such as disease outbreaks and apply mitigation and containment measures
- Public information:
 - On-going community health issues
 - Health services available to address community health issues
 - Closure of response services such as alternate care sites, medical shelters etc.
- Communicate with health care providers services and programs are available and accessible
- Maintain public health services and develop strategy for return to normal service level

Refer to Public Health & Medical EOP for complete Recovery and Demobilization procedures.

SECTION 8: APPENDICES

Appendix A: Epidemiological Investigation Steps

Step 1: Preparing for Investigation

- Research and gather information pertinent to the communicable disease(s) to be investigated.

Step 2: Establish the Existence of an Outbreak

One of the first tasks is to verify that a suspected outbreak is indeed a genuine outbreak. Before deciding whether an outbreak exists (i.e., whether the observed number of cases exceeds the expected number), the expected number of cases for the area in the given time frame must be determined.

- For a notifiable disease (one that, by law, must be reported), GCPH should have complete surveillance records through CalREDIE and local health facility provided CMR.

Step 3: Verify the Diagnosis

First, determine for sure that the problem has been properly diagnosed or analyzed—that it really is what it has been reported to be.

Verifying the diagnosis requires review of the clinical findings (the symptoms and features of illness) and laboratory results for those affected. If there remains any uncertainty regarding the laboratory findings (e.g., if they are inconsistent with the clinical findings), have a laboratory technician review the techniques being used. If there is a need for specialized laboratory work (e.g., special culturing or DNA analysis), the process to begin obtaining the appropriate specimens, isolates, and other laboratory material should be initiated as soon as possible in order to have the greatest number of patient samples.

Finally, review interview materials from several of the people who became ill. This review is required to generate working hypotheses about the cause, source, and spread of disease.

Step 4: Define and Identify Cases

Establish a case definition. It is vital to establish a case definition, or a standard set of criteria for deciding whether an individual should be classified as a case/ill/diseased.

A case definition should include the following four components:

1. **What:** Clinical information about the disease,
2. **Who:** Characteristics about the people who are affected,
3. **Where:** Information about the location or place, and
4. **When:** Specification of time during which the outbreak occurred or was believed to occur.

Ideally, the case definition should be broad enough to include most, if not all, of the actual cases, with minimal capture of false-positive cases. Recognizing a level of uncertainty in some diagnoses, it is often helpful to consider a classification scheme to categorize cases as "confirmed," "probable," or "possible."

- **Confirmed case:** laboratory verification
- **Probable case:** Has the typical clinical features of the disease without laboratory confirmation
- **Possible case:** Has fewer of the typical clinical features

When hypotheses have come into sharper focus, it may be advantageous to tighten the case definition by dropping the "possible" category. This strategy is particularly useful when travel to different hospitals, homes, or other field locations is required to gather data/information. It is important to gather as much information as possible early in the investigation so refinements may be made and a conclusion realized in the most efficient timeframe.

Identify and count cases

When identifying cases, it is best to use as many sources as possible initially.

The following types of information should be collected for every person affected:

- **Identifying information:** This may include name, address, and telephone number and allows for contacting patients.
- **Demographic information:** This may include age, sex, race, ethnicity and occupation.
- **Clinical information:** Date of onset of the outbreak. Supplementary clinical information may include whether the person was hospitalized or died.
- **Risk factor information:** Information about possible risk factors will allow for tailoring investigation to the specific disease in question.

Collect the information described above on a standard case report form in paper format and then enter the data into CalREDIE. In some cases there is not time enough to complete data entry into CalREDIE before beginning to look at the data trends and in such a case, data entry may be put temporarily on hold.

Line listing

In the line listing, each column represents an important variable, such as name or identification number, age, sex, and case classification, while each row represents a different case, by number. New cases are added to a line listing as they are identified. This simple format allows the investigator to scan key information on every case and update it easily. Here is a portion of a line listing that might have been created for an outbreak of hepatitis A (CDC Excite).

Glenn County SPIDER Plan

					Diagnostic						Lab			
					Signs and Symptoms									
Case#	Initials	Date of Report	Date of Onset	Physician Diagnosis	N	V	A	F	DU	J	HAIGM	Other	Age	Sex
1	JG	10/12	12/6	Hep A	+	+	+	+	+	+	+	AST ↓	37	M
2	BC	10/12	10/5	Hep A	+	-	+	+	+	+	+	Alt ↓	62	F
3	HP	10/13	10/4	Hep A	±	-	+	+	+	S*	+	AST ↓	30	F
4	MC	10/15	10/4	Hep A	-	-	+	+	?	-	+	Hbs/ Ag-	17	F
5	NG	10/15	10/9	NA	-	-	+	-	+	+	NA	NA	32	F
6	RD	10/15	10/8	Hep A	+	+	+	+	+	+	+		38	M
7	KR	10/16	10/13	Hep A	±	-	+	+	+	+	+	AST = 240	43	M

S*=Sclera; N=Nausea; V=Vomiting; A=Anorexia; F=Fever; DU=Dark urine; J=Jaundice; HAIGM=Hepatitis AlgM antibody test

Step 5: Describe and Orient the Data in Terms of Time, Place, and Person

After collecting data, it is possible to conduct descriptive epidemiology or characterization of the health event by time, place, and person. Develop a comprehensive description of an outbreak by showing its trend over time, its geographic extent (place), and the populations (people) affected by the disease. This description allows for initial assessment of the outbreak in light of what is known about the disease (e.g., the usual source, mode of transmission, risk factors, and populations affected) and to develop causal hypotheses.

Characterizing by time

Traditionally, time, as it relates to an outbreak, is expressed by creating an epidemic curve which serves to provide a simple visual display of the outbreak's magnitude and time trend. It will be important to note the time of any potentially contributing events or exposures.

Insert Epi Curve

With an epidemic curve it is usually possible to identify where the population/community is regarding the progression of the epidemic, and possibly to project its future course. The curve, in many cases, may also aide in the identification of the disease revealing valuable information about the incubation period. The epidemic pattern and information about the potentially associated exposure(s), person-to-person, common encounter, environmental event/exposure, etc.

Regional Epidemiologist typically constructs epidemiological curves using statistical software, most often Microsoft Excel however, more advanced software may be used should the event call for it (i.e. SPSS, SAS, and Stata). Cases are identified on the y-axis and time on the x-axis (as shown in the graph below). The epi curve may act as a measure of intervention (if any taken) effectiveness as well. For this however, it is important to include the point in time that public health was made aware of the health event. This information is outlined in the epidemiological investigation [Template 2.1](#).

It is also important to gather as much information as possible about any connections between the cases and collect control data whenever possible. An example is shown below in Figure 2.5 on the x-axis the author identified the dates for the American Legion Convention July 21 through July 25.

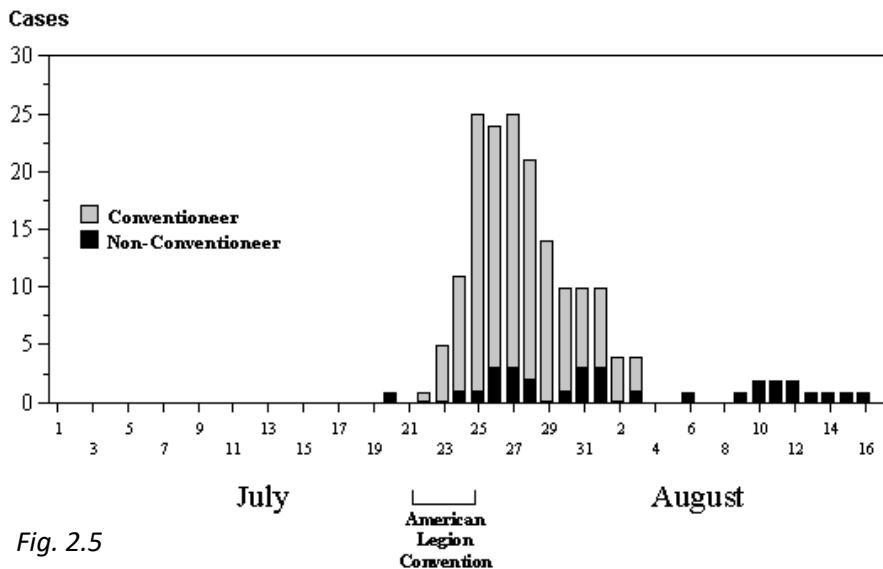


Fig. 2.5

Characterizing by place

The Regional Epidemiology Team will assess an outbreak by place providing information on the geographic extent of a problem and may also show clusters or patterns that provide clues to the identity

and origins of the problem. Illustrating any geographic patterning is accomplished by a "spot map" or the area, where the affected people live, work, or may have been exposed. Spot or incidence maps are usually constructed using ArcGIS (or similar) software by the Regional Epidemiology Team.

A spot map of cases in a community may show clusters or patterns that reflect water supplies, wind currents, or proximity to a restaurant or grocery store.

The Regional Epidemiology Team will also take into consideration the size of the population. A Population that may have potentially been exposed as well as the population from which the cases have been identified are important to document for contextual information about the severity of the outbreak. Therefore, it is good practice to calculate the attack rate to be presented in conjunction with the spot map.

Characterizing by person

Gather demographic and recent activity data from cases, when able. Controls are critical to finding an exposure associated to the cases, often without controls, possibilities are too numerous. Family members that did not become ill are sometimes a good source of control information and often public health nurses ask about the health of the family when questioning the case. When public health is notified late in progression of the outbreak it can be difficult or impossible to obtain control data.

Age and sex should be assessed, as they are often the characteristics most strongly related to exposure and to the risk of disease. Other characteristics, more specific to the disease under investigation and the setting of the outbreak, should also be considered.

Summarizing by time, place, and person

After characterizing an outbreak by time, place/geography, and person, summarize/synthesize data into a report to show the track of initial hypotheses. If hypotheses break down post-investigation, re-formulate or modify hypothesis and begin again.

Step 6: Develop Hypotheses

The hypotheses should address the source of the agent, the vehicle or vector associated with transmission, and the exposures that caused the disease. Hypotheses should be proposed in a way that can be tested.

Tools for Hypothesis Generation:

- 1) The CDC's Foodborne Outbreak Online Database ([FOOD](#))¹
- 2) The International Society for Disease Surveillance [ProMed](#)² Mail website
- 3) United States Food and Drug Administration (FDA) recall listing

4) Epidemiological curve

Any conversations with those that are ill about possible exposures should be open-ended and wide-ranging and not confined to the known sources and vehicles. These conversations may also be quite useful in hypothesis development.

Descriptive epidemiology often provides data used for generating hypotheses. If the epidemic curve points to a narrow period of exposure, inquire about events occurring around that time. Such questions about the data should lead to hypotheses that can be tested.

Step 7: Evaluate Hypotheses

There are two main approaches available to use in hypothesis evaluation, depending on the nature of the data:

1. Comparison of the hypotheses with the established facts
2. Analytic epidemiology

It is best to use the first method when evidence is so strong that the hypothesis does not need to be tested.

The second method, analytic epidemiology, is used when the disease cause is less clear. With this method, the hypotheses are tested using a comparison group to quantify relationships between various exposures and the disease. Two common methods of modeling are cohort study and case-control study. Each of these techniques has a role in outbreak investigation. Case-control studies are used when the disease is known and the exposure or cause is unsure. Cohort study may be used to analyze a population subset retrospectively for disease outcome similarities.

Testing statistical significance

In technical settings the final step in hypothesis testing is to determine how likely it is that study results could have occurred by chance alone. A test of statistical significance is used to evaluate this likelihood. Statistical significance is determined within the bounds of the data available. Statistical significance can be described as an odds ratio, relative ratio, chi-square, R2 value, etc.

Step 8: Refine Hypotheses and Carry Out Additional Studies

When traditional analytic epidemiological studies do not confirm the hypotheses, it might be necessary to reconsider or reconstruct the working hypothesis and look for new vehicles of transmission. If possible, it may be prudent at this point in the investigation process to meet with case-patients to look for common links.

Even when the analytic study identifies an association between an exposure and a disease, often there is still need to refine the hypotheses. In some situations it may be necessary to obtain more specific exposure histories or a more specific control group.

In many cases laboratory results may become available and aide in elucidating the disease associated with the outbreak. It is important to explore as many options for exposure as possible remaining open to the scenario in which multiple exposures may be responsible.

Step 9: Implementing Control and Prevention Measures

Even though implementing control and prevention measures is listed as Step 9, it should be instituted as soon as enough data has been collected to justify action. Control measures, which can be implemented early, prior to identification of the source of an outbreak, should be aimed at specific links in the chain of infection, the agent, the source, or the reservoir. Viable options may be destroying contaminated foods, sterilizing contaminated water, destroying mosquito breeding sites, or requiring an infectious food handler to stay away from work until he or she is well.

Step 10: Communicate Findings

Communicate investigation findings to others who need to know. This communication will take the form of an oral briefing for appropriate public health staff (DOC Operations Briefing) and a written report.

Presentation should describe the context, process of investigation, and recommendations regarding the disease outbreak. Present findings in scientifically objective fashion, and use data to support any conclusions and recommendations.

Additional Investigation Guidance

Environmental Health: When an outbreak is expected to be linked or associated with an eating establishment an environmental health specialist from the Glenn County should be notified in order that the location may be inspected and management questioned about ill workers.

Appendix B: Procedures for Health Emergency Declarations

For additional information, refer to Public Health Law: A Health Officers Practice Guide for CD Control in California

Procedure for Declaration of a Local Health Emergency

Authority

Health and Safety Code (HSC) Section 101080 authorizes the local Health Officer to proclaim a local health emergency whenever there is an imminent and proximate threat of the introduction of any contagious, infectious or communicable disease, chemical agent, non-communicable biologic agent, toxin or radioactive agent in the jurisdiction or any area thereof affected by the threat to the public health. Health and Safety Code 101040 authorizes the local Health Officer to take any preventive measure to protect and preserve the public health from any public health hazard during any “state of war emergency,” “state of emergency,” or “local emergency,” as defined by Section 8558 of the Government code.

Definition of Local Emergency

“The duly proclaimed existence of conditions of disaster or of extreme peril to the safety of persons and property within the territorial limits of a county, caused by such conditions as air pollution, fire, flood, storm, epidemic, riot, drought, sudden and severe energy shortage, plant or animal infestation or disease, the Governor’s warning of an earthquake or volcanic prediction, or an earthquake... or other conditions, other than conditions resulting from a labor controversy, which are or are likely to be beyond the control of the services, personnel, equipment, and facilities of that political subdivision and require the combined forces of other political subdivisions to combat...” Government Code (GC) Section 8558(c).

Deadlines

- **Issuance:** Within 10 days of the occurrence of a disaster if assistance will be requested through the California Disaster Assistance Act (CDSS).
- **Ratification:** If issued by local Health Officer, must be ratified by Glenn County Board of Supervisors within 7 days
- **Renewal:**
 - Reviewed at regularly scheduled board meetings until terminated
 - No review to exceed 14 days from last review
- **Termination:** When conditions warranting proclamation have ended

Declaring a Local Health Emergency

The Health Officer has the authority to proclaim a local health emergency under the situations listed in HSC Section 101080. Once the Health Officer has signed a written proclamation of local health emergency, the Glenn County Board of Supervisors must ratify the proclamation within 7 days. The following are the steps for declaring a Local Health Emergency:

1. Within 10 days of occurrence, the Health Officer signs a Proclamation of Local Health Emergency (template attached) and creates a proposed ratification resolution for the Glenn County Board of Supervisors (template attached). The proclamation should include type of disaster, date(s) of occurrence, and area(s) affected.
2. Request a special meeting of the Board of Supervisors to occur within 7 days of the Proclamation of Local Health Emergency.
3. Forward the Local Health Emergency Proclamation and proposed resolution to the Glenn County Board of Supervisors, local Office of Emergency Services (OES) and Regional Disaster Medical Health Specialist (RDMHS).
4. Within 7 days of the Local Health Emergency proclamation, the Board of Supervisors will meet and vote whether or not to ratify the proclamation and request concurrence from the State OES Director. The proclamation must be ratified to continue the local health emergency.
5. The adopted resolution, local health emergency proclamation, and initial damage estimate will be sent to the State OES Director.

Notification Process

1. The Health Officer will notify local OES and the RDMHS of the public health emergency and provide a copy of the proclamation.
2. The RDMHS will notify the State and coordinate any regional assets being requested.

Local Health Emergency Proclamation

WHEREAS, the California Health and Safety Code, Division 101, Part 3, Chapter 2, commencing with §101075 confers upon Local Health Officers of the political subdivisions of this state emergency powers necessary to protect public health and safety;

WHEREAS, §101080 of the California Health and Safety Code, states that "the local health officer may declare a local health emergency in the jurisdiction or any area thereof" affected by hazardous waste which is an imminent threat to the public health;

WHEREAS, Health and Safety Code Section 101080 empowers the local health officer to proclaim the existence of a local health emergency when this county or any area of the county is affected or likely to be affected by such a public health threat while the Board of Supervisors is not in session, which shall expire if not ratified by the Board of Supervisors within seven days and is subject to reaffirmation every 14 days thereafter until such local health emergency is terminated; and,

WHEREAS, the Health Officer of the county of Glenn does hereby find:

1. That conditions of certain hazardous waste in the _____ area of the County in the form of (enter what caused the hazardous health condition) occurring on DATE, and poses a substantial present or potential hazard to human health and the environment unless immediately addressed and managed; and

2. That the aforesaid threat to public health necessitates the proclamation of the existence of a local health emergency.

NOW, THEREFORE, IT IS HEREBY PROCLAIMED that a local health emergency is now threatened to exist in this county due to (hazardous waste, epidemic, etc.) in the form of (enter what caused the hazardous health condition) and,

IT IS FURTHER PROCLAIMED AND ORDERED that during the existence of said local emergency the powers, functions, and duties of the Health Officer shall be those prescribed by state law, including the provisions of Section 101085 of the Health and Safety Code, and by ordinances and resolutions of this county approved by the Board of Supervisors.

[Insert Full Name, Credentials]
Glenn County Health Officer

Date

Appendix C: Health Officer Orders

Health Officer Order for Quarantine

QUARANTINE ORDER

1) Pursuant to sections 120130 and 120175 of the California Health and Safety Code, the Health Officer of the City and County of San Francisco HEREBY ORDERS that the following person(s):

(Names of person(s) subject to quarantine)

hereinafter referred to as the subject(s), is/are quarantined under the conditions specified in this order until _____ unless released from quarantine by an authorized public health official.
(Date)

Violation of or failure to comply with this order may result in civil detention, and is a misdemeanor punishable by imprisonment, fine, or both.

2) This order is issued due to exposure of the subject(s) to a case or suspected case of [INSERT DISEASE NAME]. [Use the space below to explain any facts relevant to the decision to issue order.]

3) The subject(s) shall be quarantined at the following location:

Address City State Zip code

4) The conditions of quarantine shall be as follows (only checked items and written instructions shall apply):

___ The subject(s) shall not go beyond the lot line of the location described above, or the walls/confines of an apartment and shall not put himself/herself/themselves in immediate physical communication with any person, other than a physician, the health officer, or persons authorized by the health officer, or household members.

___ The subject(s) shall cooperate with any physician, health officer or persons authorized by the health officer who performs medical observation during the period of quarantine.

___ If the subject develops [INSERT SYMPTOMS] which are symptoms of [INSERT DISEASE NAME] during the period of quarantine, the subject must contact their medical provider and the Glenn County Public Health Department at 530-934-6588 immediately. The subject shall notify the medical provider or medical facility to alert them of their [INSERT DISEASE NAME] symptoms before visiting the office, clinic, or hospital. If the subject travels by ambulance, he/she must notify the paramedics that he/she is under a quarantine order for [INSERT DISEASE NAME].

____ Additional conditions and instructions of the local health officer:

5) The subject(s) or the subject’s authorized lawful representative may contact the following representative of the department to seek clarification of any part of this order. If the subject(s) or his/her authorized lawful representative believe that the subject has not been exposed to a case or suspected case as described in paragraph 2, or object to the appropriateness of the conditions of quarantine contained in this order, the subject or his/her lawful authorized representative may object and/or request an informal hearing by contacting the person indicated below.

SFDPH Contact Person

Daytime Telephone

6) The subject(s) or the subject’s authorized lawful representative may seek judicial relief from this order pursuant to California Penal Code Section 1473.

7) The subject may be represented by counsel at the informal hearing and any subsequent legal proceedings related to this order.

IT IS SO ORDERED.

[Insert Full Name, Credentials]
Glenn County Health Officer

Date of Issuance of Order

PROOF OF PERSONAL SERVICE

I served the Quarantine Order of the Health Officer upon the below-named person, by delivering to and leaving with the person named, at the time and place set forth:

Name of Person Served: _____

Date, Time and Place of Service:

Date: _____ Time: _____

Place: _____

I declare under the penalty of perjury under the laws of the State of California the foregoing is true and correct.

Executed on _____, at _____, California.

Name (Print): _____

Signature: _____

Release from Quarantine Order

[Amend cover letter depending on disease]

[DATE]

Mr/Ms Contact Name
Address

Dear Mr/Ms,

This letter is to notify you that your quarantine period has ended and the quarantine order put into place on (date) has been lifted as of (date). **Therefore you are cleared to return to your normal activities.**

We may contact you in the future to collect additional information from you. If you have any further questions you may call our office at 530-934-6588. Thank you for your cooperation in this important public health matter.

Sincerely,

[Insert Full Name, Credentials]
Glenn County Health Officer

Health Officer Order for Isolation

Cover Letter for Isolation Order

[Amend cover letter depending on disease]

[DATE]

Mr/Ms. [CASE NAME]
Address

Re: Isolation Order Dated _____

Dear [Client's Name],

The Glenn County Public Health Department (GCPH) is serving you with an isolation order because you have been diagnosed as a case or suspected case of [INSERT DISEASE NAME]. We have determined that your isolation is necessary for the preservation and protection of the public health. Isolation means that you must be separated from other people. [DISEASE NAME] is highly contagious and is spread from person-to-person mostly by [DESCRIBE METHODS OF TRANSMISSION]. If [DISEASE NAME] spreads in the community, it will cause illness and death.

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). In this case, the appropriate measure is isolation.

You need to remain in isolation until [DATE ORDER WILL BE LIFTED], which is the date when you will no longer be infectious to others based on available public health information. Staff members from SFDPH will be checking on you and will let you know when it is safe to return to your normal activities. Fact sheets about [DISEASE NAME] are attached to this order.

Please read the attached order carefully. If you have any further questions you may contact our office at 530-934-6588. By complying with this order, you are helping GCPH to protect the public’s health. Thank you in advance for your cooperation.

Sincerely,

[Insert Full Name, Credentials]
Glenn County Health Officer

Isolation Order

1) Pursuant to sections 120130 and 120175 of the California Health and Safety Code, the Health Officer of the City and County of San Francisco **HEREBY ORDERS** that the following person:

(Name of person subject to isolation.)

hereinafter referred to as the patient, shall be isolated under the conditions specified in this order until _____, or until this order is rescinded, whichever occurs first.
(Date)

Violation of or failure to comply with this order may result in civil detention, and is a misdemeanor punishable by imprisonment, fine, or both.

2) This order is issued because the patient has been diagnosed as a case or suspected case of _____
[INSERT DISEASE NAME]

3) The patient shall be isolated at the following location:

Address City State Zip code

4) If the patient is hospitalized, infection control practices appropriate for cases as identified in paragraph 2 of this order shall be implemented by the hospital. The patient shall not be moved from isolation or to a new isolation location without approval of the local health officer.

5) If the patient is not hospitalized, a copy of the notice attached to this order shall be prominently posted at the entrance(s) to the room(s) where the patient is confined, and the conditions of isolation shall be as follows (only checked items and written instructions shall apply):

___ The patient shall not leave their home to attend school, work, church, stores, day care, other public areas, or to visit with persons living outside their home.

___ The patient shall inform any medical providers, emergency responders, or medical facility of their [INSERT DISEASE NAME] diagnosis before seeking medical care at the office, clinic or hospital.

___ The patient shall inform ambulance personnel of their diagnosis before they are transported to or from a medical facility.

___ The patient shall have a separate bed and, if possible, a separate bedroom from other family and household members.

___ The patient shall have a separate bathroom if possible from other household members.

___ All persons, except those designated as caregiver of the patient, shall be excluded from the patient’s bedroom or sick area if no separate bedroom.

___ The patient’s caregiver(s) shall avoid coming in contact with any other persons within the household or elsewhere until every precaution has been taken to prevent the spread of infectious

material from the patient's room. Please refer to this order and attachments for appropriate precautions.

___ Household members or other close contacts who develop [DISEASE SYMPTOMS] must immediately contact the Glenn County Public Health Department at 530-934-6588.

___ The caregiver shall wear a mask, disposable gloves if available, and a washable outer garment when coming in contact with the patient or his/her environment that may have been contaminated. Upon leaving the room in which the patient is isolated, the caregiver shall discard the mask, gloves and remove outer garment and hang it in the room if not soiled, and wash hands promptly with soap and water. If the outer garment is soiled, put it in a plastic bag until laundering. If mask supplies are limited, re-use mask if it is not soiled or moist.

___ All discharges from the nose and mouth should be contained in tissues or papers and dropped into a plastic bag which shall be disposed of in accordance with appropriate disease control and containment procedures.

___ Objects which may have been contaminated by the patient shall not be shared between the patient and other household members and shall be thoroughly cleaned before being removed from the contaminated area.

___ If a separate bathroom is not available for the patient, clean and disinfect the bathroom after the patient's use. Use commercially available disinfectant and follow the manufacturer's instructions about its use.

___ Additional conditions and instructions:

- ___ Attachment A - Instructions for Airborne or Droplet Transmission
- ___ Attachment B - Instructions for Contact Transmission
- ___ Attachment C - Other

6) The patient or the patient's authorized lawful representative may contact the following representative of the San Francisco Department of Public Health to seek clarification of any part of this order. If the patient or his/her authorized lawful representative believe that the patient is not a case or suspected case as described in paragraph 2 of this order, or object to the appropriateness of the conditions of isolation contained in this order, the patient or his/her lawful authorized representative may object and/or request an informal hearing by contacting the person indicated below.

(Name of Public Health contact person)

Phone number

7) The patient or the patient's authorized lawful representative may seek judicial relief from this order pursuant to California Penal Code Section 1473.

8) The subject may be represented by counsel at the informal hearing and any subsequent legal proceedings related to this order.

IT IS SO ORDERED.

[Insert Full Name, Credentials]
Glenn County Public Health Officer

Date

Attachment A

Additional Instructions for Cases Involving Airborne or Droplet Transmission

- ___ If the patient must leave the bedroom, s/he shall wear a surgical mask when in the same room as any person not subject to isolation. The patient shall cover his/her nose and mouth with a disposable tissue when coughing or sneezing.

- ___ The caregiver shall thoroughly wash their hands with soap and water after handling the patient or any object the patient may have contaminated. The use of disposable gloves is recommended for persons caring for the patient; however, immediately after using gloves for any direct contact with body fluids, gloves should be removed and discarded and hands should be washed. Disposable gloves shall not be washed or reused.

- ___ Caregiver shall wear a surgical mask when in the patient’s bedroom.

- ___ Caregiver shall wear eye and face protection in any situation where there is a chance for exposure to droplets or splashing of body fluids.

- ___ Objects, such as eating and drinking utensils, clothing, towels, and bedding used by the patient shall be washed with soap or detergent and water before being used by any other person.

- ___ Environmental surfaces in rooms used by the patient shall be cleaned and disinfected at least once each day and when soiled with respiratory secretions, blood or other body fluids from the patient. It is recommended that the person performing the cleaning wear mask and gloves. Immediately after using gloves, gloves should be removed, discarded and hands should be washed with soap and water. Disposable gloves shall not be washed or reused.

Attachment B

Additional Instructions for Cases Involving Contact Transmission

- The caregiver shall thoroughly wash their hands with soap and hot water after handling the patient or any object the patient may have contaminated. The use of disposable gloves is recommended for persons caring for the patient; however, immediately after using gloves for any direct contact with body fluids, gloves should be removed and discarded and hands should be washed. Disposable gloves shall not be washed or reused.
- Objects, such as eating and drinking utensils, clothing, towels, and bedding used by the patient shall be washed with soap or detergent and water before being used by any other person.
- Environmental surfaces in rooms used by the patient shall be cleaned and disinfected at least once each day and when soiled with respiratory secretions, blood or other body fluids from the patient. It is recommended that the person performing the cleaning wear mask and gloves. Immediately after using gloves, gloves should be removed, discarded and hands should be washed with soap and water. Disposable gloves shall not be washed or reused.
- Tissues and other disposable items contaminated by the patient shall be placed in a paper or plastic bag for disposal. Public Health will provide instruction for proper disposal based on the disease.

PROOF OF PERSONAL SERVICE

I served the Isolation Order of the Health Officer upon the below-named person, by delivering to and leaving with the person named, at the time and place set forth:

Name of Person Served: _____

Date, Time and Place of Service:

Date: _____ Time: _____

Place: _____

I declare under the penalty of perjury under the laws of the State of California the foregoing is true and correct.

Executed on _____ at _____, California.

Name (Print): _____

Signature: _____

Notice

Isolation Order in Effect

Entry restricted to caregiver(s)
and
Health Department personnel.

All persons entering shall comply
With infection control procedures set forth in the isolation order.

By order of the Glenn County Public Health Officer

Release from Isolation Order

[Amend cover letter depending on disease]

[DATE]

Mr/Ms. [Case Name]
Address

Dear Mr./Ms.:

This letter is to notify you that your isolation period has ended and the isolation order put into place on (date) has been lifted as of (date). **Therefore you are cleared to return to your normal activities.**

We may contact you in the future to collect additional information from you. If you have any further questions you may call our office at 530-934-6588. Thank you for your cooperation in this important public health matter.

Sincerely,

[Insert Full Name, Credentials]
Glenn County Health Officer

Appendix D: Isolation & Quarantine Tools

Criteria for Non-Healthcare Facility Based Isolation or Quarantine

Case/Contact Name: _____ Phone: _____
 (Circle Case or Contact above. Case = Isolation; Contact = Quarantine)

Address: _____

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Does the person have a home? | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If the answer is “No”, stop here and refer the person to Non-Healthcare Facilities Based Isolation & Quarantine.</i> | | |
| 2. Is there a separate bedroom/area in the home for the person only? | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If the answer is “No”, stop here and refer the person to Non-Healthcare Facilities Based Isolation & Quarantine.</i> | | |
| 3. Is the person able to care for him/her self? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3a) If no, is there someone (caregiver) in the home who can care for him/her? | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If both answers are “No”, stop here and refer the person to Non-Healthcare Facilities Based Isolation & Quarantine.</i> | | |
| 4. Does the person have access to a phone line? | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If the answer is “No” stop here and refer the person to Home Based Isolation & Quarantine.</i> | | |
| 5. Does the person or caregiver speak English? | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If the answer is “No” stop here and refer the person to Home Based Isolation & Quarantine.</i> | | |
| 6. Does the person or caregiver know or can learn how to take temperature? | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If the answer is “No” stop here and refer the person to Home Based Isolation & Quarantine.</i> | | |
| <i>If the answer is “Yes”, refer the person to Office Based Isolation & Quarantine.</i> | | |

 Name of Person Completed this Screening

 Date of Screening

Evaluation for Home Suitability for Isolation or Quarantine

Client Name:		DOB:	
Address:		Telephone:	
		Other:	
Primary Caregiver Name: (if any)		Telephone:	
		Other:	
Number of Household Members:	Of which, number needs Dependent Care (if any):		
Type of Home:	Residence Description:		
┆ Single Family/Single Unit	Number of Bedrooms:		
┆ Single Family/Multiple Unit	Number of Other Rooms:		
┆ Single Family/Apartment	Number of Bathrooms with Shower:		
┆ Other (specify):			
Basic Requirements:		Yes	No
Is there a room/bedroom that can be used by the case only?			
Is the room/bedroom physically separated from other rooms by walls?			
Does the room/bedroom have a window that can be opened?			
Does the room/bedroom have a door that can be closed?			
Does the residence have electricity?			
Does the residence have running water?			
Is there a supply of potable water?			
Does the residence have a functioning telephone?			
Is there a provision for heat and hot water?			
Is there a sewer and garbage disposal system?			

Evaluator: _____

Date: _____

Initial Medical Admission Evaluation for Persons on Non-Healthcare Isolation Facility

Name:		DOB:	
Address:			
Telephone:		Cell phone:	Other:
Primary Language:		Need Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Clinical Information			
Are there symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, specify:	
Laboratory confirmed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date confirmed:	
Do you have any of the following conditions?			
High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No		Heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No	
Lung disease <input type="checkbox"/> Yes <input type="checkbox"/> No		Diabetes mellitus <input type="checkbox"/> Yes <input type="checkbox"/> No	
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No		Kidney disease <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you currently on chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you on regular dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, how frequent is your dialysis?		Date of next dialysis:	
Dialysis Facility Name:			
Dialysis Address:		Phone:	
Do you have other medical conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, specify:	
Do you have a primary healthcare provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of primary health care provider:	
Address:		Phone:	
Are you on prescription medication for any of the above condition ? <input type="checkbox"/> Yes <input type="checkbox"/> No		Pharmacy Name:	
How many days of medication do you have? _____		Address:	
		Phone:	
List Drugs: (Use the back of this sheet if needed)		Doses	
1.			
2.			
3.			
4.			
Are you on a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, specify diet:	
Do you know how to take your temperature? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Person Completed this Evaluation: _____ Date: _____

Instructions for Home Isolation

As per the Isolation Order that you are served, you will be on home isolation for ____ days (from today until _____), and should follow the instructions below during this period.

1. You are to stay home (do not go to work, school, out-of-home childcare or other public places) for the period you are on isolation.
2. If there are other household members living in the house, you must stay inside your designated room/area and avoid contacts with other household members for the duration of the isolation period.
3. You must sleep and eat in the designated room/area.
4. If there is no designated bathroom for you, you must wear a mask when going to the bathroom. Clean and disinfect the bathroom after use (see **Instructions on Home Cleaning & Disinfecting**). If you cannot do it, your primary caregiver should clean it after your use or before use by another household member.
5. You must not have visitors during the period when you are on isolation.
6. If you must have contact with other household members, wear a surgical mask when you both are in the same room/area. If you cannot wear a mask, the members of your household should wear one when they have contact with you.
7. Wash your hands frequently with soap and water, especially after coughing, sneezing, and/or blowing your nose, after going to the bathroom, or have contact with moist materials such as tissue, pampers, and used mask. A minimum of 62% alcohol-based hand sanitizer can also be used instead of soap and water if the hands are not visibly dirty.
8. Cover your mouth and nose with tissue when you sneeze or cough. Put used tissues in the garbage and wash your hands immediately with soap and water or use hand sanitizer.
9. Do not share toothbrushes, drinks, and eating utensils.
10. Check if you have any signs and symptoms of the disease and record them in a Monitoring Log. If you cannot do it, designate someone as the primary caregiver who can care for you during the isolation period.
11. If you have any signs or symptoms, or if you have any questions, or if you feel unwell, call the Department of Public Health at 530-934-6588.

Instructions for Clients on Non-Health Care Facility Isolation

As per the Isolation Order that you are served, you are placed on isolation at _____
_____ (name and address of facility) for _____
days (from today until _____), and should follow the instructions below during this period.

1. Things to bring with you (for the duration of the isolation period): change of clothing, personal items such as cell phone, toothbrush and toothpaste, medications/vitamins/herbs, razor, etc., and reading material or items that will help you pass the time while on isolation.
2. You are to stay in your assigned room/area in this facility (cannot go home, work, school, or other public places) for the period you are on isolation.
3. Your family and friends are not allowed to visit you during this time unless it is necessary.
4. You must sleep and eat in your assigned room/area and avoid contact with other persons in the facility.
5. Food will be delivered to your room/area.
6. Wear a surgical mask when you are around other people or when you go out of your assigned room/area to go to the bathroom or other common areas in the facility.
7. You will be assigned a time slot to use the shower facility if there is no shower in your room. Wear a surgical mask when you leave your room/area to use the shower facility.
8. Wash your hands frequently with soap and water if there is a sink or with an alcohol based hand sanitizer in your room/area, wash after coughing, sneezing, blowing your nose, or after using the bathroom, or contact with moist materials such as used tissue or mask. Use the hand sanitizer to clean your hands only if they are not visibly dirty.
9. Cover your mouth and nose with tissue when you sneeze or cough. Put used tissues in the garbage and wash your hands immediately with soap and water or with hand sanitizer.
10. You may be asked to assist in keeping your room/area clean, so keep it as clean as possible.
11. Someone will assist you with laundry as needed.
12. You will check and record your temperature at least daily, and for any signs and symptoms of the disease which will be explained to you. Someone will teach you if you don't know how, or assist you if you cannot do it.
13. Let the staff know if you have any questions or have needs for other support services. They will be accommodated as much as feasible.

Instructions on Home Environmental Cleaning & Disinfection

Areas Used by Person on Isolation or Quarantine

Bedroom

- Use EPA approved disinfectant to clean and disinfect surfaces daily and more frequently as needed on frequently touched surfaces (e.g., door knob, light switch). Keep only items that are needed in the bedroom and can be cleaned and disinfected with the disinfectant.
- Keep personal items that are not used in drawers or closets.
- Wear utility gloves when cleaning, keeping the room well ventilated (set aside these gloves for this cleaning purpose only). Suggestion: use a different color gloves for different purposes.
- Change linens at least weekly and as needed when soiled.
- Line trash can with plastic bags and remove bag when $\frac{1}{2}$ to $\frac{3}{4}$ full. Wear utility gloves when removing and replacing the plastic bag.
- Discard reading materials such as magazines, books in plastic bags; if they will be used by someone else, place them in a plastic bag and mark “not to be touched until 2 weeks” (write in the date).
- Consult the manufacturer’s instruction on appropriate cleaning products for electronics and other equipment.
- Wet mop the floor with EPA approved product at least once a week and when soiled. If the floor is carpeted, wear a mask when vacuuming, and make certain the room is well ventilated.
- Wash hands with soap and water after removing gloves.

Bathroom

- If the bathroom is shared with other household members, perform cleaning after use by the isolated or quarantined person; if at all possible, let the room vents for couple hours before use by other household members. If the bathroom is not shared, clean daily or as needed when soiled.
- Wear utility gloves when cleaning, keeping the room well ventilated (set aside these gloves for this cleaning purpose only). Suggestion: use a different color gloves for different purposes.
- Use EPA approved disinfectant to clean and disinfect surfaces, pay close attention to frequently touched surfaces (e.g., door knob, toilet seat, toilet bowl, flusher, faucets, etc.).
- Launder hand and bath towels frequently
- Line trash can with plastic bags and remove bag when $\frac{1}{2}$ to $\frac{3}{4}$ full. Wear utility gloves when removing and replacing the plastic bag.
- Wet mop the floor with EPA approved product frequently at least once a week and when soiled.
- Clean bathtub after each use, and at least weekly for showers stalls.
- Wash hands with soap and water after removing gloves.

Utility gloves can be disinfected by soaking in soap and water or in diluted bleach solution (1 part of bleach to 99 parts of water) after use for at least 20 minutes, rinse thoroughly, dry and then store in plastic bag until next use.

Instructions on Handling Used Eating Utensils, Laundry and Trash at Home

Eating Utensils

- Eating utensils should not be shared between person on isolation or quarantine and other household members.
- Once used, they should be cleaned with detergent and water. They can be washed with utensils used by other household members.
- Wear utility gloves when handling and washing used utensils (set aside these gloves for this purpose only).
- Paper and plastic products are not necessary. If used, they can be discarded with regular trash.
- At the end of cleaning, wash hands with soap and water.

Laundry

- Dirty laundry should be kept in covered plastic-lined hamper, or a plastic washable/ disposable laundry bag.
- Keep all the linens and laundry used by the person on isolation or quarantine in a separate laundry bag/hamper until washed. Wash the laundry bag with the rest of the laundry. Or remove and replace the plastic-lining in the hamper.
- Wear utility gloves when handling dirty linens (set aside these gloves for doing laundry only if possible. If not possible, use the gloves set aside for handling utensils). Suggestion: use different color gloves for different purposes.
- When carrying laundry, avoid “hugging” or touching your clothing.
- Wash hands with soap and water after removing gloves.
- Wash the laundry in detergent and water, dry in hot dryer. If there is no dryer, dry the clothes in direct sunlight if possible.
- Collect washed laundry in a different hamper/bag designated for “Clean laundry” only. Gloves are not needed to handle washed laundry.
- Launder pillow cases, linen and sheets at least once a week and when soiled.
- Launder hand and bath towels frequently, 2-3 times a week if possible.
- Change and launder clothing frequently especially if the person perspires a lot, for example, due to fever.

Trash

- Trash can that has a foot pedal to open the lid is preferred.
- Line trash cans with plastic bags.
- Empty trash cans frequently and when they are $\frac{1}{2}$ to $\frac{3}{4}$ full. Securely tie the plastic to ensure no leakage.
- Wear utility gloves when emptying trash (set aside these gloves for handling trash if possible. If not possible, use the gloves set aside for environmental cleaning). Suggestion: use different color gloves for different purposes.
- Carry trash away from the body, avoid touching your clothing.
- Trash can be discarded normally.
- Wash hands with soap and water after removing gloves.

Utility gloves can be disinfected by soaking in soap and water or in diluted bleach solution (1 part of bleach to 99 parts of water) after use for at least 20 minutes, rinse thoroughly with water, dry and then stored in plastic bag until next use.

Quarantine Symptom Monitoring Log Template

NAME: _____

Date of FIRST EXPOSURE: _____
exposure): _____

First Day of Monitoring (1 day after first

DATE OF LAST EXPOSURE: _____
days): _____

Last Day of Monitoring (Date of last exposure plus 10

DATE	DAY SINCE LAST EXPOSURE	TEMPERATURE (check daily prior to going to work)		COUGH (Yes/No)	Sore Throat (Yes/No)	SHORTNES S OF BREATH (Yes/No)	OTHER SYMPTOMS/ COMMENTS
		TIME	TEMP in Degrees				

Notes:

1. If you develop any of the above symptoms, contact Glenn County Public Health at 530-934-6588

PPE and Infection Control Guideline for HCW on Home Visit

1. Prior to the home visit, staff should obtain necessary supplies including masks and gloves. Obtain a spray bottle labeled with 1:100 (1 part regular bleach and 99 parts of water) bleach solution.
2. Upon arrival to the client's home, remove items (thermometer, hand sanitizer, garbage bag, specimen container and bag, etc.) that will be needed for the visit.
3. Prepare the garbage bag and the specimen bag by creating an opening (if applicable).
4. Don on the appropriate attire (mask, gloves, eye shield/goggles and gown as indicated) prior to entering the client's room/area.
5. Take only what is needed into the client's room/area and complete the tasks as quickly as possible. Explain and educate the client on what is being done, what to look for, etc.
6. If a specimen is taken, ensure the container lid is tightened before putting it in the specimen bag.
7. Remove the attire when outside of the client's room/area. Remove gloves first (see CDC Instructions on Donning and Removing PPE) peeling the gloves inside out and discard in the garbage bag. If worn, remove the eye shield/goggles next, touching only the straps; if it is re-usable, put it in a separate plastic bag labeled "used eye shield/goggles". Next, remove the gown if worn, turn the sleeves inside out and touch only the inside of the gown and discard in the garbage bag. Remove the mask last, touching only the straps and discard, or into a separate plastic bag labeled "used" if re-usable. If hands are contaminated during removal of any PPE, sanitize hands immediately. When all PPE is removed, wash hands or sanitize hands before touching anything else.
8. Seal the specimen bag if specimen is taken.
9. Explain/educate household members on what is done and the client's progress.
10. Put the specimen bag in specimen transporter/container.
11. Return items where appropriate; collect garbage bag and the plastic bags, if any. Put the garbage bag into another bigger plastic bag (preferably in the car trunk). In an outdoor setting, wear gloves to clean and disinfect the eye shield/goggles. Wipe off any dirt/soil with wet-one wipes, then use the spray bottle of bleach solution to damp wipe the entire eye shield/goggles. Let air dry.
12. Remove and discard gloves in garbage bag. Wash or sanitize hands.
13. Store the eye shield/goggles in a plastic bag labeled "clean eye shield/goggles" until use.
14. Proceed to the next home visit and repeat steps 1-8.
15. At the end of the shift, return unused supplies. Discard all disposable items including eye shield/goggles and mask.
16. Wash hands before leaving the work area.

Specimen Collection for Home Quarantine and/or Isolation

1. Complete all the forms as needed. Gather all necessary equipment such as forms, specimen collection kit and container before entering the client's room/area. Open the transport carrier/cooler so the specimen can be put in without touching the outside of the carrier.
2. The Health Worker must wear personal protective equipment, at a minimum, gloves and mask, prior to entering the client's room/area.
3. Explain to the client what will be done and why.
4. Obtain specimen as quickly as possible.
5. After the specimen has been collected, ensure the container is sealed and secured, put it in a biohazard bag.
6. Upon leaving the client's room/area, put the specimen (in biohazard bag) in the opened transport carrier.
7. Remove and discard the used PPE in the appropriate disposal bag/garbage can. Wash hands thoroughly with soap and water or hand sanitizer.
8. The specimen should be delivered to the Public Health Laboratory as soon as possible after collection.
9. Extra PPE (at a minimum gloves and mask), must be available during transport in case of a spill.
10. In case of a spill, don on gloves, cover the spill or wipe the soiled area immediately with paper towel. Clean and disinfectant the area if cleaning and disinfection agents are available. Otherwise, alert supervisor and carry out cleaning and disinfection as soon as possible.

Referral Form for Medical or Behavioral Health Services

*Referral for (circle where applicable): **Medical, Mental, Other (specify)** _____*

*Patient is on (circle where applicable): **Home or Non-Healthcare Facility**
Isolation or Quarantine*

Reason for Referral: _____

Date Service Requested (if applicable): _____

Complete as much information as possible:

Name of Patient: _____ DOB: _____

Patient Current Location/Address: _____

_____ Contact Number: _____

Medicare/Insurance: _____ ID #: _____

Name of Caregiver: _____ Contact Number: _____

Signs/Symptoms: _____

History of Present Condition (if known): _____

Current Medications (if known): _____

Present/Past Illnesses/Condition/Treatment (if known): _____

Name of Person Making Referral Contact Number Date

Post-Exposure Prophylaxis Delivery and Sign Off for Clients on Quarantine

<u>For the Health Worker:</u>	<u>For the Client:</u>
<ol style="list-style-type: none"> Collect the client's supply of drugs from the Supervisor or the designated person/area. Wear personal protective equipment (at a minimum mask and gloves) before entering the client's isolation/quarantine room. Review with the client or the primary care giver the instructions for the intake of the drug and have the client or the primary caregiver signed the delivery receipt. Advise the client to wash hands with soap and water or use hand sanitizer if hands are not visibly dirty, before signing the delivery receipt. Remove and discard the used PPE in appropriate disposal bag or waste bin after leaving the client's isolation/quarantine area. Wash hands with soap and water or use hand sanitizer if hands are not visibly soiled. 	<p>I have received the following from the Department of Public Health:</p> <ol style="list-style-type: none"> Medication _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Number of pills: _____ Written instruction on how to take the medication and the possible side effects and adverse reaction <input type="checkbox"/> Yes <input type="checkbox"/> No Number to report adverse reaction _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Name of Client/Primary Caregiver _____ Signature: _____ Date: _____ (If client cannot sign or is a child, the primary caregiver must sign for the client.)</p> <p>Name of Health Worker: _____ Signature: _____ Date: _____</p>

Re-Assessment/Checklist to Remove Persons from Isolation

Disease/Agent: _____

Infectious Period (IP): _____

Client Name: _____ Date Of Birth: _____

Contact #: _____

(Circle one) Home/Non-Healthcare Facility Address:

First Date of Signs/Symptoms: _____ Last Date of Signs/Symptoms: _____

First Date of Isolation: _____ Last Date of Isolation: _____

Duration of Isolation: ____ (A)

(Duration of Isolation = Last Date of Isolation – First Date of Isolation)

The Total Number of Days the Client must be on Isolation is calculated from the First Date of Signs/Symptoms plus the maximum range of the infectious period. (First Date of Signs/Symptoms + Maximum range of IP = Total Number of Days Must be on Isolation)

_____ + _____ = _____ (B)
(First Date of Signs/Symptoms) (IP) (Total Number of Days Must be on Isolation)

Criteria for Cessation of Isolation:

Yes No
1. Is (A) at least equal to or greater than (B)

If the answer is Yes, proceed to question #2.
If the answer is No, Client is to remain on Isolation until the Total Number of Days must be Isolation is completed.

2. Does the Client have any signs or symptoms now?

If the answer is Yes, Client must be re-assessed by a Clinician.
If the answer is No, Client can be removed from isolation and resume prior regular activities.

Recommendation (circle one): Client can be removed from isolation. Client remains on isolation.
Health Worker Name Date

Appendix E: Initial Threat Assessment Meeting (ITAM) Guide

For Use During the Initial Threat Assessment Meeting	
A. Assess the Situation (current and potential impact)	
<ol style="list-style-type: none"> 1. What type event: disease or illness, bio terrorism, extreme weather, shelter operations... 2. Is the health risk confined to one segment of our community or to the community at large? 3. If the event is disease related do we know the exposure pathways? 4. Have local medical and health care facilities been affected? 5. What other agencies and organizations are currently responding or set to respond? 6. Have any of the GCHSA Division operations been affected? 7. Have critical infrastructures been affected? 8. Have communications systems been affected? 9. Are evacuations routes open and accessible? 10. Is this a local, regional, statewide or national situation? 11. Has any agency declared that we take specific actions related to this event? 	
B. Based on the above assessment do any of the following actions need to be taken?	
1. Does provider health alert need to go out?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Do we have a pre-scripted message or fact sheets?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Do we need to start an Investigative Report?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Is there a recommended action or existing plan for this situation?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Do we need to consider suspending non-essential services?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Does the incident currently, or do we expect that it will soon, exceed our capacity to respond or require more coordination?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes to 5 or 6 move to ICS model, activate DOC, & prepare to divert staff to the response	
C. Identify additional information needed to assess threat and/or take action and assign staff	
D. Suggested Agencies and staff that Public Health may need to notify (This is not a comprehensive list of all possible contacts. Notifications will depend on the situation)	
<hr/> <ul style="list-style-type: none"> <input type="checkbox"/> HO and other Public Health staff <input type="checkbox"/> Regional Epidemiologist <input type="checkbox"/> Shasta County LRN Lab <input type="checkbox"/> RDMHS <input type="checkbox"/> LEMSA/EMS & other healthcare providers <input type="checkbox"/> Local OES (Sheriff's Office) <input type="checkbox"/> CDPH DCDC Duty Officer Local schools (via Dept. of Education) <input type="checkbox"/> EMSA Duty Officer <input type="checkbox"/> Region III county public health jurisdictions <input type="checkbox"/> Local Schools (via Dept. of Education) 	

ITAM Agenda Template

Agenda Topics –	
<p>Information –What we know: sharing current information only. Deciding and assigning actions comes later in the meeting.</p> <ol style="list-style-type: none"> 1. Situation status overview given by meeting lead 2. Roundtable report out/sharing of information by participants 3. Sharing of actions already taken by participants or agencies 	10 minutes
<p>Assessment –Assess the situation and determine immediate impact or severity of the event. <i>See Initial Threat Assessment Guide</i></p> <ol style="list-style-type: none"> 1. Assess the current and potential impact of the event using 2. Actions to consider 	10 minutes
<p>Based on assessment identify and assign immediate actions needed</p> <ol style="list-style-type: none"> 1. Confirm internal and external notifications needed and assign responsibility and timeline 2. Confirm action items and assign responsibility and timeline 3. Confirm what additional information is needed 	15 minutes
<p>RAP – Up</p> <ol style="list-style-type: none"> 1. Review decisions and assignments 2. Assure that all participants are clear on the decisions and their action items 3. If it appears that the event will be resolved using usual day-to-day work processes schedule one follow-up meeting <ol style="list-style-type: none"> a. If it is evident that a larger or coordinated response will be required do the following: 12.move to ICS mode and assign command and section chief staff 13.activate appropriate DOC level 14.make staff assignments 15.schedule Initial Action Planning meeting <p>Adjourn meeting – Remind participants to continue documenting their activities in their Individual Activity Log (i.e. ICS 214) until the event is closed.</p>	10 minutes

SECTION 9: Glossary

Acronym	Term
ACS	Alternate Care sites
ARES	Amateur Radio Emergency Services (Ham Radios)
BT	Bioterror
CAHAN	CA Health Alert Network
Cal-OES	California Office of Emergency Services: Lead agency for coordinating emergency activities related to fire and rescue, management, search and rescue, law enforcement, and public information.
CD	Communicable Disease
CDC	Centers for Disease Control and Prevention
CDPH	California Department of Public Health: A State agency that works closely with health care professionals, county governments and health plans to provide a health care safety net for California’s low-income residents and persons with disabilities.
CERC	Crisis Emergency Risk Communication (Plan)
DHS	U.S. Department of Homeland Security
DHV	Disaster Health Volunteers
DOC	Department Operations Center: An emergency operations center (EOC) specifically set up by a single department or agency such as Public Health.
DSW	Disaster Service Worker
EM	Emergency Management
EMS	Emergency Medical Services: Refers to the providers of pre-hospital 911 response and medical treatment.
EMSA	Emergency Medical Services Authority: Responsible for prompt delivery of disaster medical resources to local governments in support of their disaster medical response.
EOC	Emergency Operations Center: The physical location at which the coordination of information and resources to support incident management (on-scene operations) activities takes place.
EOM	California Public Health and Medical (EF8) Emergency Operations Manual, EOM. Provides guidance to local health departments (LHDs) on responding to disasters that require resources outside the response capability of the Operational Area (OA).
EOP	Emergency Operations Plan
FOUO	For Official Use Only
FTS	Field Treatment Site (See FTS Plan)
GMC	Glenn Medical Center
HAvBED	Hospital Available Beds for Emergencies and Disasters
HCC	Hospital Command Center: Site within the hospital or health care facility where overall emergency response and support activities are coordinated.

Glenn County SPIDER Plan

Acronym	Term
HCF	Health Care Facility
HHSA	Health & Human Services Agency
HO	Health Officer
HPP	Hospital Preparedness Program
HSEEP	Homeland Security Exercise and Evaluation Program
IAP	Incident Action Plan: An oral or written plan containing general objectives reflecting the overall strategy for managing an incident.
ICS	Incident Command System. A standardized on-scene emergency management specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries.
ITAM	Initial Threat Assessment Meeting
JERP	Joint Epidemiological Response Plan (10 County N-E CA Regional Epi Project)
JIC	Joint Information Center
JIS	Joint Information System; integrates incident information and public affairs into a cohesive organization designed to provide consistent, coordinated, accurate, accessible, timely, and complete information during crisis or incident operations.
LEMSA	Local Emergency Medical Services Agency. The agency, department, or office having primary responsibility for administration of emergency medical services in a county.
LHD	Local health department. The agency, department, or office having primary responsibility for administration of public health services in a county.
LTCF	Long Term Care Facility
LRN	Laboratory Response Network: an LRN lab provides the laboratory capacity to respond to biological and chemical terrorism and other public health emergencies.
MERS	Middle East Respiratory Syndrome
MCI	Mass Casualty Incident. An incident resulting in a large number of persons with injuries or deaths.
MCM/MP	Medical Countermeasures and Mass Prophylaxis (Plan)
MH	Mental Health
MHCC	Medical Health Coordination Center (CDPH/EMSA EOC)

Acronym	Term
MHOAC/P	Medical Health Operational Area Coordinator/Program. A functional designation within the Operational Area normally fulfilled by the county health officer and local EMS agency administrator (or designee), responsible for the development of a medical and health disaster plan and coordination of situational information and mutual aid during emergencies.
NIMS	National Incident Management System. Provides a systematic, proactive approach guiding government agencies at all levels, the private sector, and non-government organizations to work seamlessly to prevent, protect against, respond to, recover from and mitigate the effects of incidents, regardless of cause, size, location, or complexity, in order to reduce the loss of life or property and harm to the environment.
NVIH	North Valley Indian Health
OA	Operational Area. An intermediate level of the State’s emergency organization, consisting of a county and all other political subdivisions within the geographical boundaries of the county.
OA EOC	Operational Area Emergency Operations Center (County EOC)
OES	Office of Emergency Services
PEP	Post Exposure Prophylaxis
PH	Public Health
PHEP	Public Health Emergency Preparedness program
PHICS	Public Health Incident Command System
PHN	Public Health Nurse
PIO	Public Information Officer
POC	Point of contact
PPE	Personal Protective Equipment
PUI	Person Under Investigation
RDMHC/S	Regional Disaster Medical Health Coordinator or Specialist. Regional contact for local PH & medical coordination.
REHS	Registered Environmental Health Specialist
REOC	Regional Emergency Operations Center. Provide centralized coordination of resources among Operational Areas (OAs) within their respective regions, and between the OA and the State government level.
RN	Registered Nurse
SARS	Severe Acute Respiratory Syndrome
SEMS	Standardized Emergency Management System. A system required by California Government Code for managing response to multi-agency and multi-jurisdictional emergencies in California.
SPIDER	Special Pathogens Infectious Disease Emergency Response (Plan): Annex to the Glenn County PH and Medical Emergency Operations (EOP) Plan
SITREP	Situation Report

Acronym	Term
SNS	Strategic National Stockpile (AKA Medical Countermeasures Program)
SO	Sheriff's Office
SOC	State Operations Center (State EOC)