

Infectious Disease Surge Annex Tabletop Exercise TEMPLATE

Situation Manual

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PREFACE

This Infectious Disease Surge Annex Tabletop Exercise (TTX) Toolkit Template has been developed by the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE). It can be used by healthcare coalitions (HCCs) to enhance operational area awareness and capabilities to effectively address the needs of infectious disease patients as part of a whole community emergency response framework. It can also be utilized to satisfy [Funding Opportunity Announcement \(FOA\) requirements](#) for the Hospital Preparedness Program (HPP) Cooperative Agreement.

HCCs are not required to use this template and may conduct an infectious disease surge annex exercise using a pathogen/scenario of their choosing and any acceptable [Homeland Security Exercise and Evaluation Program \(HSEEP\)](#) compliant format.

Note that most scenarios using highly virulent pathogens requiring care at specialized centers do not test overall surge. Planning for these scenarios is important and should be included in the coalition annex as well as exercise plans, but this toolkit uses an anthrax scenario to help jurisdictions anticipate the specific issues related to Strategic National Stockpile (SNS) request and deployment, testing, prophylaxis, and patient care needs that create competing resource and coordination demands.

This toolkit template is intended to be edited and modified by the HCC Exercise Planning Team to satisfy the concepts and objectives each HCC intends to test. Blue text boxes and bracketed sections are included throughout the document and serve as notes to planners and prompts to enter your own text. Please delete those boxes and bracketed areas once final planning decisions are made and text has been crafted.

The complete toolkit template includes the following supporting materials for conducting an Infectious Disease Surge Annex TTX:

1. Step-by-Step Guide to Implementing the Infectious Disease Surge Annex Tabletop Exercise Template ([compliant PDF](#), [DOC](#))
2. Situation Manual (this document) ([compliant PDF](#), [DOC](#))
3. Infectious Disease Surge Annex Tabletop Exercise Presentation ([compliant PDF](#), [PowerPoint](#))
4. Participant Feedback Form ([compliant PDF](#), [DOC](#))
5. Sign-in Form ([compliant PDF](#), [DOC](#))

ASPR TRACIE developed a [HCC Infectious Disease Surge Annex Template](#) and has many [additional resources for HCCs](#) and [infectious disease planners](#). For more information, visit www.asprtracie.hhs.gov or contact our Assistance Center at 1-844-5-TRACIE or askasprtracie@hhs.gov.

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HANDLING INSTRUCTIONS

1. The title of this document is *Infectious Disease Surge Annex Tabletop Exercise (TTX) Situation Manual (SitMan)*.
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3. [Insert any local statutes or regulations with regard to document handling.]
4. For more information or questions regarding this exercise, please contact:
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TABLE OF CONTENTS

Introduction.....	1
Background.....	1
Purpose.....	1
Scope	1
Health Care Preparedness and Response Capabilities	1
Exercise Objectives	1
Roles	2
Exercise Structure.....	2
Exercise Guidelines.....	3
Exercise Assumptions and Artificialities	4
Module 1: Initial Recognition and Response.....	6
Monday morning, 8:00 am.....	6
Module 1 Discussion Questions	6
Module 1 Note Page	8
Module 2: Community Information Sharing & Coordination.....	9
Tuesday morning, 8:00 am (HAN Notification + 24 hours)	9
Module 2 Discussion Questions	9
Module 2 Note Page	11
Module 3: Ongoing Healthcare Coordination	12
Friday morning, 8:00 am and beyond (Recognition + 4 days).....	12
Module 3 Discussion Questions	12
Module 3 Note Page	14

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INTRODUCTION

Background

[May include additional background information specific to the coalition, member organizations, and threats/hazards as identified in the jurisdiction's risk assessment/ hazard vulnerability assessment and resource gap analysis.].

Purpose

The Infectious Disease Surge Annex TTX provides HCC members and leadership with a useful exercise planning template to address large numbers of patients seeking healthcare following exposure to an infectious agent. The exercise allows participants to address key issues through a series of facilitated discussions, and test and update the annex.

Scope

This toolkit is an interactive, discussion-based exercise focusing on impacts to HCCs and healthcare facilities caused by large numbers of patients seeking healthcare following exposure to an infectious agent.

The exercise is planned for a half day, and the scenario consists of three modules in chronological order and portrays an incident and its aftermath causing mass casualties.

Health Care Preparedness and Response Capabilities

[These are suggested related existing HPP program capabilities. Grantees will determine their current infectious disease medical resources in the community under normal conditions and define how they work together to determine relevant capabilities, objectives, and activities that need to be addressed during the Initial Planning Meeting.]

- **Capability 2: Health Care and Medical Response Coordination**
Objective 3: Coordinate Response Strategy, Resources, and Communications
- **Capability 3: Continuity of Health Care Service Delivery**
Objective 3: Maintain Access to Non-Personnel Resources during an Emergency
- **Capability 4: Medical Surge**
Objective 1: Plan for a Medical Surge
Objective 2: Respond to a Medical Surge

Exercise Objectives

The following exercise design objectives are focused on understanding the concept of operations of the HCC Infectious Disease Surge Annex and developing recommended actions and procedural adjustments to address potential gaps or problem areas:

1. Review existing infectious disease care assets and identify gaps that may occur in an infectious disease-related mass casualty incident.
2. Review agency/facility role in an infectious disease incident.
3. Validate assumptions in the HCC Infectious Disease Surge Annex.
4. Identify changes that need to be made in the HCC Infectious Disease Surge Annex based on the roles and capabilities of the involved partners.
5. [Other objectives identified by the Exercise Planning Team.]

Roles

- *Players* respond to the situation presented based on their current roles in their facility or HCC; expert knowledge of incident management procedures; current plans and procedures in place in their agency, jurisdiction, or organization; and insights derived from previous experience.
- *Observers* view all or selected portions of exercise play and support the group in developing responses to the situation during the discussion.
- The *Facilitator* provides situation updates and moderates discussions. They also provide additional information or resolve questions as required.
- *Data Collectors* observe and record the discussions during the exercise, participate in the data analysis, and assist with drafting the After Action Report (AAR) that will be used to suggest improvements within the infectious disease surge annex itself and future exercises.

Exercise Structure

The exercise will be a half day event. The TTX has three modules consisting of an initial incident and then the subsequent aftermath. Players in this exercise will participate in the following exercise module elements:

- Module 1 – Initial Recognition and Response
- Module 2 – Community Information Sharing and Coordination
- Module 3 – Ongoing Healthcare Coordination

Each module begins with a scenario update that summarizes the key events occurring within that time period. A series of questions following the scenario summary will guide the facilitated discussion of critical issues in each of the modules.

Planning Note: The coalition may add, delete, or modify questions based on their local plans and resources. Based on exercise priorities, time dedicated to each module will be managed by the facilitator.

The following is an approximate schedule:

- 8:00-8:30 AM – Introductions and opening remarks
- 8:30-9:00 AM – Overview of the HCC Infectious Disease Surge Annex / process during an infectious disease incident
- 9:00-9:20 AM – Table discussion Module 1
- 9:20-9:40 AM – Report out and discussion
- 9:40-10:00 AM – Table discussion Module 2
- 10:00-10:10 AM – Break
- 10:10-10:30 AM – Report out and discussion
- 10:30-10:50 AM – Table discussion Module 3
- 10:50-11:10 AM – Report out and discussion
- 11:10-11:50 AM – Wrap up and Hotwash

Planning Note: The Exercise Planning Team should use this information for planning purposes and delete this text box once decisions have been made.

This exercise could also be facilitated with a large group and no table discussion breakouts, based on Exercise Planning Team and Facilitator preference. If less than 20 people are participating in the exercise, full group facilitation is likely most effective. Facilitation will need to be adjusted if this is a virtually conducted exercise.

Attendees should sit together by facility and discipline. If there are few attendees from a specific discipline (e.g., emergency management) they should be assigned to a table that the planners feel would be most valuable from a contributions, learning, and relationship standpoint. Ideally, if there is a healthcare system participating in the TTX, the hospitals for that system should be seated together so that they can discuss any system responses to this incident as well as facility and coalition-level. Planners should avoid having tables with fewer than six members if possible. Because public health has a significant response role, consider having a table specifically for them if there are multiple attendees.

This exercise could also be conducted entirely virtually.

Exercise Guidelines

- Open, low-stress, no-fault environment.
- Comments will be non-attributable.
- Be professional and respect other’s opinions based on their knowledge.
- Responses should be based on knowledge of current plans and capabilities – you do not have to have all the answers.
- Exercise-based decisions are not precedent setting.

- Problem-solving efforts should be the focus; it is expected that more questions than answers may be generated.
- The situation updates, written material, and resources provided are the basis for discussion; it is not expected that participants will need to do additional research or review other materials prior to participation in this exercise.
- Participants are encouraged to use the SitMan as a reference and to fill out the Participant Feedback Form as you go; feedback is welcome!
- Use the notes pages available in the SitMan.

Exercise Assumptions and Artificialities

In any exercise, a number of assumptions and artificialities may be necessary to complete the exercise play in the time allotted. During this exercise, the following apply:

- The scenario for this exercise is artificial, however, it is plausible, and events occur as they are presented.
- There is no “hidden agenda” or any “trick questions.”
- All players receive information at the same time.
- Assume cooperation and support from other responders, agencies, and organizational entities.

Planning Note: Planners may change the incident or the scope as needed to fit local considerations. Scenarios should still follow the modular approach in this sample. Planners should consider adjusting patient numbers and providing any other demographic or geographic information specific to your community and designed to exceed day-to-day capabilities to test and/or “break” the system. It is important that the infectious disease patient volumes overwhelm area capabilities without being so extreme that they are unrealistic and cause participants to lose focus or focus on issues that do not contribute to functional planning. The Facilitator should have license to adjust patient volumes during the exercise to move the exercise forward.

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MODULE 1: INITIAL RECOGNITION AND RESPONSE

Monday morning, 8:00 am.

Hospitals and other healthcare facilities in the area served by your HCC are at normal staffing and supply levels. Hospitals were at their average daily occupancy for both general inpatient and intensive care unit (ICU) beds yesterday. However, this morning you are aware that both emergency medical services (EMS) and hospital emergency departments are unusually busy.

A notification is received from the state health department through the Health Alert Network (HAN) of an apparent inhalational anthrax case in a hospital about an hour away in an area served by a neighboring HCC. The source of exposure is under investigation. Per the HAN, several other potential cases have been reported and are being investigated.

Planning Note:

- Determine whether to add any at-risk population considerations, such as pediatric patients or those with access or functional needs.
- Supply those who will report out with a note pad and pen/ pencil at the beginning of the exercise and assign a scribe for each report out team, preferably someone whose handwriting is legible for later review.
- This module focuses on the health care response to this incident. Exercise Planners can choose to create sub modules or adjust this scenario if they would prefer a more detailed discussion of post-exposure prophylaxis operations, epidemiological and law enforcement investigations, and other non-medical activities.

Module 1 Discussion Questions

1. What are your initial actions upon notification of this incident? Would hospitals activate their disaster plans? Do you have an infectious disease surge plan? If yes, how is it activated?
2. Who initiates information sharing for your HCC members? What alerts and notification mechanisms are in place to ensure that HCC members and partners are aware of the incident and can share initial information about their situation and tactics?
3. Who has the coordination role at this point? What is it?
4. How do the HCC and members support this response?
 - a. If the HCC has an operations center, how is it activated and staffed and what functions does it serve? How does it interface with the Emergency Operations Center (EOC)?
 - b. If the HCC functions are conducted by/at the jurisdictional EOC, how rapid is the activation? Who provides coordination and supports the healthcare needs?
 - c. What will be the hours of operation?

5. What essential elements of information will you collect from and share with HCC members?
6. How is the Emergency Operations Center (EOC) Joint Information Center (JIC) coordinating public information with the HCC(s)?
7. What specialized resources will be needed to respond to an anthrax attack?
 - a. Are they available within your HCC? If not, how will you acquire them?
 - b. How are SNS assets requested and received both for hospital patient care and public health prophylaxis?
 - c. What is the role of the HCC in acquiring specialized resources?
8. Where would you obtain guidance or clinical advice for anthrax patient care?
9. Does your regional emerging special pathogen treatment center play a role in this scenario? If yes, how?
10. How will you ensure adequate resources are available to support the medical response during the concurrent public health response? How do you make resource requests to the State and how are those requests coordinated statewide?
11. How will you ensure clear and consistent risk communication to the public?
12. How will you ensure you have adequate supplies and resources to accommodate and support staff (e.g., sleeping accommodations, food and beverages, childcare)?
13. Will healthcare utilize closed points of distribution for employee prophylaxis if needed? How are these antibiotics obtained and distributed?

MODULE 2: COMMUNITY INFORMATION SHARING & COORDINATION

Planning Note:

- This module focuses on the health care response to this incident. Exercise Planners can choose to create sub modules or adjust this scenario if they would prefer a more detailed discussion of post-exposure prophylaxis operations, epidemiological and law enforcement investigations, and other non-medical activities.
- The questions may need to be changed based on coalition resources. The key issue for this module is defining what activities occur where (e.g., does transfer coordination occur at the hospital [particularly if there are only one / a few hospitals in the coalition], jurisdictional Emergency Operations Center [EOC], coalition physical or virtual coordination center, or receiving hospital).

Tuesday morning, 8:00 am (HAN Notification + 24 hours)

- A terrorist organization claims responsibility for releasing [aerosolized anthrax](#) at a major sporting event Friday afternoon in the city where the first case was recognized. The event was widely attended by residents of your state. Additional attacks in other geographic locations are not known nor anticipated.
- Your Governor declared a disaster and the federal government approved your state's request for Strategic National Stockpile (SNS) assets. The State has requested 12-hour Push Packs, which are arriving this morning.
- While the epidemiological investigation is ongoing, preliminary information suggests the number of residents of the region your HCC serves who were potentially exposed at the event exceeds your HCC's normal daily bed capacity.
- Hospitals, clinics, physician offices, and other healthcare facilities in the area are experiencing a surge in patients and EMS transports are also increasing. While some of these patients were exposed and seeking treatment, many others are worried well. Inpatient beds are already at 100% capacity and critical care hospital beds are at 120% capacity.
- Many of the public health and logistics resources in the region are preparing for the initial distribution of post-exposure prophylaxis.

Module 2 Discussion Questions

1. What actions do you anticipate taking based on the location of the attack and the potential surge in inpatient demand?
2. What is the community plan for prophylaxis distribution (open points of distribution) for those in the region that attended the event?
3. Who has the healthcare coordination role at this point? What is it?

4. If you have moved or plan to move hospitalized patients to facilities outside the area covered by the HCC, what EMS transport resources are available (both public safety and private services including local, mutual aid, state resources/ ambulance strike teams)? (Note: encourage EMS to discuss considerations related to both ground and air assets.)
5. How can the HCC ensure patient load balancing among hospitals or play a role in transfer decisions? How are hospitals and EMS coordinating this decision making?
6. If the HCC does not serve in this role, how will you interface with state or substate Medical Operations Coordination Cells? What role would they play?
7. How are requests for state and federal personnel to support healthcare operations coordinated? Will you need to request Federal Medical Stations or use other alternate care sites?
8. Where will antitoxin treatments from the SNS (Anthem [obitoxaximab], Anthrasil [anthrax immune globulin], and Abthrax [raxibacumab]) be delivered?
 - a. Who has information about local and federal stockpiles? How do you communicate with them?
 - b. Do you need to ensure continuous refrigeration or will they be kept in the supplied coolers and rapidly used?
 - c. Will the SNS request include the piggyback IV tubing and saline bags needed to administer?
9. How will the intravenous antibiotics be allocated to hospitals by the State/RSS site? Based on request, pro rata based on size of the facility, or other metrics?
10. What other treatment products and supporting supplies are you expecting or will you need? How will you request additional ventilators and antibiotics from the SNS?
11. Since patients with mild illness may not be able to be hospitalized due to capacity, will you set up an Alternate Care Site (ACS)?
 - a. How will they be staffed and supplied?
12. What sites may be suitable to provide antibody infusions to anthrax patients not requiring hospitalization?
13. How are you triaging patients to distinguish among and appropriately refer the worried well, exposed patients needing post-exposure prophylaxis, and exposed and symptomatic patients who do not need hospitalization?
 - a. How are you managing this process in addition to your usual patient population?
 - b. How are you following up with referred worried well patients? How do you communicate with patient instruction on when to seek medical care?
14. How are the healthcare facilities managing the increased need for ICU-level care? What is the coalition role?
15. How will resource allocation decisions in a scarce resource environment be made regionally (e.g., transportation, staff, supplies)?

MODULE 3: ONGOING HEALTHCARE COORDINATION

Planning Note: This module focuses on the health care response to this incident. Exercise Planners can choose to create sub modules or adjust this scenario if they would prefer a more detailed discussion of post-exposure prophylaxis operations, epidemiological and law enforcement investigations, and other non-medical activities.

Friday morning, 8:00 am and beyond (Recognition + 4 days)

- The initial distribution of post-exposure prophylaxis is winding down. Public health agencies are leading the efforts to coordinate distribution of the remaining 60-day course of antibiotics and vaccination of those who were exposed.
- National media coverage is intense, and many persons who had no connection with the initial incident continue to burden emergency departments with minor complaints and requests for prophylaxis.
- The number of new patients presenting with anthrax symptoms is declining, but hospitals remain overwhelmed due to long length of stay of the anthrax patients.
- Hospitals within the HCC are operating at 200% capacity with very high acuity.
- Two federal medical stations staffed by federal staff have been established in central locations in the State to assist with general inpatient care.
- The SNS is working with usual vendors to continue to support delivery of antibiotics – multiple different treatment regimens are being used due to relative shortages of meropenem and fluoroquinolones like ciprofloxacin.
- The region lacks sufficient ICU capacity to manage the current number of ICU patients at the conventional level though outright triage of resources is not currently needed
- Several cases of anaphylaxis have occurred after receiving monoclonal antibody treatment, resulting in at least one fatality. Cases of anaphylaxis were expected, but they are generating substantial patient concern and media coverage.
- Hospital supplies of chest tubes, chest tube drainage sets, and lumbar puncture supplies are exhausted at many facilities.

Module 3 Discussion Questions

1. Does the HCC have a coordination role at this point? What is it? If not, who is coordinating healthcare resource issues?
2. How will the HCC work towards resupplying or redistributing needed equipment and supplies?
3. How will the HCC and state coordinate to develop guidance for limiting use of chest tubes and lumbar puncture kits?

4. What is the HCC's role in crisis standards of care recommendations?
5. What types of staffing shortages would occur and how can the HCC help address them?
6. How are patients being tracked that received prophylaxis or monoclonal antibodies?
7. What role is telemedicine playing in the management of patients? Is telemedicine being used in other ways?
8. Have any other federal assets (e.g., DMATs, NDMS) in addition to SNS and Federal Medical Stations (FMS) been deployed? Are resources available through Emergency Management Assistance Compact (EMAC)? How are they being integrated into the response?
9. If you had not initially transferred patients out of the region to enable load balancing or level loading, is the option being considered?
10. What state and federal emergency authorities and waivers has your HCC been operating under? Are they sufficient to meet your requirements?
11. What plans and resources are available to support the post-exposure vaccination effort?
12. What is your communication strategy to alleviate the public fear of anaphylaxis from prophylaxis or monoclonal antibodies?
13. What efforts can be made to divert worried well to seek medical attention at facilities other than hospital settings?

