



Attachment A Local Level Planning Considerations

Public Health and Medical Special Events Planning Guide and Tool Kit

**Florida Department of Health (FDOH)
Bureau of Preparedness and Response (EPR)**

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I. Introduction

This Local Level Planning Considerations document is an attachment to the Public Health and Medical Special Events Planning Guide which provides general background information and assumptions related to special events planning. It is recommended that you first read the general information found in the base document.

This document was created to assist local level planners tasked with preparing for and responding to special events. Although this document emphasizes planning for a National Security Special Event (NSSE), the considerations are scalable and can be used to plan for any special event.

The Florida Department of Health Central Office provides support to your jurisdiction in planning for and responding to a special event. It is recommended that you also read Attachment B: State Planning Considerations to help achieve an understanding of what support the State can provide to you.

This document contains enclosures that may also be of use to you in your planning. Additional resources are noted in the base document.

II. Recommended Sequence of Actions

- A. Establish communications – This will continue through the entire planning process and event.
 - Set up frequent and routine communications immediately with Department of Health Bureau of Preparedness and Response (EPR) and, if they are assigned to the event, the Assistant Secretary for Preparedness and Response (ASPR) Region IV Regional Emergency Coordinator (REC).
 - Contact previous event hosts to obtain information on their planning process, lessons learned, challenges, and AAR documentation (if available).
 - Begin internal communications.
 - Initiate stakeholder communications (hospitals, blood services, lab, medical examiner, emergency medical services, etc).

- B. Identify general mission areas – The majority of this is intuitive but each county is a little different on ownership of processes. This is based on your county, roles of your county health department (CHD) in emergency or planned operations, and/or the requirements of the event planning leaders. The NSSE may be conducted as an operation completely divergent from your county emergency operations center (EOC) operations, or may utilize components of it. An example is that local/city elements have the lead role for the event planning and operations. ESF8, as configured in the Comprehensive Emergency Management Plan (CEMP), needs to be aware of the medical response, take the lead on planning their particular areas of responsibility and support others.
 - Areas of responsibility – Broad general areas (i.e., disease and environmental surveillance, pre-hospital triage/treatment/transport, medical response, etc) should be determined and a lead assigned for each.

- Concepts of operations and response – Identify how things are “visioned” based on the need and scope of the event. Reviewing past event descriptions, results, lessons learned or any descriptive articles can help paint this picture. For example, will there be first aid stations in the field? What level of acuity will be managed there? What services will be needed? Who will staff them, what supplies and equipment are needed? What safety issues are contemplated for this event and how will other agencies (HazMat) be involved? What is the communications plan and who has responsibility for it? How will medical triage and patient transport be handled? What is the capacity for medical throughput from Emergency Room bed capability to intensive care unit (ICU)/burn beds?
- C. Review existing emergency plans – Use your existing plans as much as possible. In most cases, they will be your consequence management (CM) plans.
- Take an all hazards approach. You may or may not have access to threat information. The Emergency Operations Plan (EOP), Mass Casualty Incident (MCI), Risk Communications, Continuity of Operations Plan (COOP), Mass Prophylaxis, Alternate Care Site (ACS), etc, can serve as the basis for your operations. Review these in the context of this event specifically. For example, you alternate care site(s) may not fit this event planning.
 - Consequence management plans will focus on response to an event and those plans already developed should address CM.
- D. Develop work groups
- Base on the major response functions (Consider: Pre-hospital Triage and Treatment; Disease Surveillance; Environmental Surveillance; Food Safety; Hospital; Patient Movement/Evacuation; Alternate Care Site; Laboratory) Do not limit to these, determine what is appropriate for your mission.
 - Define the scope and parameters of the work groups.
 - Appoint an appropriate team leader. The most critical aspect is to make sure that your team leader is capable and has the resources needed to accomplish the task.
 - Establish meeting schedules and milestones that encompasses the entire planning period.
- E. Conduct gap analysis (See below for specific areas)
- Complete a needs assessment to meet the concept of operations (CONOPs) response. Base this on what, where, when, who and how.
 - Identify specific gaps – what is truly needed to mitigate the threat or meet the mission requirement based on the CONOPs?
 - Identify potential sources for closing the gap – Start with local resources, Medical Reserve Corps (MRCs) in the area, other volunteers, state assets, and then federal assets.
 - If requesting either state or federal assets, you must have strong justification for each request you make.
- F. Training and exercises
- Base all training needs on the requirements of the mission and **begin training early.**

- Exercises should be scheduled closer to the event (keep in mind that everyone will be doing the same thing). Full scale exercises are very hard to schedule as most partner agencies are involved in training and exercising as well. You may want to consider a series of tabletop and functional exercises. The event leadership will typically have a series of 2 or 3 tabletops where all agencies participate.

G. Finalize plans

III. Planning Considerations

A. GAP ANALYSIS

This is a critical first step and will be necessary to continually conduct a gap analysis through the entire process as “new” needs come up and as plans get further developed. Some areas to be considered are listed below. Based on the event, not all of these may be within the purview of ESF8 or the Health and Medical Subcommittee. Also a major consideration for gap analysis would be seasonal threats (hurricanes, tornadoes, etc).

- Medical surge capability for each facility (include trauma center level designation, response tier, specific provider specialties, bed availability to include specialty beds, aero medical capability, facility decontamination)
- Emergency Department (ED) surge capacity
- Medical, ancillary and support staff
- Emergency Medical Services (EMS), Advanced Life Support (ALS) vs. Basic Life Support (BLS). How does your county fit into the state Ambulance Plan?
- Air assets available to include potential aerial port of embarkation (APOE) sites
- MCI supplies/equipment to include trauma supplies/kits, MCI trailers, ventilators, oxygen provision , dialysis etc
- Decontamination capability
- Medical Countermeasures (biological , chemical, radiological)
- Blood
- Disease surveillance (electronic systems, infection control practitioners within hospitals, sentinel providers)
- Alternate treatment sites-geographic considerations may be different than your usual planning.
- Patient tracking
- Response staffing (e.g., medical, non-medical, veterinary, epidemiology, environmental health, points of dispensing, etc)
- Critical incident stress management (CISM) capability
- Environmental surveillance
 - Chemical, Biological, Radiological, Nuclear, Explosive (CBRNE)
 - Air and water quality if applicable
 - Hotels and food
- Veterinary services
- Mortuary (capacity); alternate refrigerated warehouse capacity
- Laboratory (capacity, staffing, security)
- Sheltering
- Risk Communication (information and subject matter experts)
- Personal protective equipment (PPE) caches

- Communication plan using the Emergency Disaster Incident Communications System (EDICS), Military Auxiliary Radio System (MARS) or other capability; hospital inclusion in communication plan

B. STAFFING

Staffing for all missions will be a challenge. In some cases you may need to negotiate the level of support being asked of you (numbers of individuals, centralized versus decentralized, mobile versus static, hours, etc). Medical staffing is a finite resource and you may have difficulty recruiting appropriate volunteers. Consider the following agencies for medical and non-medical support:

- Medical Reserve Corps – Professional, paraprofessional medical staff
- Colleges – Medicine and Nursing
- Citizen’s Emergency Response Corps (CERT) – Non-medical support staff
- Citizens & Organizations Active in Disasters (COAD) / Voluntary Organizations Active in Disasters (VOAD) – Volunteer management organizations to recruit volunteers
- Mutual Aid (Regional, State staff assistance)
- Federal level staff assistance

C. PRE-HOSPITAL

This includes all medical activities that are conducted prior to a patient being treated in a hospital setting. Who in your community is the lead for pre-hospital triage, treatment and transport? Who would be the lead for establishing a medical system to support operations (first aid stations, field medical, comfort stations, etc)? Here are some things to consider:

- Field medical activities to support crowds/events – These would be fixed sites either in buildings of opportunity, mobile clinics, or tents. Disaster Medical Assistance Teams (DMATs), State Medical Response Teams (SMRTs,) volunteer-staffed medical aid stations can be used to support this. Also for events held in stadiums or coliseums, there are typically existing first aid stations set up within those structures. Most stadiums or coliseums have memorandums of understanding/agreement or contracts with fire rescue, EMS, or private practitioners to staff these. Will you need additional support? What will the medical treatment protocols be?
 - Assets – The number of attendees combined with the potential threat should determine what capability is needed which will drive the assets you plan for.
 - Security – This is a primary concern. How close is the site to the designated venue? What is the anticipated “mood” of the crowds? Is law enforcement presence recommended? Consider access to the site. How will it be identified to attendees (i.e., signage)? Access to the site itself should only be one way in/out.
 - Communications – It is critical to maintain communications with the site(s). How will this be accomplished? Primary communications means and a backup should be identified.
 - Non-traditional patient care facilities – Identify multiple locations that could be used. Conduct an assessment that would include space, power, access, patient flow, proximity to the event, etc. You may be

asked to provide medical support at specific hotels (housing dignitaries).

- Responder safety and medical care – Will you need one or more medical stations to provide care? Based on the operations or threat, is it necessary or recommended for this event beyond normal practice? If providing care, what are the protocols?
 - Medical stations could be fixed sites either in buildings of opportunity, mobile clinics, or tents. There should be separate areas for attendee and general public medical sites.
 - Is the risk such that you need medical capability imbedded with the responders?
 - Based on the environmental conditions, do responders need “rest” or “cooling” sites identified?
 - PPE – What threats exist that would dictate various levels and/or types of PPE (crowd control/riot agents, chem/bio, etc)? Do responders have appropriate PPE based on the threat?
 - If respirators are to be worn, who will conduct fit testing? Who will accomplish the medical review/evaluation? Is there a mechanism to conduct fit testing and the medical evaluations for fit testing?
 - What is the capability to locally supply the necessary PPE?
 - If the capability is limited, what capabilities exist at the state/federal level?
 - Based on the situation and environmental factors, the Health and Medical Subcommittee should recommend work/rest cycles, heat index information, hydration, etc. How will this information be communicated?
- Comfort sites – These are used extensively for outdoor events and are intended to prevent medical issues by providing hydration, shade or cooling off areas. The timing and location of the event should dictate the necessity for these. While not necessarily a “medical” issue, these types of sites could be placed under the health and medical purview. Partnering with Red Cross, Salvation Army, or other non-governmental organizations would be a way to staff and equip these sites. **Keep in mind that responder and public sites need to be separate.**
- Patient treatment/transportation documentation/information reporting – Jurisdictions will need to determine the trigger point for creating treatment documentation and patient tracking. This should be developed in conjunction with the appropriate designated medical authority, EMS and the documentation should be reviewed by the appropriate legal authority. Locally developed treatment forms can be used. Most EMS organizations have a treatment and transport form already in use.
 - Treatment protocols –Are standardized treatment protocols for attendees and also responders available or do they need to be developed? Depending on the situation, they may be different.
 - Patient transport – Does the local EMS system have the capacity to handle MCIs without assistance? Local mass casualty plans should identify tiers or triggers to call for mutual aid. Florida’s Ambulance Deployment Plan Standard Operating Procedure should be a planning consideration when identifying assets based on event tiers/triggers.

Anticipate road closures and diversion. Will the event affect non-event related medical response (ie, referrals, routine ambulance response, etc)? Who will be communicating that information to surrounding stakeholders and how will they do so?

- Medical strike teams (Hospital, Crowd, Responder) – If used these are small teams that can be used for triage and immediate treatment in multiple environments. They can respond to casualty collection points and can be pre-staged to deploy as an augmenting force to other medical assets.
 - Scene Decompression – Typically handled by EMS. However, should an excessive amount of casualties be encountered, normal transportation plans could be aborted and ESF4 may end up coordinating scene decompression where patients are taken outside the local area to regional facilities or alternate care sites. What would be the role of ESF8?
 - Emergency Room decompression- keep in mind that throughput is the key element to successful patient movement (see below).
- Decontamination – Gross decontamination is typically done by Fire Rescue. Individual decontamination needs to be considered. Are there decontamination tents available within the county/region? If not, does the state DOH have these available in sufficient quantity to meet the geographical assessment? If at a fixed site, are there shower units available that could be used for decontamination? In some areas, the Salvation Army may have portable shower units that can be used for this. Who will staff the decontamination area? Consider how you will capture contaminated water.
 - External support – What are the regional/state/federal assets that are capable of filling identified gaps? This could include people, supplies, equipment, regional/state caches, Strategic National Stockpile (SNS), etc.
 - Patient Tracking – What processes are currently in-place to track patients from the point of incident to definitive care? What will be the trigger point to initiate patient tracking for responders or attendees? How will information be relayed between the point of incident, hospitals, ESF8, fire/rescue?
 - Is there a single system used in your area? Do you have enough equipment to support a large response? Is additional training needed?
 - Veterinary support for working animals – In planning for a NSSE, this area falls under Health and Medical. The Department of Health and Human Services (HHS) has National Veterinary Response Teams that can deploy depending on the SEAR level of the event and the number of working animals. If federal animals are involved, who provides their wellness and immediate care? They provide wellness checks, triage and immediate care. Local veterinarians can be used for definitive care. How many animals will be working? Can existing law enforcement contracts/agreements meet the projected need? Where will the teams be housed? What are some preventive actions that can be done prior to the event? Decontamination for working animals also needs to be addressed. From an environmental perspective, provide in-service training on wellness, first

aid, etc to handlers/riders. If the federal asset is not available, the state has the State Animal Response Team (SART) which may be deployed. Local Disaster Animal Response Teams may volunteer as well.

- Detainee Care – If large numbers of demonstrators are expected to be detained, law enforcement may need assistance with medical screening of detainees. Does law enforcement have the capability and need augmentation? What level of provider is appropriate? What will the scope of the screening be?
- Dental Care – Where can a responder, from outside the area, go if they have an emergent dental issue? Recruit area dentists to be available to provide walk-in service for Federal and state responders who are deployed. Reimbursement and billing for services rendered are up to the individual's agency and/or insurances.
- Arbovirus considerations – If an outdoor activity, what is the historic rate of occurrence for the time period? Coordinate with mosquito control for spraying/control measures as necessary.

D. MEDICAL SYSTEM

- Hospitals –Hospitals play a key role in medical response and are “soft” targets. Identify hospitals that have not had a vulnerability assessment within the past 12 months and coordinate scheduling through law enforcement. Specific points of contact from each of the facilities need to be designated for planning and coordinating medical and security issues. Provide the facilities with a copy of the Hospital Special Event Planning Issues document, [See Enclosure 1](#).
 - Facility Capabilities – Identify by facility, their individual capabilities with particular attention to specialties (ie, neurological, burn beds, etc).
 - Identify aero medical capability such as how many and what size helicopters can land there.
 - Identify which facilities have decontamination capability.
 - Security – Based on location and threat
 - Coordinate additional security needs with the Law Enforcement Subcommittee.
 - Hospital Vulnerability Assessments – within past 12 months.
 - Identify specific facilities for primary response for red, green, yellow patients.
 - Identify specific facilities that would be treating dignitaries.
 - Establish points of contact within the facility for medical and security coordination.
 - Medical Supplies/Equipment – Based on the threats, do facilities have all of the supplies/equipment necessary to respond? For example: oxygen availability, ventilators, medications, etc.
 - Reporting – Three key elements should be reported: bed status, specialty availability and bypass status. The nature of the event should determine frequency of reporting.
 - Surge plans – Each facility should have a disaster plan to address surge capability. Using the MCI tiers, the number of expected

- attendees, and event modeling, identify a percentage above the average census. Address both ED surge as well as in-patient surge.
- Hospital Decompression – Identify trigger points that would generate patient movement plans to decompress medical facilities. This will normally need to begin 6-8 hours after the incident.
- Patient Movement – Determine by distance, facilities that could receive MCI patients. Local facilities are those within your immediate area (county, metropolitan). Regional facilities should be identified based on a mileage radius and transport time (ie, within 120 miles or 40 minute one-way air time)
 - Local – Typically EDs and EMS do this on a daily basis so there will probably not be a need to develop a specific tactical plan for this. However, all need to be aware of the process and it needs to be defined.
 - Regional – Identify facilities where patients could be delivered for specialized treatment, bed space. Obtain contact information of individuals or positions that you will always be able to contact, such as the Medical Officer on Duty (MOD) or Administrator on Duty (AOD).
 - State – Identify facilities that are out-of-region that could serve as receiving facilities. This will require state-level coordination.
 - Federal – Coordinate with Veteran’s Affairs Area Emergency Manager for National Disaster Medical System (NDMS) evacuation.
 - Transportation – Depending on the SEAR level, other assets may be available. Local EMS has mutual aid agreements with surrounding jurisdictions. Consider non-traditional transportation (ie, Air National Guard, US Coast Guard, buses) to enhance existing capability. The state ambulance plan can be activated (ground/air) during emergencies.
 - Patient Movement Cell – Identify triggers where local patient movement cell would be activated. Identify at what point assistance from the state movement cell would be requested? Can they be combined into a single function? What information would be required to transfer a patient from one facility to another? Identify local individuals who would be responsible for coordinating patient movement, including placing patients and APOE set up/management.
 - Patient Tracking – How will these patients be tracked?
 - Reunification – At the local/regional level, reunification is the responsibility of ESF8. Most hospitals do this as part of their daily business and it is recommended that they continue. However, there may be situations that ESF8 will need to coordinate reunification with partners such as the American Red Cross. For out of region transfers, the State should have overall responsibility for coordinating reunification.
 - Costs – Is there a declaration of a state of emergency? If so, normal billing/reimbursement practices should be followed. What if there is no declaration and there is an event that requires movement out of the area? These questions should be anticipated.
 - Supplies/Equipment Caches – What caches are locally or regionally available? Based on existing inventories and threat assessment are

there items that should be requested (portable ventilators, MC oxygen generation, PPE, etc)?

- Other considerations:
 - VIP/Dignitary Care – Depending on the level of event, additional security measures may be needed. During NSSEs, the US Secret Service will coordinate this directly with the facilities concerned. This may alter or diminish patient flow at this facility. Based on the number of patients who are under USSS control, there is a remote possibility that the ED would be placed on diversion. Determine if the medical system stress, caused by patients under USSS control, will impact normal facility operations or their ability to support a local MCI.
 - Responder versus attendee treatment areas – It is highly recommended that treatment areas for these two groups be separate.
 - Billing – This is a responsibility of the facility and they would use normal billing processes. However, if a declaration of emergency is issued those processes will change and ESF8 should be aware of those changes and provide information to facilities.
 - Call Center – In some cases a medical call center should be considered to assist out-of-town visitors with basic health information.
 - Blood supply levels

- Alternate Care Sites (ACS) – Identify primary and backup sites to be used during an MCI that exceeds the capacity of the local hospitals. ACSs can also be used as a staging site for NDMS-level evacuation. Define the scope of care provided (stabilization/maintenance, minor injuries, etc). Define staffing (local or state request), supplies and equipment. Establish a target timeframe for opening.
 - Location
 - If pre-staging an alternate care asset and the mission allows, consider placing at or near the primary response facility. Having the additional surge capability there can reduce the impact large numbers of casualties can have on a facility.
 - If standing up an alternate care asset or facility in response to an event that has already occurred, placement should be based on the primary purpose of the ACS. For example: 1) treatment of green/yellow patients and maintenance of patient for <24 hours to reduce ED surge; 2) maintenance of stable patients >24 hours to reduce hospital surge; 3) staging area for evacuation. Each of these three scenarios would affect staffing, supplies/equipment, and location.
 - Staffing
 - Pre-staged: Can this be staffed by the facility? If so, the facility could bill for services—but not for supplies/equipment provided with the ACS. This capability is enhanced if the ACS is located in proximity to the facility.
 - Post-event: Do you have an ACS site plan? If so, is the staff mix specified appropriate for the mission? If not, how will you staff the site?

- Mortuary Services – What is the capacity of the medical examiner? Are there mutual aid agreements with surrounding counties? Use any

existing mass fatality plan as the basis. Develop triggers for requesting outside assistance from the Florida Emergency Mortuary Operations Response System (FEMORS) team and/or federal Disaster Mortuary Response Operations Team (DMORT).

E. MEDICAL COUNTERMEASURES (MCM)

A local and regional inventory should be taken as soon as possible for antibiotic caches and antidotes. Existing distribution plans can be tailored to meet the needs for a specific event. Identify multiple distribution sites and modalities to allow for appropriate decision-making should an incident occur.

- Countermeasures
 - Local – State – Federal – Local caches provide a rapid response for initial distribution to attendees. During NSSEs, USSS will provide MCM for their charges. Local distribution will be required for all other responders, attendees, and public. Obtain a rough estimate of the number of responders and attendees to determine the initial amount of MCM provided (typically a 3- or a 10-day course).
 - Prioritization for Distribution – Depending on the type of event and attendees, do local plans need to be modified? Can additional priorities be accommodated from local caches if they exist?
 - MCM – Approach the need from a chemical, biological, radiological or nuclear event. Use a tiered approach beginning with local caches, state and then federal assets. Any request should be based on a gap analysis. Some of the more common types of MCM are antibiotics, chemical antidotes (to include Chempacks), and radiological antidotes such as, KI, Prussian Blue, DTPA.
 - Staging of assets – Where will these be secured until needed? Who can authorize dispensing? Can these be forward deployed or mobile?
- Points of Dispensing (PODs) – Existing SNS distribution plans should be used as the basis for event planning.
 - Strike Teams – Are there sufficient local teams to set up and run PODs? Are team members trained? At what point would mutual aid be necessary?
 - Locations - Consider multiple locations that can be used (depending on plume modeling, traffic and transportation restrictions)
 - Process (VIP/Dignitary – Attendee – Public – Responder) - Is a separate closed POD needed for dignitaries/attendees? How does the existing distribution model need to be modified to account for this added layer of population?
- Radiation Population Monitoring Stations
 - Community Reception Center (CRC), in-conjunction with PODs – Who are your local experts? What will the flow be for establishing a CRC? Who will provide population monitoring and who will staff the CRC? Is there a local capability for decontamination processes at the CRC? Who is responsible for staffing the CRC and decontamination areas? What is done with the population monitoring data? Who is responsible for tracking? The Bureau of Radiation Control (ERC) and the US Department of Energy can assist with developing planning concepts. Another source would be local health and medical staff

who have been trained in Radiation Emergency Assistance Center Training Site (REAC/TS) training (REAC/TS). Consider establishing this as a work group with ERC, local agencies (ie, HAZMAT, LE) and local medical professionals who have completed REAC/TS training. See the Radiological Annex to the state CEMP for more detail on radiological event management.

F. SURVEILLANCE

- Disease surveillance – What systems are currently in place? Identify what disease categories need to be tracked and reported on. To get a good situational analysis of disease within the community multiple systems should be used as well as comparative data and rates from prior years.
 - ESSENCE – Ensure all facilities are using for syndromic reporting. Reports should be based on “Chief Complaint”. Include zip code to ensure that easy identification of visitors.
 - Sentinel physicians, selected provider groups – Send explanatory letter asking for by-exception reporting. Visitors will typically not have assigned primary care providers and will go to an urgent care center or walk-in clinic.
 - National Retail Data Monitoring database – This database monitors all over-the-counter (OTC) medications within an area and can be stratified by zip code.
 - Hotels – Send explanatory letter asking for heightened awareness at all attendee hotels if known.
 - Responder clinics/aid stations – Establish a reporting process for capture and review of data to identify trends.
 - Poison Control Center – Establish liaison to share information. Obtain a daily report of calls to the center.
 - Hospitals – How will you engage facilities as part of your early warning system?
 - Consider meeting with Infection Control Practitioners to establish mechanism to report clusters, outbreaks or any unusual illnesses.
 - What information would you provide to EDs concerning recognition of symptoms of biological or chemical exposures?
 - BIOSENSE – This is a Centers for Disease Control and Prevention (CDC) program that reports disease at Department of Defense (DoD) and VA medical facilities. Disease surveillance group should incorporate this information into their analyses.
 - Daily Summary – Specify a specific time for a complete daily summary. At a minimum, the report should include an overall situation description and a breakdown of the following:
 - Categories of Disease: Actual, expected and percentage increase or decrease.
 - Hospital ED Visits: Actual, expected and percentage difference (include overall and break out of specific facilities).
- Environmental – It is up to the local host to determine which agencies participate on specific planning subcommittees. Ensure that the appropriate representation is on each committee responsible for planning. HAZMAT issues are typically addressed by the Fire, Life, Safety and

Health Subcommittee. Strongly recommended that Public Health have a representation on that subcommittee.

- Chemical, Radiological and Nuclear – Surveillance is normally conducted by HAZMAT. In some cases public health planners partner with fire rescue/HAZMAT to plan surveillance activities. Informational reports should be sent to the Health and Medical Operations Incident Command or ESF8 and positive findings should be treated as a sentinel event and reported immediately.
- Biological – Public health is typically the lead agency for this through BioWatch. If there is no BioWatch program established this surveillance can be conducted by Civil Support Teams as needed. For those jurisdictions with BioWatch, begin involving the Biowatch Advisory Committee (BAC) early. Also early coordination with the state and federal leads for the program will be necessary.
 - For NSSEs, the Department of Homeland Security (DHS) will more than likely deploy a BioWatch monitoring system for the event if the jurisdiction is not part of the program cities. The US Secret Service will conduct all CBRN monitoring with in the venue itself.
 - For lower SEAR events, early coordination for modeling, additional monitors, support staffing and laboratory testing is critical.
 - Monitors – Identify the existing monitors and evaluate the need for additional monitors around the venue.
 - ◇ Request modeling specific to the primary venue site and determine the additional monitors needed (if any).
 - ◇ Develop enhanced collection schedule and coordinate with the laboratory responsible for testing.
 - ◇ Determine distribution of non-negative and negative results.
 - Conference call attendees will be approved by the US Secret Service.
- Beach/Water and Air Quality – Depending on the time of year, location and planned events, consider coordinating with the responsible agencies for daily reports. Public health advisories should be briefed daily.

G. FOOD SAFETY

Within Florida, retail food is a responsibility of the Department of Business and Professional Regulation (DBPR). As such, that organization should be the lead agency with Federal Food and Drug Administration (FDA) to plan for food safety and defense activities. The US Department of Agriculture will have a role in prevention and response. The Department of Agriculture and Consumer Services and DOH will also have significant roles. Consider establishing a task force that is co-led by DBPR and FDA. **FOOD SAFETY IS NOT FOOD SITE INSPECTIONS.** The lead federal agency will have the ultimate decision on all matters. Will you be concerned with food safety for the event only? Will you be covering responder food preparation/feeding sites? What are the limits you will be operating under? For example: There is a problem with the food preparation for a specific venue and, under normal circumstances, production would be stopped. Under the NSSE Federal guidelines, that decision is made by the U.S. Secret Service. Timely communication is critical to prevent problems.

- Identify all agencies and define roles. Keep legislative and statutory requirements in mind, but remember these must be balanced with the mission requirements.
 - Develop organizational structure by function.
 - Develop reporting/communications structure between the Task Force and Incident Command.
- Identify food defense requirements and establish the assignment.
 - Identify caterers and retailers that service the venue and responder/workers.
 - Identify restaurants/other regulated facilities that will be the basis of the food defense assignments.
- Identify training and exercises to orient individuals from all agencies into the task force.
 - Reporting information on problems found in a timely manner is critical and should be stressed throughout the training.
 - It is critical that differences between what food inspectors do on a routine basis and what they will do for this event is understood.
- Develop a single Food Safety Task Force identification badge. Having a single standard credential will help avoid confusion and conflicts with vendors.
- Work with host to obtain vendor listing and meet with vendors regularly to ensure understanding of the food defense assignments.

H. RISK COMMUNICATIONS

Ensure representation on appropriate subcommittee. All communications with the media should be carefully evaluated. Communications security is a serious concern and certain type of information released could jeopardize operations and safety. You must obtain approval from the lead agency (normally through your subcommittee) before speaking to the media about any thing related to your event. Questions from the media and public should be funneled through a single source for approval and response. Do you have a public information officer (PIO) or spokesperson? Who are your subject matter experts (SME)? What is the lead federal agency and local Executive Steering Committee policy on speaking to the media?

- Develop messaging for general public, attendees, and responders/workers.
 - Evaluate risks and threats for health and safety.
 - Develop timeline and strategy for general public messaging.
 - Identify the message, the target audience, and the methodology for communicating it. (Consider using social media as one means of public messaging).
 - Review Crisis & Emergency Risk Communication (CERC) Portal messaging and create local repository of PH messaging based on threats.
 - Develop SME listing for media inquiries and threat messaging.

- Ensure primary and back up information officers are included as part of Joint Information Center (JIC) staffing.

I. GENERAL

- ESF8 - Depending on the event, multiple emergency operations centers (EOCs) will be activated, (unified, consequence management, county, even city EOCs could be activated) and ESF8 support may be requested. Determine which ones are “must fill” and hours of operations. Does your CHD have enough trained staff to meet all of the needs? Work within the region and then state for staff assistance. If you transfer from event to consequence management, is there a change in personnel and site for operations?
- Threats
 - Has a threat assessment been completed for this event? Review your County Emergency Management Plan (CEMP) and compare to the specific threat assessment. This combined with the gap analysis will help focus efforts.
 - Planning for contingencies such as hurricanes during the event is critical. How will the event be impacted and how will that impact the health and medical community? How are attendees of the event going to be taken care of? How will that impact your ability to respond?
- Information/communications flow during operations – Clearly define reporting requirements within the operational structure as well as
 - Local ESF8 to State ESF8
 - ESF8 to Multi-Agency Communication Center (MACC) ESF8
 - Health and Medical Incident Command Operations to ESF8
- Lab testing/reporting – Ensure a Laboratory Testing and Surge Plan is completed. How are routine labs going to be impacted? Frequency of testing for collected surveillance samples? Suspicious substance testing? Does the lab have sufficient staff for surge in testing? Are there any additional physical security needs for the lab?
- Credentialing – There will be specific credentialing requirements set forth. Ensure you are aware of those for both individuals as well as vehicular requirements. Typically you will need name, social security number, title, passport size digital photo, and a strong justification for obtaining the credential. Credential requests should be kept to an absolute minimum.
- Transportation (general) – Each team established should identify requirements for vehicles. How are veterinarians going to respond? Ask that question for each mission and also include logistics needs as well. What are the security requirements for the specific vehicle?
- Communications with Partners (Fed, State, Local, hospital, law enforcement) – Establish links early on. The most critical thing you can do is have frequent communication with individuals and organizations supporting the event.

- Consider establishing formal work groups for Food Safety, BioWatch, Patient Movement, Laboratory, etc. Ensure all levels are included/invited to those work group meetings.
 - Set up a secure SharePoint or other site that will allow all organizations to access and share large documents.
-
- What type of training and exercises will need to be conducted? Trainings, table tops should be conducted prior to full scale exercises in most instances. What types of exercises would best include all aspects of response (law enforcement, fire rescue, EMS, hospitals, ESFs, etc)? Are the scenarios used tiered to the various response levels? [See Enclosure 2](#). Are there non-traditional roles that need to be exercised for integration (Food defense, biological monitoring/transition to response, ACS, etc)?
 - Critical Incident Stress Management – Who provides this locally on a routine basis? If the number of responders exceeds that capacity, how will you meet this need? Most metropolitan areas have CISM teams that can be placed on standby. The State Attorney General and DOH have CISM teams also have teams established. Who would you coordinate with for their services, if needed? Where will you site them? What will be the specific role and limitations?

Enclosure 1: Hospital Special Event Planning Issues

This is intended to be an outline to drive discussion and frame issues. It is not all inclusive.

1. Command
 - a. HICS training
 - b. Augmented training of senior personnel
 - c. Command post resources and back-up location / power / staffing
 - d. Use of standardized action planning and operational periods
2. Coordination
 - a. Location of 800mhz radio set or other radio/back communications systems
 - b. Logins to EM Resource and EM Track for command center for key staff
 - c. Liaison with local EOC / law enforcement / EMS
3. Staffing
 - a. Vacation policies during event
 - b. Staffing during hours of event
 - c. Augmentation capability in case of incident (including consideration of access / traffic issues)
 - d. Decon team, equipment availability / augmentation capability
 - e. Information desk
 - f. Telecomm / IT
 - g. Facilities
 - h. Security (see section below as well)
4. Hospital services
 - a. Elective surgeries and appointments – should NOT expect formal request to halt elective cases, etc.
 - b. Parking issues / traffic issues – trucks and vans may have to be screened. Hospitals will NOT be in credentialed area but traffic congestion is likely.
 - c. Likely volumes – moderate increase due to increased visitors to metro area, may be weather dependent.
5. Contamination / Decontamination
 - a. Increased radiation detection equipment / radiation badges for staff
 - b. Supplies – walk-off plastic sheeting, tape, detergent powder, etc.
 - c. Decontamination supplies – wet decon
 - d. Decon supplies – ‘dry’ decon
 - e. Staff PPE
 - f. Augmentation of decon capacity with additional tenting / resources (including possibly pre-deploying FD decon trailers)
6. Medical supplies
 - a. Irritants – proparacaine (100 bottles), morgan lenses (100 sets plus), albuterol (1000 doses)
 - b. General – dT boosters, morphine (10 grams), benzodiazepines, antibiotics.
 - c. Nerve agent – Mark 1 kits, bulk atropine, Chempacks.
7. Chempack education and use
8. VMI – ventilators / education
9. Surveillance / patient tracking – will need info submitted on EVERY patient associated with event seen in ED. Will need to account for all patients evaluated / admitted

10. Record-keeping – rapid screening sheet / clipboards.
11. Surge capacity
 - a. Decontamination
 - b. Triage areas (supplies, records, staffing)
 - c. Critical care augmentation
 - d. Med / surgical care areas
 - e. Flat – space areas for cots, etc.
 - f. Ambulatory patient redistribution planning – communication of need to local county EOC.
 - g. Areas for family reunification.
12. Prisoner / protestor care – what area of department, follow-up issues and contact information issues.
13. Law enforcement officer care – what area of department, strongly recommended to separate law enforcement or other responder care from prisoner or protestor care areas. Define policy on armaments and ammunition, etc.
14. VIP care
 - a. Area for treatment
 - b. Release of information
 - c. Other special protocols for VIP treatment
 - d. Coordination with Federal law enforcement (USSS) if appropriate
15. Security
 - a. Access controls
 - b. Facility monitoring (including video and video feeds)
 - c. Entrance restrictions
 - d. Visitor restrictions?
 - e. Suspicious substance policies
 - f. Suspect device policies / bomb threat
 - g. Security event policies (active shooter, etc)
16. Infection Control / Laboratory
 - a. Respiratory hygiene practices in triage / other areas
 - b. Healthcare worker PPE education and fit-testing updates, etc.
 - c. Lower threshold for respiratory isolation, case work-up
 - d. Surveillance and reporting to FDOH
 - e. Unexplained death and critical illness reporting
 - f. Illness / injury and ANY death in event attendee to be reported
 - g. Testing and sample submission protocols / lab resources (both supplies for surge and personnel particularly microbiology)
17. Public Relations
 - a. PIO appointed 24/7
 - b. Messages to media including potential for press conferences if needed
 - c. Coordination with other agencies / facilities / JIC
18. Staff education / Communication
 - a. Emergency plans at hospital
 - b. Emergency plans at home
 - c. Staff notification and communications plans (emails, hotlines, bulletins, etc)
 - d. Emergency contact information posted / available
 - e. Incident specific
 - i. Patient tracking / reporting
 - ii. Injury patterns
 - iii. Chemical / biologic agent education
 - iv. Fever/rash, fever/respiratory symptom containment and reporting

19. Crisis Management

- a. Facility shelter-in-place plan (chemical or biologic event)
- b. Civil unrest planning
- c. Secondary device / bomb planning
- d. Utilities failure (should test and have adequate fuel for back-up generators)
- e. Staff prophylaxis program testing and pharmaceutical availability

Enclosure 1a: Hospital Emergency Management Plan Checklist

| ELEMENT | COMPLETED | PARTIAL COMPLETION | NOT DONE |
|---|-----------|-----------------------|-------------|
| Introduction | | | |
| Objectives | | | |
| Goals | | | |
| Responsibility | | | |
| HVA | | | |
| Integration & Exercising | | | |
| Command Structure | | | |
| Cooperative planning | | | |
| Procedures & Operations | | | |
| Activation/Initiation | | | |
| Personnel notification | | | |
| Identification of personnel | | | |
| Assignments of personnel | | | |
| EOC operation | | | |
| Patient flow | | | |
| Security/traffic control | | | |
| Communication | | | |
| Patient admission/registration | | | |
| Triage/Disaster tags | | | |
| News media | | | |
| Hotline | | | |
| Family of victims, visitors, outpatients | | | |
| Supplies/equipment (including pharmacy) | | | |
| Morgue | | | |
| Building evacuation | | | |
| Continuing and/or reestablishing operation | | | |
| Off-site care | | | |
| Essential utility alternatives | | | |
| Isolation & decontamination | | | |
| Orientation & education | | | |
| Annual plan evaluation | | | |
| HICS Job Action Sheets | | | |
| Specific Departmental Plans | | | |
| Forms/Resources | | | |

(courtesy of Eric Weller)

Enclosure 2: ESF8 Special Event Planning Scenarios

Tier 1 – high likelihood, low consequence events – small numbers of victims (no or specialized mutual aid)

1. Food-borne outbreak (particularly protestors or others staying in non-monitored facilities)
2. Weather related
 - a. Heat – PH, EMS, hospitals
 - b. Storm damage – tornado / straightline winds – EMS, hospitals
3. Boating related (would involve water rescue teams – possibly multi-jurisdictional)
4. Vehicular crashes
5. Traffic jams / road closures – affecting EMS vehicle movement
6. Pepper spray and other limited irritant chemical exposures – EMS and hospital treatment / decon
7. Suspicious Substance incidents – HAZMAT/Law Enforcement Secondary: PH, hospital, EMS guidance
8. EOD – small detonated or suspect explosive device – EMS support issues / response issues
9. Protestor injuries
10. Utilities failure including natural gas, cellular, power
11. Triggered detection – BDS, BW, venue or other sensors

Tier 2 – moderate likelihood, moderate consequence – larger number of victims (mutual aid required, not catastrophic event)

1. Explosive event - moderate
2. Vehicular crashes (multi-vehicle, bus, vehicle into crowd)
3. VIP involvement
4. Larger chemical incident
5. Weather-related – see above but larger scale / scope
6. Larger food-related outbreak (e.g.: norovirus)
7. Trampling trauma – protestors or others
8. Major utilities failure (blackout, others)
9. Drinking water contamination – small scale or limited effects

Tier 3 – low likelihood, high consequence (catastrophic) event

1. Explosive event – large or RDD, end of spectrum would include nuclear device
2. Large-scale chemical release / plume (transportation or terrorist)
3. Biologic agent dissemination
4. Large structural collapse
5. Aircraft crash
6. Drinking water contamination – large scale or major clinical effect