VARIANCE TO STAGE 2 OF CALIFORNIA'S ROADMAP TO MODIFY THE STAY-AT-HOME ORDER

COVID-19 VARIANCE ATTESTATION FORM

FOR County of Contra Costa

June 5, 2020

Background

On March 4, 2020, Governor Newsom proclaimed a State of Emergency because of the threat of COVID-19, and on March 12, 2020, through Executive Order N-25-20, he directed all residents to heed any orders and guidance of state and local public health officials. Subsequently, on March 19, 2020, Governor Newsom issued Executive Order N-33-20 directing all residents to heed the State Public Health Officer's Stay-at-Home order which requires all residents to stay at home except for work in critical infrastructure sectors or otherwise to facilitate authorized necessary activities. On April 14th, the State presented the Pandemic Roadmap, a four-stage plan for modifying the Stay-at-Home order, and, on May 4th, announced that entry into Stage 2 of the plan would be imminent.

Given the size and diversity of California, it is not surprising that the impact and level of county readiness for COVID-19 has differed across the state. On May 7th, as directed by the Governor in Executive Order N-60-20, the State Public Health Officer issued a local variance opportunity through a process of county self-attestation to meet a set of criteria related to county disease prevalence and preparedness. This variance allowed for counties to adopt aspects of Stage 2 at a rate and in an order determined by the County Local Health Officer. Note that counties desiring to be stricter or move at a pace less rapid than the state did not need a variance.

In order to protect the public health of the state, and in light of the state's level of preparedness at the time, more rapid movement through Stage 2 as compared to the state needed to be limited to those counties which were at the very lowest levels of risk. Thus, the first variance had very tight criteria related to disease prevalence and deaths as a result of COVID-19.

Now, 11 days after the first variance opportunity announcement, the state has further built up capacity in testing, contact tracing and the availability of PPE. Hospital surge capacity remains strong overall. California has maintained a position of stability with respect to hospitalizations. These data show that the state is now at a higher level of preparedness, and many counties across the state, including those that did not meet the first variance criteria are expected to be, too. For these reasons, the state is issuing a second variance opportunity for certain counties that did not meet the criteria of the first variance attestation. This next round of variance is for counties that can attest to meeting specific criteria indicating local stability of COVID-19 spread and specific levels of county preparedness. The criteria and procedures that counties will need to meet in order to attest to this second

variance opportunity are outlined below. It is recommended that counties consult with cities, tribes and stakeholders, as well as other counties in their region, as they consider moving through Stage 2

Local Variance

A county that has met the criteria in containing COVID-19, as defined in this guidance or in the guidance for the first variance, may consider modifying how the county advances through Stage 2, either to move more quickly or in a different order, of California's roadmap to modify the Stay-at-Home order. Counties that attest to meeting criteria can only open a sector for which the state has posted sector guidance (see Statewide industry guidance to reduce risk). Counties are encouraged to first review this document in full to consider if a variance from the state's roadmap is appropriate for the county's specific circumstances. If a county decides to pursue a variance, the local health officer must:

1. Notify the California Department of Public Health (CDPH), and if requested, engage in a phone consultation regarding the county's intent to seek a variance.

2. Certify through submission of a written attestation to CDPH that the county has met the readiness criteria (outlined below) designed to mitigate the spread of COVID-19. Attestations should be submitted by the local health officer, and accompanied by a letter of support from the County Board of Supervisors, as well as a letter of support from the health care coalition or health care systems in said county.[1] In the event that the county does not have a health care coalition or health care system within its jurisdiction, a letter of support from the relevant regional health system(s) is also acceptable. The full submission must be signed by the local health officer.

All county attestations, and submitted plans as outlined below, will be posted publicly on CDPH's website.

CDPH is available to provide consultation to counties as they develop their attestations and COVID-19 containment plans. Please email Jake Hanson at Jake.Hanson@cdph.ca.gov to notify him of your intent to seek a variance and if needed, request a consultation.

County Name: Contra Costa

County Contact: Christopher Farnitano, M.D.

Public Phone Number: (925) 957-5403

Readiness for Variance

The county's documentation of its readiness to modify how the county advances through Stage 2, either to move more quickly or in a different order, than the California's roadmap to modify the Stay-at-Home order, must clearly indicate its preparedness according to the criteria below. This will ensure that individuals who are at heightened risk, including, for

[1] If a county previously sought a variance and submitted a letter of support from the health care coalition or health care systems but did not qualify for the variance at that time, it may use the previous version of that letter. In contrast, the County Board of Supervisors must provide a renewed letter of support for an attestation of the second variance.

example, the elderly and those with specific co-morbidities, and those residing in long-term care and locally controlled custody facilities and other congregate settings, continue to be protected as a county progresses through California's roadmap to modify the Stay-at-Home order, and that risk is minimized for the population at large.

As part of the attestation, counties must provide specifics regarding their movement through Stage 2 (e.g., which sectors, in what sequence, at what pace), as well as clearly indicate how their plans differ from the state's order.

As a best practice, if not already created, counties will also attest to plan to develop a county COVID-19 containment strategy by the local health officer in conjunction with the hospitals and health systems in the jurisdiction, as well as input from a broad range of county stakeholders, including the County Board of Supervisors.

It is critical that any county that submits an attestation continue to collect and monitor data to demonstrate that the variances are not having a negative impact on individuals or healthcare systems. Counties must also attest that they have identified triggers and have a clear plan and approach if conditions worsen to reinstitute restrictions in advance of any state action.

Readiness Criteria

To establish readiness for a modification in the pace or order through Stage 2 of California's roadmap to modify the Stay-at-Home order, a county must attest to the following readiness criteria and provide the requested information as outlined below:

- **Epidemiologic stability of COVID-19.** A determination must be made by the county that the prevalence of COVID-19 cases is low enough to be swiftly contained by reintroducing features of the stay at home order and using capacity within the health care delivery system to provide care to the sick. Given the anticipated increase in cases as a result of modifying the current Stay-At-Home order, this is a foundational parameter that must be met to safely increase the county's progression through Stage 2. The county must attest to:

    - Demonstrated stable/decreasing number of patients hospitalized for COVID-19 by a 7-day average of daily percent change in the total number of hospitalized confirmed COVID-19 patients of <+5% **-OR-** no more than 20 total confirmed COVID-19 patients hospitalized on any single day over the past 14 days.

      Contra County has 14 to 18 hospitalized confirmed COVID-19 patients countywide on any single day over the past 14 days using a 7-day moving average. Contra Costa County has not had 20 or more confirmed COVID-19 patients countywide using a 7-day moving average since May 10, 2020. See attached data for previous two weeks of hospitalization numbers by date. This information is also available on our Public Dashboard: https://www.coronavirus.cchealth.org/dashboard

    - 14-day cumulative COVID-19 positive incidence of <25 per 100,000 -OR- testing positivity over the past 7 days of <8%.

Contra Costa County's reported testing positivity has been <8% since April 17, 2020, and presently stabilized at approximately 3% for the past 4 weeks. See attached data for previous 7 day positivity percentage. This information is also available on our Public Dashboard: https://www.coronavirus.cchealth.org/dashboard

NOTE: State and Federal prison inmate COVID+ cases can be excluded from calculations of case rate in determining qualification for variance. Staff in State and Federal prison facilities are counted in case numbers. Inmates, detainees, and staff in county facilities, such as county jails, must continue to be included in the calculations.

Facility staff of jails and prisons, regardless of whether they are run by local, state or federal government, generally reside in the counties in which they work. So, the incidence of COVID-19 positivity is relevant to the variance determination. In contrast, upon release, inmates of State and Federal prisons generally do not return to the counties in which they are incarcerated, so the incidence of their COVID-19 positivity is not relevant to the variance determination. While inmates in state and federal prisons may be removed from calculation for this specific criteria, working to protect inmates in these facilities from COVID-19 is of the highest priority for the State.

- Counties using this exception are required to submit case rate details for inmates and the remainder of the community separately.

As of June 5th, 2020 in Contra Costa County's Detention Facilities we have completed 651 tests, with a 0.8% case rate (5 positive tests).

As of June 5th, 2020 Contra Costa County's overall community positive rate is 3.1% based a 7-day rolling average.

- **Protection of Stage 1 essential workers.** A determination must be made by the county that there is clear guidance and the necessary resources to ensure the safety of Stage 1 essential critical infrastructure workers. The county must attest to:
  - Guidance for employers and essential critical infrastructure workplaces on how to structure the physical environment to protect essential workers. Please provide, as a separate attachment, copies of the guidance(s).

The Health Officer Order for Sheltering at Home Appendix A titled Social Distancing Protocol Is guidance for all businesses and workers on protecting themselves and their customers. Appendix A is attached. Link to all COVID19 health officer orders is at this link: https://www.coronavirus.cchealth.org/health-orders

Please see guidance developed by Contra Costa County Risk Management COVID-19 Exposures and the Workplace Guidelines gives clear guidance to protect employees for the County including all essential workers. This guidance is included as an attachment.

- Availability of supplies (disinfectant, essential protective gear) to protect essential workers. Please describe how this availability is assessed.

The logistics section within Contra Costa Health Services' Department Operations Center (DOC) engages in ongoing proactive and reactive assessment of supply availability.

Proactive monitoring of supply availability and supply chain stability occurs through the procurement research unit within the logistics section. This team keeps an updated list of suppliers that have been able to confirm their ability to fill orders for essential supplies. The unit also makes regular inquiries and test purchases to ensure information given to requestors within the community is as accurate as possible.

Reactive measures employed within Logistics includes the ongoing strategic leveraging of mutual aid cached items as provided through state and federal mutual aid requesting (CDPH, MHOAC Program, and Strategic National Stockpile (SNS) allocations). At the direction of the county Health Officer, in addition to being made available to essential partners, these items are grouped into strategic caches by areas of special purpose (Hospitals & Clinics, Outbreak Sites, Community Need, First Responders, as well as a cache of last resort).

- **Testing capacity.** A determination must be made by the county that there is testing capacity to detect active infection that meets the state's most current testing criteria, (available on CDPH website). The county must attest to:

  - Minimum daily testing capacity to test 1.5 per 1,000 residents, which can be met through a combination of testing of symptomatic individuals and targeted surveillance. Provide the number of tests conducted in the past week. A county must also provide a plan to reach the level of testing that is required to meet the testing capacity levels, if the county has not already reached the required levels.

The current testing capacity in Contra Costa County is as follows:
Community Sites: 790
State Sites: 396
County Sites:1240

Total Testing Capacity in Contra Costa County = 2,426 test per day. This is the equivalent of 2.11/1,000.

CCHS has met the commitment of testing capacity of 1.5/100K

For the past 7 days the CCC number of test/100K is as follows (based on CalREDIE reporting which is an undercount of actual tests as some results are delayed due to delayed lab reporting):
6/4/20 67
6/3/20 66
6/2/20 62
6/1/20 66
5/31/20 63
5/30/20 68

5/29/20 71

Contra Costa has 3 state-sponsored OptumServe testing sites and we are developing a multiprong approach to increase utilization of our State Site resources:

1) Consider a new location for our Brentwood site location. We experienced a drop in testing when we relocated to the Griffith site. We will review this consideration with our County testing taskforce.

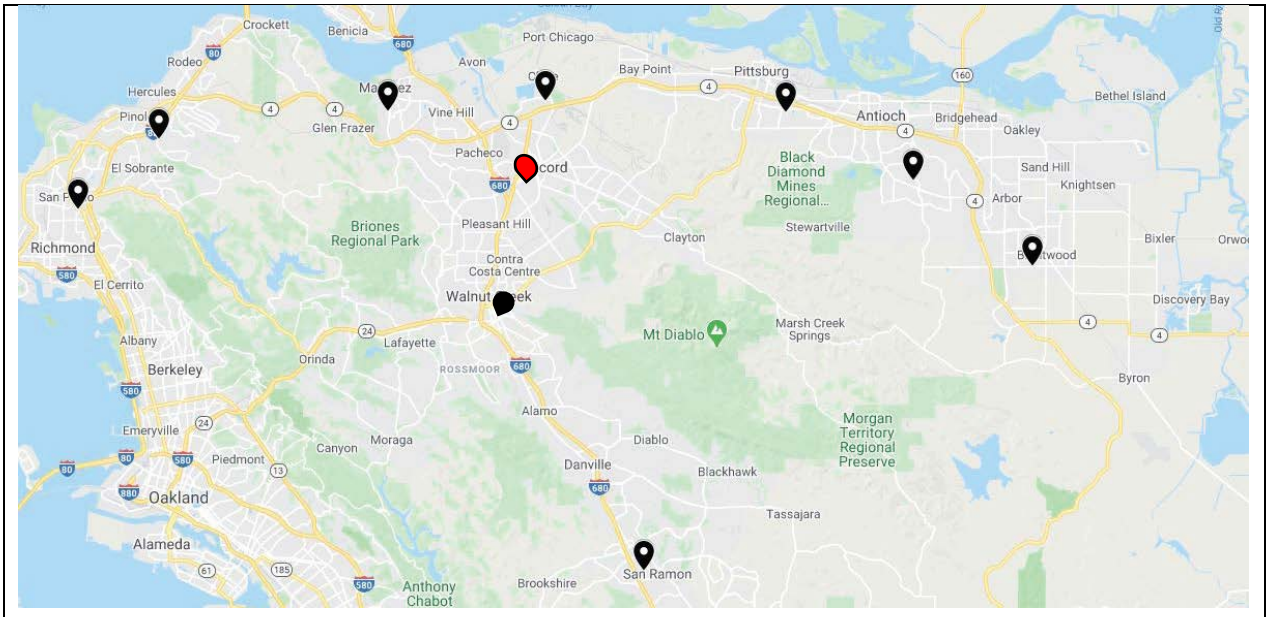
Collection Site	**Avg Tests/Day**
193 Griffith Ln, Brentwood – 2nd site	51
850 2nd Street, Brentwood -1st site	84

2) Messaging/Advertising via partners:

a. School district messaging-robo dialers & listserv, as suggested on the OptumServe weekly call
b. Local papers and websites, including Brentwood's local paper, social media, Nextdoor
c. Partnering with the 2020 Census recruitment. We will be overlaying the message for COVID-19 testing with census outreach materials/platforms
d. Reaching out to local chamber of commerce to work with our business community
e. Meeting next week with our marginalized communities outreach taskforce open new messaging and messaging platforms.

o Testing availability for at least 75% of residents, as measured by the presence of a specimen collection site (including established health care providers) within 30 minutes driving time in urban areas, and 60 minutes in rural areas. Please provide a listing of all specimen collection sites in the county and indicate if there are any geographic areas that do not meet the criteria and plans for filling these gaps if they exist. If the county depends on sites in adjacent counties, please list these sites as well.

In addition to the sites listed, CCC is in the process of opening a site in the Monument Corridor (Concord CA) show in red.



CCHS has met this commitment

- Please provide a COVID-19 Surveillance plan, or a summary of your proposed plan, which should include at least how many tests will be done, at what frequency and how it will be reported to the state, as well as a timeline for rolling out the plan. The surveillance plan will provide the ability for the county to understand the movement of the virus that causes COVID-19 in the community through testing. [CDPH has a community sentinel surveillance system that is being implemented in several counties. Counties are welcome to use this protocol and contact covCommunitySurveillance@cdph.ca.gov for any guidance in setting up such systems in their county.]
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Contra Costa County is a participant grantee of the CDPH community sentinel surveillance system and following the protocol in collaboration with that team and the county-sponsored testing sites and clinical lab

In addition, our team has built in several surveillance triggers into our real-time data analytics dashboard including:

- Any city where the 7-day moving average of new cases twice or more higher than the previous 14-day moving average of new cases (minimum 5 cases)
- More than 5 cases at the same home or apartment building or location in past 14 days (can add more intelligence as case linking improves) - hot spot identification
- More than 10% decline in testing based on weekday reported date compared to previous 7 days
- More than 10% increase in hospitalization, ICU or ventilators (minimum increase 5)
- More than 10% increase in positive rate compared to previous 7 days

- **Containment capacity.** A determination must be made by the county that it has adequate infrastructure, processes, and workforce to reliably detect and safely

isolate new cases, as well as follow up with individuals who have been in contact with positive cases. The county must attest to:

- Enough contact tracing. There should be at least 15 staff per 100,000 county population trained and available for contact tracing. Please describe the county's contact tracing plan, including workforce capacity, and why it is sufficient to meet anticipated surge. Indicate which data management platform you will be using for contact tracing (reminder that the State has in place a platform that can be used free-of-charge by any county).

Contra Costa County has approximately 1.15 million residents, which would require 173 contact tracers (15 contact tracers per 100,000 population).

The Case and Contact Investigation/Tracing Branch in our ICS structure currently has 86 staff that have all been trained in case investigation and contact tracing most of whom are current employees of Contra Costa Health Services who have been redirected to this important work. Our Case Investigation Unit is conducting contact tracing work in addition to case investigation. There are 58 staff currently doing contact tracing work.

We plan to hire a total of 131 staff, starting the week of June 9, 2020 and continuing every week through mid-August. These positions include 5 additional Public Health Nurses starting the week of June 9, 2020, 6 Public Health Managers the week of June 16, 2020, and a total of 25 Disease Investigators and 9 Public Health Program Specialists scheduled to start the weeks of June 22 and 29, 2020. In addition, our county has authorized hiring of an additional 86 temporary emergency workers and we are estimating hiring these positions beginning the week of June 29, 2020, with waves of hiring 10-12 contact tracers a week through beginning of August.

At the conclusion of the proposed hiring, which is estimated to be August 17, 2020, the Case and Contact Investigation Branch will have 217 staff that are all trained to do contact tracing work, with 189 doing contact tracing activities. All of these positions will include contact tracing work as well as continuing to work with CDPH on the development of CalConnect.

- Availability of temporary housing units to shelter at least 15% of county residents experiencing homelessness in case of an outbreak among this population requiring isolation and quarantine of affected individuals. Please describe the county's plans to support individuals, including those experiencing homelessness, who are not able to properly isolate in a home setting by providing them with temporary housing (including access to a separate bathroom, or a process in place that provides the ability to sanitize a shared bathroom between uses), for the duration of the necessary isolation or quarantine period. Rooms acquired as part of Project Roomkey should be utilized.

The County has closed all of the Homeless Shelters and moved the residence at these shelters into hotels Under Project Room Key. Contra Costa County has procured 567 hotel rooms for individuals who are experiencing homelessness. The County are also moving some of the homeless that are living on the streets to hotel rooms. Contra Costa County has approximately 2,277 homeless individuals based on the 2020 Point in Time count. This meets 25% of our homeless population according to our 2020 Point in Time count.

- **Hospital capacity.** A determination must be made by the county that hospital capacity, including ICU beds and ventilators, and adequate PPE is available to handle standard health care capacity, current COVID-19 cases, as well as a potential surge due to COVID-19. If the county does not have a hospital within its jurisdiction, the county will need to address how regional hospital and health care systems may be impacted by this request and demonstrate that adequate hospital capacity exists in those systems. The county must attest to:
  - County (or regional) hospital capacity to accommodate COVID-19 positive patients at a volume of at a minimum surge of 35% of their baseline average daily census across all acute care hospitals in a county. This can be accomplished either through adding additional bed capacity or decreasing hospital census by reducing bed demand from non-COVID-19 related hospitalizations (i.e., cancelling elective surgeries). Please describe how this surge would be accomplished, including surge census by hospital, addressing both physical and workforce capacity.

Attachment: Medical Health Multi Agency Coordination Guide and Surge Plan

Contra Costa County's

- ICU available capacity is 47% (101 beds available / 215 total ICU beds) on June 3rd, 2020. 40% of Contra Costa County's ICU beds have been available for the past 4 weeks.
- Ventilator availability is at 86% (241 available ventilators / 280 total ventilators) on June 3rd, 2020. Similar capacity has been available for the past 4 weeks.
- PPE: all 8 acute care hospitals have certified more than 30 day supply of adequate PPE.

  - County (or regional) hospital facilities have a robust plan to protect the hospital workforce, both clinical and nonclinical, with PPE. Please describe the process by which this is assessed.

As described in the **Protection of Stage 1 essential workers** section above, Contra Costa Health Services Department Operations Center Logistics section – working at the direction of the Health Officer has implemented both proactive and reactive methodologies to supply and procure for the county health system as well as all providers of healthcare within the county. This is achieved by continuously collecting data and testing the current state of the PPE and essential item(s) supply chains as well as maximizing our ability to leverage sources of mutual aid (state, federal, private donation, etc to respond to hospital requests and engage in 'proactive pushes' of supplies.

In both keeping a mission tasked, dedicated cache of supplies for hospital, healthcare, and first responder usage as well as intelligence on 'stateside' suppliers with inventory in stock and ready to ship, the county is able to respond to surge needs within the same user group.

We have established a regular meeting frequency with all area hospitals coordinated with the Hospital Council of Northern California. We bring in hospital executives and physician leaders to share and review surge plans, testing strategies, scarce resource allocation plans, and PPE protocols. We have discussed gradual resumption on routine clinical services in a phased approach requiring adequacy of PPE. All eight area hospitals have certified in writing that they have adequate PPE to protect their employees and clinicians, they have access to a 30-day supply of PPE and can independently procure adequate PPE to meet their needs going forward, and they have not needed to submit a request for assistance in obtaining PPE to the County Emergency Operations Center in the last 14 days.

- **Vulnerable populations.** A determination must be made by the county that the proposed variance maintains protections for vulnerable populations, particularly those in long-term care settings. The county must attest to ongoing work with Skilled Nursing Facilities within their jurisdiction and describe their plans to work closely with facilities to prevent and mitigate outbreaks and ensure access to PPE:

  - Describe your plan to prevent and mitigate COVID-19 infections in skilled nursing facilities through regular consultation with CDPH district offices and with leadership from each facility on the following: targeted testing and patient cohorting plans; infection control precautions; access to PPE; staffing shortage contingency plans; and facility communication plans. This plan shall describe how the county will (1) engage with each skilled nursing facility on a weekly basis, (2) share best practices, and (3) address urgent matters at skilled nursing facilities in its boundaries.

See attached Congregate Living Facility Guidance for Prevention and Management of COVID 19 plan.

  - Skilled nursing facilities (SNF) have >14-day supply of PPE on hand for staff, with established process for ongoing procurement from non-state supply chains. Please list the names and contacts of all SNFs in the county along with a description of the system the county must track PPE availability across SNFs.

CDPH has directed all SNFs to complete the daily CDPH Skilled Nursing Facility Poll on a daily basis – see attached report. In that, SNFs are queried on PPE on hand for a 14 day supply. Currently, emergent needs are sent to the Congregate Living Unit for follow up. The Congregate Living Unit is currently working on a process to establish quantity and type of PPE needed to maintain a 14 day supply on hand. Current CDPH data will be utilized to assist in the development. SNF's are also receiving PPE supplies from FEMA directly which is being tracked through Logistics and the Health Care Coalition.

- **Sectors and timelines.** Please provide details on the county's plan to move through Stage 2. These details should include which sectors and spaces will be opened, in what sequence, on what timeline. Please specifically indicate where the plan differs from the state's order. Any sector that is reflective of Stage 3 should not be included in this variance because it is not allowed until the State proceeds into Stage 3. For additional details on sectors and spaces included in Stage 2, please see https://covid19.ca.gov/industry-guidance/ for sectors open statewide and https://covid19.ca.gov/roadmap-counties/ for sectors available to counties with a variance.

Contra Costa plans to move forward with allowing swimming pools, campgrounds for families, and outdoor dining to open as soon as our application for a variance is approved. We plan to allow hair salons and barber shops on June 17, 2020. We plan to allow indoor dining, gym and fitness centers, bowling alleys, indoor museums, and hotels for tourism and individual travel starting July 1, 2020. We will evaluate other activities once they are allowed by the state and the state issues industry specific guidance.

We have established a Strategic Policy Group made up of our Health Director, Health Officer, Deputy Health Officers and public health experts. This Strategy Policy Group meets twice weekly to consider policy questions.

We also participate in an Ad-Hoc Committee on COVID-19 Economic Impact and Recovery established by our Board of Supervisors. This Ad-Hoc Committee meets weekly to consider different sectors in our county. Here is a link to the latest agenda: http://64.166.146.245/agenda_publish.cfm?id=&mt=ALL&get_month=6&get_year=2020&dsp=ag&seq=1634

- **Triggers for adjusting modifications.** Please share the county metrics that would serve as triggers for either slowing the pace through Stage 2 or tightening modifications, including the frequency of measurement and the specific actions triggered by metric changes. Please include your plan, or a summary of your plan, for how the county will inform the state of emerging concerns and how it will implement early containment measures.

We plan on using the state watch list metrics to follow as triggers for slowing the pace through Stage 2 or tightening modifications: **Case rate per 100,000 (sum of past 14-days) does not exceed 25. Test positivity (7-day average does not exceed 8%. % change in 3-day average COVID+ hospitalized patients does not exceed 10%8%. % change in 3-day average hospital. % of ICU beds currently available is not less than 20%. % of ventilators currently available is not less than 25%. In addition, we developed with other bay area counties a set of indicators that we have been tracking to ensure we are prepared to detect, manage, and mitigate any surge in cases in our county:**

Indicators:

1. The Total Number of Cases in the Community is Flat or Decreasing, and the Number of Hospitalized Patients with COVID-19 is Flat or Decreasing
2. We Have Sufficient Hospital Capacity to Meet the Needs of our Residents
3. Sufficient COVID-19 Viral Detection Tests Are Being Conducted Each Day
4. We Have Sufficient Case Investigation, Contact Tracing, and Isolation/Quarantine Capacity
5. We Have At Least A 30-Day Supply of Personal Protective Equipment (PPE) Available for All Healthcare Providers

- **COVID-19 Containment Plan**

Please provide your county COVID-19 containment plan or describe your strategy to create a COVID-19 containment plan with a timeline.

Contra Costa County is committed to protecting the community and is actively engaged with cities, hospitals, EMS, health plans, law enforcement, justice, community-based organizations and business on all aspects of our COVID-19 containment strategy and continue to iterate.

Contra Costa County has developed extensive data monitoring infrastructure and working actively with CDPH and are pilot county #2 using CalConnect to make sure to be strategically prepared for robust case investigations and contact tracing. As of June 5th, 2020 all of case investigators and tracers are using the new platform, and only the outbreak investigations are done outside this system.

Contra Costa County is actively working to develop a more comprehensive COVID-19 specific containment plan. The Contra Costa Healthcare Surge Plan and the Region 2 Multi-Agency Coordination Guide will be a part of that plan, and will be updated to reflect the learnings so far from the COVID epidemic. We plan to complete our first version of a comprehensive updated COVID-19 plan by June 30, 2020.

In addition, Contra Costa County continues to work with our community partners to aid people in isolating and quarantining themselves.

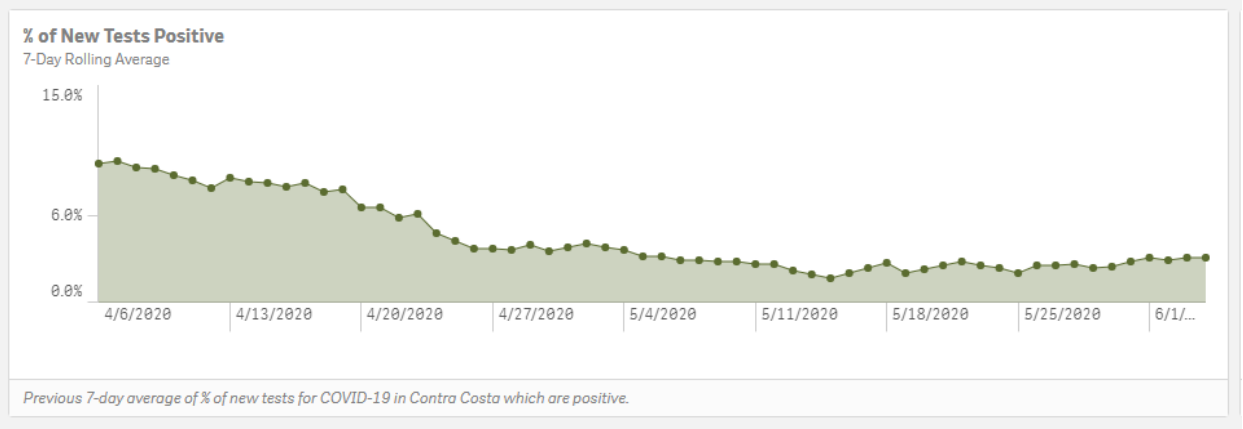
Contra Costa County will continue to iteratively expand and resource these initiatives as needed going forth and have instituted an Incident Command System that oversees the entire COVID-19 response.

While not exhaustive, the following areas and questions are important to address in any containment plan and may be used for guidance in the plan's development. This containment plan should be developed by the local health officer in conjunction with the hospitals and health systems in the jurisdiction, as well as input from a broad range of county stakeholders, including the County Board of Supervisors. Under each of the areas below, please indicate how your plan addresses the relevant area. If your plan has not yet been developed or does not include details on the areas below, please describe how you will develop that plan and your timeline for completing it.

Testing

- Is there a plan to increase testing to the recommended daily capacity of 2 per 1000 residents?
- Is the average percentage of positive tests over the past 7 days <8% and stable or declining?
- Have specimen collection locations been identified that ensure access for all residents?
- Have contracts/relationships been established with specimen processing labs?
- Is there a plan for community surveillance?

Contra Costa County testing capacity is 2426 daily which exceed the 2 per 1000 residents recommended. The average percentage of positive tests using 7 day rolling average is 3.1% as of June 4, 2020



Current Specimen collection locations are in all areas of the county please see map under testing section.
Established contract/relationship are established with
Contra Costa Public Health Lab
Contra Costa Regional Medical Center Lab
Quest Lab
Lab Corp
Kaiser Regional Labs
UCSF Biohub participant with secure contract
Contra Costa Is a part of the CDPH/CCHS Community Surveillance Grant. Our data analytics exam has built a community surveillance hot spot triggers into our COVID-19 dashboard.

Contact Tracing

- How many staff are currently trained and available to do contact tracing?
- Are these staff reflective of community racial, ethnic and linguistic diversity?
- Is there a plan to expand contact tracing staff to the recommended levels to accommodate a three-fold increase in COVID-19 cases, presuming that each case has ten close contacts?
- Is there a plan for supportive isolation for low income individuals who may not have a safe way to isolate or who may have significant economic challenges as a result of isolation?

Contra Costa County has approximately 1.15 million residents, which would require 173 contact tracers (15 contact tracers per 100,000 population). We have a Case and Contact Investigation Branch in our ICS Structure which currently has 86 staff. Our branch includes Epidemiology/Data/Communications Unit, Admin Triage Unit, Case Investigation Unit, and Contact Tracing Unit. Our diverse staff in the Case and Contact Investigation Branch are all trained and capable of doing contact tracing. We have 5 Public Health Nurses starting next week; 25 Disease Investigation Technicians starting by the end of June; 8 Public Health Program Specialists starting by the end of June; and 56 Temporary Emergency Service Workers that will be on boarding through the end of June and beginning of July. Our current staff are comprised of disease investigators, public health nurses, epidemiologists, environmental health specialists, and more. Our objective is to have 180 staff that are all capable of doing contact tracing. Our contact tracing staff represent racial, ethnic and linguistic diversity of our community.

Living and Working in Congregate Settings

- How many congregate care facilities, of what types, are in the county?
- How many correctional facilities, of what size, are in the county?
- How many homelessness shelters are in the county and what is their capacity?
- What is the COVID-19 case rate at each of these facilities?
- Is there a plan to track and notify local public health of COVID-19 case rate within local correctional facilities, and to notify any receiving facilities upon the transfer of individuals?
- Do facilities have the ability to adequately and safely isolate COVID-19 positive individuals?
- Do facilities have the ability to safely quarantine individuals who have been exposed?
- Is there sufficient testing capacity to conduct a thorough outbreak investigation at each of these facilities?
- Do long-term care facilities have sufficient PPE for staff, and do these facilities have access to suppliers for ongoing PPE needs?
- Do facilities have policies and protocols to appropriately train the workforce in infection prevention and control procedures?
- Does the workforce have access to locations to safely isolate?
- Do these facilities (particularly skilled nursing facilities) have access to staffing agencies if and when staff shortages related to COVID-19 occur?

There are over 500 congregate care facilities in Contra Costa County – approximately 29 SNFs and the rest are assisted living facilities, residential care facilities for the elderly and board and cares. We track COVID-19 cases, deaths and outbreaks at these facilities, and this is posted on our public dashboard. We are in contact with congregate care facilities and they have the ability to request PPE from our Logistics section as needed. They also have access to isolation via the State as well as access to staffing should they need it.

We have 5 Detention facilities in our county, and Contra Costa Health Services provides health services at them all. Three of these are adult facilities and two are juvenile. All people entering into custody are booked, symptom screened and tested upon arrival. Regardless of test result, people entering custody are quarantined. We also have sufficient lab capacity for our testing. Contra Costa County have performed 651 tests as of June 4th, 2020 with 5 positive results in total for all of detention.

Protecting the Vulnerable

- Do resources and interventions intentionally address inequities within these populations being prioritized (i.e. deployment of PPE, testing, etc.)?
- Are older Californians, people with disabilities, and people with underlying health conditions at greater risk of serious illness, who are living in their own homes, supported so they can continue appropriate physical distancing and maintain wellbeing (i.e. food supports, telehealth, social connections, in home services, etc.)?

Using available data Contra Costa Health Services created a COVID-19 Vulnerability Index, early in the pandemic to identify the highest risk individuals using a regression model. Telephonic outreach was performed to 7000 highest risk individuals assessing clinical as well resource needs to help them avoid high risk situations.

A playbook was developed and shared with the wider community-based organization.

Acute Care Surge

- Is there daily tracking of hospital capacity including COVID-19 cases, hospital census, ICU census, ventilator availability, staffing and surge capacity?
- Are hospitals relying on county MHOAC for PPE, or are supply chains sufficient?
- Are hospitals testing all patients prior to admission to the hospital?
- Do hospitals have a plan for tracking and addressing occupational exposure?

Contra Costa County has developed a public facing dashboard that shares operational statistics, testing data, capacity and indicators.

https://www.coronavirus.cchealth.org/dashboard

We are working with our Hospital Council to poll the hospitals about their plan for tracking and addressing occupational exposures. Because they all have robust infection control programs, we assume that that this is in place.

All hospitals are not currently testing all patients prior to admission. However, all hospitals are testing all surgical patients and testing others as indicated. We will poll the hospitals as their policies and practices evolve during this pandemic.

All hospitals are relying on both their normal PPE supply chains as well as the County MHOAC for PPE supplies.

Essential Workers

- How many essential workplaces are in the county?
- What guidance have you provided to your essential workplaces to ensure employees and customers are safe in accordance with state/county guidance for modifications?
- Do essential workplaces have access to key supplies like hand sanitizer, disinfectant and cleaning supplies, as well as relevant protective equipment?
- Is there a testing plan for essential workers who are sick or symptomatic?
  Is there a plan for supportive quarantine/isolation for essential workers?

The County Emergency Operations Center has been working with essential workers for healthcare facilities on assisting them on getting PPE, include hand sanitizer and disinfectant.

The County's Health Officer Order for Staying at Home Appendix A – Social Distancing Protocols, which is attached

Contra Costa County Risk Management has developed guidance titled COVID-19 Exposures and the Workplace Guidelines. This document is attached.

Interim Guidance for Prioritizing Testing of ASYMPTOMATIC PERSONS for COVID-19 has been developed that is attached. The Contra Costa Health Services Strategic

Planning Group is developing a testing plan for testing essential workers such as grocery store workers.

Special Considerations

- Are there industries in the county that deserve special consideration in terms of mitigating the risk of COVID-19 transmission, e.g. agriculture or manufacturing?
- Are there industries in the county that make it more feasible for the county to increase the pace through Stage 2, e.g. technology companies or other companies that have a high percentage of workers who can telework?

The County has four petroleum refineries that supply a large percentage of the fuels for the State. Our Hazardous Materials Division of Contra Costa Health Services Department works closely with these facilities to ensure covid safety protocols are followed.

Community Engagement

- Has the county engaged with its cities?
- Which key county stakeholders should be a part of formulating and implementing the proposed variance plan?
- Have virtual community forums been held to solicit input into the variance plan?
- Is community engagement reflective of the racial, ethnic, and linguistic diversity of the community?

County Administrators, Health Director, Health Officer and Deputy Health Director attend weekly city manager meetings.

The Variance plan is in development and will include key stakeholders representing community, county government, city government, health services, detention health, public health, social services, first responders, law enforcement, community based organizations and business community. Virtual community forums to provide input on the plan and will be reflective of the racial, ethnic, and linguistic diversity of the community via regional community care coalitions, advisory boards and commissions.

Relationship to Surrounding Counties

- Are surrounding counties experiencing increasing, decreasing or stable case rates?
- Are surrounding counties also planning to increase the pace through Stage 2 of California's roadmap to modify the Stay-at-Home order, and if so, on what timeline? How are you coordinating with these counties?
- What systems or plans are in place to coordinate with surrounding counties (e.g. health care coalitions, shared EOCs, other communication, etc.) to share situational awareness and other emergent issues.
- How will increased regional and state travel impact the county's ability to test, isolate, and contact trace?

Contra Costa County in collaboration with other core Bay Area Health Officers developed a Metrics Group that developed a data governance infrastructure to begin sharing COVID-19 related data for situational awareness. The Association of Bay Area Health Officers has twice weekly conference calls to share ideas and approaches, situational awareness and coordinated action. Core bay area health officers also communicate by phone and email several times a week to compare and collaborate.
Our contact tracing teams are in close collaboration when they have a case or contacts that are living or working across counties.

The MHOAC program supports collaboration with the other Bay Area counties to assist in mutual aid for medical resources across Region 2 of California. Through the use of ReddiNet and other regional communication programs, situational awareness is maintained during local and regional disasters.

In addition to your county's COVID-19 VARIANCE ATTESTATION FORM, please include:

- Letter of support from the County Board of Supervisors
- Letter of support from the local hospitals or health care systems. In the event that the county does not have a hospital or health care system within its jurisdiction, a letter of support from the relevant regional health system(s) is also acceptable.
- County Plan for moving through Stage 2

All documents should be emailed to Jake Hanson at Jake.Hanson@cdph.ca.gov.

I Christopher Farntiano, M.D., hereby attest that I am duly authorized to sign and act on behalf of the County of Contra Costa. I certify that the County of Contra Costa has met the readiness criteria outlined by CDPH designed to mitigate the spread of COVID-19 and that the information provided is true, accurate and complete to the best of my knowledge. If a local COVID-19 Containment Plan is submitted for the County of Contra Costa, I certify that it was developed with input from the County Board of Supervisors/City Council, hospitals, health systems, and a broad range of stakeholders in the jurisdiction. I acknowledge that I remain responsible for implementing the local COVID-19 Containment Plan and that CDPH, by providing technical guidance, is in no way assuming liability for its contents.

I understand and consent that the California Department of Public Health (CDPH) will post this information on the CDPH website and is public record.

Printed Name Christopher Farnitano, M.D.

Signature 

Position/Title County Health Officer

Date June 5, 2020

Candace Andersen

Chair
Contra Costa County Board of Supervisors
District Two

309 Diablo Road
Danville, CA 94526

Office: (925) 957-8860
Fax: (925) 820-3785
Cell: (925) 768-2163
candace.andersen@bos.cccounty.us

June 5, 2020

Sonia Y. Angell, M.D., MPH
State Public Health Officer
California Department of Public Health
P.O. Box 997377, MS 0500
Sacramento, CA 95899-7377

RE: Letter of Support for Contra Costa County Attestation of Readiness for California Pandemic Resilience Roadmap Stage 2

Dear Dr. Angell:

On behalf of my colleagues on the Contra Costa County Board of Supervisors, I am submitting this letter of support of the Contra Costa County Public Health Officer's request for a variance.

Contra Costa County has been able to maintain a flat epidemiological curve over a prolonged period of time. Contra Costa County Health Officer Dr. Christopher Farnitano has kept the Board of Supervisors fully apprised of the status of COVID-19 in our community and most recently, he presented his "Five Indicators", our version of a containment plan, which includes specific criteria for the reopening of Contra Costa County and to guide critical decisions in support of the public's health and well-being. Our Board of Supervisors supports Dr. Farnitano's request for concurrence to move as quickly as permitted by the Governor and California Department of Public Health.

The Contra Costa County Board of Supervisors fully supports Dr. Farnitano's attestation that Contra Costa County meets all of the readiness criteria and his desire to increase the pace at which the County advances through Stage 2 of the Governor's Pandemic Roadmap.

Best regards,

Candace K. Andersen
Chair, Contra Costa County Board of Supervisors

CC: Contra Costa County Board of Supervisors
David Twa, Contra Costa County Administrator
Sharon Anderson, Contra Costa County Counsel
Dr. Christopher Farnitano, M.D., Contra Costa County Health Officer
Anna Roth, Contra Costa County Health Services Director

ANNA M. ROTH, R.N., M.S., M.P.H.
HEALTH SERVICES DIRECTOR

SAMIR B. SHAH, M.D., FACS
ACTING CHIEF EXECUTIVE OFFICER
CHIEF MEDICAL OFFICER
CONTRA COSTA REGIONAL MEDICAL CENTER
AND HEALTH CENTERS

CONTRA COSTA
HEALTH SERVICES

CONTRA COSTA REGIONAL
MEDICAL CENTER
AND HEALTH CENTERS

2500 Alhambra Avenue
Martinez, California 94553-3156

Ph 925-370-5000

Chris Farnitano, MD
Health Officer, Contra Costa County
1220 Morello Ave, Suite 200 Martinez, CA 94553

Dear Dr. Farnitano,

Contra Costa Regional Medical Center and Health Centers is prepared to accommodate a surge of more than 35% due to COVID-19 cases in addition to providing care to non COVID-19 patients, as outlined in our surge plan and additionally has adequate PPE to protect our employees and clinicians.

We understand that Contra Costa County will use this letter to support their application for a variance to move through the stages to re-open.

Sincerely,

Samir B. Shah, MD, FACS
Acting Chief Executive Officer
Chief Medical Officer

KAISER PERMANENTE

May 26, 2020

Dr. Chris Farnitano

Public Heath Officer, Contra Costa County

1220 Morello Ave, Suite 200

Martinez, CA 94553

Re: Variance to Stage 2 of California's Roadmap to Modify the Stay-at-Home Order

Dear Dr. Farnitano,

In response to your request, Kaiser Foundation Hospital Walnut Creek and Antioch Medical Centers:

- Has capacity to accommodate a minimum surge of 35% due to COVID-19 cases, in addition to providing usual care for its non-COVID-19 patients.

Has adequate Personal Protective Equipment (PPE) to protect its workforce. ***The hospital does have a 30 day supply of PPE on hand due to the PPE stewardship program which includes PPE conservation and reprocessing efforts, however, the Days on Hand (DOH) inventory levels can shift quickly with any changes in patient census, changes in reprocessing, or changes to PPE regulation and usage.***

We understand that Contra Costa County has requested this information in order to assess its readiness to request a local variance to move to Stage 2 in California's Roadmap to Modify the Stay-At-Home Order.

Sincerely,

Kerry J Easthope
Area Finance Officer,
Kaiser Foundation Hospital – Walnut Creek and Antioch Medical Centers

JOHN MUIR HEALTH

John Muir Medical Center
Walnut Creek Campus

1601 Ygnacio Valley Road
Walnut Creek, CA 94598-3122
T. (925) 939-3000

Community-based, not-for-profit

June 1, 2020

Chris Farnitano, MD Health Officer
Contra Costa Country
1220 Morello Avenue
Suite 200
Martinez, CA 94553
Chris.farnitano@cchealth.org

Dr. Farnitano,

In response to your request, I am certifying on behalf of John Muir Health Walnut Creek and Concord Campuses that we certify the following:

Both Hospitals have adequate PPE to protect our employees and clinicians. We have access to a 30-day supply of PPE and can independently procure adequate PPE to meet our needs going forward. We have not needed to submit a request for assistance in obtaining PPE to the County Emergency Operations Center in the last 14 days.

Date of certification: 6/1/2020

Sincerely,

Ray Nassief
Senior Vice President, Hospital Operations and Ancillary Services

KAISER PERMANENTE

June 5, 2020

Dr. Chris Farnitano

Public Health Officer, Contra Costa County

1220 Morello Avenue

Suite 200

Martinez, CA 94553

Re: Variance to Stage 2 of California's Roadmap to Modify the Stay-at-Home Order

Dear Dr. Farnitano,

In response to your request, Kaiser Foundation Hospital Richmond :

- Has capacity to accommodate a minimum surge of 35% due to COVID-19 cases, in addition to providing usual care for its non-COVID-19 patients.

Has adequate Personal Protective Equipment (PPE) to protect its workforce. ***The hospital does have a 30 day supply of PPE on hand due to the PPE stewardship program which includes PPE conservation and reprocessing efforts, however, the Days on Hand (DOH) inventory levels can shift quickly with any changes in patient census, changes in reprocessing, or changes to PPE regulation and usage.***

We understand that Contra Costa County has requested this information in order to assess its readiness to request a local variance to move to Stage 2 in California's Roadmap to Modify the Stay-At-Home Order.

Sincerely,

Debora Chew, Chief of Staff, on behalf of Edmund D. Chan

Edmund D. Chan
Senior Vice President/Area Manager
Kaiser Foundation Hospital – Richmond

SAN RAMON
REGIONAL MEDICAL CENTER
JOHN MUIR HEALTH PARTNER
A COMMUNITY BUILT ON CARE

June 5, 2020

Chris Farnitano, MD Health Officer
Contra Costa County
1220 Morello Ave
Suite 200
Martinez, CA 94553
Chris.farnitano@cchealth.org

Dr. Farnitano,

In response to your request, I am certifying on behalf of San Ramon Regional Medical Center that we have adequate PPE to protect our employees and clinicians. We have access to a 30-day supply of PPE and can independently procure adequate PPE to meet our needs going forward. We have not needed to submit a request for assistance in obtaining PPE to the County Emergency Operations Center in the last 14 days.

Moreover, our hospital has capacity to accommodate a minimum surge of 35% due to COVID-19 cases, in addition to providing usual care for its non-COVID-19 patients.

Date of certification: 6/5/2020

Sincerely,

Ann Lucena
Chief Executive Officer
San Ramon Regional Medical Center
6001 Norris Canyon Rd
San Ramon, CA 94583

Sutter Health

May 19, 2020

Chris Farnitano, MD
Health Officer, Contra Costa County

1220 Morello Ave, Suite 200
Martinez, CA 94553

Dr. Farnitano,

In response to your request, Sutter Health's integrated health delivery system:

- Is prepared to accommodate a surge of 35% due to COVID-19 cases in addition to providing care to non COVID-19 patients, as outlined in the surge plan submitted to the State of California, and

- Has adequate PPE to protect our employees and clinicians.

We understand that Contra Costa County will use this letter to support their application for a variance to move through the stages to re-open.

Sincerely,

Stephen H. Lockhart, MD, PhD
Chief Medical Officer, Sutter Health

Appendix A: Social Distancing Protocol (Updated April 29, 2020)

Business name:

Facility Address:

Approximate gross square footage of space open to the public:

Businesses must implement all applicable measures listed below, and be prepared to explain why any measure that is not implemented is inapplicable to the business.

Signage:

☐Signage at each public entrance of the facility to inform all employees and customers that they should: avoid entering the facility if they have COVID-19 symptoms; maintain a minimum six-foot distance from one another; sneeze and cough into a cloth or tissue or, if not available, into one's elbow; wear face coverings, as appropriate; and not shake hands or engage in any unnecessary physical contact.

☐Signage posting a copy of the Social Distancing Protocol at each public entrance to the facility.

Measures To Protect Employee Health (check all that apply to the facility):

☐ Everyone who can carry out their work duties from home has been directed to do so.

☐ All employees have been told not to come to work if sick.

☐ Symptom checks are being conducted before employees may enter the work space.

☐ Employees are required to wear face coverings, as appropriate.

☐ All desks or individual work stations are separated by at least six feet.

☐ Break rooms, bathrooms, and other common areas are being disinfected frequently, on the following schedule:

- ☐ Break rooms:
- ☐ Bathrooms:
- ☐ Other

☐ Disinfectant and related supplies are available to all employees at the following location(s):

☐ Hand sanitizer effective against COVID-19 is available to all employees at the following location(s):

☐ Soap and water are available to all employees at the following location(s):

☐ Copies of this Protocol have been distributed to all employees.

☐ Optional—Describe other measures:

Measures To Prevent Crowds From Gathering (check all that apply to the facility):

☐ Limit the number of customers in the store at any one time to which allows for customers and employees to easily maintain at least six-foot distance from one another at all practicable times.

☐ Post an employee at the door to ensure that the maximum number of customers in the facility set forth above is not exceeded.

☐ Placing per-person limits on goods that are selling out quickly to reduce crowds and lines. Explain:

☐ Optional—Describe other measures:

Measures To Keep People At Least Six Feet Apart (check all that apply to the facility)

☐ Placing signs outside the store reminding people to be at least six feet apart, including when in line.

☐ Placing tape or other markings at least six feet apart in customer line areas inside the store and on sidewalks at public entrances with signs directing customers to use the markings to maintain distance.

☐ Separate order areas from delivery areas to prevent customers from gathering.

☐ All employees have been instructed to maintain at least six feet distance from customers and from each other, except employees may momentarily come closer when necessary to accept payment, deliver goods or services, or as otherwise necessary.

☐ Optional—Describe other measures:

Measures To Prevent Unnecessary Contact (check all that apply to the facility):

☐ Preventing people from self-serving any items that are food-related.

☐ Lids for cups and food-bar type items are provided by staff; not to customers to grab.

☐ Bulk-item food bins are not available for customer self-service use.

☐ Not permitting customers to bring their own bags, mugs, or other reusable items from home.

☐ Providing for contactless payment systems or, if not feasible, sanitizing payment systems regularly. Describe:

☐ Optional—Describe other measures (e.g. providing senior-only hours):

Measures To Increase Sanitization (check all that apply to the facility):

☐ Disinfecting wipes that are effective against COVID-19 are available near shopping carts and shopping baskets.

☐ Employee(s) assigned to disinfect carts and baskets regularly.

☐ Hand sanitizer, soap and water, or effective disinfectant is available to the public at or near the entrance of the facility, at checkout counters, and anywhere else where people have direct interactions.

☐ Disinfecting all payment portals, pens, and styluses after each use.

☐ Disinfecting all high-contact surfaces frequently.

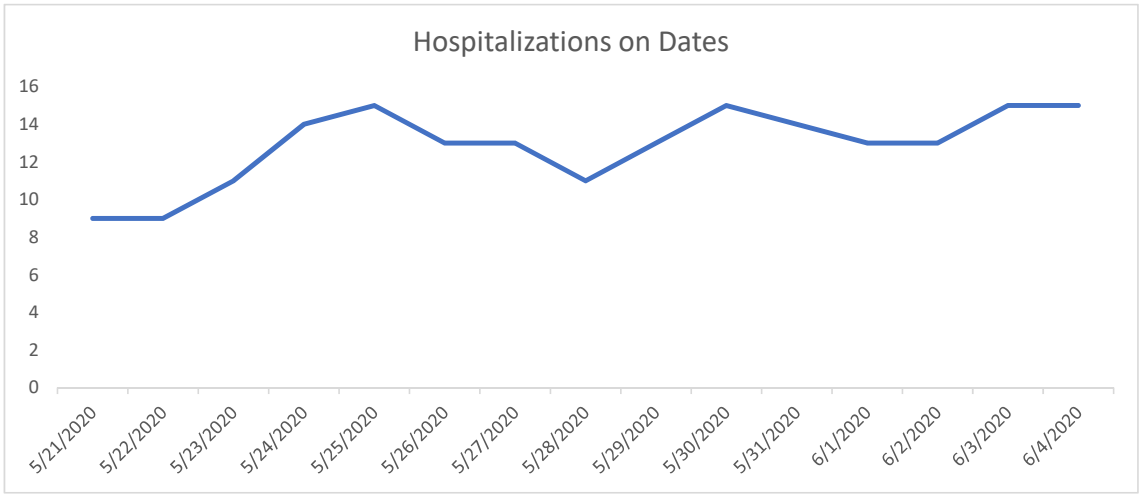
☐ Optional—Describe other measures:

* Any additional measures not included here should be listed on separate pages and attached to this document.

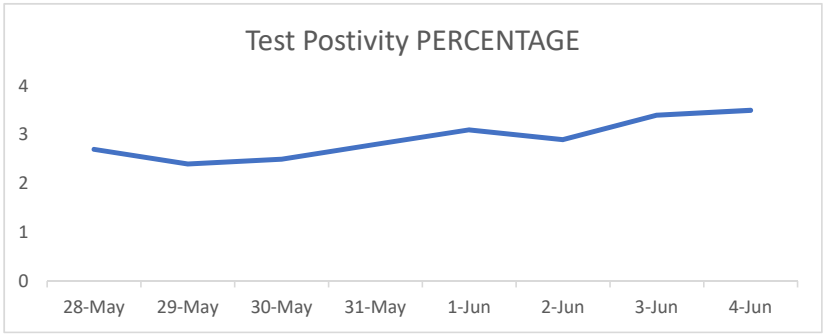
You may contact the following person with any questions or comments about this protocol:

Name: **Phone number:**

Date	Total # of Patients Hospitalized
5/21/2020	9
5/22/2020	9
5/23/2020	11
5/24/2020	14
5/25/2020	15
5/26/2020	13
5/27/2020	13
5/28/2020	11
5/29/2020	13
5/30/2020	15
5/31/2020	14
6/1/2020	13
6/2/2020	13
6/3/2020	15
6/4/2020	15



Date	Test Postivity
28-May	2.7
29-May	2.4
30-May	2.5
31-May	2.8
1-Jun	3.1
2-Jun	2.9
3-Jun	3.4
4-Jun	3.5



RISK MANAGEMENT
SAFETY AND
LOSS CONTROL

COVID-19 Exposures and the Workplace Guidelines

Revised May 15, 2020 1500 hours

Living document updated as circumstances change.
This document supersedes all previous versions.

Revised May 15, 2020 1500 hours
Living document updated as circumstances change. This document supersedes all previous versions.

COVID-19 Exposures and the Workplace

County employees play an essential role in community disaster response, whether they are performing in their primary roles or as Disaster Service Workers. This document is designed for County employees to understand COVID-19 exposures and procedures in the workplace.

This document contains information compiled by Risk Management provided specifically for county employees and operations with assistance from Public Health and Occupational Health.

This document resides on the Risk Management intranet site. You can use the Table of Contents titles and to go directly to topics of interest within this document. Additional links in the text lead to topics within the document, intranet sites, and outside websites.

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EXPOSURES AND THE WORKPLACE

This portion of the document describes exposures in the workplace and is designed for County employees to understand:

- Symptoms of COVID-19 (also known as *novel coronavirus*).
- When and how long to self-isolate when symptoms are present.
- When to return to the workplace after illness or exposure.

REMINDERS

- Protect and respect employee health information during any communications regarding symptoms, exposures, and response. Refer to Equal Employment Opportunity Commission guidelines.
- If you are sick – stay home. All employees should be instructed to remain home and monitor symptoms or developing symptoms, even if there is no concern for workplace exposure.
- Follow the most current County Administrator's Office guidelines on how to account for leave of absence resulting from COVID-19 exposures and the workplace.
- Employees should continue to follow normal preventive actions while at work and home, including cleaning hands and avoiding touching eyes, nose, or mouth with unwashed hands, and practicing social distancing.

SYMPTOMS

During this time of COVID-19 Public Health Order and response, all employees should monitor themselves for symptoms of illness. The most common symptoms of COVID-19 are ***fever, tiredness, and dry cough***. Some patients may have less-common symptoms such as ***aches and pains, chills, nasal congestion, runny nose, sore throat, headache, or new loss of sense of smell and taste***. These symptoms often come on gradually. If you have fever, cough, and difficulty breathing, remove yourself from the workplace, stay at home, isolate from others, and seek medical attention if needed, by calling your healthcare provider. Unsure what your symptoms may mean? Review the following resources to further evaluate symptoms:

- "Is it Cold, Flu, or Coronavirus?" available on the Health Services website.
- CDC Covid-19 Symptoms and Self-Checker

‡For tracking purposes, note your health status and symptom onset using the attached calendar resource tool.

DEFINITIONS

Critical Infrastructure Workers is a list of employment sectors identified by Homeland Security. The list includes (but is not limited to) government services, contractors, and internal service providers (e.g., custodial services, facilities maintenance, mail services, recycling, telecommunications, information technology, network services) that enter and work in these environments. These internal service providers will be characterized by and may be screened based on the setting in which they work (SOS vs. Non-SOS).

Essential Government Functions are the critical activities that are performed by governments that enable them to provide vital services, exercise civil authority, and maintain safety of the general public during a disruption of normal activities.

Sensitive Occupation/Services Settings (SOS) are defined as people living and working in congregate living facilities such as skilled nursing, board and care, assisted living, and other congregate senior-living facilities, shelters, group homes, residential treatment programs, detention facilities, healthcare/healthcare workers/first

responders, and dialysis centers, and those receiving dialysis or chemotherapy in a facility.

Non-Sensitive Occupations/Services Settings (Non-SOS) are defined as all other County community service and general office facilities, internal services departments (information technology, network services, telecommunications, facilities maintenance, etc.).

Screening means using measures to identify symptoms, infection, and exposure risks for COVID-19. For example, 911 dispatchers use a series of questions to identify risks prior to contact with emergency responders. Screening is conducted prior to entry to some county facilities and operations. Screening may include measuring the employee's temperature and assessing symptoms prior to starting work or entering a county facility. Ideally, temperature checks should happen before an individual enters the facility.

Self-monitoring means monitoring yourself for fever (100.0 degrees Fahrenheit or greater) by taking your temperature twice a day and remaining alert for respiratory symptoms (e.g., cough, shortness of breath, sore throat).

Active monitoring means a public health authority assumes responsibility for establishing regular communication with potentially exposed people to assess for the presence of fever or respiratory symptoms.

Unprotected Exposure is defined as an individual's exposure to an individual with presumed or positive COVID-19 diagnosis without the use of personal protective equipment (PPE) such as a respirator, face shield, or gloves, depending on the specific work environment.

Close contact is defined as being within approximately 6 feet of a person diagnosed with COVID-19 for a prolonged period (10 minutes or more) or having unprotected direct contact with infectious secretions or excretions of the person. Living with a presumed or positive COVID-19 individual is also considered close contact.

Asymptomatic is defined as a person that is a carrier for COVID-19 but is neither experiencing nor demonstrating symptoms. Persons with COVID-19 can infect others for up to 2 days before they become symptomatic.

Exposed Asymptomatic is defined as a person who has or may have had close contact to a person diagnosed with COVID-19 but has not developed noticeable symptoms of any kind. Even though not displaying symptoms, these persons should practice extra precaution by maintaining a safe social distance from others including at home and in the workplace.

Positive Asymptomatic is defined as an individual that has tested positive for COVID-19 but is no longer experiencing symptoms. These individuals may need to follow special precautions depending on their work setting or may be allowed to work with other positive COVID-19 patients or clients.

DEPARTMENT SUPERVISOR GUIDANCE

The purpose of this section is to provide Department Supervisors guidance on:

1. What to do if an employee reports symptoms or illness.
2. What to do if an employee is turned away after screening.
3. What to do if an employee in your workplace is tested positive for COVID-19.
4. The employee's healthcare provider states that the employee is presumptively positive for COVID-19.
    - IMMEDIATELY contact your appropriate Department Personnel. Department Personnel shall take the following actions:

1. Instruct the employee to stay at home and follow any instructions/orders from their medical provider or Public Health for isolation.
    a. Provide this document to the ill employee.
    b. *NOTE: You don't need to notify Public Health of this information, they are informed directly by medical providers.*
2. Identify any individuals that may have been in close contact (see definition) with the ill employee, notify the exposed employees, and ask these individuals to self-monitor for symptoms.

a. Do not disclose to those identified employees the identity of the employee who tested positive for COVID-19.
b. Provide this document to the identified exposed employees.
    i. Review the definition of symptoms.
    ii. Discuss use of the calendar resource tool to document self-monitoring efforts and results.
    iii. Asymptomatic persons/staff can now seek testing at any one of 8 community testing sites across the County – call (844) 421-0804 for an appointment.

3. Due to personnel privacy restrictions, DO NOT disclose the name or other personal/health information of the employee, except on a strict need-to-know basis. DO NOT disclose the name or other information of the employee to the media or other third party. Contact your department's County Counsel if you have further questions.
4. Refer to the attached Decision Tree and review actions needed with the ill employee **and** any identified exposed employee(s) regarding symptom monitoring or self-isolation.
    a. A doctor's note clearing the employee to resume work is not needed.
    b. Resuming work may require special procedures or precautions, depending on the occupation or work setting. See the CDC Essential Workers Do's and Don'ts.
5. Review the cleaning and decontamination steps in this document.
6. Communicate with the rest of affected staff: "*A Covid-19 illness has been identified in <give location> <give date and time>. All staff that have had close contact with the ill person have been addressed individually and provided specific instructions. Remaining staff that did not have close contact or were not present at the time and location above do not need to quarantine and can continue to self-monitor for symptoms.*"
7. Department Supervisors with exposure and medical questions not answered in this document can contact Dr. Tom Gamsky at County Vista Oaks Occupational Medicine via email to Tgamsky@cchealth.org, with the understanding that the clinic is operating on limited hours at this time.

EMPLOYEES IN NON-SOS SETTINGS

If you develop symptoms such as a fever, cough, or difficulty breathing, remove yourself from work, stay at home, practice safe social distancing, even from family members, and call your healthcare provider to report your concerns. While not everyone will need testing for COVID-19, especially if symptoms are mild enough to treat at home or if family members have already tested positive, community testing is becoming more widely available and is encouraged; contact the COVID-Testing Phone Line 1-844-421-0804. If symptoms worsen, continue to stay at home and seek medical attention. Notify your supervisor that you are out ill and are following precautions due to possible COVID-19. You will get additional instruction from your departmental personnel unit.

EMPLOYEES IN SOS SETTINGS

If you develop symptoms and work in a Sensitive Occupation or Setting (SOS), remove yourself from the workplace immediately and isolate. Inform your supervisor that you are following precautions in consideration of possible COVID-19 by remaining home and out of the workplace. In addition, inform your supervisor of the following conditions that apply:

- You have been in close proximity to clients or patients diagnosed with COVID-19.
- You have been in direct contact with positive, confirmed case(s) of COVID-19.
- You may have been exposed to COVID-19 in a community setting or due to recent travel within 14 days.

Contact your medical provider to seek testing for COVID-19. Inform your medical provider you have developed symptoms, the conditions above that apply, and that you work in a sensitive occupation or setting. Emphasize the importance of COVID-19 testing to diagnose your illness; if testing is not available through your healthcare provider, call the COVID-Testing Phone Line 1-844-421-0804. If you test positive for COVID-19 and there are concerns for exposures in the workplace, Public Health will notify all impacted SOS departments

and settings of positive tests for County employees and workers and provide guidance on necessary response.

EMPLOYEE RESPONSIBILITIES

- Self-monitor at least daily for symptoms related to COVID-19. ‡For tracking purposes, note your health status and symptom(s), if observed, using the attached calendar resource tool.
- Remove yourself from work or stay at home if you develop symptoms.
- Promptly notify your supervisor of your illness if you leave work or stay home and inform them you are following precautions due to possible COVID-19.
- If instructed to do so, observe Public Health Instructions for Home Isolation and Quarantine.
- If you do not have a documented close contact with a COVID-19 positive individual, you do not need to quarantine but should continue to self-monitor for symptoms.
- Review and comply with these guidelines including symptom monitoring, resuming work, wearing face coverings, social distancing protocols and additional preventive measures.
- Notify your supervisor if you have any questions about these guidelines.

NEGATIVE COVID-19 TEST

If you test negative for COVID-19, you will still need to remain home and continue to monitor your symptoms. Follow the guidance of your doctor, which may be specific to your individual health needs. If you have symptoms (defined above), stay at home for at least 3 days (72 hours) after your general symptoms have resolved and 3 days after your fever has resolved, without the use of fever-reducing medication (antipyretics such as aspirin, Tylenol). This applies to all individuals, whether they work in a sensitive occupation or not. ‡Use attached calendar resource tool.

SYMPTOMS OF COVID-19 or POSITIVE COVID-19 TEST

If you test positive for COVID-19, you will need to stay at home until you are well; this is called home isolation. Follow instructions from your healthcare provider and Public Health.

Stay at home for at least 10 days after your symptoms such as fever, cough, body aches, and sore throat began and a full 3 days after all symptoms (including fever) have resolved. For example, if all of your symptoms resolve on day 5, you can resume work on day 10, if they resolve on day 9 resume work on day 12, etc. If you still have cough and fever, stay at home an additional 3 days (72 hours) after you are free of all symptoms including fever without the use of fever-reducing medication (antipyretics such as aspirin, Tylenol). ‡Use attached calendar resource tool.

CLOSE CONTACT/HOUSEHOLD MEMBERS (Exposed Asymptomatic)

If you have close contact with someone or a household member that has presumed symptoms or tested positive for COVID-19, you are considered an exposed, asymptomatic individual. You will most likely be instructed by your healthcare provider or Public Health to stay home (quarantine), even though you don't feel sick. There is a very real risk of transmission of the virus among household members. Inform your supervisor of a possible household exposure.

- Non-SOS employees should review the Decision Tree and follow the directions from their departmental personnel contact.
- SOS employees should stay home, out of the workplace. These employees will be instructed to quarantine themselves by their supervisor or under guidance developed by the Public Health Division.

Exposed employees should monitor for any signs of illness, including a temperature of 100.0°F or more. Note that most people develop symptoms between 2-8 days after exposure; many younger people will have mild to

moderate symptoms so may feel just fine. Quarantine is 14 days or 14 days after your household member no longer needs to be isolated, whichever is longer. ‡Use attached calendar resource tool.

Note that close contact is defined differently for healthcare occupations and settings: being within approximately 6 feet of a person with COVID-19 for a prolonged period of time (10 minutes or more) or having unprotected direct contact with infectious secretions or excretions of the patient or client.

CONTACT WITH SYMPTOMATIC PERSONS (Exposed Asymptomatic)

- If you have contact with a symptomatic individual, such as fever or cough, you are considered an exposed, asymptomatic individual. Monitor yourself for symptoms.
- Maintain social distancing in the community and at home. Keep social distance at work or work from home.
- If you develop symptoms or feel ill, stay home and maintain a very safe social distance from family members. Notify your supervisor you are out ill. ‡Use attached calendar resource tool.
- If you seek medical attention, call ahead for instructions and report your potential exposure to COVID-19.

RESUMING WORK

Deciding when you are well and can return to the workplace will depend on your symptoms and occupation. Work with your supervisor and departmental personnel contact to coordinate time off and how to resume work.

Non-SOS Employees

Whether you had mild symptoms, presumed COVID-19 symptoms, or a positive COVID-19 test, stay at home for at least 10 days after your symptoms such as cough, body aches, and sore throat began and a full 3 days after all symptoms (including fever) have resolved. For example, if all of your symptoms resolve on day 5, you can resume work on day 10, if they resolve on day 9 resume work on day 12, etc. If you still have cough and fever, stay at home an additional 3 days (72 hours) after you are free of all symptoms including fever without the use of fever-reducing medication (antipyretics such as aspirin, Tylenol).

SOS Employees

Employees that work in sensitive occupations or settings will need careful evaluation before they return to their work settings. The employee's healthcare provider, occupational medical provider, or Public Health will provide instructions and monitoring methods before resuming work is recommended. Once the employee is authorized to resume work, they may be instructed to follow special precautions such as:

- Prescreening employee's temperature and assessing symptoms prior to entering SOS facilities. (Note that some county facilities are implementing screening for all entrants.)
- Wear a face covering at all times while at work and until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer. (Note Contra Costa County has implemented a recommendation for a face covering in public.)
- Restrict contact with immunocompromised individuals until 14 days after illness onset.
- Follow hand hygiene, respiratory hygiene, cough etiquette procedures, and social distancing.
- Self-monitor for symptoms and seek medical re-evaluation if respiratory symptoms recur or worsen.

CLEANING AND DECONTAMINATION STEPS AND PROCEDURES

County buildings and operations are using enhanced cleaning and disinfection routines that include more frequent cleaning and special attention to "high-touch" surfaces such as door knobs, door push bars, public phones, etc. This enhanced cleaning is provided by various County custodial services units and other cleaning services provided through leased facility agreements. In addition, staff have access to disinfection and cleaning materials for cleaning around the office as needed.

In cases where further cleaning or decontamination may be needed after a primary exposure, defined as an employee with fever and cough at work, or an employee tested COVID-19 positive*, the following guidelines apply: ***Employee discloses result to the County or Public Health provides guidance to SOS work settings.*

For Areas Impacted by Ill Employees:

- Close off and do not enter areas used by ill employee and wait as long as practical before cleaning and disinfecting.
- Open outside doors and windows to increase air circulation to area.

For Cleaning:

- If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.
- For disinfection, use Products with Environmental Protection Agency approved emerging viral pathogens and follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time).
- For porous surfaces and examples of products suitable for cleaning them, see American Chemistry Council approved porous surface cleaning list.
- If the items can be laundered, launder items in accordance with the manufacturer's instructions using the warmest appropriate water setting for the items and then dry items completely. Do not shake dirty laundry.
- Clean and disinfect hampers or other carts transporting laundry.
- Cleaning staff should wear disposable gloves and gowns that are compatible with the disinfectant products being used for all tasks in the cleaning process, including handling trash. Additional PPE maybe required based on cleaning/disinfectant product. Follow the recommended PPE for the products to assess if need for further PPE.
- Cleaning staff should immediately wash hands after removal of gloves.

***If custodial staff are unable to clean site, request specialty cleaning services through Public Works Facilities Service Center (925) 313-7052.** Examples: Servepro, Service Masters, Clean Harbors, Crime Scene Cleaners.

- County-owned office and non-office buildings – contract specialty cleaning service.
- County-leased buildings – confer with property owner if cleaning staff have proper training, materials, and equipment, or is there a need to contract specialty cleaning service.
- Health Services – healthcare settings can use trained environmental services staff, if properly equipped and trained.
- Sheriff detention settings evaluate if detention services workers can conduct the cleaning with guidance, if properly equipped and trained or contract for specialty cleaning.
- Probation institution settings evaluate if institutional services workers can conduct the cleaning with guidance if properly equipped and trained or contract for specialty cleaning.

DECISION TREE ATTACHMENT

- See attached decision trees for Non-SOS and SOS settings.

CALENDAR TOOL ATTACHMENT

‡ See attached calendar tool for tracking symptoms and when to resume work

REFERENCES

Employee Exposures: Health Services Department, Public Health Communicable Disease Review May 14, 2020
Health Services Department, Vista Oaks Occupational Medicine Review May 14, 2020
CAO Mail Broadcast EMPLOYEE LEAVE UPDATE April 8th THROUGH May 31st April 6, 2020
Centers for Disease Control and Prevention
https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html
https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html
https://www.cdc.gov/coronavirus/2019-ncov/downloads/Factsheet-for-Patients-2019-nCoV.pdf
https://www.cdc.gov/coronavirus/2019-ncov/community/critical-workers/implementing-safety-practices.html
Equal Employment Opportunity Commission
https://www.eeoc.gov/facts/pandemic_flu.html

Decontamination Procedures:
Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html
EPA Approved Cleaning Materials (List N), https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2
American Chemistry Council recommendations for porous materials, https://www.americanchemistry.com/Novel-Coronavirus-Fighting-Products-List.pdf

RE-OPENING AND SOCIAL DISTANCING PROTOCOLS

As County departments bring staff back into the office and resume more normal business operations, they will need to establish Social Distancing Protocols specific to current working conditions, fixed locations, and field operations as outlined in this document. These documents use the template Appendix A – Social Distancing provided in the Health Order issued on April 29, 2020 and Cal/OSHA standards including Injury Illness Prevention Program (IIPP) and current guidelines for COVID-19 for site safety assessments. We recognize that each department's work site is different – space size, configuration, and building location.
The guidelines in this document are designed to provide the framework for departments to create specific protocols for staff to work safely. The specific protocols shall be maintained and updated as circumstances change. Protocols shall be communicated to all impacted staff through training and making them readily available. See and follow:

- The Social Distancing Protocol Attachment for a template that shall be customized and implemented for each work environment.
- The COVID-19 Assessment Checklist Attachment that shall be used to ensure the efficacy of Social Distancing programs.

SOCIAL DISTANCING PROTOCOLS

Social Distancing Protocols are required by the Health Orders. These strategies are designed to prevent close contact with others to reduce the spread of COVID-19. Every reasonable measure should be employed to maintain social distancing during County activities. These measures shall include steps such as:

- Maintaining a six-foot social distance at all times, except when required to complete essential business activities and wearing a face covering or respiratory protection.
- Requiring face coverings to be worn by persons entering County facilities.
- Prohibiting gatherings of any size, including for exercising, breaks or eating.
- Strictly controlling "choke points" and "high-risk areas" where workers or the public may be likely to congregate, queue, or are unable to maintain six-foot social distancing.
- Arranging facility furniture and workspaces to maintain six-foot distancing.
- Additional steps should be considered where feasible and based on business needs:
    - Converting facility fixtures to hands-free activators where feasible.
    - Alternate or staggered shifts, rotational remote work to reduce the number of employees working in proximity to one another.
    - Alternating break schedules as needed.
    - Changing work procedures to video, teleconferencing, and "no touch" methods where possible.
    - Assigning telecommuting to staff, where possible.

SAFETY AND JOB HAZARD ASSESSMENTS

Many work practices may need to be deferred, updated, and reviewed to ensure that they prevent worker exposures to COVID-19. Strategies to prevent these exposures are included in this guidance and will be documented in each department or facility's specific Social Distancing Protocols:

- Update departmental Injury and Illness Prevention Programs (IIPP) to reference this guidance document and specific social distancing protocols.
- Consult the County Injury and Illness Prevention Program for additional guidance.
- Review new and established job tasks for hazards and controls under COVID-19 conditions.
- Document new procedures for meetings, trainings, and other common job tasks.

- Train staff and contractors on new procedures and document it on a training roster. See COVID-19 Safety Training Tailgate Topic Attachment.
- Perform frequent assessments of workspaces and tasks to ensure Social Distancing Protocols and prevention strategies are functioning properly. See the COVID-19 Assessment Checklist Attachment.
- If there is reduced staffing in the office or the field, consider which procedures may need to be altered including changes to security measures, communication methods or emergency response procedures. Cross train and identify alternate contacts and emergency evacuation leaders to ensure coverage.
- For any accommodation requests or concerns, confer with Human Resources.

RESPONSIBILITIES

DEPARTMENTS

- Establish department-specific Social Distancing protocols, procedures, and updates safety programs in accordance with the guidance provided in this document. Departments may contact riskmsafety@riskm.cccounty for assistance creating Social Distancing protocols, procedures, and updating safety programs.
- Confer with Human Resources to address accommodation requests or concerns.
- Departments will want to provide information on the Employee Assistance Program.

RISK MANAGEMENT

- Collaborates with Public Health, Occupational Health, Human Resources, Labor Relations, and County Counsel to update these guidelines as conditions change and distribute to Department Heads and Safety Coordinators.
- Assists Departments with developing or reviewing updated job hazard analyses for tasks and procedures that require updates related to COVID-19 and Social Distancing requirements.
- Assists Departments with developing or reviewing site and task specific Social Distancing Protocols.
- Available for walkthroughs to conduct assessments of facility and work task Social Distancing Protocols.
- Conducts audits of facility and work task Social Distancing Protocols.

SUPERVISORS

- Share workplace safety protocols with staff.
- Communicate expectations with staff and ensure that staff and visitors are following prevention strategies of cough etiquette, good hand hygiene, social distancing, and wearing a face covering.
- Know and follow the Covid-19 Exposures in the Workplace document and procedures if employees report they are ill.
- Provide this document and the Covid-19 Exposures in the Workplace document to staff.
- Monitor prevention strategies for effectiveness and make corrections where needed.
- Allow staff the time to perform cleaning practices.
- Perform periodic assessments of the worksite and work practices to ensure compliance.
- Train staff on this guidance and department-specific protocols and document it on a training roster.
- Monitor the workspace for adequate disinfection supplies and re-stock before they are depleted.

EMPLOYEES

- Participate in screening procedures (where applicable) AND self-monitor for symptoms daily before going to work (‡ the calendar tool attachment is available to document self-monitoring).
- Follow prevention strategies of cough etiquette, good hand hygiene, social distancing, and wearing a face covering.
- Stay home if you don't feel well.

- If you develop symptoms, notify your supervisor that you are out ill and are following precautions due to possible COVID-19.
- Read and understand the COVID-19 Exposures and the Workplace document and procedures.
- Read and understand the workplace safety protocols for your assigned work location(s).
- Use disinfection materials frequently throughout the day on your assigned work surfaces, office equipment, tools and equipment; read Disinfection and Sanitation section for more information.
- Report the need to re-stock disinfection materials before they are depleted.
- Report safety concerns or suggestions to your supervisor.

SIGNAGE

Signage is an important tool to communicate safety information to employees and the public related to prevention methods, social distancing protocols, and more.

- Locations that are appropriate for posting signage include:
  - Public entrance(s)
  - Employee entrance(s)
  - Lobbies, reception desks
  - Meeting rooms, training rooms, conference rooms, interview rooms, offices
  - Hallways
  - Stairwells
  - Elevators and elevator lobbies
  - Restrooms
  - Sinks – handwashing reminders
- Standardized signs from Health Services, OSHA, or the CDC can be used throughout the County:
  - Exterior door signs have already been created and distributed to Safety Coordinators
  - Prevention protocols (don't touch face, cough etiquette, handwashing, social distancing, face covering)
  - Social Distancing Protocols
  - Self-monitoring for symptoms of COVID-19
  - Reminders to wear face coverings
  - How to wear, handle, and dispose of a face covering
  - Handwashing and sanitizing techniques
  - Glove hygiene
  - Elevator protocols

See Signage Attachment for thumbnails, hyperlinks, and instructions for printing, ordering or receiving electronic files.

SCREENING

Screening for symptoms of COVID-19 is an important prevention method that prevents sick individuals from entering or remaining in the workplace. Screening may be conducted in multiple ways:

- SOS facilities and staff such as healthcare, detention, and first responders use temperature and symptom screening prior to entrance to the workplace.
- In addition, these healthcare and detention facilities are conducting temperature and symptom screening for visitors prior to entry.
- In Non-SOS facilities, employees should self-monitor for symptoms daily before going to work. If symptoms are noted, employees should stay out of the workplace, seek medical attention, and notify their supervisor. ‡For tracking purposes, employees can note their health status and symptom(s), if any, using the attached calendar resource tool.
- At this time, do not temperature screen employees or visitors at locations other than those listed above.

ROOM OCCUPANCY LIMITS, CALCULATIONS, AND POSTING

Departments should establish room occupancy limits as an important method to provide proper six-foot social distancing. The room size and configuration will have to be assessed. on a case by case basis. Once evaluated for maximum safe occupancy, the limits should be posted on the room and communicated to all affected staff and visitors. See Attachment for Social Distancing Floor Plan Examples.

EMPLOYEE WORKSPACE CONFIGURATION

- Evaluate and post occupancy limits on offices and enclosed workspaces designed to maintain six-foot social distancing.
- For a separate, enclosed office with a design occupancy of one person is considered appropriate for social distancing. A separate, enclosed office designed to provide seating for 6 at a desk and task table may need to reduce the number of people in the room to allow social distancing, depending on the size and configuration of the room.
- For occupants of open floor plans and cubicles, face coverings are required:
  - Stagger or re-orient desks and work stations to give at least a six-foot distance between occupants.
  - Cubicles with or without walls of any height are considered open workspaces and require at least a six-foot distance between occupants wearing a face covering at all times.
- Encourage disinfection frequently throughout the day of work surfaces and office equipment.
- Implement disinfection procedures between users of shared work stations and equipment.
- Discourage employees from using other employees' phones, desks, offices, or work tools and equipment, when possible. If necessary, clean and disinfect them before and after each use.
- Follow the County Ergonomics Program and department-specific procedures for preventive measures, evaluations, training, and equipment ordering, tracking, and handling.

LOBBY, RECEPTION AND WAITING AREAS

- Post occupancy limits designed to maintain six-foot social distancing for public lobby, reception, and waiting areas.
- Place markings or other indicators where visitors may line up or accumulate that enforces social distancing.
- Remove or mark seating to maintain distancing.
- Ensure reception windows are opened in a manner that maintains social distancing; for example, every other window can serve clients if the arrangement maintains proper distancing.
- Screens, barriers, signage, and alternate communication methods (e.g. telephone, intercom) can be used to encourage proper distancing.
- Separate or disable computer kiosks to maintain distancing.
- Provide wastebaskets and tissues for cough hygiene.
- Provide hand sanitizing stations.

BREAK ROOMS, KITCHENETTES, AND KITCHENS

- Limit the number of staff that can occupy shared break and kitchen areas. Post reminders of the maximum occupancy of these rooms based on size and layout to allow six-foot social distancing.
- Post signage encouraging handwashing before and after preparing food.

- Shared water bottles or filtering water dispensers should be avoided. Filling glasses, mugs, and other reusable bottles, which may cause cross-contamination, is discouraged. If dispensers are used, prevent cross-contamination by avoiding contact with the spigot and disinfecting the controls after each use.
- Shared mugs, glasses, dishes, and utensils should be avoided.
- Shared appliances such as microwaves, refrigerators, toasters, vending machines, and "single serve pod" coffee machines should be disinfected before and after each use or at least daily.
- Disinfect tables, counters, and fixtures at least daily.
- Sharing of any food or beverage is strictly prohibited unless it is provided in single-serve sealed wrapper or container.
- Avoid use of shared towels and sponges; paper toweling can be used to wash/scrub dishes.
- Create schedules that allow employees set times to access break rooms for meal preparation and eating.
- Stagger table seating to maintain six-foot distancing. Where distancing can be maintained, employees may eat in the break room or kitchen without a face covering.
- Where it is not possible to maintain six-foot distancing, employees should adhere to break room schedules or eat in separate areas such as vacant offices, conference rooms, personal vehicles, or at their desks.

CONFERENCE ROOMS

- Refer to the room occupancy section above to calculate the maximum safe occupancy that maintains six-foot social distancing.
- Post occupancy limits designed to maintain six-foot social distancing.
- Remove or mark seating and tables to maintain six-foot social distancing.
- Disinfect the surfaces, computer and monitor equipment, and conference phones before and after each use.

ELEVATORS

- Where possible, limit elevator occupancy to provide six-foot social distancing.
- Post signage inside elevators at elevator lobbies and landings with these guidelines.
- For example, elevators that normally have enough space to accommodate 10 people would need to be evaluated and limited so that the occupants can maintain distance between themselves as much as possible by each standing in a corner.
- Occupants should avoid reaching across each other to activate buttons; it is ideal for the individual closest to the controls to operate them for all occupants.
- Employees and visitors are encouraged to use touchless means of activating buttons such as using a tissue or paper toweling.

HALLWAYS, AISLEWAYS AND STAIRWELLS

Evaluate walkways for foot traffic patterns to reduce areas that create chokepoints:

- Encourage employees not to stop and congregate in the hallways.
- When encountering another person in a hall or aisle, stop and allow them to briefly pass by.
- Some hallways or aisleways may be converted to one-way traffic (train staff and post signage).

FIELD WORK

- Determine if field work is necessary or if it can be postponed or achieved by other means such as video or teleconferencing.

- For home visits that can't be avoided or conducted virtually, contact Risk Management for a review of procedures and requirements prior to commencing this work.
- Conduct a job hazard assessment and document procedures for COVID-19 conditions.
- Ensure that personal protective equipment (PPE), face covering or N95 without a valve, disinfectants, and hand hygiene measures are considered and supplied in a field "go kit."

MEETING GUIDELINES

- The County is currently not supporting congregate meetings or trainings; continue to do this work virtually during Stage 2 of the pandemic response.
- Limit meetings to only those required for essential work, compliance, or other mandatory reasons if they can be conducted in a manner that maintains social distancing.
- Consider using video or teleconferencing when possible for work-related meetings and gatherings.
- Consider canceling, adjusting, or postponing large work-related meetings or gatherings that can only occur in-person.
- When video or teleconferencing is not possible, hold meetings in open, well-ventilated spaces.
- Ensure a six-foot distance is maintained when entering and exiting the meeting room.
- The person responsible for organizing the meeting should take care to disinfect any work surfaces before and after use.

TRAINING GUIDELINES

- The County is currently not supporting congregate meetings or trainings; continue to do this work virtually during Stage 2 of the pandemic response.
- Limit trainings to only those required for essential work, compliance, or other mandatory reasons if they can be conducted in a manner that maintains social distancing.
- Evaluate each training delivery and document procedures for social distancing and disinfection of any hands-on materials.
- Communicate the new procedures to students, host department, and instructor(s).

VEHICLE TRANSPORT PROCEDURES

- When drivers are alone in a vehicle, they do not need to wear a face covering.
- Drivers should avoid carpooling with coworkers unless they are in the same household.
- When transporting a suspect or confirmed COVID-19 case or other aerosol transmissible diseases, follow vehicle transport procedures prescribed under department aerosol transmissible disease programs (Cal/OSHA 8 CCR 5199 (c)(5)(C)) including the following general steps:
  - Place the passenger in the back seat.
  - Have the passenger wear a face covering or mask.
  - The County driver wearing an N95 without a valve that they are authorized to use (see Respiratory Protection Section).
  - The vehicle air conditioning controls should be set to normal air flow and fresh outside air, not re-circulate.
  - Windows can be open partly or completely.
- Pool vehicles shared between users, single occupancy drivers:
  - Drivers should wear a face covering that does impair driving while using a pool vehicle.
  - Pool vehicles should be disinfected and ventilated before and after each use; maintaining ventilation while using is encouraged by using the air conditioner on the fresh air setting or keeping windows open.

BREAKTIME EXERCISES

- Breaktime exercises such as walking should be conducted in a manner that maintains six-foot distancing unless the walkers are from the same household.
- Walking pathways should be wide enough that allows proper distancing or walkers should space themselves appropriately.
- Face coverings are not required during outdoor exercise.
- Face coverings are required for indoor exercises while social distance is maintained.
- Exercise equipment should not be shared.
- Alternatives include:
  - Creating and communicating a one-way path of walking around a facility.
  - Discouraging groups of walkers.
  - Staggering and scheduling breaks to prevent a large number of employees from trying to use the same exercise area at the same time.
- An example at 2530 Arnold Drive, Martinez - walking around the edges of the parking lot away from traffic provides more maneuverability and distancing versus walking around the building and the narrow pathway located behind it.

CONTRACTOR AND VENDOR GUIDANCE

- Contractors and vendors that enter County facilities will follow face covering and Social Distancing Protocols.
- Where applicable, ask for contractor/vendor COVID protocols for review prior to starting work.
- Where applicable, provide contractors and vendors with County facility protocols and ask contractors to follow them unless their protocol is more stringent.
- Keep copies of any shared protocols at each job site.

SAFETY CONCERNS

Employees with safety concerns related to these procedures, availability of disinfection and cleaning supplies, and updated job tasks should communicate directly with their supervisor, manager, or safety coordinator. Safety concerns can also be directed to Risk Management Safety and Loss Control via email at RiskMSafety@riskm.cccounty.us.

DISINFECTION AND SANITATION

Departments should confirm cleaning schedules and supplies to maintain the cleanliness of the workspace are stocked and available. This includes:

- Confirming cleaning and disinfection schedules with Public Works Custodial Services, or for leased buildings, the assigned custodial support.
- Clean and sanitize breakrooms, handwashing facilities, and restroom areas daily with disinfectants effective against COVID-19.
- All high touch areas, including entry and exit areas, high traffic areas, elevator buttons, etc. are cleaned frequently and at least daily.
- Using a tissue or paper toweling to touch shared buttons, dispensers, switches, etc. can prevent cross-contamination.
- Handwashing facilities, soap, and paper toweling are available to all staff.
- Hand sanitizer is available to staff and visitors.
- Disinfection materials such as cleaners and wipes are provided throughout the workplace.

- Staff should be encouraged to use disinfection materials frequently throughout the day on their work surfaces, office equipment, and shared equipment.
- Time is built into tasks and the workday to perform cleaning practices.
- Hand sanitizers that can be wall mounted or placed on a stand can be requested by completing a Corrigo work order to Public Works.
- If unavailable through normal purchasing routes, hand sanitizers, sanitizing wipes, and cleaning materials can be requested by emailing eoc.logistics@cccoes.us.

GLOVE GUIDANCE

Gloves are not a substitute for hand hygiene. Gloves pose a cross-contamination risk when worn improperly for long durations or between work areas. Gloves should be reserved for direct patient care, food preparation, or when using chemicals that could harm the skin.

Hand hygiene should be adhered to with proper handwashing or use of sanitizing gel:

- Frequently and throughout the day.
- After using the restroom.
- Before and after eating.
- Before putting gloves on.
- After removing soiled gloves.
- Before and after handling a soiled respirator.
- After putting on and performing a user seal check on a used N95.
- Carefully remove gloves using proper technique to prevent hand contamination.

BUSINESS TRAVEL CONSIDERATIONS

- Carefully consider whether business travel is necessary.
- If necessary travel is within the United States, review CDC Coronavirus and Travel in the US Guidance.
- If necessary travel is outside the United States, review CDC Traveler's Health Notice for the latest guidance and recommendations.

REFERENCES

Health Services Department, Public Health Communicable Disease Review May 7, 2020
Health Services Department, Vista Oaks Occupational Medicine Review May 7, 2020
Contra Costa County Health Services Health Orders https://www.coronavirus.cchealth.org/
Contra Costa County Health Services Appendix A Social Distancing Protocol (Updated April 29, 2020)
Risk Management Intranet Site COVID-19 Resources
Centers for Disease Control and Prevention
https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-business-response.html
World Health Organization
https://www.who.int/docs/default-source/coronaviruse/getting-workplace-ready-for-covid-19.pdf
Cal/OSHA https://www.dir.ca.gov/dosh/coronavirus/Health-Care-General-Industry.html
State of California
https://covid19.ca.gov/roadmap/#guidance
https://covid19.ca.gov/pdf/checklist-office-workspaces.pdf

FACE COVERINGS, SURGICAL MASKS, N95 RESPIRATORY PROTECTION

This document describes cloth face covering, surgical mask, and N95 respirator use to control exposures during COVID-19 conditions, the general job tasks or conditions where they are recommended or required, and the steps needed to ensure that county users are safe and compliant while wearing them. It is important to understand the differences between a cloth face covering, surgical mask, and N95 respirator:

- A cloth face covering is designed and effective to protect others from a sick or asymptomatic user.
- A surgical mask is a loose-fitting face covering that protects others from a sick or asymptomatic user.
- An N95 respirator is designed and effective to protect the user from others. An N95 is required for contact with any presumed or known positive COVID-19 case with an active infection or within the latency period.

This document does **not** cover the use of respiratory protection in the hospital, health centers, alternate care facilities, public health division, or detention medical units which follow separate respiratory protection programs, nor does it cover respiratory protection for air contaminants other than COVID-19.

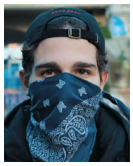
DEFINITIONS

Face Covering means a covering made of cloth, fabric, or other soft or permeable material, without holes or exhalation valves, that covers only the nose and mouth and surrounding areas of the lower face. See the CDC face covering guidelines.

- A face covering may be factory-made or handmade and improvised from ordinary household materials.
- A covering that hides or obscures the wearer's eyes or forehead is not considered an appropriate face covering.
- Examples of acceptable cloth face coverings include a scarf or bandana; a neck gaiter; a homemade covering made from a t-shirt, sweatshirt, or towel, held on with rubber bands or otherwise; or a mask, which need not be medical-grade.







Surgical mask describes a loose-fitting face covering made of non-woven material that is intended to be worn by health professionals to prevent large droplets and sprays from entering the user's mouth and respiratory tract and to protect others from the user's exhaled breath that may contain liquid droplets and aerosols. Surgical masks may also be provided to sick individuals to protect others from their exhaled breath, coughs, and sneezes that may contain disease particles. Surgical masks are not designed to protect the wearer from inhaling disease particles.

N95 respirator describes a tight-fitting, filtering facepiece that can be worn over the face to protect the user by removing 95% of particles that are 0.3 microns and greater in size. An N95 should be approved by the National Institute of Occupational Safety and Health (NIOSH) or a similar certifying international agency. The filtration material on the mask is a non-woven polypropylene fiber and may include additional layers. Some N95 respirators have an exhalation valve which reduces the resistance to exhalation; these valves are not filtered so others are not protected from the user's exhalation, making them unsuitable as a face covering. Examples:



X Note – N95's with valves should not be worn around others as they do not act as a protective face covering.

FACE COVERING USER GUIDE

FACE COVERING REQUIRMENTS

A surgical mask or cloth face covering is required when:

- Inside of, or in line to enter, any essential business or facility engaging in minimum basic operations.
- Engaged in work to provide essential government functions.
- Interacting in person with any member of the public.
- Working in any space visited by members of the public, such as reception areas, service counters, public restrooms, cashier and checkout areas, waiting rooms, service areas, and other spaces used to interact with the public, regardless of whether anyone from the public is present at the time.
- Working in any space where food is prepared or packaged for sale or distribution to others.
- Working in or walking through common areas such as hallways, stairways, elevators, and parking facilities.
- While occupying any room or enclosed area when other people (except for members of the person's own household or residence) are present.
- Entering public access areas of medical facilities and clinics.
- Experiencing flu-like, COVID-19, or other respiratory symptoms (sick employees are encouraged to stay home).
- When operating, waiting for, or riding public transportation, paratransit, taxi, private car service or ride sharing vehicle.

FACE COVERINGS NOT REQUIRED

A face covering is not required to be worn when:

- A person is in a personal office; best practice is to keep the door closed if the face covering is off.
- When a person is alone in a private, single room.
- While driving alone in a vehicle.
- Only those members of a person's household are present.
- While engaged in outdoor recreation such as walking, hiking, bicycling, or running, providing six-foot social distancing is maintained.
- A medical professional has advised that wearing as face covering may pose a risk to the person wearing the mask for health-related reasons.
- Wearing a face covering would create a risk to the person related to their work as determined by local, state, or federal regulators or workplace safety guidelines.
- An individual has trouble breathing or is unconscious, incapacitated, or otherwise unable to remove the face covering without assistance.

FACE COVERING GUIDANCE

The majority of face coverings required for county workplaces are not surgical masks or N95 respirators, which are critical supplies that must continue to be reserved for healthcare workers and other medical first responders,

as recommended by current CDC guidance.

Face coverings are required to be used ***in addition to*** practicing social distancing and maintaining cough and hand hygiene, which are proven methods against spreading the virus. Face coverings are ***not*** intended to substitute for PPE required for job tasks.

Face coverings should:

- Fit snugly but comfortably against the side of the face.
- Be secured with ties or ear loops.
- Include multiple layers of fabric.
- Allow for breathing without restriction.
- Be able to be laundered and machine dried without damage or change to shape.
- Be kept clean and sanitary, laundering and machine drying between uses as recommended.

FACE COVERING CARE

When putting on, wearing, and removing face coverings, users should:

- Wash their hands before applying the face covering securely.
- Avoid touching the face covering while wearing.
- Remove the face covering by touching only the straps of the face covering.
- Not touch their eyes, nose, or mouth when removing the face covering.
- Immediately after removing the face covering, place it in a temporary storage container (paper sack, plastic container, etc.).
- Wash hands immediately after removing the face covering.
- Launder and machine dry the face covering daily.
- Avoid cross-contamination between the face covering and other surfaces or individuals.

RESPIRATORY PROTECTION PROGRAMS AND N95 USE

The goal of a respiratory protection program (RPP) is to prevent employee exposures to harmful airborne contaminants such as dusts, chemicals, and aerosolized droplets that can cause disease. Preferred control methods are provided in a hierarchy where engineering methods (e.g., ventilation and fume hoods) or administrative methods (e.g., eliminating or restricting access to work areas, risks, and exposures) are the highest priorities. Respiratory protection and other PPE are the last controls used when all other preferred methods have been evaluated and implemented.

There are several types of respiratory protection programs in the County. Contact your Supervisor for more information:

- During normal county operations, many county departments already have and use a written respiratory protection program describing authorized respirator user groups, respirator types and styles, and specific job tasks that require respiratory protection.
- The Contra Costa County Respiratory Protection Program covers general requirements and procedures for the use of respiratory protection throughout the county and is available on the Risk Management intranet site.
- More recently, as a response to the rapidly changing COVID-19 environment, several departments have implemented brand new respiratory protection programs or specific addendums to their existing programs to describe the most current procedures to control exposures.

Mandatory respirator use describes when an employee must be protected from a potential airborne exposure based on monitoring data, exposure calculations, safety data sheet requirements, best practice, etc. These users must fulfill all required elements of the written respiratory protection program.

Voluntary respirator use describes when an employee is not required to wear a respirator, but they are allowed or even encouraged to use one if desired and they sign a voluntary use form that describes safe respirator use.

Risk Management is available to consult with departments on the program requirements and can assist with documenting current COVID-19 and normal county procedures for respiratory protection. Send requests to riskmsafety@riskm.cccounty.us or call (925) 335-1400.

REQUIRED ELEMENTS OF A RESPIRATORY PROTECTION PROGRAM

- A written document describing responsibilities, job tasks and classifications, authorized respirator users, implementation steps, and recordkeeping procedures.
- Each authorized user assigned mandatory respirator use must complete:
  - ✓ An annual medical evaluation.
  - ✓ Annual training on respiratory protection.
  - ✓ An annual fit test on each make and model of respirator that will be used.

RESPIRATORY PROTECTION REQUIRED

Complete medical evaluation, training, and fit testing to wear an N95 respirator if you are assigned tasks such as:

- Working in close contact with another individual, defined as within 6 feet for longer than 10 minutes.
- Transporting individuals in a vehicle for county business.
- Entering alternate care facilities (follow verbal or posted directions on all required PPE and precautions).
- Entering medical treatment areas for known or presumed positive COVID-19 cases.

RESPIRATORY PROTECTION RECOMMENDED

While N95 respirators should be conserved for healthcare workers, some departments may provide them to employees for use on a voluntary basis. If provided to you by your department, wear an N95 respirator on a voluntary basis and sign the Voluntary Use Form if you are assigned tasks such as:

- Conducting routine activities while maintaining social distance of at least 6 feet.
- Brief contact with another individual, less than 10 minutes.
- Entering public access areas of medical facilities and clinics.

RESPIRATORY PROTECTION TRAINING

Respiratory protection training is required for all N95 mandatory users and can be provided by these methods:

- Target Solutions online class CCC Respiratory Protection (self-assign available).
- Classroom Respiratory Protection Training (general or custom class can be provided by Risk Management).
- Tailgate safety training topic Respiratory Protection (request from Risk Management).

N95 STORAGE AND EXTENDED/RE-USE PROCEDURES

The following methods for putting on, taking off, and storing an N95 respirator for re-use and extended use during COVID-19 operations is listed below:

Filtering Facepiece N95 Respirator Guidelines for Re-use During COVID-19 Operations	
CDC guidelines for extending the use of N95 respirators during COVID-19 response https://www.cdc.gov/coronavirus/2019-ncov/hcp/healthcare-supply-ppe.html and https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html CDC guidelines for proper methods to put on and take off an N95 respirator: https://www.cdc.gov/niosh/docs/2010-133/pdfs/2010-133.pdf	
Putting on	• Use a pair of clean gloves when putting on a new or used N95 respirator and performing a user seal check. • Discard the gloves after putting on a used N95 respirator and any adjustments are made to ensure the respirator is sitting comfortably on your face with a good seal.
Usage Times	The following conditions for N95 use, reuse, storage, and disposal can be followed: • Recommend using an N95 no longer than 8 hours of use • Dispose of respirator sooner than 8 hours of use if: o It becomes damaged or malfunctions o If breathing through the respirator becomes restricted or difficult o It becomes contaminated with blood or bodily fluid o There are more than 5 uses/re-uses o It is used with a presumed or confirmed positive COVID-19 client o It is exposed to an aerosol generating procedure (policy is for Behavioral Health staff NOT to be present during this type of medical procedure)
Taking Off for Re-Use	• In between uses, keep N95s in a clean, breathable container such as a paper bag that is labeled with the employee's name. • Perform proper hand hygiene with sanitizer or soap and water (or put on clean gloves if supply is available) BEFORE touching the N95 to remove it and place it in the storage bag. • Use the straps to remove the respirator. Avoid touching the outside OR inside of the respirator. If inadvertent contact is made with the inside of the respirator, discard the respirator and perform hand hygiene as described above. • Perform hand hygiene AFTER placing the N95 in the storage bag and closing it. • Dispose of storage bag after 5 uses/re-uses.
Taking Off for Disposal	• Perform hand hygiene (or put on clean gloves) BEFORE touching the N95 to remove it or handle. • Avoid touching the outside of the respirator during disposal and only touch the elastic straps. • Lean over the trash receptacle, remove the elastic straps and let the N95 drop into the trash. • Perform hand hygiene AFTER removing and disposing of the N95.
Strategies to Prolong N95 Use	• Wearing barriers such as face shields to prevent droplet spray contamination can prolong the N95 usage time, although this equipment is not readily available at this time.
Reminders for N95 Users	• Always perform a physical inspection and user seal check when putting on and taking off the N95. • Minimize unnecessary contact with the respirator surface at all times. • Maintain strict adherence to hand hygiene practices. • Remember to keep your hands away from your eyes, face, and mouth. • Use proper technique when putting on and taking off PPE.

REFERENCES

Health Services Department, Public Health Communicable Disease Review April 21, 2020
Health Services Department, Vista Oaks Occupational Medicine Review April 21, 2020
Contra Costa County Respiratory Protection Program http://insidecontracosta.org/485/Respiratory-Protection-Program
Contra Costa County Health Services Health Orders https://www.coronavirus.cchealth.org/
Centers for Disease Control and Prevention

https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover.html
https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/diy-cloth-face-coverings.html
https://www.cdc.gov/niosh/npptl/respirators/testing/NonNIOSH.html

National Institute of Occupational Safety and Health (NIOSH)
https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/n95list1.html

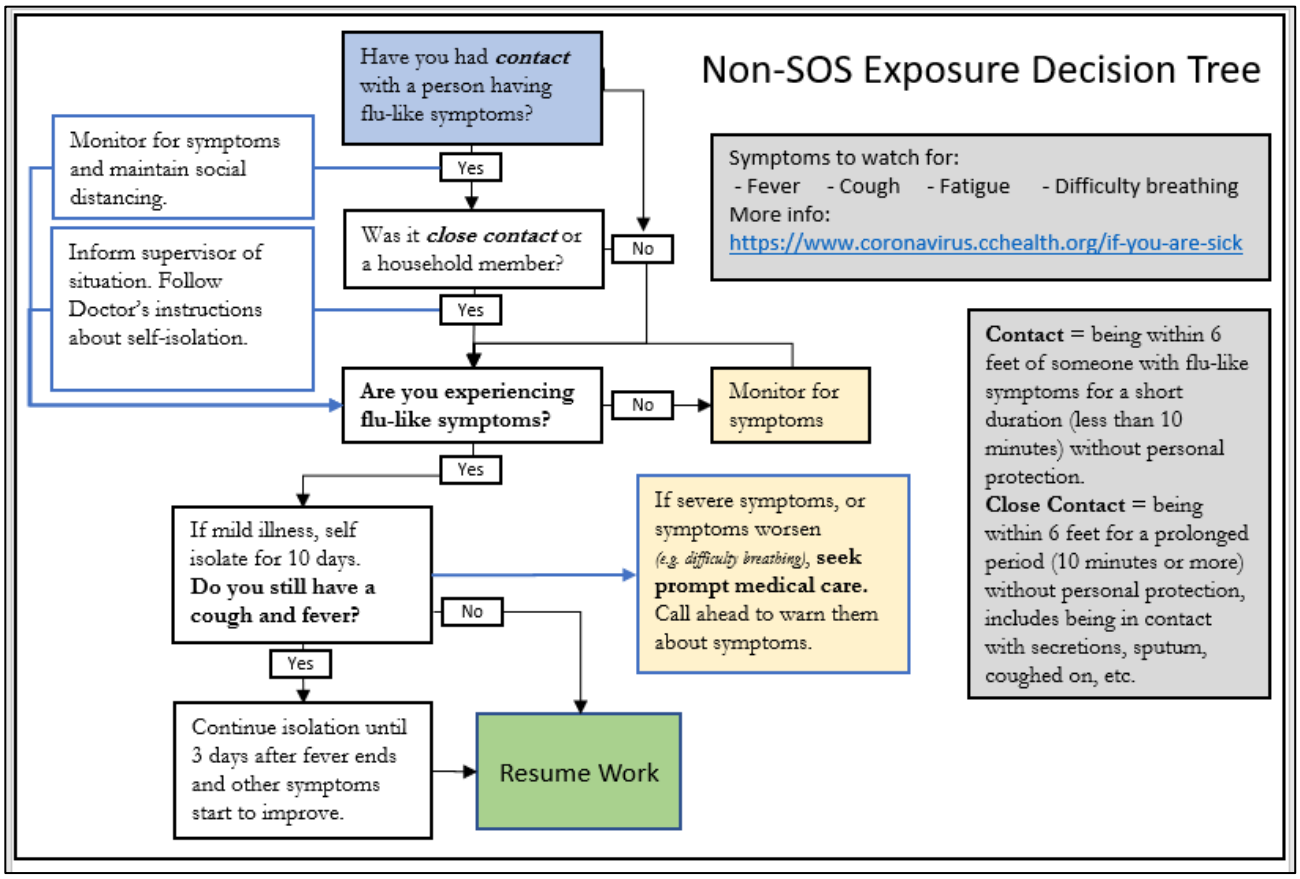
DOCUMENT REVISION HISTORY

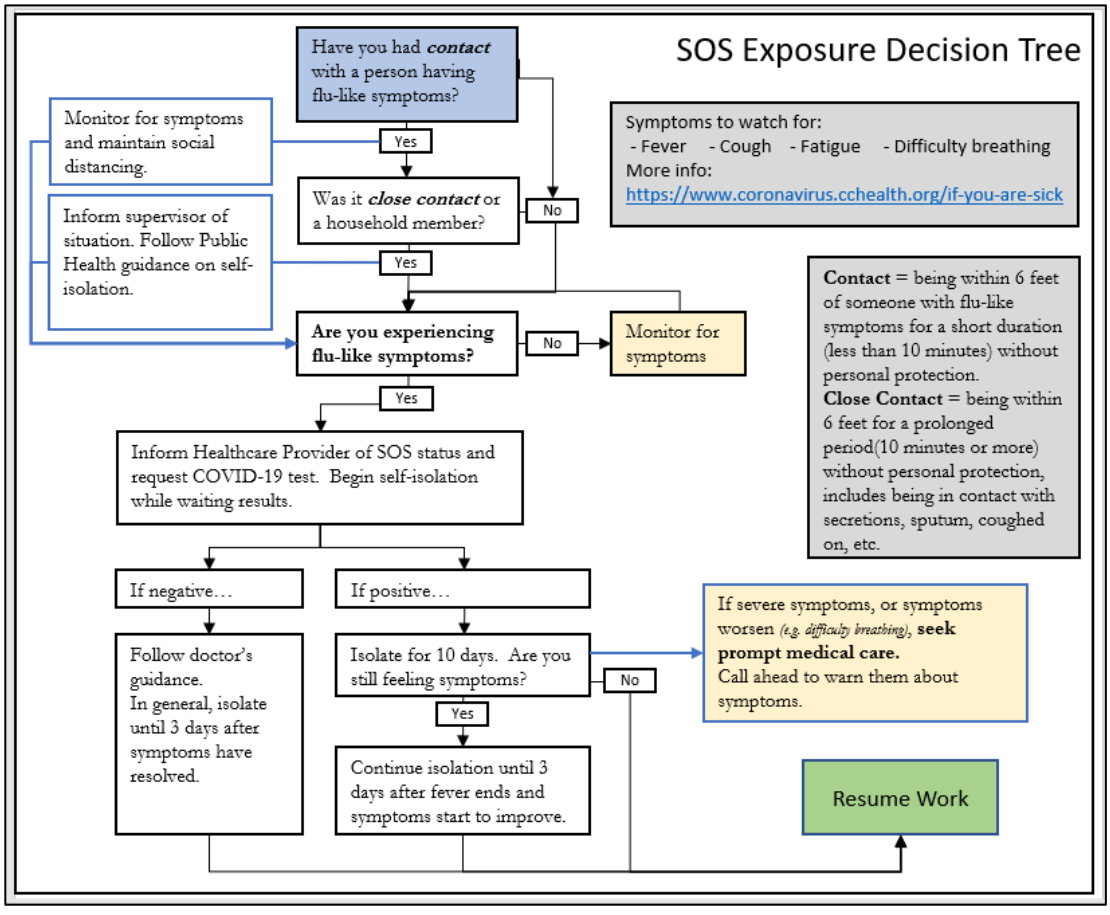
DATE	CHANGES
April 9, 2020	• Added definition of Critical Infrastructure services and workers • Added definition of Screening • Added Department Supervisor Guidance section • Added examples of face covering and screening activities in use at the county • Added CDC Interim Guidance for Critical Worker Safety Practices • Added CDC Essential Worker Do's and Don'ts link • Added reference to CAO Employee Leave Update dated April 6, 2020
April 20, 2020	• Added Table of Contents • Added asymptomatic definition • Updated decision tree to include special precautions when resuming work in an SOS setting • Added face covering, surgical mask, and N95 respirator information • General formatting review and update
May 7, 2020	• Symptoms - Updated symptoms according to CDC guidelines on May 7, 2020 • Employees in Non-SOS Settings and Employees in SOS Settings - Added the contact phone number for community COVID-19 testing appointments • Department Supervisor Guidance of the Exposures and the Workplace section - Added a script for communicating identified illness in the workplace to employees that did not have close contact • Exposures and the Workplace section - Added employee responsibilities • Added new section addressing Re-opening and Social Distancing Protocols • Updated document and flow chart to address new CDC guidelines to stay home at least 10 days after symptoms begin (aligns with May 14, 2020 Health Order) • Updated the Calendar Resource Tool to include instructions on recording temperature and self-monitoring • Added Facility-specific Social Distancing Protocol template attachment • Added example standardized signage attachment

May 15, 2020	• Created and added links to the Risk Management intranet quick link page for COVID-19 Resources
	• Added a cover page
	• Re-opening and Social Distancing Protocols:
	  ○ Aligned language with Cal/OSHA guidance and office checklist
	  ○ Added COVID-19 Assessment Checklist as an attachment
	  ○ Consolidated responsibility section
	  ○ Added Department and Risk Management responsibilities

	○ Added training, documentation, cleaning materials and time, and assessment language to Supervisor Responsibilities ○ Added participating in screening, self-monitoring, and reporting the need to restock cleaning materials to Employee Responsibilities ○ Added attachment for Social Distancing Floor Plan Example ○ Clarified the vehicle transport procedures • Training Attachment – Added safety training attachment • Signage Attachment - Added Elevator Occupancy Poster example, Room Occupancy Poster, Water Dispenser Hygiene Poster

DECISION TREE ATTACHMENT





CALENDAR RESOURCE TOOL ATTACHMENT

Calendar Resource Tool for COVID-19						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Day ___	Day ___	Day ___	Day ___	Day ___	Day ___	Day ___
Day ___	Day ___	Day ___	Day ___	Day ___	Day ___	Day ___
Day ___	Day ___	Day ___	Day ___	Day ___	Day ___	Day ___
Day ___	Day ___	Day ___	Day ___	Day ___	Day ___	Day ___
Day ___	Day ___	Day ___	Day ___	Day ___	Day ___	Day ___
This calendar resource tool can be used to monitor your health, record daily temperature monitoring*, track your contact with symptomatic individuals, self-isolation times, and symptoms by date of onset and resolution to help you determine your health status and when it is appropriate to resume work. * When using this tool as a daily temperature record, note the time the reading was taken and the device used _____						

Alternate Example:

Onset of symptoms: _____
Date

Date general symptoms have resolved:

_____ + 3 days = _____ is the date you can resume work, unless you have a fever.
Date Date

Date fever resolved* _____ + 3 days = _____ is the date you can resume work.
Date Date

*free of all symptoms including fever without the use of fever-reducing medication (antipyretics such as aspirin, Tylenol)

SOCIAL DISTANCING PROTOCOL TEMPLATE

This section contains the following resource examples for County Departments to create living documents of their social distancing protocols for communication and training purposes:

- County Health Order Appendix A – Social Distancing Protocol
- Department Template for Social Distancing Protocol – attached as an example .pdf file in this document, but available in soft copy to all Department Heads and Safety Coordinators or by sending an email to riskmsafety@riskm.cccounty.us.

RISK MANAGEMENT
SAFETY AND
LOSS CONTROL

Social Distancing Protocol

Contra Costa County
<Department Name>

<ADDRESS>

<DATE>

Policy

The purpose of this document is to establish social distancing protocols specific to the <Department Name> to ensure staff and visitor safety in COVID-19 conditions.

References

Contra Costa County COVID-19 Exposures and the Workplace Guidelines

<Department Name> Social Distancing Protocol

Responsibilities

Safety Coordinator or Site Supervisor

- Draft and maintain this protocol and make it available to all affected staff.
- Review and update this protocol as conditions and guidelines change.

First Line Supervisors

- Read and understand their responsibilities under the County Exposures and the Workplace Guidelines and this protocol.

Employees

- Read and understand their responsibilities under the County Exposures and the Workplace Guidelines and this protocol.
- Communicate safety concerns and suggestions related to this program to their supervisor.

Social Distancing Protocol

The social distancing protocol for the <Department Name> is included as Attachment 1.

Protocols in addition to those listed in Attachment 1 include:

<list additional protocols>

Training and Communication

The County Exposure in the Workplace guidelines and <Department> Social Distancing Protocols should be made available to staff and contractors to ensure understanding and compliance.

Recordkeeping

Records of the following will be maintained in the Department Safety Files:

- Each reviewed version of this protocol
- Written work procedures and job hazard assessments created for COVID-19 conditions
- Inspections and observations related to this protocol
- Staff training records on this protocol

Program Evaluation

The Safety Coordinator will periodically evaluate the effectiveness of this protocol through inspection, observations, and review of current guidelines.

DATE	REVIEWED BY	SUMMARY OF CHANGES

Attachment 1: <Department> Social Distancing Protocol

Appendix A: Social Distancing Protocol

Business name: Click or tap here to enter text.

Facility Address: Click or tap here to enter text.

Approximate gross square footage of space open to the public: Click or tap here to enter text.

Businesses must implement all applicable measures listed below, and be prepared to explain why any measure that is not implemented is inapplicable to the business.

Signage:

☐Signage at each public entrance of the facility to inform all employees and customers that they should: avoid entering the facility if they have a cough or fever; maintain a minimum six-foot distance from one another; sneeze and cough into a cloth or tissue or, if not available, into one's elbow; and not shake hands or engage in any unnecessary physical contact.

☐Signage posting a copy of the Social Distancing Protocol at each public entrance to the facility.

Measures To Protect Employee Health (check all that apply to the facility):

☐ Everyone who can carry out their work duties from home has been directed to do so.

☐ All employees have been told not to come to work if sick.

☐ Symptom checks are being conducted before employees may enter the work space.

☐ All desks or individual work stations are separated by at least six feet.

☐ Break rooms, bathrooms, and other common areas are being disinfected frequently, on the following schedule:

- ☐ Break rooms:
- ☐ Bathrooms:
- ☐ Other (Click or tap here to enter text.): Click or tap here to enter text.

☐ Disinfectant and related supplies are available to all employees at the following location(s): Click or tap here to enter text.

☐ Hand sanitizer effective against COVID-19 is available to all employees at the following location(s): Click or tap here to enter text.

☐ Soap and water are available to all employees at the following location(s): Click or tap here to enter text.

☐ Copies of this Protocol have been distributed to all employees.

☐ Optional—Describe other measures: Click or tap here to enter text.

Measures To Prevent Crowds From Gathering (check all that apply to the facility):

☐ Limit the number of customers in the store at any one time to Click or tap here to enter text.[insert maximum number here], which allows for customers and employees to easily maintain at least six-foot distance from one another at all practicable times.

☐ Post an employee at the door to ensure that the maximum number of customers in the facility set forth above is not exceeded.

☐ Placing per-person limits on goods that are selling out quickly to reduce crowds and lines. Explain: Click or tap here to enter text.

☐ Optional—Describe other measures: Click or tap here to enter text.

Measures To Keep People At Least Six Feet Apart (check all that apply to the facility)

☐ Placing signs outside the store reminding people to be at least six feet apart, including when in line.

☐ Placing tape or other markings at least six feet apart in customer line areas inside the store and on sidewalks at public entrances with signs directing customers to use the markings to maintain distance.

☐ Separate order areas from delivery areas to prevent customers from gathering.

☐ All employees have been instructed to maintain at least six feet distance from customers and from each other, except employees may momentarily come closer when necessary to accept payment, deliver goods or services, or as otherwise necessary.

☐ Optional—Describe other measures: Click or tap here to enter text.

Measures To Prevent Unnecessary Contact (check all that apply to the facility):

☐ Preventing people from self-serving any items that are food-related.

☐ Lids for cups and food-bar type items are provided by staff; not to customers to grab.

☐ Bulk-item food bins are not available for customer self-service use.

☐ Not permitting customers to bring their own bags, mugs, or other reusable items from home.

☐ Providing for contactless payment systems or, if not feasible, sanitizing payment systems regularly. Describe: Click or tap here to enter text.

☐ Optional—Describe other measures (e.g. providing senior-only hours): Click or tap here to enter text.

Measures To Increase Sanitization (check all that apply to the facility):

☐ Disinfecting wipes that are effective against COVID-19 are available near shopping carts and shopping baskets.

☐ Employee(s) assigned to disinfect carts and baskets regularly.

☐ Hand sanitizer, soap and water, or effective disinfectant is available to the public at or near the entrance of the facility, at checkout counters, and anywhere else inside the store or immediately outside where people have direct interactions.

☐ Disinfecting all payment portals, pens, and styluses after each use.

☐ Disinfecting all high-contact surfaces frequently.

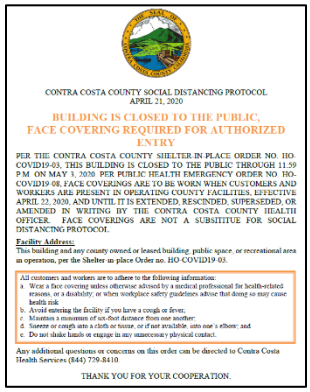
☐ Optional—Describe other measures: Click or tap here to enter text.

* Any additional measures not included here should be listed on separate pages, which the business should attach to this document.

You may contact the following person with any questions or comments about this protocol:

Name: Click or tap here to enter text. **Phone number:** Click or tap here to enter text.

SIGNAGE ATTACHMENT



CONTRA COSTA COUNTY SOCIAL DISTANCING PROTOCOL
APRIL 21, 2020

BUILDING IS CLOSED TO THE PUBLIC, FACE COVERING REQUIRED FOR AUTHORIZED ENTRY

PER THE CONTRA COSTA COUNTY SHELTER-IN-PLACE ORDER NO. HO-COVID19-03, THIS BUILDING IS CLOSED TO THE PUBLIC THROUGH 11:59 P.M. ON MAY 3, 2020. PER PUBLIC HEALTH EMERGENCY ORDER NO. HO-COVID19-08, FACE COVERINGS ARE TO BE WORN WHEN CUSTOMERS AND WORKERS ARE PRESENT IN OPERATING COUNTY FACILITIES, EFFECTIVE APRIL 22, 2020, AND UNTIL IT IS EXTENDED, RESCINDED, SUPERSEDED, OR AMENDED IN WRITING BY CONTRA COSTA COUNTY HEALTH OFFICER. FACE COVERINGS ARE NOT A SUBSITITUE FOR SOCIAL DISTANCING PROTOCOL.

Facility Address:
This building and any county owned or leased building, public space, or recreational area in operation, per the Shelter in place Order no. HO-COVID19-03.

All customers and workers are to adhere to the following information:
a. Wear a face covering unless otherwise advised by a medical professional for health-related reasons, or a disability; or when workplace safety guidelines advise that doing so may cause health risk
b. Avoid entering the facility if you have a cough or fever.
c. Maintain a minimum of six-foot distance from one another.
d. Sneeze or cough into a cloth or tissue, or if not available, into one's elbow; and
e. Do not shake hands or engage in any unnecessary physical contact.

Any additional questions or concerns on this order can be directed to Contra Costa Health Services (844) 779-8410

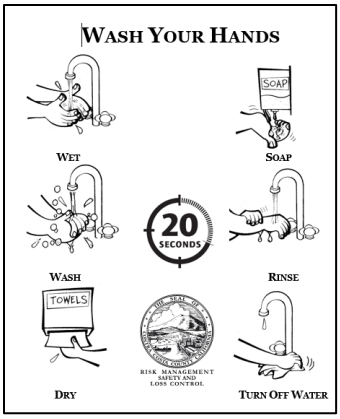
THANK YOU FOR YOUR COOPERATION.

Building Closure and Face Covering Poster: Visit Risk Management intranet site or send an email to RiskmSafety@riskm.cccounty.us to request a pdf

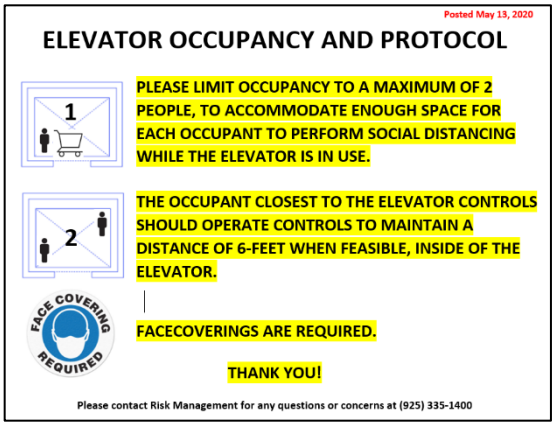
Face Covering Required Sign: https://www.coronavirus.cchealth.org/social-media-tools?pgid=k9bl9y6i-9ac80b20-84bb-11ea-8c85-12879e2400f0

Stay Home When You Are Sick Poster: https://www.cdc.gov/coronavirus/2019-ncov/downloads/StayHomeFromWork_Horizontal.pdf

Prevention Protocols (don't touch face, cough etiquette, handwashing, social distancing, face covering): https://www.cdc.gov/coronavirus/2019-ncov/downloads/stop-the-spread-of-germs-11x17-en.pdf



Handwashing and sanitizing techniques: Visit Risk Management intranet site, email RiskmSafety@riskm.cccounty.us to request a pdf or email graphics@pw.cccounty.us to request printed window and mirror clings



Elevator Occupancy and Face Covering Poster: Visit Risk Management intranet site or send an email to RiskmSafety@riskm.cccounty.us to request a word template

Room Occupancy Limit Poster

Visit Risk Management intranet site or Email RiskmSafety@riskm.cccounty.us to request a pdf

Water Dispenser Hygiene Poster

Visit Risk Management intranet site or Email RiskmSafety@riskm.cccounty.us to request a pdf

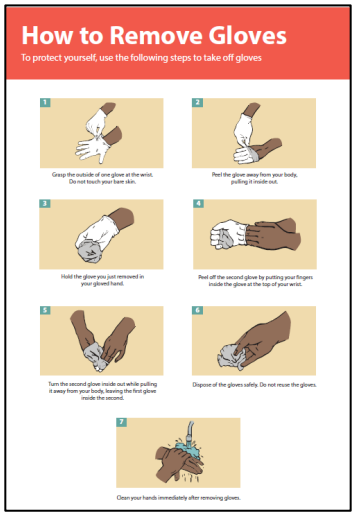
Self-Monitoring for Symptoms Of COVID-19

Visit:

https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms.pdf

How to Safely Wear and Take Off a Face Covering:

https://www.cdc.gov/coronavirus/2019-ncov/downloads/cloth-face-covering.pdf



How to Remove Gloves:

https://www.cdc.gov/vhf/ebola/pdf/poster-how-to-remove-gloves.pdf

COVID-19 ASSESSMENT CHECKLIST ATTACHMENT

CONTRA COSTA COUNTY **COVID-19 ASSESSMENT CHECKLIST**

Facility: _____ Inspected by: _____

Date: _____

Inspection Point		OK	No	N/A
1.0	**Screening Procedures**			
1.1	Procedures for temperature checks have been established.			
1.2	Procedures for symptom screening have been established.			
1.3	Methods for self-monitoring symptoms are dcoumented and communicated.			
2.0	**Cleaning and Disinfecting Workspace**			
2.1	Procedures for frequent cleaning and disinfecting of personal and shared use work areas have been established.			
2.2	Procedures for frequent cleaning and disinfecting of common use surfaces have been established.			
2.3	Adequate EPA-approved cleaning and disinfecting materials are readily available and stocked.			
2.4	Handwashing facilities, including soap and paper towels, are readily available.			
2.5	Hand sanitizer is available for use by public and staff.			
2.6	Shared use appliances such as microwaves and water discpensers are disinfected before and after use.			
2.7	Restrooms are maintained in a clean and sanitary condition.			
2.8	Disposable gloves are provided for cleaning and disinfection activities, if required.			
3.0	**Social Distancing in the Office**			
3.1	Measures such as physical barriers or visual cues used for maintaining 6-foot social distance are implemented.			
3.2	Choke points, or spaces where gatherings may occur, have been modified to promote a 6-foot distance.			
3.3	Hallways and aisleways for foot traffic have been limited or made one-direction.			
3.4	Separate routes for entry and exit into office spaces, lobbyies, or other shared locations are designated.			
3.5	Workspaces are reconfigured or alternate work areas are provided to promote6-foot social distancing.			
3.6	Shared spaces such as meeting rooms, break rooms, and training rooms have furniture adjusted or removed to enable 6 feet of social distance.			
3.7	In-person meetings and gatherings are limited to ensure a 6-foot social distance is maintained.			
3.8	Face coverings are worn when in any shared work area or office where workers or members of the public are present.			
3.9	Entry procedures that promote a 6-foot physical distance and limit gatherings into controlled access locations have been established			
4.0	**Social Distancing in the Field**			
4.1	Adequate EPA-approved cleaning and disinfecting materials are readily available inside county vehicle.			
4.2	Hand sanitizer is available for use when inside county vehicle or in the field.			
4.3	Safety tailgate meetings are conducted using methods to limit in-person gathering, such as through the use of email or video.			
4.4	Face coverings are worn for use when outside of vehicle at travel destination.			
4.5	Vehicle occpuancy is limited to one-person, except for operations which require transport of clients, patients, or detainees.			
5.0	**General Procedures**			
5.1	Adequate time and space for workers to clock in and out at the beginning and end of the work shift without crowding.			
5.2	Adequate time for workers to implement cleaning practices has been provided.			
5.3	Procedures for staggering shifts or increasing the number of shifts have been estabilished.			
5.4	Occupancy for elevator use is limited to enable 6-foot distancing.			
6.0	**Signage Posted**			
6.1	To encourage self monitoring for symptoms before and during shifts.			
6.2	To encourage employees to stay home if they are sick.			
6.3	For maximum occupancy of common use areas inlcuding but not limited to, meeting rooms or break rooms, elevators.			
6.4	Requiring face coverings to be worn.			
6.5	Encouraging frequent hand washing			
7.0	**Training and Communication**			
7.1	Communicate the County Exposure in the Workplace Guidance to staff and contractors.			
7.2	Train staff on unit, facility, and task specific Social Distancing Protocol.			
7.3	Exhange Social Distancing Protocols with contractors.			

COVID-19 SAFETY TRAINING TAILGATE TOPIC ATTACHMENT

Created May 15, 2020

COVID-10 SAFETY TRAINING

This safety training tailgate is a digest of the County living guidance document *COVID-19 Exposures in the Workplace* and contains information for employee and contractors on the following key concepts:

- How COVID-19 (*novel coronavirus*) spreads
- How to stay safe and prevent COVID-19 exposures
- Department-specific Social Distancing protocols
- Symptoms of COVID-19
- How to self-monitor for symptoms
- When and how long to self-isolate when symptoms are present
- When to return to the workplace after illness or exposure

Stay informed by checking the Health Services website and the living guidance document on the Risk Management intranet site.

HOW THE VIRUS SPREADS

New information about COVID-19 is being discovered as doctors and scientists continue to research and respond to this pandemic. What we know about how the virus spreads:

- Spreads mainly from person-to-person.
- Spreads between people who are in close contact with one another (within about 6 feet) for longer than about 10 minutes.
- Droplets produced when a person talks, coughs, or sneezes can land in the mouths or noses of people nearby, be inhaled into other's lungs, or land on surfaces and contaminate them.

BASIC PREVENTION STEPS

PROTECT YOURSELF

- Wash your hands often with soap and water or hand sanitizer.
- Avoid touching your eyes, nose, and mouth.
- Avoid close contact with people who are sick.
- Stay at least 6-feet away from others where possible.

PROTECT OTHERS

- STAY HOME IF YOU ARE SICK
- Cover your cough or sneeze with a tissue or your elbow.
- Wear a face covering over your nose and mouth.
- Clean and disinfect frequently touched objects and surfaces.

DEPARTMENT-SPECIFIC SOCIAL DISTANCING PROTOCOLS

As Departments resume more normal work and service activities, they will be establishing specific Social Distancing Protocols for each facility and work environment.

- These protocols will be documented and updated as conditions change; it is important to review and understand them for each facility you work in.
- Offices, lobbies, break rooms and even elevators will be evaluated to ensure that they are arranged in a manner that limits occupancy numbers to maintain social distances of at least six feet.
- Some job tasks will be cancelled, postponed, or will need to be re-evaluated for COVID-19 safety.
- Contractor safety and social distancing protocols will need to be reviewed and documented:
  - Departments will request and exchange social distancing protocols with contractors.
  - Internal county service providers should request and exchange social distancing protocols with the departments that they serve.
- Training and communication on new guidelines, protocols, job tasks, and procedures is required as conditions and protocols change.

EMPLOYEE SAFETY STEPS

- Follow your job safety protocols and training.
- Wear required personal protective equipment (PPE).
- Follow your Department-specific Social Distancing Protocols.
- Read and follow the safety signage in your workplace.
- Review and understand the County COVID-19 Exposure in the Workplace guidelines.
- Wear your face covering properly and keep it clean and sanitary.
- Use disinfection materials frequently throughout the day on your assigned work surfaces, office equipment, tools and equipment; read Disinfection and Sanitation section for more information.
- Report the need to re-stock PPE and disinfection materials before they are depleted.
- Report safety concerns and suggestions to your supervisor, Safety Coordinator, or Risk Management at RiskmSafety@riskm.cccounty.us.

SYMPTOMS OF COVID-19

All employees should self-monitor for symptoms of illness at least daily and before coming to work. The most common symptoms of COVID-19 are ***fever, tiredness, and dry cough***. Some patients may have less-common symptoms such as ***aches and pains, chills, nasal congestion, runny nose, sore throat, headache, or new loss of sense of smell and taste***. These symptoms often come on gradually. If you have fever, cough, and difficulty breathing, remove yourself from the workplace, stay at home, isolate from others, and seek medical attention if needed, by calling your healthcare provider. Unsure what your symptoms may mean? Review "Is it Cold, Flu, or Coronavirus?" or the CDC Covid-19 Symptoms and Self-Checker.

HOW TO SELF-MONITOR FOR SYMPTOMS

- Participate in screening procedures AND self-monitor at least daily for symptoms related to COVID-19.
- Check in with yourself on your overall health, any new symptoms you may be feeling, and take your temperature at home before coming to work.
- Document, characterize, and track your health status and symptom(s), if observed. There is a calendar resource tool in the Exposure Guideline document and on the Risk Management intranet site.
- Remove yourself from work or stay at home if you develop symptoms.
- Promptly notify your supervisor of your illness if you leave work or stay home and inform them you are following precautions due to possible COVID-19.

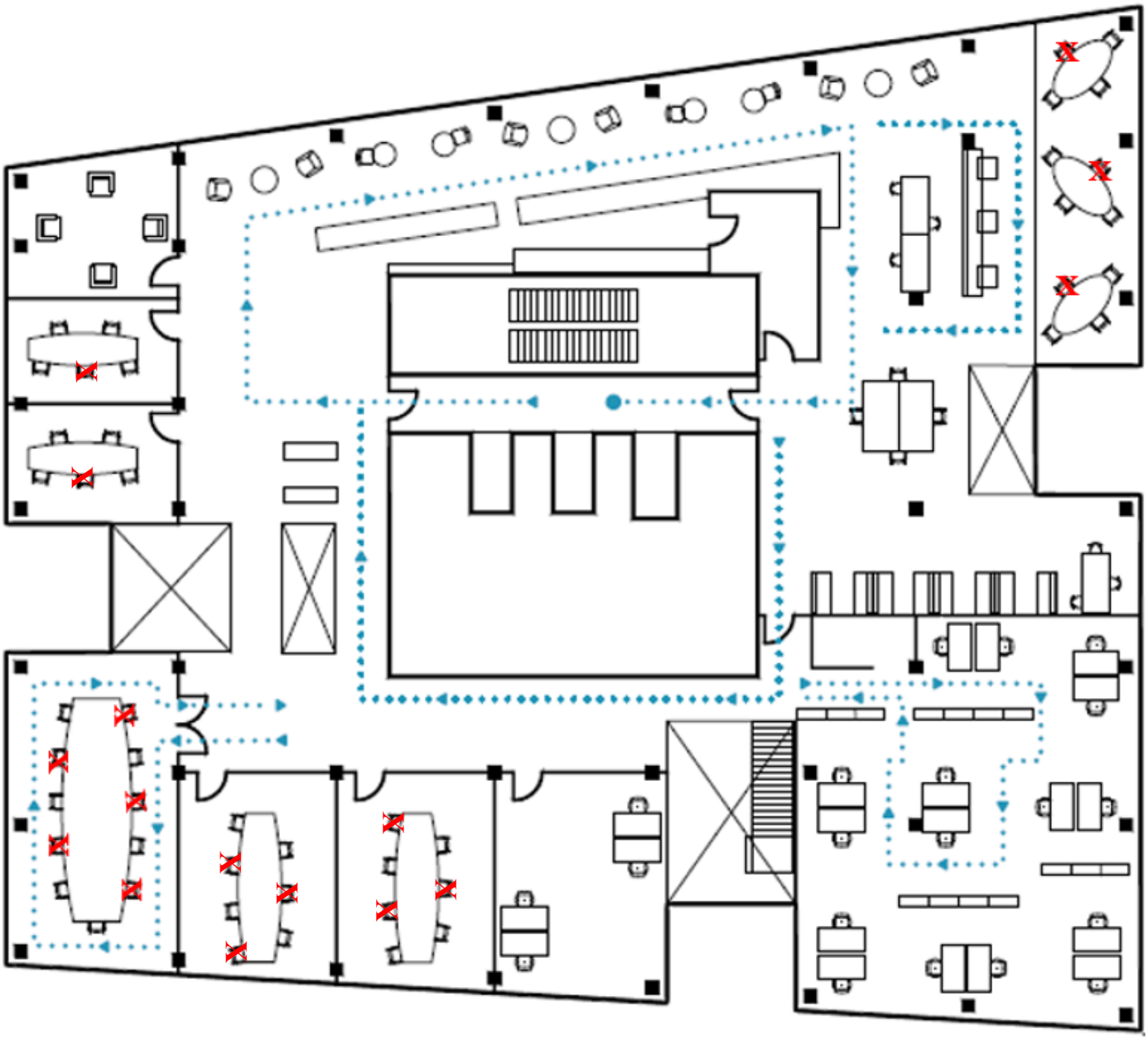
SELF-ISOLATION AND RESUMING WORK

- Follow your healthcare provider's instructions for treatment and self-isolation if you develop symptoms.
- Work with your supervisor and departmental personnel to review the isolation times and calculations in the Exposure guidelines.
- If instructed to do so, observe Public Health Instructions for Home Isolation and Quarantine.
- Whether you had mild symptoms, presumed COVID-19 symptoms, or a positive COVID-19 test, stay at home for at least 10 days after your symptoms such as cough, body aches, and sore throat began and a full 3 days after all symptoms (including fever without the use of fever-reducing medication) have resolved.
- Note that employees in sensitive occupations and settings may need to follow additional steps before resuming work.
- If you are symptom-free and awaiting test results or do not have a documented close contact with a COVID-19 positive individual, you do not need to quarantine but should continue to self-monitor for symptoms.
- Notify your supervisor if you have any questions about these guidelines.

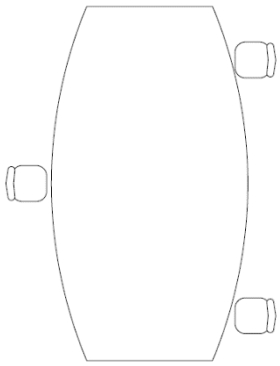
SOCIAL DISTANCING FLOOR PLAN EXAMPLES ATTACHMENT

Key:

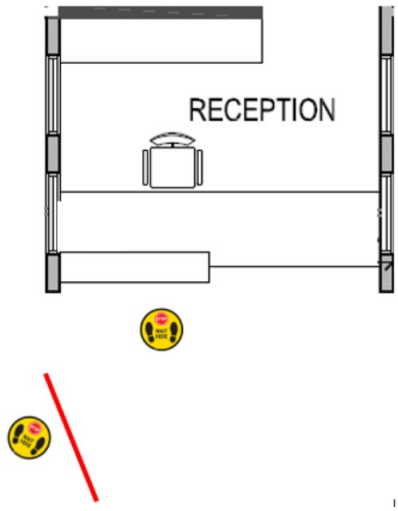
- Red X's indicate chairs that were removed or taken out of service with the goal of preventing occupants from sitting directly across from or within six feet of one another.
- Blue dots and arrows indicate foot traffic patterns that prevent choke points where occupants pass by each other while walking or reduces/prevents foot traffic near work stations.



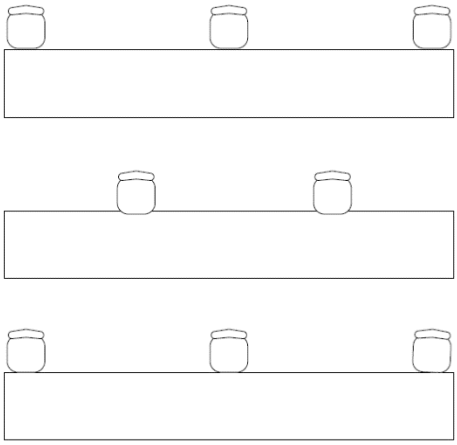
Small Table Configuration



Reception Desk Queue



Classroom Example



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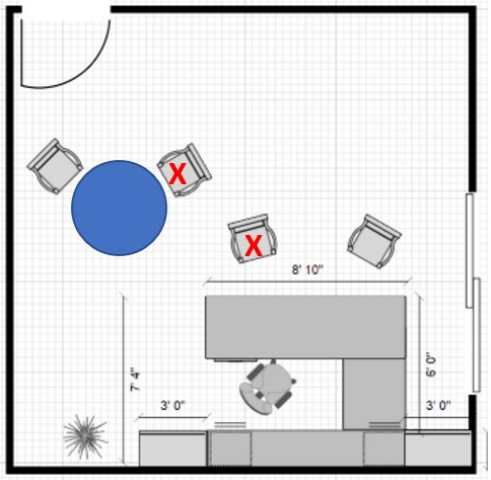
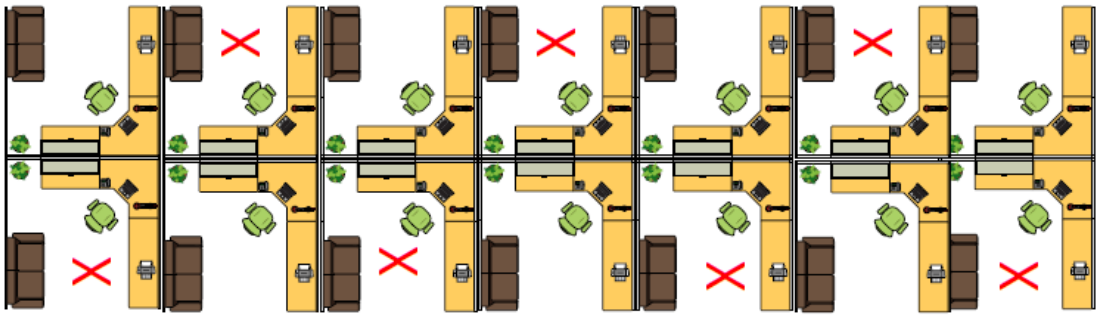
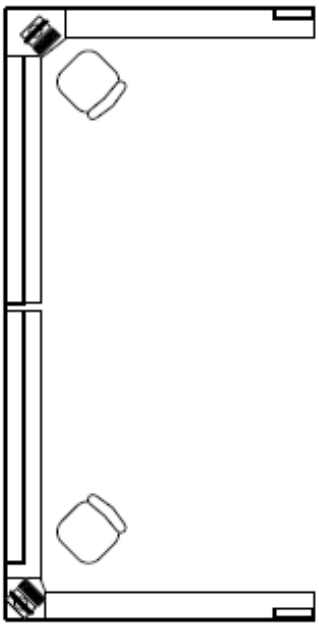
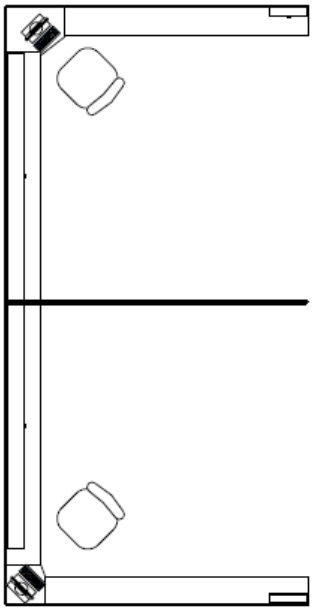


Cubicle Row Example



Cubicle Examples





Contra Costa Health Services

Healthcare Surge Plan - 2020

A. Overview

Healthcare surge, as used here, refers to a condition in which the local healthcare system is overwhelmed as a result of a catastrophic emergency. The following definition is given by the California Department of Public Health:

> ***A healthcare surge is proclaimed in a local jurisdiction when an authorized local official, such as a local health officer or other appropriate designee, using professional judgment determines, subsequent to a significant emergency or circumstances, that the healthcare delivery system has been impacted, resulting in an excess in demand over capacity in hospitals, long-term care facilities, community care clinics, public health departments, other primary and secondary care providers, resources and/or emergency medical services. The local health official uses the situation assessment information provided from the healthcare delivery system partners to determine overall local jurisdiction/Operational Area medical and health status.***[1]

Surge capacity refers to the ability of hospitals and other healthcare providers to evaluate and care for a markedly increased volume of patients – challenging or exceeding the normal capacity of a hospital or healthcare system. Individual hospitals plan for and routinely handle surge requirements resulting from seasonal fluctuations in respiratory ailments, environmentally based conditions, and community incidents. In Contra Costa County, as throughout most of California, hospitals routinely function at or near capacity. Moderately sized incidents with several to, perhaps, hundreds of patients are handled in accordance with the County's Multi-Casualty Incident Plan. Patients are transported to hospitals throughout the county and throughout the region to avoid seriously overloading any single hospital. However, very large-scale incidents or widespread disease outbreaks may overwhelm the capacity of many or all hospitals and other health care providers within a region. Responding to such incidents requires the close coordination and cooperation of hospitals, skilled nursing facilities, health centers and community clinics, governmental agencies, and other healthcare providers.

The purpose of this plan is to provide a framework for the management of healthcare surge needs resulting from an incident that overwhelms the capacity of the healthcare system in Contra Costa and nearby counties in order to meet the overall goal of minimizing mortality and morbidity.

B. Emergency Operations and Management

The Medical Surge Capacity Plan is a tool to be used when needed in conjunction with the Contra Costa Health Services Emergency Plan and the Contra Costa County Emergency Operations Plan. Contra Costa Health Services will be the lead agency coordinating medical surge activities. Emergency operations shall be conducted in accordance with the California

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[1] *California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies, Foundational Knowledge*, issued 2008, p. 11.

Standardized Emergency Management System (SEMS) and the National Incident Management System (NIMS).

C. Surge Levels

Five levels of healthcare surge are recognized by the California Department of Public Health to describe the status of a local (Operational Area) healthcare system using color codes ranging from green for day-to-day operations to black for the most significant healthcare surge. The surge level, which is determined in Contra Costa County by the Health Officer or his designee, refers to the status of the healthcare system as a whole and not to the status of any specific healthcare facility.

Surge Level Green

Surge Level Green is the normal day-to-day operating level of the county's healthcare system. Under Surge Level Green, some individual hospitals may be at Census Alert 1 or 2[2], but the healthcare system as a whole is operating within normal seasonal parameters.

Surge Level Yellow

Surge Level Yellow is the condition of the healthcare system in which most healthcare facilities are experiencing surge but are able to manage the situation within their organizational frameworks. Surge Level Yellow may be proclaimed, for example, during an unusually severe seasonal influenza. Surge Level Yellow serves to alert healthcare facilities and providers within the Operational Area (county), facilities and providers outside the operational area, and officials at various levels of government of the status of the healthcare system. However, no further governmental action is required.

Trigger: All or most hospitals on Census Alert 2 for three or more consecutive days.

Procedure: Health Officer directive upon recommendation of EMS Director.

Actions:

(1) EMS notification to hospitals, County Office of Emergency Services, Region II Regional Disaster Medical/Health Coordinator/Specialist (REMHC/S), and State Emergency Medical Services Authority (EMSA) and Department of Public Health Duty Officers.

(2) Hospitals request regulatory relief as appropriate.

[2] The Census Alert system was developed by the hospitals in Contra Costa and Alameda Counties with the Hospital Council of Central and Northern California and the support of the two counties' EMS Agencies to have a common vocabulary for identifying hospital status resulting from high inpatient volume. "Census Alert 1" indicates that a hospital has initiated some pre-planned steps to handle unusually high patient volume. "Census Alert 2" indicates that a hospital has taken most or all of its pre-planned steps to handle peak patient volume.

Surge Level Orange

Surge Level Orange is issued when healthcare facilities within the operational area can no longer handle surge demands within their own organizational frameworks after taking steps to expand capacity and curtail non-essential services. A local emergency *may* be proclaimed. The Health Officer may issue appropriate appeals to healthcare providers regarding extending capacities and hours of operations and to the public to avoid seeking non-emergency care.

Trigger: All or most hospitals on Census Alert 2, all or most hospitals have sought regulatory relief, and one or more hospitals have sought local government assistance with respect to surge demand.

Procedure: County Health Officer directive upon recommendation of County Emergency Medical Services (EMS) Director.

Actions:

(1) EMS notification to hospitals and other healthcare providers, County Office of Emergency Services, Region II RDMHC/S, and State EMSA and Department of Public Health Duty Officers.

(2) All hospitals request regulatory relief and begin activation of hospital surge plans as appropriate.

(3) Hospital bed polling increased from once to three times daily.

(4) Daily hospital conference call coordinated by EMS to assess hospital status and needs.

(5) Hospitals advised to cancel elective and non-essential procedures.

(6) Public information announcement issued by Health Officer.

(7) Local emergency proclamation may be issued.

Surge Level Red

Surge Level Red is issued when the local healthcare system is not capable of meeting the demand for care and assistance from outside the Operational Area is required. A local emergency is proclaimed and a State of Emergency Declaration may be issued by the Governor. Contra Costa Health Services will open its Departmental Operating Center (DOC) and the County's Emergency Operating Center (EOC) may be opened.

Trigger: All hospitals on Census Alert 2, all hospitals have sought regulatory relief, most or all hospitals are seeking local government assistance with respect to surge demand.

Procedure: Health Officer directive upon recommendation of EMS Director or Health Services DOC Director.

Actions:

(1) Action items 1 through 6, above.

(2) Hospitals activate hospital surge plans to the full extent consist with the situation at and applicable local Health Officer and gubernatorial directives, including statutory suspensions.

(2) Local emergency proclaimed and Governor's State of Emergency Declaration and appropriate emergency directives requested.

(3) State assistance requested in coordinating transfer of patients to out-of-county hospitals.

(4) Health Services Departmental Operating Center (DOC) and/or Operational Area Emergency Operating Center (EOC) activated.

Surge Level Black

Surge Level Black is issued when the local healthcare system is severely overwhelmed and is falling significantly short of meeting the demand for care. Significant medical resources from outside the Operational Area are required. A local emergency is proclaimed and the Governor is requested to issue a State of Emergency Declaration and appropriate emergency directives, including statutory suspensions. The County may consider opening Alternate Care Sites.

Trigger: All hospitals are overwhelmed and have sought regulatory relief, most or all hospitals requested local government assistance with respect to surge demand, and local government has been unable to provide needed assistance directly or through normal medical mutual aid channels.

Procedure: Health Officer directive upon recommendation of Health Services DOC Director.

Actions:

(1) Action items 1 through 4, above.

(2) State and/or Federal Medical Resources requested.

(3) Alternate Care Site(s) may be activated.

D. Planning Scenarios

The need for surge capacity may arise from a number of different scenarios ranging from a great earthquake to a highly toxic and widespread chemical release to pandemic influenza or other acutely infectious disease outbreak. The circumstances of such an incident may be natural or human-made, accidental or deliberate, time limited or continuing over an extensive period, localized in one county or region or spread over the state or nation. Each scenario presents its own set of considerations and constraints that will impinge on how surge capacity is handled. Key variables affecting surge capacity include:

(1) Number of patients

(2) Acuity of patients

Decontamination required?

Treat and release or hospital admission?

Specialized or complex surgical or medical treatment needed?

Ventilator needed?

Isolation required?

(3) Duration of incident

(4) Geographic scope

Are other areas impacted so that outside assistance is not available?

(5) Impact of incident on medical personnel and facilities

Earthquake damage to hospitals?

Hospital staff impacted by illness?

While each event will present its own unique set of challenges, for planning purposes four general scenarios have been considered.

Scenario #1 – Acute Infectious Disease

This scenario includes pandemic influenza, novel diseases such as severe acute respiratory syndrome (SARS), and infectious diseases thought to be potentially associated with bioterrorism such as smallpox. The scenario presents special challenges related to potential long duration, widespread impact, impact on health care workers, and impact on supply lines and community infrastructure. Additionally, there may be need for isolation and other protective measures. Large numbers of patients may be ventilator dependent. Pandemic disease outbreak presents unique problems in that (1) large numbers of healthcare personnel may be affected and (2) large areas of the state and nation may be simultaneously impacted thus limiting mutual aid response.

Scenario #2 – Acute Botulinum or other Acute Chemical Poisoning

This scenario includes major industrial accidents (refineries, chemical plants, tank cars), industrial sabotage, or terrorist attack. While relatively localized and time limited when compared to pandemic influenza, this scenario has the potential of affecting a population over many square miles and may result in patients seeking medical treatment over days or weeks. In 1993, an Oleum (sulfuric acid) railroad tank car release in Contra Costa County sent 22,000 persons to local hospitals and clinics seeking treatment over a 10-day period. While very few persons required emergency treatment or hospitalization, the sheer volume of patients severely impacted hospital resources and required the establishment of an alternate (non-hospital) to provide patient screening and triage over a period of several days. Under Scenario #2, there may be need for large amounts of nerve agent antidotes or anti-toxin not normally available in quantity at local hospitals. There may also be a demand for ventilators.

Scenario #3 – Trauma and Burn Care

Scenario #3 includes major earthquake and large-scale attack by explosive or incendiary device. This scenario is much more time limited and is apt to be more geographically focused. A great earthquake on the Hayward fault, however, is likely to cause widespread death and destruction throughout the East Bay and is likely to cripple hospitals located along the fault.

Scenario #4 – Radiation Induced Injury

This scenario includes spread of radioactive material over a large population by "dirty bomb" or other means, as well as attack by nuclear explosion. Depending on the device or material used, medical issues range from minor to catastrophic. Psychological effects may be profound. Staff availability may be impacted due to illness or safety concerns.

E. Resources for Medical Surge

1. Facilities

(a) Acute care hospitals

Table 1 shows the surge capacities reported by each of the county's nine acute care hospitals under each of the four planning scenarios. Surge capacity is reported as the number of additional patients (all patients and monitored patients) that could be handled by the hospital over and above the average daily census under austere medical conditions. The numbers are reflective of physical capacity without regard to staffing. The table also shows for each hospital the sources of the reported surge capacity; e.g., available staffed beds, early discharges, surge tents, etc. While surge capacity is reported without regard to staffing capability, a large proportion of the surge capacity reported by each facility (varies by scenario) is from staffed vacant beds, early discharges, and cancelled elective procedures. Thus, a certain amount of surge can be accomplished without compromising staffing levels.

Surge capacity to handle a major influenza epidemic is shown in Table 2. These figures utilize the reported surge capacities for an acute infectious disease scenario and the estimated increased hospital bed demand calculated using the Centers for Disease Control and Prevention FluSurge 2.0 software. Demand assumptions are for the peak week of a 6-week duration, 35 percent infection rate event, maximum scenario.[3] Overall, Contra Costa would have a shortage of some 223 hospital beds, including 114 monitored beds, with hospitals at their reported maximum surge capacity.[4]

(b) Other in-patient facilities

Skilled nursing and other non-acute-care in-patient facilities represent a secondary source of surge capacity. Table 3 provides a listing of all licensed in-patient facilities in the county (including the Veterans Administration Martinez Rehabilitation and Long Term Care facility, which is not licensed by the State). Not including acute care hospitals, these inpatient facilities account for a total of 3,525 beds. Assuming these facilities collectively could handle a surge of ten percent of licensed capacity, they could absorb some 350 additional patients. Primary use for this additional capacity would probably be for lower acuity patients discharged from acute care hospitals.

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[3] These assumptions produce the highest single-week surge using the CDC FluSurge 2.0 software. Lengthening the duration, lowering the infection rate, or changing from a "maximum" to a "most likely" scenario, would reduce the maximum weekly admissions. Note also that, using CDC assumptions on length of hospital stay, results in the peak weekly admissions approximating the peak hospital census.

[4] Note that, using CDC assumptions on length of hospital stay, results in the peak weekly admissions approximating the peak hospital census.

(c) Outpatient facilities

Table 3 lists Contra Costa Health Services health centers and other licensed outpatient facilities including community clinics, dialysis clinics, private psychiatric clinics, and surgery-centers. CCHS and community clinics can provide important resources for dispensing, triage, and outpatient care to divert patients away from hospital emergency departments when hospital care is not required. All community clinics are represented by the Community Clinic Consortium of Contra Costa County. Through the Consortium, community clinics have developed disaster plans, have acquired disaster and personal protective equipment and supplies, and have participated with Contra Costa Health Services in disaster exercises.

(d) Closed hospitals

The real estate identified as former hospitals in Contra Costa County have all been explored and no longer remain opens for quick conversion and re-opening during a surge event.

(e) Alternate Care Sites

Schools, hotels, or other facilities may be designated as Alternate Care Sites during a disaster or other large-scale emergency. The level of care will be primarily supportive care. Alternate Care Sites will be operated by CCHS in partnership with Contra Costa County Employment and Human Services Department and Contra Costa Health Services, the American Red Cross and Contra Costa Public Works to assist with the provision of wrap around services, staff and other resources.

2. Personnel

Hospitals in Contra Costa and throughout most of the state operate at or near the minimum nurse staffing level required for the number of patients in the facility. While the number of personnel may be increased significantly on a short-term basis to handle certain surge situations, it is clear that, under any long-term scenario involving infectious disease or other conditions that may incapacitate hospital staff or present significant hazards to hospital staff, care may have to be provided under austere conditions that depart significantly from existing staffing ratios.

(a) Hospital and skilled nursing facility personnel can be effectively increased by 50 percent through implementation of extended shifts. Accommodation will need to be made for staff childcare.

(b) Contra Costa Health Services nursing personnel not normally assigned to hospital or health center operations may be reassigned to provide patient care at hospitals, health centers, clinics, or Alternate Care Sites.

(c) Field paramedics and EMTs may be enlisted to assist in patient care at Alternate Care Sites.

(d) Disaster Service Workers may be assigned to County-operated facilities, including Alternate Care Sites.

(d) Volunteer nurses and physicians may be recruited from the community as needed.

3. Equipment and supplies

Contra Costa's hospitals and clinics have obtained a wide variety of disaster equipment and supplies under the federal Health Resources and Services Administration (HRSA) and Hospital Preparedness Program (HPP) grants and other federal programs

aimed at enhancing preparedness of local healthcare systems. Major categories of disaster equipment and supplies that impact surge capacity are as follows:

(a) Decontamination units – All hospitals are equipped with decontamination units and related equipment and supplies.

(b) Surge shelters – All hospitals are equipped with two surge shelter tents and related equipment and supplies (cots, lighting, generators, air conditioner/heater units, etc.) to handle up to 18 non-ambulatory patients per tent.

(c) Trauma and burn cache – John Muir Trauma Center has been equipped with an augmented trauma and burn cache designed to handle 50 trauma patients.

(d) Pharmaceuticals – All hospitals have stockpiled pharmaceutical caches. The County has a plan in place for implementation of the Strategic National Stockpile.

(e) Ventilators – Hospitals report a total inventory of 147 full-scale ventilators and an average daily usage of 73, leaving an average availability of 74 full-scale ventilators to meet surge needs. Hospitals report that an additional 82 full-scale ventilators can be obtained from affiliated facilities or leased from vendors, bringing the total number of full-scale ventilators available for surge to about 156. Forty portable disposable ventilators are additionally stockpiled at each of the county's nine acute care hospitals, for a total of 360 portable disposable ventilators..

(f) CHEMPACKS – Three CHEMPACK caches containing enough nerve-agent antidotes to treat 2,000 persons.

(g) Protective supplies and equipment – All hospitals have obtained personal protective equipment and supplies including powered air purifying respirators (PAPRs), protective clothing, portable HEPA filters, and supplies of N95 masks. Except for the PAPRs, community clinics have obtained similar protective equipment and supplies for disaster response.

(h) Communications and infrastructure –. CCRMC and the CCHS clinics have upgraded computer networks, installed emergency power, and obtained outside lighting to enhance operational capabilities. Additionally, each community clinic is equipped with a 880mHz radio for backup communications to the CCRMC Command Center. All hospitals, skilled nursing facilities and clinics have access to the ReddiNet System as redundant communication in which CCHS EMS division maintains net control.

4. Resource Tracking

Contra Costa Office of emergency Services and Contra Costa Health Services will utilize the WebEOC platform for all resource requests and tracking needs. All hospital and outpatient facility equipment purchased with HPP funds are tracked using the Sortly App. These resources can be shared between the health system when needed.

F. Alternate Care Sites

The *California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies* defines a government-authorized Alternate Care Site as:

> ***A location that is not currently providing healthcare services and will be converted to enable the provision of healthcare services to support, at a minimum, inpatient and/or outpatient care required after a declared catastrophic emergency. These specific sites are not part of the expansion of an existing healthcare facility (i.e., extensions of***

general acute care hospitals, clinics, or long-term care facilities), but rather are designated under the authority of the local government.

The basic concept of operations is as follows:

(1) One or more Alternate Care Sites will be established as needed and as resources permit to provide in-patient comfort care and minimal medical care to persons for whom hospitalization is not appropriate and for whom home care is not a viable option as population-based standards of care are adopted during a catastrophic health emergency. Because resources for care at Alternate Care Sites are expected to be extremely limited, these sites will focus on admissions directly from the community rather than transfers from licensed healthcare facilities.

(2) Location of Alternates Care Sites will be selected jointly be Contra Costa Health Services, Department of Employment and Human Services, and American Red Cross from among shelter sites identified by American Red Cross. High schools identified as shelter sites by the Red Cross will likely be most suitable for Alternate Care Site operations.

(3) Alternate Care Sites will be managed in accordance with SIMS/NEMS under a joint command including the Departments of Employment and Human Services and Health Services. Employment and Human Services will be responsible for overall management and administration of Alternate Care Sites. Contra Costa Health Services will be responsible for medical management and patient care.

(4) The American Red Cross will assist with logistical support including the provision of standard emergency shelter supplies and food. Red Cross personnel, however, will not be expected to enter an Alternate Care Site once patients are present.

(5) In selecting Alternate Care Site locations, consideration will be given to providing access to persons living in low-income communities.

(6) Disaster Services Workers from cities and County departments in addition to Employment and Human Services and Health Services as well as community health care volunteers will likely be needed to assist in the staffing of Alternate Care Sites.

Skillled Nursing Facilities
Contra Costa County

What is the name of the skilled nursing facility?	Facility Address	County	Skilled Nursing Facility POC	Email for Skilled Nursing Facility POC	Facility Telephone	Licensed Beds	Current Resident Census
ALHAMBRA CONVALESCENT HOSPITAL	331 ILENE STREET, MARTINEZ, CA - 94553	CONTRA COSTA	Nina Gilbert	alhabm@ebsnff.com	(925) 228-2020	44	36
ANTIOCH CONVALESCENT HOSPITAL	1210 A STREET, ANTIOCH, CA - 94509	CONTRA COSTA	Phylene Sunga	Psunga@ebsnfs.com	(925) 757-8787	99	86
BAYBERRY SKILLED NURSING AND HEALTHCARE CENTER	1800 ADOBE STREET, CONCORD, CA - 94520	CONTRA COSTA	Harmandeep Saroya	harmandeepsaroya@lifegen.net	(925) 825-1300	99	86
CREEKSIDE HEALTHCARE CENTER	1900 CHURCH LANE, SAN PABLO, CA - 94806	CONTRA COSTA	Janet Rotich	JCRotich@Marinerhealthcare.com	(510) 235-5514	80	72
DANVILLE POST-ACUTE REHAB	336 DIABLO ROAD, DANVILLE, CA - 94526	CONTRA COSTA	Taylor Ellis	tellis@danvillerehab.com	(925) 837-4566	54	46
DIAMOND RIDGE HEALTHCARE CENTER	2351 LOVERIDGE ROAD, PITTSBURG, CA - 94565	CONTRA COSTA	Diamond Ridge Healthcare Center	ajscott1@savasc.com	(925) 427-4444	120	100
GREENRIDGE SENIOR CARE	2150 PYRAMID DRIVE, EL SOBRANTE, CA - 94803	CONTRA COSTA	Linda joseph	Ljoseph97@gmail.com	(415) 235-3897	60	34
LA CASA VIA TRANSITIONAL CARE CENTER	1449 YGNACIO VALLEY ROAD, WALNUT CREEK, CA - 94598	CONTRA COSTA	JC Davis	Jcd@aspenskilledhealth.com	(925) 939-5820	97	77
LEGACY NURSING AND REHABILITATION CENTER	1790 MUIR ROAD, MARTINEZ, CA - 94553	CONTRA COSTA	Gerjel Bautista	don@legacypostacutecare.com	(925) 228-8383	96	65
LONE TREE CONVALESCENT HOSPITAL	4001 LONE TREE WAY, ANTIOCH, CA - 94509	CONTRA COSTA	Karen Pillow	Karen.pillow@ebsnfs.com	(925) 754-0470	99	87
MANOR CARE HEALTH SERVICES-TICE VALLEY	1975 TICE VALLEY BOULEVARD, WALNUT CREEK, CA - 94595	CONTRA COSTA	MANORCARE HEALTH SERVICES TICE VALLEY	Carlos.Bernardo2@HCR-ManorCare.com	(925) 906-0200	120	99
MANORCARE HEALTH SERVICES - ROSSMOOR	1226 ROSSMOOR PARKWAY, WALNUT CREEK, CA - 94595	CONTRA COSTA	Melissa Katz - Administrator	Melissa.Katz@hcr-manorcare	(925) 975-5000	155	108
MORAGA POST ACUTE	348 RHEEM BOULEVARD, MORAGA, CA - 94556	CONTRA COSTA	Craig Bills	Craig.bills@moragapa.com	(925) 376-5995	49	41
ORINDA CARE CENTER LLC	11 ALTARINDA ROAD, ORINDA, CA - 94563	CONTRA COSTA	Eleanor Bongat	DON@orindacare.Com	(925) 254-6500	47	32
PITTSBURG SKILLED NURSING CENTER	535 SCHOOL STREET, PITTSBURG, CA - 94565	CONTRA COSTA	David De Guzman	david.deguzman@pittsburgsnc.com	(925) 432-3831	49	43
PLEASANT HILL POST ACUTE	1625 OAK PARK BOULEVARD, PLEASANT HILL, CA - 94523	CONTRA COSTA	Craig Bills	Craig.bills@pleasanthillpa.com	(925) 935-5222	51	45
SAN MIGUEL VILLA	1050 SAN MIGUEL ROAD, CONCORD, CA - 94518	CONTRA COSTA	san miguel villa	smvdon@ebsnfs.com	(925) 825-4280	190	171
SAN PABLO HEALTHCARE AND WELLNESS CENTER	13328 SAN PABLO AVENUE, SAN PABLO, CA - 94806	CONTRA COSTA	Seyna Smith	Administrator@sanpablohc.com	(510) 235-3720	108	99
SHIELDS NURSING CENTER	3230 CARLSON BOULEVARD, EL CERRITO, CA - 94530	CONTRA COSTA	ROSELINE NKWUO	roseline@shieldsnursingcenters.com	(510) 525-3212	45	30
SHIELDS RICHMOND NURSING CENTER	1919 CUTTING BOULEVARD, RICHMOND, CA - 94804	CONTRA COSTA	Shields Richmond Nursing Center	jocelle@shieldsnursingcenters.com	(510) 233-8513	84	69
STONEBROOK HEALTHCARE CENTER	4367 CONCORD BOULEVARD, CONCORD, CA - 94521	CONTRA COSTA	Yvette Ortega	yvette@stonebrookhc.com	(925) 689-7457	120	82
TAMPICO TERRACE CARE CEN	130 TAMPICO STREET, WALNUT CREEK, CA - 94598	CONTRA COSTA	Marjorie Ellks	marjorie@tampicoterrace.com	(925) 933-7970	128	
THE REUTLINGER COMMUNITY	4000 CAMINO TASSAJARA, DANVILLE, CA - 94506	CONTRA COSTA	Elena Davidenko	Edavidenko@rcjl.org	(925) 964-2067	60	44

Skillled Nursing Facilities
Contra Costa County

What is the name of the skilled nursing facility?	Facility Address	County	Skilled Nursing Facility POC	Email for Skilled Nursing Facility POC	Facility Telephone	Licensed Beds	Current Resident Census
VALE HEALTHCARE CENTER	13484 SAN PABLO AVENUE, SAN PABLO, CA - 94806	CONTRA COSTA	Diltar Sidhu	d.sidhu@marinerhealthcare.com	(510) 232-5945	202	191
VINTAGE ESTATES OF RICHMOND	955 23RD STREET, RICHMOND, CA - 94804	CONTRA COSTA	James Jordan	jamesjordan3@icloud.com	(510) 237-5182	34	28
WALNUT CREEK SKILLED NURSING AND REHABILITATION CENTER	1224 ROSSMOOR PARKWAY, WALNUT CREEK, CA - 94595	CONTRA COSTA	Dorothy Couto	dorothycouto@lifegen.net	(925) 937-7450	180	147
WILLOW PASS HEALTHCARE CENTER	3318 WILLOW PASS ROAD, CONCORD, CA - 94519	CONTRA COSTA	Binoy Ephrem	binoy.ephrem@willowpasshc.net	(925) 689-9222	83	69
WINDSOR MANOR REHABILITATION CENTER OF CONCORD	3806 CLAYTON ROAD, CONCORD, CA - 94521	CONTRA COSTA	Mary Goldhoff	conadmin@windsorcares.com	(925) 689-2266	190	166
WINDSOR ROSEWOOD CARE CENTER	1911 OAK PARK BOULEVARD, PLEASANT HILL, CA - 94523	CONTRA COSTA	Sam Schaber	rosadmin@windsorcares.com	(925) 935-6630	113	100

CONTRA COSTA HEALTH SERVICES

Skilled Nursing Facilities
PPE On-Hand Report

ALHAMBRA CONVALESCENT HOSPITAL-MARTINEZ

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	1-3Days	15+Days	15+Days	15+Days	15+Days	15+Days
6/1/2020	1-3Days	15+Days	15+Days	15+Days	15+Days	15+Days

ANTIOCH CONVALESCENT HOSPITAL-ANTIOCH

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	8-14Days	8-14Days	4-7Days	4-7Days	8-14Days	8-14Days
6/1/2020	8-14Days	8-14Days	4-7Days	4-7Days	8-14Days	8-14Days

BAYBERRY SKILLED NURSING AND HEALTHCARE CENTER-CONCORD

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	15+Days	15+Days	8-14Days	15+Days	15+Days	15+Days
6/1/2020	15+Days	15+Days	8-14Days	15+Days	15+Days	15+Days

CREEKSIDE HEALTHCARE CENTER-SAN PABLO

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	8-14Days	8-14Days	8-14Days	8-14Days	8-14Days	8-14Days
6/1/2020	8-14Days	8-14Days	8-14Days	8-14Days	8-14Days	8-14Days

DANVILLE POSTACUTE REHAB-DANVILLE

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	1-3Days	1-3Days	1-3Days	1-3Days	1-3Days	1-3Days
6/1/2020	1-3Days	1-3Days	1-3Days	1-3Days	1-3Days	1-3Days
6/1/2020	1-3Days	1-3Days	1-3Days	1-3Days	1-3Days	1-3Days

DIAMOND RIDGE HEALTHCARE CENTER-PITTSBURG

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	1-3Days	4-7Days	4-7Days	1-3Days	4-7Days	4-7Days
6/1/2020	1-3Days	8-14Days	4-7Days	1-3Days	4-7Days	4-7Days

GREENRIDGE POST ACUTE-EL SOBRANTE

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	15+Days	15+Days	15+Days	1-3Days	15+Days	15+Days
6/1/2020	15+Days	15+Days	15+Days	1-3Days	15+Days	15+Days

CONTRA COSTA HEALTH SERVICES

Skilled Nursing Facilities
PPE On-Hand Report

LA CASA VIA TRANSITIONAL CARE CENTER-WALNUT CREEK

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	4-7Days	4-7Days	4-7Days	4-7Days	8-14Days	8-14Days
6/1/2020	4-7Days	4-7Days	4-7Days	4-7Days	8-14Days	8-14Days
6/1/2020	4-7Days	4-7Days	4-7Days	4-7Days	8-14Days	8-14Days

LEGACY NURSING AND REHABILITATION CENTER-MARTINEZ

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/1/2020	8-14Days	8-14Days	8-14Days	8-14Days	8-14Days	8-14Days

LONE TREE CONVALESCENT HOSPITAL-ANTIOCH

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	8-14Days	15+Days	4-7Days	8-14Days	8-14Days	15+Days
6/1/2020	8-14Days	15+Days	4-7Days	8-14Days	8-14Days	15+Days
6/1/2020	8-14Days	15+Days	4-7Days	8-14Days	8-14Days	15+Days

MANOR CARE HEALTH SERVICESTICE VALLEY-WALNUT CREEK

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	15+Days	15+Days	15+Days	15+Days	15+Days	15+Days
6/1/2020	15+Days	15+Days	15+Days	15+Days	15+Days	15+Days
6/1/2020	15+Days	15+Days	15+Days	15+Days	15+Days	15+Days

MANORCARE HEALTH SERVICES ROSSMOOR-WALNUT CREEK

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	8-14Days	8-14Days	4-7Days	8-14Days	15+Days	8-14Days
6/1/2020	8-14Days	8-14Days	4-7Days	8-14Days	15+Days	4-7Days

MORAGA POST ACUTE-MORAGA

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	8-14Days	15+Days	8-14Days	8-14Days	15+Days	15+Days
6/7/2020	8-14Days	8-14Days	15+Days	8-14Days	8-14Days	8-14Days
6/1/2020	8-14Days	15+Days	8-14Days	8-14Days	15+Days	15+Days

ORINDA CARE CENTER LLC-ORINDA

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	8-14Days	8-14Days	8-14Days	8-14Days	8-14Days	8-14Days
6/1/2020	8-14Days	8-14Days	8-14Days	8-14Days	8-14Days	8-14Days

CONTRA COSTA HEALTH SERVICES

Skilled Nursing Facilities
PPE On-Hand Report

6/1/2020	8-14Days	8-14Days	8-14Days	8-14Days	8-14Days	8-14Days

PITTSBURG SKILLED NURSING CENTER-PITTSBURG

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	4-7Days	4-7Days	4-7Days	4-7Days	4-7Days	4-7Days
6/1/2020	4-7Days	4-7Days	1-3Days	1-3Days	4-7Days	4-7Days

PLEASANT HILL POST ACUTE-PLEASANT HILL

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	8-14Days	15+Days	15+Days	15+Days	15+Days	15+Days
6/1/2020	8-14Days	8-14Days	8-14Days	8-14Days	8-14Days	8-14Days

SAN MIGUEL VILLA-CONCORD

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	4-7Days	4-7Days	4-7Days	4-7Days	4-7Days	4-7Days
6/1/2020	4-7Days	4-7Days	4-7Days	4-7Days	4-7Days	4-7Days

SAN PABLO HEALTHCARE AND WELLNESS CENTER-SAN PABLO

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	8-14Days	15+Days	8-14Days	15+Days	15+Days	15+Days
6/1/2020	8-14Days	15+Days	4-7Days	8-14Days	15+Days	15+Days
6/1/2020	8-14Days	15+Days	4-7Days	8-14Days	15+Days	15+Days

SHIELDS NURSING CENTER-EL CERRITO

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	8-14Days	8-14Days	8-14Days	8-14Days	15+Days	15+Days
6/1/2020	8-14Days	8-14Days	8-14Days	8-14Days	15+Days	15+Days

SHIELDS RICHMOND NURSING CENTER-RICHMOND

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	4-7Days	15+Days	4-7Days	4-7Days	15+Days	15+Days
6/1/2020	4-7Days	15+Days	4-7Days	4-7Days	15+Days	15+Days

STONEBROOK HEALTHCARE CENTER-CONCORD

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	1-3Days	4-7Days	4-7Days	4-7Days	4-7Days	4-7Days
6/1/2020	1-3Days	4-7Days	4-7Days	4-7Days	4-7Days	4-7Days
6/1/2020	1-3Days	4-7Days	4-7Days	4-7Days	4-7Days	4-7Days

CONTRA COSTA HEALTH SERVICES

Skilled Nursing Facilities
PPE On-Hand Report

TAMPICO TERRACE CARE CENTER-WALNUT CREEK

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	15+Days	15+Days	15+Days	15+Days	15+Days	15+Days
6/1/2020	15+Days	15+Days	15+Days	15+Days	15+Days	15+Days

THE REUTLINGER COMMUNITY-DANVILLE

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	15+Days	15+Days	15+Days	15+Days	15+Days	15+Days
6/1/2020	15+Days	15+Days	15+Days	15+Days	15+Days	15+Days

VALE HEALTHCARE CENTER-SAN PABLO

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	15+Days	15+Days	15+Days	4-7Days	15+Days	15+Days
6/1/2020	15+Days	15+Days	15+Days	4-7Days	15+Days	15+Days
6/1/2020	15+Days	15+Days	15+Days	4-7Days	15+Days	15+Days

VINTAGE ESTATES OF RICHMOND-RICHMOND

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	8-14Days	8-14Days	8-14Days	8-14Days	8-14Days	8-14Days
6/1/2020	8-14Days	8-14Days	8-14Days	8-14Days	8-14Days	8-14Days
6/1/2020	8-14Days	8-14Days	8-14Days	8-14Days	8-14Days	8-14Days

WALNUT CREEK SKILLED NURSING AND REHABILITATION CENTER-WALNUT

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	4-7Days	4-7Days	15+Days	4-7Days	4-7Days	0Days
6/1/2020	8-14Days	4-7Days	15+Days	1-3Days	4-7Days	0Days

WILLOW PASS HEALTHCARE CENTER-CONCORD

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	4-7Days	4-7Days	4-7Days	4-7Days	4-7Days	4-7Days
6/1/2020	4-7Days	4-7Days	4-7Days	4-7Days	4-7Days	4-7Days

WINDSOR MANOR REHABILITATION CENTER OF CONCORD-CONCORD

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	1-3Days	1-3Days	0Days	1-3Days	1-3Days	1-3Days
6/1/2020	4-7Days	1-3Days	0Days	1-3Days	1-3Days	1-3Days

CONTRA COSTA HEALTH SERVICES

Skilled Nursing Facilities
PPE On-Hand Report

WINDSOR ROSEWOOD CARE CENTER-PLEASANT HILL

CreationDate	N95s	Face Masks	Eye Protection	Gowns	Gloves	Hand Sanitizers
6/7/2020	8-14Days	8-14Days	8-14Days	8-14Days	8-14Days	8-14Days
6/1/2020	4-7Days	4-7Days	1-3Days	4-7Days	4-7Days	4-7Days

ANNA M. ROTH, RN, MS, MPH
HEALTH SERVICES DIRECTOR
CHRIS FARNITANO, MD
HEALTH OFFICER

CONTRA COSTA
HEALTH SERVICES

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1220 Morello, Suite 200
Martinez, CA 94553
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Fax (925) 957-2651

Interim Guidance for Prioritizing Testing of ASYMPTOMATIC PERSONS for COVID-19

Contra Costa Health Services encourages widespread testing of asymptomatic individuals to detect asymptomatic infection and prevent the spread of Covid-19. As testing capacity expands, priority consideration should be given to the following groups of individuals for testing, based on exposure risk and close contact with vulnerable populations.

Surveillance testing applies to persons of unknown or previously negative status – persons who are previously positive should not be re-tested. Asymptomatic surveillance testing does not designate an individual as a PUI (Person Under Investigation) and does not require the same level of PPE as a PUI.

Close Contacts to Persons Who Have Covid-19: Test asymptomatic close contacts to known cases, as they are at high risk for infection.

- Close contacts in the General Community – from household, intimate, social and workplace settings – will be quarantined, tested and isolated if positive
- Close contacts in Sensitive Occupations or Settings (SOS) * have urgent priority for quarantine and testing
- Close contacts in Congregate Living Facilities have urgent priority with testing of all staff and residents upon detection of an outbreak

Testing in Congregate Living Facilities: Test asymptomatic residents and staff in congregate facilities with 10 or more residents, monthly and upon admission.

- Newly Admitted Residents should be tested prior to admission and quarantined for 14 days
- Facility Staff should be screened daily and tested at least monthly
- Residents should be screened daily and offered testing at least monthly

Testing in Healthcare Settings and among First Responders: Consider testing asymptomatic patients and staff in healthcare and among first responders monthly, based on exposure risk.

- Newly Hospitalized Patients should be tested upon admission and then at least monthly
- Pregnant Women and Patients having Elective Surgeries or Procedures should be tested within 72 hours prior to (or upon) presentation to the hospital
- Newborn infants born to mothers with suspected or confirmed Covid-19 should be tested
- Dialysis and Active Chemotherapy Patients receiving treatment in facilities such as dialysis or infusion centers should be tested at least monthly
- Healthcare Workers screen daily and consider testing monthly
- First Responders screen daily and consider testing monthly

Testing in the Community: Asymptomatic persons in community settings may also be tested, for prevention, screening and surveillance.

- Workers in High Contact Public and Work Settings screen daily and consider testing monthly
- Persons in the Community without risk factors may also be tested

*** SOS = Sensitive Occupations and Settings**

Sensitive settings include:
Skilled nursing facilities
Elder care facilities
Jails
Homeless shelters
Rehab programs
Other congregate living settings
Dialysis centers
Hospitals

Sensitive occupations include:
Health care workers
First responders
Caregivers for the elderly and medically vulnerable
Workers in other congregate living settings

Effective May 6, 2020

CALIFORNIA REGION 2 MEDICAL HEALTH MULTI-AGENCY COORDINATION GUIDE

Interim Draft

January 31st, 2019

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HANDLING INSTRUCTIONS

The attached guide is labeled as For Official Use Only (FOUO) and may contain sensitive information meant to support emergency planning and response and other types of sensitive but unclassified information requiring protection against unauthorized disclosure. It contains information that may be exempt from public release under the Freedom of Information Act (5 U.S.C. 552).

This report and its associated parts are to be controlled, stored, handled, transmitted, distributed, and disposed of in accordance with U.S. Department of Homeland Security policy relating to FOUO information and is not to be released in written or oral form to the public, the media, or other personnel who do not have a valid "need-to-know" without prior approval from agency representatives.

When unattended, this report and its associated documents are to be stored in a locked container or area offering sufficient protection against theft, compromise, inadvertent access, and unauthorized disclosure.
For questions pertaining to the handling of this report, please contact the Association of Bay Area Health Officials (ABAHO)

Disclaimer: This guide, and its subsequent parts, were developed to assist agency executives in regional decision making during extreme events where resources may or may not be available to the entire population. The users of this guide will be working with imperfect information; however, all decisions are made in good faith and for the greatest good. The contents of this guide do not dictate how decisions will be made but instead provides guidance to inform the decision-making process.

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INTRODUCTION

The Purpose of this Handbook is to provide the framework for Multi-Agency Coordination (MAC) Group activities during an emergency with medical/health (M/H) implications affecting some or all of California Mutual Aid Region 2 (See Appendix 1 for Region 2 Map). This Handbook is intended to provide guidelines and procedures for use by a coordination organization.

Multi-agency coordination is a process that allows multiple agencies and jurisdictions to work together more efficiently and effectively. Multi-agency coordination occurs on a regular basis whenever personnel from different agencies interact for preparedness, mitigation, response and recovery activities. Multi-agency coordination may be pre-planned with established protocols or occur on an informal basis, depending on the nature and scope of the emergency. Cooperating agencies that pre-establish operational procedures and protocols in advance can enhance coordination during emergencies[1].

The Standardized Emergency Management System (SEMS), National Incident Management System (NIMS), and Incident Command System (ICS), refer to a Multi-Agency Coordination System (MAC System), as the combination of facilities, personnel, equipment, and procedures that support effective information management, incident prioritization, and resource allocation. The primary function of a MAC System is to coordinate activities and prioritize incident demands for scarce resources. MAC Systems provide support, coordination and assistance with policy-level decisions. Emergency Operations Centers (EOC) and MAC Groups are two examples of MAC System elements.

The primary functions supported by a MAC System include:

Situation Assessment
This includes the collection, processing and display of relevant information to create a common operating picture. It includes the receipt and verification of Situation Reports and may include the consolidation of multiple Situation Reports.

Information Sharing
Multi-agency coordination supports information sharing between emergency response organizations and assists with keeping elected and appointed officials informed.

Incident Prioritization and Resource Allocation
It is sometimes necessary to establish incident priorities for the allocation of scarce resources. MAC Groups (see below) are commonly used for this purpose. Primary considerations for M/H include: • Life and safety threat • Damage or threat to healthcare delivery facilities • Damage or threat to medical and health system infrastructure • Environmental health impact • Incident complexity and duration • Other criteria established by the MAC System

Support Interagency Activities
A primary function of the MAC System is to coordinate, support and assist with policy-level decisions and interagency activities relevant to emergency management activities, policies, and strategies.

[2] Section adopted from California Public Health and Medical Emergency Operations Manual, 2011 Page 57-58

HOW TO USE THIS DOCUMENT

The California Region 2 M/H MAC Guide identifies seven areas required to complete the mission of the MAC Group. This guide is therefore broken down into seven distinct parts, each part necessary to complete prior to moving to the next section. This guide should be read in its entirety, however, those with specific roles can move to their appropriate sections with ease. The reader will also find implementation checklists throughout the sections to assist in completing critical tasks.

The seven domains for this guide include:

- **California Region 2 M/H MAC Guide Concept:** This section defines the concept of operations for the MAC Group, provides details on positions, and describes how the MAC group is organized.
- **Notification and Initial Actions:** This section focuses on initial actions and triggers that activate the MAC Group. The processes for notifying, activating, and assembling the MAC Group are found in this section.
- **Multi Agency Coordinator:** This section focuses on the actions, and forms, to be completed by the MAC Coordinator to aid in facilitating MAC Group functions.
- **Agency Representatives:** This section focuses on the role of the Agency Representatives and actions that are to be taken during or before a MAC Group meeting or call.
- **Scarce Resource Allocation Toolkit:** This section is to be used in conjunction with the aforementioned sections when a scarce resource is being allocated.
- **MAC Group:** This section focuses on the MAC Group meeting, outcomes, and framework.
- **Annual Review:** This section outlines plan components that need to be reviewed, and assessed, annually in order for the plan to function.

1. CALIFORNIA REGION 2 MAC GROUP CONCEPT

FUNCTIONS

Multi-Agency Coordination (MAC) Group: A MAC Group may be established within any discipline or at any SEMS level to provide strategic guidance and direction to support incident management activities, establish priorities, allocate scarce resources, and coordinate among involved agencies[2].

MAC Groups include agency administrators/executives or their designees who are authorized to represent and commit agency resources and funds. Pre-established MAC Group processes will facilitate the effectiveness of the MAC Group during an emergency with respect to the following functions:

- Providing coordinated decision making
- Establishing priorities
- Committing agency resources and funds
- Allocating resources among cooperating agencies or jurisdictions; and
- Providing strategic guidance to support incident management activities

There are three possible levels for a MAC Group Function that include,

Operational Area
An incident within an Operational Area (OA) having medical and health implications is likely to involve many entities, including the local health department (LHD), local environmental health department (EHD), local emergency medical services agency (LEMSA), and others. During emergency system activations, the OA MAC Group typically meets once per operational period and establishes priorities and disseminates this information to the Operational Area Emergency Operations Center (OA EOC) for implementation through OA EOC Action Plans. MAC Group intelligence gathering, and information exchange activities are usually accomplished through the information systems established by the OA EOC.

Regional
When an emergency has regional implications, multi-agency coordination is achieved by bringing together responsible executives from various political levels such as county governments, local health jurisdictions, and/or State agencies to coordinate through a MAC Group.

State
During large-scale emergencies that require statewide response and coordination, a statewide MAC Group may be formed that includes affected jurisdictions and State response agencies. The statewide MAC Group evaluates statewide situational information, establishes incident priorities, prioritizes and allocates scarce resources, and maintains effective communication regarding MAC Group activities.[6]

This guide focuses on the organization and functions of the Region 2 M/H MAC Group.

[2] Section adopted from California Public Health and Medical Emergency Operations Manual, 2011 Page 57-58

MISSION

The R2 M/H MAC Group will provide agency representation and participation for making policy recommendations and allocating scarce resources.

Day-to-day M/H policy decisions and resource allocations are made by local health officials at the jurisdictional level. During an emergency activation, when multiple Operational Areas (OAs) are affected, a R2 M/H MAC Group may be tasked to make policy recommendations, allocate scarce resources, or make scarce resource allocation recommendations from a regional perspective (See Appendix 1). This requires that multiple health officials agree to a decision-making process different from day-to-day and/or individual OA operations.

In instances requiring scarce resource allocation FIRESCOPE and Cal OES processes prioritize *incidents.* In FIRESCOPE "ultimately high priority *incidents* will receive at least some of the critical resources they've requested." Due to the structure of the M/H mutual aid system the concept of *incident* has been shifted to the OA level in this document. In some circumstances Region 2 OAs may be considered to be at equal risk for a threat such as a bioterrorism incident, large-scale infectious disease outbreak, or catastrophic earthquake. In these cases, it may not be necessary to allocate scarce resources based on prioritized OAs. Consequently, the process for allocating scarce M/H resources described in this handbook may or may not involve the prioritization of OAs.

COMPOSITION

The R2 M/H MAC Group is comprised of Medical/Health Agency Administrators/Executives (AAs) who have the authority to make decisions and commit agency resources, or their designees who have been authorized to represent the agency in accordance with their letter of delegation. An individual assigned to a R2 M/H MAC Group is called an Agency Representative (AREP)[3].

R2 M/H MAC Group AREPs who are appointed by their AA should receive a letter of delegation of authority (See Appendix 2). This letter should specify authority to the representative, along with any specific limitations. AAs should designate at least two alternate AREPs who will stand in for the primary member when they are not available. The alternates will have the same scope and authority as the primary AREP.

The R2 M/H MAC Group membership should be based upon the statutory responsibility of a jurisdiction or agency to abate the emergency. Each emergency situation will dictate who should be mobilized to serve on a R2 M/H MAC Group. R2 M/H MAC Group members may represent:

- Local Health Departments
- Local Health Officers
- Local Environmental Health Departments
- Local Emergency Medical Services Agencies
- County Departments of Behavioral/Mental Health
- Medical Health Operational Area Coordinators (MHOACs)
- State government
- Federal government
- Tribal Health Entities
- Other Government Agencies involved in Public Health and Medical Emergency Response.

It is important to note that each agency retains its jurisdictional authority and responsibility. It is also recommended that local health jurisdictions include a Public Information Officer (PIO) in the process to ensure consistency in messaging. Updating membership to the MAC Group is imperative for the group to function therefore the composition of the MAC group can be found in the annual review section of the document.

[3] Section amended from California Statewide Multi-Agency Coordination System Guide page 17, California Government Code 8607, FIRESCOPE 410-1, page 5

INTERAGENCY COORDINATION

Assisting and cooperating agencies without medical/health statutory or regulatory authority may be requested by the R2 M/H MAC Group to provide subject matter expertise, intelligence or information regarding incidents such as:

- Regional Disaster Medical and Health Coordination (RDMHC) Program
- Emergency Medical Services Providers
- Health Care Facilities, including but not limited to hospitals, community clinics and skilled nursing facilities
- Local Emergency Management Agencies
- Non-Governmental, Community-Based and Faith-Based Organizations involved in Public Health and Medical Emergency Response
- Other jurisdictions which are or may be impacted or affected by the incident

During emergencies, the State of California utilizes Regional Emergency Operation Centers (REOCs) to manage and coordinate information and resources among the Operational Areas (OAs) within the mutual aid region and also between the OA and the state level. The REOC coordinates emergency response functions, including Medical/Health regional situational awareness and Medical/Health resource ordering.

The R2 M/H MAC Group may be hosted at an EOC. Ideally, the host EOC provides the R2 M/H MAC Group with some of the needed support as the situation warrants. If the host EOC is unable to fill the support positions, the R2 M/H MAC Coordinator will submit resource requests for staff through the host EOC and perform those functions until the positions are staffed.

POSITION DESCRIPTIONS

The following positions must be established to implement the R2 M/H MAC Group. These positions may be integrated into the host EOC to support only the R2 M/H MAC Group.

Operational Area Medical/Health AAs	
Tasks	• With at least one other AA, approve the activation of a R2 M/H MAC Group. • Approve agency participation in an activated R2 M/H MAC Group. • Serve as or appoint R2 M/H MAC Group AREP(s) through a written delegation of authority. • Recommend issues needing R2 M/H MAC Group action. • Provide approval of R2 M/H MAC Group new or amended policies. • Implement R2 M/H MAC Group decisions and/or recommendations within the jurisdiction in coordination with the EOC.

R2 M/H MAC Group AREP	
Authority	R2 M/H MAC Group AREP's must, by the nature of their designation as AA or through a written delegation of authority from their AA, have full authority to represent their agency to**:** • Recommend new or amended policy to AAs for approval. • Commit to expenditures of their organization's funds and utilization of resources on behalf of the AA. • Determine criteria for, and make recommendations about allocation of federal, state, and/or privately-owned scarce resources at a regional level • Determine criteria for, and make decisions about, allocation of locally owned scarce resources at a regional level.
Tasks	**R2 M/H MAC Group AREP Tasks:** • Obtain situational information and any other report needed for R2 M/H MAC Group prioritization and allocation from their EOC, Health DOC, and/or AA. • Communicate and disseminate information to AAs including R2 M/H MAC Group decisions, recommendations and media information. • Maintain communications and information sharing with REOC, OA EOCs, Health DOCs, and other Medical and Health Stakeholders. • Orient R2 M/H MAC Group AREP Alternate(s) and keep them current on decisions, recommendations, issues, and new business. • Discuss with their alternates the California R2 M/H MAC Guide and Working Guidelines. • Identify scarce resource needs among R2 OAs • Prioritize OAs if applicable. • Allocate locally owned scarce resources. • Make recommendations for allocation of federal, state, and/or privately-owned scarce resources.

R2 M/H MAC Coordinator	
Role	The R2 M/H MAC Coordinator serves as the R2 M/H MAC Group facilitator and helps to direct the R2 M/H MAC Group toward accomplishing its mission. **The R2 M/H MAC Coordinator is not an AREP and does not participate in the R2 M/H MAC Group decision making process**. **The R2 M/H MAC Coordinator may be staffed by someone from the RDMHC/S or MHOAC Program**. The R2 M/H MAC Coordinator must be knowledgeable of the Incident Command System (ICS) and MAC System within SEMS. It is critical that the R2 M/H MAC Coordinator have excellent facilitation skills and establish credibility with the R2 M/H MAC Group AREPs. The R2 M/H MAC Coordinator requests staff from the host EOC to support the R2 M/H MAC Group.
Tasks	The R2 M/H MAC Coordinator ensures the completion of the following: • Conducts initial screening of issues to evaluate if they are appropriate for R2 M/H MAC Group consideration. • Assigns and supervises assigned personnel. • Manages the host facility and ensures necessary equipment is available. • Facilitates the R2 M/H MAC Group decision making process including display of information and providing a regional situation report for prioritization of resource needs of OAs and scarce resource allocation/recommendations. • Establishes a daily schedule for meetings and conference calls and provides schedule and agenda information to all R2 M/H MAC Group participants. • Documents R2 M/H MAC Group activities including conference calls or in-person meetings and distributes information to R2 M/H MAC Group AREPs and others as needed. • Requests subject matter experts (SMEs) to assist the R2 M/H MAC Group. • Ensures the final documentation package of R2 M/H MAC Group activities is completed. • Facilitates all conference calls and R2 M/H MAC Group meetings. • Orients new members to the R2 M/H MAC Group.
Potential MAC Coordinators	MAC Coordinators must be individuals with disaster/EOC experience **AND** have the ability to facilitate large group discussions under austere conditions. The primary pool of MAC Coordinators that should be considered first for appointment: • Non-impacted MHOAC Coordinators • RDMHS Secondary options include non-impacted: • Local EMS Administrators or • Health Officers

SUPPORT FUNCTIONS

The following ICS positions may be established to support the R2 M/H MAC Group. These positions may be integrated into the host EOC or assigned as separate positions to support only the R2 M/H MAC Group.

POSITION	TASKS
Logistics Section Chief	• Reserves conference call times and disseminates access information to all participants. • Provides general supply and equipment logistical support.
Communications Unit Leader	• Prepares and implements communications plans and install, test, and maintain communications equipment
Facilities Unit Leader	• Arranges work area, equipment, and supplies for R2 M/H MAC Group activities (See Appendix 3).
Planning Section Chief	• Provides short term, strategic and contingency planning to meet R2 M/H MAC Group needs.
Situation Unit Leader	• Collects the Situation Status Reports from AREPs and any additional information needed by the R2 M/H MAC Group for prioritization and scarce resource allocation/recommendation. • As needed, contacts REOC for clarification and updates on incident status reports and scarce resource needs. • Develops and displays all needed schedules, tables, data sheets or other information.
Resource Status Unit Leader	• Provides information regarding the allocation and release of scarce resources. • Tracks scarce resource requests through the REOC Logistics Section and visually displays the allocation of scarce resources for the next operational period.
Documentation Unit Leader	• Creates documentation packages for all R2 M/H MAC Group decisions and recommendations. • Keeps accurate email distribution lists and other contact information for distribution of decisions, recommendations, and documents. • Records meeting minutes.
Technical Specialists / SMEs	• Are supervised by the R2 M/H MAC Coordinator. • Are not R2 M/H MAC Group members. • Provide technical information/expertise related to a specific issue brought before the R2 M/H MAC Group, e.g., neonatal and pediatric subject matter expert. • Assist the R2 M/H MAC Group in making informed decisions and recommendations.
Public Information Officer	• Communicates R2 M/H MAC Group decisions to the Joint Information Centers (JIC) at the host EOC and/or REOC. • Maintains appropriate dissemination of information to the public about the R2 M/H MAC Group activities. • In coordination with the host EOC PIO develops a plan for release of information to the media.

GUIDANCE: The annual review process describes additional information for training that is strongly encouraged for all R2 M/H MAC Group AREPs and R2 M/H MAC Coordinators.

COMPLIANCE

The MAC System is a component of the California Standardized Emergency Management System (SEMS) as well as the National Incident Management System (NIMS). The California Emergency Services Act (ESA) requires the utilization of the SEMS for managing multi-agency and multi-jurisdictional responses to emergencies in California. The four components of SEMS are Incident Command System (ICS), MAC System, California Disaster and Civil Defense Master Mutual Aid Agreement (MMAA) and Operational Area (OA) concept[4]. The following authorities and references recognize use of multi-agency coordination in emergency management:

- 2012-2016 US DHHS ASPR Healthcare Preparedness Capability 3: Emergency Operations Coordination, Function 3: Support healthcare response efforts through coordination of resources: Identify available healthcare resources, Resource management implementation, Public health resource support to healthcare organizations, Managing and resupplying resource caches, and Inventory management system

- 2017-2022 US DHHS ASPR Health Care Preparedness and Response Capability 2: Health Care and Medical Response Coordination, Objective 3: Coordinate Response Strategy, Resources, and Communication, Activity 1: Identify and Coordinate Resource Needs during an Emergency

- CDC's Public Health Preparedness Capabilities: National Standards for State and Local Planning March 2011. CAPABILITY 3: Emergency Operations Coordination, Function 4: Manage and sustain the public health response, Task 2: Track and account for all public health resources during the public health response

- National Incident Management System

- California Code of Regulations, Title 19, Division 2, Chapter 1 - Standardized Emergency Management System

- California Health and Safety Code §1797.153 – Medical Health Operational Area Coordination (MHOAC)

- California Health and Safety Code §101025-101165 – Powers and Duties of Local Health Officers and Local Health Departments

- California Public Health and Medical Emergency Operations Manual (EOM)

- Appendix 4 diagrams the flow of resource requests and assistance during emergencies per SEMS

[4] Section directly adapted from California Statewide Multi-Agency Coordination System Guide. February 2013. Section III, page 3

2. NOTIFICATION AND INITIAL ACTIONS

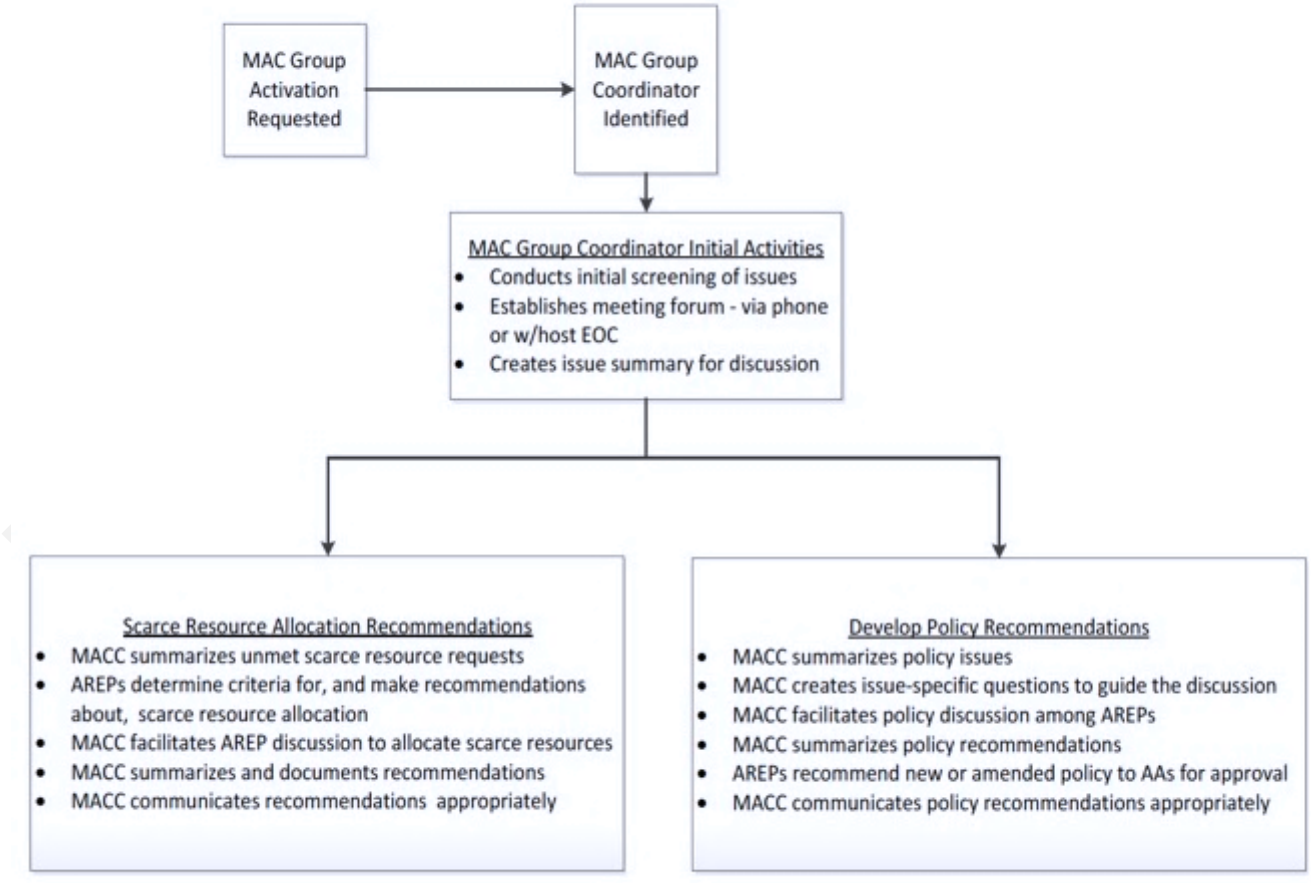
TRIGGERS

When two or more R2 M/H AAs, Health Officers, and/or MHOACs from different OAs, or the RDMHC/S identifies a need to:

Triggers	
☐	Recommend allocation of scarce resources at a regional level (federal, state, or privately owned)
☐	Allocate scarce resources at a regional level (locally owned)
☐	Propose new or amended medical/health policies, and/or, resolve common medical/health issues among multiple OAs.

Then, the R2 M/H MAC Group will be activated. The process is outlined below in Table 1.

Table 1: Activation and Communication Process



*MACC = MAC Coordinator

IMPLEMENTATION CHECKLIST #2.1

Activation and Notification. Ensure activation and notification of the MAC group.

BEFORE GETTING STARTED: Review the position descriptions, confirm that triggers have been met and appoint a MAC Coordinator.

Key Steps Activation	Responsible Party
☐ With at least one other AA, approve the activation of a R2 M/H MAC Group ☐ Appoint MAC Coordinator ☐ Determine Activation Level (see Table 2) ☐ Determine MAC Group Composition ○ Approve agency participation in an activated R2 M/H MAC Group ○ Serve as or appoint R2 M/H MAC Group AREP(s) through a written delegation of authority ○ Consider support functions to participate ☐ Recommend issues needing R2 M/H MAC Group action	MAC Coordinator, AA, and/or RDMHC
Key Steps Notification	**Responsible Party**
Note: The notification process below is updated annually. ☐ Log-in in Everbridge with SMC Health Network specific username and password ☐ Select “Notifications” from top menu ☐ Select “New Notification” on the upper left side ☐ Complete “Create Message” ○ 4a. “Body” should contain message text ○ 4b. “Message Type” – select “Polling” and type “Message Received” into “Text Response” ○ 4c. If files associated, select blue “Attach Files” option under “Message Type” ☐ Select Contacts by choosing “Groups” ○ 5a. Click “Groups” and select relevant recipients. Select “Ok” to proceed. ☐ Scroll to the bottom of the page and select the orange “Send” button	MAC Coordinator
Note: Prepopulated message templates are found within the notification platform	

Table 2. Activation Matrix

Activation Level	Event Severity	Positions to Activate	Support Positions
Partial	MAC support is only needed for a portion of CA R2.	☐ MAC Coordinator ☐ AREPs or OA Health Administrators ☐ MHOAC	☐ State Partners as needed ☐ SMEs as needed ☐ PIO
Full	MAC support is needed for all of CA R2.	☐ MAC Coordinator ☐ AREPS or OA Health Administrators ☐ MHOAC ☐ State Partners	☐ SMEs ☐ PIO ☐ Support functions

3. MULTI-AGENCY COORDINATOR

MASTER CHECKLIST

Ensure completion of the following actions. This list includes all actions needed to be completed by the MAC Coordinator. Continue to other checklists to complete all actions in further detail.

Key Steps		Associated Checklists
☐	Triggers for activation are met	Triggers
☐	RDMHC/S or appointed MAC Coordinator sends notification to AREPs (MHOAC and Health Officers)	Implementation Checklist 2.1
☐	RDMHC/S or appointed MAC Coordinator lists issues to be discussed by the MAC Group and determines call type ○ Situational Awareness Call OR ○ Decision Making Call	Implementation Checklist 3.1
☐	RDMHC/S or appointed MAC Coordinator sets conference call date and time if meeting is not in person	Implementation Checklist 3.2
☐	RDMHC/S or appointed MAC Coordinator completes Conference Call Agenda	Implementation Checklist 3.2
☐	RDMHC/S or appointed MAC Coordinator and MAC Group convene and complete either ○ Situational Awareness Call OR ○ Decision Making Call	Proceed to MAC Group Meeting
☐	MAC Coordinator facilitates meeting and uses Scarce Resource Toolkit as needed	Scarce Resource Survey
☐	MAC Coordinator completes Approval Forms if scarce resource is allocated	Proceed to Approval Forms
☐	RDMHC/S or appointed MAC Coordinator completes MAC Group IAP as needed	Implementation Checklist 3.3

IMPLEMENTATION CHECKLIST #3.1

List each issue, or resource, to be discussed during MAC Group meeting.

BEFORE GETTING STARTED: Issues can be found in by reviewing situational awareness forms such as MHOAC Sit Rep forms and Logistics requests.

Key Steps	Responsible Party
☐ MAC group completes policy decision **AND/OR** ☐ MAC group completes scarce resource allocation	MAC Coordinator

No.	Issue Being Discussed	Policy Issue or Scarce Resource Allocation?
1		
2		
3.		

IMPLEMENTATION CHECKLIST #3.2

Conference call. Ensure completion of MAC Group conference call materials.

BEFORE GETTING STARTED: Ensure conference call agenda is complete and sent to MAC group members before call or meeting. Follow key steps below and complete forms.

	Key Steps	Responsible Party
☐	R2 M/H MAC Group AREPs notified	MAC Coordinator
☐	Time and location determined and communicated	
☐	Meeting agenda and R2 M/H MAC Group issues prepared	
☐	Complete Conference Call Agenda using Guidance and Template	

Conference Call Agenda Guidance

Briefing:

- Current situation updates, probable future situation (e.g. assessment of the current healthcare system for event and non-event related illness, projected demand surge from incident, related illness and related resource needs, projected reduction of available space, staff and other response capability [e.g. equipment/supplies]);
- Current issues described;
- New issues introduced;
- Questions/clarification.

Discussion/Decision/Recommendation Portion

- Review MHOAC and RDMHC Program Situation Status reports and unfilled Scarce Resource Request forms for background information to allocate or recommend allocation of scarce resources;
- Review identified and new issues and have OA AREPs and SMEs complete the scarce resource survey as needed
- Review criteria for establishing operational area priorities and prioritize operational areas if needed for scarce resource allocation and summarize prioritization.
    - This includes the maintaining of essential services and unique capabilities of the total healthcare system;
- Discussions, decisions, and/or recommendations on issues;
- Allocate or recommend allocation of scarce resources;
- Discuss how to resolve media and VIP interface issues;
- Consider needs for contingency and strategic specific plans

R2 M/H MAC Group Meeting Outcomes

- Decisions/recommendations/priorities/allocations determined and communicated to affected parties;
- Decision or recommended action is identified and documented;
- Draft new policy or revise policy; communicate with Agency Administrators for approval, as necessary; plan in place for media interfacing

Sample Medical-Health MAC Group Conference Call Agenda

R2 M/H MAC Group Conference Call Template	
Call Type	☐ Informational ☐ Decisional
MAC Coordinator	
Agency Representatives	
Regional Updates	Short bullet statements with key points or information items (e.g. incident updates, VIP visits, newor ongoing key initiatives, etc.)
Report on Scarce Resources	Short bullet statement(s) related to the flow/availability of resources.
Incident Outlook	Projections for the next X hours or X days
Report on Incidents	• Current incident information presented in priority order • New activity(s)
Issue Identification/Resolution	• **Issue:** Name of individual presenting the issue followed by a short issue statement • **Decision/Recommendation:** Document the decision/recommendation
Decisions/Recommendations for Allocation of Scarce Resources	Discussion of proposed allocations by R2 M/H MAC Group Agency Representatives
Necessary Actions/Follow up	

Schedule Next Conference Call	
Conference Call Number	
Conference Call Passcode	
Date	
Time	

Blank Medical-Health MAC Group Conference Call Agenda

R2 M/H MAC Group Conference Call Template	
Call Type	☐ Informational ☐ Decisional
MAC Coordinator	
Agency Representatives	
Regional Updates	
Report on Scarce Resources	
Incident Outlook	
Report on Incidents	
Issue Identification/Resolution	
Decisions/Recommendations for Allocation of Scarce Resources	
Necessary Actions/Follow up	

Schedule Next Conference Call	
Conference Call Number	
Conference Call Passcode	
Date	
Time	

IMPLEMENTATION CHECKLIST #3.3

Complete IAP. Ensure incident action plan completed and distributed for each operational period the MAC Group is activated.

BEFORE GETTING STARTED: When gathering situational awareness ensure use/availability of MHOAC Situation Report Form and or other sources of incident intelligence.

1. Incident Name	2. Operational Period #		
	2A. DATE:	FROM:	TO:
	2B. TIME:	FROM:	TO:
3. Situation Summary			

4. Current Incident Management Structure (fill in additional positions as appropriate)		
INCIDENT COMMAND STAFFF		**CONTACT INFO**
Incident Commander		
Deputy Incident Commander		
Liaison Officer		
Safety Officer		
Public Information Officer		
INCIDENT SECTION CHIEFS		
Operations Section Chief		
Planning Section Chief		
Logistics Section Chief		
Finance Section Chief		
RDMHC/S		
RDMHC		
RDMHS		
MAC GROUP		
MAC COORDINATOR		
MAC Coordinator		
AGENCY REPRESENTATIVES		
Operational Area		

MAC GROUP SUPPORT POSITIONS		Phone No.
Logistics Section Chief		
Communications Unit Leader		
Facilities Unit Leader		
Planning Section Chief		
Situation Unit Leader		
Resource Status Unit Leader		
Documentation Unit Leader		
Technical Specialists		
Public Information Officer		
SME – EMS		
SME – Pediatric Critical Care		
SME – Behavioral Health		
SME – Environmental Health		
SME – Public Health		
SME – Policy and Legal		
SME – Healthcare Delivery Services」		
5. Health and Safety Briefing: Identify potential incident health/safety hazards & develop necessary measures (remove hazard, provide PPE, warn people of the hazard) to protect responders.		
Weather		
Safety/Security		

5. Issues for Resolution			
5a. Issue	**5b. Strategies / Tactics**	**5c. Resources Required**	**5d. Assignment**

Prepared by

PRINT NAME/TITLE:

DATE/TIME:

4. AGENCY REPRESENTATIVES

DECISION MAKING FRAMEWORK

The framework below describes the structure for making both policy decisions **and** scarce resource allocation decisions. This framework is augmented by the values and process that drive decision making.

Decision-Making by Consensus: Consensus decision making is the ideal process for a R2 M/H MAC Group. Reaching consensus does not necessarily imply that the agreed upon decision is a group member's first choice; it represents the best decision that a member can support or implement at the time. When a R2 M/H MAC Group decision is made, AREPs should anticipate, identify, and document circumstances that could necessitate modifying the decision in the future.

Chances for Consensus can be strengthened by:

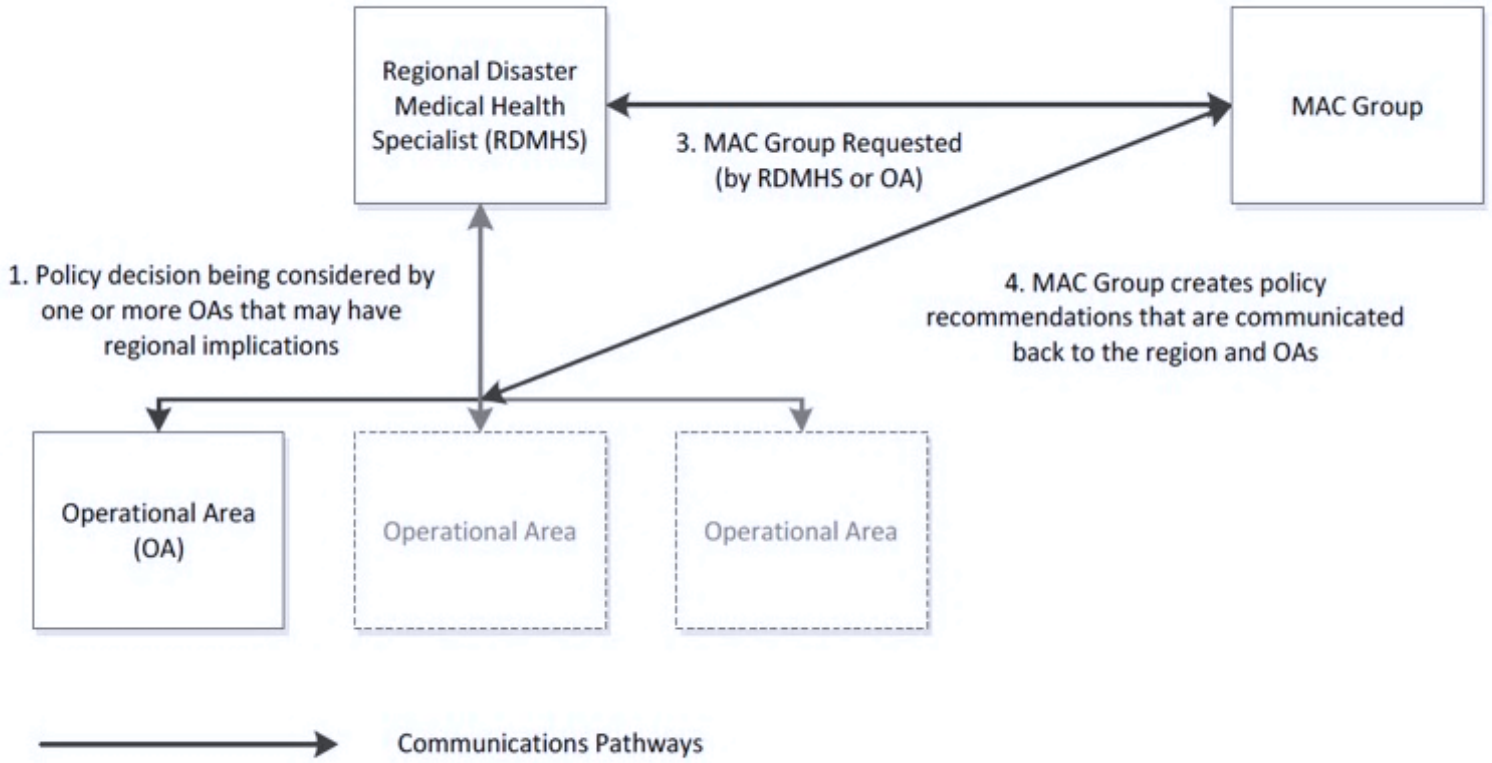
- ☐ Recognition of complex issues that may present difficulty in achieving consensus.
- ☐ Advance notice to AREPs of issue-related information.
- ☐ Thorough analysis and presentation of issues and related information to the R2 M/H MAC Group.

Decision-Making Without Consensus. Consensus decision making may not always be achieved. Options when consensus is not reached:

- ☐ AREPs who can support or implement the decision can do so. AREPs who cannot support or implement the decision can decide not to implement and choose to act independently from the R2 M/H MAC Group.
- ☐ Not a desirable situation but may be most practical to resolve the issue when there is agreement among most represented agencies/organizations.
- ☐ Requires documentation clearly explaining the lack of consensus.
- ☐ Defer the decision for consideration at a later date.
- ☐ Facilitate collaboration among AAs to resolve the issue and bring back to the R2 M/H MAC Group.
- ☐ Assign responsibility to an AREP for developing more information about the issue and bring back to the R2 M/H MAC Group at a specific time and date.
- ☐ Wait for further development of the situation that created the issue and bring back to the R2 M/H MAC Group at that time.

Modifying Decisions. If circumstances relative to the decision change over time and one or more AAs can no longer support the original decision, the R2 M/H MAC Group will review and modify the decision if necessary.

Table 2: SEMS Compliant Decision-Making Communications Flowchart



VALUES TO GUIDE DECISION MAKING

The purpose of this section is to present the common values inherent to ethical decision making. These values provide a structure for discussion that ensures all the important aspects of each issue are considered.

GUIDANCE
Overarching Principle: Greatest good for the greatest number The values below should be also taken into consideration during the deliberation process, however, specific emphasis should be paid to two principles: **Transparency and Consistency.**

Accountability: holding decision-makers responsible for their actions and ensuring process for evaluating decision making process

Apolitical: having no interest or involvement in political affairs and acting in an impartial manner

Beneficence: preserving the welfare of others through affirmative acts to promote well-being and save lives

Consistency: ensuring messaging, decision making, and the allocation process, are consistent among policy makers and jurisdictions

Duty to Care: adhering to a standard of reasonable care while performing acts that could potentially harm others

Fairness: applying consistent, equitable, and nondiscriminatory policies and practices

Inclusiveness: agencies ensure that their processes are developed explicitly with stakeholder views in mind

Justice and Equity: making appropriations of resources in a fair and just manner given extreme circumstances

Proportionality: demanding policies necessary and proportional to the scope and severity of the circumstances

Reciprocity: mutual benefit for those involved

Respect for persons: upholding individual autonomy, privacy, dignity, and bodily integrity

Respect for Community Norms: respecting the cultural values of the region or jurisdiction in question

Solidarity: shared obligations and social cohesion

Stewardship: preserving the effectiveness and impact of resources and services as best as possible

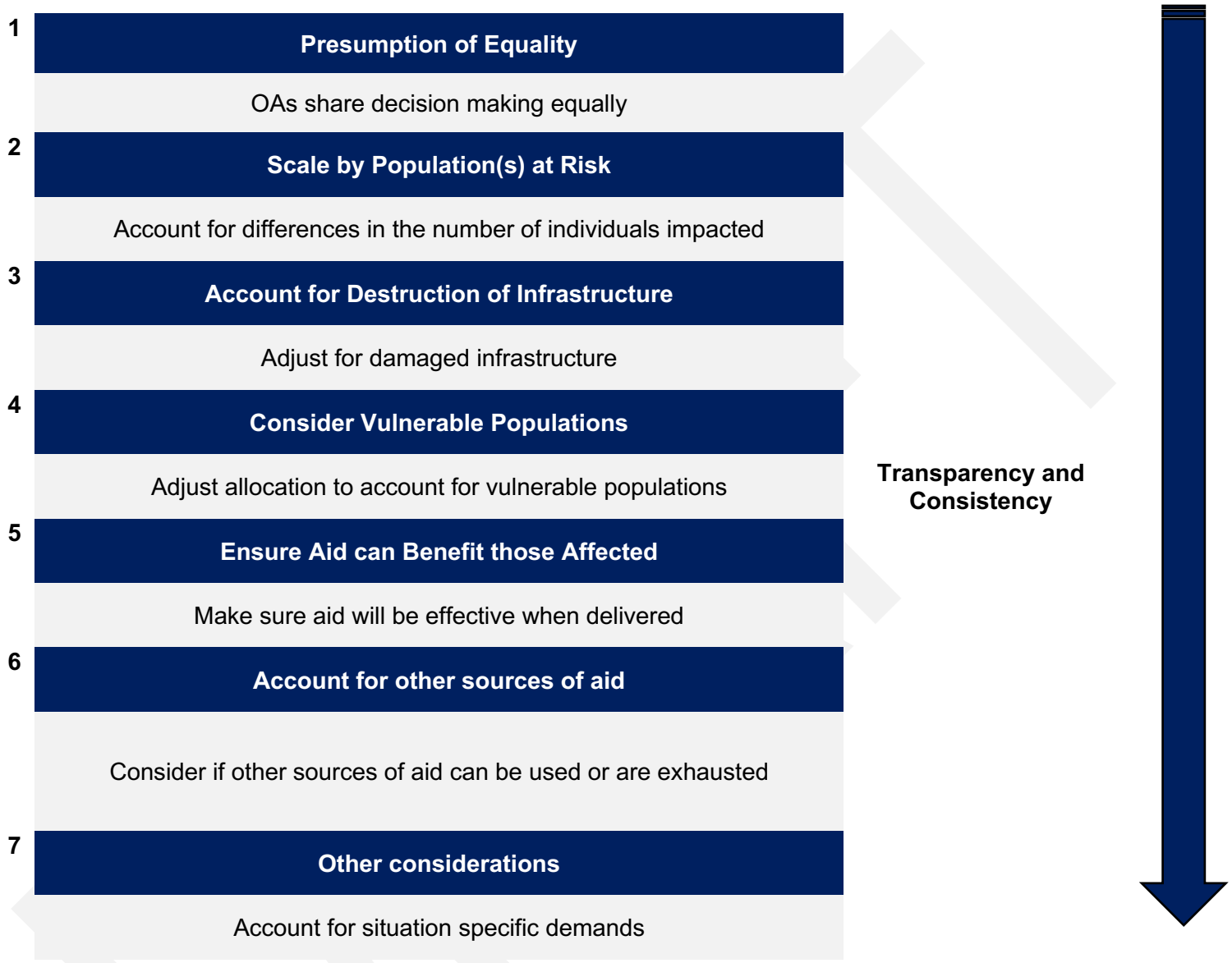
Transparency: providing open access to information and the decision-making processes

Utility: achieving the greatest good for the greatest number

Veracity: truth-telling

These considerations were developed by conducting a review of current literature, completing interviews with partners from State and Local government, large urban area(s), and academia. The considerations listed above are found to be consistent across plans, policies, and current thinking. For a full list of documents reviewed, see Appendix 8.

DECISION MAKING PROTOCOL[5]



[5] This logic model was adapted for OA use, and includes ethical framework guidelines, from the following source. Knebel AR, Sharpe VA, Danis M, Toomey LM, Knickerbocker DK. I*nforming the gestalt: an ethical framework for allocating scarce federal public health and medical resources to states during disasters*. Disaster Med Public Health Prep. 2014; 8:79–88.

5. SCARCE RESOURCE ALLOCATION TOOLKIT

ASSUMPTIONS

The following is assumed for the scarce resource allocation process.

1. This process is not intended to be utilized for all resources to be allocated but focused on scarce resources.

2. The R2 M/H MAC Group has the authority to allocate the resource.

3. Standard resource requesting procedures are already in place and will be followed. These procedures are in accordance with the Standardized Emergency Management System (SEMS) and the National Incident Management System (NIMS).

4. The requestor is unable to obtain resources within a reasonable time frame from vendors, contractors, MOU/MOAs, corporate offices, and other non-traditional sources.

5. Attempts at conservation, reutilization, adaption, and substitution have been performed maximally.

6. The first request received by the R2 M/H MAC Group does not automatically get the resource.

7. Not all available scarce resources may be immediately allocated or distributed in anticipation of how the incident may develop.

8. Allocation may be impacted by whether more of the resource or alternate resource becomes available, based on incident projection and needs.

9. The decision process is designed to be used in any stage of a disaster response when there is scarcity of a specific resource needed by affected OAs.

10. Scarcity is defined relative to a specific resource and a specific timeframe. It means that in spite of strategic stockpiling and regional cooperation and allocation, the demand or need for the specific resource exceeds the supply that is available or expected to become available within a specified period of time.

11. A separate allocation decision should be made for each scarce resource.

12. Decision makers must be prepared to make allocation decisions in two possible sets of circumstances:

    a. When some or all affected OAs have made formal requests for assistance and,
    b. When the events effects on OAs governance prevent it from making a formal request, but when there is an expectation of extreme need based on available information.

13. Decision making will probably be based on incomplete information until situational awareness improves.

14. It is likely that some resources will be adequate to meet the needs and should be distributed as needed. Other resources or sets of resources will be scarce and cannot be provided to all who need them. In the latter case, other available and suitable resources can be substituted to provide ‘‘functionally equivalent’’ resources.

EXAMPLES OF SCARCE RESOURCE EVENTS

Event Type	Potential Scarce Resources	SMEs to include in MAC Group
Pandemic Influenza	Ventilators, Masks, Vaccines, Tamiflu, ICU Beds, Medical Transport, Medical/Nursing Personnel	Public Health Director, Communicable Disease Controller, Chief Epidemiologist, EMS Director
Earthquake	Hospital Beds, Regular Cots, Bariatric Cots, Shelter Management Personnel (Clinical staff and Mental Health staff), IV Poles, Medical Transport, Medical Supplies/Equipment, Mobile Medical Units	EMS Director, Health Service Director, Environmental Health Director, BHRS Director, CalOES Representative
Wildfire	Hospital Beds, Regular Cots, Bariatric Cots, Shelter Management Personnel (Clinical staff and Mental Health staff), IV Poles, Medical Transport, Medical Supplies/Equipment, Mobile Medical Units	EMS Director, Health Service Director, Environmental Health Director, BHRS Director, CalFire Representative, CalOES Representative
Bioterrorism	Prophylaxis, Hospital Beds, Medical Transport, POD Personnel	EMS Director, Public Health Director, Environmental Health Director, Representative from Law Enforcement
Active Shooters	Hospital Beds, Blood Products, Medical/Nursing Personnel, Medical Transport	EMS Director, Health Service Director, Representative from Law Enforcement
Infectious Disease Outbreaks	Potential scarce resources depend on type of ID outbreaks. Disease Investigators, Epidemiologists, Lab Technicians	Public Health Director, Communicable Disease Controller, Chief Epidemiologist, PHL Director

IMPLEMENTATION CHECKLIST #5.1

Complete scarce resource form for your Operational Area OR discuss as a group during MAC Group meeting. Ensure completion with appropriate SMEs.

INSTRUCTIONS: The following criteria allow OAs and the Region to evaluate their situation[6]. Decision makers should use a consistent approach for gathering data, sources of data include SMEs, MHOAC SITREP forms, and other situational awareness data points.

OA INFORMATION	
Issue for Deliberation:	
Incident Priorities:	

Allocation Criteria	Situation
1. Size of total population	
Description: In the early stage of the event, situational awareness will often limit information about absolute numbers of harmed and threatened lives. Therefore, allocation decisions will also consider the size of the population in an affected area.	
2. Size of population affected by the event	
Description: Consistent with the mission of protecting the public from harm and providing aid to those who are least able to help themselves, allocation decisions should consider the number of affected residents in the total population affected. This criterion will take into consideration the number of affected residents in each OA.	
3. Extent to which affected people are likely to benefit from intervention	
Description: As with allocation decisions at any level, whether among individual patients, segments of the population, or political entities, public health and medical resources are likely to be most effectively utilized if they are allocated to those who are expected to benefit most from receiving resources. The reasoning is that the chance of survival for those who are fatally wounded and those who are slightly wounded is not likely to be significantly altered by deferring treatment. A strategy that prioritizes resources for those most likely to benefit, improves chances for survival overall.	

[6] This survey was amended for OA use by modifying the survey found in - Knebel AR, Sharpe VA, Danis M, Toomey LM, Knickerbocker DK. *Informing the gestalt: an ethical framework for allocating scarce federal public health and medical resources to states during disasters*. Disaster Med Public Health Prep. 2014; 8:79–88.

Allocation Criteria	Situation
4. Size of population anticipated to be at additional risk of harm **Description:** Allocation decisions will take into consideration the extent to which the disaster is anticipated to cause additional harm as it unfolds.	
5. Size of the AFN population affected **Description:** To ensure that population-based allocation decisions do not exacerbate the condition of individuals with AFN needs in an affected OA, the percentage of individuals with special needs among an OA's population will be considered. These individuals who require assistance for medical, mental, or psychological disabilities, and whose health depends on regular contact with the health care system, are at risk for additional harm if medical resources are unavailable to them in disaster situations.	
6. Size of the population below the poverty threshold **Description:** To ensure that population-based allocation decisions do not exacerbate the condition of individuals with limited financial and other resources, the prevalence of poverty in the affected OAs will be considered.	
7. Size of medically underserved areas/populations **Description:** Allocation decisions will consider medically underserved populations so as to not further disadvantage them. The medically underserved population areas within the affected OA will be identified using situational awareness forms and discussions.	
8. Degree of destruction of medical and public health infrastructure and resources **Description:** Allocation decisions will take into consideration the degree of destruction of the medical infrastructure (e.g., hospital, out of hospital behavioral health) and the ability to perform public health functions (e.g., epidemiologic investigations, laboratory services, public information) in the affected state as a result of the disaster, as OAs with greater destruction are less able to meet needs without assistance. OAs with greater destruction will receive a higher rating.	

Criterion and Definition	Situation
9. **Ease of rapid delivery of outside the OA (from other OAs, state or federal) resources**	
Description: Allocation decisions will take into consideration the degree of destruction of roads, rail lines, airports, and other critical infrastructure for the purpose of evaluating the feasibility of outside the OA or regions asset delivery. Severe damage may diminish the likelihood that medical resources can be delivered in a sufficiently timely fashion to save lives that are in imminent danger. **Note:** the positioning of resources for an event with prior warning will occur in advance of the decisions regarding scarce resource allocation.	
10. Degree of destruction of local infrastructure	
Description: Allocation decisions will take into consideration the degree of destruction of roads, rail lines, and airports for the purpose of evaluating the ability of the population to exit the disaster area. The inability of the population to exit will increase the need to provide medical aid.	
11. Likelihood that allocated public health and medical resources from outside of the OA or Region (other OAs, state, or federal) can be used to meet needs.	
Description: Allocation decisions will take into consideration the ability of affected OAs to deploy and utilize the resources once received. OAs with the ability to quickly and effectively utilize the public health and medical resources from outside of the OA should be considered.	
12. Access to alternative sources of aid	
Description: Allocation decisions will take into consideration the ability of affected OAs to seek and provide mutual assistance prior to seeking state/federal assistance. OAs already receiving assistance from other OAs under the mutual aid agreement that substantially address the resource gap receive a lower rating on this element.	
13. Degree of critical State and Regional priorities affected	
Description: Allocation decisions will take into consideration critical state or national priorities beyond those of the Region. Those OAs where a disaster is expected to have an effect on state/federal interests such as crucial transportation, energy, communication, and/or nuclear safety resources should be considered.	
14. Equal consideration of each OA	
Description: At the same time that the size of the population in an affected OA should be taken into account to evaluate the greatest aggregate good, therefore, each affected OA should receive attention during discussion(s).	

Justification Criteria	
Top Criteria for Decision Making	1. 2. 3. 4 5.
Discuss, or note, the top criteria from above and the types of populations affected by the event.	
Allocation Decision:	
Notes:	

6. MULTI AGENCY COORDINATION GROUP

IMPLEMENTATION CHECKLIST #6.1

MAC Group meeting. Convene MAC Group and facilitate meeting.

BEFORE GETTING STARTED: Ensure conference call agenda has been updated and all parties have access to either EOC meeting space or conference line. Ideally, R2 M/H MAC Group AREPs, R2 M/H MAC Coordinator and other personnel requested by the R2 M/H MAC Group should attend R2 M/H MAC Group meetings in person. If unable to attend in person, a teleconference option should be made available.

Meeting Format:

- The R2 M/H MAC Coordinator will facilitate all meetings.
- All routine meetings will begin at predetermined times.
- Meetings should last no longer than 3 hours.
- Coordination/information sharing between the R2 M/H MAC Coordinator and the R2 M/H MAC Group AREPs should happen prior to the R2 M/H MAC Group meetings to ensure issue(s) are clearly and concisely described and managed.
- Recommended issues for discussion during R2 M/H MAC Group meetings will be summarized and provided by R2 M/H MAC Coordinator or provided by AREPs who have identified the issue in writing in advance of all meetings.
- New issues will be conveyed from the R2 M/H MAC Coordinator to the group in one of the following ways: conference calls before a meeting, in writing before a meeting, or at the beginning of a meeting for last-minute issues.
- All briefing materials will be included in the permanent R2 M/H MAC Group record

Key Steps	Responsible Party
R2 M/H MAC Group Meeting Objectives: ☐ Provide an informational update on the regional situation status. ☐ Prioritize resource needs of OAs for the allocation of scarce resources. ☐ Proactively identify, clarify and resolve regional medical/health issues. ☐ Recommend new or adjusted policy to AAs for approval. ☐ Allocate scarce resources or make recommendations about scarce resource allocation at a regional level. ☐ Make and document all decisions and recommendations. ☐ Determine the need for contingency plans as appropriate. ☐ Provide guidance for upcoming media releases, VIP visits and AA briefings involving the R2 M/H MAC Group.	MAC Coordinator
IF SCARCE RESOURCE IS BEING ALLOCATED USE SCARCE RESOURCE TOOLKIT	

Meeting Facilitation To facilitate the R2 M/H MAC Group process, each meeting should be organized in the following manner: **Introduction/Ground Rules:** ☐ R2 M/H MAC Group Coordinator facilitates the meeting ☐ Roll call ☐ Review working guidelines including behavior expectations and business/decision making protocol (see Appendix 5). ☐ Optional well-being check-in with AREPs. **Briefing:** ☐ Current situation updates, probable future situation (e.g. assessment of the current healthcare system for event and non-event related illness and injuries, projected demand surge from the incident, related illness and related resource needs, projected reduction of available space, staff and other response capabilities); ☐ Describe current issues and answer questions for clarification. **Discussion/Decision/Recommendations:** ☐ Identify alternatives and solutions for current issues and/or policy recommendations; ☐ Review MHOAC and OA Situation Status Reports and unfilled scarce resource requests; ☐ Review or develop criteria to prioritize scarce resource needs of OAs using the Implementation Checklist #5.1; ☐ Consider the need for contingency and strategic planning. **Outcomes:** ☐ Determine policy recommendations, allocate locally owned scarce resources or recommend allocation of federal, state, or privately-owned scarce resources, and communicate to affected parties; ☐ Identify and document decisions and recommendations; ☐ Draft new policy or revised policy (communicate with AAs for approval, as necessary); ☐ In coordination with the host EOC PIO, develop a plan for release of information to the media.	MAC Coordinator and MAC Group

7. APPROVAL FORMS

IMPLEMENTATION CHECKLIST #7.1

Ensure issues for resolution are accounted for, scored, scarce resource requests forms are completed as applicable. Complete all other documentation.

BEFORE GETTING STARTED: This section is the final step in the process, ensure that all other steps have been accounted for.

Key Steps	Responsible Party
Documentation & Record Keeping The following documentation package will be developed by the Document Unit Leader, or MAC Coordinator. and will be retained by the host EOC: ☐ Attendance at all R2 M/H MAC Group meetings. ☐ All information presented at R2 M/H MAC Group meetings. ☐ R2 M/H MAC Group decisions and supporting documentation. ☐ All scarce resource allocation documents signed by the R2 M/H MAC Coordinator and MAC Group as needed ☐ All decision criteria used by the R2 M/H MAC Group to prioritize incidents and allocate scarce resources. ☐ All notes taken during R2 M/H MAC Group meetings and conference calls **Note: These discoverable materials are subject to external requests**	MAC Coordinator, Assigned AREP, or Document Unit Leader
Communicating R2 M/H MAC Group Decisions ☐ All decisions will be documented and signed by the R2 M/H MAC Coordinator and/or AREPs. ☐ The R2 M/H MAC Coordinator will promptly disseminate all R2 M/H MAC Group decisions to the host EOC, the REOC, other OA EOCs, and other agencies and organization's leadership. ☐ AREPs will promptly disseminate all R2 M/H MAC Group decisions and other requested information to their AA. ☐ The R2 M/H MAC Group PIO will promptly disseminate R2 M/H MAC Group decisions to the public through the REOC PIO or through coordination with the JIC.	MAC Coordinator and AREPS

IMPLEMENTATION CHECKLIST #7.2

Ensure approval form is completed and signed by all parties in attendance.

Approval Form			
Purpose	This form is the final approval for allocating a scarce resource. All members who completed the previous steps or were involved in scarce resource discussions must complete and sign off on this form.		
Issue Being Approved			
Prepared By:		**MAC Group Representative**	
Name		**Name**	
Title		**Title**	
Agency		**Agency**	
Signature		**Signature**	
MAC Group Representative		**MAC Group Representative**	
Name		**Name**	
Title		**Title**	
Agency		**Agency**	
Signature		**Signature**	
MAC Group Representative		**MAC Group Representative**	
Name		**Name**	
Title		**Title**	
Agency		**Agency**	
Signature		**Signature**	
MAC Group Representative		**MAC Group Representative**	
Name		**Name**	
Title		**Title**	
Agency		**Agency**	
Signature		**Signature**	
MAC Group Representative		**MAC Group Representative**	
Name		**Name**	
Title		**Title**	
Agency		**Agency**	
Signature		**Signature**	

NOTES

8. ANNUAL REVIEW PROCESS

ANNUAL REVIEW PROCESS

This guide can be modified at any time and will be updated to ensure accuracy at least annually. The agencies involved will jointly evaluate their progress in implementing this guide and revise and develop new content, attachments, or goals, as appropriate.

The following components **must** be reviewed annually:

- ☐ Training List
- ☐ Notification Process
- ☐ CA R2 M/H MAC Group Composition and Contacts

TRAINING LIST:

Name	Required						Recommended				
	I-100	I-200	I-700	M-480	CDPH EOM Training	Notification Platform	Facilitator Training	I-300	I-400	IS-701.a	Planning Section Chief

HOST AGENCY NOTIFCATION PROCESS

Annually, an Operational Area will allow the MAC Coordinator, or their designee, to use a local (OA) alert and notification system for communicating with the MAC Group. This process will allow direct notification to the MAC Group from the MAC Coordinator. This process will be reviewed annually. Training for each MAC Coordinator will be required. The form below is completed during the annual review process.

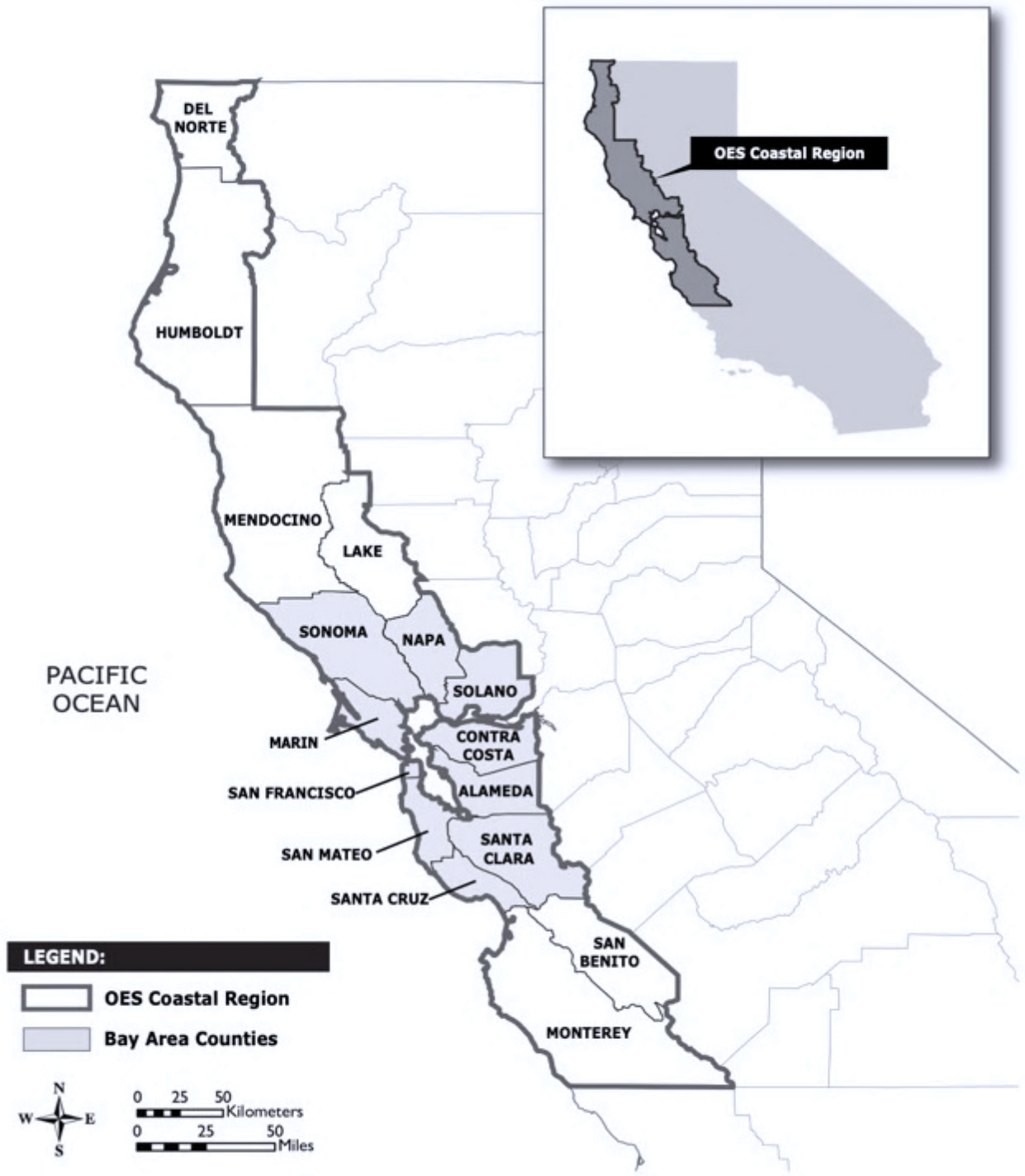
HOST AGENCY NOTIFICATION FORM	
Year	
Host Operational Area	
Host Operational Area Point of Contact	
Notification Platform	
Step by Step Instructions for Host OA Notification Platform	
MAC Coordinator	
Training Needed (Y/N)	
Conference Call Number and Passcode	

ANNUAL CA R2 M/H MAC GROUP COMPOSITION AND CONTACTS

OPERATIONAL AREA	AGENCY ADMINITRATOR/AREP	RDMHC	RDMHCS	MHOAC	PUBLIC INFORMATION OFFICER

APPENDICES

Appendix 1: Map of California Mutual Aid Region II



Appendix 2: Sample Letter of Delegation of Authority

(On Agency or Organization Letterhead)

Date: [Current Date]

Subject: Region 2 Medical/Health Multi-Agency Coordination (R2 M/H MAC) Group Agency Representative (AREP) Appointment

To: [Name of R2 M/H MAC Group AREP]

You are hereby delegated to act on my behalf as a MAC Group AREP on the Region 2 Medical/Health MAC Group. In that capacity, you are authorized to represent [name of your agency/organization]'s interests in R2 M/H MAC Group deliberations to do, as necessary, any or all of the following: *

1. Prioritize resource needs of Operational Areas.
2. Allocate scarce resources.
3. Commit agency funds and resources.
4. Provide new or amended Medical/Health policies for my approval.
5. Resolve common Medical/Health issues among multiple Operational Areas.

This delegation is effective the date of this document and will remain effective until the R2 M/H MAC Group completes its work, or until relieved of your assignment, whichever comes first.

I ask that you brief me or my designee daily on the current situation, scarce resource allocation decisions or recommendations, and policy recommendations that have been agreed upon or any major changes of events.

Print Name: _____

Agency Administrator: _____

Signature: _____

Agency Administrator: _____

* Limitations on authority can be included as necessary by local health jurisdiction, added as an amendment to the letter of authority.

Appendix 3: R2 M/H MAC Group Logistical Needs in Host EOC

The following should be available or assembled to support a R2 M/H MAC Group operation:

Telephones:

- ☐ Access to a phone for the R2 M/H MAC Group Agency Representatives and R2 M/H MAC Coordinator
- ☐ 2 conference phones
- ☐ Connectivity:
- ☐ Computers and/or laptops
- ☐ Emergency back-up power
- ☐ Internet connectivity for the R2 M/H MAC Group and Support Staff.
- ☐ Ability to network R2 M/H MAC Group AREPs laptops to EOC printers

Work Areas:

- ☐ Tables and/or desks for each R2 M/H MAC Group AREPs and R2 M/H MAC Coordinator
- ☐ Closed meeting room with table and chairs for size of R2 M/H MAC Group (Includes white boards, room for easel boards, space to post information on walls)
- ☐ Electronic Display
- ☐ 1 electronic display for projection and/or monitoring news stations
- ☐ Printers and Copy Machines:
- ☐ Access to printers and copy machines

FAX Machine:

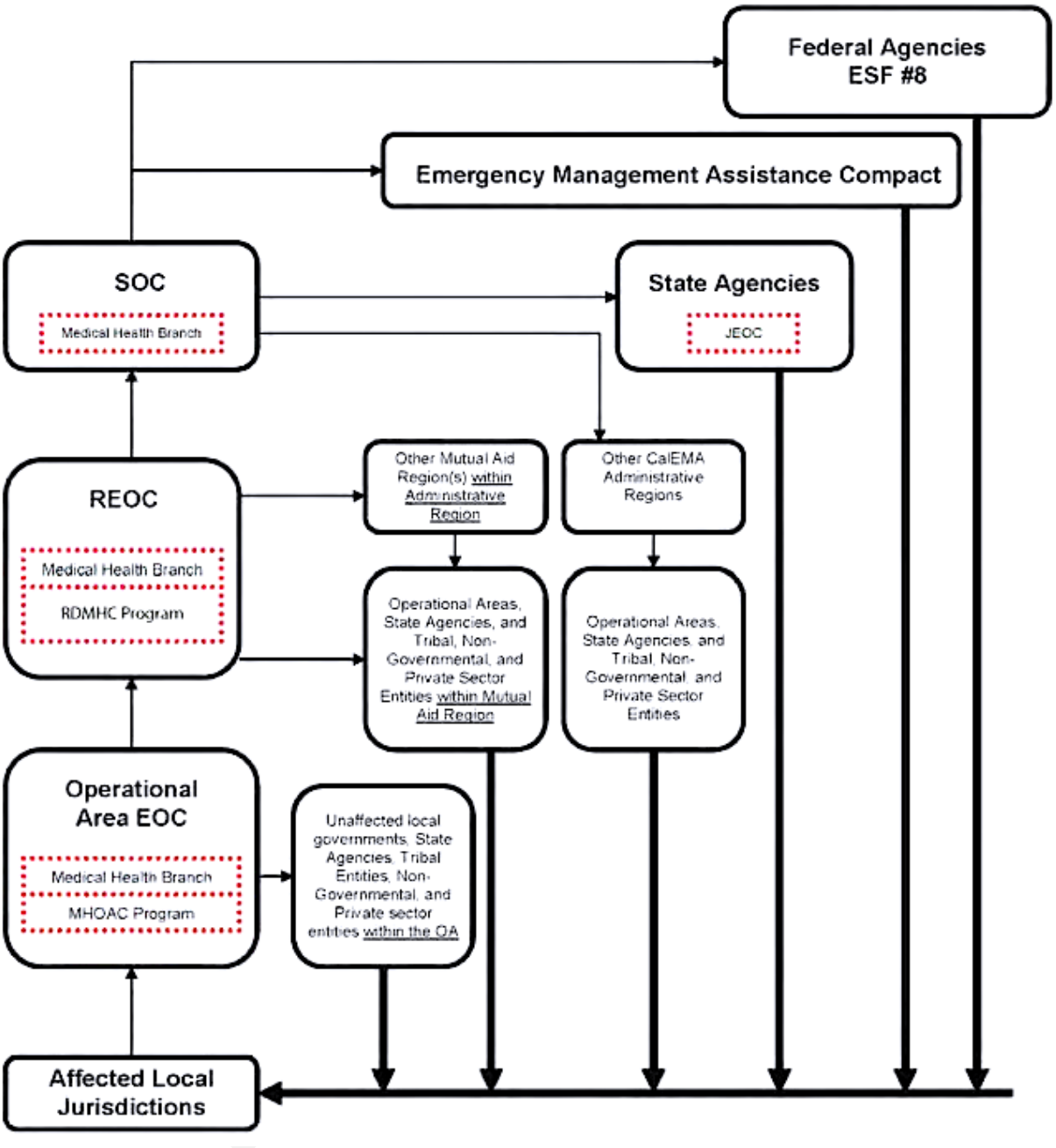
- ☐ Access to a FAX machine that doesn't interfere with EOC activities
- ☐ TV Monitor and VCR/DVD:
- ☐ Access to VCR/DVD with monitor
- ☐ Office Supplies:
- ☐ Paper, pencils, pens, paper clips, masking tape, file folders, markers, file boxes, local telephone directory, easel boards, dry markers easel pads

Miscellaneous:

- ☐ R2 M/H MAC Group Incident Action Plan and Implementation Checklist #5.1 (wall display size)
- ☐ CA R2 M/H MAC Guide

Appendix 4: Flow of Resource Requests and Assistance During Emergencies

Acquired from California Public Health and Medical Emergency Operations Manual, Page 50



Appendix 5: Example of R2 M/H MAC Group Working Guidelines

Behavior Expectations

- Let each person fully express an idea - don't interrupt
- Everyone has an equal voice
- Listen to understand, not just to respond
- No side conversations
- Friendly disagreement is okay
- Start & end on time
- Keep your sense of humor
- Be frank and honest - make constructive criticism
- Everyone has the responsibility to contribute and share ideas
- Cell phones on vibrate/No texting
- Step out of the room for taking phone calls and texting
- Schedule call/text breaks
- Inform the group at the beginning of the meeting if you have to leave early

Business/Decision Making

- Be organized – plan action steps
- Follow the group's decision-making process
- Come prepared to meetings
- Follow through on commitments for work assigned
- Try for consensus
- Obligation to bring up differing opinions
- Make informed decisions
- Have a standing parking lot
- Silence is consensus

Appendix 6: Acronyms

AA: Agency Administrator ACS: Alternate Care Site AREP: Agency Representative

Cal OES: California Governor's Office of Emergency Services

EOC: Emergency Operations Center ESA: California Emergency Services Act

ICS: Incident Command System

ICU: Intensive Care Unit

JIC: Joint Information Center

LEMSA: Local Emergency Medical Services Agency

LHD: Local Health Department

MACC: MAC Coordinator

MAC Coordinator: Multi-Agency Coordination Group Coordinator

MAC Group: Multi-Agency Coordination Group MAC System: Multi-Agency Coordination System M/H: Medical/Health

MHOAC: Medical Health Operational Area Coordination

NICU: Neonatal Intensive Care Unit

NIMS: National Incident Management System

OA: Operational Area

PICU: Pediatric Intensive Care Unit

PIO: Public Information Officer

RDMHC: Regional Disaster Medical and Health Coordinator

RDMHS: Regional Disaster Medical and Health Specialist

REOC: Regional Emergency Operations Center

SEMS: Standardized Emergency Management System

Appendix 7: Definition of Terms

Agency: A division of government with a specific function. In the Incident Command System, agencies are defined either as jurisdictional (having statutory responsibility for incident management) or as assisting or cooperating (providing resources or other assistance).

Agency Administrator: Person(s) in charge of the agency/agencies or jurisdiction(s) that has responsibility to respond to an incident and for administering policy for an agency or jurisdiction. An Agency Administrator (or other public official with jurisdictional responsibility for the incident) usually makes the decision to establish an Area Command and MAC Groups.

Agency Representative: An individual assigned to a MAC Group with delegated authority to represent their agency in carrying out the roles and responsibilities of the group.

Area Command: An organization to oversee the management of multiple incidents that are being managed by a separate ICS organization or to oversee the management of a very large incident that has multiple Incident Management Teams engaged.

Assisting Agency: An agency directly contributing operational, support or service resources to another agency.

Cooperating Agency: An agency supplying assistance other than direct operational or service functions to the incident (e.g., utility companies, hotels, etc.)

Delegation of Authority: A statement provided to the Agency Representative on a Multi-Agency Coordination (MAC) Group by the Agency Administrator delegating authority and assigning responsibility. This can include objectives, priorities, expectations, constraints and other considerations or guidelines as needed.

Emergency Operations Center: The physical location at which the coordination of information and resources to support incident management (on-scene operations) activities normally takes place. An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. Under SEMS, EOCs are organized by the five functions (Management, Operations, Planning / Intelligence, Logistics and Finance / Administration).

Hospital Available Beds for Emergencies and Disasters (HAvBED): A federally funded web-based system for bed capacity reporting. This system allows states to collect and report hospital bed availability. This data is then used to inform decision-makers at the state, regional, and federal levels for situational awareness for planning and emergency response activities relating to deployment of federal mobile assets.

Incident: An occurrence, natural or manmade, that requires a response to protect life or property. Incidents can, for example, include major disasters, emergencies, terrorist attacks, terrorist threats, civil unrest, wildland and urban fires, floods, hazardous materials spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, tropical storms, tsunamis, war-related disasters, public health and medical emergencies, and other occurrences requiring an emergency response.

Incident Command System: A standardized on-scene emergency management construct specifically designed to provide an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.

Incident Management Team: The Incident Commander and appropriate Command and General Staff personnel assigned to manage an incident. Incident Management Teams consist of Type1, 2, 3 and 4 designations; Type 1 Teams are assigned to the most complex incidents, while Type 4 Teams are assigned to the least complex incidents.

Joint Information Center: A facility established to coordinate all incident-related public information activities. It is the central point of contact for all news media. Public information officials from all participating agencies should co-locate at the JIC.

Joint Information System: Integrates incident information and public affairs into a cohesive organization to provide consistent, coordinated, accurate, accessible, timely and complete information during incident operations. Provides a structure and system for developing and delivery of coordinated interagency messages.

Jurisdiction: A range or sphere of authority. Public agencies have jurisdiction at an incident related to their legal responsibilities and authority. Jurisdictional authority at an incident can be political or geographical (e.g., Federal, State, tribal, local boundary lines) or functional (e.g., law enforcement, public health).

Local Emergency Medical Services Agency: The agency, department, or office having primary responsibility for administration of emergency medical services in a county or multiple county, including disaster medical preparedness and response.

Local Health Department: The agency, department, or office having primary responsibility for administration of public health services in a county or city.

Local Health Officer: City and county health officers are authorized by the Health and Safety Code to take any preventive measure necessary to protect and preserve the public health from any public health hazard during a local emergency or State of Emergency within their jurisdiction. Preventive measures include abatement, correction, removal, or any other protective steps which may be taken against any public health hazard that is caused by a disaster and affects public health. The local health officer may proclaim a local emergency if he or she has been specifically designated to do so by ordinance adopted by the governing body of the jurisdiction (H&S Code, Section 101310). When a health emergency has been declared by a local health officer or board of supervisors, the local health officer has supervision and control over all environmental health and sanitation programs and personnel employed by the county during the State of Emergency.

Medical Health Operational Area Coordination Program: A comprehensive program under the direction of the MHOAC that supports the 17 functions outlined in Health and Safety Code §1797.153.

Multi-Agency Coordination Group: A group of administrators, or their appointed representatives, who are authorized to commit agency resources and funds. A MAC Group can provide coordinated decision-making and resource allocation among cooperating agencies, and may establish the priorities among incidents, harmonize agency policies, and provide strategic guidance and direction to support incident management activities. MAC Groups may also be known as multi-agency committees, emergency management committees, or as otherwise defined by the Multi-Agency Coordination System.

Multi-Agency Coordination Systems: Provides the structure to support coordination for incident prioritization, scarce resource allocation, communications systems integration and information coordination. The elements of Multi-Agency coordination systems include facilities, equipment, personnel, procedures and communications. The two most commonly used elements are EOCs and MAC Groups.

National Incident Management System: A set of principles that provides a systematic, proactive approach guiding government agencies at all levels, nongovernmental organizations, and the private sector 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.

Operational Area: Under SEMS, the operational area means and intermediate level of the state's emergency management organization which encompasses the county and all political subdivisions located within the county including special districts. The operational area manages and / or coordinates information, resources, and priorities among local governments within the operational area, and serves as the coordination and communication link between the local government level and regional level.

Operational Period: The time scheduled for executing a given set of operation actions, as specified in the Incident Action Plan. Operational periods can be of various lengths, although usually they last 12 to 24 hours.

Prioritization: The prioritization of incidents based on their established rating score. The MACS 429 Form is used to prioritize incidents from highest to lowest score as listed the MACS 430 Form. Where multiple incidents receive the highest rating score, the Medical/Health MAC Group weighs each category to establish the final prioritization. Life safety scores are paramount in the prioritization process.

Regional: Because of its size and geography, the state has been divided into six mutual aid regions. The purpose of a mutual aid region is to provide for the more effective application and coordination of mutual aid and other emergency related activities. In SEMS, the regional level manages and coordinates information and resources among operational areas within the mutual aid region, and also between the operational areas and the state level. The regional level also coordinates overall state agency support for emergency response activities within the region.

Regional Disaster Medical and Health Coordination Program: A comprehensive program under the direction of the Regional Disaster Medical and Health Coordinator that supports information flow and resource management during unusual events and emergencies. This program includes the Regional Disaster Medical and Health Specialist.
Region Emergency Operations Center: Regional facilities representing each of Cal OES's three Administrative Regions (Inland, Coastal and Southern). REOCs provide centralized coordination of resources among Operational Areas within their respective regions, and between the Operational Areas and State level.

Resources: Personnel and major items of equipment, supplies, and facilities available or potentially available for assignment to incident operations and for which status is maintained. Resources are described by kind and type and may be used in operational support or supervisory capacities at an incident or at an Emergency Operations Center.

Scarce Resource: Resources requested by more than one Operational Area and the request for all Operational Areas cannot be filled to meet the requested deployment time.

Situation Report: Confirmed or verified information regarding the specific details relating to an incident.

Standardized Emergency Management System: The Standardized Emergency Management System (SEMS) is the cornerstone of California's emergency response system and the fundamental structure for the response phase of emergency management. SEMS is required by the California Emergency Services Act (ESA) for managing multiagency and multijurisdictional responses to emergencies in California. The system unifies all elements of California's emergency management community into a single integrated system and standardizes key elements. SEMS incorporates the use of the Incident Command System (ICS), California Disaster and Civil Defense Master Mutual Aid Agreement (MMAA), the Operational (OA) Area concept and multiagency or inter-agency coordination. State agencies are required to use SEMS and local government entities must use SEMS in order to be eligible for any reimbursement of response-related costs under the state's disaster assistance programs.

State: The state level of SEMS tasks and coordinates state resources in response to the requests from the REOCs and coordinates mutual aid among the mutual aid regions and between the regional level and state level. The state level also serves as the coordination and communication link between the state and the federal disaster response system.

State Operations Center: The SOC is the Emergency Operations Center at the State level. This center coordinates with the National Operations center and coordinates and supports activities at individual state- level agency-specific Department Operations Centers.

Technical Specialist: Person with special skills that can be used anywhere within the Incident Command System organization. No minimum qualifications are prescribed, as technical specialists normally perform the same duties during an incident that they perform in their everyday jobs, and they are typically certified in their fields or professions.

Unified Command: An application of ICS used when more than one agency with incident jurisdiction or when incidents cross political jurisdictions. Agencies work together through the designated members of the Unified Command, to establish a common set of objectives and strategies and a single Incident Action Plan.

Appendix 8: Sources

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Interviews
The project management team conducted extensive interviews with local, regional, and state stakeholders as well as partners from large urban areas and academia.

Staffing Support for Long-term Care (LTC) Facilities

Problem statement:

- Many LTC facilities are unable to safely and effectively care for patients who develop COVID 19 while protecting their staff.
- Mission assignments from the SOC to EMSA may include evaluation and support for LTC facilities.
- EMSA has insufficient resources internally or with its response partners to provide long-term support for an increasing number of impacted facilities.

EMSA can initiate two types of missions:

- 72-hour Medical Strike Team deployment
    - EMSA will deploy a medical strike team to identified LTC facilities to conduct short term on-site assessments to include:
        - Review of the facilities' staffing and resources needs
        - Review of infection control and safety measures
        - Provide refresher education and training on the appropriate use of PPE to facility staff
        - Supplement facility staffing deficiencies and provide immediate patient care
    - A short time extension of up to 48 hours may be granted if deemed necessary by the strike team and approved by the County and State.

- 1-2 week response missions with CAL-MAT deployment
    - Provide medical support for facilities with critical staffing and infection control deficiencies that cannot be resolved with 3-5 days.
    - EMSA will deploy CAL-MAT and healthcare personnel from other agencies, including administrative and logistical staff, to provide facility support for patient care and infection control to prevent loss of life and stabilize facility operations.

- After one-week CAL-MAT will begin to demobilize personnel with the expectation of returning services to the facility by the end of two weeks.
- Other long-term solutions must be considered if facility support is needed beyond two weeks.

In addition to the two types of EMSA missions, CA Health Corps may be assigned to support LTC facilities when determined appropriate. The process for deploying Health Corps staffing for LTC Facilities is as follows:

- The CDPH District Office and the MHOAC work with the facility to assess staffing needs.
- The MHOAC submits a Resource Request using Sales Force if a staffing need is determined necessary.
- The Resource Request is routed to the RDMHS if staffing is not available in the Operational Area.
- The RDMHS routes the Resource Request, via Sales Force, to the State (MHCC) if the needed resources are not available in the Region.
- The MHCC will vet the request and route to the ESF 8 MAC group for approval and prioritization.
- If CA Health Corps staff are approved to support the LTC facility:
  - CDPH District Office will work with the LTC facility to complete the required MOU.
  - Once completed, the MOU is sent to the state ESF 8 MAC group for signature and execution.
- The Health Corps Deployment Team assigns Health Corps staffing.
  - The Health Corps Deployment Team will utilize Health Corps staff from within 50 miles of the requesting facility to the extent possible.
  - The Health Corps Deployment Team schedules, manages, and tracks staff hours.
  - Health Corps personnel are assigned to the facility for up to one week. Any additional time must be approved by the State.

Mission Strategies:

- Obtain on-site support from agencies with regulatory authority and responsibility for LTC facilities.
- Request LHD and/or CDPH liaison to work with EMSA to ensure ongoing awareness of the LTC facility status.
- Provide an update after 72 hours to notify the regulatory agency if the facility cannot rebound quickly and may need longer-term support.
- Discussion, with appropriate officials, after one week of staff support to allow the regulatory agency to consider additional options for the facility to maintain patient care safely.
- After two weeks of staffing support at the facility without significant progress toward self-sufficiency, EMSA will request that the LHD or CDPH identify alternate facilities to accept patients and begin facility evacuation.