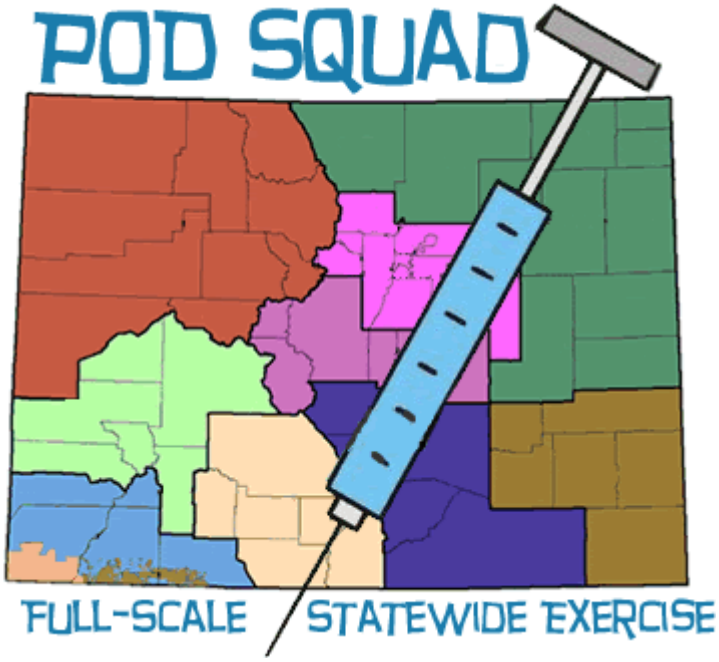

AFTER ACTION REPORT FOR SOUTHEAST COLORADO

S.E. Regional Transfer Point 11/16/07
Bent County Point of Dispensing 11/17/07
Prowers County Point of Dispensing 11/17/07

Respectfully submitted by:
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4. *This document should be used in conjunction with the Exercise Evaluation Guide forms that were used for evaluation during the exercise. They can be located in Appendix B of this document.*

5. *For more information, please contact a member of the S.E Colorado EPRD Exercise Planning Team:*

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Executive Summary

The 2007 POD Squad mass vaccination full-scale, statewide exercise was conducted by the Colorado Department of Public Health and Environment (CDPHE) Emergency Preparedness and Response Division (EPRD) in partnership with local public health departments and nursing services throughout the state of Colorado. POD Squad tested the following target capabilities:

1. *Mass Prophylaxis*
2. *Emergency Public Information and Warning*
3. *Medical Supplies Management and Distribution*
4. *Emergency Operations Center Management*

This exercise was designed to test coordinate, manage, operate, and support a statewide mass vaccination Point of Dispensing (POD) exercise in Colorado to prepare for a potential influenza pandemic by evaluating the state and local public health capacity to perform the following measurable objectives for local public health agencies:

Local Public Health Agencies (LPHAs):

- *Obtain and maintain flu vaccine and medical supplies; and transport, distribute, and track these medical assets during an incident according to the S.E. Colorado Strategic National Stockpile (SNS) plan, and the individual hospital SNS receipt plan. (applicable only to LPHAs opening a Regional Transfer Point on November 16, 2007)*
- *Establish and maintain Incident Command at the Point-of-Dispensing (POD) site per organizational charts, protocols and procedures established in the LPHA POD plan.*
- *Set up, operate and break-down a POD per protocols and procedures established in LPHA POD plan*
- *Establish and maintain timely and accurate communication with the CDPHE, local partners, the public, and the media, as applicable.*

The CDPHE exercise design team reflected local public health agencies, state personnel and partnering agencies. The S.E. Colorado Planner participated as a regional point of contact on monthly planning conference calls with state personnel. Southeast Colorado identified planning responsibilities and local points of contact for this exercise in June of 2007.

This was the first full-scale exercise conducted by the CDPHE EPRD Exercise Planning Team; however in 2004, S.E. Colorado implemented a nine county full scale RTP and POD exercise. In addition to several county Regional Transfer Point (RTP) and POD exercises conducted at the regional and local level, three statewide exercises led up to the culmination of POD Squad:

1. *2005 Functional Exercise "Fowl Play"*
2. *2006 Advanced Tabletop "Squawk Talk" (October 2006)*
3. *2006 Functional Exercise "Squawk Talk" (December 2006).*

S.E. Colorado participated in the above mentioned statewide exercises in preparation for this full scale POD Squad exercise.

Timing, Background, Circumstances

The POD Squad exercise followed an intense and successful media campaign developed and implemented by CDPHE. This was very helpful in assisting local jurisdictions with public awareness of influenza issues, to include pandemics. It also was instrumental in getting partners involved in the exercise. Both Bent County and Prowers County provided activities to the general public at local events prior to the full scale exercise.. Events were football and basketball games. Activities drew attention of the crowd at half time to influenza issues to further develop a knowledge of influenza issues, such as seasonal flu, pandemic flu, and preventative measures such as respiratory hygiene, obtaining a flu vaccine, and staying home when you are ill.

Southeast Colorado implemented a full scale RTP exercise in 2004. Prowers and Bent County also concluded successful POD exercises in 2004. The Improvement Plan matrix identified in 2004 was implemented into this exercise series. Summaries for each jurisdiction can be found under the capability summary for that jurisdiction.

Section 1: Exercise Overview

Exercise Name

POD Squad Statewide Full Scale Exercise

Duration

Friday, November 16th, 2007
7:00 am – 12:00

And

Saturday, November 17th, 2007
8:30am – 12:00

Exercise Date

November 16th, 2007 Regional Transfer Point
November 17, 2007 Point of Dispensing

Sponsors

Colorado Department of Public Health and Environment
Baca County Nursing Service
Bent County Nursing Service
Kiowa County Nursing Service
Otero County Health Department
Prowers County Public Health Nursing Service

Program

Department of Health and Human Services (HHS) Centers for Disease Control and Prevention (CDC) Public Health Emergency Preparedness (PHEP) Cooperative Agreement Budget Period 8 (2007-08)

Mission

Protect
Response
Victim Care

Capabilities

Mass Prophylaxis
Medical Supply Management

Type of Exercise

Full Scale, Operational

Funding Source

Colorado Department of Public Health and Environment
Local jurisdictions involved with financial support and time.

Classification
Unclassified

Communications
Amateur Radio Emergency Services
800 megahertz radios
Cell phone
Land line
Talkarounds
Email
fax

Scenario Type
Pandemic/ Disease Outbreak

Location
Regional Transfer Point: Otero County, Colorado
Bent County Point of Dispensing (POD):
Las Animas Sherriff's Office
Prowers County Point of Dispensing (POD):
Prowers County Fairgrounds

Participating Organizations
Baca County Emergency Management
S.E. Colorado Hospital and Long Term Care
Baca County Sheriff's Office
Bent County Emergency Management
Bent County Nursing Service
Colorado Division of Emergency Management
Colorado State Patrol
High Plains Community Health Center
Kiowa County Emergency Management
Kiowa County Nursing Service
Otero County Health Department
Otero County Emergency Management
Prowers County Emergency Management
Arkansas Valley Medical Center
Prowers Medical Center
Prowers County Public Health Nursing Service
La Junta Ambulance
La Junta Fire Department
Lamar Ambulance Service
S.E. Land & Environment
City of La Junta/ La Junta Police Department
City of Lamar (Police, Public Works)
Town of Las Animas
Bent County Sheriff
Otero County: Sheriff, Public Works, County Commissioners
Prowers County: Sheriff, County Commissioners
Prowers County Sheriff Posse
Otero County Road and Bridge

Number of Participants in S.E. Colorado

Public Health Responders & Partners	*103*
Volunteers	*3*
General Public (those that were vaccinated)	*708*
Total	*814*

Section 2: Exercise Design Summary

Exercise Purpose and Design

The POD SQUAD Statewide Full Scale Exercise was created to test statewide coordination of Medical Supply Management and Distribution, Mass Prophylaxis Operations, Emergency Public Information, and Emergency Operation Center activation. Depending on the jurisdiction, one or more of these target capabilities may have been tested.

In Southeast Colorado, Mass Prophylaxis was implemented and evaluated in Bent and Prowers Counties. The region also implemented Medical Supply Management in Otero County and evaluated coordination with Baca, Bent, Crowley, Kiowa, Otero and Prowers Counties. Hospitals were included in the medical supply management piece of the exercise to test their SNS Hospital Receipt Plan annex to their disaster plans.
The Southeast region tested both of the Mass Prophylaxis and Medical Supply Management capabilities in 2004. The design team and participants implemented the improvement plan matrix for 2004 into the 2007 POD Squad Full Scale Exercise to evaluate if the new RTP facility and staffing plans were ideal for medical supply management. This also gave Bent and Prowers County the opportunity to test new locations and drive through concepts for POD operations.

There were several trainings and exercises that led up to this full scale exercise. For a more in depth design and funding summary, please refer to the CDPHE After Action Report.

Exercise Objectives, Capabilities, and Activities

Capabilities-based planning allows for exercise planning teams to develop exercise objectives and observe exercise outcomes through a framework of specific action items that were derived from the Target Capabilities List (TCL). The capabilities listed below form the foundation for the organization of all objectives and observations in this exercise. Additionally, each capability is linked to several corresponding activities and tasks to provide additional detail.

Based upon the identified exercise objectives below, the exercise planning team has decided to demonstrate the following capabilities during this exercise:

Objective 1: *Obtain and maintain flu vaccine supplies; transport, distribute and track medical assets during an incident according to the State SNS Plan, the Regional SNS Plan, and hospitals SNS receipt plans.*

Associated Target Capability:
Medical Supply Management and Distribution
Activities-

- *Direct Medical Supplies Management and Distribution Tactical*
- *Activate Medical Supplies Management and Distribution*
- *Establish Security*
- *Cold Chain Storage and Transfer*
- *Warehouse Operations and Distribution*
- *Demobilize*

Objective 2: *Establish and maintain Incident Command at the Point of Dispensing site per organizational charts, protocols and procedures established for the LPHA POD plan.*

Objective 3: *Set up, operate and break down a POD per protocols and procedures established in the LPHA POD plan.*

Associated Target Capability:

Mass Prophyaxis

Activities

- *Direct Mass Prophyaxis Tactical Operations*
- *Activate Mass Prophylaxis*
- *Conduct Triage for Symptoms*
- *Conduct Medical Screening*
- *Conduct Mass Dispensing*
- *Adverse Events Monitoring*
- *Demobilize*

Section 3: Analysis of Capabilities

Bent County

Capability 1: Mass Prophylaxis and Vaccination-

Capability Description: *The capability to protect the health of the population through a mass prophylaxis and/or vaccination campaign following an event. This includes the provision of appropriate follow-up medical care, as well as the communication messages to address the concerns of the public. Bent County identified some minor improvements they would like to make, however the implementation of their POD plan was very successful.*

Capability Summary:

The location utilized for the POD in Bent County was the Sheriff Office parking lot. This location was highly secure with entrance and egress identified for minimal opportunities for accidents.

Multidisciplinary coordination was apparent during planning, training that were in place prior to the exercise. Use of incident command was reflected in planning meetings, development of an Incident Action Plan in coordination with emergency management. The IAP was followed during the full scale exercise and also reflected in briefings during the exercise. The Emergency Manager played an integral role in planning and served as the deputy incident commander during exercise play. Law enforcement also played an integral role in planning and implementation. Since the drive through concept varied from the walk in POD tested in 2004, Bent County knew they needed security to support moving vehicles through a location. Law enforcement agencies were key in planning a successful drive through POD. . Amateur Radio Emergency Services provided redundant communication so that officials could communicate from POD to POD, and with the CDPHE Departmental Operation Center.

Bent County Nursing Service, Bent County Sheriff and Emergency Management conducted a drill prior to exercise for staff and volunteers to prepare them for their response role, become familiar with the POD layout, and to test functions in place. Several volunteers drove through the POD during the drill. Bent County was able to identify ways that flow and accountability could be improved, which was reflected in an updated IAP that was distributed the morning of the full scale exercise.

Contingency planning was required throughout the preparatory stages for this exercise and Bent County adapted quickly to implement improvements and overcome obstacles along the way. The drive through concept was well received in Bent County by the general public and response community. With communicable disease, the concept aids in mass prophylaxis while keeping social distancing optimum.

Comparing the number of persons in the vehicle with the number of persons in the vehicle to receive a vaccination was a redundant system to prevent persons that are not to be vaccinated safe. These numbers were captured on the windshield with a dry erase marker. Persons were required to sit for 5 minutes prior to leaving the site to monitor adverse reactions. Times were monitored from the time vaccinations were provided and documented by vaccination and waiting area personnel.

Security of Entrance and egress locations was provided by law enforcement officers, as well as traffic flow and safety protocols that were developed for exercise play. Protocols were in place to keep the general public, staff and volunteers as safe as possible. This included requesting that people and pets stay in their vehicles, put their vehicle in park at each station, and turn off their engines. It also included safe handling of sharps and the use of sharps containers.

The evaluator observed personnel checking vaccine coolers for quality assurance. Conversations with the Incident Commander and persons monitoring packing and storage of vaccine to assure safety of vaccine were overheard by exercise support staff.

Bent County met the statewide exercise objectives and vaccinated 116 persons. Bent County staffed the POD with agency staff and response partners that came together for a team of 18 total.

Activity 1.1: Direct Mass Prophyaxis Tactical Operations

Activity Description: *In response to notification of an incident requiring mass prophylaxis, provide overall management and coordination of mass prophylaxis operations.*

Observation of Task 1.1: *Coordinate distribution/administration of mass prophylaxis*

Strength:

During the morning briefing, Incident Action Plans were provided to staff and volunteers by the planning section and Incident Commander to communicate the day's tactical operations. This included protocols and procedures for the key stations within the POD and ICS personnel. Packets were assembles to provide personnel with job action sheets so they understood the flow of traffic, stations to be assembled for POD operations, and safety precautions to maintain to protect the public. Personnel were provided radios for tactical communications and received direction from those assembled in the Incident Command Post as Incident Commander, Safety Officer, Public Information Officer, Logistics, Operations and so forth. As the exercise unfolded, command and general staff upheld the incident action plan and briefed personnel on changes due to injects, such as suspension of play. Media and the general public were informed of POD operational hours during the preceding immunization campaign and were observed lined

up in their cars at the onset of the exercise to receive their vaccinations. During the exercise, the Incident Commander had to alter play due to an inject that required suspended operations for a few minutes. These changes were communicated to personnel by the command and general staff.

References: *Tactical Operations is outlined in the Bent County POD plan. Procedures and protocols for various stations were also outlined in the Incident Action Plan that was distributed to personnel [Name of the task and the applicable plans, policies, procedures, laws, and/or regulations and 1-2 sentences describing their relation to the task]*

***Analysis*:** *The Bent POD staff and partners participated in a drill the week before the exercise to test their flow charts, IAP directives and vaccination protocols prior to the full scale exercise. This activity provided the team and opportunity to practice response roles and tactical operations prior to implementing the full scale exercise. This also afforded command and general.staff the opportunity to update the IAP to reflect the adjustments and provide direction with confidence during the exercise. Coordination with emergency management partners prior to and during the exercise provided learning experiences for POD general and command staff on how to apply completed ICS training principles to this exercise. The emergency manager provided support during the exercise by playing the Deputy IC.*

Recommendations: *ICS command staff provided a briefing, however knowledge of staff may have been strengthened if supervisors provided more detailed briefings to their staff to reiterate protocols, or clarify job action sheets for those that may not have been in on the planning meetings.*

Observation 1.2: *Coordinate public information regarding point of dispensing locations.*
Strength:

The Public Information Officer was prepared with press releases and contact information for public information specialists at CDPHE the day of the exercise. A public information campaign was conducted statewide and locally prior to the exercise with the press coming to a drill the week before the exercise to take photographs of the activity and provide a story to the public about the upcoming exercise dates and locations.. Awareness activities were conducted during sporting events to draw the public's attention prevention steps they can take to stay healthy, such as obtaining a flu shot, hand washing and respiratory hygiene. During the day of the exercise, unit logs and evaluator notes reveal that the newspaper contact came to the exercise, however did not want to comply with security measures in place, so departed.

References: *The communication section of the POD plan.*

Analysis:
The communication section of the POD plan was put into play and media invited to participate in planning meetings and the exercise on November 17th. . The PIO was new to this position and was prepared to coordinate with the media the day of the exercise. The IAP identified a PIO and protocols in place for coordinating with the media and protecting the privacy of individuals. These observations were made by the S.E. Planner the day of the exercise at the morning briefing, in the evaluator notes following the exercise, and newspaper articles that covered the exercise in the Rocky Ford Gazette.

Recommendations: *Assure that the media is aware of safety protocols ahead of time so they can anticipate what they need to do to comply during POD operations. Aside from this recommendation, this was an area of strength for Bent County. Identify a location that media should be directed to at the POD site.*

Observation 1.3: *Coordinate with the RTP to re-supply PODs as needed.*
Strength

During the RTP exercise held on November 16th, Bent County Nursing Service coordinated with Area Command to re-supply the POD after vaccine that was transported to the RTP from CDPHE and was found to be compromised. Bent County was unable to utilize the vaccine from CDPHE for the POD exercise on November 17th, 2007. Area Command coordinated with CDPHE to implement contingency planning. Bent County Nursing Service would use their own private vaccine for the exercise and obtain reimbursement from CDPHE by billing through the Emergency Preparedness and Response Contract.

Area of Improvement

In Southeast Colorado, transport teams and LPHA's were to simulate medical supply transport from the RTP to the local jurisdiction. The simulation included empty boxes. Most likely during a disaster, vaccine is not the only medical supply that teams will need to transport. The transport team did not transport the empty boxes back to their jurisdiction to complete the medical supply management and distribution process.

References: *Southeast Colorado Regional SNS Plan*

Analysis: *Bent County Nursing Service coordinated well with Area Command during the RTP exercise on November 16th, and implemented contingency planning to obtain vaccine for the POD exercise on November 17th, 2007. This was documented in Area Command unit logs and evaluator notes. Phone calls and emails also verified that this coordination between the POD and RTP took place. The RTP staff received, allotted and distributed assets to the Bent County Transport team as outlined in the regional SNS plan and these activities were documented in unit logs kept by personnel providing incident command and general staff roles. The transport team did not transport the empty boxes back to the jurisdiction to complete the objective of medical supply distribution.*

Recommendations: *The only recommendation is to follow through with distribution to local jurisdictions by transport teams, even if all of the materials to transport, such as vaccine, are not available. As indicated in other recommendation areas in the Medical Supply Management of this document, considering a Liaison Officer at the RTP may also improve the outcome.*

Activity 2: Activate Mass Prophylaxis

Activity Description: *Upon notification, activate PODs for mass prophylaxis operations.*

Observation 2.1 *Initiate call down lists for mass prophylaxis site staffing.*
Strength

Prior to this full scale exercise, Bent County conducted a drill to test their POD layout and standard operating procedures. This allowed for POD personnel and security plans to be tested and streamlined to facilitate optimum POD flow. Personnel were contacted by phone

to staff the POD and to notify partners of POD operations. In order to implement the POD security plan, this included law enforcement agencies. Personnel were required to check in at the Sheriff's Office to obtain badges, vests, radios and written Incident Action Plans. Incident Command Staff provided a morning briefing to communicate the Incident Action Plan. Personnel were assigned to various stations and provided Job Action Sheets, protocols for that station. Regularly established status reports were provided to the CDHE Regional Liaison and documented in the status reports developed by CDPHE.

References: *POD Squad Statewide Exercise Plan, CDPHE situation reports from the Departmental Operations Center.*

Analysis: *Personnel were notified of POD implementation, the time they would need to report to the POD and were required to check in at the POD to obtain necessary resources to fulfill their response role at the POD. Evaluation staff documented the check in procedure for Bent County. Amateur Radio Emergency Services provided communication from the POD Incident Commander to the CDPHE DOC and documented these transactions.*

Recommendations: *None*

Observation 2.2 *Ensure mass prophylaxis site operations are established in accordance with Memoranda of Agreement*

Strength

A formal Memoranda of Agreement was not observed during this exercise, however verbal agreements were observed during planning meetings for this exercise with the Sheriff's Office. The drive through concept was new for Bent County, as was the site identified for the exercise. Areas were identified in the IAP for locating ambulances at the site, as well as law enforcement vehicles and personnel that would direct traffic flow and maintain security. Parking spaces were also identified for staff in the IAP. The POD was ready to receive the general public and vaccinate them in their vehicles and implemented their plans at the onset of exercise play. According to evaluator notes, 34 persons were vaccinated between 8:00 and 8:30am. The average time it took participants to go from start to the waiting area was approximately 2 -3 minutes.

References: *Bent County POD Plan*

Analysis: *Bent County partners wanted to test a new POD layout and facility by utilizing the Sheriff Office Parking Lot for a drive through POD operations. This allowed people to stay in their cars and obtain vaccine without having to park and go inside a facility. This layout is useful during foul weather where people would have been standing outside in the weather if this were a walk in POD. It also prevents the spread of disease by implementing social distancing which is applicable with a pandemic.*

Recommendations: *Formalize memoranda of agreement with the Sheriff's Office and update the POD plan to reflect primary, secondary and tertiary POD facilities and models for implementing a POD in Bent County. Review the Fairgrounds/Arena for additional drive through site POD operations that may accommodate additional traffic lanes.*

Observation 2.3 *Assemble needed supplies and equipment for POD operations including materials to prepare oral suspension.*

Strength

Personnel assembled medical supplies in various stations at the POD, forms to collect data at screening stations, and office resources to set up administrative functions in the POD Incident Command Post. Signs were located throughout the POD to direct the flow of traffic and maintain security of the POD. These observations were documented by evaluation staff.

References: *Bent County POD Plan and Incident Action Plan*

Analysis: *Personnel assembled medical supplies at each station, according to the POD plan and the Incident Action Plan. Signs were located to direct traffic flow and maintain safety protocols and security procedures for the POD. Go Kits complete with administrative resources were set up for Incident Command and general staff.*

Recommendations: *None*

Observation 2.4 *Prepare informative materials for POD staff, patients, and media.*

Strength

Prepare informative materials for POD staff, patients and media

See activity 1.2

Observation 2.5 *Provide internal and external security for POD sites.*

Strength

Security of POD operations was well documented in the IAP and evaluation notes. This was also observed by the Regional Planner upon entrance into the POD site. Law Enforcement personnel were assigned to direct traffic into the POD and for implementing security procedures during play. This included signage to direct the general public to put their vehicle in park at each station and shut their engines off to prevent injury to staff and others. Stringent security protocols were implemented while accommodating prisoners that were to obtain vaccinations. A law enforcement officer was also part of the transport team during the RTP exercise on November 16th, when vaccine was to be secured from the RTP to the local jurisdiction. These activities were documented in the unit logs of the RTP, and the POD IAP.

References: *Bent County IAP and POD Plan*

Analysis: *From data collected during planning meetings, the Bent County IAP and evaluator notes, the security observations made were a real strength in Bent County. No injuries or security incidences were identified.*

Recommendations: *None*

Observation 2.6 *Provide prophylaxis to POD staff, first responders, and critical infrastructure personnel and their families in accordance with the local POD plan.*

Strength

POD personnel, response partners and volunteers were provided vaccinations according to the POD plan according to evaluator notes and unit logs.

Observation 2.7 *Establish plans to meet the unanticipated transportation needs for the following:*

Strength

POD personnel altered the drive through concept to provide vaccinations to those that walked to the POD. The layout was also updated to allow special needs individuals, such as prisoners to be vaccinated. This required security protocols that adapted POD functions to allow for administering vaccinations to other individuals or families that arrived on foot. Another special needs group identified and served were those from an alcohol abuse center. Drivers with frail family members commented on how much easier it is to bring disabled people to a drive through POD, rather than a facility where they have to park and walk in. This was documented in unit logs and evaluator notes.

References: *Not Applicable*

Analysis: *During the 2004 full scale exercise, providing teams to homebound individuals was implemented, however not included in the 2007 exercise. The plans for implementing a drive through POD allowed for family members to accommodate disabled family members while maintaining safety of their family members by not exposing them to standing in long lines inside or outside a facility.*

Recommendations: *None*

Activity 3: Conduct Triage for Symptoms

Activity Description: *Conduct initial screening of individuals prior to their entering the POD in order to prevent symptomatic individuals from potentially contaminating the POD.*

Observation 3.1 *In the event of a communicable disease, ensure initial triage is performed either at staging area or in area separate from mass prophylaxis site to prevent contamination of site.* ***3.2*** *Transport symptomatic individuals to appropriate health facility prior to their entering mass prophylaxis site.*

Strength

An ambulance was located at the POD to transport sick or injured individuals who may need acute care. A screening station was set up to provide information to individuals about influenza and to answer questions, or refer them to their physician. A triage station was not set up to separate ill people from healthy at this POD, however people were required to stay in their vehicles which aids in diminishing the spread of disease to others who participated in the drive through POD. The incident commander responded to an inject regarding individual with symptoms. The inject assumed the person was standing in line within a facility. The Incident Commander suspended exercise play for 10 minutes until symptoms could be identified. EMS and the physician were involved in the assessment. Evaluators documented the decisions and activities that took place to address the inject. The Bent POD did have a plan in place to move symptomatic people out of the drive through line and implemented it upon receipt of this inject.

References: *Bent County POD Plan*

Analysis: *Discussion during exercise planning meetings indicated that nursing professionals believed the triage station to be obsolete with a drive through POD. There was not a need to prevent sick individuals from entering the POD because they were contained outside in their vehicle. The Bent County POD did have EMS located at the POD to transport sick or injured individuals to medical facilities.*

Recommendations: *Update the Bent POD Plan to reflect how a drive through POD may differ from a walk in POD with triage protocols.*

Activity 4: Conduct Medical Screening

Activity Description: *Review patient screening documentation and available medical history to*

determine proper course of treatment.

Observation 4.1 *Provide information to each individual* ***4.2*** *Identify medical history and exposure* ***4.3*** *Ensure sufficient staffing at the POD site screening station to prevent initial bottlenecks.*

Strength

Information regarding influenza and vaccinations were provided to each individual as they entered the drive through POD. This information was provided in English and Spanish. Within the screening station, medical history and individuals with contraindications were identified by nursing personnel. Anyone that should not obtain a vaccination was marked with a black X on their right hand. Screening personnel marked on the windshield how many persons were in the car, and how many would be provided vaccine. This was a redundant system for vaccinators to be sure that persons who should not receive vaccine did not. Staffing patterns were adequate to maintain efficient flow through the POD and numbers documented per every fifteen minutes to monitor flow.

References: *Bent County POD Plan*

Analysis: *Redundant systems assured quality control quality control of POD operations and safety of individuals arriving at the POD.*

Recommendations: *None*

Activity 5: Conduct Mass Dispensing

Activity Description: *Provide patients with appropriate prophylaxis and maintain inventory control.*

Observation 5.1 *Waiting at dispensing station, rate at which dispensing centers process patients.*

Strength

The rates per hour were identified in observation 2.2 and maintained throughout the exercise.. The only waiting that occurred was when vehicles lined up outside the POD waiting for the exercise to begin.

Observation 5.2 *Implement plan to treat minors*

Area of Improvement

Bent County POD did not implement a plan to vaccinate minors. This was decided early on in exercise planning.

Observation 5.3 *Maintain a system for inventory management to ensure availability of vaccine and supplies.*

Strength

Evaluators documented conversations and monitoring of vaccine between the incident commander and supply staff throughout the day. Appropriate cooling packs were used to maintain vaccine no vaccine was documented as compromised by POD staff or evaluators, although evaluators could not verify if thermometers were used. Entries included pertinent questions asked by the incident commander regarding appropriate cooling mechanisms, monitoring, documenting and viability.

Observation 5.4 *Submit re-supply orders early enough to prevent running out of vaccine and supplies.*

Strength

Re-supply orders were not required during this POD exercise, however were well tested during the RTP exercise held on November 16th in Southeast Colorado. Refer to activity 1.3.

Observation 5.6 *Ensure availability and distribution of pre-printed drug information sheets.*
Strength

POD personnel distributed pre-printed materials regarding vaccine to individuals participating in the POD. Information was provided in English and Spanish.

Observation 5.7 *Utilize SNS protocol to request additional vaccine allocation.*
Strength

Utilization of the SNS protocol for to request additional vaccine was tested during the RTP portion of the exercise. Refer to activity 1.3.

References: *Bent County POD Plan*

Analysis: *The above mentioned observations indicated monitoring of vaccine to assure proper storage. Evaluators documented the flow of the clinic and rates were ideal. The only observation that required a recommendation was 5.2.*

Recommendations: *Include vaccination of minors in future exercises.*

Activity 6: Adverse Events Monitoring

Activity Description: *Through monitoring, identify individuals who have an adverse reaction to vaccine and initiate alternate therapies.*

Observation 6.1 *Track outcomes and adverse events following vaccination.*
Strength

Evaluators documented that systems were in place to monitor adverse events should they occur. No adverse events were identified. Individuals were directed to a waiting area after receiving the vaccination and prior to leaving the POD. The waiting area was monitored by a physician, who documented times that people received their vaccine and times they left the waiting area. No adverse events were identified. 100% of patient records were collected during this exercise.

During the After Action Conference, variables in appropriate waiting times (depending on the vaccine used and event) would be considered in planning for the appropriate space needed for adverse events monitoring. For example, monitoring smallpox vaccinations may take longer than flu vaccinations.

Observation 6.3 *Adverse events documented and reported to appropriate entity as described in the POD plan.*
No adverse events were identified so reporting is not applicable.

References: *Bent County POD Plan*

Analysis: *Adverse events monitoring was well documented by medical staff and no adverse reporting was required.*

Recommendations: *Consider that more space in the layout may be needed for vaccinations that require extended monitoring.*

Activity 7: Demobilize

Activity Description: *Upon completion, stand down POD operations, return site to normal operations, and release or re-deploy staff.*

Observation 7.1 *Debrief POD personnel*

Strength

90 % of POD personnel, volunteers and partners were debriefed immediately following the exercise by the controller.

Observation 7.2 *Reconstitute mass prophylaxis personnel and supplies.*

Strength

Demobilization activities began at 11:30 with removal of all equipment from the location where vaccinations were administered. Vaccine supplies were accounted for, as were radios and personnel. Demobilization activities were written into Job Action Sheets that were distributed to POD personnel.

References:

Bent County POD Plan

Analysis: *The above mentioned strengths indicate that Bent County anticipated demobilization as part of the exercise and response, documented and accounted for personnel and equipment.*

Recommendations: *None*

Prowers County

Capability 1: Mass Prophylaxis and Vaccination-

Capability Description: *The capability to protect the health of the population through a mass prophylaxis and/or vaccination campaign following an event. This includes the provision of appropriate follow-up medical care, as well as the communication messages to address the concerns of the public.*

Capability Summary:

Prowers County implemented their POD plan with the assistance of many partners; providing optimum security staffing, excellent site selection for a drive through POD, and redundant communication systems.

The drive through concept was introduced at planning meetings to response partners, who aided in organization of the concept. Prowers County Public Works personnel provided cones, signage, and mobile barriers. Law Enforcement (Sheriff's Office, Lamar Police Department, and Sheriff's Posse) provided optimum security of entrance and egress points, traffic flow and safety. Other multi-disciplinary efforts included emergency management field staff providing Incident Action Plan meetings and a completed IAP for the day of the exercise. This was instrumental in applying training that public health staff obtained in the past two years with ICS.

The local emergency manager provided resources, such as the mobile command unit to house the command and general staff. The mobile command unit included internet, 800MHz

communications and video surveillance. Fire and ambulance support remained at the site until POD operations demobilized following the conclusion of the exercise. The Department of Transportation provided a sign to direct the general public to the POD. This sign was located on Main Street and identified free flu vaccine availability, location, and times of operations.

IT personnel in Prowers County provided mobile communication systems to back up communication efforts. Amateur Radio Emergency Services provided redundant communication so that officials could communicate from POD to POD, and with the CDPHE Departmental Operation Center. In addition to redundant communication systems, Prowers County had translators available at each station within the POD to provide support for non-English speaking individuals seeking treatment.

The site chosen for the drive through POD operations was the Sand & Sage Fairgrounds. The location gave ample space to accommodate multiple response agency vehicles. The layout was developed by the Homeland Security Regional Coordinator for safety precautions and optimum traffic flow. Observing the difference (improvement) from the POD traffic flow in 2004 concluded the improvement plan identified in 2004 has been successfully executed in 2007.

Prowers County Public Health Nursing Service implemented incident command and activated additional staff to address the demand. PCPHNS developed a media campaign in coordination with CDPHE. The general public was well informed of flu season, vaccine availability, exercise date and location, and testing of disaster plans. This was evident with the turnout the Prowers County had during the exercise. The Public Information Officer provided the media with press releases prior to and during the exercise. Prowers County will want to revisit Immunization Protocols to assure vaccine monitoring, documentation and reporting are followed.

Activity 1.1: Direct Mass Prophyaxis Tactical Operations

Activity Description: *In response to notification of an incident requiring mass prophylaxis, provide overall management and coordination of mass prophylaxis operations.*

Observation 1.1 *Coordinate distribution/administration of mass prophylaxis*
Strength

POD Site leadership were identified prior to opening the POD and provided training to accomplish Mass POD operations. Trainings included a POD training provided by CDPHE and documented in CO-Train, Hospital SNS Receipt Plan training conducted in Prowers County and documented in Co-Train. Organizational charts identified leadership early in the planning stages and were provided to personnel at staff meetings. An Incident Action Plan was developed and provided to POD personnel by the Incident Commander. The Incident Commander provided a briefing to direct personnel as to the objectives for response.

References: *Not Applicable*

Analysis: *Trainings that led up to the exercise prepared leadership for the response role they provided during the exercise.*

Recommendations: *None*

Observation 1.2 *Coordinate public information regarding point of dispensing locations.*
Strength

Public Information was coordinated prior to the exercise with press releases that included time and location of POD operations. On October 24th an article was provided to the public through the Lamar Ledger. On October 20th, the Holly Shopper outlined upcoming flu shot clinics including the full scale POD Squad exercise. On November 6th a press release was

provided to the media regarding the exercise, times of operation and the location. On November 16th, the story was printed in the Lamar Ledger. Prowers County also involved the public in an activity at a football game half time to create better awareness of influenza issues and transmission of disease. During the exercise, a department of transportation sign was used on Main Street to alert the public of the exercise and vaccine location.

References: *Prowers County POD Plan*

Analysis: *Public Information was provided statewide and within the jurisdiction to create awareness about pandemics, what the public can do to protect themselves, and participation in the exercise. Aside from publications, Prowers County included the public in activities to build awareness. These actions were well documented by the press.*

Recommendations: *none*

Observation 1.3 *Coordinate with the RTP to re-supply PODs as needed.*

Strengths

During the RTP exercise held on November 16th, Prowers County Nursing Service coordinated with Area Command to re-supply vaccine that was transported to the RTP from CDPHE and was found to be compromised. Prowers County was unable to utilize the vaccine from CDPHE for the POD exercise on November 17th, 2007. Southeast Area Command, located in Otero County, coordinated with CDPHE to implement contingency planning. Prowers County Public Health Nursing Service would use their own private vaccine for the exercise and obtain reimbursement from CDPHE by billing through the Emergency Preparedness and Response Contract. The Prowers County Point of contact interacted with Area Command to determine the appropriate course of action to obtain vaccine for the next day's exercise.

Area of Improvement

In Southeast Colorado, transport teams and LPHA's were to simulate medical supply transport from the RTP to the local jurisdiction. The simulation included empty boxes. Most likely during a disaster, vaccine is not the only medical supply that teams will need to transport. During planning meetings prior to the exercise, PCPHNS coordinated with Prowers Medical Center and determined that the Nursing Service would transport the simulated medical supplies back to their jurisdiction from the RTP in Otero County. Although the simulated medical supplies were available for the Prowers Transport Team to pick up, the transport team did not sign for, nor pick up the empty boxes and thus did not transport the empty boxes back to their jurisdiction to complete the medical supply management and distribution process.

References: *Southeast Colorado Regional SNS Plan, Prowers County POD Plan, Prowers Medical Center SNS Receipt Plan*

Analysis: *According to evaluator notes, RTP unit logs and actions taken by the Prowers Point of Contact, coordination with Area Command for vaccine was accomplished and well documented. Vaccine was secured for POD operations through Area Command and contingency plans put into place after finding that vaccine transported from the state was compromised. Coordination took place between S.E. Area Command and CDPHE to accomplish reimbursement for private vaccine that Prowers County Public Health would use for the exercise, then be reimbursed for by CDPHE through the EPR contract.*

According to evaluator notes, RTP unit logs and actions taken by the Prowers transport

team, medical supply management and distribution was not completed. Documentation by evaluators and Area Command Liaison unit logs also revealed the local point of contact was communicated with by email and phone as to RTP updates by Area Command. The transport team was not aware of these updates and indicated frustration to RTP personnel during play. When these issues were discussed at a local emergency planning meeting following the exercise, some players indicated they did not know the goal was to simulate medical supply management and had stated that they did not read the exercise plan.

***Recommendations**: Players should be encouraged to read the exercise plan prior to play, as well as review the plans they are testing, such as the regional SNS plan. Those organizing planning meetings should review the exercise plan with players to assure if there are any questions regarding exercise objectives or rules of play, they are answered. Increase communication between local authorities and transport teams and maintain documentation.. There is also a recommendation for a liaison officer at the RTP in addition to the one that was located at S.E. Area Command. See Medical Supply Management and Distribution section.*

Activity 2: Activate Mass Prophylaxis

***Activity Description:** Upon notification, activate PODs for mass prophylaxis operations.*

***Observation 2.1** Initiate call down lists for mass prophylaxis site staffing.*

Strength

Prowers County initiated call down lists by using reverse 911 to alert staff, volunteers and partners of SNS POD operations. The dispatch center would usually notify agency personnel during a disaster. Once key staff were notified, leadership within the agency would notify staff and volunteers of mass prophylaxis operations and put them on stand by. Prowers County wanted to test the 911 system, so utilized this resource to notify staff of mass prophylaxis operations.

Staff, volunteers and partners were directed to report to the fairgrounds for the POD exercise. A briefing was conducted by the Incident Commander at approximately 7:30 am. An Incident Action Plan was distributed to key POD personnel. The IAP identified procedures and protocols for POD safety and operations, ICS organizational chart for the POD, POD layout, safety messages, unit logs to keep actions taken documented, and stations within the POD.

Staff, volunteers and partners reported to the fairgrounds and completed a formal check in process. Personnel that were assigned to document the check in and check out process remained in their location to complete the process throughout the exercise. This maintained accountability for personnel during the incident.

Area of Improvement
Evaluators observed that while the IAP was distributed to personnel, it was not followed by key ICS staff. Logistics and Planning Section Chiefs were assigned to vaccination and screening stations, respectively. Evaluators and the controller also observed and documented that people within the incident command structure were not located at the Incident Command Post, but roaming.

***References:** Prowers POD IAP*

***Analysis:** Although an IAP was developed and distributed, the ICS structure in the POD did not adhere to it. Not having incident command personnel at the ICP to document response actions and decisions diminished accountability of disaster response. Unit logs and documentation were not obtained from Command and*

General staff.

Recommendations: *Update IAP and conduct briefings to reflect changes made in Incident Command organizational charts. Have Command and General ICS staff located at the ICP to document response activities and decisions as if this were a disaster rather than an exercise. Have key ICS personnel complete and ICS forms class. Add reverse 911 to POD plan as a way to notify POD staff.*

Observation 2.2 *Ensure mass prophylaxis site operations are established in accordance with Memoranda of Agreement*

Strength

POD site selection was optimal for drive through POD operations. The site allowed for response vehicles such as fire trucks, EMS and law enforcement to move around with ease without hampering POD operations. The location and layout also allowed for traffic flow patterns to prevent major streets and intersections from being blocked or congested. There was plenty of room between POD stations to prevent bottlenecks and to assure optimum safety with moving vehicles, however sorting of vehicles could be moved closer to screening to allow more room between vehicle sorting and the vaccination station. Signage, cones and barricades were located at the entrance, at each station and exits. Signs included stop signs, informative signs, and safety directions, such as putting vehicles in park and shutting off engines. The POD site also had facilities for staff check-in/check out activities, as well as staff support; including restrooms, break area and food availability. It was observed in the IAP and evaluator notes that plenty of parking was identified for staff and volunteers. Portable toilets were available on site. Building surveys and risk assessments were completed by environmental health personnel prior to the exercise. Partners in law enforcement provided security on streets leading to the POD, traffic flow within the POD and security of ingress and egress locations. Stations were staffed with knowledgeable personnel to provide documentation to individuals, conduct appropriate screening, provide vaccinations, and to monitor for safety following vaccinations.

Areas of Improvement

According to evaluator and controller notes and a vaccinator unit log, PCPHNS immunization protocols were not implemented or followed while transporting vaccine from PCPHNS to the POD site. Vaccine coolers were transported without thermometers. Monitoring and documentation of vaccine was not maintained during exercise play. 10 Vials or 100 doses of vaccine were found frozen by the vaccination station at approximately 10:30 am. The vaccination station personnel reported the findings to incident command personnel. It was determined that a vaccine cooler located at a vaccination table contained -20 degree ice packs. The -20 degree ice packs were transferred from the large storage cooler in the 4-H building to the small cooler at the vaccination station. The -20 degree ice packs were removed from cooler at the vaccine station and the Operations Chief was notified. The frozen vaccine was immediately put into bags and marked non-viable, thereby being separated from viable vaccine.

References: *Colorado Immunization Manual, PCPHNS Immunization Protocols*

Analysis: *Although both state and local transport of vaccine resulted in compromised vaccine, response varied as did outcomes with vaccine handling and decisions made for use during this exercise. During the RTP section of this exercise, protocols were followed by CDPHE to verify viability with manufacturers of vaccine in question. Temperature monitoring was well documented by RSS personnel that packed the vaccine and by RTP personnel during exercise play. Thermometers were located in*

the coolers transported by CDPHE to the RTP. Directions for monitoring vaccine and documentation were located on the transport coolers. Once the temperature read 34.2 for vaccine at the RTP it was reported to CDPHE immunization officials.

Recommendations: *Transport vaccine according to Colorado Immunization Protocols with thermometers. Consider purchasing thermometers for transport of vaccine. Monitor and document temperature readings and keep documentation on the coolers. Consider updating local protocols to have a second person checking vaccine packing procedures for temperature sensitive materials to be transported. Provide just-in-time training to those handling vaccine, or assign only those proficient with vaccine protocols to handle vaccine. A drill to test the layout with a few vehicles and personnel prior to the full scale exercise may be a way to catch details that could be changed prior to the exercise.*

Observation 2.3 *Assemble needed supplies and equipment for POD operations including materials to prepare oral suspension.*

Strength

Clipboards, office supplies, tables, go kits, radios, medical supplies, and other medical materials to administer vaccine were available at the POD for personnel. An Incident Command Post provided shelter for ICS personnel, computers, video capabilities and communication capabilities. Redundant communication systems were available: Mobile communication systems made available by Prowers County IT, Amateur Radio Emergency Services, and the mobile command unit also had communication capabilities.

References: *Not Applicable*

Analysis: *Well thought out supply lists were made and logistical support provided by logistics was optimum for POD operations.*

Recommendations: *None*

Observation 2.4 *Prepare informative materials for POD staff, patients, and media.*

Strength- See observation 1.2

Observation 2.5 *Provide internal and external security for POD sites.*

Strength

Internal and External security points were well thought out in planning meetings and documented in the Prowers IAP. Optimum security was provided during transport of vaccine and was provided by the Prowers County Sheriff's Office during the RTP exercise. The Lamar Police Department provided personnel to monitor traffic flow on the streets leading to the POD while the Sheriff's Office provided security within the POD. The Sheriff's Posse assured that the site ingress and egress were secure.

Area of Improvement

Some staff could not identify vehicles that were not part of the exercise. They were not in line to obtain vaccinations, however were not identified with responders.

References: *Prowers POD Plan, IAP*

Analysis: *According to evaluations and observations expressed in the de-briefing that followed the exercise, security steps that were outlined in the IAP were followed. No security issues were identified and staffing was optimal. Provide those that may arrive to the POD to assist with set up with vehicle identification. This may include a laminated sign that could be put on the dash or door of the vehicle.*

Recommendations: *Update security protocols to have roaming vehicles identified.*

Observation 2.6 *Provide prophylaxis to POD staff, first responders, and critical infrastructure personnel and their families in accordance with the local POD plan.*

Strength

POD staff provided vaccinations to volunteers, response partners and POD personnel either during or directly following the exercise prior to the de-briefing. A Safety Officer and Deputy Safety Officer were assigned to locations in the POD to cover the large geographic areas within the POD. This worked very well to maintain monitoring of vaccinations and sharps containers as well as observation areas where patients were located following vaccine administration. No safety issues were documented by safety officers.

References: *Prowers County POD Plan*

Analysis: *In 2004 vaccinating of responders was also tested during a full scale exercise. During an event, particularly a vaccine shortage, local officials may be required to provide vaccine to specific risk populations, as was the case in 2004. Changes in the plan reflect how asset shortages may alter this practice.*

Recommendations: *None*

Observation 2.7 *Establish plans to meet the unanticipated transportation needs for the following:*

Strength

The concept of drive through POD operations allows family members to bring disabled or Frail family members through a POD without walking requirements associated with a walk-in facility. In 2004, homebound clients were included in the plan and tested, however it was not included in 2007. While gaining feedback from the general public that participated in this exercise, the drive through concept made obtaining vaccine for frail family members much easier to accomplish by keeping the family member in the car.

Area of Improvement

Accommodations were not made for walk-ins, however those that did walk in returned home and got in their vehicles to obtain vaccinations.

References: *Prowers POD plan*

Analysis: *Prowers County has tested walk- in POD operations (2004) to include homebound individuals, and drive through POD operations in 2007. Time and funding limitations may limit putting all the vaccination concepts together at one time.*

Recommendations: *None*

Activity 3: Conduct Triage for Symptoms

Activity Description: *Conduct initial screening of individuals prior to their entering the POD in order to prevent symptomatic individuals from potentially contaminating POD*

Observation 3.1 *In the event of a communicable disease, ensure initial triage is performed either at staging area or in area separate from mass prophylaxis site to prevent contamination of site.* ***3.2*** *Transport symptomatic individuals to appropriate health facility prior to their entering mass prophylaxis site.*

Strength

An ambulance was located at the Prowers POD to transport sick or injured individuals who may need acute care. A screening station was set up to provide information to individuals about influenza and to answer questions, or refer them to their physician. A triage station was not set up to separate ill people from healthy at this POD, however people were required to stay in their vehicles which aids in diminishing the spread of disease to others who participated in the drive through POD. Since people obtaining vaccinations did not enter POD facilities, but remained in their car, local officials felt a triage station is a moot point. Disease specific information was provided to individuals obtaining vaccinations. The drive through POD supports social distancing by not exposing large crowds to ill individuals.

Activity 4: Conduct Medical Screening

Activity Description: *Review patient screening documentation and available medical history to determine proper course of treatment.*

Observations 4.1 *Provide information to each individual* ***4.2*** *Identify medical history and exposure* ***4.3*** *Ensure sufficient staffing at the POD site screening station to prevent initial bottlenecks.*

Strength

Informed Consent forms were provided to each individual by screening personnel who were prepared to assist them with questions that applied to medical history, past allergic reactions to vaccine, or contraindications to vaccine. Forms were completed by individuals requesting to be vaccinated, and collected by POD personnel. Bi-lingual staff was also available at each station within the POD to provide translation services. Those screened out of the vaccination process were marked on their hand with a red x to assure they did not get vaccinated.

References: *Prowers County POD Plan*

Analysis: *According to evaluator notes and vaccination personnel, there was very little waiting throughout the medical screening process. Individuals participating in the exercise who were obtaining vaccinations commented on how quickly this process was accomplished. Evaluator notes conclude that throughput was optimal and maintained throughout the exercise.*

Recommendations: *None*

Activity 5: Conduct Mass Dispensing

Activity Description: *Provide patients with appropriate prophylaxis and maintain inventory control.*

Observation 5.1 *Waiting at dispensing station, rate at which dispensing centers process patients.* ***5.2*** *Implement plan to treat minors*

Strength

The rate of persons vaccinated per hour, according to evaluator notes was 126. Waiting time at the dispensing station averaged 6 – 15 minutes, depending on how many people they had in the car. The dispensing station had 3 lines to sort single individuals in a car to lane 1, multiple adults to line 2, and those with children to line 3. Vaccinators provided treatment to minors upon parent or guardian consent. Supplies were well organized on small tables that allowed cars through the lines. Clipboards were used to maintain patient information. According to evaluator notes, the vaccination station was monitored hourly to see if they needed more vaccine by runners and the Operations Chief.

Observation 5.3 *Maintain a system for inventory management to ensure availability of vaccine and supplies.*

Area of Improvement

Additional assistance was needed by vaccinators to draw up vaccine according to vaccinator unit logs. One person maintained the paperwork, while one person administered vaccine. Although the vaccination station was monitored for needed supplies, the vaccine cooler were not monitored or documented for temperature. This resulted in frozen vaccine. Refer to observation 2.2.

References: *Prowers POD Plan*

Analysis: *While reading evaluator notes and unit logs of vaccinators, it is indicated that additional monitoring of supplies or preparation of vaccine would assist the vaccinators in this function. While a walk-in POD serves one individual at a time, a drive through POD serves many persons at a vaccination station, depending on the car load.*

Recommendations: *Revisit POD Plan to update staffing patterns needed for a drive through POD to include more people to draw up vaccine. Recruit additional staff for the vaccine station that can draw up vaccine for nursing personnel who are vaccinating. This position could also monitor and document vaccine thermometer temperatures in the coolers.*

Observation 5.4 *Submit re-supply orders early enough to prevent running out of vaccine and supplies.*

Strength

Prowers County Public Health Nursing Service simulated re-supplying vaccine during the RTP portion of the exercise. See Activity 1.3.

References: *Southeast Colorado Regional SNS Plan*

Analysis: *See Activity 1.3.*

Recommendation: *None*

Observation 5.6 *Ensure availability and distribution of pre-printed drug information sheets.*

Strength

Fact Sheets regarding drug information were provided to each individual. These sheets were

available in English and Spanish. Translators were available at each station of the POD for personnel that did not speak English.

References: *Prowers County POD Plan*

Analysis: *Printed materials in English and Spanish provide efficiency and accuracy to POD personnel assisting non-English speaking individuals. Translators are able to assist POD staff who process people through the stations that may not speak English. This prevents bottle necks at stations and assures accuracy when serving non-English speaking participants.*

Recommendations: *None*

Observation 5.7 *Utilize SNS protocol to request additional vaccine allocation.*

Strength

SNS protocols were used and demonstrated by Prowers County Public Health Nursing Service during the RTP portion of the exercise. See Activity 1.3.

References: *Southeast Colorado Regional SNS Plan*

Analysis: *PCPHNS demonstrated in 2004 and 2007 capabilities in activating SNS request protocols, coordinating with Southeast Area Command, and CDPHE during SNS operations from the state to local level. These were documented in the 2004 AAR, and the situation reports generated by CDPHE during the POD Squad Full Scale Exercise.*

Recommendations: *None*

Activity 7: Demobilize

Activity Description: *Upon completion, stand down POD operations, return site to normal operations, and release or re-deploy staff.*

Observation 7.1 *Debrief POD personnel*
7.2 *Reconstitute mass prophylaxis personnel and supplies.* ***7.3*** *Complete administrative items following the order to demobilize.* ***7.4*** *Provide a staff debriefing.*

Strength

POD personnel, volunteers and response partners were provided a debriefing by the controller, evaluator and Incident Commander for the POD. The debriefing was provided immediately following the conclusion of the exercise. Notes were obtained to capture feedback from the participants. Demobilization activities were coordinated and equipment was accounted for, to include: radios, clipboards, vaccine coolers, tables, vests and office supplies. Controllers and evaluators provided documentation to evaluation staff responsible for writing the AAR.

References: *Prowers County POD Plan*

Analysis: *Demobilization protocols were followed by POD personnel and supplies were returned to PCPHNS. Transition was made by personnel to return to day to day*

operations at the agency.

Recommendations: *None*

Capability 2: Medical Supplies Management and Distribution

Capability Description: *Medical Supplies Management and Distribution is the capability to obtain and maintain medical supplies and pharmaceuticals prior to an incident and to transport, distribute, and track these materials during an incident.*

Capability Outcome:

Critical medical supplies and equipment are appropriately secured, managed, distributed, and re-stocked in a timeframe appropriate to the incident.

Capability Summary:

The Medical Supplies Management and Distribution capability was also tested in Southeast Colorado in 2004 during a nine county exercise, and an improvement plan was developed from that exercise. When the opportunity arose to participate in the statewide full scale POD Squad exercise, Southeast Colorado decided to implement and test improvements that were derived from the 2004 exercise. Improvements included a new Regional Transfer Point (RTP) Facility Memorandum of Agreement; and new RTP staffing patterns and personnel. The Capability was tested in 6 counties of Southeast Colorado to include: Baca, Bent, Kiowa, Otero/Crowley, and Prowers Counties during the POD Squad exercise.

Planning and Training was conducted and documented prior to the POD Squad exercise by providing hospitals with Strategic National Stockpile (SNS) plan templates for receiving SNS assets. Training was also provided to hospitals to overview SNS strategies. Leaders from local public health agencies were provided a two day POD training prior to the exercise to review successful exercise concepts, SNS protocols, and applying incident command to medical supply management. Completion of incident command courses were at an optimal level prior to the POD Squad Exercise in all jurisdictions that participated in S.E. Colorado.

Exercise planning meetings included law enforcement agencies, emergency managers, local public health agencies (LPHA), healthcare entities, volunteers, elected officials and municipalities. Input of these agencies during planning provided for a well orchestrated exercise and response..

Incident Command was implemented and Southeast Area Command provided direction and control of medical supply management between CDPHE and RTP functions. A Liaison Officer communicated and maintained communication with local jurisdictional authorities during exercise play. Local jurisdictions were responsible for transporting medical supplies from the RTP (located in Otero County) back to their local jurisdictions in conjunction with their security transport personnel.

The RTP was exercised in 2004 in Southeast Colorado. At that time, there were nine jurisdictions that the RTP served. An improvement plan matrix was developed from the AAR of 2004. Key areas of improvement were:

- ◊ *Choice of Facility*
- ◊ *Anticipate extended RTP functions*
- ◊ *Staffing skills sets needed for RTP functions needed to be revisited*
- ◊ *Lateral re-distribution of assets, within the region and between regions*

At a quarterly emergency and preparedness meeting held in the summer of 2007, regional point of contact roles, as well as local point of contact roles were identified and documented to clarify responsibilities for exercise planning and implementation.

A new facility was chosen for the 2007 POD Squad Exercise, based on federal guidelines for RTP facilities, to include a fence around the facility, equipment needed to move large quantities of

materiel, and back up source of electricity (generator) and access to fuel for the generator. The new facility tested in this exercise proved to be a much better location for receiving SNS assets, breaking them down into allotments, and disbursing them to the local jurisdictions. Memorandums of Agreement were completed for the new facility by Otero County Health Department. Otero County Health Department has now identified and tested a primary and secondary facility for RTP use.

New staffing to identify logistical skill sets, rather than nursing skill sets proved to make movement of supplies more efficient. Public Works personnel were utilized for staffing the RTP which was a definite improvement from the exercise in 2004. Although they did not have equipment to move around, they followed protocol, utilized incident command well, and approached the empty boxes used to simulate SNS assets as if they were real. They accounted for and allotted proper materials to local jurisdictions playing in the exercise. Nursing (RN's) were also located in the RTP for medical references, tracking and monitoring of vaccine and providing vaccinations to RTP personnel.

Since SNS assets, such as a push package, or federal medical stations are mainly hospital supplies, the Southeast Planner wanted to include hospitals in SNS planning, training and exercising. It was also identified by the state (HRSA) in 2004 that hospitals were required to have SNS receipt plans. For these reasons, Southeast Colorado assisted hospitals in the jurisdiction with developing a SNS receipt plan, provided training to hospitals on the Strategic National Stockpile, and invited them to be involved in the POD Squad Full Scale exercise to test these plans. A key part of the updated regional SNS plan and Hospital SNS Receipt Plan was to coordinate with the Local public health agency.

Another improvement made from 2004 was an Incident Action Plan that was developed by Area Command to cover safety issues, transport protocols, communications, RTP set up, notification procedures, risks and those responsible for implementing response. RTP personnel developed precise and thorough unit logs to document actions taken, challenges that arose and final determinations for medical supplies.

Use of Area Command at Otero County Health Department and implementation of incident command at the RTP were a huge improvement from 2004. This is due to additional education that has been completed in the region with incident command since 2004, and the opportunity to work within an incident command system during two disasters in the past year. Documentation and unit logs were impeccably kept at Area Command, to include all correspondence with local points of contact within public health agencies, appropriate hospitals, RTP incident command and CDPHE (RSS, transport teams). Also documented at Area Command was the communication between the Liaison Officer and local points of contact, hospitals and other outside agencies.

Briefings conducted by the Incident Commander at the RTP were frequent to address changes as they occurred with RTP personnel. Briefings were concise, professional and documented in unit logs. Briefings were also conducted between Area Command and the RTP Incident Commander frequently to keep communication accurate as decisions were made by CDPHE, the RSS, and the Departmental Operation Center.

Use of 800 megahertz radios at Area Command and the RTP proved to be very helpful during the exercise. An evaluator commented on the professional protocol that was used at CDPHE, S.E. Area Command, and the RTP. This was a result of training and drills conducted by OCHD personnel in 2006.

CDPHE followed Colorado Immunization Manual protocols for packing and transporting vaccine with appropriate cool packs and thermometers to monitor the temperature of vaccine. Coolers were labeled with safety and proper temperature information and logs. This aided RN personnel at the RTP to determine the temperature of vaccine, which was 34.2 upon arrival at the RTP. Appropriate temperatures for this vaccine range from 35 -46 degrees Fahrenheit or 2 – 8 degrees

Celsius, according to the Colorado Immunization Manual. It was unclear if CDPHE believed the vaccine was cooler while in flight, however Colorado Immunization Manual protocols were followed to contact the manufacturer to determine viability of vaccine in question. Appropriate packing, tracking and reporting of compromised vaccine was reflected during the RTP exercise which caused for frustration for local authorities as this process is time consuming. These actions taken were well documented throughout play. Determining proper use of vaccine once it is compromised with manufacturer and CDPHE authorities was followed during the RTP portion of the exercise and documented by nursing personnel as to temperature and amounts of vaccine that were received. Once the decision was made that the vaccine was compromised, it was separated from viable vaccine supplies.

Overall, 10 persons staffed Area Command, 37 persons staffed the RTP teams, and two persons from each jurisdiction played as transport teams in Baca, Bent, Kiowa, Otero/Crowley and Prowers Counties.

Three of the six jurisdictions in Southeast Colorado completed the medical supply management objectives and details of strength and improvement areas are identified in the observations below. The jurisdictions that completed the medical supply management and distribution in S.E. Colorado were Kiowa, Crowley and Otero Counties.

Exercise support was provided by Baca and Kiowa Counties during both the RTP and POD exercises conducted on November 16th and 17th. Both counties provided evaluators and controllers to support exercise activity in the other counties.

Activity 1: Direct Medical Supplies Management and Distribution Tactical

Activity Description: *In response to a need for medical assets, provide overall management and coordination for Medical Supplies Management and Distribution.*

Observation 1.1 *Check inventory of needed resources* ***1.3*** *Maintain communication with transportation vendors during distribution of medical supplies.*

Strength

The Liaison Officer at Area Command maintained communication with local authorities overseeing SNS operations in their jurisdiction. Local authorities were to keep transport teams apprised of developments and decisions, such as delay in delivery of SNS assets. Notifications were provided to local jurisdictions by Area Command as to estimated time of arrival of assets to the airport, again when the assets were at the airport, and during delays due to questions regarding viability of vaccine. These communications were well documented in unit logs kept at Area Command, as well as evaluator notes. Notifications were provided by redundant systems of communication, such as email, phone and 800 megahertz radios. Area Command kept white boards with current information as negotiations for vaccine ensued. This kept track of inventory, demands for assets in each jurisdiction, and verification with CDPHE on asset availability.

Area of Improvement

Local transport teams expressed frustration with waiting for assets and felt they were not updated frequently enough. According to RTP unit logs, some transport teams self deployed to the RTP prior to notification resulting in extended waiting periods. Unit logs were not available to reveal how frequently local points of contact provided updates to transport teams, nor were there evaluators to oversee this part of the exercise. Evaluators were located in the RTP and Area Command. Use of WEB EOC was also suggested to provide documentation

within the region during a real event.

References: *Southeast CO Regional SNS Plan, Area Command IAP*

Analysis: *Exercises and disasters bring many un-anticipated obstacles to overcome in order to provide efficient response for our citizenry. Assuming when exercise play or disasters will occur, and how it will unfold will disappoint responders and the general public. Self reporting is not a suggested practice in disaster management. Communications between the Liaison officer and local points of contact were frequent and documented. Written Notifications from Area Command clearly stated the estimated time of arrival of assets, when transport teams should arrive at the RTP, when the assets were on the ground in Otero County, and delays of transfer of vaccine due to compromised vaccine. Due to fair weather and no shortages of vaccine reported in the United States, these obstacles were not anticipated by participants at the beginning of play. During an exercise, participants need to be ready to respond to a number of circumstances, just as in a real event and adapt plans to get the job done.*

Recommendations: *Revisit POD Plans and the Southeast Regional SNS Plan To update communication protocols between local authorities and transport teams. Consider adding a stand alone Liaison Officer to the RTP ICS structure. During this exercise, the deputy IC was to assume the liaison role.*

Activity 2: Activate Medical Supplies Management and Distribution

Activity Description: *Upon identification of medical resource shortfalls and/or SNS deployment, activate warehousing operations.*

Observation 2.1 *Establish medical supplies warehouse management structure* ***2.2*** *Activate warehousing operations for receipt of medical assets.*

Strength

Otero County conducted several planning meetings, trainings and drills throughout the year to prepare for this exercise. Included in planning meetings were completion of a Memorandum of Agreement for the new RTP facility which afforded Southeast Colorado a higher level of security and warehousing capabilities should a disaster occur where SNS assets are required. Discussions between the Otero County Health Department and Otero County Public Works Director provided a very positive outcome of utilizing the Road and Bridge crews for RTP staffing. This required ICS training and SNS training to be provided to municipal employees. These efforts provided for a successful coordination of the Regional Transfer Point functions.

Warehousing management structure identified in the Southeast Regional SNS Plan was communicated through an IAP that was distributed to local jurisdictions and RTP personnel. Area Command identified structure and staffing that was to be implemented at the RTP and Area Command to support response objectives. ICS organizational charts were reviewed in briefings conducted by the Area Commander and the RTP Incident Commander. These briefings were well documented in unit logs and evaluator notes. Reporting requirements were communicated to personnel that would staff the RTP through training and the IAP. Notifications to local jurisdictions were well documented as well as activation protocols for RTP staff. Credentialing of personnel to staff the RTP was implemented at the RTP. Personnel were accounted for throughout play and documentation was maintained. Badges were provided to RTP personnel as were ICS vests, an IAP, job action sheets and RTP layout maps. Frequent briefings were conducted by the Incident Commander (IC) at the RTP to reflect the many changes that occurred due to compromised vaccine.

Area of Improvement

The Supply Unit was not prepared to provide coordination at the onset of the exercise. The IC

provided proper forms for tracking check in procedures and re-assigned personnel to conduct the check in and credentialing process until the Supply Unit personnel arrived. Since the supply unit personnel had check in and credentialing documentation, the Sheriff personnel located at entrances did not have proper check lists to reference those arriving until the exercise was underway.

Area Command found that they did not have enough personnel to meet the demand during the exercise and had to call in additional staff. The AC was also the PIO. There was not a planning section chief, however a deputy IC was assigned which proved to be crucial in documenting activities.

References: *Southeast Colorado Regional SNS Plan*

Analysis: *The improvement plan that was identified in the 2004 exercise that tested Medical Supply Management was successfully implemented during the POD Squad exercise. Critical skill sets provided by Otero County Road and Bridge improved the receiving, allotment and disbursement of SNS assets in Southeast Colorado. Personnel accustomed to warehousing and transport provided great skill sets for transporting SNS assets from the airport to the RTP and warehousing functions of receiving, allotment and disbursement. The new facility for RTP functions also tested well for security functions, movement of transport teams and warehouse space. The receiving team at the airport believed they needed time to assure the delivery from the National Guard was accurate. Discussions regarding the need for vaccine monitoring personnel on board the Blackhawk would ensure accurate chain of custody.*

Recommendations: *Personnel who are an integral part of response need to delegate errands in order to fulfill their response role.*

Observation 2.3 *Identify needed transportation assets for medical supplies.*

Strength

The State Patrol identified 3 alternate routes from the airport to the RTP so they had flexibility that may be required due to weather or trains blocking the roads. They did not share specific routes that would be used until the day of the exercise to prevent compromised security during transport. Drivers cooperated with chain of custody forms that they were required to sign at the La Junta Airport, as well as drivers arriving at the RTP to receive these assets. Local Points of Contact provided names and identifications of transport teams that would arrive at the RTP, as well as license plate information on vehicles they would arrive in. Law Enforcement personnel were an integral part of transport teams to secure assets until they reached their local jurisdiction.

References: *Southeast Colorado Regional SNS Plan*

Analysis: *According to evaluator notes and unit logs, records of transport vehicles and teams were well maintained, as were chain of custody forms by transport teams.*

Recommendations: *None*

Activity 3: Establish Security

Activity Description: *Upon activation of warehouse, activate Medical Supplies Management and Distribution plan.*

Observation 3.1 *Execute plan for credentialing RTP personnel.*

Strength

Prior to check in of RTP staff at the facility, law enforcement officers were provided a list of personnel that would be arriving at the gate. Individuals were identified at the gate prior to entering the RTP facility.
The Incident Command and General staff executed credentialing procedures for RTP personnel. Area Command also credentialed personnel that fulfilled Area Command Functions. A formal check in procedure required ID of those arriving to Area Command and the RTP. Badges were provided for all personnel, as were appropriate ICS vests, job action sheets, and the IAP. The IAP included safety messages, objectives for response, ICS organizational chart, RTP layout, and contact information. Once the RTP and Area Command personnel were properly credentialed, briefings were conducted by the AC and IC at their locales.

Law Enforcement provided ingress and egress security at gates, facility entrances and at the airport during SNS asset arrival and transport to the RTP. The Otero County Sheriff's Office fulfilled this function during exercise play.

Area of Improvement

Area Command arranged for media to be at the airport, however did not communicate this to law enforcement assigned to securing the airport and transport team.

References: *Southeast Regional SNS Plan, Area Command IAP*

Analysis: *Security procedures were executed and protocols followed to maintain security at the RTP. Arrangements with and credentialing of media needs to be communicated to law enforcement.*

Recommendations: *Review protocols for*

Activity 4: Warehouse Operations and Distribution

Activity Description: *After delivery of medical assets to warehouse facility, repackage pharmaceuticals and other assets and distribute them to Points of Dispensing and other health facilities*

Observation 4.1*Assemble RTP warehouse teams (receiving order mgt, distribution).* ***4.2*** *Inventory medical supplies warehouse resource levels* ***4.3*** *Provide quality control/quality assurance for requested medical assets prior to shipping.* ***4.4*** *Track supply requests.*

Strength

See observation 2.1 in addition to this narrative. RTP personnel were organized into three teams: SNS Receiving, Allotment and Disbursement. Staff were assigned to a team and provided a briefing on specific protocols for that team. Activity at the RTP was coordinated through an incident command structure that communicated well with Area Command and the IC at the RTP held several briefings during exercise play to assure a common operating picture for RTP personnel. Changes in allotments received from AC were updated and documented by RTP personnel. Receiving times and condition of SNS materiel was well documented and communicated to CDPHE. RTP personnel conferred with supervisory personnel as to the changes in allotments and changed documentation accordingly. AC maintained documentation of the allotment changes due to availability of vaccine from CDPHE following their exercise on November 15th, compromised vaccine, and available vaccine in each county.

Computers, office go kits and internet capabilities were conducted within the logistics section. This provided inventory systems to track SNS assets that arrived at the RTP and that were signed for at the RTP by local transport teams.

Quality Control was well demonstrated by Area command and RTP personnel. The vaccine that was received at the RTP was identified with proper temperature that was to be maintained for viability of vaccine, as well as a document to monitor thermometer readings at regular intervals. Thermometers were packed in the vaccine coolers from CDPHE. Area Command and RTP personnel verified proper amounts of medical supplies that Southeast Colorado was to receive, including empty boxes for simulation and vaccine supplies. It was determined during play that the National Guard delivered vaccine that was to go to Alamosa to Southeast Colorado. The mistake was identified and the National Guard was contacted by Area Command to return to Otero County to retrieve the vaccine intended for Alamosa. Corrections were made and Alamosa was notified that a delay in their estimated time of arrival was anticipated.

References: *Southeast Regional SNS Plan, Area Command/RTP IAP*

Analysis: *The challenges that arose due to additional allotments of available vaccine, compromised vaccine and the demand for vaccine to conduct POD operations the day following this exercise; revealed that lateral re-distribution of SNS assets is essential for efficient movement of assets to areas in need. This was an area of improvement identified in 2004 during the full scale nine county exercises conducted in Southeast Colorado. Timely coordination within and between regions is critical in order to save lives.*

Recommendations: *Revisit the Southeast Regional SNS Plan and State SNS Plan to create lateral re-distribution protocols. The State Patrol is an appropriate partner for small amounts of critical supplies between regions, however is not the answer for large amounts of medical equipment.*

Activity 6: Demobilize

Activity Description: Inventory, reorganize, and reconstitute stockpiles to return pre-incident levels, and release personnel from Medical Supplies Management and Distribution duties.

Observation 6.1 *Execute plan to reduce warehouse operations as distribution needs ease.*

Strength

A clear directive was provided at the RTP to begin demobilization activities by the Incident Commander. The briefing included check out procedures, conclusion of receipt team activities, and getting equipment returned to the warehouse. Included in job action sheets were demobilization activities for each position. Non essential staff was requested to complete the check out process through the supply unit which included returning of badges, vests and notes from the exercise. Equipment that was transported to the RTP by IT personnel at Otero County included go kits with computers and office supplies. These were packed up, inventoried and transported to their original location. Radios and other communication devices were accounted for and inventoried.

References: *Southeast Regional SNS Plan*

Analysis: *Logistics provided excellent documentation of the demobilization process. AC and the IC at the RTP provided excellent notification and documentation of the demobilization process in respective facilities. These efforts provided accountability for staff and equipment as well as transitioning to day to day operations following response.*

Recommendations: *None*

Section 4: Conclusion

Southeast Colorado has made great strides in multi-disciplinary coordination with planning, training and exercising. ICS and NIMS training levels have developed a greater understanding and use of command structures in public health response. Between 2004 and 2007, full scale Strategic National Stockpile exercises have been conducted, to include Regional Transfer Point and POD implementation in both years. Improvement plan matrixes are used in planning cycles that identify training needs or the need for updated plans and protocols. Pandemic Influenza scenarios have been used in all exercise cycles.

A greater focus on medical supply management will be required to assure supplies requested get to their local destination. Improvements in cold chain storage and transport of vaccine will improve the outcome during POD operations.

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Appendix A: Improvement Plan for S.E. Colorado

This IP has been developed specifically for Southeast Colorado as a result of the POD Squad Full-Scale Mass Vaccination Exercise conducted on November 16-17, 2007. These recommendations accumulated from the debriefing that followed the exercise in each jurisdiction, the After Action Report, and the After Action Conference that were completed in each jurisdiction.

Table A, below, documents Bent County's Improvement Plan Matrix.

Table B, below, documents Otero County's Improvement Plan Matrix.

Table C, below, documents Prowers County's Improvement Plan Matrix.

Table A. *Improvement Plan Matrix for Bent County*

Capability	Observation Title	Recommendation	Corrective Action Description	Capability Element	Primary Responsible Agency	Agency POC	Start Date	Completion Date
Mass Pro;hy	1.2 coordinate Public info	Review POD security protocols with media prior to arrival to POD	Future exercises	Planning	BCNS	K. Donkle	08/08	08/09
Mass Prophy	2.2	Formalize MOU w/S.O and fairgrounds	Complete MOU with facility, add to POD plan	Planning	BCNS BentSO	K.Donkle	01/08	08/08
Mass Prophy	5.7	Include minors in future exercises	Plan for vaccination of minors	planning	BCNS	K.Donkle	01/08	08/09
Medical Supply Mgt	1.3	Transport Team needs to follow through to get medical supplies to local jurisidction	Review medical supply management target capability at planning meetings. Repeat medical supply mgt ex next year	Training Planning	BCNS Bent S.O.	K.Donkle G.Oyen	01/08	/09

Table B. *Improvement Plan Matrix for Otero County*

Capability	Observation Title	Recommendation	Corrective Action Description	Capability Element	Primary Responsible Agency	Agency POC	Start Date	Completion Date
Medical Supply Mgt	1.1 Direct Medical Supply Mgt	Local transport teams should not self deploy	Review Regional SNS Plan with local jurisdictions	Planning Training	Otero & Prowers	Trainer & Planner	March EPR meeting	Next exercise
		Utilize Web EOC	Obtain Web EOC training for local ph	Planning Training	Otero & Prowers	Trainer & Planner	June 2008	June 2009
		Assign personnel to complete ICS organization chart when exercising	Activate personnel for AC, send home if not needed	Planning	Otero	Mr. Ritter		Next Exercise
	2.1Establish Med Supplies warehouse mgt/tracking	RTP personnel requested SNS forms review	Provide overview of SNS tracking system	Training	Otero	Meredith Bradfield and Karen Blondin	March 2008	August 1, 2008
	Activate personnel who check in others earlier	Supply Unit report to set up staff accountability systems	Vary times for staff reporting	planning	Otero	Karen Blondin, Rick Ritter	August 2008	Next exercise

Table C *Improvement Plan Matrix for Prowers County*

Capability	Observation Title	Recommendation	Corrective Action Description	Capability Element	Primary Responsible Agency	Agency POC	Start Date	Completion Date
Mass Prophy	2.1 Initiate call Down lists, use of ICS	ICS Command & General Staff need to adhere to IAP or alter IAP and brief staff	ICS Forms Class Completion for command staff	training	PCPHNS	J.Brown	April 1, 2008	August 8, 2008

	2.2 Transport of Vaccine- protocols	Follow CO Immuiz protocols for transport	Update PCPHNS IZ protocols to include transport, add just in time training for those transporting vaccine, or utilize proficient staff for transport, purchase thermometers for transport	Planning Training Equipment	PCPHNS	J.Brown	March 1, 2008	August 8, 2008
	2.5 Security	ID roaming vehicles that are not response	Provide dash signs for personnel that may be assisting with signage, etc.					
			Repeat medical supply mgt exercise					
Medical Supply Mgt	1.3 Coordinate With RTP	Complete transport back to local jurisdiction		Planning Training exercise	PCPHNS Planner trainer	J.Brown	01/08	08/09

Mass Prophylaxis

Exercise Evaluation Guide

Capability Description:

Mass Prophylaxis is the capability to protect the health of the population through administration of critical interventions (e.g., antibiotics, vaccinations, antivirals) to prevent the development of disease among those who are exposed or potentially exposed to public health threats. This capability includes the provision of appropriate follow-up and monitoring of adverse events, as well as risk communication messages to address the concerns of the public.

Capability Outcome:

Appropriate drug prophylaxis and vaccination strategies are implemented in a timely manner upon the onset of an event to prevent the development of disease in exposed individuals. Public information strategies include recommendations on specific actions individuals can take to protect their family, friends, and themselves.

Jurisdiction or Organization:	**Name of Exercise: "POD Squad" Full Scale Mass Vaccination Exercise**
Location:	**Date: Saturday November 17, 2007**
Evaluator:	**Evaluator Contact Info:**
Note to Exercise Evaluators: Only review those activities listed below to which you have been assigned	

Tasks Observed *(check those that were observed and provide the time of observation)*

Note: Asterisks (*) denote Performance Measures and Performance Indicators associated with a task. Please record the observed indicator for each measure

Tasks/*Observation Keys*	Time of Observation/ Task Completion
1.1. Coordinate distribution/administration of mass prophylaxis. – *Identify and train site leadership prior to opening the POD (i.e. just-in-time-training)* – *Ensure sufficient staff to address expected throughput*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☒
1.2. Coordinate public information regarding point of dispensing (POD) locations. – *Citizens provided necessary information (e.g., location of PODs, hours of operation, transportation, etc…)* – *Online information available* – *Plain English used in press releases and press conferences* – *Information translated into foreign languages wherever appropriate* – *Information available and accessible to individuals who are hearing impaired, visually impaired, etc…*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☒
1.3. Coordinate with the RTP to re-supply PODs as needed (*this may be simulated*). – *Communications secured with correct RTP contact (request sent to RTP, not CDPHE)* – *Maintain accurate inventory* – *Implement plan to restock PODs prior to exhaustion of supplies*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☒
1.4 Optional: LPHA may add additional tasks here	

Activity 1: Direct Mass Prophylaxis Tactical Operations

Delete Activity

Activity Description: In response to notification of an incident requiring mass prophylaxis, provide overall management and coordination of mass prophylaxis operations.

Activity 2: Activate Mass Prophylaxis

Delete Activity

Activity Description: Upon notification, activate PODs for mass prophylaxis operations.

Tasks Observed *(check those that were observed and provide the time of observation)*

Note: Asterisks (*) denote Performance Measures and Performance Indicators associated with a task. Please record the observed indicator for each measure

Tasks/*Observation Keys*	**Time of Observation/ Task Completion**	
2.1. Initiate call-down lists for mass prophylaxis site staffing. – *Identify and contact primary POD staff as per your local POD Plan.* – *Initiate call-down list (contact information accurate and up-to-date)* – *Identify anticipated and surge staff to meet anticipated need* – *Establish incident command at the POD as per POD Plan* – *Establish security and formal check-in/check-out procedure for all staff in the POD.* – *Conduct briefing and just-in-time training to all staff (e.g., orientation and site walk-through)* – *Distribute Job Action Sheets for all staffed positions within the POD.* – *Prepare to provide regularly established status reports to your assigned CDPHE Regional Liaison position using proper ICS situation report forms.*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐	
**** Percentage of identified personnel receiving notification of the operation.***	**TARGET** **100%**	**ACTUAL**
**** Percentage of site leadership that received appropriate pre-event training***	**TARGET** **100%**	**ACTUAL**
**** Percentage of other personnel that received just-in-time training.***	**TARGET** **100%**	**ACTUAL**
2.2. Ensure mass prophylaxis site operations are established in accordance with Memoranda of Agreement (MOAs)/Memoranda of Understanding (MOUs). – *POD site selected is listed in county's POD plan* – *Ensure access to building promptly provided* – *Assign personnel appropriately*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐	

Tasks Observed *(check those that were observed and provide the time of observation)*

Note: Asterisks (*) denote Performance Measures and Performance Indicators associated with a task. Please record the observed indicator for each measure

	Tasks/*Observation Keys*	**Time of Observation/ Task Completion**
	**** Was the POD set up to receive members of the general public, according to local POD plan?***	**Yes** ☐ **No** ☐
	**** Were there cars waiting for parking spaces?***	**Yes** ☐ **No** ☐
	**** Was there space to accommodate triaged patients exposed to communicable diseases?***	**Yes** ☐ **No** ☐
	**** Was the site accessible to emergency vehicles (e.g., ambulances), disabled populations, and logistical equipment (e.g., supply trucks)?***	**Yes** ☐ **No** ☐
	**** Were there any power failures during the operations?***	**Yes** ☐ **No** ☐
	**** Did any temperature sensitive products have to be disposed of due to the storage temperature?***	**Yes** ☐ **No** ☐
	**** Were other general complaints received (e.g. the number of sanitary facilities provided onsite)?***	**Yes** ☐ **No** ☐
2.3.	Assemble needed supplies and equipment for POD operations including materials to prepare oral suspension. – *Pharmaceuticals (e.g., vaccines)* – *Medical supplies* – *Administrative supplies (e.g., paper, pens, clipboards)* – *Communications devices (e.g., two-way radios, cell phones)* – *Proper signage for public to identify/understand the layout of the POD*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐
	**** Were all supplies specified in the POD plan available prior to the scheduled opening of the facility?***	**Yes** ☐ **No** ☐

Tasks Observed *(check those that were observed and provide the time of observation)*

Note: Asterisks (*) denote Performance Measures and Performance Indicators associated with a task. Please record the observed indicator for each measure

	Tasks/*Observation Keys*	**Time of Observation/ Task Completion**
2.4.	Prepare informative materials for POD staff, patients, and media – *Information regarding the dispensing site (e.g., location, hours, steps in the dispensing process)* – *Detailed information regarding the nature of the emergency* – *Signs and symptoms of the disease* – *Key phone numbers (e.g., hotlines) and websites* – *Answers to frequently asked questions*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐
2.5.	Provide internal and external security for POD sites. – *Identify and contact on-site security personnel* – *Obtain equipment to support security function* – *Perform security checks prior to the opening of the facility* – *Establish procedures to secure the facility and critical supplies during non-operational hours* – *Credential and provide access rosters for all site staff* – *Provide security escort for critical supplies (e.g., vaccine)* – *Provide continuous on-site security of critical medications* – *Provide secure space to store critical medical supplies* – *Secure private health information and personal information (e.g., social security numbers, dates of birth) in accordance with local, State or Federal regulations*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐
	**** Dispensing operations were not disrupted by the actions of others (e.g., disruption of supply chain, unrest within the facility).***	**Yes** ☐ **No** ☐
2.6.	Provide prophylaxis to POD staff, first responders, and critical infrastructure personnel and their families in accordance with local POD plan – *Pre-existing list of POD staff, first responders, and critical infrastructure personnel and family eligible for treatment exists*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐

Tasks Observed *(check those that were observed and provide the time of observation)*

Note: Asterisks (*) denote Performance Measures and Performance Indicators associated with a task. Please record the observed indicator for each measure

Tasks/*Observation Keys*	**Time of Observation/ Task Completion**	
**** Percent of POD staff, first responders, and critical infrastructure personnel and their families given prophylaxis prior to POD opening to general public***	**TARGET 100%**	**ACTUAL**
A safety officer is appointed to monitor and address POD staff safety issues	**Yes** ☐	**No** ☐
2.7. Establish plans to meet the unanticipated transportation needs for the following: – *Sick individuals who cannot get to the facility* – *Disabled individuals who cannot get to the facility* – *Healthy individuals without vehicles* – *Individuals who cannot reach the site due to inclement weather (e.g., snow)*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐	
2.8 *Optional: LPHA may add additional tasks here*		

Activity 3: Conduct Triage for Symptoms

Delete Activity

Activity Description: Conduct initial screening of individuals prior to their entering the POD in order to prevent symptomatic individuals from potentially contaminating POD.

Tasks Observed *(check those that were observed and provide the time of observation)*

Note: Asterisks (*) denote Performance Measures and Performance Indicators associated with a task. Please record the observed indicator for each measure

	Tasks/*Observation Keys*	Time of Observation/ Task Completion	
3.1.	In the event of a communicable disease, ensure initial triage is performed either at staging area or in area separate from mass prophylaxis site to prevent contamination of site. – *Clinical personnel available to staff triage station* – *Disease-specific information disseminated to the public* – *Necessary supplies obtained* – *Be ready to provide updates to local hospitals, EMS, emergency manager(s) and / or outpatient clinics regarding need to transfer sick persons from POD to appropriate medical facility for treatment.*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐	
	**** Percentage of patients triaged prior to entry into the dispensing site.***	**TARGET** **100%**	**ACTUAL**
	**** Waiting time at triage station***	Average wait time _____ minutes	
3.2.	Transport symptomatic individuals to appropriate health facility prior to their entering mass prophylaxis site. – *Symptomatic individuals transported to health facility* – *Emergency medical service (EMS) units standing by to transport symptomatic individuals*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐	
	**** Transportation assets are available to bring symptomatic individuals to appropriate treatment facility***	**TARGET** **Yes** ☐ **No** ☐	**ACTUAL**
3.3.	Optional: LPHA may add additional tasks here	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐	

Activity 4: Conduct Medical Screening

Delete Activity

Activity Description: Review patient screening documentation and available medical history to determine proper course of treatment.

Tasks Observed *(check those that were observed and provide the time of observation)*

Note: Asterisks (*) denote Performance Measures and Performance Indicators associated with a task. Please record the observed indicator for each measure

	Tasks/*Observation Keys*	**Time of Observation/ Task Completion**	
4.1.	Provide information to each individual. – *Frequently asked questions provided to individuals in a printed form that is available in multiple languages or in an audio format (in multiple languages) for the functionally illiterate, visually impaired, etc…* – *Uniform information provided regarding the current situation (e.g., recent exposure and cases)* – *Information provided on the vaccine(s) to be dispensed*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐	
	**** Percentage of individuals receiving appropriate information.***	**TARGET** **100%**	**ACTUAL**
4.2.	Identify medical history and exposure. – *Medical history discussed* – *Past allergic reactions discussed* – *Individuals with contraindications or medical conditions referred to clinicians according to site plans* – *Privacy of individual maintained* – *Personnel are available to assist with the completion of medical screening forms*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐	
	**** Percentage of patients receiving medical screening form.***	**TARGET** **100%**	**ACTUAL**
4.3.	Ensure sufficient staffing at the POD site screening station to prevent initial bottlenecks. – *Staff pulled from other stations to assist with screening, as needed/feasible* – *Information provided to those waiting to be screened* – *Monitor flow of the public through the POD*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐	
	**** Waiting time at medical screening station.***	**Average wait time _____ minutes**	

Tasks Observed *(check those that were observed and provide the time of observation)*

Note: Asterisks (*) denote Performance Measures and Performance Indicators associated with a task. Please record the observed indicator for each measure

	Tasks/*Observation Keys*	Time of Observation/ Task Completion
4.4	*Optional: LPHA may add additional tasks here*	

Activity 5: Conduct Mass Dispensing

Delete Activity

Activity Description: Provide patients with appropriate prophylaxis and maintain inventory control.

Tasks Observed *(check those that were observed and provide the time of observation)*

Note: Asterisks (*) denote Performance Measures and Performance Indicators associated with a task. Please record the observed indicator for each measure

	Tasks/*Observation Keys*	Time of Observation/ Task Completion
5.1	**** Rate at which dispensing centers or vaccination clinics process patients (persons per hour).***	Average persons per hour _____
	**** Waiting time at dispensing station.***	Average wait time _____ minutes
	**** Percentage of general population that was successfully provided vaccine***	Percent of county residents vaccinated _____
5.2.	Implement plan to treat minors. – *Parent/Guardian informed of treatment* – *Plan for treating minors without attending parent/guardian implemented*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐

Tasks Observed *(check those that were observed and provide the time of observation)*

Note: Asterisks (*) denote Performance Measures and Performance Indicators associated with a task. Please record the observed indicator for each measure

	Tasks/*Observation Keys*	**Time of Observation/ Task Completion**
5.3.	Maintain a system for inventory management to ensure availability of vaccine and medical supplies. – *Monitor vaccine supply and anticipate additional requests*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐
5.4.	Submit re-supply orders early enough to prevent running out of vaccine and supplies. – *Re-supply of assets made prior to running out* – *Throughput of PODs monitored to prevent supply depletion*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐
	**** Medical resources re-ordered prior to depletion.***	**Yes** ☐ **No** ☐
5.6.	Ensure availability and distribution of pre-printed drug information sheets. – *Information made available in all languages spoken in community, or readily translated* – *Phone number included where public could call for additional information*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐
5.7	Utilize SNS protocol to request additional vaccine allocation - *Utilize the CDPHE Regional Request for SNS Assets Form* - *The form is faxed or emailed directly to CDPHE SNS Branch* - *The local agency calls CDPHE to confirm receipt of the Request for SNS Assets Form within 30 minutes*	
5.8	Optional: LPHA may add additional tasks here	

Activity 6: Adverse Events Monitoring

Delete Activity

Activity Description: Through monitoring, identify individuals who have an adverse reaction to vaccine and initiate alternate therapies.

Tasks Observed *(check those that were observed and provide the time of observation)*

Note: Asterisks (*) denote Performance Measures and Performance Indicators associated with a task. Please record the observed indicator for each measure

Tasks/*Observation Keys*	**Time of Observation/ Task Completion**	
6.1. Track outcomes and adverse events following vaccination. – *System in place to track adverse events* – *Documentation established on each case of adverse reaction*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐	
**** Individuals provided with vaccine are monitored prior to leaving POD***	**Yes** ☐ **No** ☐	
**** Percentage of patient records collected.***	**TARGET** **100%**	**ACTUAL**
**** The percent of patients given the correct (i.e., the prescribed) countermeasure***	**TARGET** **100%**	**ACTUAL**
**** Percent of patients who receive instructions for adverse event reaction and informed about follow-up requirements.***	**TARGET** **100%**	**ACTUAL**
6.3. Adverse events documented and reported to the appropriate entity as described in the POD plan.	Time: Task Completed?	

Tasks Observed *(check those that were observed and provide the time of observation)*

Note: Asterisks (*) denote Performance Measures and Performance Indicators associated with a task. Please record the observed indicator for each measure

Tasks/*Observation Keys*	Time of Observation/ Task Completion
	Fully ☐ Partially ☐ Not ☐ N/A ☐
6.4 Optional: LPHA may add additional tasks here	

Activity 7: Demobilize

Delete Activity

Activity Description: Upon completion, stand down POD operations, return site to normal operations, and release or re-deploy staff.

Tasks Observed *(check those that were observed and provide the time of observation)*

Note: Asterisks (*) denote Performance Measures and Performance Indicators associated with a task. Please record the observed indicator for each measure

Tasks/*Observation Keys*	Time of Observation/ Task Completion	
7.1. Debrief POD personnel. – *Initial lessons learned conducted* – *Issues and accomplishments of mission documented* – *Plan described to personnel to return to prior readiness state*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐	
**** Percentage of staff debriefed after vaccine distribution.***	**TARGET** **100%**	**ACTUAL**

Tasks Observed *(check those that were observed and provide the time of observation)*

Note: Asterisks (*) denote Performance Measures and Performance Indicators associated with a task. Please record the observed indicator for each measure

	Tasks/*Observation Keys*	**Time of Observation/ Task Completion**	
7.2.	Reconstitute mass prophylaxis personnel and supplies. – *Inventories completed* – *Request replacement resources*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐	
	**** Percentage of equipment accounted for upon completion of the operation.***	**TARGET** **100%**	**ACTUAL**
7.3.	Complete administrative items following the order to demobilize – *Determination of who will take possession of all records once POD is demobilized* – *Logging of all documentation being turned over* – *Packing and transfer of records to appropriate local or State official*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐	
	**** Percentage of records returned to appropriate officials.***	**TARGET** **100%**	**ACTUAL**
7.4.	Provide a staff debriefing. – *Determine Critical Incident Stress Management (CISM) needs as applicable* – *Transition to normal operations*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐	
7.5	Optional: LPHA may add additional tasks here		

Observations Summary

Write a general chronological narrative of responder actions based on your observations during the exercise. Provide an overview of what you witnessed and, specifically, discuss how this particular Capability was carried out during the exercise, referencing specific Tasks where applicable. The narrative provided will be used in developing the exercise After-Action Report (AAR).

Evaluator Observations

Record your key observations using the structure provided below. Please try to provide a minimum of three observations for each section. There is no maximum (three templates are provided for each section; reproduce these as necessary for additional observations). Use these sections to discuss strengths and any areas requiring improvement. Please provide as much detail as possible, including references to specific Activities and/or Tasks. Document your observations with reference to plans, procedures, exercise logs, and other resources. Describe and analyze what you observed and, if applicable, make specific recommendations. Please be thorough, clear, and comprehensive, as these sections will feed directly into the drafting of the After-Action Report (AAR). Complete electronically if possible, or on separate pages if necessary.

Strengths

1. Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ☐ No ☐

a) Analysis: (Include a **discussion** of what happened. When? Where? How? Who was involved? Also describe the **root cause** of the observation, including contributing factors and what led to the strength. Finally, if applicable, describe the positive **consequences** of the actions observed.)

b) Recommendation: (Even though you have identified this issue as a strength, please identify any recommendations you may have for enhancing performance further, or for how this strength may be institutionalized or shared with others.)

2. Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ☐ No ☐

a) Analysis:

b) Recommendation:

Areas for Improvement

1. Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ☐ No ☐

a) Analysis: (Include a **discussion** of what happened. When? Where? How? Who was involved? Also describe the **root cause** of the observation, including contributing factors and human performance issues. Finally, if applicable, describe the negative **consequences** of the actions observed.)

b) Recommendation: (Write a recommendation to address the root cause. Relate your recommendations to needed changes in plans, procedures, equipment, training, mutual aid support, management and leadership support.)

3. Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ☐ No ☐

a) Analysis:

b) Recommendation:

2. Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ☐ No ☐

a) Analysis:

b) Recommendation:

3. Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ☐ No ☐

a) Analysis:

b) Recommendation:

Medical Supplies Management and Distribution

Exercise Evaluation Guide

Medical Supplies Management and Distribution

Exercise Evaluation Guide

Capability Description:

Medical Supplies Management and Distribution is the capability to obtain and maintain medical supplies and pharmaceuticals prior to an incident and to transport, distribute, and track these materials during an incident.

Capability Outcome:

Critical medical supplies and equipment are appropriately secured, managed, distributed and restocked in a timeframe appropriate to the incident.

Jurisdiction or Organization: **Colorado Department of Public Health and Environment**	**Name of Exercise:** **"POD Squad" Full Scale Mass Vaccination Exercise**
Location:	**Date:** **Friday November 16, 2007**
Evaluator:	**Evaluator Contact Info:**
Note to Exercise Evaluators: Only review those activities listed below to which you have been assigned	

Activity 1: Direct Medical Supplies Management and Distribution Tactical

Delete Activity

Activity Description: In response to a need for medical assets, provide overall management and coordination for Medical Supplies Management and Distribution.

Tasks Observed *(check those that were observed and provide the time of observation)*

Note: Asterisks (*) denote Performance Measures and Performance Indicators associated with a task. Please record the observed indicator for each measure

Tasks/*Observation Keys*	**Time of Observation/ Task Completion**
1.1. Check inventory of needed resources. - *Use the CDC RITS system to inventory CDPHE resources*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐
1.3. Maintain communications with transportation vendors during distribution of medical supplies. – *Communication maintained with drivers and security personnel via cell phone and/or radio communication*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A

Activity 2: Activate Medical Supplies Management and Distribution

Delete Activity

Activity Description: Upon identification of medical resource shortfalls and/or SNS deployment, activate warehousing operations.

Tasks Observed *(check those that were observed and provide comments)*

Note: Asterisks (*) denote Performance Measures and Performance Indicators associated with a task.

Please record the observed indicator for each measure

Tasks/*Observation Keys*	**Time of Observation/ Task Completion**
2.1. Establish medical supplies warehouse management structure.	Time:

Tasks Observed *(check those that were observed and provide comments)*

Note: Asterisks (*) denote Performance Measures and Performance Indicators associated with a task.

Please record the observed indicator for each measure

Tasks/*Observation Keys*	**Time of Observation/ Task Completion**
– *Identify Manager* – *Establish reporting requirements* – *Implement the use of ICS at the RSS/RTP site*	Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐
2.2. Activate warehousing operations for receipt of medical assets. – *Warehouse staffed and operational prior to delivery of assets* – *Staffing sufficient for expected warehouse needs* – *Material handling equipment is available*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐
2.3. Identify needed transportation assets for medical supplies. – *Drivers briefed on process* – *Drivers provided with chain-of-custody form* – *Appropriate vehicles identified* – *Refrigeration available and adequate during transport*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐

Activity 3: Establish Security

Delete Activity

Activity Description: Upon activation of warehouse, activate Medical Supplies Management and Distribution security plan.

Tasks Observed *(check those that were observed and provide comments)*

Note: Asterisks (*) denote Performance Measures and Performance Indicators associated with a task.

Please record the observed indicator for each measure

Tasks/*Observation Keys*	**Time of Observation/ Task Completion**
3.1. Execute plan for credentialing RSS/RTP personnel. – *All personnel have badges regardless of role* – *No one present without badges* – *Badges are collected prior to end of shift*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐

Activity 4: Warehouse Operations and Distribution

Delete Activity

Activity Description: After delivery of medical assets to warehouse facility, repackage pharmaceuticals and other assets and distribute to Points of Distribution (PODs) and other health facilities.

Tasks Observed *(check those that were observed and provide comments)*

Note: Asterisks (*) denote Performance Measures and Performance Indicators associated with a task.

Please record the observed indicator for each measure

Tasks/*Observation Keys*	**Time of Observation/ Task Completion**
4.1. Assemble RSS/RTP warehouse teams (receiving, order management, picking, packaging, quality control, and shipping). – *Job action sheets provided* – *Just-in-time training completed, as required*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐

Tasks Observed *(check those that were observed and provide comments)*

Note: Asterisks (*) denote Performance Measures and Performance Indicators associated with a task.

Please record the observed indicator for each measure

Tasks/*Observation Keys*	Time of Observation/ Task Completion
4.2. Inventory medical supplies warehouse resource levels. – *Document deliveries and distribution of medical resources* – *Future resource needs projected*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐
4.3. Provide quality control/quality assurance for requested medical assets prior to shipping. – *Check orders and correct errors* – *Label outbound orders clearly*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐
4.4. Track supply requests – *Documentation maintained consistent with SNS plan* – *Delivery confirmed and documented*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐
Time it takes to transport vaccine from RSS to RTP.	**RTP Location_____** **Transport Time _____**

Activity 6: Demobilize

Delete Activity

Activity Description: Inventory, reorganize, and reconstitute stockpiles to return to pre-incident levels, and release personnel from Medical Supplies Management and Distribution duties.

Tasks Observed *(check those that were observed and provide comments)*

Note: Asterisks (*) denote Performance Measures and Performance Indicators associated with a task.

Please record the observed indicator for each measure

Tasks/*Observation Keys*	**Time of Observation/ Task Completion**
6.1. Execute plan to reduce warehouse operations as distribution needs ease. – *Shorten hours of operation* – *Release non-essential staff* – *Pack up and return equipment to state of readiness* – *Re-supply RSS resources to state of readiness*	Time: Task Completed? Fully ☐ Partially ☐ Not ☐ N/A ☐

Observations Summary

Write a general chronological narrative of responder actions based on your observations during the exercise. Provide an overview of what you witnessed and, specifically, discuss how this particular Capability was carried out during the exercise, referencing specific Tasks where applicable. The narrative provided will be used in developing the exercise After-Action Report (AAR).

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Strengths

1. Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ☐ No ☐

a) Analysis: (Include a **discussion** of what happened. When? Where? How? Who was involved? Also describe the **root cause** of the observation, including contributing factors and what led to the strength. Finally, if applicable, describe the positive **consequences** of the actions observed.)

b) Recommendation: (Even though you have identified this issue as a strength, please identify any recommendations you may have for enhancing performance further, or for how this strength may be institutionalized or shared with others.)

2. Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ☐ No ☐

a) Analysis:

b) Recommendation:

3. Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ☐ No ☐

a) Analysis:

b) Recommendation:

Areas for Improvement

1. Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ☐ No ☐

a) Analysis: (Include a **discussion** of what happened. When? Where? How? Who was involved? Also describe the **root cause** of the observation, including contributing factors and what le to the problem. Finally, if applicable, describe the negative **consequences** of the actions observed.)

b) Recommendation: (Write a recommendation to address the root cause. Relate your recommendations to needed changes in plans, procedures, equipment, training, mutual aid support, management and leadership support.)

2. Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ☐ No ☐

a) Analysis:

b) Recommendation:

3. Title:

Related Activity:

Record for Lesson Learned? (Check the box that applies) Yes ☐ No ☐

a) Analysis:

b) Recommendation: