

**St. Louis Regional Healthcare Coalition
Healthcare Subcommittee
Regular Meeting**

Meeting Details

DATE: Wednesday, November 10, 2021 CONVENED: 0930 HRS ADJOURNED: 1039 HRS
CHAIRS: J. Campbell C. Minks

Attendance 63%

MEMBERS: S. Austermann N. Blaes E. Brandmeyer R. Charney B. Chotrow L. French
T. Horton B. Liedtke D. McDonald D. Mullen V. Poston S. Pratt
R. Roth H. Sandkuhl M. Tanton E. Timmer

PARTNERS: C. Blank B. Chambers D. Chambers K. Foerst S. Icenhower R. Nicholls
J. O'Brien S. Peterson A. Taylor B. Zoref

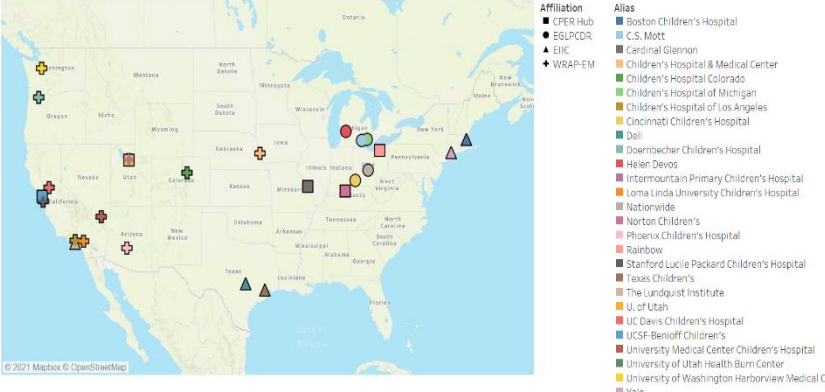
GUESTS: P. West

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop
Call to Order	Meeting called to order at 0930 hours by J. Campbell via Teams.	No further action required.
Meeting Objectives	J. Campbell shared September meeting objectives: <ol style="list-style-type: none"> 1. Update Healthcare Subcommittee Goal Development Plan via leader progress reports; identify any barriers to success 2. Review HRSA Pediatric Pandemic Grant purpose, players, and opportunities 3. Determine CY 2022 subcommittee goals/initiatives and leadership 4. Examine ASPR MRSE requirements, performance metrics, and planning team needs 5. Update subcommittee members on coalition/regional activities, initiatives, and opportunities 	<p>Objective Complete</p> <p>Objective Complete</p> <p>Objective Complete</p> <p>Objective Complete</p> <p>Objective Complete</p>
Meeting Minutes	<p>Refer to Attachments A, A1, A2 of meeting materials packet.</p> <p>C. Minks submitted draft meeting minutes from Wednesday, September 8, 2021 for review and approval.</p> <p>Discussion No discussion.</p> <p>Recommendation Approve as submitted.</p> <p>Decision M. Tanton motioned to approve; L. French seconded. Membership approved meeting minutes as submitted.</p>	No further action required.
Announcements		
Introductions	<p>J. Campbell invited new members and partners to provide brief introduction.</p> <p>New participants during November include:</p> <p>Phoebe West Regional Pediatric Pandemic Network Program Manager SSM Cardinal Glennon Children's Hospital</p>	

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop
Introductions cont.	Robbyn Roth Emergency Management Coordinator Kindred Hospital	Subcommittee welcomed new members. No further action required.
Old Business	Deliberately left blank.	
Goal Development Plan Reports		
Goal 1: Membership & Recruitment	<p>Refer to Attachment B of meeting materials packet.</p> <p>J. Campbell provided the following updates:</p> <p><u>Workgroup Highlights</u></p> <p>Developed outline for Healthcare Subcommittee participation flier, with participation responsibilities, benefits, expectations, and instructions.</p> <p><u>Upcoming Activities</u></p> <ul style="list-style-type: none"> - Finalize and distribute participation flier - Identify representation “soft spots” for future focused action(s) <p>No challenges or barriers identified.</p> <p>Next workgroup meeting December 1.</p>	<p>J. Campbell to coordinate next workgroup meeting and provide update during next meeting.</p>
Goal 2: Support Technology	<p>J. O’Brien provided the following updates:</p> <p><u>Workgroup Highlights</u></p> <p>Received vendor demonstration of pilot St. Louis Healthcare Subcommittee website and verified platform included all “preferred features” and functionality identified by membership.</p> <p>Approved contract agreement for services and associated costs.</p> <p><u>Upcoming Activities</u></p> <ul style="list-style-type: none"> - Finalize website agreement - Establish routine content management process(es) with vendor - Commence final design/development prior to “Go-Live” - Anticipated December 31, 2021 <p>Next workgroup meeting pending; workgroup members coordinating via email to finalize goal activity.</p>	<p>J. O’Brien to coordinate next workgroup meeting and provide update during next meeting.</p>
Goal 3: Subcommittee Report	<p>J. Campbell provided the following updates:</p> <p><u>Workgroup Highlights</u></p> <p>Collecting feedback, suggestions, and new content for St. Louis Healthcare Subcommittee 2021 Report, such as</p> <ul style="list-style-type: none"> - Organizational drill/exercise highlights - Member celebrations/shoutouts - Budget profile and expenses tracking 	

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop
Goal 3: Subcommittee Report cont.	<p><u>Upcoming Activities</u></p> <ul style="list-style-type: none"> - Collecting feedback, suggestions, and new content ideas for CY2021 Final Report. - Submit DRAFT St. Louis Healthcare Subcommittee 2021 Report for review/approval during January 2022 <p>No challenges or barriers identified.</p>	<p>Participants provide content to J. Campbell by 11/30/21.</p> <p>J. Campbell to coordinate next workgroup meeting and provide update during next meeting.</p>
Goal 4: Subcommittee Administration	<p>C. Minks provided the following updates:</p> <p><u>Workgroup Highlights</u></p> <p>Approved new subcommittee charter during last meeting, and offered technical support and template governance materials to Healthcare Coalition Charter Workgroup to strengthen regional linkages.</p> <p><u>Upcoming Activities</u></p> <ul style="list-style-type: none"> - Coordinate with Healthcare Coalition Charter Workgroup to harmonize respective documents to maximize effectiveness 	<p>C. Minks to coordinate next workgroup meeting and provide update during next meeting.</p>
Goal Plan Summary	<p>J. Campbell opened meeting for subcommittee goal plan development discussion. No additional discussion occurred.</p> <p><u>Next Steps</u></p> <ul style="list-style-type: none"> - Goal workgroup leaders schedule November and December meetings - Goal workgroup leaders submit electronic progress report form for CY2021 Annual Report 	<p>All goal leaders to complete actions as approved.</p>
Workgroup Reports		
Pediatric Surge Planning	<p>M. Tanton provided the following updates:</p> <p><u>Workgroup Highlights</u></p> <p>No meeting during this reporting period; Missouri Pediatric Surge Planning Workgroup to be incorporated in ASPR Region VII Regional Disaster Health Response Ecosystem (RDHRE) for continued capability development.</p> <p>ASPR Region IVV RDHRE conducting survey of healthcare providers and organizations to assess readiness for non-pediatric facilities to provide pediatric disaster services, if required.</p> <p>Participants requested to submit organizational feedback via this link: RDHRE Pediatric Disaster Readiness Assessment</p> <p><u>Upcoming Activities</u></p> <p>No challenges or barriers identified.</p> <p>Next workgroup meeting November 11.</p>	<p>Participants to submit feedback as requested.</p> <p>M. Tanton to coordinate next workgroup meeting and provide update during next meeting.</p>

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop
Coalition Partner Updates		
Public Health	No updates.	T. Shaw/J. Hauser provide update during next meeting.
Emergency Medical Services (EMS)	<p>H. Sandkuhl provided the following updates:</p> <p><u>Sector Highlights</u></p> <p>Approximately 25% of regional EMS staff remain unvaccinated for COVID-19. EMS Subcommittee coordinating education/awareness outreach and delivering booster vaccines to interested staff.</p> <p>Many EMS professionals request vaccine reactively, once a crew member is infected and they directly observe the related challenges and hardship.</p> <p><u>Upcoming Activities</u></p> <p>No upcoming activities</p> <p>Next meeting TBD.</p>	J. Nowak/H. Sandkuhl to provide update during next meeting.
Emergency Management	No update.	B. Chambers to provide update during next meeting.
EMResource	B. Zoref reported EMResource advisory committee meeting scheduled next week.	B. Zoref to provide update during next meeting.
Mass Fatality	No update.	K. Hargrave to provide update during next meeting.
Interoperable Communication	S. Icenhower reported ongoing discussions related to supporting healthcare partners with monthly 700 and 800 MHz radio testing.	T. Horton provide update during next meeting
New Business		
HRSA Pediatric Pandemic Grant Overview	<p>R. Charney provided updates on recently awarded grants to develop an interstate pediatric disaster collaborative.</p> <p><u>Background</u></p> <p>EMS for Children Innovation & Improvement Center is supported via Health Resources & Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS).</p> <p>Award totals \$3M with 0% financed with nongovernmental sources. Regional Pediatric Pandemic Network (RPPN) is supported via HRSA.</p> <p>Congressional drivers for RPPN include the following:</p> <ul style="list-style-type: none"> - Behavioral health - Gaps in community engagement - eHealth & a workforce gapped in optimization - Disparate access and resources - Magnification of disparities <p>Network includes five (5) children’s hospitals interconnected via a “hub and spoke” model. Participating organizations and program leaders are:</p>	

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop												
<p>HRSA Pediatric Pandemic Grant Overview cont.</p>	<table border="1" data-bbox="394 163 1206 338"> <thead> <tr> <th>Hospital Name</th> <th>Site PI Name</th> </tr> </thead> <tbody> <tr> <td>University Hospitals-Rainbow Babies and Children's Hospital</td> <td>Deanna Dahl Grove</td> </tr> <tr> <td>University of California San Francisco-Benioff Children's Hospital</td> <td>Nicolaus Glomb</td> </tr> <tr> <td>University of Louisville School of Medicine-Norton Children's Hospital</td> <td>Mary Fallat</td> </tr> <tr> <td>University of Utah, Primary Children's</td> <td>Hilary Hewes</td> </tr> <tr> <td>Saint Louis University-Cardinal Glennon Children's Hospital</td> <td>Rachel Charney</td> </tr> </tbody> </table> <p data-bbox="394 373 1166 464">Program supported by ASPR Pediatric Disaster Centers of Excellence to disseminate best practices in regional pediatric disaster preparedness, response and recovery. Network includes:</p> <p data-bbox="394 495 837 514">Center for Pediatric Everyday Readiness-Regional Pediatric Pandemic Network</p>  <p data-bbox="394 919 553 947"><u>RPPN Mission</u></p> <p data-bbox="394 978 1198 1098">CPER RPPN provides a foundation for the nation's children's hospitals and related pediatric SMEs to strengthen collaboration and coordination with existing local, state, regional, and national emergency preparedness systems.</p> <p data-bbox="394 1129 1174 1220">Ensures the needs of all children are addressed within both every day and global health threats, through enhanced pediatric readiness, including preparedness, response, recovery, and pandemic activities.</p> <p data-bbox="394 1251 529 1278"><u>RPPN Goals</u></p> <ol data-bbox="440 1310 1182 1703" style="list-style-type: none"> 1. Expand the scope and number of collaborations and partnerships of children's hospitals with systems of preparedness 2. Improve pediatric readiness across health systems influenced by children's hospitals 3. Increase the capacity and capability of telehealth/telehealth to address children's unique needs during a disaster or global health threat. 4. Accelerate the real-time dissemination & uptake of research informed pediatric care to address the needs of children and their families. <p data-bbox="394 1734 513 1761"><u>Next Steps</u></p> <ul data-bbox="440 1793 1203 1948" style="list-style-type: none"> - Continuing coordinating within network core group - Announce opportunities for cross-functional regional collaboration - Provide routine updates on progress and accomplishments 	Hospital Name	Site PI Name	University Hospitals-Rainbow Babies and Children's Hospital	Deanna Dahl Grove	University of California San Francisco-Benioff Children's Hospital	Nicolaus Glomb	University of Louisville School of Medicine-Norton Children's Hospital	Mary Fallat	University of Utah, Primary Children's	Hilary Hewes	Saint Louis University-Cardinal Glennon Children's Hospital	Rachel Charney	
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TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop
HRSA Pediatric Pandemic Grant Overview cont.	Membership thanks Dr. R. Charney and P. West for their regional contributions and committed to support RPPN via regional collaborative planning efforts.	No further action required.
2022 Goal Development	<p>J. Campbell facilitated discussion on short- and long-term deliverables to improve St. Louis Healthcare Subcommittee and sector performance, with intent to develop preliminary CY 2022 goals.</p> <p><u>Discussion</u> Membership suggested the following focus areas for next year:</p> <ul style="list-style-type: none"> - Website development, management, and visibility - Healthcare EM Academy design - Operating budget, awards, and expense tracking - Integrated healthcare system and bistate coalition exercises <p><u>Recommendation</u> Leadership incorporates proposed focus areas into goal development work and introduce metrics/objectives to measure success, as appropriate.</p> <p><u>Decision</u> J. Campbell and C. Minks to develop goals from discussion outcomes and share as DRAFT goal workplan during next meeting.</p>	J. Campbell and C. Minks to provide update during next meeting.
2022 Subcommittee Chair Elections	<p>J. Campbell reported current leadership term concludes December 31, 2021 and opened the floor for new Chair and Vice Chair nominations.</p> <p><u>Discussion</u> J. Campbell and C. Minks volunteered to serve as Chair and Vice Chair for CY 2022 term.</p> <p>Members offered support and encouragement to the Chairs for their contributions in 2021, and excitement continued actions during 2022.</p> <p><u>Recommendation</u> St. Louis Healthcare Subcommittee 2022 leadership is Jason Campbell as Chair and Cody Minks as Vice-Chair.</p> <p><u>Decision</u> S. Icenhower motioned to approve; H. Sandkuhl seconded. Membership approved 2022 leadership recommendation as submitted.</p>	No further action required.
Regional Initiatives		
Healthcare Coalition & SMOC	<p>S. Icenhower provided the following updates:</p> <p>Last meeting July 16, 2021</p> <ul style="list-style-type: none"> - August meeting replaced with Charter workgroup meeting - Sept and Oct cancelled due to quorum <p>Performed final review of revised St. Louis Region C Chempack Site Manual</p> <ul style="list-style-type: none"> - Preparing submission to MO SEMA and development of education content <p>SMOC duty officer rotation schedule in development.</p> <p>Next meeting scheduled Friday, November 19 at 0900 hours.</p>	S. Icenhower/B. Zoref to provide coalition update during next meeting.

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop																										
Training and Exercise T&E Subcommittee Report	Refer to Attachment C of meeting materials packet. S. Peterson provided the following updates: St. Louis Healthcare Training Newsletter – November released. This issue includes Center for Domestic Preparedness (CDP) resident courses. STL Integrated Preparedness Planning Workshop (IPPW) conducted Nov 9 to identify planning, training, drill/exercise target opportunities for regional development. Healthcare-related outcomes include: <table border="1" data-bbox="393 529 1205 625"> <thead> <tr> <th></th> <th colspan="3">Q1 2022</th> <th colspan="3">Q2 2022</th> <th colspan="3">Q3 2022</th> <th colspan="3">Q4 2022</th> </tr> </thead> <tbody> <tr> <td>Health Care</td> <td></td> <td></td> <td>Plan: Burn Annex</td> <td>MTTX Burn MCI</td> <td>MRSE</td> <td>TTX Burn Annex</td> <td>CBRN E Decon. Wksp</td> <td>Radiation Surge Annex Wksp</td> <td>Radiation Training TBD</td> <td></td> <td>Radiation Training TBD</td> <td>*Hazm Operations for EMTs</td> </tr> </tbody> </table>		Q1 2022			Q2 2022			Q3 2022			Q4 2022			Health Care			Plan: Burn Annex	MTTX Burn MCI	MRSE	TTX Burn Annex	CBRN E Decon. Wksp	Radiation Surge Annex Wksp	Radiation Training TBD		Radiation Training TBD	*Hazm Operations for EMTs	<div style="background-color: #00FF00; padding: 5px;">S. Peterson to provide coalition update during next meeting.</div>
	Q1 2022			Q2 2022			Q3 2022			Q4 2022																		
Health Care			Plan: Burn Annex	MTTX Burn MCI	MRSE	TTX Burn Annex	CBRN E Decon. Wksp	Radiation Surge Annex Wksp	Radiation Training TBD		Radiation Training TBD	*Hazm Operations for EMTs																
Organizational T&E Opportunities	No organizational T&E opportunities shared.	No further action required.																										
Grant Funding Programs ASPR Medical Response & Surge Exercise (MRSE)	Refer to Attachment D, D1 of meeting materials packet. D. Chambers provided the following updates: <u>Overview</u> Exercise “formally known as” Coalition Surge Test (CST) still required to be conducted annually by June 30. Coalition participation is required for ASPR grant eligibility and must include <ul style="list-style-type: none"> - Leader representatives from each core healthcare coalition sector - 20% surge of regional inpatient staffed beds <ul style="list-style-type: none"> o ED, Medicine, ICU, PACU, Post-Critical o Other bed types may be included at HCC discretion - Bed confirmation and patient transfer tracking - Evaluation based upon HPP Performance Measures <u>Next Steps</u> Identify healthcare subcommittee representative(s) to support Coalition-based Exercise Planning Team (EPT).	Interested participants to notify S. Peterson by December 31, 2021. <div style="background-color: #00FF00; padding: 5px;">B. Zoref to provide update during next meeting.</div>																										
Regulatory/Accreditation																												
Survey Activity	No update	No further action required.																										
Open Discussion	No update.	No further action required.																										
Resources and Literature																												
ASPR TRACIE – The Express	Refer to Attachments E, E1 of meeting materials packet. J. Campbell shared two (2) issues of ASPR TRACIE – The Express. October featured topics include: <ul style="list-style-type: none"> - COVID-19 lessons learned for HCC implementation - Blood supply management 																											

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop
ASPR TRACIE – The Express cont.	<ul style="list-style-type: none"> - Hospital and Fire Department roles during decontamination response - Excess mortality challenges and solutions - Hospital behavioral health surge challenges 	No further action required.
Meeting Conclusion		
Action Item Review	<p>J. Campbell reviewed action items from November meeting:</p> <p><u>Finalize CY 2021 goals</u></p> <ul style="list-style-type: none"> - Participation brochure - Website design and launch - Annual report - Goal workgroup leaders facilitate July and August meetings, then share progress/outcomes via electronic Healthcare Subcommittee Report Submission Form <p><u>St. Louis MRSE</u></p> <ul style="list-style-type: none"> - Participate on Exercise Planning Team - Contribute to development and quality of exercise materials <p><u>Prepare for CY 2022 success</u></p> <ul style="list-style-type: none"> - Incorporate goals & objectives into workplan 	
Next Meeting	<p>Wednesday, January 12, 2022 0930 – 1100 hours Microsoft Teams</p>	No further action required.
Adjournment	J. Campbell adjourned the meeting at 1039 hours	No further action required

Respectfully submitted,

Jason Campbell
Chair
St. Louis Healthcare Subcommittee

St. Louis Regional Healthcare Subcommittee

Regular Meeting
Wednesday, November 10, 2021



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Agenda & Meeting Objectives

- I. Update Healthcare Subcommittee Goal Development Plan via leader progress reports; identify any barriers to success
- II. Review HRSA Pediatric Pandemic Grant purpose, players, & opportunities
- III. Determine CY 2022 subcommittee goals/initiatives & leadership
- IV. Examine ASPR MRSE requirements, performance metrics, & planning team needs
- V. Update subcommittee members on coalition/regional activities, initiatives, & opportunities

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Review Meeting Minutes

- Last Meeting - Wednesday, September 08, 2021
 - Refer to [Attachments A, A1, & A2](#) for details
 - Updated Membership Expansion progress
 - 26% increase in new subcommittee members
 - Approved new Healthcare Subcommittee Charter
 - Reviewed Goal progress & action items; all goals trending positively with no barriers/obstacles reported
- Next Steps
 - Review & approve

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Announcements Introductions

- New Participants Welcome!
- Introduction
 - Name
 - Organization/Agency
 - Emergency Management Role



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Goal Development Plan Reports I – Membership & Recruitment

- Workgroup Highlights
 - Developed outline for Healthcare Subcommittee participation flier
 - Includes participation responsibilities, benefits, expectations, & enrollment instructions
- Upcoming Activities
 - Finalize & distribute participation flier
 - Identify representation “soft spots” for future focused action(s)

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Goal Development Plan Reports I – Membership & Recruitment

- Challenges or Barriers
 - None to report
- Next Meeting
 - Dec 1

Goal 1	Cultivate an inclusive healthcare subcommittee that is reflective of the St. Louis community and includes representation from all provider/facility types.		
	Description	Deadline	Completion
Objective 1A	Coordinate with local/state partners to identify applicable healthcare organizations and facilities within subcommittee geographic scope.	31-May	100%
Objective 1B	Review, verify, and update current subcommittee membership roster.	31-May	100%
Objective 1C	Develop healthcare subcommittee one-page summary sheet with membership responsibilities, benefits, enrollment details, and FAQs.	31-May	26 - 50%
Objective 1D	Distribute subcommittee summary sheet to all eligible healthcare organizations.	30-Jun	26 - 50%
Objective 1E	Monitor membership expansion and healthcare facility representation; revise strategy for Goal 1 achievement if/as required.	31-Dec	26 - 50%
Objective 1F	Update contact information for all current and new subcommittee members.	30-Jun	100%

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Goal Development Plan Reports

2 – Support Technology

- Workgroup Highlights

- Received vendor demonstration of pilot St. Louis Healthcare Subcommittee website
 - Verified platform included all “preferred features” & functionality identified by membership
- Approved contract agreement for services & associated costs

- Upcoming Activities

- Finalize website agreement
- Establish routine content management process(es) with vendor
- Commence final design/development prior to “Go-Live”
 - Anticipated December 31, 2021

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Goal Development Plan Reports

2 – Support Technology

- Challenges or Barriers

- None reported

- Next Meeting

- Dec 1

Goal 2	Implement healthcare subcommittee membership support technology to resolve identified interface gaps.		
	Description	Deadline	Completion
Objective 2A	Develop and distribute electronic survey to determine and rank specific membership portal needs/features.	31-May	100%
Objective 2B	Analyze and report membership portal survey results during Regular Meeting.	30-Jun	100%
Objective 2C	Identify potential portal solutions that support/resolve critical needs, as defined by survey results.	30-Jun	100%
Objective 2D	Establish portal solution for subcommittee membership and verify resolution of critical gaps.	30-Sep	76 - 99%

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Goal Development Plan Reports

3 – Subcommittee Report

- Workgroup Highlights
 - Collecting feedback, suggestions, & new content for St. Louis Healthcare Subcommittee 2021 Report
 - Drill/exercise highlights
 - Member celebrations/shoutouts
 - Budget profile & expenses tracking

- Next Steps
 - Submit DRAFT St. Louis Healthcare Subcommittee 2021 Report for review/approval
 - January 2022

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Goal Development Plan Reports

3 – Subcommittee Report

- Challenges or Barriers
 - None to report

- Next Meeting
 - Dec 1

Goal 3	Elevate healthcare subcommittee visibility and accountability via production of semiannual reports.		
	Description	Deadline	Completion
Objective 3A	Coordinate with HCC Coordinator and partner subcommittee chairs to identify content/data to maximize report utility and relevance.	31-May	100%
Objective 3B	Develop DRAFT report outline and dashboard for review/approval by appropriate regional partners/leaders.	31-May	100%
Objective 3C	Distribute initial subcommittee report to full membership and designated partner recipients.	30-Jun	100%
Objective 3D	Incorporate applicable report revisions/improvements and distribute annual report to all recipients.	31-Dec	76 - 99%

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Goal Development Plan Reports

4 – Subcommittee Administration

- Workgroup Highlights
 - Approved new subcommittee charter
 - Shared new governance materials with & offered technical support to Healthcare Coalition Charter Workgroup to strengthen linkages
- Upcoming Activities
 - Continue monitoring for effectiveness via prescribed review & feedback cycles

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Goal Development Plan Reports

4 – Subcommittee Administration

- Challenges or Barriers
 - None to report
- Next Meeting

Goal 4	Optimize healthcare subcommittee management via revision/alignment of applicable Charters, Bylaws, and other administrative materials.		
	Description	Deadline	Completion
Objective 4A	Verify all applicable documents are included in subcommittee review/revision scope.	30-Jun	100%
Objective 4B	Review current subcommittee Charter; document recommended edits and submit revised version to subcommittee for review/approval.	30-Jun	100%
Objective 4C	Coordinate with HCC Coordinator and Coalition Committee Chairs to strengthen alignment of approved Healthcare Subcommittee Charter with applicable coalition/STARRS administrative documents; support revision as appropriate.	30-Sep	100%
Objective 4D	Verify all applicable coalition and healthcare subcommittee management materials are aligned for optimal administrative coordination for upcoming year.	31-Dec	76 - 99%

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Goal Development Plan Reports Conclusion

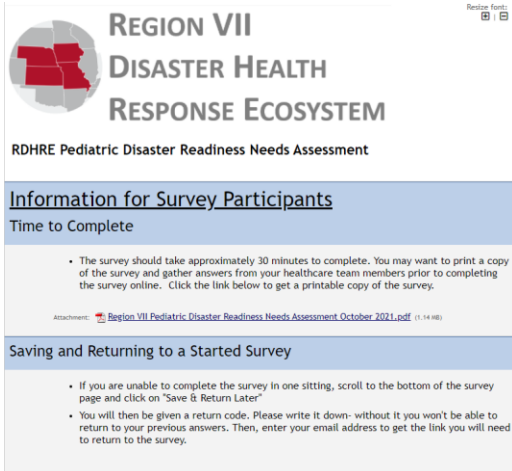
- Next Steps – Subcommittee
 - Discussion, questions, clarification
 - Update Plan with objective progress reports
- Next Steps – Goal Leaders
 - Schedule workgroup meetings to advance tasks & projects
 - November & December
 - Submit monthly progress reports via electronic *Report Form*

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Workgroup Reports Pediatric Surge Planning

- Workgroup Highlights
 - No meeting during this reporting period
 - Incorporating MO group into Region VII RDHRE
- Upcoming Activities
 - RDHRE Pediatric Disaster Readiness Survey
 - Deadline November 30
- Next Meeting
 - Nov 11, 2021



**REGION VII
DISASTER HEALTH
RESPONSE ECOSYSTEM**

RDHRE Pediatric Disaster Readiness Needs Assessment

Information for Survey Participants

Time to Complete

- The survey should take approximately 30 minutes to complete. You may want to print a copy of the survey and gather answers from your healthcare team members prior to completing the survey online. Click the link below to get a printable copy of the survey.

Attachment: [Region VII Pediatric Disaster Readiness Needs Assessment October 2021.pdf](#) (11/14 KB)

Saving and Returning to a Started Survey

- If you are unable to complete the survey in one sitting, scroll to the bottom of the survey page and click on "Save & Return Later"
- You will then be given a return code. Please write it down- without it you won't be able to return to your previous answers. Then, enter your email address to get the link you will need to return to the survey.

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Coalition Partner Updates Public Health

- [Sector Highlights](#)
- [Upcoming Activities](#)
- [Challenges](#)
- [Next Meeting](#)

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Coalition Partner Updates EMS

- [Sector Highlights](#)
- [Upcoming Activities](#)
- [Challenges](#)
- [Next Meeting](#)

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Coalition Partner Updates Emergency Management

- [Sector Highlights](#)
- [Upcoming Activities](#)
- [Challenges](#)
- [Next Meeting](#)

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Coalition Partner Updates EMResource

- [Sector Highlights](#)
- [Upcoming Activities](#)
- [Challenges](#)
- [Next Meeting](#)

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Coalition Partner Updates Mass Fatality

- [Sector Highlights](#)
- [Upcoming Activities](#)
- [Challenges](#)
- [Next Meeting](#)

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Coalition Partner Updates Interoperable Communication

- [Sector Highlights](#)
- [Upcoming Activities](#)
- [Challenges](#)
- [Next Meeting](#)

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New Business

HRSA Regional Pediatric Pandemic Network Overview

Funding

- EMS for Children Innovation & Improvement Center is supported via Health Resources & Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS)
 - Award U07MC37471 totals \$3M with 0% financed with nongovernmental sources
- Regional Pediatric Pandemic Network (RPPN) is supported via HRSA
 - Award U1143532 totals \$9.7M with 0% financed with nongovernmental sources
- Pediatric Center for Disaster Excellence, Eastern Great Lakes Pediatric Consortium for Disaster Response is supported via Assistant Secretary Preparedness & Response (ASPR)
 - Award U3REPI90615-01-01 totals \$2.85M with 0% financed with nongovernmental sources



Disclaimer

- Content is that of the authors & does not necessarily represent the official views of, nor an endorsement by ASPR, HRSA, HHS, or the U.S. Government.

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New Business

Congressional drivers for RPPN

- At the time of a pandemic
 - Behavioral health
 - Gaps in community engagement
 - eHealth & a workforce gapped in optimization
 - Disparate access & resources
 - Magnification of disparities



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New Business RPPN Composition

- Network of five (5) children’s hospitals using the “hub & spoke” model:

Hospital Name	Site PI Name
University Hospitals-Rainbow Babies and Children’s Hospital	Deanna Dahl Grove
University of California San Francisco-Benioff Children’s Hospital	Nicolaus Glomb
University of Louisville School of Medicine-Norton Children’s Hospital	Mary Fallat
University of Utah, Primary Children’s	Hilary Hewes
Saint Louis University-Cardinal Glennon Children’s Hospital	Rachel Charney

- Centralized support
 - ASPR WRAP-EM, EGL & EMSC Innovation and Improvement Center
- Clinical & implementation arm activities in all hospital sites
- PI roles for managing tension between prescriptive work & hub site growth
- Network of networks supporting the children’s hospital hubs

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ASPR Pediatric Disaster Centers of Excellence support the Network



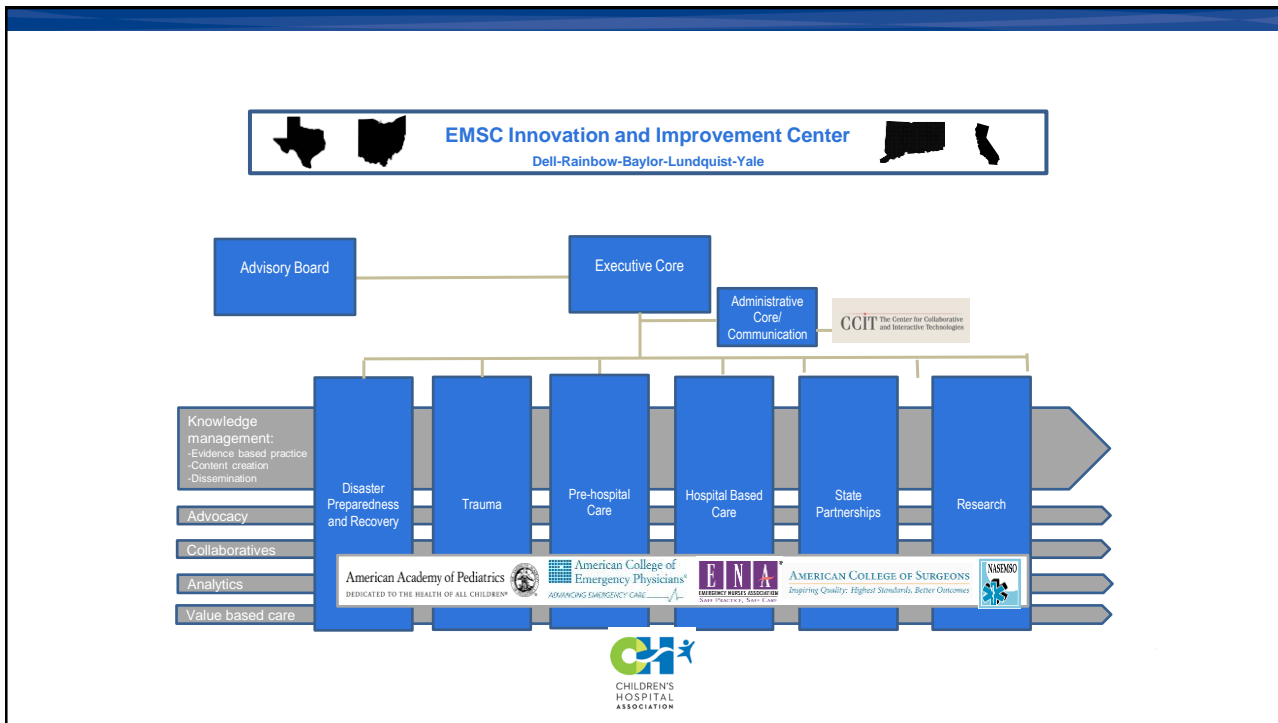
- Designated in 2019 through a competitive grant process
- Designed to disseminate best practices in regional pediatric disaster preparedness, response & recovery
- ASPR Eastern Great Lakes (ASPR EGL) COE
 - Anchored at UH Rainbow Babies and Children’s Cleveland Ohio
 - Michigan/Ohio
 - Hubs in 6 children’s hospitals
- ASPR Western Regional Alliance for Pediatric Emergency Management (WRAP-EM) COE
 - Anchored at UCSF Benioff Children’s Hospital
 - California, Arizona, Oregon, Washington, Nevada, Utah
 - 14 healthcare centers



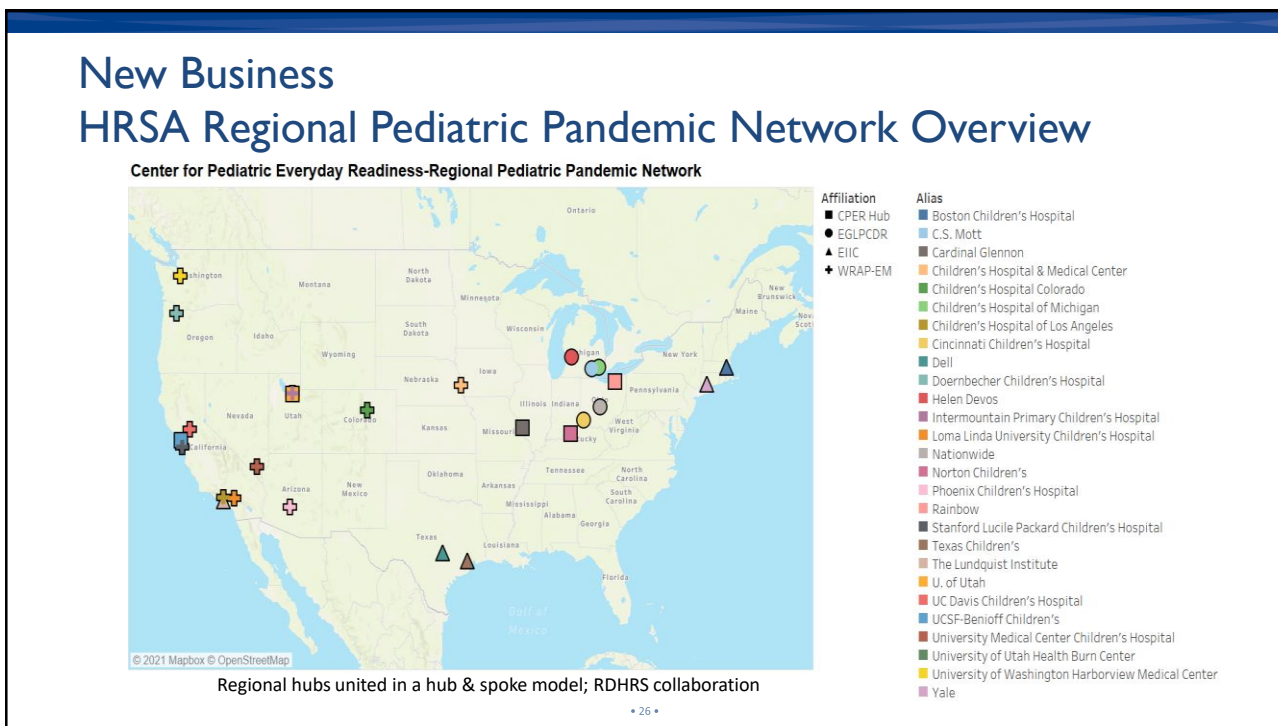
“Contributing to a national model for pediatric disaster preparedness, response and recovery”

+ 24 +

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New Business

RPPN Mission Statement

- CPER RPPN provides a foundation for the nation's children's hospitals & related pediatric SMEs to strengthen collaboration & coordination with existing local, state, regional, & national emergency preparedness systems
- Ensures the needs of all children are addressed within both every day and global health threats, through enhanced pediatric readiness, including preparedness, response, recovery & pandemic activities.



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New Business

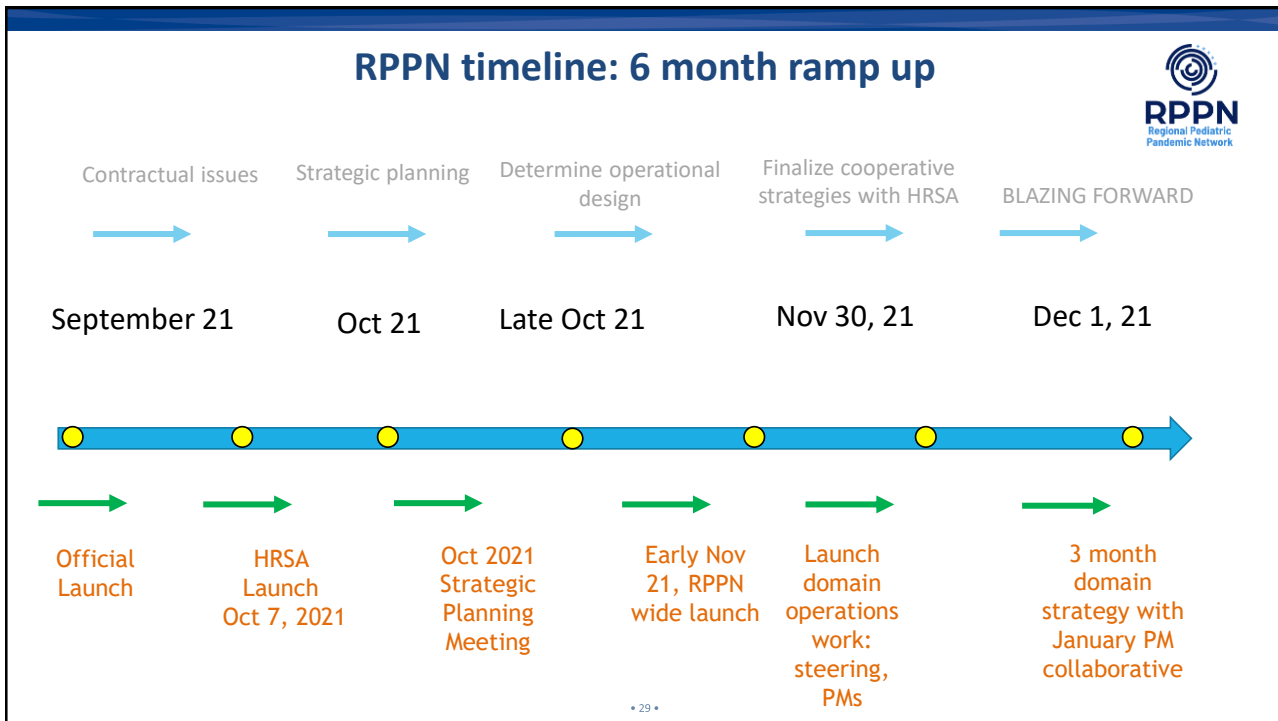
RPPN Primary Goals Discussion

- 1) Expand the scope & number of collaborations and partnerships of children's hospitals with systems of preparedness
- 2) Improve pediatric readiness across health systems influenced by children's hospitals
- 3) Increase the capacity & capability of telehealth/telehealth to address children's unique needs during a disaster or global health threat.
- 4) Accelerate the real-time dissemination & uptake of research informed pediatric care to address the needs of children and their families.



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New Business RPPN Domains

- Analytics
- Equity and Care Regionalization
- Health Information Portability
- Mental Health
- Research
- Collaboratives
- Pediatric Readiness
- Telehealth
- Surge and Surveillance
- Trauma
- Drills
- Deployable Assets
- Infectious Disease
- CBRN
- Medical Home
- Reunification
- Prehospital
- Knowledge and Education
- Legal and Ethical

BARNES JEWISH
Hospital
HealthCare

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New Business

HRSA Pediatric Pandemic Grant Overview

- Next Steps
 - Continuing coordinating within network core group
 - Announce opportunities for cross-functional regional collaboration
 - Provide routine updates on progress & accomplishments
- Questions?
 - Rachel Charney, M.D.
rachel.charney@health.slu.edu
 - Phoebe West
Phoebe.west@health.slu.edu

Saint Louis University, SSM Health Cardinal Glennon Children's Hospital Receive \$2 Million as Part of New Regional Pediatric Pandemic Network

by Maggie Rotermond

Media Inquiries ▾

The sub-grant is part of more than \$48 million awarded to UH Rainbow Babies & Children's Hospital to establish the Regional Pediatric Pandemic Network



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New Business

2022 Goal Development

- Current Status
 - Anticipate 100% completion for CY 2021 goals
 - Membership Expansion
 - Website Technology
 - Outcomes Reporting
 - Governance Improvement
 - Need to discuss short- & long-term deliverables to develop CY 2022 goals
 - Goals to support of STL Healthcare Subcommittee mission:

Cultivate a network of St. Louis healthcare sector partners to:

- Strengthen organizational, industry, & community healthcare preparedness
- Advance healthcare emergency management concepts & capabilities
- Support cross-functional healthcare communication & collaboration
- Provide regulatory/accreditation compliance solutions

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New Business

2022 Goal Development

- Discussion
 - Are there capability or performance “soft spots”?
 - Determine CY 2022 target outcomes & deliverables
 - Website development, management, & visibility
 - Drill & exercise library
 - Membership resource page
 - Healthcare EM Academy design
 - Operating budget, awards, & expense tracking
 - Current funds & allocations
- Next Steps
 - Record CY 2022 goal recommendations
 - Develop DRAFT Cy 2022 workplan with specific objectives, metrics, & milestones



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New Business

2022 Chair Elections

- Current Status
 - Chair: Jason Campbell
 - Vice-Chair: Cody Minks
 - Current term concludes December 31, 2021
- Next Steps
 - Identify 2022 Chair & Vice-Chair nominations/volunteers
 - Discuss Chair & Vice-Chair candidates
 - Strengths, gaps, & qualifications
 - Vote to elect 2022 leaders
 - Facilitate leadership transition

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Regional Initiatives Healthcare Coalition & SMOC

- Coalition Committee Highlights
 - Last meeting July 16, 2021
 - August meeting replaced with Charter workgroup meeting
 - Sept & Oct cancelled due to quorum
 - Approved revised *St. Louis Region C Chempack Site Manual*
 - Reviewed CY2020 & CY2021 grant deliverables
 - Received community COVID-19 vaccine progress report
- Next Meeting
 - November 19, 2021

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Training & Exercise Subcommittee Report

- Subcommittee Highlights
- Current Status
 - *St. Louis Healthcare Training Newsletter – November*
 - Refer to [Attachment C](#) for details
 - Highlights education/training opportunities related to Healthcare EM & industry hazards
 - STL Integrated Preparedness Planning Workshop conducted Nov 9
 - Identified planning, training, drill/exercise target opportunities for regional development

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Training Newsletter
Healthcare: November 2021


St. Louis Area Regional Response System

Below are current and former training opportunities that apply to Emergency Management in the Healthcare Sector. All listings will contain the course title, dates, location, a brief description, and a link for registration and additional information. If you have training opportunities you would like shared in this format or questions, please email Samantha Peterson at the St. Louis Area Regional Response System (STARRS) at samantha.peterson@empowermy.org.

Most of these trainings require a FEMA Incident Identification Number (SID). Please visit the FEMA SID website <https://icds.fda.gov/FEMA/SID/> to register for a SID or for a forgotten SID.

Additional Training Opportunities can be found at Missouri Emergency Management Agency at <https://www.training.com/officers> and find Illinois Emergency Management Agency Training Opportunities at <https://public.sma.state.il.us/sma/Training/OnlineRegClasses.asp>.

<p>National Healthcare Coalition Preparedness Conference</p> <ul style="list-style-type: none"> • November 30 – December 2 • Orlando, Florida • Register at: https://emh.cymt.com/register/06106871e3d-4241-9774-d4e02861195?websitePage=04814c4c-9693-4566-8682-1d0e8eb3a712 <p>Re-connect in person with those attendees who work in emergency management, healthcare facilities, voluntary organizations and all levels of government! We are Evolving the Challenges of Today into the Solutions for Tomorrow by sharing best practices, building partnerships, and providing over 40 sessions of content to advance skillsets.</p>	<p>G191-V-ICS/EOC Interface Workshop</p> <ul style="list-style-type: none"> • Dec 14 & 15 2021, from 830 – 1230 pm • Virtual • https://samttraining.com/courses/1703/officers-pr-8121 <p>The course provides an opportunity for emergency management and response personnel to begin developing an Incident Command System (ICS)/Emergency Operations Center (EOC) interface for their communities. The course covers ICS and EOC characteristics, responsibilities and functions and depends heavily on activities and group discussions to facilitate an interface.</p>
<p>Pending: ICS 300 Intermediate Incident Command System</p> <ul style="list-style-type: none"> • January 10, 11, & 12 • Rock Community Fire Protection District • Registrations Pending! <p>Prerequisites: IS 100, IS 200, IS 700, and IS 800. This course provides training for personnel who require advanced application of the Incident Command System (ICS). This course expands upon information covered in ICS 100 and ICS 200.</p>	<p>Pending: ICS400 Advanced Incident Command System</p> <ul style="list-style-type: none"> • February 28, March 1 • Rock Community Fire Protection District • Registrations Pending! <p>Prerequisites: ICS 100, ICS 200, ICS 300, IS 700 & IS 800. This course provides training for personnel who require advanced applications of the Incident Command System (ICS).</p>

Training & Exercise Subcommittee Report

- Discussion

- Review proposed Healthcare 2022 POETE elements

	Q1 2022			Q2 2022			Q3 2022			Q4 2022		
Health Care			Plan: Burn Annex	VTTX Burn MCI	MRSE	TTX Burn Annex	CBRN E Decon Wksp	Radiation Surge Annex Wksp	Radiation Training TBD		Radiation Training TBD	*Hazmat Operations for EMS *TECC

- Discussion additions, revisions, omissions
- Submit improvement recommendations to STARRS

- Next Steps

- Next meeting TBD

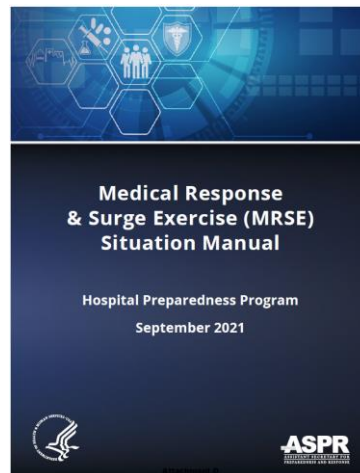
Grant Funding Update Medical Response & Surge Exercise (MRSE)

- Current Status

- Refer to [Attachment D1](#) & [D2](#) for details
 - Exercise “formally known as” Coalition Surge Test (CST)
- Conducted annually with required elements for ASPR grant eligibility
 - Includes leader representatives from each core healthcare coalition sector
 - Simulates 20% surge of regional inpatient staffed beds
 - ED, Medicine, ICU, PACU, Post-Critical
 - Other bed types may be included at HCC discretion
- Includes bed confirmation & patient transfer tracking
- Evaluation based upon HPP Performance Measures

- Next Steps

- Identify healthcare subcommittee representative(s) to support Coalition-based Exercise Planning Team



Regulatory/Accreditation Survey Updates Member Experience

- BJC Parkland Health Center



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Open Discussion

- Topics missed?
- Good for the order?
- Celebrations & shoutouts?



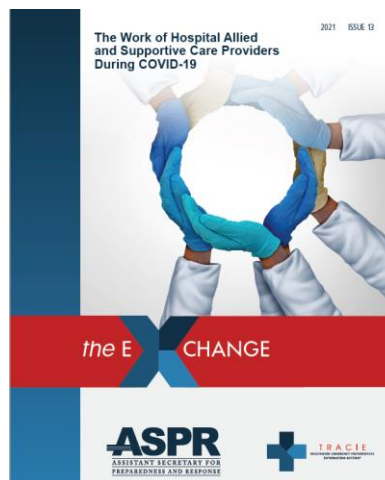
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Resources & Literature

ASPR TRACIE

- Express – October 2021
 - COVID-19 lessons learned for HCC implementation
 - Blood supply management
 - Hospital & Fire Department roles during decontamination response
 - Excess mortality challenges & solutions
 - Hospital behavioral health surge challenges
- Refer to Attachments E & EI



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Action Item Review

- Meeting Action Items
 - Finalize CY 2021 goals
 - Participation brochure
 - Website design & launch
 - Annual report
 - St. Louis MRSE
 - Participate on Exercise Planning Team
 - Contribute to development & quality of exercise materials
 - Prepare for CY 2022 success
 - Facilitate leadership transition
 - Incorporate goals & objectives into workplan

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Next Meeting

- St. Louis Healthcare Subcommittee Meeting
 - Wednesday, January 12, 2022
 - 0930 – 1100 hours
 - Microsoft Teams
 - Activities include:
 - CY2021 membership attendance audit
 - CY2022 goal review & workgroup assignments
 - Website review

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THANK YOU!!



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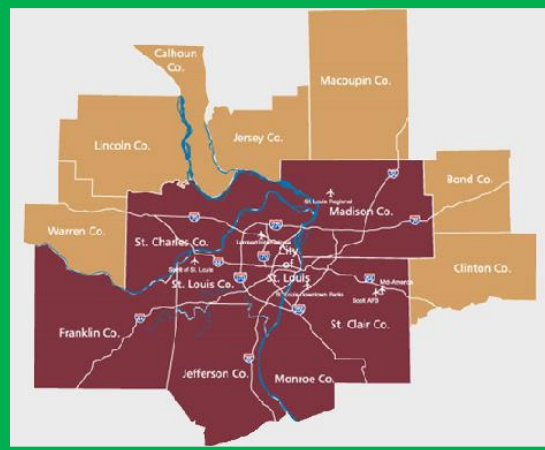
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**St. Louis Healthcare Coalition
Healthcare Subcommittee Regular Meeting
Wednesday, November 10, 2021 0930 - 1100 Hours
Attendance Report**

#	First Name	Last Name	Email	Role	Join Time	Leave Time	Duration
1	Scott	Austermann	SA36369@bjc.org	Member	11/10/2021, 9:29:43 AM	11/10/2021, 10:37:08 AM	1h 7m
2	Nicholas	Blaes	EM94363@bjc.org	Member	11/10/2021, 9:29:04 AM	11/10/2021, 10:37:05 AM	1h 8m
3	Christopher	Blank	CXB1191@bjc.org	Partner	11/10/2021, 9:49:18 AM	11/10/2021, 10:47:12 AM	57m 53s
4	Eric	Brandmeyer		Member	11/10/2021, 9:48:00 AM	11/10/2021, 10:36:54 AM	48m 54s
5	Jason	Campbell	jxc9312@BJC.org	Member	11/10/2021, 9:25:16 AM	11/10/2021, 10:37:19 AM	1h 12m
6	Billy	Chambers		Partner	11/10/2021, 9:29:55 AM	11/10/2021, 10:37:06 AM	1h 7m
7	Dale	Chambers	dale@stlstarrs.org	Partner	11/10/2021, 9:56:06 AM	11/10/2021, 10:37:04 AM	40m 58s
8	Rachel	Charney	rachel.charney@health.slu.edu	Member	11/10/2021, 9:28:10 AM	11/10/2021, 10:37:02 AM	1h 8m
9	Brenda	Chotrow	chotbm@mercy.net	Member	11/10/2021, 9:30:07 AM	11/10/2021, 10:04:27 AM	34m 19s
10	Kyle	Foerst		Partner	11/10/2021, 9:26:09 AM	11/10/2021, 10:14:19 AM	48m 9s
11	Murrel	French	MLF1576@bjc.org	Member	11/10/2021, 9:25:47 AM	11/10/2021, 10:37:07 AM	1h 11m
12	Tracy	Horton	Tracy.Horton@stlukes-stl.com	Member	11/10/2021, 9:56:07 AM	11/10/2021, 10:37:23 AM	41m 16s
13	Shawn	Icenhower	SI22394@bjc.org	Partner	11/10/2021, 9:28:11 AM	11/10/2021, 10:37:02 AM	1h 8m
14	Brian	Liedtke	BL19364@bjc.org	Member	11/10/2021, 9:29:07 AM	11/10/2021, 10:31:55 AM	1h 2m
15	Derek	McDonald	Derek.McDonald@va.gov	Member	11/10/2021, 9:30:35 AM	11/10/2021, 9:59:15 AM	28m 39s
16	Cody	Minks	Cody.Minks@ssmhealth.com	Member	11/10/2021, 9:15:52 AM	11/10/2021, 10:37:09 AM	1h 21m
17	Dennis	Mullen	dmmullen@mrhsl.com	Member	11/10/2021, 9:29:57 AM	11/10/2021, 9:36:46 AM	6m 48s
18	Dennis	Mullen	dmmullen@mrhsl.com	Member	11/10/2021, 9:38:21 AM	11/10/2021, 10:37:29 AM	59m 7s
19	Ryan	Nicholls	nichollsr@wustl.edu	Partner	11/10/2021, 9:27:55 AM	11/10/2021, 10:36:58 AM	1h 9m
20	John	O'brien	John.Obrien@ssmhealth.com	Partner	11/10/2021, 9:31:29 AM	11/10/2021, 9:47:56 AM	16m 26s
21	Samantha	Peterson	sam@stlstarrs.org	Partner	11/10/2021, 9:29:58 AM	11/10/2021, 10:37:08 AM	1h 7m
22	Vanessa	Poston	VP30235@bjc.org	Member	11/10/2021, 9:30:25 AM	11/10/2021, 10:37:07 AM	1h 6m
23	Susan	Pratt	spratt@cfass-stl.com	Member	11/10/2021, 9:28:32 AM	11/10/2021, 10:37:02 AM	1h 8m
24	Robbyn	Roth	Robbyn.Roth@kindred.com	Member	11/10/2021, 9:27:10 AM	11/10/2021, 9:57:10 AM	30m
25	Robbyn	Roth	Robbyn.Roth@kindred.com	Member	11/10/2021, 9:58:23 AM	11/10/2021, 10:37:13 AM	38m 49s
26	Helen	Sandkuhl		Member	11/10/2021, 9:44:33 AM	11/10/2021, 10:37:11 AM	52m 37s
27	Michele	Tanton	MT19628@bjc.org	Member	11/10/2021, 9:27:09 AM	11/10/2021, 10:37:05 AM	1h 9m
28	Anna	Taylor	anna.taylor@wustl.edu	Partner	11/10/2021, 9:28:10 AM	11/10/2021, 10:37:08 AM	1h 8m
29	Erica	Timmer	EXT5687@bjc.org	Member	11/10/2021, 9:29:23 AM	11/10/2021, 10:37:12 AM	1h 7m
30	Phoebe	West	phoebe.west@health.slu.edu	Guest	11/10/2021, 9:31:16 AM	11/10/2021, 10:04:42 AM	33m 26s
31	Brad	Zoref	brad@stlstarrs.org	Partner	11/10/2021, 9:28:36 AM	11/10/2021, 10:37:38 AM	1h 9m

ST. LOUIS REGIONAL HEALTHCARE COALITION

Healthcare Subcommittee 2021 Annual Report



Our Mission

Cultivate a network of healthcare sector partners to:

- Strengthen organizational, industry, and community healthcare preparedness
- Advance healthcare emergency management concepts and capabilities
- Support cross-functional healthcare communication and collaboration
- Provide regulatory/accreditation compliance solutions

Our Membership



27 Hospitals & Healthcare Organizations



8 CMS Provider Types



10 Community Partner Agencies



52 Emergency Management Professionals

Reflection from our Leaders

Reflecting on 2021, it is difficult not to frame the year – our challenges, achievements, setbacks, and successes – around the ongoing COVID-19 pandemic disaster.

Healthcare workers have been personally and professionally tested during the last two years. Our friends and family are suffering, our colleagues on the frontline are anguished, our stakeholders are worried, and we are all exhausted.

Yet amid it all, our regional healthcare infrastructure remains strong. St. Louis healthcare systems and organizations throughout the metro area have discovered new methods of collaboration and innovation, all to provide excellent care to those needing it most. Often within the swirls of adversity, there is also purpose and inspiration.

Despite all the harm COVID-19 has inflicted, it has allowed healthcare workers, public health partners, and emergency managers to discover new levels of individual resolve to do whatever necessary to lead their community through disaster.

The St. Louis Healthcare Subcommittee began the year with two new Chairs determined to make a difference. However, before jumping into subcommittee business, we thought it was important to establish a work environment that reflected and amplified values of professionalism, structure, transparency, and dependability.

Once these standards were communicated, the subcommittee organized 2021 work around four key goals. Volunteers assembled into workgroups and delivered on milestones years in the making, as detailed in this annual report.

Some of the most rewarding and fulfilling moments of our careers have originated from the opportunity to Chair this St. Louis Healthcare Subcommittee.

We thank you all for your incredible dedication to the St. Louis community, the emergency management profession, and each other. We are excited to build on our success through 2022 and continue strengthening our region's healthcare preparedness together.



Jason Campbell, CEM, MPA



Cody Minks, DrPH(c), MPH, MA, MEP

Goal Development

In January 2021, the St. Louis Healthcare Subcommittee approved an ambitious goal development plan to focus work around 4 key improvement areas:

- Membership Tracking & Recruitment
- Technology Integration
- Reporting & Transparency
- Governance & Structure

Goal-specific workgroups were established with volunteers leading projects and delivering products designed to advance Healthcare Subcommittee performance and effectiveness. Workgroup achievements and goal outcomes are detailed below.

Membership Tracking & Recruitment

Goal 1	Cultivate an inclusive healthcare subcommittee that is reflective of the St. Louis community and includes representation from all provider/facility types.	
Description		Status
Objective 1A	Coordinate with local/state partners to identify applicable healthcare organizations and facilities within subcommittee geographic scope.	100%
Objective 1B	Review, verify, and update current subcommittee membership roster.	100%
Objective 1C	Develop healthcare subcommittee one-page summary sheet with membership responsibilities, benefits, enrollment details, and FAQs.	100%
Objective 1D	Distribute subcommittee summary sheet to all eligible healthcare organizations.	76 - 99%
Objective 1E	Monitor membership expansion and healthcare facility representation; revise strategy for Goal 1 achievement if/as required.	100%
Objective 1F	Update contact information for all current and new subcommittee members.	100%

During 2021, the Goal 1 workgroup reviewed/updated the Healthcare Subcommittee participant roster and leveraged technology to establish a directory for membership and partners. Additionally, targeted recruitment activity this year increased regional healthcare organization participation by approximately 26%. Also, during this reporting

period, Goal 1 workgroup volunteers produced a brochure highlighting the mission of Healthcare Subcommittee, benefits and expectations of membership, and opportunities to participate. This brochure will be distributed as a recruitment tool to continue membership expansion during 2022, with the goal of increased participation within under-represented healthcare disciplines of the St. Louis region.

Technology Integration

Goal 2	Implement healthcare subcommittee membership support technology to resolve identified interface gaps.	
	Description	Status
Objective 2A	Develop and distribute electronic survey to determine and rank specific membership portal needs/features.	100%
Objective 2B	Analyze and report membership portal survey results during Regular Meeting.	100%
Objective 2C	Identify potential portal solutions that support/resolve critical needs, as defined by survey results.	100%
Objective 2D	Establish portal solution for subcommittee membership and verify resolution of critical gaps.	100%

The Goal 2 workgroup led a methodical analysis of Healthcare Subcommittee technology solutions in 2021, to identify cost-efficient strategies to improve business functions and advance membership services/resources. Following review and discussion, members unanimously approved the launch of a new Healthcare Subcommittee website to facilitate virtual interactions, host meeting materials, announce training/exercise opportunities, and establish an electronic library with resources such as plans, guidance documents, performance reports, and asset inventories. Our new website is scheduled to launch January 2022. Workgroup volunteers will continue coordinating next year to curate content, monitor site analytics, and market to coalition partners to maximize the value of this new technology

Reporting & Transparency

Goal 3	Elevate healthcare subcommittee visibility and accountability via production of semiannual reports.	
	Description	Status
Objective 3A	Coordinate with HCC Coordinator and partner subcommittee chairs to identify content/data to maximize report utility and relevance.	100%
Objective 3B	Develop DRAFT report outline and dashboard for review/approval by appropriate regional partners/leaders.	100%
Objective 3C	Distribute initial subcommittee report to full membership and designated partner recipients.	100%
Objective 3D	Incorporate applicable report revisions/improvements and distribute annual report to all recipients.	100%

In 2021, the Healthcare Subcommittee started producing a midyear and annual report to update regional leaders and coalition partners on initiative progress/challenges, individual participant achievements, and healthcare industry highlights/updates. Members provided valuable feedback and suggestions to improve the report quality, and broader distribution of all reports will improve transparency of subcommittee operations.

Governance & Structure

Goal 4	Optimize healthcare subcommittee management via revision/alignment of applicable Charters, Bylaws, and other administrative materials.	
	Description	Status
Objective 4A	Verify all applicable documents are included in subcommittee review/revision scope.	100%
Objective 4B	Review current subcommittee Charter; document recommended edits and submit revised version to subcommittee for review/approval.	100%
Objective 4C	Coordinate with HCC Coordinator and Coalition Committee Chairs to strengthen alignment of approved Healthcare Subcommittee Charter with applicable coalition/STARRS administrative documents; support revision as appropriate.	100%
Objective 4D	Verify all applicable coalition and healthcare subcommittee management materials are aligned for optimal administrative coordination for upcoming year.	100%

During this reporting period, the Goal 4 workgroup significantly revised the *St. Louis Healthcare Subcommittee Charter*. A summary of changes includes organizing content into distinct administrative sections, incorporating previously approved participant definitions, defining leadership roles/structures, standardizing equitable voting processes and vote allocation, and outlining Healthcare Subcommittee standard work. The new charter was reviewed during the September 2021 meeting and unanimously approved by membership. Goal 4 workgroup volunteers coordinated with Healthcare Coalition Committee leadership to standardize and align administrative materials for optimal outcomes and will continue governance collaboration in 2022 with new Chairs.

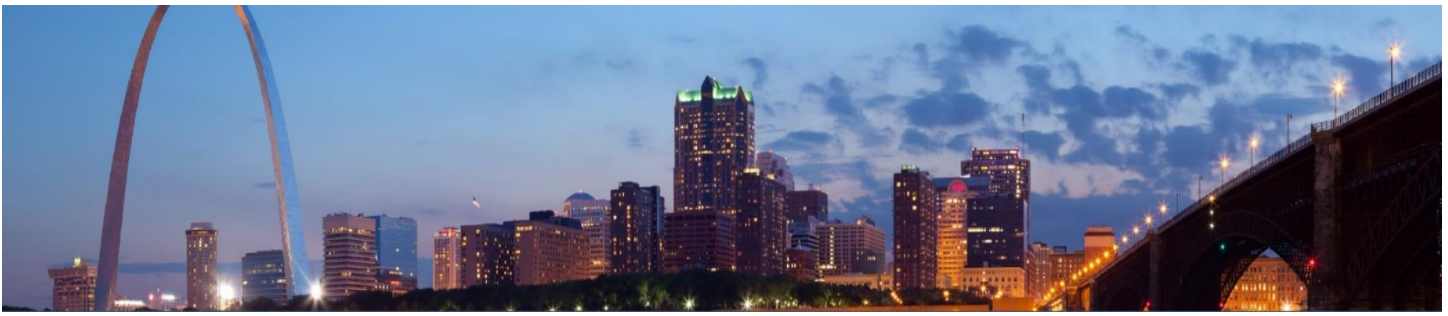
Highlights & Celebrations

TJC EM Standards Review Panel Appointment

Throughout 2021, Jason Campbell represented Barnes-Jewish Hospital (BJH) and the St. Louis region as a healthcare emergency management expert on The Joint Commission (TJC) Standards Review Panel (SRP). TJC SRP was tasked to develop new hospital emergency management accreditation requirements that would enrich the survey experience and improve overall healthcare sector disaster resilience. Following 18 months of collaboration with cross functional industry experts, TJC released the new EM chapter for publication, with an effective date of July 1, 2022. SRP members are confident the new EM standards will contribute to improved healthcare emergency management service quality and effectiveness in the years ahead.

Regional Pediatric Pandemic Network Award

In September 2021, St. Louis University (SLU) Hospital received a \$2 million grant award from the Health Resources & Services Administration (HRSA) to serve as 1 of 5 hospitals leading a new Regional Pediatric Pandemic Network (RPPN). The RPPN mission is to build a foundation to strengthen pediatric disaster management capabilities at all levels. Dr. Rachel Charney, SLU Hospital Emergency Medicine Pediatrician, was appointed RPPN site director to coordinate all St. Louis regional actions. The Healthcare Subcommittee and coalition partners look forward to collaborating with Dr. Charney on local initiatives to advance the RPPN mission.



Get Involved

- Complete an electronic [Participant Form](#) to receive communications and meeting invitations
- Visit our [Website](#) for additional details and participation opportunities
- Contact Healthcare Subcommittee Chairs for any questions, suggestions, or ideas

Contact Us

2022 Chair

Jason Campbell

Jason.Campbell@bjc.org

314-280-5993

2022 Vice Chair

Cody Minks

Cody.Minks@ssmhealth.com

314-989-2407

Current Members

- Anderson Hospital
- Barnes-Jewish Hospital
- Barnes-Jewish West County Hospital
- Betty Jean Kerr People's Health Centers
- Christian/Alton Memorial Hospital
- Center For Urologic Surgery LLC
- CenterPointe Hospital
- Eastern Missouri Psychiatric Hospital
- Fresenius Medical Care Tesson Ferry Dialysis Services
- Kindred Hospital
- Memorial Hospital Belleville - Shiloh
- Mercy Hospital St. Louis
- Mercy Hospital Jefferson Home Health
- Mercy Hospital South
- Mercy Rehabilitation Hospital
- Missouri Baptist Medical Center
- Parkland Health Center
- Progress West Hospital
- South City Hospital
- SSM SLU Hospital
- SSM Cardinal Glennon Children's Hospital
- St. Louis Children's Hospital
- St. Louis VA HealthCare System
- St. Luke's Hospital
- Timberlake Surgery Center - St. Louis Spine and Orthopedic

Get Involved

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Contact Now

2022 CHAIR

Jason Campbell
Jason.Campbell@bjc.org

2022 VICE CHAIR

Cody Minks
Cody.Minks@ssmhealth.com

Attachment C



**ST. LOUIS
REGIONAL
HEALTHCARE
COALITION**

**HEALTHCARE
SUBCOMMITTEE**

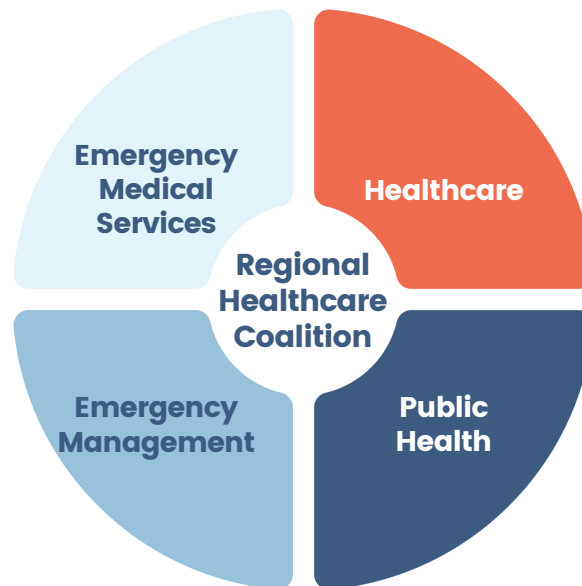
About Us

The St. Louis Healthcare Subcommittee is a group of public & private healthcare service organizations collaborating to improve community medical disaster resilience.

Our Mission

Cultivate a network of healthcare partners to:

- Strengthen community healthcare preparedness
- Advance healthcare emergency management
- Support cross-functional healthcare collaboration
- Provide regulatory compliance solutions



What is a Healthcare Coalition?

A healthcare coalition (HCC) is a group of individual health care and response organizations in a defined location. HCCs play a critical role in developing health care delivery system preparedness and response capabilities

Benefits of Participation

- Strengthen organizational & regional partnerships via industry collaboration
- Enhance disaster health capabilities via planning, training, & testing
- Influence regional disaster strategy, grant fund allocation, & program direction
- Gain advantages in organizational regulatory or accreditation compliance
- Support a more resilient STL community

Expectations

Healthcare Subcommittee participants are expected to:

- Contribute to discussions & learning sessions
- Enrich regional healthcare preparedness programming, including training, drills, & exercises
- Have responsibility for organizational emergency management programs
- Support regional incident response & recovery operations if/as appropriate





ST. LOUIS REGIONAL HEALTHCARE COALITION HEALTHCARE SUBCOMMITTEE

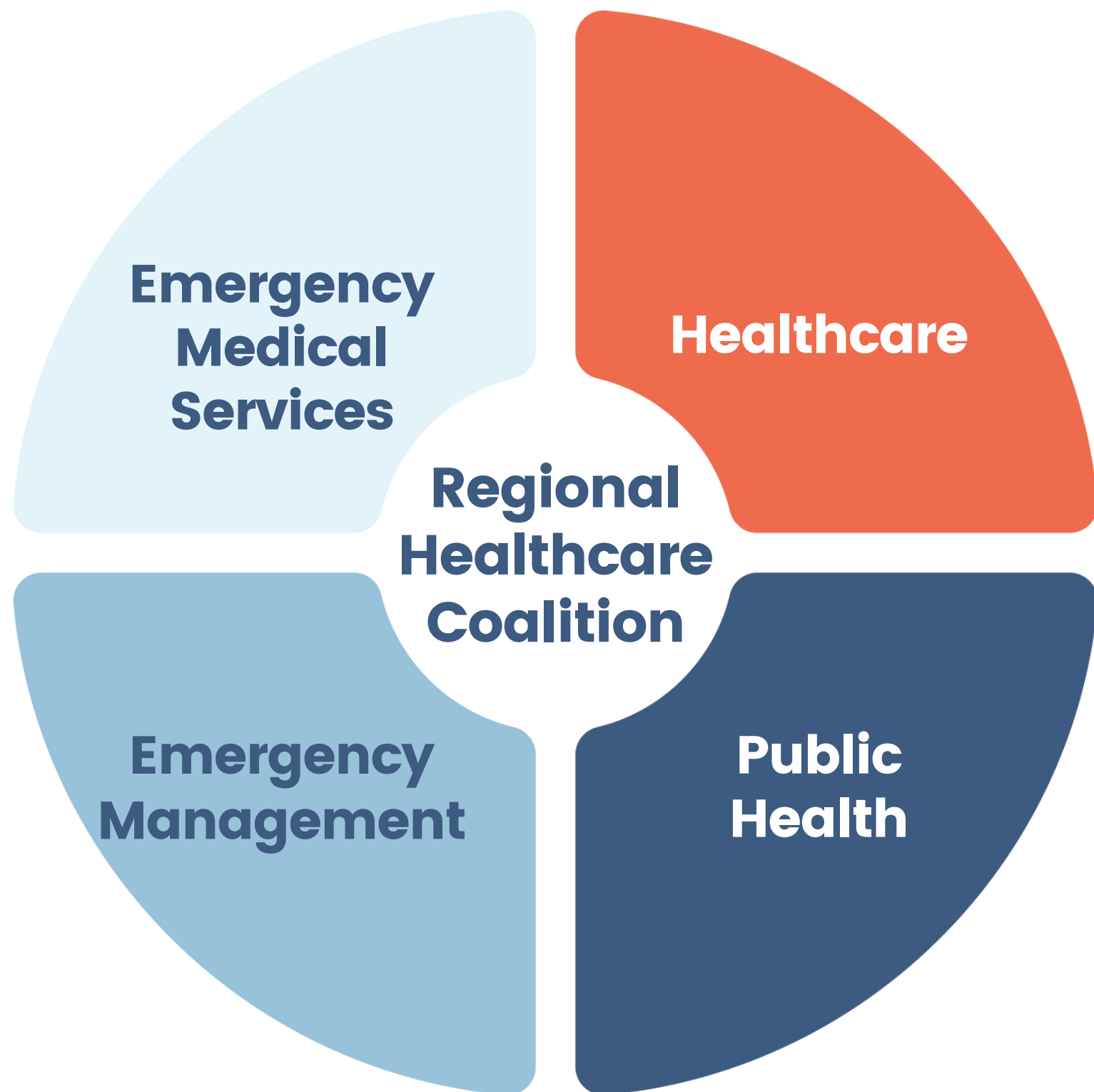
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- Provide regulatory compliance solutions



What is a **Healthcare Coalition?**


A healthcare coalition (HCC) is a group of individual health care and response organizations in a defined location. HCCs play a critical role in developing health care delivery system preparedness and response capabilities.



Benefits of Participation

- Strengthen organizational & regional partnerships via industry collaboration
- Enhance disaster health capabilities via planning, training, & testing
- Influence regional disaster strategy, grant fund allocation, & program direction
- Gain advantages in organizational regulatory or accreditation compliance
- Support a more resilient STL community

Expectations

- Healthcare Subcommittee participants are expected to:
 - Contribute to discussions & learning sessions
 - Enrich regional healthcare preparedness programming, including training, drills, & exercises
 - Have responsibility for organizational emergency management programs
 - Support regional incident response & recovery operations if/as appropriate
- 

Current Members

- Anderson Hospital
- Barnes-Jewish Hospital
- Barnes-Jewish West County Hospital
- Betty Jean Kerr People's Health Centers
- Christian/Alton Memorial Hospital
- Center For Urologic Surgery LLC
- CenterPointe Hospital
- Eastern Missouri Psychiatric Hospital
- Fresenius Medical Care Tesson Ferry Dialysis Services
- Kindred Hospital
- Memorial Hospital Belleville – Shiloh
- Mercy Hospital St. Louis
- Mercy Hospital Jefferson Home Health
- Mercy Hospital South
- Mercy Rehabilitation Hospital
- Missouri Baptist Medical Center
- Parkland Health Center
- Progress West Hospital
- South City Hospital
- SSM SLU Hospital
- SSM Cardinal Glennon Children's Hospital
- St. Louis Children's Hospital
- St. Louis VA HealthCare System
- St. Luke's Hospital
- Timberlake Surgery Center – St. Louis Spine and Orthopedic



Get Involved

- Complete an [electronic participant form](#) to receive communications & meeting invites
- Visit the WEBSITE for additional details & participation opportunities
- Contact Healthcare Subcommittee Chairs for any questions or suggestions

Contact Us

2022 CHAIR

Jason Campbell
Jason.Campbell@bjc.org

2022 VICE CHAIR

Cody Minks
Cody.Minks@ssmhealth.com

**St. Louis Regional Healthcare Coalition
Healthcare Subcommittee Regular Meeting
CY 2021 Attendance Tracking**

No.	Organization	Name - Delegate(s)	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Attendance %
Members															
1	Anderson Hospital	E. Brandmeyer	A		A		A		P		P		P		50%
2	Barnes-Jewish Hospital	J. Campbell - E. Hooks, N. Blaes	P		P		P		D		P		P		100%
3	Barnes-Jewish West County Hospital	E. Timmer - J. Barczewski	A		A		D		A		P		P		50%
4	Betty Jean Kerr People's Health Centers	R. Carter - C. Matthews-Snow	A		D		A		A		P		A		33%
5	Christian/Alton Memorial Hospital	B. Liedtke	P		P		P		P		P		P		100%
6	Center For Urologic Surgery LLC	S. Pratt	P		P		P		P		A		P		83%
7	CenterPointe Hospital	H. Thomas - J. Haalboom	P		A		A		D		A		A		33%
8	Eastern Missouri Psychiatric Hospital	M. Leasure	P		P		P		P		A		A		67%
9	Fresenius Medical Care Tesson Ferry Dialysis Services	E. Wondell	P		A		A		A		A		A		17%
10	Memorial Hospital Belleville - Shiloh	L. French - E. Perham, N. Corliss	D		A		P		P		P		P		83%
11	Mercy Hospital St. Louis	D. Carver	P		P		A		A		A		A		33%
12	Mercy Hospital Jefferson Home Health	B. Chotrow	A		P		P		P		P		P		83%
13	Mercy Hospital South	K. Mooramn	A		A		A		A		A		A		0%
14	Mercy Rehabilitation Hospital	D. Mullen	A		A		P		P		P		P		67%
15	Missouri Baptist Medical Center	V. Poston	P		P		P		P		P		P		100%
16	Parkland Health Center	B. Barton	A		P		P		P		A		A		50%
17	Progress West Hospital	S. Austermann	A		A		A		P		P		P		50%
18	South City Hospital	N. Yanko - J. Mahon	P		P		A		D		P		A		67%
19	SSM SLU Hospital	C. Minks - H. Sandkuhl	P		P		P		P		P		P		100%
20	SSM Cardinal Glennon Children's Hospital	R. Charney	P		P		P		P		P		P		100%
21	St. Louis Children's Hospital	M. Tanton	P		P		A		P		A		P		67%
22	St. Louis VA HealthCare System	D. McDonald	A		A		A		A		P		P		33%
23	St. Luke's Hospital	G. Christmann - T. Horton	D		D		P		P		P		D		100%
24	Timberlake Surgery Center - St. Louis Spine and Orthopedic	L. Abrams	A		P		P		P		A		A		50%
Partners															
25	BJC Healthcare	S. Icenhower - C. Blank	P		P		P		P		P		P		100%
26	City of St. Louis Department of Health	J. Hauser	P		P		A		A		A		A		33%
27	Medstar Ambulance	J. Nowak	P		A		A		P		A		A		33%
28	Mercy Health System	A. Blevins	P		A		A		A		A		A		17%
29	Missouri State Emergency Management Agency	B. Chambers	P		A		A		P		P		P		67%
30	Office of the Regional Medical Examiner	K. Hargrave	A		A		P		P		A		A		33%
31	St. Charles County Department of Public Health	M. Richard - N. Kohlberg	P		A		A		A		D		A		33%
32	Saint Louis University	J. Langan	A		A		A		A		P		A		17%
33	SSM Healthcare	J. O'Brien	P		P		P		P		A		P		83%
34	St. Louis Area Regional Response System (STARRS)	B. Zoref - D. Chambers, S. Peterson	P		P		P		P		P		P		100%
35	St. Louis County Department of Public Health	N. Shaw	A		A		P		P		A		A		33%
36	St. Louis Fusion Center	K. Foerst	A		P		P		P		A		P		67%
37	Washington University	A. Taylor - R. Nicholls	P		P		P		A		P		P		83%
Membership Total: 41			% Committee Present			58%		63%		58%		75%		63%	63%

D = Appointed Designee

A = Absent

P = Present

■ = No Meeting Scheduled / Meeting Cancelled

**St. Louis Healthcare Subcommittee
2022 Goal Workplan**

Goal 1	HCS Website: Launch, Monitor, & Manage				
	Description	Deadline	Workgroup Leader	Completion	Notes
Objective 1A	Finalize preliminary website design, aesthetics, and content organization.	31-Jan		0 - 25%	Unlimited changes allowed within first 30 days of publishing.
Objective 1B	Integrate existing HCS intake and participation tools into new website.	28-Feb		0 - 25%	
Objective 1C	Establish web traffic monitoring and analytics reporting process to verify utility and identify potential growth areas.	31-Mar		0 - 25%	
Objective 1D	Establish HCS document library intake and upload process, including verification and categorization methods.	31-Mar		0 - 25%	
Objective 1E	Advertise HCS website via no less than three (3) regional/coalition communication campaigns.	30-Jun		0 - 25%	

Goal 2	HCS Budget: Audit & Management				
	Description	Deadline	Workgroup Leader	Completion	Notes
Objective 2A	Identify and audit all existing HCS/HCC revenue streams and expenditures to establish an operational fiscal profile.	31-Mar		0 - 25%	
Objective 2B	Establish budget monitoring and reporting process for routine updates and fiscal awareness.	30-Jun		0 - 25%	
Objective 2C	Assess alternative and/or supplemental methods of revenue; submit suggestions to leadership.	30-Sep		0 - 25%	

Goal 3	HCS Membership: Recruitment & Engagement				
	Description	Deadline	Workgroup Leader	Completion	Notes
Objective 3A	Review membership roster and identify at least three (3) healthcare provider types for focused recruitment efforts.	28-Feb		0 - 25%	
Objective 3B	Develop and execute focused recruitment action(s) for each provider type identified in Objective 3A.	31-Mar		0 - 25%	
Objective 3C	Expand membership roster by two (2) organizations within each provider type identified in Objective 3A.	30-Jun		0 - 25%	
Objective 3D	Coordinate with HCS members and partners to identify outreach/engagement improvement opportunities.	30-Apr		0 - 25%	May be achieved facilitated discussion, survey, etc.
Objective 3E	Propose at least three (3) HCS engagement opportunities/events for participants.	30-Jun			Examples include speakers, conference delegations, professional development, team building, etc.

**St. Louis Healthcare Subcommittee
2022 Goal Workplan**

Goal 4	HCS Academy: Foundation & Strategic Planning				
	Description	Deadline	Workgroup Leader	Completion	Notes
Objective 4A	Define core competencies and learning objectives for St. Louis "Healthcare EM Academy".	31-Mar		0 - 25%	
Objective 4B	Develop "Healthcare EM Academy" curriculum, including education topics, literature, teaching method(s), resources, and course completion verification process.	30-Jun		0 - 25%	
Objective 4C	Establish "Healthcare EM Academy" strategic plan, including target participants, implementation timeline and milestones, funding, and sustainment.	30-Sep		0 - 25%	

Training Newsletter

Healthcare: January 2022



St. Louis Area Regional Response System

Below are current and future training opportunities that apply to Emergency Management in the Healthcare Sector. All listings will contain the course title, dates, location, a brief description, and a link for registration and additional information. If you have training opportunities you would like shared in this format or questions, please email Samantha Peterson at the St. Louis Area Regional Response System (STARRS) at Samantha.Peterson@ewgateway.org.

Many of these trainings require a FEMA Student Identification Number (SID). Please visit the FEMA SID website: <https://cdp.dhs.gov/FEMASID> to register for a SID or for a forgotten SID.

Additional Training Opportunities can be found at Missouri Emergency Management Agency at: <https://sematraining.com/offerings> and find Illinois Emergency Management Agency Training Opportunities at: <https://public.iema.state.il.us/iema/Training/OnlineReg/classes.asp>.

K0051 Exercise Program Management Workshop

- Jan 18, 2022 10:00 – 2 PM CST
- Virtual from Emergency Management Institute
- <https://training.fema.gov/emigrams/2021/1694-training%20opportunity-k0051%20exercise%20program%20management.pdf?d=12/17/2021>

K0051 Exercise Program Management is a basic-level course that provides a comprehensive overview of exercise program management. Participants will gain a better understanding of Exercise Program Management.

MGT465- Recovering from Cybersecurity Incidents

- February 15-16, from 8AM-5PM
- Jefferson City, Mo
- <https://sematraining.com/courses/1862/offers/8246>

The Recovering from Cybersecurity Incidents course is designed to provide guidance to a jurisdiction on the actions necessary to effectively recover from a cybersecurity attack.

AWR-934V Hospital Incident Command System

- Jan 19, 2022 11:00 – 1:00 PM CST
- Virtual from Center for Domestic Preparedness
- <https://cdp.dhs.gov/training/course/AWR-934-V7>

The Recovering from Cybersecurity Incidents course is designed to provide guidance to a jurisdiction on the actions necessary to effectively recover from a cybersecurity attack.

L1301- Continuity Planning

- February 23-24, from 8AM – 5PM
- Jefferson City Mo
- <https://sematraining.com/courses/1849/offers/8226>

The goal of this course is to help continuity practitioners understand continuity roles and responsibilities, and provide the knowledge sets, skills, and tools necessary to help develop and maintain a viable continuity plan for their organization and community.

L1302 – Continuity of Operations Program Management

- April 12-13, from 8AM – 5PM
- Jefferson City, Mo
- <https://sematraining.com/courses/1850/offers/8227>

The goal of this course is to provide continuity planners and program managers the knowledge, skills, and tools necessary to help them develop a holistic continuity capability.

G300-ICS300 Intermediate Incident Command System

- August 2-4, from 8AM – 5PM
- Warren County EMA
- <https://sematraining.com/courses/29/offers/8240>
- Prerequisites- IS 100, IS 200, IS 700, and IS 800

Individuals who may assume a supervisory role in incidents. Note: During a Type 3 incident, some or all of the Command and General Staff positions may be activated, as well as Division/Group Supervisor and/or Unit Leader level positions.

G2300 – Intermediate Emergency Operations Center Functions

- May 4-6, from 8AM – 5PM
- St. Charles County EOC
- <https://sematraining.com/courses/1526/offers/8244>

The G2300 Intermediate Emergency Operations Center Functions is a three-day course with the goal of assisting individuals and jurisdictions who desire to develop or improve their Emergency Operation Centers (EOC).

G400-ICS400 Advanced Incident Command System

- October 4-5, from 8AM – 5PM
- Warren County EMA
- <https://sematraining.com/courses/29/offers/8240>
- Prerequisites- IS 100, IS 200, ICS 300, IS 700, and IS 800

The target audience for this course is senior personnel who are expected to perform in a management capacity in an Area Command or Multi-Agency Coordination Entity.

Training Events (Conferences, Summits & Workshops)

2022 National ResilienceEXCH Virtual Summit

Date/Time: Jan 25-27th, 12:30PM – 6:00PM EST
Location: Virtual

Topics Include: Public/Private Partnerships, Healthcare, Information Sharing, Civil Unrest, Training, Planning, Preparedness, and Response, Risk Management, Critical Infrastructure Resiliency, Emerging Threats, Cyber, and More!

Registration & More Information:
<https://resilienceexch.org>

2022 Preparedness Summit

Date/Time: April 3-7
Location: Atlanta, Georgia

The theme of our next Preparedness Summit, Reimagining Preparedness in the Era of COVID-19, will provide an opportunity to reflect on lessons learned from current and previous responses, and highlight tools, resources, and learnings that we can apply into the future.

Registration & More Information:
<https://www.preparednesssummit.org>



Medical Response & Surge Exercise (MRSE) Situation Manual

Hospital Preparedness Program

September 2021



ASPR
ASSISTANT SECRETARY FOR
PREPAREDNESS AND RESPONSE

ACKNOWLEDGEMENTS

The Medical Response & Surge Exercise (MRSE) was created by the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR). Special thanks are due to Jennifer Hannah, Deputy Director of the National Healthcare Preparedness Programs (NHPP), who led development of the MRSE exercise. ASPR would like to express sincere gratitude to NHPP Field Project Officers Angela Krutsinger, Kevin Sheehan, David Csernak, Ann Nguyen, Duane Wagner, Susan Sutton-Clawson, Sharon Cox, William Mangieri, Paul Link, and Senior Medical Advisor Richard Hunt; ASPR's Office of Strategy, Policy, Planning, and Requirements (SPPR) Evaluation Branch team members Darrin Donato, Debjani Das, Thomas Greer, and Clifton Smith; ASPR Technical Resources, Assistance Center, & Information Exchange (TRACIE) Team,; ASPR's Division of Exercise, Evaluation, and After Action (E2A2) Exercise Branch, including Elizabeth Catarious and William Moore; Jon Krohmer and the US Department of Transportation's Office of EMS; David Lehrfeld and the Oregon Health Authority; Brian Ritchie and the State of Alaska Department of Health and Social Services; Lyle Moore and the Colorado Hospital Association; and Mark Ross and the Florida Hospital Association. We are extremely thankful to all for their valuable strategic guidance, insights, and continuous interest in this exercise.

ASPR would also like to acknowledge the Design Team members: ASPR NHPP team members David Csernak, Angela Krutsinger, and Kevin Sheehan; Deloitte Consulting team members Olugbadero Yerokun, Lauren Cuddy Egbert, Peter Telaroli, Haidi Al-Shabrawey, Aldemaro Alberto Algarra Gonzalez, and Katherine Gorbach; Gryphon Scientific team members Robert Stephan, Mark Kazmierczak, and Audrey Cerles; and Strategy 4Ward Consulting team member Jonathan Pearson.

A special thanks to the Hospital Preparedness Program (HPP) recipients and Health Care Coalitions (HCCs) who graciously provided their time and invaluable insights through webinars and a survey. Finally, we profoundly thank South Dakota Healthcare Coalition and West Region Healthcare Coalition of Colorado for participating in a full pilot exercise of the MRSE and providing feedback as part of the development of the MRSE.

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1.0 INTRODUCTION

The **Medical Response & Surge Exercise (MRSE)** was created by the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR). The exercise procedures and supporting materials described in the Situation Manual (SitMan) are aligned with updated the Federal Emergency Management Agency (FEMA) Homeland Security Exercise and Evaluation (HSEEP) guidelines issued in 2020. The MRSE is a functional exercise, which HSEEP describes as “an operations-based exercise designed to test and evaluate capabilities and functions while in a realistic, real-time environment.”

The MRSE and this SitMan were produced with input, advice, and assistance from the National Healthcare Preparedness Programs’ (NHPP) Exercise Design Team (hereafter referred to as “Design Team”). This team included NHPP representatives as well as a number of emergency preparedness and response subject matter experts from federal, state, and private sector organizations.

This SitMan provides exercise participants, which include exercise players, subject matter experts, facilitators, observers, and evaluators from participating agencies and organizations, with background information on the exercise’s scope, schedule, and objectives. It also presents the scenario narrative and discussion questions that will drive participant discussions during the exercise. The information in this document is current as of the date of publication and is subject to change. All exercise participants may view the SitMan.

For more information about this exercise and requirements of the Hospital Preparedness Program (HPP) Cooperative Agreement, please contact your regional HPP Field Project Officer.

1.1 RELATED DOCUMENTS AND TOOLS

This exercise requires the use of three documents:

- **Situation Manual (this document)** – The core document provided to all participants in an exercise. It provides in-depth instructions for how to plan and conduct the MRSE.
- **Evaluation Plan** – Outlines the goals and purpose of exercise evaluation for a health care coalition (HCC) and guides the Exercise Evaluator (see section 2.10 below) through assisting during the exercise, gathering information, and facilitating the After-Action Review (AAR). The Evaluation Plan helps the Exercise Evaluator turn information collected during the exercise into a meaningful After-Action Review and Improvement Plan (IP) in concert with exercise participants.

- **Exercise Planning and Evaluation Tool** – The Excel-based tool is used primarily by the Exercise Evaluator to document decisions and results throughout the exercise, including the *Phase I: Plan & Scope* and *Phase III: Review*. The tool includes sequentially organized tabs that may be viewed by clicking on each tab’s name at the bottom of the screen. All required exercise data collection – including data for HPP Cooperative Agreement performance measures – will be completed in the Exercise Planning and Evaluation Tool.

2.0 EXERCISE OVERVIEW

2.1 BACKGROUND

ASPR leads the country in preparing for, responding to, and recovering from the adverse health effects of emergencies and disasters. ASPR’s programs improve the nation’s ability to withstand adversity, strengthen health and emergency response systems, and enhance national health security. This portfolio of programs and activities— which includes HPP— engages health care stakeholders from all 50 states, U.S. territories, freely associated states, major metropolitan areas, and Washington, D.C., as well as from across the health care industry – empowering private health care to share ownership in addressing the risks and vulnerabilities across the spectrum of disaster care delivery. The portfolio represents a collection of building blocks that form a comprehensive, national system for health care preparedness and response.

ASPR’s HPP is the primary source of federal funding specifically for health care delivery system readiness. The program aims to improve patient outcomes, minimize the need for federal and supplemental state resources during emergencies, and enable rapid recovery from catastrophic events through the development of HCCs. HCCs incentivize and support diverse and often competitive health care organizations with differing priorities and objectives to work together to save lives during disasters and emergencies that exceed the day-to-day capacity and capability of individual health care and emergency response systems. HCCs serve an important communication and coordination role within their jurisdictions, given the many public and private entities that must come together to ensure health care delivery system readiness.

To describe what health care delivery system partners, including HCCs, health care organizations, and emergency medical services (EMS), must do to effectively prepare for and respond to emergencies, ASPR developed the [2017-2022 Health Care Preparedness and Response Capabilities](#). Medical Surge, listed as Capability Four, is the ability to evaluate and care for a markedly increased volume of patients that exceeds normal operating capacity.

Providing an effective medical surge response is dependent on the planning and response capabilities developed by HCCs and other stakeholders. Medical surge requires building capacity and capability.¹

Surge capacity is the ability to manage a sudden influx of patients. It is dependent on a well-functioning incident command system (ICS) and the variables of space, supplies, and staff. The surge requirements may extend beyond placing patients into beds, and should include all aspects related to clinical services (e.g., laboratory studies, radiology exams, operating rooms).

Surge capability is the ability to manage patients requiring very specialized medical care. Surge requirements span a range of medical and health care services (e.g., expertise, information, procedures, or personnel) that are not normally available at the location where they are needed (e.g., pediatric care provided at non-pediatric facilities or burn care services at a non-burn center). Surge capability also includes special interventions in response to uncommon and resource intensive patient diagnoses (e.g., Ebola, radiation sickness) to protect medical providers, other patients, and the integrity of the medical care facility.

The MRSE is designed to examine and evaluate the ability of HCCs and other stakeholders to support medical surge, and specifically, how coalitions help patients receive the care they need at the right place, at the right time, and with the right resources during medical surge; decrease deaths, injuries, and illnesses resulting from medical surge; and promote health care delivery system resilience in the aftermath of medical surge.

2.2 CONFIDENTIALITY

All exercise participants should use appropriate guidelines to ensure proper control of information within their areas of expertise and protect this material in accordance with current directives. Exercise participants should follow their existing policies and procedures with regard to information security and confidentiality. In accordance with the HIPAA 1974 Privacy Act, no individual patient information should be shared as a part of this exercise². Information about surge patients provided in MRSE materials is hypothetical in nature and will not reflect

¹ Office of the Assistant Secretary for Preparedness and Response. [2017-2022 Health Care Preparedness and Response Capabilities](https://www.phe.gov/Preparedness/planning/hpp/reports/Documents/2017-2022-healthcare-pr-capabilities.pdf). <https://www.phe.gov/Preparedness/planning/hpp/reports/Documents/2017-2022-healthcare-pr-capabilities.pdf>. Accessed August 2021.

² [The Privacy Act of 1974](https://www.hhs.gov/foia/privacy/index.html). <https://www.hhs.gov/foia/privacy/index.html>. Accessed August 2021.

information related to any real patients.

Some exercise material is intended for the exclusive use of exercise planners and evaluators, but participants may view other materials that are deemed necessary to their performance. All exercise participants may view this SitMan. Authority for public release of exercise materials to third parties resides with HHS ASPR.

ASPR will use the information submitted by HCCs and HPP recipients to evaluate and inform progress in achieving evidence-based benchmarks and objective standards; performance measures data, including data from local health departments; outcomes of annual preparedness exercises including strengths, weaknesses and associated corrective actions; and accomplishments highlighting the impact and value of the HPP activities in their jurisdictions. Information provided by HCCs and HPP recipients from the MRSE may also be used to inform the future design of the national program. As such, HCCs and recipients are requested to ensure all data accurately reflect the HCC's experience during the exercise.

2.3 PURPOSE AND SCOPE

The purpose of the MRSE is to provide HCCs with an opportunity to test their surge response and preparedness capabilities. The scenario used in the MRSE is defined by the HCC, but all exercises will test an HCC and its members' capacity to accommodate a surge of patients equal to at least 20% of its staffed bed capacity³ and to ensure availability of staffed beds, supplies and equipment, and personnel across its membership.

2.4 EXERCISE OBJECTIVES

The exercise includes six required objectives. However, HCCs may develop additional objectives to meet the needs of their members provided the standard actions in the exercise are followed in order to meet HPP Cooperative Agreement requirements. Due to the flexibility of the exercise scenario, HCCs may include additional objectives which support their members in meeting additional exercise requirements (e.g., Joint Commission, Centers for Medicare and Medicaid Services (CMS), state and local jurisdictional requirements, etc.) apart from HPP requirements.

The Design Team identified the following standard objectives for the MRSE functional exercise:

³ Only certain bed types are included in this calculation. Additional bed types may be included based on the incident scenario defined by the HCC. The accompanying Exercise Planning and Evaluation Tool will calculate the number of patients based on inputs from the HCC.

- Assess an HCC's capacity to support a large-scale, community-wide medical surge incident
- Evaluate a multitude of coalition preparedness and response documents and plans, including specialty surge annexes, transfer agreements, coordination plans with other state HCCs, and all other relevant plans
- Evaluate coalition members' ability to communicate and coordinate quickly to find and match available staffed beds, transportation, supplies and equipment, and personnel during a large-scale surge incident
- Assist HCCs and their members with improvement planning based on MRSE outcomes
- Serve as a data source for performance measure reporting required by the HPP Cooperative Agreement
- Provide a flexible exercise which could be customized to meet the needs and/or exercise requirements of HCCs

2.5 EXERCISE OUTCOMES

ASPR identified the following required outcomes for the MRSE functional exercise. However, as with the exercise objectives, HCCs are encouraged to include additional expected outcomes based on the needs of their members, such as:

- The HCC has validated all applicable response plans and identified gaps which remain unaddressed.
- The HCC is better prepared to respond to a large-scale surge inpatients.
- HCC members have improved their capacity to assess the availability of and secure access to key resources such as staffed beds, personnel, supplies and equipment, and patient transport during a large-scale community incident.
- The HCC has strengthened its role in sharing information, situational awareness, and coordination during a large-scale community incident.

2.6 EXERCISE STRUCTURE

This MRSE functional exercise is an HCC-led, operations-based exercise. Participants are expected to act in their real-life roles when considering this scenario, offering observations to the forum, making strategic and operational decisions, and complying with real-world procedures. The exercise facilitator will ensure that the discussions move along at an appropriate pace, covering each discussion topic sufficiently and allowing all participants an opportunity to contribute.

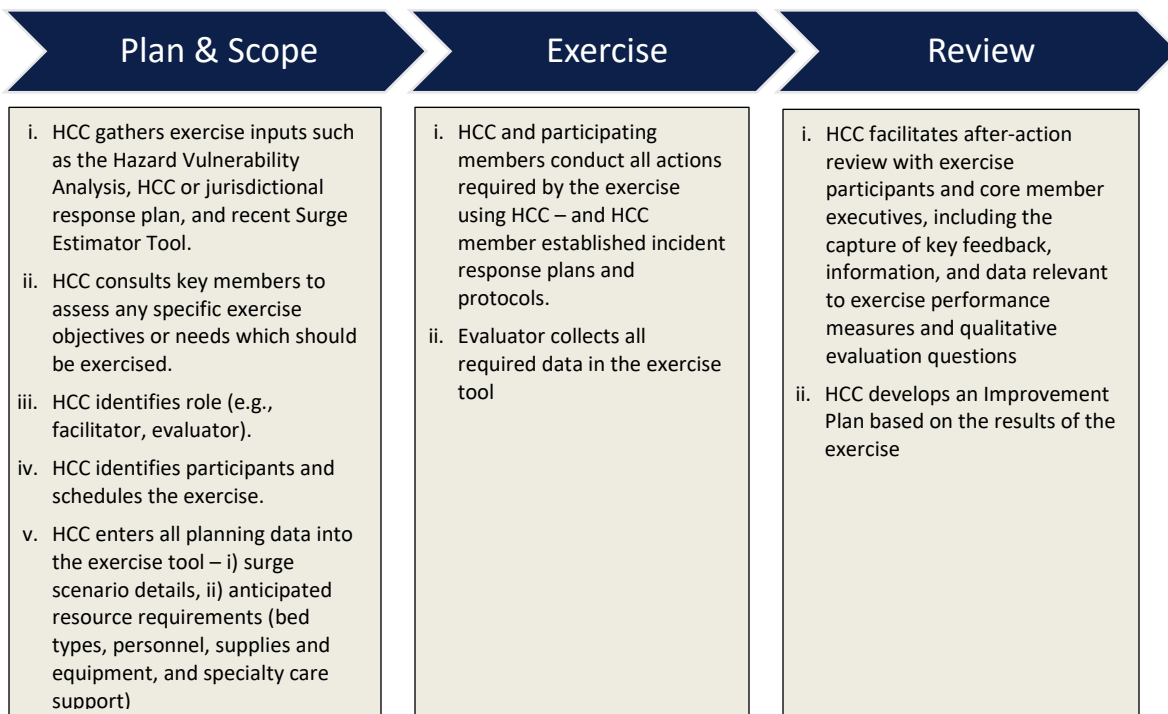
During the course of the MRSE functional exercise, participants will be asked to address topics such as alerts and notifications; situational assessment and information management; operational coordination; resource allocation and mobilization; workforce protection, patient movement and patient care; fatality management; and public information and warning. These discussion topics have been selected by the Design Team and will be used to guide participants' discussions and enable the recording of information for evaluation purposes during the AAR.

Although the exercise requires an HCC to follow as closely as possible its real-world procedures for managing a surge incident and no real patients will be moved or otherwise disturbed. Similarly, no real resources such as supplies, equipment, or EMS response resources will be moved or otherwise disturbed. HCCs may expand the exercise from a functional exercise to a higher-level exercise, if they choose to do so, provided it does not significantly alter the exercise objectives or the HCC's ability to report data related to HPP performance measures.

2.7 EXERCISE PHASES

The MRSE functional exercise follows three phases as illustrated in the figure below. Further detail about the requirements of each phase are discussed in the sections below.

Figure 1: Three Phases of the Medical Response & Surge Exercise



2.8 EXERCISE RULES

Participants should consider the following exercise ground rules to ensure that the objectives are met in a reasonable amount of time and that the exercise runs smoothly:

- Use the pre-established scenario to set parameters for exercise activities and participant discussions.
- Be honest in their assessment and reporting of information such as resource availability.
- Keep the overarching exercise objectives in mind throughout the exercise.
- Participate in the discussions as appropriate to your role.
- Comply with real-world response procedures; responses should be based on the current capabilities of your organization, using only existing abilities and resources.
- Participate openly and focus discussions on relevant topics—asking questions, sharing thoughts, and offering forward-looking and problem-solving suggestions are strongly encouraged, as these actions will enhance the exercise experience.
- Keep your comments focused and consider the time constraints of the exercise.
- Respect the observations, opinions, and perspectives of others, as the discussions will explore a variety of policies, decisions, actions, and relevant key issues from different sources.
- Frame the exercise as an open, low-stress environment to encourage participant discussion and recommendations to improve the current processes.
- Prioritize real-world emergency actions over exercise actions.

2.9 USING REAL-WORLD EVENTS IN LIEU OF THE MRSE

HPP Cooperative Agreement requirements allow for the use of some types of real-world events in lieu of the Medical Response & Surge Exercise. In the event that an HCC has a real-world incident which meets certain requirements, the HCC can use the data from the real-world event to respond to each applicable performance measure. HCCs who wish to utilize a real-world event in lieu of conducting the MRSE must meet the following requirements:

- The real-world surge incident must be equal to or greater than 20% of the required staffed bed types and other scenario-specific staffed bed types used in the MRSE (see the *Calculating the Scale of the Surge* section below).
- At least one of each of the HCC core members must participate in the real-world incident response.

- At least one executive from each of the participating core member organizations must participate in the AAR.
- The HCC is able to capture the data points required to report all MRSE performance measures. To strengthen the possibility of meeting this requirement, HCCs can pre-identify resource needs for a range of surge incident types (e.g., from the HCC Hazard Vulnerability Analysis) as done in the *Identifying Anticipated Resources Required for the Surge* section below.
- The HCC must use the Exercise Planning and Evaluation Tool to document the real-world incident and provide data required by HPP (e.g., performance measures).
- The HCC must submit an AAR and IP to HPP after the real-world incident in line with the reporting requirements of the HPP Cooperative Agreement for both exercises and real-world events.
- The real-world surge incident has a discrete beginning and end (“bookends”) and is not a slow surge build up. Preferred real-world incidents to be used in lieu of the MRSE last no more than one week. Generally speaking, the COVID-19 response cannot be used in lieu of conducting the MRSE unless there is a specific COVID-19 surge event lasting less than one week.

If HCCs have questions about using a real-world event in lieu of conducting the MRSE, please contact your regional HPP Field Project Officer.

2.10 PARTICIPANT ROLES AND RESPONSIBILITIES

Table 1: Required Exercise Roles (generally staffed at the HCC level)

Exercise Role	Role Description
HCC Readiness and Response Coordinator (RRC)	The lead role for planning and preparing for the exercise. RRCs should be familiar with the HCC’s Hazard Vulnerability Analysis, Preparedness and Response Plans, Specialty Surge Annexes, Surge Estimator Tool, the coalition membership, and other jurisdictional response plans.

Exercise Role	Role Description
HCC Clinical Advisor(s) or Designee	<p>This role will provide clinical guidance and coordination assistance pertaining to acute care medical surge readiness and response operations to include trauma, burn, infectious disease, pediatric, CBRNE (chemical, biological, radiological, nuclear, and high yield explosives), and evacuation emergencies. The individual(s) should be a physician, advanced practice provider, or registered nurse and should be from a lead or co-lead hospital or health care organization and be clinically active (i.e., works shifts/sees patients).</p>
Exercise Facilitator	<p>This role will guide the participants through the exercise actions, ensuring all HPP-required exercise tasks are completed. The Exercise Facilitator should be a separately-designated or delegated individual, but also serve as the RRC if no other individuals are available to fill the RRC role. It is generally recommended the RRC, Exercise Facilitator, and evaluator be different individuals given both the burden as well as best practice of the evaluator being an objective observer not involved in the implementation of the exercise actions. The Exercise Facilitator triggers the exercise incident response by contacting the Duty Officer (Notification System Representative).</p>
Exercise Evaluator	<p>The lead role for documenting the actions of the HCC and its members during the test and evaluating the exercise results. This role will summarize the exercise results and facilitate the AAR session. In principle, this person should be an objective observer and be designated separately from the RRC, but can be a staff person of the HCC or a member organization. The Homeland Security Exercise and Evaluation (HSEEP) guidelines suggest the Exercise Evaluator be involved in the full lifecycle of the exercise, including <i>Phase I: Plan & Scope</i> to understand the exercise objectives, performance measures, and the exercise materials such as the SitMan, MRSE Evaluation Plan, and the accompanying tool.</p>

Exercise Role	Role Description
Duty Officer (Notification System Representative)	<p>The Duty Officer is the individual(s) designated in the relevant HCC or jurisdictional response plan for receiving notice of emergency incidents, triggering the HCC’s response plan, and determining the response level.</p> <p>Although some HCCs may not utilize this term or fund this role, the exercise refers to this role as the Duty Officer for simplicity. The HCC should utilize the same person or persons for this role as it would during a real-world event. This is a very limited role in the exercise and may be performed by an individual of the HCC’s choosing.</p>

2.11 EXERCISE FACILITATION

The exercise will be guided by the Exercise Facilitator. The facilitated exercise uses an approach based on the exercise objectives in order to create the decision-making environment for participants to act in their respective roles. The Exercise Facilitator will lead exercise participants through a discussion of the activities the HCC and its members would take in conjunction with each individually-defined exercise objective. In general, the Exercise Facilitator will:

- Keep discussions on track with exercise objectives and within established time limits to ensure that all issues are explored (time permitting).
- Keep side conversations to a minimum, controlling group dynamics and strong personalities, as needed.
- Speak competently and confidently about the subject at hand but will not dominate the conversation.
- Possess subject-matter expertise relevant to the issues presented in the exercise.
- Be aware of local plans and procedures.
- Solicit discussion on key activities and decisions that the participating organizations would perform in response to the exercise topic(s).
- Press the exercise participants, throughout the exercise, to discuss their biggest challenges and to make commitments on how to address those challenges.

3.0 PHASE I: PLAN & SCOPE

This phase should begin well in advance of the beginning of the actual exercise. In this phase,

HCCs will determine exercise roles, understand members' specific needs from the exercise, define their surge scenario, and begin to enter planning and scoping data in the exercise tool. By the end of this phase, the scenario, objectives (beyond those mandated by HPP), and desired outcomes for the exercise will be clearly defined and scheduled for a specific future date. Note although there is no requirement for low- or no-notice format of the exercise, HCCs are encouraged to consider this option to mimic a real-world incident.

3.1 CONSULTING HCC MEMBERS

The exercise is designed to be as flexible as possible in order to meet an HCC's tailored needs. Individual HCC members may be subject to other specific exercise requirements to retain certifications or for other purposes. For example, hospitals and long-term care facilities may be subject to certain emergency preparedness requirements as defined by CMS. To encourage member participation and to broaden the utility of the Medical Response & Surge Exercise, the HCC is encouraged to consult its members during *Phase I: Plan & Scope* in order to tailor the exercise to meet member needs beyond the requirements of the HPP Cooperative Agreement. Member needs can influence the exercise objectives, HCC-defined scenario, incident type, member participation, the scale of the exercise, the resources required to manage the surge (e.g., personnel), additional exercise outputs or reporting, and/or other aspects of the exercise. The RRC can build these additional member needs into the MRSE as needed. HCCs should document any outputs needed by members to meet these additional requirements. *Note: the exercise should not be altered in a way which would change the HPP-mandated core objectives of the exercise (section 2.4) or impede the HCC and/or HPP Cooperative Agreement recipients' ability to report performance measures per HPP requirements.* Sample text for consulting HCC members is provided in Table 3 at the end of the *Phase I: Plan & Scope* section.

3.2 DEFINING THE SURGE SCENARIO

The specific scenario used to drive exercise play is defined by the HCC. However, all exercises will test an HCC and its members' capacity to accommodate a surge of patients equal to 20% of its staffed bed capacity. The HCC is required to determine staffed bed availability from member facilities, identify available supplies, equipment, and personnel within the HCC and among facilities that the HCC is reaching out to for assistance. This includes health care facilities outside of the HCC. The HCC will select a surge incident from its Hazard Vulnerability Analysis or another incident scenario it would like to exercise. To shape the remainder of the exercise, the HCC will also classify its hazard by the medical surge categories from the 2017-2022 Health Care Preparedness and Response Capabilities. Information about the hazard, scenario, and surge type

is captured in the exercise tool during *Phase I: Plan & Scope*.

3.3 CALCULATING THE SCALE OF THE SURGE

In this planning step, the HCC will enter the total staffed beds within its member organizations by bed category. The exercise tool will automatically calculate the number of patients resulting from the incident based on the number of staffed beds in the HCC (i.e., 20% of staffed beds required for the incident). Staffed bed types included in the calculation include the required medical surge beds plus any optional beds relevant for the HCC’s surge incident scenario as selected by the HCC. Staffed bed types are summarized in Table 2 below. If HCCs would like to utilize their Surge Estimator Tool (SET) to complete this step, Appendix A maps SET bed types to those required by the exercise.

Table 2: Required and optional staffed bed types used by the Medical Response & Surge Exercise

Staffed Bed Type	Calculation
Emergency Department Beds	Required for all exercises
General Medical Unit Beds	Required for all exercises
ICU beds (SICU, MICU, CCU)	Required for all exercises
Post Critical Care (Monitored / stepdown) Beds	Required for all exercises
Surgical Unit Beds (pre-op, post-op, & procedural)	Required for all exercises
Labor and Delivery Unit Beds	Based on surge type defined by the HCC
Psychiatric Unit Beds	Based on surge type defined by the HCC
General Pediatric Unit Beds	Based on surge type defined by the HCC
Pediatric and Neonatal ICU Beds	Based on surge type defined by the HCC
Oncology Unit Beds	Based on surge type defined by the HCC

EXERCISE SCALE – STAFFED BED CALCULATION EXAMPLE

An HCC has chosen to use pediatric surge as a scenario to test for the exercise. The coalition has determined that it has **1,000 staffed beds of the five types required** for all exercises, and **100 pediatric and neonatal ICU beds that will serve as their scenario-based optional staffed beds**. In order to test 20% of its staffed bed capacity, the HCC uses the following calculation to determine the number of surge patients in the exercise:

20% of 1000 staffed beds of the five types required for all exercises = **200**

20% of 100 pediatric and neonatal ICU staffed beds = **20**

Total numbers of surge patients in the exercise = 200 + 20 = **220**

The exercise tool will automatically calculate the number of surge patients based on the number of staffed beds entered by the HCC.

In the tool, the HCC must allocate the total surge patients to the participating clinical care members (e.g., acute care hospitals). The number of patients allocated to a facility will be used to determine sufficiency of available resources such as appropriate, staffed beds, personnel, supplies and equipment, and EMS response resources required to triage and transport patients. This allocation is also a key input into some performance measures used for evaluation purposes during the exercise.

The Clinical Advisor or a designee filling this role should provide details regarding the patient injuries from the incident to be provided to facilities in *Phase II Exercise*. Please note that the goal is to provide the types of injuries patients will have, the number of patients that will be in critical condition, etc., rather than to create a list of conditions and injuries for each individual patient. Facilities will utilize this information to inform patient triage decisions, including estimating the number of surge patients who will require admission and inpatient care. The number of patients requiring admission for inpatient care is used to calculate MRSE performance measures.

3.4 IDENTIFYING ANTICIPATED RESOURCES REQUIRED FOR THE SURGE

This step should be completed with input from the HCC's Clinical Advisor or a designee filling this role. The exercise focuses on the HCC and participating members' ability to share information and ensure availability of key resources to care for patients during a large-scale

surge. The exercise is meant to be highly flexible and tailored to an HCC-defined incident. Therefore, in this step, the HCC will define other resources it anticipates being required to manage the surge. In addition to staffed bed types selected in the prior step, the resources include personnel, pharmaceutical supplies, equipment, and EMS response resources. HCCs should carefully identify the specific resources required for the incident scenario being exercised. Although lists of resources are provided as options, HCCs are encouraged to identify additional or alternative resource types critical to caring for surge patients during the incident. **This step is critical to the remainder of the exercise and serves as the foundation for some performance measures used for exercise evaluation purposes.** The exercise tool will guide the HCC through the selection process. At the beginning of the Exercise phase, the HCC will confirm its selections from *Phase I: Plan & Scope*.

3.5 IDENTIFYING EXERCISE PARTICIPANTS

HCCs will determine which of its member organizations will participate in the exercise. **All Core Members – hospitals, EMS, emergency management organizations, and public health agencies – are required participants.** The HCC should select additional members to participate based on the scenario or other needs. Key roles such as the Exercise Facilitator, Exercise Evaluator, and Duty Officer (Notification System Representative) are also to be assigned in this step during *Phase I: Plan & Scope*. Core members and additional invited members should be documented in the exercise tool. Similarly, individuals assigned to the required exercise roles should be documented in the exercise tool. The number of invited members to the exercise is used to calculate MRSE performance measures.

3.6 SCHEDULING THE EXERCISE

This exercise does not have a low- or no-notice component although some HCCs may wish to implement the exercise under those conditions. For scheduled exercises, HCCs will contact invited members to confirm a date and time. HCCs should provide guidance to invited members regarding the amount of time they will be expected to participate. However, there is no specific time requirement or time ceiling. In these communications, the HCC may wish to describe the incident scenario and conditions along with some details about the exercise structure. HCCs may determine whether to host the exercise in person or virtually according to their response plan. Sample member invitation language is provided in Table 3 below.

Table 3: Sample Communications – Phase I: Plan & Scope

Communication	Sample Text
<p>Consulting HCC Members</p>	<p>Dear <i>[member name]</i>,</p> <p><i>[HCC name]</i> is making preparations for this year’s Medical Response & Surge Exercise (MRSE), an operations-based exercise required for the Hospital Preparedness Program (HPP) Cooperative Agreement. The exercise will follow the <i>[response plan title]</i>, focusing on response actions such as information sharing and resource mobilization for a large, community-wide surge incident. The proposed incident we are planning to exercise is <i>[scenario description]</i>.</p> <p>HPP encourages HCCs to consult members regarding other exercise requirements which could be met by the MRSE (e.g., Joint Commission or Centers for Medicare & Medicaid). HCCs can incorporate member needs provided they do not change the core objectives of the MRSE or impede our ability to report certain data.</p> <p>If you would like to use the MRSE to serve other exercise needs you have, kindly send us a summary of your requirements, including specific documents or outputs you may require for compliance. We will attempt to build them into this year’s MRSE exercise.</p> <p>Kind regards,</p> <p><i>[Name]</i> <i>[RRC]</i> <i>[HCC name]</i></p>
<p>Participant Invitation</p>	<p>Dear <i>[member name]</i>,</p> <p><i>[HCC name]</i> will conduct this year’s Medical Response & Surge Exercise (MRSE) on <i>[expected date]</i> at <i>[time]</i>. The exercise is expected to last <i>[expected duration]</i>. The MRSE is an operations-based exercise required by the Hospital Preparedness Program (HPP) Cooperative Agreement. The exercise will follow the <i>[response plan title]</i>, focusing on response actions such as information sharing and resource mobilization for a large, community-wide surge incident. The incident we are planning to exercise is <i>[scenario description]</i>.</p> <p>Based on the scenario we plan to exercise, we have identified <i>[member name]</i> as an essential participant in this this year’s exercise.</p> <p>To satisfy HPP cooperative agreement requirements – all core HCC members (hospitals, emergency medical services, emergency management organizations, and public health agencies) are required participants. Further, HPP requires executives from core member institutions to participate in the After-Action Review, which is scheduled for <i>[date/time]</i>.</p> <p><i>[instructions for how to participate in the exercise]</i></p> <p>Kindly confirm your intention to participate by responding to this message with the name/s of the individual/s who will represent your organization.</p> <p><i>[Name]</i> <i>[RRC]</i> <i>[HCC name]</i></p>

4.0 PHASE II: EXERCISE

This phase begins when the Exercise Facilitator kicks off the exercise on the scheduled day. This phase will largely follow the standard response actions included in the Health Care Coalition Response Plan or other jurisdictional response plan.⁴ The participants may consult the Situation Manual, but the Exercise Planning and Evaluation Tool will guide the Exercise Facilitator and Evaluator through the exercise actions and provide guidance for data collection required at each step.

4.1 RESPONSE ACTIONS IN THE EXERCISE

The exercise follows the standard response actions included in the HCC's jurisdictional response plan (i.e., the HCC Response Plan). The participants will conduct these actions in concert with scenario-specific challenges designed to stress the health system. The exercise is intended to be very challenging and stress the overall surge capacity of the HCC; it is expected that most HCCs will not be able to complete all tasks fully. Pushing such stresses on the community health system is important for testing your current response systems, identifying gaps in preparedness, and informing improvement planning. The exercise tool will guide the participants through required tasks and collect all data required to support evaluation of the exercise. The HCC should conduct incident response actions as they are defined in the HCC or other jurisdictional response plan. The general flow of the exercise includes the following actions:

1. HCC **recognizes** event through appropriate channels (exercise starts).
2. HCC **activates** its response plan or equivalent.
3. HCC **notifies** exercise participants that an incident has occurred and provides preliminary information to include anticipated patient numbers type(s), resource requirements, and any other relevant information to assist hospitals in preparing for the surge (e.g., timelines).
4. HCC **mobilizes** its incident management team (if applicable) or will work within its existing jurisdictional response framework.

⁴ Assistant Secretary for Preparedness and Response. 2017. [Healthcare Coalition Response Plan](https://asprtracie.hhs.gov/technical-resources/resource/4525/healthcare-coalition-response-plan).
<https://asprtracie.hhs.gov/technical-resources/resource/4525/healthcare-coalition-response-plan>

5. Exercise participants manage a series of challenges related to **ongoing situational awareness, information sharing, resource coordination, and patient tracking.**
6. End exercise.

4.2 Step 1: Start Exercise

The Exercise Facilitator triggers the exercise incident response by contacting the Duty Officer (Notification System Representative). Reading from the script provided in the exercise tool, the Exercise Facilitator initiates direct communications with the Duty Officer (Notification System Representative). Although the exercise materials refer to this role as the “Duty Officer” for simplicity, the HCC should follow its governing response plan for receiving notice of the incident.

The Exercise Facilitator provides details of the incident to the Duty Officer: i) incident location, ii) anticipated scale, and iii) likely number of patients and injuries. The Exercise Facilitator will clearly communicate that the incident is an exercise, no patients will be moved or otherwise disturbed, and no actual resources will be used or moved. The Duty Officer (Notification System Representative) recognizes the incident as defined in the HCC’s response plan.

The Exercise Evaluator documents the start time in the exercise tool.

4.3 Step 2: Activation

In this step, the Duty Officer (Notification System Representative) begins the process to activate the response, designating the response level appropriate to the surge incident communicated by the RRC. The response level should follow the HCC’s response plan or other jurisdictional response plan.

4.4 Step 3: Notification

The HCC should determine which of its members should be notified based on the surge type and scale as per the HCC or other jurisdictional response plan. HPP encourages HCCs to notify all members regardless of their formal participation in the exercise. The HCC completes the required notification steps using the defined notification channels. Notified members are requested to acknowledge and respond to initial emergency notification by a deadline determined by the HCC. Sample notification text is provided in Table 4 below. In the Exercise Planning and Evaluation Tool (exercise tool), the Exercise Evaluator documents the list of notified members.

In the exercise tool, the Exercise Evaluator documents the notified members who acknowledged

and responded to the notification, and whether they acknowledged the notification within the time requested by the HCC. The tool will also calculate the percent of contacted members who acknowledged and responded to the initial emergency notification (MRSE PM14).

4.5 Step 4: Mobilization

In this step, the HCC will mobilize the response team (e.g., Incident Management Team, if applicable) using the defined process in the HCC's response plan. The Exercise Evaluator documents the time the HCC or team was mobilized and meets for the first time (virtual or in person per the HCC's response plan). The Exercise Evaluator documents attendance at the first meeting of the HCC against the participants identified in *Phase I: Plan & Scope* (Performance Measure N1). The tool will calculate the time (in minutes) between the incident trigger (start of the exercise) and the time the HCC was mobilized and met for the first time.

4.6 Step 5: Incident Operations

Once the HCC is mobilized, the members will confirm the anticipated resource needs documented during *Phase I: Plan & Scope*. The members will review the incident scenario, scale, total number of patients, as well as the anticipated resource requirements pre-established in the exercise tool. They will confirm or modify all resource needs – staffed bed types, personnel, pharmaceuticals, supplies and equipment, EMS-related assets, and other first responder resources. This final set of requirements will serve as the foundation for the remainder of the exercise. Final selections are documented in the exercise tool by the Exercise Evaluator.

Information Sharing and Resource Coordination

In this step, the HCC will be communicating with participating members to maintain situational awareness, share information, assess resource availability, and support identification and sharing of resources. Communication with members during this step should follow the channels articulated in the HCC's governing response plan, although HCCs are encouraged to maintain situational awareness with all HCC members and not only exercise participants. Sample communication language for each need is provided in Table 4 below although HCCs may adapt this language to their needs.

Confirm Availability of EMS Resources. The HCC begins by contacting participating EMS agencies to request current availability of pre-identified, critical EMS-related resources defined in *Phase I: Plan & Scope* (and confirmed in Step 5 above). These EMS resources are required to triage and transport patients during the incident. Sample communications to EMS participants

are provided in Table 4 below. In the exercise tool, the Exercise Evaluator documents the list of EMS agencies contacted, whether they responded (MRSE PM15), whether they responded by the requested deadline, and the HCC's determination regarding the sufficiency of the EMS resources to triage and transport incident patients (MRSE PM18). If HCCs do not have direct relationships or communication with EMS agencies, they should follow the protocol established in their response plans to confirm EMS resource availability (e.g., through an EMS Council, Emergency Communication Center, local Emergency Operations Center, Public Safety Answering Point). The principle goal of this step is to document the availability of appropriate EMS-related resources required to triage and transport surge patients.

Conduct Staffed Bed Census and Patient Allocation. In parallel, the HCC will conduct a current staffed bed census of participating clinical care members for the required and additional bed types. Additional staffed bed types are those identified by the HCC as relevant for the selected surge type during *Phase I: Plan & Scope* (and confirmed in Step 5 above). The exercise tool will clearly state which beds should be censused. In the same communication, the HCC will allocate surge patients to each participating clinical care member (facility). The HCC will send each facility the total number of patients to expect along with their anticipated injuries defined by the Clinical Advisor in *Phase I: Plan & Scope*. Note that injuries are not assigned for each patient. This information will be used by facilities to inform patient triage and determination of the number of patients who will require inpatient care and admission versus outpatient care. Patients who require inpatient care and admission will need an appropriate, staffed bed while patients in need of outpatient care will not in this exercise.

Sample communications for participating clinical care members are provided in Table 4 below. Contacted members are requested to reply within the time limit set by the HCC's response plan. If there is no time limit set in the response plan, the HCC should include a time limit during the exercise via the communication to the member facility. If any surging facility either reports having limited availability of appropriate staffed beds or the HCC determines staffed bed availability is at risk of being insufficient, the HCC may contact other HCC members, neighboring HCCs, or the State Health Authorities for assistance. In the exercise tool, the Exercise Evaluator documents (i) the list of clinical care members (facilities) contacted, (ii) whether they responded (MRSE PM15), (iii) whether they responded by the deadline requested by the HCC, and (iv) the staffed bed counts in their responses.

Confirm Availability of Personnel, Pharmaceutical Supplies, and Equipment. Either after or in the same communication as the staffed bed census request, the HCC will request participating clinical care members to assess the sufficiency of current stock levels of supplies and equipment

identified in *Phase I: Plan & Scope* and confirmed in Step 5. The assessment is based upon the number of surge patients the facility will receive as assigned by the HCC in *Phase I: Plan & Scope*. Participants are asked to determine sufficiency of resource availability for the patients they are receiving due to the incident. The resources are those required for the scenario as defined by the HCC during *Phase I: Plan & Scope* and include personnel, pharmaceutical supplies, and equipment. Participants should report the sufficiency of each resource type separately. Table 4 below contains sample communications text that HCCs may adapt to their needs. For each category or resource (e.g., personnel, staffed beds, and other critical resources) catalogued in the exercise tool, the Exercise Evaluator documents: i) the number of HCC members (including facilities and EMS) who were contacted with an initial information request about resources, ii) the number of HCC members contacted about resources who responded by the deadline requested by the HCC (MRSE PM15), and iii) whether or not sufficient quantities of every pre-identified critical resource type were available at all facilities (MRSE PM16, partially MRSE PM17). If one or more members reports insufficient availability of any one of the resource types, that type should be noted as insufficient for managing the surge.

Support Resource Sharing. The HCC should review responses and assess the availability of the various resource types. If any surging clinical care member either reports having limited/insufficient resource availability or the HCC determines resources are at risk of being insufficient, the HCC contacts other HCC members, neighboring HCCs, or the State Health Authorities to identify available supplies or equipment for the at-risk member. If the HCC identifies alternative sources of insufficient resources, it should also ensure transportation for the resources is available. For each of personnel, staffed beds, and other critical resources, catalogued in the exercise tool, the Exercise Evaluator updates the tables of critical resources, personnel, and staffed beds to reflect any changes in availability. For example, if the one member facility had insufficient critical care physicians, but the HCC was able to identify physicians from another member (where sufficient agreements or privileges are in place) to support the surging facility, the Exercise Evaluator would classify critical care physicians as being sufficient. Table 4 below contains sample text that HCCs may use when communicating with stakeholders about resource sharing. Where additional resources (personnel, pharmaceutical supplies, equipment) are secured to support the surge, adjustments can be made in the exercise tool in the respective tables (MRSE PM16 adjustments, MRSE PM17 adjustments).

Patient Tracking

Confirm Staffed bed Availability for Patients. In this action, the HCC contacts all clinical care facilities receiving surge patients to report: i) number of existing patients at the beginning of the exercise, ii) number of those patients who could be safely discharged to accommodate surge patients, iii) number of surge patients requiring admission for inpatient care based on triage assessment, iv) number of surge patients requiring outpatient care who will not be admitted based on your triage assessment, and v) number of surge patients admitted for inpatient care with an appropriate, staffed bed and after safe discharge of patients from the original patient census.

Table 4 below provides sample communications text that HCCs can adapt to their needs. In the exercise tool, the Exercise Evaluator documents the list of surging facilities contacted as well as the contents of their responses as described in this paragraph.

Tracking Patient Transfer. If patients at one or more facilities do not have an appropriate, staffed bed, the HCC provides the transferring facility with options for receiving facilities and requests the transferring facility to identify an appropriate, staffed bed for patients at receiving facilities as well as engage EMS to identify appropriate transport for each patient. Facilities may use their own transport and both internal and contracted patient transport services, as appropriate for the patient.

Participating surging facilities that have patients without an appropriate, staffed bed are requested to report back to the HCC to confirm: i) the number of patients requiring transport to a receiving facility, ii) the number of patients requiring inpatient care for whom the facility was able to place at a receiving facility with an appropriate, staffed bed *and* with appropriate transport to the receiving facility, iii) the number of patients requiring inpatient care for whom the facility was able to identify an appropriate staffed bed at a receiving facility, but for whom it was unable to identify transport to the receiving facility, and iv) the number of patients for whom it found neither staffed beds nor transport (MRSE PM19 adjustments).

In the exercise tool, the Exercise Evaluator documents the responses from each facility.

Table 4: Sample Communications – Phase II: Exercise

Communication	Sample Text
<p>Incident notification to all HCC members</p>	<p>***EXERCISE EXERCISE EXERCISE EXERCISE***</p> <p>Incident Notification</p> <p>Today, the [HCC name] is conducting the Medical Response & Surge Exercise, an operations-based exercise. [incident description] has occurred. We estimate [number of surge patients] will require immediate triage, transport, and care from our members. If you have been identified as an essential participant in today’s exercise, stay alert for forthcoming communications.</p> <p>We request you to acknowledge receipt of this notification by [deadline].</p> <p>[HCC Representative Name] [Title] [HCC name]</p>
<p>EMS agencies – request availability of transport and other resources</p>	<p>***EXERCISE EXERCISE EXERCISE EXERCISE***</p> <p>Today, the [HCC name] is conducting the Medical Response & Surge Exercise, an operations-based exercise. We are expecting approximately [number of surge patients] to require triage and transport services in the area as a result of [scenario description]. Their injuries include [description of patient conditions or injuries]. Note: this is an exercise so there are no actual surge patients, and no resources or patients are to be moved or otherwise affected during the exercise.</p> <p>Please confirm the current number of the following resources you have available by [deadline].</p> <ul style="list-style-type: none"> • [List of pre-identified, critical EMS resources]. <p>Kind regards, [Name] [Exercise Facilitator] [HCC name]</p>
<p>Clinical care members – current staffed bed census</p>	<p>EXERCISE EXERCISE EXERCISE EXERCISE</p> <p>Today, the [HCC name] is conducting the Medical Response & Surge Exercise, an operations-based exercise which evaluates our capacity to manage a large-scale, community-wide patient surge. We are expecting approximately [number of surge patients] to require care across our region, including [number expected at this member facility] at your facility as a result of [scenario description]. The patients will have injuries, including [patient injuries and conditions]. You must determine how many will require admission for inpatient care and how many patients will be cared for in outpatient settings. Note: this is an exercise so there are no actual surge patients, and no resources or patients are to be moved or otherwise affected during</p>

Communication	Sample Text
	<p>the exercise.</p> <p>Please confirm the current number of staffed beds you have immediately available by the types below. Please respond by <i>[deadline]</i>.</p> <ul style="list-style-type: none"> • Emergency Department beds. • General Medical Unit beds. • ICU beds (SICU, MICU, CCU). • Post Critical Care (Monitored / stepdown) beds. • Surgical Unit beds (pre-op, post-op, & procedural). • <i>[List of additional pre-identified, critical bed types].</i> <p>Kind regards,</p> <p><i>[Name]</i> <i>[Exercise Facilitator]</i> <i>[HCC name]</i></p>
<p>Clinical care members – resource availability (personnel and supplies and equipment)</p>	<p>EXERCISE EXERCISE EXERCISE EXERCISE</p> <p>Today, the <i>[HCC name]</i> is conducting the Medical Response & Surge Exercise, an operations-based exercise which evaluates our capacity to manage a large-scale, community-wide patient surge. We are expecting approximately <i>[number of surge patients]</i> to require care across our region, including <i>[number expected at this member facility]</i> at your facility as a result of <i>[scenario description]</i>. Their injuries include <i>[description of patient conditions or injuries]</i>. Note: this is an exercise so there are no actual surge patients, and no resources or patients are to be moved or otherwise affected during the exercise.</p> <p>If you receive <i>[number of patients expected at this facility]</i>, will you have sufficient or insufficient immediate availability of the following resources? For those resources which may experience shortages, please indicate if you require HCC support in identifying alternative sources. Kindly reply by <i>[deadline]</i>.</p> <ul style="list-style-type: none"> • <i>[List of pre-identified, critical personnel types required to manage patient surge].</i> • <i>[list of pre-identified, critical supplies and equipment required to manage patient surge].</i> • Would you require HCC support in identifying alternative sources of these resources? If so, which? <p>Kind regards,</p> <p><i>[Name]</i> <i>[Exercise Facilitator or other title]</i> <i>[HCC name]</i></p>

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Communication	Sample Text
<p>Clinical care – confirm staffed bed availability</p>	<p>EXERCISE EXERCISE EXERCISE EXERCISE</p> <p>In the context of today’s Medical Response & Surge Exercise conducted by [HCC name], we are contacting you to request information about staffed bed availability and patient needs. As a reminder, you have received [number of surge patients expected at this member facility] that require admission to your facility. Their injuries include [description of patient conditions or injuries]. Note: this is an exercise so there are no actual surge patients, and no resources or patients are to be moved or otherwise affected during the exercise.</p> <p>Based on the number of patients expected at your facility, could you kindly note the following by [deadline]?</p> <ul style="list-style-type: none"> a) Number of existing patients at the beginning of the exercise. b) Number of those patients who could be safely discharged to accommodate surge patients. c) Number of surge patients requiring admission for inpatient care based on your triage assessment. d) Number of surge patients requiring outpatient care who will not be admitted based on your triage assessment. e) Number of surge and existing patients requiring admission for inpatient care with an appropriate, staffed bed after patients are discharged. f) Number of patients requiring admission for inpatient care without an appropriate, staffed bed who require transfer to another facility for inpatient care. g) Of those requiring transfer to another facility for care, for how many are you able to identify an appropriate, staffed bed at a receiving facility <i>and</i> appropriate transport? h) Number of patients for whom you are unable to find an appropriate, staffed bed at a receiving facility and/or appropriate transport? <p>Kind regards, [Name] [Exercise Facilitator or other title] [HCC name]</p>
<p>Seeking additional resources from HCC member or other organization</p>	<p>EXERCISE EXERCISE EXERCISE EXERCISE</p> <p>Today, the [HCC name] is conducting the Medical Response & Surge Exercise, an operations-based exercise which evaluates our capacity to manage a large-scale, community-wide patient surge. We are expecting approximately [number of surge patients] to require care across our region due to [scenario description]. Their injuries include [description of patient conditions or injuries]. We have identified a need for additional [personnel / staffed beds / supplies and equipment] to care for patients. Note: this is an exercise so there are no actual surge patients, and no resources or patients are to be moved or otherwise affected during the exercise.</p> <p>Please confirm the availability of the following resources to be shared with members</p>

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Communication	Sample Text
	<p>of [HCC name] to accommodate the large-scale surge inpatients. Kindly reply by [deadline].</p> <ul style="list-style-type: none"> • [list and quantity of resources required]. <p>Kind regards, [Name] [Exercise Facilitator or other title] [HCC name]</p>

4.7 END EXERCISE

If the HCC has set a time limit for the exercise, the Exercise Facilitator should stop the exercise at the designated time. If no specific time limit was established in *Phase I: Plan & Scope*, the HCC should determine the amount of time it wishes to continue to identify available resources and patient transport options to meet the surge requirements. In these cases, the Exercise Facilitator and the RRC may determine when to stop the exercise. The timing of the scheduled AAR in *Phase III: Review (After-Action Discussion and Improvement Planning)* may determine the end of the exercise. As executives are expected to be present during the AAR, scheduling the review in advance will be important to ensure their participation. When the exercise is ended by the Exercise Facilitator, all participating members will be notified and invited to *Phase III: Review* activities. In the exercise tool, the Exercise Evaluator marks the time of the end of the exercise and beginning of the Review phase.

Note: The Medical Response & Surge Exercise is designed to mimic extreme stress on the local health care system. If the exercise is performed correctly, it is expected that most HCCs will not be able to meet 100% of its pre-identified resource requirements to respond to the surge incident. The exercise results – even when “unsuccessful” in some respects – will assist the HCC in determining where challenges exist in its ability to respond to large-scale patient surges.

5.0 PHASE III: REVIEW (AFTER-ACTION DISCUSSION AND IMPROVEMENT PLANNING)

Before beginning *Phase III: Review*, the Exercise Evaluator will ensure all required data are

entered in the exercise tool. Key findings will be documented through the AAR which outlines participant discussion topics, highlighting strengths, areas for improvement, decisions, and recommendations identified by participants during the exercise. The AAR may also identify gaps in: (i) existing resources, roles, and responsibilities, (ii) notification and activation procedures, and (iii) information sharing coordination processes and protocols. It may also capture courses of action and specific resources necessary to implement response activities. The HCC should follow the AAR by creating an IP. *Guidance for both AAR facilitation and documentation as well as IP creation is provided in the Exercise Planning and Evaluation Tool and in the MRSE Evaluation Plan.*

5.1 CONVENING EXECUTIVES FOR THE REVIEW

Although executives are not required to participate in the exercise itself, *HPP requires that at least one executive from each HCC core member organization participates in the Review phase's AAR.* The RRC should ensure participation of executives in the review by confirming their participation in advance. The Exercise Facilitator and Exercise Evaluator will convene the participants for the Review phase. In the exercise tool, the Exercise Evaluator will have already listed the expected participants in the AAR. Once the review begins, the Exercise Evaluator will document which core member organizations were represented by at least one executive (MRSE PM20).

5.2 REVIEWING THE EXERCISE RESULTS

The Exercise Planning and Evaluation Tool and the MRSE Evaluation Plan should be the primary source of guidance for conducting the AAR. The Exercise Evaluator may begin by reviewing the exercise objectives and discussing to what extent the exercise achieved them. The exercise objectives are included in the introduction of this document but are also presented here for convenience:

- Assess an HCC's capacity to support a large-scale, community-wide medical surge incident
- Evaluate a multitude of coalition preparedness and response documents and plans, including specialty surge annexes, transfer agreements, coordination plans with other state HCCs, and all other relevant plans
- Evaluate coalition members' ability to communicate and coordinate quickly to find and match available staffed beds, transportation, supplies and equipment, and personnel during a large-scale surge incident

- Assist HCCs and their members with improvement planning based on MRSE outcomes
- Serve as a data source for performance measure reporting required by the HPP Cooperative Agreement
- Provide a flexible exercise which could be customized to meet the needs and/or exercise requirements of HCCs

QUANTITATIVE RESULTS

The Exercise Evaluator tracks a significant amount of data during the exercise. These data include those data elements required to calculate/evaluate performance measures but also numerous data points for use by the HCC in evaluating its actions during the exercise. The exercise tool provides a dashboard which the Exercise Evaluator should summarize during the AAR, highlighting successes and gaps in the response.

Performance measures as well as evaluation guidelines and assistance for interpreting quantitative results from the exercise can be found in the MRSE Evaluation Plan.

QUALITATIVE DISCUSSION QUESTIONS

The Exercise Planning and Evaluation Tool provides discussion questions in each phase and most actions of the exercise. With the Exercise Evaluator, participants can use these questions to guide AAR discussion and reflect on improvement planning. The responses to these questions are documented in the exercise tool by the Exercise Evaluator in discussion with the RRC, the Exercise Facilitator, and other participants. The Exercise Evaluator can review the responses to these questions to stimulate discussion amongst the review participants.

5.3 IMPROVEMENT PLANNING

In this step, the Exercise Evaluator – in conjunction with the RRC and Exercise Facilitator – leads a discussion with participants to use the outputs of the AAR to develop plans for HCC improvement, including action items, timelines, and associated owners. These plans will be documented in the *Phase III Improvement Plan* tab of the Exercise Planning and Evaluation Tool.

Appendix A: Crosswalk of Staffed Bed Types Between the Surge Estimator Tool and the Medical Response & Surge Exercise

Some HCCs may wish to utilize their most recent SET as the source for staffed bed counts required in *Phase I: Plan & Scope*. To facilitate the use of the SET, below is a crosswalk between the bed types from the SET and their equivalent in the MRSE.

SET Bed Type	MRSE Staffed Bed Type Equivalent
Adult Psychiatric	Psychiatric Unit Beds
Burn Floor Beds	Post Critical Care (Monitored / stepdown) Beds
Burn ICU	ICU Beds (SICU, MICU, CCU)
Closed / Inactive Floor Beds	Not Included in the MRSE
Floor Beds	General Medical Unit Beds
ICU Beds	ICU Beds (SICU, MICU, CCU)
Monitored / Stepdown Beds	Post Critical Care (Monitored / Stepdown) Beds
Neonatal ICU (NICU)	Neonatal ICU Beds
Nursery Beds	Labor and Delivery Unit Beds
Operating Room Beds	Surgical Unit Beds (pre-op, post-op, & procedural)
Pediatric ICU	Pediatric ICU Beds
Pediatric Psychiatric	Psychiatric Unit Beds
Pediatrics Floor Beds (Inpatient)	General Pediatric Unit Beds
Pre-induction, Post Anesthesia and Procedural Beds	Surgical Unit Beds (pre-op, post-op, & procedural)

Appendix B: Glossary

Term	Definition
After-Action Review (AAR)	A document intended to capture observations of an exercise and make recommendations for post-exercise improvements. The final AAR and Improvement Plan (IP) are printed and distributed jointly as a single AAR/IP following an exercise. See Improvement Plan.
Centers for Medicare and Medicaid Services (CMS)	A federal agency that administers the nation’s major health care programs including Medicare, Medicaid, and Children’s Health Insurance Program (CHIP). It collects and analyzes data, produces research reports, and works to eliminate instances of fraud and abuse within the health care system. The CMS Final Rule – which applies to many HCC member types – includes requirements for drills and exercises. Some of these requirements may be met by MRSE in certain situations.
Community	A political entity that has the authority to adopt and enforce laws and ordinances for the area under its jurisdiction. In most cases, the community is an incorporated town, city, township, village, or unincorporated area of a county; however, each State defines its own political subdivisions and forms of government.
Community-wide	A means by which residents, emergency management practitioners, organizational and community leaders, and government officials can collectively understand and assess the needs of their respective communities and determine the best ways to organize and strengthen their assets, capacities, and interests.
Critical Care	Critical care helps people with life-threatening injuries and illnesses. It might treat problems such as complications from surgery, accidents, infections, and severe breathing problems. It involves close, constant attention by a team of specially-trained health care providers. Critical care usually takes place in an ICU or trauma center.

Term	Definition
Disaster	A hazard impact causing adverse physical, social, psychological, economic, or political effects that challenges the ability to respond rapidly and effectively. Despite a stepped-up capacity and capability (call-back procedures, mutual aid, etc.) and change from routine management methods to an incident command/management process, the outcome is lower than expected compared with a smaller scale or lower magnitude impact (see “emergency” for important contrast between the two terms).
Emergency	A hazard impact causing adverse physical, social, psychological, economic, or political effects that challenges the ability to respond rapidly and effectively. It requires a stepped-up capacity and capability (call-back procedures, mutual aid, etc.) to meet the expected outcome, and commonly requires change from routine management methods to an incident command process to achieve the expected outcome (see “disaster” for important contrast between the two terms).
Emergency Management	Includes Federal, State, territorial, tribal, substate regional, and local governments; non-governmental organizations (NGOs); private sector organizations; critical infrastructure owners and operators; and all other organizations and individuals who assume an emergency management role.
Emergency Medical Services (EMS)	Services, including personnel, facilities, and equipment required to ensure proper medical care for the sick and injured from the time of injury to the time of final disposition (which includes medical disposition within a hospital, temporary medical facility, or special care facility; release from the site; or being declared dead). EMS specifically includes those services immediately required to ensure proper medical care and specialized treatment for patients in a hospital and coordination of related hospital services.

Term	Definition
Emergency Support Function-8 (ESF-8)	<p>ESF-8 provides the mechanism for coordinated federal assistance to supplement state, tribal, and local resources in response to the following:</p> <ul style="list-style-type: none"> • Public health and medical care needs. • Veterinary and/or animal health issues in coordination with the U.S. Department of Agriculture (USDA). • Potential or actual incidents of national significance. • A developing potential health and medical situation. <p>Reference: “Emergency Support Functions.” Public Health Emergency. http://www.phe.gov/Preparedness/support/esf8/Pages/default.aspx#8. Accessed 6 Aug. 2020.</p>
Evacuation	The organized, phased, and supervised withdrawal, dispersal, or removal of patients, personnel, and visitors from dangerous or potentially dangerous areas.
Exercise	An instrument to train for, assess, practice, and improve performance in <i>prevention, protection, response, and recovery capabilities</i> in a risk-free environment. Exercises can be used for: testing and validating policies, plans, procedures, training, equipment, and interagency agreements; clarifying and training personnel in roles and responsibilities; improving interagency coordination and communications; identifying gaps in resources; improving individual performance; and identifying opportunities for improvement.
Functional Exercise	A single- or multi-agency operations-based exercise designed to evaluate capabilities and multiple functions using a simulated response. Characteristics of a functional exercise include simulated deployment of resources and personnel, rapid problem solving, and a highly stressful environment.
Hazard	Something that is potentially dangerous or harmful, often the root cause of an unwanted outcome.

Term	Definition
Hazard vulnerability analysis (HVA)	A systematic approach to identifying all hazards that may affect an organization and/or its community, assessing the risk (probability of hazard occurrence and the consequence for the organization) associated with each hazard, and analyzing the findings to create a prioritized comparison of hazard vulnerabilities. The consequence, or “vulnerability,” is related to both the impact on organizational function and the likely service demands created by the hazard impact.
Health care coalition (HCC)	A group of individual health care and response organizations (e.g., hospitals, EMS, emergency management organizations, public health agencies, etc.) in a defined geographic location. HCCs play a critical role in developing health care delivery system preparedness and response capabilities. HCCs serve as multi-agency coordinating groups that support and integrate with ESF-8 activities in the context of incident command system (ICS) responsibilities.
Health care coalition (HCC) member	An entity within the HCC’s defined boundaries that actively contributes to HCC strategic planning, operational planning and response, information sharing, and resource coordination and management. Membership is evidenced by memoranda of understanding (MOU), letters of agreement, and/or attendance at an HCC meeting in the past fiscal year. Representation can be achieved through an authorized representative from the member organization or an authorized representative of a group or network of member organizations (e.g., an integrated health care delivery system or corporate network). In instances where there are multiple entities of an HCC member type, there may be a subcommittee structure that establishes a lead entity to communicate common interests to the HCC (e.g., multiple dialysis centers forming a subcommittee). For example, if a subcommittee lead participates in an HCC meeting, the members engaged in that subcommittee (through MOU, letters of agreement, and/or attendance at a subcommittee meeting in the past budget year) are also considered represented.

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Term	Definition
Health care executive	A decision-maker for his/her respective organization and should have decision-making power that includes, but is not limited to, allocating or reallocating resources, changing staffing roles and responsibilities, and modifying business processes in his/her organization. Typical titles of executives with decision-making power include: Chief Executive Officer, Chief Operating Officer, Chief Medical Officer, Chief Clinical Officer, Chief Nursing Officer, State and/or Local Director of Public Health, Director of Emergency Management, Administrator on Duty, or Chief of EMS, among others.
Health care facility	Any asset where point-of-service medical care is regularly provided or provided during an incident. It includes hospitals, integrated health care systems, private physician offices, outpatient clinics, nursing homes, and other medical care configurations. During an emergency response, alternative medical care facilities and sites where definitive medical care is provided by EMS and other field personnel would be included in this definition.
Homeland Security Exercise and Evaluation Program (HSEEP)	Doctrine and policy provided by the U.S. Department of Homeland Security for the design, development, conduct, and evaluation of preparedness exercises. The terminology and descriptions related to exercise in this document is a Homeland Security industry application of emergency management concepts and principles.
Improvement Plan	Identifies specific corrective actions, assigns them to responsible parties, and establishes targets for their completion.
Incident	An occurrence, natural or human-caused, that requires a response to protect life or property. Incidents can, for example, include major disasters, emergencies, terrorist attacks, terrorist threats, civil unrest, wildland and urban fires, floods, hazardous materials spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, tropical storms, tsunamis, war-related disasters, public health and medical emergencies, and other occurrences requiring an emergency response.

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Term	Definition
Incident command system (ICS)	The combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.
Incident management team (IMT)	An Incident Commander and the appropriate Command and General Staff personnel assigned to an incident. The level of training and experience of the IMT members, coupled with the identified formal response requirements and responsibilities of the IMT, are factors in determining “type,” or level, of IMT.
Joint Commission	An independent, not-for-profit organization that accredits and certifies health care organizations and programs in the United States. Joint Commission accreditation and certification standards are the basis of an objective evaluation process designed to help health care organizations measure, assess, and improve performance. The Joint Commission in EM03.01.03 requires two emergency response exercises (at least one to include an escalating event where the local community is unable to support the event), and at least one to include participation in a community-wide exercise. MRSE may meet a hospital’s Joint Commission exercise requirements in some cases.
Jurisdiction	A range or sphere of authority. Public agencies have jurisdiction at an incident related to their legal responsibilities and authority. Jurisdictional authority at an incident can be political or geographical (e.g., Federal, State, tribal, local boundary lines) or functional (e.g., law enforcement, public health, school).
Medical Surge	The ability to evaluate and care for a markedly increased volume of patients that exceeds normal operating capacity.
Member	HCC members that represent a type of facility or organization (e.g., all nursing facilities, all hospitals, or all EMS agencies within one HCC).
Participating	A member organization or executive is considered participating if they are physically or remotely connected to the exercise and AAR in real time.

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Term	Definition
Resources	Personnel and major items of equipment, supplies, and facilities available or potentially available for assignment to incident operations and for which status is maintained.
Response	Activities that address the short-term, direct effects of an incident. Response includes immediate actions to save lives, protect property, and meet basic human needs. Response also includes the execution of emergency operations plans and of mitigation activities designed to limit the loss of life, personal injury, property damage, and other unfavorable outcomes.
Stakeholders	Includes HCC core members—hospitals, EMS, emergency management organizations, and public health agencies—additional HCC members, and the ESF-8 (Public Health and Medical Services) lead agency.
Surge Capacity	The ability to manage a sudden influx of patients. It is dependent on a well-functioning ICS and the variables of space, supplies, and staff. The surge requirements may extend beyond placing patients into staffed beds and should include all aspects related to clinical services (e.g., laboratory studies, radiology exams, operating rooms).
Surge Capability	The ability to manage patients requiring very specialized medical care. Surge requirements span a range of medical and health care services (e.g., expertise, information, procedures, or personnel) that are not normally available at the location where they are needed (e.g., pediatric care provided at non-pediatric facilities or burn care services at a non-burn center). Surge capability also includes special interventions in response to uncommon and resource intensive patient diagnoses (e.g., Ebola, radiation sickness) to protect medical providers, other patients, and the integrity of the medical care facility.

Appendix C: Guidance for Using a Real-world Incident in Lieu of the MRSE

The MRSE was designed as a functional exercise thus the associated documents and tools were developed with that point in mind. However, HCCs may utilize information from a real-world incident to meet the HPP requirements associated with the MRSE, including reporting program performance measures. Real-world incidents must adhere to the parameters articulated in section 2.9 of the SitMan.

As HCCs are required to use the Exercise Planning and Evaluation Tool to report on its real-world incidents, there are specific points in the exercise which must be adapted. Guidance for how to complete the three exercise phases for real-world incidents follows below.

Phase I Plan & Scope

Information about the HCC's real-world incident must be retrofitted to the exercise requirements during this phase. HCCs must enter all required data in the Exercise Planning and Evaluation Tool.

- Consult HCC Members – note if the real-world incident is being used to meet accreditation or other exercise requirements of its members.
- Define the Surge Scenario – describe the real-world incident, including the surge type options in the tool.
- Calculate the Scale of the Surge – enter the total staffed beds in the HCC for the required types and the optional bed types used during the real-world incident. If the number of patients requiring inpatient admission to a member facility in the real-world incident is not greater than or equal to the figure calculated by the tool, the real-world incident does not qualify for use in lieu of the MRSE. For example, if the tool calculates a surge of 200 patients and the HCC's real-world incident involved inpatient care is for 150 patients, the incident does not meet HPP requirements.
- Identifying Anticipated Resources for the Surge – in consultation with the HCC Clinical Advisor or other designee, the HCC should review the real-world incident and identify the resources it would require to meet surge needs during a similar event in the future. Selections may or may not correspond to those

actually used during the real-world incident.

- Identifying Exercise Participants – in this section, HCCs should identify the members who were required to meet the surge needs of the real-world incident, regardless of their actual participation in the response to the incident.
- Scheduling the Exercise – HCCs should enter the date of the real-world incident.
- Qualitative Questions – HCCs should attempt to answer all relevant qualitative questions for the phase to support improvement planning.

Phase II Exercise

For this phase, HCCs should consult their records to document the actions of the real-world incident response such as mobilization of the HCC response team. It can review its communications systems to document responsiveness of its members to information requests and other communications sent by the HCC. The HCC should document the number of patients for whom its members were able to secure an appropriate staffed bed within a reasonably short time. Additionally, it should document surging facilities' resource availability, including facilities who may have experienced shortages of staffed beds, personnel, and supplies and equipment during the real-world incident. If any patients required transport between facilities to receive an appropriate, staffed bed and associated care, HCCs can document this in the Exercise Planning and Evaluation Tool. The HCC should attempt to answer all relevant qualitative questions for the phase to support improvement planning.

Phase III Review

Real-world incidents which require activation of the HCCs response plan will require an AAR and associated improvement planning. Each HCC should utilize the Exercise Planning and Evaluation Tool to guide its AAR and improvement planning.



Medical Response & Surge Exercise (MRSE) Evaluation Plan

Hospital Preparedness Programs

September 2021



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1.0 INTRODUCTION

The **Medical Response & Surge Exercise (MRSE)** was created by the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR). The exercise procedures and supporting materials described in the Situation Manual (SitMan) and this Evaluation Plan are aligned with updated the Federal Emergency Management Agency (FEMA) Homeland Security Exercise and Evaluation (HSEEP) guidelines issued in 2020. MRSE is a functional exercise, which HSEEP describes as “an operations-based exercise designed to test and evaluate capabilities and functions while in a realistic, real-time environment.”

MRSE and this Evaluation Plan were produced with input, advice, and assistance from the National Healthcare Preparedness Programs’ (NHPP) Exercise Design Team (hereafter referred to as “Design Team”). This team included NHPP representatives as well as a number of emergency preparedness and response subject matter experts from federal, state, and private sector organizations.

This Evaluation Plan provides Exercise Evaluators the information needed to evaluate the ability of respective agencies/organizations to facilitate the care and transportation of patients due to surge, with a focus on the processes for requesting, coordinating, and employing resources at the local, state, and federal levels. The information in this document is current on the date of publication and is subject to change.

For more information about the requirements of the Hospital Preparedness Program (HPP) Cooperative Agreement, please contact your regional HPP Field Project Officer. For more information about HPP and/or MRSE evaluation, you may also contact the Evaluation Branch of HHS/ASPR/Office of Strategy, Planning, Policy, and Requirements (SPPR) at msharper@hhs.gov.

1.1 RELATED DOCUMENTS AND TOOLS

This exercise requires the use of three documents:

- **Situation Manual** – The core document provided to all participants in an exercise. It provides in-depth instructions for how to plan and conduct the MRSE.

- **Evaluation Plan (this document)** – Outlines the goals and purpose of exercise evaluation for a health care coalition (HCC) and guides the Exercise Evaluator (see section 3.2 Assigning an Exercise Evaluator below) through assisting during the exercise, gathering information, and facilitating the After-Action Review (AAR). The Evaluation Plan helps the Exercise Evaluator turn information collected during the exercise into a meaningful AAR and Improvement Plan (IP) in concert with exercise participants.
- **Exercise Planning and Evaluation Tool** – The Excel-based tool is used primarily by the Exercise Evaluator to document decisions and results throughout the exercise, including the *Phase I: Plan & Scope* and *Phase III: Review*. The tool includes sequentially organized tabs that may be viewed by clicking on each tab’s name at the bottom of the screen. All required exercise data collection – including data for HPP Cooperative Agreement performance measures will be completed in the Exercise Planning and Evaluation Tool.

2.0 EXERCISE OVERVIEW

2.1 BACKGROUND

ASPR leads the country in preparing for, responding to, and recovering from the adverse health effects of emergencies and disasters. ASPR’s programs improve the nation’s ability to withstand adversity, strengthen health and emergency response systems, and enhance national health security. This portfolio of programs and activities, which includes the Hospital Preparedness Program (HPP) Cooperative Agreement, engages health care stakeholders from all 50 states, U.S. territories, freely associated states, major metropolitan areas, and Washington, D.C., as well as from across the health care industry, empowering private health care to share ownership in addressing the risks and vulnerabilities across the spectrum of disaster care delivery. The portfolio represents a collection of building blocks that form a comprehensive, national system for health care preparedness and response.

ASPR’s HPP is the primary source of federal funding specifically for health care delivery system readiness. The HPP Cooperative Agreement aims to improve patient outcomes, minimize the need for federal and supplemental state resources during emergencies, and enable rapid recovery from catastrophic events through the development of health

care coalitions (HCCs). HCCs incentivize and support diverse and often competitive health care organizations with differing priorities and objectives to work together to save lives during disasters and emergencies that exceed the day-to-day capacity and capability of individual health care and emergency response systems. HCCs serve an important communication and coordination role within their jurisdictions, given the many public and private entities that must come together to ensure health care delivery system readiness.

To describe what health care delivery system partners, including HCCs, health care organizations, and emergency medical services (EMS), must do to effectively prepare for and respond to emergencies, ASPR developed the 2017-2022 Health Care Preparedness and Response Capabilities. Medical Surge, listed as Capability Four, is the ability to evaluate and care for a markedly increased volume of patients that exceeds normal operating capacity. Providing an effective medical surge response is dependent on the planning and response capabilities developed by HCCs and other stakeholders. Medical surge requires building capacity and capability.¹

Surge capacity is the ability to manage a sudden influx of patients. It is dependent on a well-functioning incident command system (ICS) and the variables of space, supplies, and staff. The surge requirements may extend beyond placing patients into beds and should include all aspects related to clinical services (e.g., laboratory studies, radiology exams, operating rooms).

Surge capability is the ability to manage patients requiring very specialized medical care. Surge requirements span a range of medical and health care services (e.g., expertise, information, procedures, or personnel) that are not normally available at the location where they are needed (e.g., pediatric care provided at non-pediatric facilities or burn care services at a non-burn center). Surge capability also includes special interventions in response to uncommon and resource intensive patient *diagnoses* (e.g., *Ebola*, *radiation sickness*) to

This MRSE is designed to examine and evaluate the ability of HCCs and other

¹ Office of the Assistant Secretary for Preparedness and Response. [2017-2022 Health Care Preparedness and Response Capabilities](https://www.phe.gov/Preparedness/planning/hpp/reports/Documents/2017-2022-healthcare-pr-capabilities.pdf).
<https://www.phe.gov/Preparedness/planning/hpp/reports/Documents/2017-2022-healthcare-pr-capabilities.pdf>. Accessed August 2021.

stakeholders to support medical surge, and specifically, how coalitions help patients receive the care they need at the right place, at the right time, and with the right resources during medical surge; decrease deaths, injuries, and illnesses resulting from medical surge; and promote health care delivery system resilience in the aftermath of medical surge.

2.2 CONFIDENTIALITY

All exercise participants should use appropriate guidelines to ensure proper control of information within their areas of expertise and protect this material in accordance with current directives. Exercise participants should follow their existing policies and procedures with regard to information security and confidentiality. In accordance with the HIPAA 1974 Privacy Act, no individual patient information should be shared as a part of this exercise². Information about surge patients provided in MRSE materials is hypothetical in nature and will not reflect information related to any real patients.

ASPR will use the information submitted by HCCs and HPP recipients to evaluate and inform progress in achieving evidence-based benchmarks and objective standards; performance measures data, including data from local health departments; outcomes of annual preparedness exercises including strengths, weaknesses and associated corrective actions; and accomplishments highlighting the impact and value of the HPP activities in their jurisdictions. Information provided by HCCs and HPP recipients from the MRSE may also be used to inform the future design of the national program. As such, HCCs and recipients are requested to ensure all data accurately reflect the HCC's experience during the exercise.

2.3 PURPOSE AND SCOPE

The purpose of the MRSE is to provide HCCs and their members with an opportunity to test their surge response and preparedness capabilities. The scenario used in the MRSE is defined by the HCC, but all exercises will test an HCC and its members' capacity to

² [The Privacy Act of 1974](#).

<https://www.hhs.gov/foia/privacy/index.html>. Accessed August 2021.

accommodate a surge of patients equal to at least 20% of its staffed bed capacity³ and to ensure availability of staffed beds, supplies and equipment, and personnel across its membership.

2.4 EXERCISE OBJECTIVES

The exercise includes six required objectives. However, HCCs may develop additional objectives to meet the needs of their members provided the standard actions in the exercise are followed in order to meet HPP Cooperative Agreement requirements. Due to the flexibility of the exercise scenario, HCCs may include additional objectives which support their members in meeting additional exercise requirements (e.g., Joint Commission, Centers for Medicare and Medicaid Services (CMS), state and local jurisdictional requirements, etc.) apart from the HPP requirements.

The Design Team identified the following standard objectives for the MRSE functional exercise:

- Assess an HCC's capacity to support a large-scale, community-wide medical surge incident
- Evaluate a multitude of coalition preparedness and response documents and plans, including specialty surge annexes, transfer agreements, coordination plans with other state HCCs, and all other relevant plans
- Evaluate coalition members' ability to communicate and coordinate quickly to find and match available staffed beds, transportation, supplies and equipment, and personnel during a large-scale surge incident
- Assist HCCs and their members with improvement planning based on MRSE outcomes
- Serve as a data source for performance measure reporting required by the HPP Cooperative Agreement
- Provide a flexible exercise which could be customized to meet the needs and/or exercise requirements of HCCs

³ Only certain bed types are included in this calculation. Additional bed types may be included based on the incident scenario defined by the HCC. The accompanying Exercise Planning and Evaluation Tool will calculate the number of patients based on inputs from the HCC.

2.5 EXERCISE OUTCOMES

ASPR identified the following required outcomes for the MRSE functional exercise. However, as with the exercise objectives, HCCs are encouraged to include additional expected outcomes based on the needs of their members, such as:

- The HCC has validated all applicable response plans and identified gaps which remain unaddressed.
- The HCC is better prepared to respond to a large-scale surge in patients.
- HCC members have improved their capacity to assess the availability of and secure access to key resources such as staffed beds, personnel, supplies and equipment, and patient transport during a large-scale community incident.
- The HCC has strengthened its role in sharing information, situational awareness, and coordination during a large-scale community incident.

2.6 USING REAL-WORLD EVENTS IN LIEU OF THE MRSE

If the HCC has selected to use a real-world event in lieu of conducting the MRSE, it should consult section 2.9 and Appendix C of the exercise Situation Manual to review parameters and requirements. There are restrictions for the types of real-world events which can be used in lieu of MRSE. Use of the Exercise Planning and Evaluation Tool is required for real-world events. HCCs should conduct Phase I Plan & Scope retroactively based on the real-world event scenario, completing all required data entry for personnel and other resource types as well as members required it would expect to need for the incident. The Situation Manual provides further instruction for how to complete the three phases of the exercise.

3.0 EVALUATION OF THE MRSE

3.1 PURPOSE OF MRSE EVALUATION

The goal of exercise evaluation is to validate strengths, identify areas for improvement, and highlight lessons learned for HCCs and their participating member organizations in a real or simulated response scenario to inform improvement planning. ASPR will use performance measures, AAR, and Improvement Plan information collected through the Exercise Planning and Evaluation Tool and reported annually by HCCs to inform Hospital

Preparedness Program (HPP) Cooperative Agreement evaluation at regional and national levels. Each HCC conducting the MRSE will, through the exercise and subsequent AAR, evaluate the performance of their individual HCC and identify specific strengths, challenges, and lessons learned that their HCC will use to conduct Improvement Plans to strengthen their response plans, policies and procedures, technical assistance requests, coordination efforts, and other improvement efforts. To ensure these evaluation goals are met, each HCC will select an Exercise Evaluator to observe the exercise (including all three exercise phases), to ensure HCCs properly document exercise outcomes, and to document outputs of the AAR and improvement planning. All crucial data to support evaluation will be recorded through the Exercise Planning and Evaluation Tool.

A combination of quantitative and qualitative information is collected through the Exercise Planning and Evaluation Tool to help your Exercise Evaluator and your HCC evaluate HCC response and identify strengths, areas for improvement, and lessons learned. Throughout the exercise, most exercise actions will require the Exercise Evaluator to help exercise participants track specific quantitative data points in the Exercise Planning and Evaluation Tool, some of which will be used to calculate exercise performance measures. Other qualitative data points and observations should be recorded in the Exercise Planning and Evaluation Tool to support the HCC's ability to evaluate the results of the exercise, including conducting the After-Action Report and creating an Improvement Plan.

3.2 ASSIGNING AN EXERCISE EVALUATOR

The Exercise Evaluator may be personnel from the HCC, a member organization, or a third-party. The Exercise Evaluator must be identified before the beginning of *Phase I Plan & Scope*.

Suggested criteria to use when assigning an Exercise Evaluator include:

- Well-versed in the HCC Response Plan
- Willingness and ability to attend for the full exercise, including *Phase I Plan & Scope*, *Phase II Exercise*, and *Phase III Review*
- General knowledge of Medical Surge as defined in the 2017-2022 Health Care Preparedness and Response Capabilities
- Ability to objectively observe and document the actions of exercise participants

- Ability to interpret HCC and member organization actions to respond to qualitative questions
- Proficiency in the basic functions of Microsoft Excel
- Ability to facilitate the AAR with exercise participants
- Ability and willingness to participate in Improvement Plan development

The Exercise Evaluator must be provided with and must dedicate time in advance of the exercise to understanding the following documents:

- The HCC's Response Plan
- The MRSE Situation Manual
- The MRSE Exercise Planning and Evaluation Tool
- The MRSE Evaluation Plan (this document)

3.3 EXPECTED EVALUATION PRODUCTS

The MRSE Exercise Evaluator will participate for the entire duration of the exercise, including Phases I through III. The following required products are the responsibility of the Exercise Evaluator:

A completed Exercise Planning and Evaluation Tool consisting of complete data on the following Exercise Planning and Evaluation Tool tabs:

- *Phase I Plan & Scope*
- *Phase II Exercise Initial Actions*
- *Phase II Exercise Operations*
- *Phase III After-Action Review*
- *Phase III Improvement Plan*

Select data from this tool (highlighted in the self-calculating Performance Measures tab) will be uploaded by the HCC into the Coalition Assessment Tool as part of end-of-year HCC reporting for the HPP Cooperative Agreement and will satisfy the HPP requirement for providing exercise-related performance measure data and AAR and Improvement Plan documentation. Once HCCs and their HPP recipients upload these data into HPP data collection systems (the Coalition Assessment Tool for HCCs and PERFORMS for

recipients) these data will be used for analysis to support program communications and decision-making.

3.4 EVALUATOR INSTRUCTIONS AND GUIDELINES

Exercise Evaluators observe exercise activities and help the HCC collect data, assess data, and analyze data to understand what happened during the exercise, and what strengths, challenges, and lessons learned emerged from the experience. During all phases of the exercise, the Exercise Evaluator will document the actions of the HCC and its members and will help exercise participants to accurately record information in the Exercise Planning and Evaluation Tool. At the end of *Phase II*, the Exercise Evaluator will analyze the collected information to understand the outcomes of the exercise, gather some initial ideas regarding strengths, challenges, and lessons learned, and prepare for the AAR in *Phase III*. In *Phase III*, the Exercise Evaluator will facilitate the AAR with all HCC members participating in the exercise and will help with HCC develop and Improvement Plan. Per the Homeland Security Exercise and Evaluation (HSEEP) guidelines, Exercise Evaluators will be involved in the full lifecycle of the exercise. The Exercise Evaluator must have full access to information during the exercise such as communication between the HCC and members related to resource availability. Exercise Evaluator responsibilities before, during, and after the exercise are outlined in the table below.

Table 1: Exercise Evaluator Responsibilities and Evaluation Products

Exercise Phase	Responsibilities	Evaluation Products
Before the Exercise	<ul style="list-style-type: none"> • Confirm your ability to attend the full MRSE exercise, including <i>Phase I Plan & Scope</i>, which will occur before Phases II and III • Review relevant exercise materials, with special emphasis on the goals and objectives of the exercise and the Exercise Evaluator’s role: <ul style="list-style-type: none"> ▪ The MRSE Situation Manual ▪ The MRSE Exercise Planning and Evaluation Tool 	N/A

Exercise Phase	Responsibilities	Evaluation Products
	<ul style="list-style-type: none"> ▪ The MRSE Evaluation Plan (this document) • Review materials relevant to HCC response (including HCC Response Plan; policies and procedures) 	
Phase I Plan & Scope	<ul style="list-style-type: none"> • Observe exercise participants as they define the surge scenario, calculate the scale of the surge, and identify required resources. While other exercise participants will make these decisions, help participants interpret and correctly define the scale of the surge and the required resources based upon exercise requirements anywhere there is misunderstanding • Certify that the <i>Phase I Plan & Scope</i> is completed and that information on the <i>Phase I Plan & Scope</i> tab of the Exercise Planning and Evaluation Tool is completely and accurately filled in 	Completed <i>Phase I Plan & Scope</i> tab in the Exercise Planning and Evaluation Tool
Phase II Exercise	<ul style="list-style-type: none"> • Report to your respective exercise location no later than one hour before the beginning of your venue’s exercise play • Ensure that your cellphone and satellite phone (if applicable) are with you and are fully charged so that you can communicate with other exercise staff. Bring your cellphone charger with you • Upon arrival at the start of shift, check in with the Readiness and Response Coordinator (RRC) and/or Exercise Facilitator at your location, and introduce yourself to participants • Throughout the exercise, do not prompt players with specific responses or interfere with player performance in any way. The only guidance the Exercise Evaluator should give participants is related to compliance with the exercise requirements themselves • As strengths, challenges, and lessons learned arise, do not discuss these with exercise players. However, 	Completed <i>Phase II Exercise Initial Actions</i> and <i>Phase II Exercise Operations</i> tabs in the Exercise Planning and Evaluation Tool

Exercise Phase	Responsibilities	Evaluation Products
	<p>Exercise Evaluators may talk to players to clarify events and gain insight into their decisions and actions. Record your own private notes on strengths, challenges, and lessons learned for use during facilitation of the AAR</p> <ul style="list-style-type: none"> • The Exercise Planning and Evaluation Tool provides discussion questions in each phase and most actions of the exercise. The responses to these questions are documented in the Exercise Planning and Evaluation Tool by the Exercise Evaluator in discussion with the RRC, the Exercise Facilitator, and other participants. The Exercise Evaluator can review the responses to these questions to stimulate discussion amongst the participants during the AAR. Responses from earlier stages will pre-populate into the <i>Phase III: After-Action Review</i> tab in the Exercise Planning and Evaluation Tool • Ensure the <i>Phase II Exercise Initial Actions</i> and <i>Phase II Exercise Operations</i> tabs are filled in fully and in accordance with the play of the HCC throughout the exercise 	
<p>Phase III After-Action Review</p>	<ul style="list-style-type: none"> • Facilitate discussion during the AAR using the scripts and tables included in the <i>Phase III After-Action Review</i> tab of the Exercise Planning and Evaluation Tool • Collect information regarding which member organizations have at least one executive participating in the AAR using the table in the Exercise Planning and Evaluation Tool • The <i>Phase III After-Action Review</i> tab will populate with information regarding the exercise. Share this with AAR participants so they are able to reflect on the outcome of the exercise • Walk participants through a discussion of strengths and of challenges during the exercise that identified gaps, 	<p>Completed <i>Phase III After-Action Review</i> tab in the Exercise Planning and Evaluation Tool</p>

Exercise Phase	Responsibilities	Evaluation Products
	<p>weaknesses, and areas for improvement. During the discussion, identify how you want participants to share insights (raising hands, speaking out, etc.). Create a comfortable and inclusive environment for sharing and encourage everyone to provide their own observations and perspectives. Solicit all participant insights before offering your own.</p> <ul style="list-style-type: none"> • As participants share feedback, take notes. After receiving feedback, summarize and enter it into the Exercise Planning and Evaluation Tool. Review the contents with participants to ensure the summary reflects the main points of conversation • Document the most significant lessons learned regarding the HCC’s ability to respond to the surge event that point to areas for HCC improvement planning • Ensure the <i>Phase III After-Action Review</i> tab in the Exercise Planning and Evaluation Tool is filled out completely 	
<p>Phase III Improvement Planning</p>	<ul style="list-style-type: none"> • Participate in HCC processes for improvement planning based upon strengths, challenges, and lessons learned documented in the <i>Phase III After-Action Review</i> tab • Exercise Evaluators will support the HCC in using the outputs of the Exercise Planning and Evaluation Tool <i>Phase III After-Action Review</i> tab to develop plans for HCC improvement, including action items, timelines, and associated owners. These plans will be documented in the <i>Phase III Improvement Plan</i> tab of the Exercise Planning and Evaluation Tool • Ensure that the <i>Phase III Improvement Plan</i> tab in the Exercise Planning and Evaluation Tool is filled out completely 	<p>Completed <i>Phase III Improvement Plan</i> tab in the Exercise Planning and Evaluation Tool Completed Exercise Planning and Evaluation Tool</p>

Exercise Phase	Responsibilities	Evaluation Products
	<ul style="list-style-type: none"> Ensure that all tabs of the Exercise Planning and Evaluation Tool are complete and provide the finalized Exercise Planning and Evaluation Tool to the HCC for HCC documentation and submission of required annual HPP Cooperative Agreement data to ASPR 	

3.5 HOSPITAL PREPAREDNESS PROGRAM PERFORMANCE MEASURES

As previously discussed, ASPR will use performance measures, AAR information, and Improvement Plan information collected through the Exercise Planning and Evaluation Tool and reported annually by HCCs to inform Hospital Preparedness Program (HPP) Cooperative Agreement evaluation.

The HPP Cooperative Agreement MRSE Performance Measures (whose results are calculated in the Exercise Planning and Evaluation Tool on the *Performance Measures* tab) will be used by ASPR to assess national and regional performance across HCCs for evaluation of the HPP Cooperative Agreement.

Table 2: HPP Cooperative Agreement MRSE Performance Measures

Performance Measure	Description
PM 14	Percent of contacted HCC members acknowledging initial emergency notification
PM 15	Percent of contacted HCC members who responded to the initial information request
PM 16	Percent of all pre-identified, critical required personnel types that were met by participating HCC members to manage patient surge
PM 17	Percent of all pre-identified, critical resources that were met by participating HCC members to manage patient surge

Performance Measure	Description
PM 18	Percent of all pre-identified, critical EMS resources that were met to safely respond to triage and transportation needs
PM 19 (previously PM 18)	Percent of patients requiring inpatient care who were placed at a receiving facility with an appropriate staffed bed by the end of the exercise
PM 20 (previously 15 for the CST and 24 for the HST)	Percent of HCC core members with at least one executive participating in the exercise AAR
PM 21 (previously PM 23)	Percent of all pre-identified, critical HCC members that participated in the exercise

3.6 PERFORMANCE MEASURES IMPLEMENTATION GUIDANCE

Performance measures to be used by ASPR will be automatically calculated by the Exercise Planning and Evaluation Tool. The descriptions under each performance measure below detail the operational intent of the performance measure, the data points in the Exercise Planning and Evaluation Tool used to calculate the performance measure, and the calculation. *HCCs using real-world events in lieu of MRSE should consult the Situation Manual for how to collect data correctly for these performance measures.*

Performance Measure 14: Percent of contacted HCC members acknowledging initial emergency notification

Operational Intent: This measure provides insight into communication among HCC members during a simulated or real medical surge event.

Data Points in the Exercise Planning and Evaluation Tool: The responses to the data requests outlined below are used to calculate this performance measure.

Numerator	Number of HCC members that that acknowledged initial emergency notification within the time specified by the HCC.
Denominator	Total number of HCC members who were sent the initial emergency notification

Calculation: Number of listed HCC members that acknowledged initial emergency notification within the time specified by the HCC / Total number of HCC members who were sent the initial emergency notification

Performance Measure 15: Percent of contacted HCC members who responded to the initial information request

Operational Intent: This measure provides insight into communication among HCC members during a simulated or real medical surge event

Data Points in the Exercise Planning and Evaluation Tool: The responses to the data requests outlined below are used to calculate this performance measure.

Numerator	Number of HCC members (including facilities and EMS) that acknowledged and responded to the initial information request within the specified amount of time.
Denominator	Number of HCC members (including facilities and EMS) that were contacted with an initial information request.

Calculation: Number of contacted HCC members (including facilities and EMS) that acknowledged and responded to the initial information request within the time specified by the HCC / Total number of HCC members (including facilities and EMS) that were contacted with an initial information request.

Performance Measure 16: Percent of all pre-identified, critical required personnel types that were met by participating HCC members to manage patient surge

Operational Intent: This measure provides insight into an HCC’s ability to provide sufficient personnel support to appropriately respond to a simulated or real medical surge event

Data Points in the Exercise Planning and Evaluation Tool: The responses to the data requests outlined below are used to calculate this performance measure

<p>Numerator</p>	<p>Number of pre-identified, critical required personnel types that were fully met by your HCC and its members to manage patient surge</p> <p>Mark each of the critical personnel types below as ‘fully met’ or ‘had shortages’. Responses are limited to those personnel types identified as critical to the incident by the HCC during Phase I Plan & Scope. Note facilities may be within or outside the HCC’s boundaries as needed by the HCC and the incident being exercised.</p> <p>Personnel Types</p> <ul style="list-style-type: none"> • Critical Care Physicians • Critical Care Nurses • Advanced Practice Nurses • Physicians Assistants • Respiratory Therapists • Pharmacists • Dieticians, Physiotherapists, and Occupational Therapists • Mental Health Clinicians, Social Workers, Chaplaincy, and Clinical Ethicists • Trauma, Emergency Department, and Perioperative Services • Pediatrics, Neonatal, and Obstetric Services • Laboratory and Diagnostic Imaging Services • Environmental Services Staff • Clinical Supply Staff • Sterile Processing Technicians • Facilities and Information Technology • Security • Admin and Finance • Other (describe below)
<p>Denominator</p>	<p>Total number of required personnel types pre-identified as critical to manage patient surge for the incident during the Plan & Scope Phase. HCCs using a real-world event in lieu of MRSE should consult the Situation Manual section for how to complete Phase I Plan & Scope for this performance measure.</p> <p>Personnel Types</p>

	<ul style="list-style-type: none"> • Critical Care Physicians • Critical Care Nurses • Advanced Practice Nurses • Physicians Assistants • Respiratory Therapists • Pharmacists • Dieticians, Physiotherapists, and Occupational Therapists • Mental Health Clinicians, Social Workers, Chaplaincy, and Clinical Ethicists • Trauma, Emergency Department, and Perioperative Services • Pediatrics, Neonatal, and Obstetric Services • Laboratory and Diagnostic Imaging Services • Environmental Services Staff • Clinical Supply Staff • Sterile Processing Technicians • Facilities and Information Technology • Security • Admin and Finance • Other (describe below)
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Calculation: Number of pre-identified personnel types fully met by HCC and its members (critical + optional) / Total number of personnel types pre-identified as critical (critical + optional) for managing patient surge

Performance Measure 17: Percent of all pre-identified, critical resources that were met to manage patient surge

Operational Intent: This measure provides insight into an HCC’s ability to provide sufficient critical resources to appropriately respond to a simulated or real medical surge event

Data Points in the Exercise Planning and Evaluation Tool: The responses to the data requests outlined below are used to calculate this performance measure.

Numerator	<p>Number of required, pre-identified, critical resources (critical + optional staffed beds, pharmaceutical supplies, and equipment type) that were fully met by your HCC and its members to manage patient surge</p> <p>Mark each of the pre-identified critical resource types (critical + optional beds, pharmaceutical supplies, and equipment type) below as ‘fully met’ or ‘had shortages’. For beds, responses are limited to required types and optional types identified as critical to the incident by the HCC during</p>
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Phase I Plan & Scope. For other resource types, responses are limited to those identified as critical to the incident during Phase I Plan & Scope. Note facilities may be within or outside the HCC's boundaries as needed by the HCC and the incident being exercised.

Critical patient care bed types (required)

- Emergency department beds
- General medical unit beds
- ICU beds (SICU, MICU, CCU)
- Post critical care (monitored/stepdown) beds

Surgical unit beds (pre-op, post-op, and procedural)

Other bed types (optional)

- Labor and Delivery Unit beds
- Psychiatric unit beds
- General pediatric unit beds
- Pediatric ICU beds
- Neonatal ICU beds
- Oncology unit beds
- Other (describe below)

Pharmaceutical Supplies

- Analgesia and sedation
- Anesthesia
- Antibiotics and Antivirals
- Tetanus vaccine
- Pressor medications
- Antiemetics
- Respiratory medications
- Anticonvulsant drugs
- Antidotes
- Psychotropic medications
- Other (specify)

Non-pharmaceutical supplies and Equipment Types

- Blood products
- Intravenous Fluids | infusion pumps
- Ventilators
- Bedside monitors
- Airway suction (peds/adults)
- Surgical equipment and supplies
- Other (specify)

<p>Denominator</p>	<p>Total number of required critical resources pre-identified as critical to manage patient surge for the incident during the Plan & Scope Phase. HCCs using a real-world event in lieu of MRSE should consult the Situation Manual section for how to complete Phase I Plan & Scope for this performance measure.</p> <p>Critical patient care bed types (required)</p> <ul style="list-style-type: none"> • Emergency department beds • General medical unit beds • ICU beds (SICU, MICU, CCU) • Post critical care (monitored/stepdown) beds <p>Surgical unit beds (pre-op, post-op, and procedural)</p> <p>Other bed types (optional)</p> <ul style="list-style-type: none"> • Labor and Delivery Unit beds • Psychiatric unit beds • General pediatric unit beds • Pediatric and neonatal ICU beds • Oncology unit beds • Other (describe below) <p>Pharmaceutical Supplies</p> <ul style="list-style-type: none"> • Analgesia and sedation medications (oral and injectable) • Anesthesia medications • Antibiotics (oral and injectable) • Antivirals • Tetanus vaccine • Pressor medications • Antiemetics • Respiratory medications • Anticonvulsant drugs • Antidotes (e.g., atropine, hydroxocobalamin) • Psychotropic medications <p>Non-pharmaceutical supplies and Equipment Types</p> <ul style="list-style-type: none"> • Blood products • Intravenous fluids • Infusion pumps • Ventilators • Bedside monitors • Airway suction (adult and pediatric) • Surgical equipment and supplies
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	<ul style="list-style-type: none"> • Supplies needed to administer pharmaceuticals, blood products, and intravenous fluids • Other (describe below)
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Calculation: Number of pre-identified, critical resources (critical + optional beds, pharmaceutical supplies, and equipment type) met by the HCC and its members / Total number of critical resources (critical + optional beds, pharmaceutical supplies, and equipment type) pre-identified by the HCC required to manage patient surge

Performance Measure 18: Percent of all pre-identified, critical EMS resources that were met to safely respond to triage and transportation needs

Operational Intent: This measure provides insight into an HCC’s ability to provide sufficient EMS resources to appropriately respond to a simulated or real medical surge event

Data Points in the Exercise Planning and Evaluation Tool: The responses to the data requests outlined below are used to calculate this performance measure

Numerator	<p>Number of pre-identified, critical EMS resource types (personnel, transport, supplies & equipment) that were fully met by the HCC and its members to safely respond to triage and transportation needs.</p> <p>For each of the pre-identified, critical EMS resource types (personnel, transport, supplies & equipment) below, mark if it was fully met. Responses are limited to those types identified as critical to the incident by the HCC during Phase I Plan & Scope. Definitions of EMS resources can be found in the EMS National Incident Management System (NIMS). Note participating EMS agencies may be within or outside the HCC’s boundaries as needed by the HCC and the incident being exercised.</p> <ul style="list-style-type: none"> • Ground ambulance (BLS) • Ground ambulance (ALS) • Multi-patient medical transport vehicle • Air ambulance fixed-wing (critical care transport) • Air ambulance fixed-wing (non-critical care transport) • Air ambulance rotary-wing (critical care transport) • Air ambulance rotary-wing (non-critical care transport) • Incident management team (on scene) • Hazmat team • Decontamination Team • Search and Rescue Team
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	<ul style="list-style-type: none"> • Mass Casualty Support Unit • Specialized Protective Equipment • Other (describe below)
Denominator	<p>Total number of required EMS resource types (personnel, transport, supplies & equipment) pre-identified as critical to manage patient surge for the incident during Phase I Plan & Scope.</p> <p>(Select all that apply)</p> <ul style="list-style-type: none"> • Ground ambulance (BLS) • Ground ambulance (ALS) • Multi-patient medical transport vehicle • Air ambulance fixed-wing (critical care transport) • Air ambulance fixed-wing (non-critical care transport) • Air ambulance rotary-wing (critical care transport) • Air ambulance rotary-wing (non-critical care transport) • Incident management team (on scene) • Hazmat team • Decontamination team • Search and Rescue team • Mass Casualty Support Unit • Specialized Protective Equipment • Other (describe below)

Calculation: Number of pre-identified, critical EMS resource types (personnel, transport, supplies & equipment) required to safely respond to patient triage and transportation needs which were fully met by the HCC’s EMS members / Total number of EMS resource types (personnel, transport, supplies & equipment) pre-identified by the HCC as critical for triage and transportation of patients

Performance Measure 19 (Previously PM 18): Percent of patients requiring inpatient care who were placed at a receiving facility with an appropriate staffed bed by the end of the exercise

Operational Intent: This measure demonstrates the ability of an HCC to load share to meet initial patient care needs in a simulated or real medical surge event

Data Points in the Exercise Planning and Evaluation Tool: The responses to the data requests outlined below are used to calculate this performance measure. Note facilities may be within or outside the HCC’s boundaries as needed by the

HCC and the incident being exercised.

Numerator	<ul style="list-style-type: none"> a. Number of surge patients admitted for inpatient care with an appropriate, staffed bed after safe discharge of any patients from the initial census. b. Number of patients requiring inpatient care the facility was able to place at a receiving facility with an appropriate, staffed bed and with appropriate transport to the receiving facility
Denominator	<ul style="list-style-type: none"> c. Total number of patients at all member facilities as reported in the current bed census participating in the exercise d. Number of patients in the initial patient census who could be safely discharged to accommodate surge patients e. Number of surge patients requiring admission for inpatient care based on all facilities' triage assessment

Calculation: (The number of surge patients admitted for inpatient care with an appropriate, staffed bed after safe discharge of any patients from the initial census + number of patients requiring inpatient care the facility was able to place at a receiving facility with an appropriate, staffed bed and with appropriate transport to the receiving facility) / (The total number of patients at all member facilities as reported in the current bed census participating in the exercise - the number of patients in the initial patient census who could be safely discharged to accommodate surge patients + the number of surge patients requiring admission for inpatient care based on all facilities' triage assessment). Shown in equation format: $(a+b)/(c-d+e)$.

Performance Measure 20 (Previously PM 24): Percent of HCC core members with at least one executive participating in the exercise After Action Review

Operational Intent: This measure provides insight into the extent to which HCC core member organizations' executives are engaged in the lessons learned event of the required surge exercise to enable systematic learning

Data Points in the Exercise Planning and Evaluation Tool: The responses to the data requests outlined below are used to calculate this performance measure

Numerator	<p>Number of HCC core members with at least one executive that participated in the exercise AAR below:</p> <ul style="list-style-type: none"> • Hospital • EMS
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	<ul style="list-style-type: none"> • Public Health • Emergency Management
Denominator	<p>Total number of HCC core members required for this exercise. Note at least one-member organization from each category is required to participate in MRSE. However, if the HCC has an HPP-approved waiver for one or more member types, it may reduce or remove the number of required core member participants for the waived categories during Phase I Plan & Scope.</p> <ul style="list-style-type: none"> • Hospital • EMS • Public Health • Emergency Management

Calculation: Number of HCC core members with at least one executive participating in the exercise AAR / Total number of core members.

Performance Measure 21: Percent of all pre-identified, critical HCC members that participated in the exercise

Operational Intent: Participation of HCC members is crucial to truly test preparedness and response capabilities. Thus, this measure is intended to gauge the extent to which HCC core member organizations are engaged in coalition exercises

Data Points in the Exercise Planning and Evaluation Tool: The responses to the data requests outlined below are used to calculate this performance measure

Numerator	<p>Number of pre-identified, critical members of each type who participated in the exercise by member type. Participation is defined as having joined the exercise for at least one of Phase I or Phase II while participating fully in Phase III. For example, if a member joins Phase II and Phase III, the member has participated. A member cannot be considered as having participated by joining only Phase I and Phase II. HCCs may consult the <i>2017-2022 Health Care Preparedness and Response Capabilities</i> for more information about member types.</p> <ul style="list-style-type: none"> • Hospital • Public Health • EMS • Emergency Management • Laboratory
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	<ul style="list-style-type: none"> • Pharmacy • Long Term Care Facility • Nursing Home • Other (specify)
Denominator	<p>Number of pre-identified, critical members of each type to manage patient surge:</p> <ul style="list-style-type: none"> • Hospital • Public Health • EMS • Emergency Management • Laboratory • Pharmacy • Long Term Care Facility • Nursing Home • Other (specify)

Calculation: Number of pre-identified, critical HCC members that participated / Total number of pre-identified, critical HCC members invited to participate in the exercise

Appendix A: After-Action Review Discussion Questions

The Exercise Planning and Evaluation Tool provides discussion questions during each exercise phase. Below is a consolidated list of questions the Exercise Evaluator will ask during the different phases of the exercise. Participants can use these questions to guide AAR and Improvement Plan discussions. The responses to these questions are documented in the Exercise Planning and Evaluation Tool during the AAR by the Exercise Evaluator in discussion with the RRC, the Exercise Facilitator, and other participants.

Exercise Phase/Action	Discussion Questions
Plan & Scope	<ol style="list-style-type: none"> 1. Did all contacted members confirm their availability to participate in the exercise? 2. Will HCC members be using the exercise to meet other requirements? If so, which? <ol style="list-style-type: none"> a. Joint Commission b. CMS c. PHEP d. EMS-related exercise requirements e. Other (please specify)
Incident Recognition	<ol style="list-style-type: none"> 3. How is the HCC notified? 4. Identify Initial Incident Details <ol style="list-style-type: none"> a. What, When, Where b. Responding units c. Reported injuries (approx. # & type) 5. Identify Current Operating Conditions: <ol style="list-style-type: none"> a. Weather b. Traffic c. Other factors impacting operations
Notification	<ol style="list-style-type: none"> 6. What is the primary and secondary system utilized to notify and activate an HCC response? 7. What is the process used to notify and mobilize your support team? 8. What were the primary and secondary systems utilized to alert HCC members?

Exercise Phase/Action	Discussion Questions
Mobilization	9. If applicable, what positions are part of your HCC's incident management team during the exercise? 10. If applicable, what positions were activated for this response? 11. How long did it take for you to activate your support team? 12. Were there any barriers/issues with notification/activation/mobilization?
Incident Operations	13. Were all planned/expected members of your incident management team able to participate in the exercise? 14. Were any barriers faced that would hinder participation?
Information Sharing	15. Which incident reporting system/sharing platform is used by the HCC to collect and share information (e.g., CST 2.0 tool to provide dropdowns of known systems with options for others)? 16. Who maintains this system? 17. Who from the HCC has access to the system? 18. What process do you use to manage ongoing requests for information from HCC members and other stakeholders?
Resource Coordination	19. Describe the process used to manage and coordinate resources (staff, supplies, equipment, etc.) 20. What process do you use to manage requests for resources from HCC members and other stakeholders? 21. What process do you use to facilitate the management and distribution of resources across HCC members?
Patient Tracking	22. Was mutual aid required? Were there any issues or concerns? 23. What additional resources does EMS require (staff, equipment, etc.) to care and transport patients? 24. Based on the chosen scenario, what is the estimated EMS response time? 25. What is the process for EMS to provide updates to hospitals? 26. Who is responsible for determining patient transport locations? 27. Based on the chosen scenario, what is the estimated time that it takes EMS to triage and transport all patients to a receiving facility?

Appendix B: Glossary

Term	Definition
After-Action Review (AAR)	An After-Action Review is a facilitated discussion to identify strengths, challenges, gaps, and weaknesses, and lessons learned. Information from the After-Action Review should be used for improvement planning.
Improvement Plan	The Improvement Plan identifies specific corrective actions, assigns them to responsible parties, and establishes targets for their completion.
Community	A political entity that has the authority to adopt and enforce laws and ordinances for the area under its jurisdiction. In most cases, the community is an incorporated town, city, township, village, or unincorporated area of a county; however, each State defines its own political subdivisions and forms of government.
Community-wide	A means by which residents, emergency management practitioners, organizational and community leaders, and government officials can collectively understand and assess the needs of their respective communities and determine the best ways to organize and strengthen their assets, capacities, and interests.
Disaster	A hazard impact causing adverse physical, social, psychological, economic or political effects that challenges the ability to respond rapidly and effectively. Despite a stepped-up capacity and capability (call-back procedures, mutual aid, etc.) and change from routine management methods to an incident command/management process, the outcome is lower than expected compared with a smaller scale or lower magnitude impact (see “emergency” for important contrast between the two terms).
ESF-8	<p>ESF-8 provides the mechanism for coordinated federal assistance to supplement state, tribal, and local resources in response to the following:</p> <ul style="list-style-type: none"> • Public health and medical care needs • Veterinary and/or animal health issues in coordination with the U.S. Department of Agriculture (USDA) • Potential or actual incidents of national significance • A developing potential health and medical situation <p>Reference “Emergency Support Functions.” Public Health</p>

Term	Definition
	<p>Emergency. http://www.phe.gov/Preparedness/support/esf8/Pages/default.aspx#8. Accessed 6 Aug. 2020.</p>
Emergency	<p>A hazard impact causing adverse physical, social, psychological, economic or political effects that challenges the ability to respond rapidly and effectively. It requires a stepped-up capacity and capability (call-back procedures, mutual aid, etc.) to meet the expected outcome, and commonly requires change from routine management methods to an incident command process to achieve the expected outcome (see “disaster” for important contrast between the two terms).</p>
Emergency Management	<p>Includes Federal, State, territorial, tribal, substate regional, and local governments, nongovernmental organizations (NGOs), private sector organizations; critical infrastructure owners and operators, and all other organizations and individuals who assume an emergency management role.</p>
Emergency Medical Services (EMS)	<p>Services, including personnel, facilities, and equipment required to ensure proper medical care for the sick and injured from the time of injury to the time of final disposition (which includes medical disposition within a hospital, temporary medical facility, or special care facility; release from the site; or being declared dead). EMS specifically includes those services immediately required to ensure proper medical care and specialized treatment for patients in a hospital and coordination of related hospital services.</p>
Evacuation	<p>The organized, phased, and supervised withdrawal, dispersal, or removal of patients, personnel, and visitors from dangerous or potentially dangerous areas.</p>
Exercise	<p>An instrument to train for, assess, practice, and improve performance in <i>prevention, protection, response, and recovery capabilities</i> in a risk-free environment. Exercises can be used for: testing and validating policies, plans, procedures, training, equipment, and interagency agreements; clarifying and training personnel in roles and responsibilities; improving interagency coordination and communications; identifying gaps in resources; improving individual performance; and identifying opportunities for improvement</p>

Term	Definition
Functional Exercise	A single- or multi-agency operations-based exercise designed to evaluate capabilities and multiple functions using a simulated response. Characteristics of a functional exercise include simulated deployment of resources and personnel, rapid problem solving, and a highly stressful environment.
Hazard	Something that is potentially dangerous or harmful, often the root cause of an unwanted outcome.
Health care coalition (HCC)	A group of individual health care and response organizations (e.g., hospitals, EMS, emergency management organizations, public health agencies) in a defined geographic location. HCCs play a critical role in developing health care delivery system preparedness and response capabilities. HCCs serve as multi-agency coordinating groups that support and integrate with ESF-8 activities in the context of incident command system (ICS) responsibilities.
Health care coalition (HCC) member	An HCC member is defined as an entity within the HCC’s defined boundaries that actively contributes to HCC strategic planning, operational planning and response, information sharing, and resource coordination and management. Membership is evidenced by memoranda of understanding (MOU), letters of agreement, and/or attendance at an HCC meeting in the past fiscal year. Representation can be achieved through an authorized representative from the member organization or an authorized representative of a group or network of member organizations (e.g., an integrated health care delivery system or corporate network). In instances where there are multiple entities of an HCC member type, there may be a subcommittee structure that establishes a lead entity to communicate common interests to the HCC (e.g., multiple dialysis centers forming a subcommittee). For example, if a subcommittee lead participates in an HCC meeting, the members engaged in that subcommittee (through MOU, letters of agreement, and/or attendance at a subcommittee meeting in the past budget year) are also considered represented.

Term	Definition
Health care executive	An executive is a decision-maker for his/her respective organization and should have decision-making power that includes, but is not limited to, allocating or reallocating resources, changing staffing roles and responsibilities, and modifying business processes in his/her organization. Typical titles of executives with decision-making power include: Chief Executive Officer, Chief Operating Officer, Chief Medical Officer, Chief Clinical Officer, Chief Nursing Officer, State and/or Local Director of Public Health, Director of Emergency Management, Administrator on Duty, or Chief of EMS, among others.
Health care facility	Any asset where point-of-service medical care is regularly provided or provided during an incident. It includes hospitals, integrated health care systems, private physician offices, outpatient clinics, nursing homes, and other medical care configurations. During an emergency response, alternative medical care facilities and sites where definitive medical care is provided by emergency medical services (EMS) and other field personnel would be included in this definition.
Homeland Security Exercise and Evaluation Program (HSEEP)	Doctrine and policy provided by the U.S. Department of Homeland Security for design, development, conduct, and evaluation of preparedness exercises. The terminology and descriptions related to exercises in this document is a Homeland Security industry application of emergency management concepts and principles.
Incident	An occurrence, natural or human-caused, that requires a response to protect life or property. Incidents can, for example, include major disasters, emergencies, terrorist attacks, terrorist threats, civil unrest, wildland and urban fires, floods, hazardous materials spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, tropical storms, tsunamis, war-related disasters, public health and medical emergencies, and other occurrences requiring an emergency response.
Incident command system (ICS)	The combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.

Term	Definition
Jurisdiction	A range or sphere of authority. Public agencies have jurisdiction at an incident related to their legal responsibilities and authority. Jurisdictional authority at an incident can be political or geographical (e.g., Federal, State, tribal, local boundary lines) or functional (e.g., law enforcement, public health, school).
Medical Surge	The ability to evaluate and care for a markedly increased volume of patients that exceeds normal operating capacity.
Participants	A member organization or executive is considered to be participating if they are physically or remotely connected to the exercise and After-Action Review in real time.
Resources	Personnel and major items of equipment, supplies, and facilities available or potentially available for assignment to incident operations and for which status is maintained.
Response	Activities that address the short-term, direct effects of an incident. Response includes immediate actions to save lives, protect property, and meet basic human needs. Response also includes the execution of emergency operations plans and of mitigation activities designed to limit the loss of life, personal injury, property damage, and other unfavorable outcomes.
Response Plan	A Response Plan meets the required components identified in the FOA. An HCC Response Plan describes HCC operations that support strategic planning, information sharing, and resource management. The plan also describes the integration of these functions with the ESF-8 lead agency to ensure information is provided to local officials and to effectively communicate and address resource and other needs requiring ESF-8 assistance.
Stakeholders	Includes core HCC members—hospitals, emergency medical services (EMS), emergency management organizations, and public health agencies—additional HCC members, and the Emergency Support Function-8 (ESF-8, Public Health and Medical Services) lead agency.

Term	Definition
Surge Capacity	The ability to manage a sudden influx of patients. It is dependent on a well-functioning incident command system (ICS) and the variables of space, supplies, and staff. The surge requirements may extend beyond placing patients into beds and should include all aspects related to clinical services (e.g., laboratory studies, radiology exams, operating rooms).
Surge Capability	The ability to manage patients requiring very specialized medical care. Surge requirements span a range of medical and health care services (e.g., expertise, information, procedures, or personnel) that are not normally available at the location where they are needed (e.g., pediatric care provided at non-pediatric facilities or burn care services at a non-burn center). Surge capability also includes special interventions in response to uncommon and resource intensive patient diagnoses (e.g., Ebola, radiation sickness) to protect medical providers, other patients, and the integrity of the medical care facility.

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U.S. Department of Health and Human Services

Public Health Emergency



The Express: December 2021

As we ring out yet another unprecedented year, the ASPR TRACIE team would like to offer our stakeholders and their loved ones our most sincere wishes for a healthy and safe holiday season. We continue to be in awe of your dedication and appreciate the chance to share your resources and experiences.

This issue of The Express highlights the following resources:

- [Healthcare Operations during the COVID-19 Pandemic Speaker Series](#) (new recordings)
- [Healthcare Coalition Engagement in COVID-19 Assessment](#)
- [Monoclonals and More: Allocation and Distribution of Outpatient COVID-19 Treatments](#) (supplemental resource)
- ASPR's [Side-by-Side Overview of Outpatient Therapies Authorized for Treatment of Mild-Moderate COVID-19](#)
- [Healthcare Coalition Chemical Emergency Surge Annex Template](#)
- [Using the ASPR TRACIE Burn Surge Templates to Enhance a Healthcare Coalition](#)
- ASPR's [Guide to Compassionate and Empathic Dialogue](#)
- CMS [Updated Basic Emergency Preparedness Training](#) Now Available

Please continue to access our [Novel Coronavirus Resources Page](#), the National Institutes of Health [Coronavirus Disease 2019 \(COVID-19\) Treatment Guidelines](#), and CDC's [Coronavirus webpage](#), and [reach out](#) if you need technical assistance.

Healthcare Operations during the COVID-19 Pandemic (Speaker Series)

We have added two recordings to [this speaker series](#):

- Dr. Alison Whelan (Chief Academic Officer of the Association of American Medical Colleges) shares [lessons learned in medical education during COVID-19](#).
- Jim Duke (Paramedic/RN, Owner/Operator, Com-Care EMS, and Chair, West Kentucky Healthcare Coalition [WKYHCC]) and BJ Newbury (MS, CHES, and WKYHCC Coordinator) share how the WKYHCC, Kentucky Department of Corrections, Kentucky State Penitentiary, and local emergency medical services collaborated to [identify and treat COVID-19 positive inmates](#).

Healthcare Coalition (HCC) Engagement in a Multi-phased COVID-19 Assessment

[This infographic](#) highlights findings from a multi-phased effort that included an online survey open to all HCCs about various aspects of their response to the pandemic and eight focus groups with a subset of survey respondents. Access [the full report](#) and the [Next Generation Healthcare Coalitions: Learning and Evolving from COVID-19 webinar](#) for more information.

Monoclonals and More: Allocation and Distribution of Outpatient COVID-19 Treatments

[This resource](#) highlights information on currently available monoclonal antibody (mAb) therapeutics and introduces additional COVID-19 prophylactics and treatments anticipated to be authorized in the future. It serves as a supplement to the information provided in [this webinar](#), where speakers share information on the latest COVID-19 treatments, potential new treatments, current recommendations for using mAb therapeutics, and issues in providing equitable access.

ASPR's Side-by-Side Overview of Outpatient Therapies Authorized for Treatment of Mild-Moderate COVID-19

This [regularly updated table](#) summarizes key information for all outpatient therapies currently authorized under emergency use in the U.S. for treatment of mild-moderate COVID-19.

Healthcare Coalition Chemical Emergency Surge Annex Template

The initial response to a chemical incident lies with first responders and the hospitals, but HCCs can be critical to a coordinated, consistent response. [This template](#) provides general headers and descriptions for a sample HCC chemical emergency surge annex.

Using the ASPR TRACIE Burn Surge Templates to Enhance a Healthcare Coalition

Annette Newman (MS, RN, CCRN, Community Outreach/Burn Disaster Coordinator and Western Region Burn Disaster Consortium Coordinator) shares [how a healthcare coalition used ASPR TRACIE burn surge templates](#) during actual incidents and exercise templates to help with the planning process. Access our other [healthcare system preparedness considerations speaker series recordings](#) for more information.

ASPR's Guide to Compassionate and Empathic Dialogue

ASPR worked with the American Foundation, Puerto Rico Region, to develop [this guide](#) (and related [presentation](#) and [flashcard](#)) to help emergency response and recovery personnel engage effectively and empathically with their stakeholders in a multi-hazard environment. It includes an overview of the emotional phases of a disaster, the essential steps of offering compassionate and empathic communication, and supportive evidence-based information and resources.

CMS Updated Basic Emergency Preparedness Training Now Available

The [Emergency Preparedness \(EP\) Basic Training](#) is intended to establish knowledge of federal EP regulations and the ability to identify circumstances of noncompliance with individual federal regulations for each affected provider and supplier type. Compliance with EP regulations is a factor for facilities' eligibility for funding from CMS. This 17-hour, self-paced training can bolster proficiency with conducting EP surveys and understanding of how the EP regulations overlap across multiple provider types. The course is geared for surveyors but has been made available to the public for provider/supplier education. The course updates reflect the 2019 Burden Reduction changes, as well as additional guidance and clarifications, to include preparedness for

emerging infectious diseases. For technical assistance, please email HelpDesk@qsep.org. For policy-related inquiries, please contact QSOG_EmergencyPrep@cms.hhs.gov.

Emergency Use Authorization: EVUSHELD

The U.S. Food and Drug Administration [granted Emergency Use Authorization \(EUA\) for AstraZeneca's long-acting antibody \(LAAB\) combination EVUSHELD \(AZD7442\)](#). EVUSHELD (AZD7442) is now authorized during this pandemic for the pre-exposure prophylaxis of adults and certain pediatric individuals with immune compromised systems and thus are not expected to mount an adequate immune response following vaccination, or for whom vaccination is not indicated due to health conditions or a history of severe allergic reactions. EVUSHELD (AZD7442) is not a substitute for vaccination. In alignment with the EUA, the U.S. Department of Health and Human Services will oversee the fair and equitable allocation and distribution of EVUSHELD (AZD7442).

Register Today: 2022 Preparedness Summit

Registration for the [2022 Preparedness Summit](#), to be held April 3–7, 2022, in Atlanta, is officially open! The 2022 Preparedness Summit, Reimagining Preparedness in the Era of COVID-19, will provide an opportunity to reflect on lessons learned from current and previous responses, and highlight tools, resources, and learnings that we can apply into the future. Take advantage of early-bird rates—[register today!](#)

Subscribe to the Division of Critical Infrastructure Protection's Bulletins

In the lead up to the holidays and in light of critical cyber threats, Healthcare and Public Health Sector stakeholders need to strengthen their computer network defenses against potential malicious cyber-attacks. The [Division of Critical Infrastructure Protection](#) (CIP) recommends stakeholders review the U.S. Cybersecurity and Infrastructure Security's (CISA) Apache Log4j Vulnerability Guidance webpage and the CISA Insights [Preparing for and Mitigating Potential Cyber Threats](#). To stay informed on cybersecurity subscribe to the [CIP cybersecurity bulletins](#).

COVID-19 Clinical Rounds

Peer-to-Peer Virtual Communities of Practice, a collaborative effort between ASPR, the National Emerging Special Pathogen Training and Education Center ([NETEC](#)), and [Project ECHO](#), hosts weekly training opportunities where

clinicians from the U.S. and abroad who have experience treating patients with COVID-19 shared their challenges and successes. [Access past sessions](#) and [sign up](#) to receive updates.

