St. Louis Regional Healthcare Coalition
Healthcare Subcommittee
Regular Meeting

Meeting Details

DATE:	Wednesday, September 08, 2021	CONVENED:	0930 HRS	ADJOURNED:	1039 HRS
CHAIRS:	J. Campbell	C. Minks			

Attendance

MEMBERS:	S. Austermann	N. Blaes	E. Brandmeyer	R. Carter	R. Charney	B. Chotrow
	G. Christmann	L. French	E. Hooks	T. Horton	S. Icenhower	B. Liedtke
	C. Matthews-Snow	D. McDonald	D. Mullen	V. Poston	H. Sandkuhl	E. Timmer
	N. Yanko					
PARTNERS:	B. Chambers	D. Chambers	N. Kohlberg	S. Peterson	A. Taylor	B. Zoref
	J. Langan					

GUESTS:

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: 1. Update Healthcare Subcommittee Goal Development Plan via leader progress reports; identify any barriers to success 2. Review/approve Healthcare Subcommittee CY2021 Charter 3. Update subcommittee members on coalition/regional activities, initiatives, & opportunities	**Objective Complete** **Objective Complete** **Objective Complete**
Meeting Minutes	Refer to **Attachments A, A1, & A2** of meeting materials packet. C. Minks submitted draft meeting minutes from Wednesday, July 14, 2021 for review and approval. **Discussion** No discussion. **Recommendation** Approve as submitted. **Decision** C. Christmann motioned to approved; H. Sandkuhl seconded. Minutes approved as submitted.	No further action required.
Announcements		
Introductions	J. Campbell invited new members and partners to provide brief introduction. New Members during September include: **Joanne Langan** Disaster Preparedness Coordinator SLU Valentine School of Nursing **Scott Austermann** Manager, Endoscopy BJC Progress West	Subcommittee welcomed new members. No further action required.

Attachment A

<table>
<tr><th>TOPIC
Focus</th><th>DISCUSSION/RECOMMENDATION
Analyze</th><th>ACTION ITEMS
Develop</th></tr>
<tr><td>Participant Roster Update</td><td>Refer to Attachments F of meeting materials packet.

J. Campbell provided updates on the electronic participant form and Participant Roster progress.

Current roster reflects new participants gained via recruitment efforts, and career transitions for regional partners. Participant breakdown as follows:

<table>
<tr><th>Participant Type</th><th>Total</th></tr>
<tr><td>Total Participants</td><td>45</td></tr>
<tr><td>Healthcare Representatives</td><td>36</td></tr>
<tr><td>Voting Members</td><td>23</td></tr>
<tr><td>Delegate Representatives</td><td>13</td></tr>
<tr><td>Partners</td><td>9</td></tr>
</table>

Participant Roster used as the primary directory used for subcommittee business, including email correspondences and meeting notices.

Participant form remains active for new submissions, accessible via this link: Healthcare Subcommittee Participant Form</td><td>J. Campbell to provide update during next meeting.

New participants to submit form entry, as needed.</td></tr>
<tr><td>Old Business</td><td>Deliberately left blank.</td><td></td></tr>
<tr><td colspan="2">Goal Development Plan Reports</td><td></td></tr>
<tr><td>Goal 1: Membership & Recruitment</td><td>Refer to Attachment B of meeting materials packet.

J. Campbell provided the following updates:

<u>Workgroup Highlights</u>

No meeting during this reporting period.

J. Campbell shared workgroup leader transition.

<u>Upcoming Activities</u>

Workgroup coordinating to:

- Complete membership data review
- Develop DRAFT Healthcare Subcommittee “one-pager”

No challenges or barriers identified.

Next workgroup meeting TBD.</td><td>J. Campbell to coordinate next workgroup meeting and provide update during next meeting.</td></tr>
<tr><td>Goal 2: Support Technology</td><td>C. Minks provided the following updates:

<u>Workgroup Highlights</u>

- Defined workgroup mission:
    o Create a virtual environment where all regional healthcare provider types may connect to share common assets and information to foster regional collaboration.</td><td></td></tr>
</table>

Attachment A

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop
Goal 2: Support Technology cont.	- eCoalitions developed STL Healthcare Subcommittee protype website for review/consideration <u>Upcoming Activities</u> - Coordinating with workgroup to review website design and contract proposal Next workgroup meeting Wednesday, October 6 at 1300 hours. Participants to include workgroup members and STARRS leadership.	J. O'Brien to coordinate next workgroup meeting and provide update during next meeting.
Goal 3: Subcommittee Report	J. Campbell provided the following updates: <u>Workgroup Highlights</u> - Healthcare Subcommittee Mid-Year Report approved and submitted to Coalition leadership and STARRS BOD. <u>Upcoming Activities</u> - Collecting feedback, suggestions, and new content ideas for CY2021 Final Report. No challenges or barriers identified.	Participants provide revision and improvement feedback to J. Campbell by Nov 30, 2021. J. Campbell to coordinate next workgroup meeting and provide update during next meeting.
Goal 4: Subcommittee Administration	C. Minks provided the following updates: <u>Workgroup Highlights</u> - Workgroup completed revision and submitted DRAFT CY2021 Charter to Subcommittee for review/discussion and approval o Included under "New Business" - Workgroup members participating on Healthcare Coalition Charter Workgroup to create linkages/harmony within charters <u>Upcoming Activities</u> - Coordinate with Healthcare Coalition Charter Workgroup to harmonize respective documents to maximize effectiveness	C. Minks to coordinate next workgroup meeting and provide update during next meeting.
Goal Plan Summary	J. Campbell opened meeting for subcommittee goal plan development discussion. No additional discussion occurred. <u>Next Steps</u> - Goal workgroup leaders schedule September and October meetings - Goal workgroup leaders submit electronic progress report form for November meeting update	All goal leaders to complete actions as approved.

Attachment A

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop
Workgroup Reports		
Pediatric Surge Planning	J. Campbell provided the following updates: Workgroup Highlights No meeting during this reporting period. Upcoming Activities SLCH hosting TEEX Pediatric Disaster Response & Emergency Preparedness course September 30 - October 1, 2021 No challenges or barriers identified. Next workgroup meeting TBD	Participants encouraged to register once details available. M. Tanton to coordinate next workgroup meeting and provide update during next meeting.
Coalition Partner Updates		
Public Health	N. Kohlberg provided the following updates: Sector Highlights - Regional COVID-19 vaccine booster clinics pending Upcoming Activities - Monitoring COVID-19 delta variant case increases and coordinating for larger vaccine booster clinics, as anticipated. Challenges No challenges reported.	T. Shaw provide update during next meeting.
Emergency Medical Services (EMS)	H. Sandkuhl provided the following updates: Sector Highlights - EMS still experiencing higher staff transmission - Updating EMS community education for broader virtual capabilities Upcoming Activities - No upcoming activities Next meeting TBD.	J. Nowak/H. Sandkuhl to provide update during next meeting.
Emergency Management	B. Chambers reported EMAs continuing to support regional and coalition partners.	B. Chambers to provide update during next meeting.
EMResource	G. Christmann reported EMResource progress halted due to COVID-19 delta variant surge. No new features to be considered until healthcare conditions/environment more appropriate.	

Attachment A

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop
EMResource cont.	H. Sandkuhl reported additional discussion during regional EMResource meeting focused on single sign-on. Discussions to continue during next meeting.	A. Blevins/B. Zoref to provide update during next meeting.
Interoperable Communication	T. Horton reported supporting healthcare partners with 700 and 800 MHz system handheld radio frequency verification. Specific questions/concerns were related to code-plugs and full interoperability between discipline-specific talk groups. Reported potential gap is SMOC duty officer radio ability to interface with EM radios for Charity Classic Golf Tournament. C. Christmann shared proper code plugs were installed in 2018, but legal agreements between individual HSOs and State of Missouri authorities challenge universal information sharing. Recommend Interoperable Communication Subcommittee review MOSWIN and SLATER talk groups with B. Marler, and identify necessary next steps for full functionality. No major updates to occur during COVID-19 surge activity.	T. Horton provide update during next meeting
Mass Fatality	No report.	K. Hargrave to provide update during next meeting.
New Business		
Healthcare Subcommittee Revised Charter	Refer to **Attachment C and C1** of meeting materials packet. J. Campbell reported the following details: Current Status St. Louis Healthcare Subcommittee Charter reviewed by Goal workgroup, with suggested revisions and improvements submitted for approval. All revisions to previous version reflected via "Track Changes" and embedded comments. Revision Overview - Reformatted Charter into five (5) distinct sections: o Overview o Participation o Structure o Meetings o Voting - Added Charter purpose and January 2021 mission statement - Incorporated March 2021 revised participant definitions - Expanded participation benefits and responsibilities - Clarified roles and structure, and added leadership eligibility, terms. and transitions - Established standard work and management for all meeting types	

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop

Healthcare Subcommittee Revised Charter cont.	- Strengthened voting processes and measures via:
	  ○ Verifying quorum standards
	  ○ One (1) vote allocation for individual Healthcare Organizations
	  ○ Defining primary and secondary voting officiants
	  ○ Detailing standard and alternative voting methods, including conditions
	- Added standard business matrix to
	  ○ Define leadership duties/terms
	  ○ Outline core functions, deliverables, and frequency of standard work
	
	Discussion
	No discussion.
	
	Recommendation
	Approve revised Charter as submitted.
	
	Decision
	E. Hooks motioned to approved; G. Christmann seconded.
	
	Voting members unanimously approved revised Charter.
	
	Next Steps
	
	Continue coordination with Healthcare Coalition Executive Committee Charter review workgroup to create linkages between administrative documents
		J. Campbell to distribute new STL Healthcare Subcommittee Charter with meeting minutes.
		
		S. Icenhower/B. Zoref to provide update during next meeting.

Regional Initiatives		

Healthcare Coalition & SMOC	B. Zoref provided the following updates:
	- Last meeting occurred Friday, July 16, 2021
	  ○ August meeting cancelled due to lack of content and busy schedules
	- SMOC thrice-weekly meetings continue
	  ○ Includes state partners
	- SMOC is monitoring Charity Classic Golf Tournament activity, with V. Poston and S. Icenhower as POCs.
	  ○ No concerning reports or activity to date
	- Next meeting scheduled Friday, September 17 at 0900 hours.
		S. Icenhower/B. Zoref to provide coalition update during next meeting.

Training and Exercise		
T&E Subcommittee Report	Refer to **Attachment D** of meeting materials packet. S. Peterson provided the following updates: - Thank you for participating in regional T&E needs survey ○ Healthcare EM submitted the most responses!	

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop
T&E Subcommittee Report cont.	St. Louis UASI THIRA/SPR 2021 Exercise Series - Registration link: https://www.surveymonkey.com/r/THIRASPR - Five (5) virtual TTXs focused on specific mission areas & core capabilities - Cross-functional & cross-agency participation	Participants encouraged to register. S. Peterson to provide coalition update during next meeting.
Organizational T&E Opportunities	No organizational T&E opportunities shared.	No further action required.
Grant Funding Programs		
UASI, HPP, and PHEP	D. Chambers provided the following updates: Grant Highlights - Anticipating reactionary HPP/PHEP funding post-COVID-19 - Missouri State continuing to develop state-wide COVID-19 After Action Report (AAR) - Regional Coalition Surge Test (CST) requirement from ASPR updated o Initial indications is a higher-quality exercise with more relevant and actionable outcomes	D. Chambers to provide update during next meeting.
Regulatory/Accreditation		
TJC New EM Chapter	J. Campbell reported the following details related to TJC EM SRP: Current Status - Proposed new EM Chapter currently in Field Review for broader comments and input - SRP to review feedback and submit final revisions/recommendations to TJC by Sept 29, 2021 Revision Summary Review, discussion, and editing within 4 phases aligned to key program elements - Leadership support and administration of EM programs - Program activities aligned to each EM phase - Program activities aligned to TJC six (6) critical EM areas - Outputs and outcomes effectiveness monitoring Expands EM requirements in: - Continuity of Operations (COOP) and Crisis Standards of Care (CSC) - Staff education and training competence - Program effectiveness monitoring/evaluation o drills/exercises, reporting, & performance metric integration	

Attachment A

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop
TJC New EM Chapter cont.	Next Steps - Anticipated implementation CY2022 - New standards implementation likely to have positive effect on actual hospital disaster outcomes	No further action required.
Survey Activity	C. Minks provided highlights from recent TJC EM mock survey at SSM St. Charles and De Paul hospitals. EM specific highlights include: - Surveyor alluded to "next generation" of TJC EM chapter - COVID-19 incident analysis and After Action Report (AAR) - Exercise activity and corrective action management - Staff support, including well-being and burnout management Surveyor had military background and relevant EM experience.	No further action required. Subcommittee members to share relevant EM survey experience during upcoming meetings.
Open Discussion		
HRSA Regional Pediatric Pandemic Network	R. Charney announced appointment to Site Director of U.S. HHS Health Resources & Service Administration (HRSA) Regional Pediatric Pandemic Network Grant. Dr. Charney leads one (1) of five (5) sites in the country.	Subcommittee congratulated Dr. Charney on the appointment. No further action required.
National Preparedness Month	J. Campbell announced September 2021 as National Preparedness Month, and highlighted weekly themes and readiness tools. Weekly themes to celebrate and encourage emergency management activity include: - Week 1: Make a Plan - Week 2: Build a Kit - Week 3: Cost-Efficient Preparedness - Weeky 4: Youth EM Engagement CDC Webinar #BringDownBarriers to Emergency Preparedness & Response - Sept 15 at 1200 hours CST - https://www.zoomgov.com/j/1600814729?pwd=Njc4YUxvYzNTSUZ5em9NOWF5TE1PUT09%20	Participants encouraged to register. 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. August featured topics include: - COVID-19 pediatric lessons - Support service role(s) during hospital disasters - Suicide & mental health management - HPP funding opportunity announcements	No further action required.

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop
Meeting Conclusion		
Action Item Review	J. Campbell reviewed action items from September meeting: Goal Development Plan - Goal workgroup leaders facilitate July and August meetings, then share progress/outcomes via electronic Healthcare Subcommittee Report Submission Form Healthcare Subcommittee Charter - J. Campbell and C. Minks to continue coordination with STL Healthcare Coalition Executive Committee Charter Review workgroup to improve synergy between regional governance documents. Healthcare Sector Specific T&E Program - C. Minks to coordinate T&E workgroup initial meeting and provide update during next meeting.	
Next Meeting	Wednesday, November 10, 2021 0930 – 1100 hours Microsoft Teams	No further action required.
Adjournment	J. Campbell adjourned the meeting at 1039 hours	No further action required

Respectfully submitted,

Jason Campbell
Chair
STARRS Healthcare Subcommittee

Attachment A

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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/approve Healthcare Subcommittee CY2021 Charter

III. Update subcommittee members on coalition/regional activities, initiatives, & opportunities

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Attachment A1

Review Meeting Minutes

- Last Meeting - Wednesday, July 14, 2021
  - Refer to Attachments A, A1, & A2 for details
  - Discussed opportunities for regional healthcare-specific EM academy
    - Focused on common challenges & shared solutions
    - Setting "core competency" skill development for healthcare EM professionals
  - Reviewed Goal progress & action items; all goals trending positively with no barriers/obstacles reported
    - Focused discussion on establishing Healthcare Subcommittee website
    - Approved Healthcare Subcommittee CY2021 Mid-Year Report
- Next Steps
  - Review & approve

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Announcements Introductions

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

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Attachment A1

Announcements
Participant Roster Update

- Current Status
  - Refer to Attachment F for details
  - Reflects new participants & organizational transitions
  - Primary directory used for subcommittee business, including email correspondences & meetings
  - Form remains active for new submissions

Participant Type	Total
Total Participants	45
Healthcare Representatives	36
Voting Members	23
Delegate Representatives	13
Partners	9

STARRS Healthcare Subcommittee Membership Form - 2021

Purpose:

1. Verify and update STARRS Healthcare Subcommittee member roster.
2. Update contact information for STARRS Healthcare Subcommittee membership.
3. Identify members able to assist STARRS Healthcare Subcommittee via a Liaison or Goal Workgroup support role.

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Goal Development Plan Reports
I – Membership & Recruitment

- Workgroup Highlights
  - No meeting this reporting period
- Upcoming Activities
  - Coordinating workgroup to
    - Finish healthcare organization representation review
    - Develop DRAFT Healthcare Subcommittee "one-pager"
      - What is mission & purpose Healthcare Subcommittee?
      - Who are members & partners?
      - What are responsibilities & expectations?
      - What are benefits?

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Attachment A1

Goal Development Plan Reports
1 – Membership & Recruitment

- Challenges or Barriers
  - Time & bandwidth
- Next Meeting
  - TBD

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	76 - 99%
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	0 - 25%
Objective 1D	Distribute subcommittee summary sheet to all eligible healthcare organizations.	30-Jun	0 - 25%
Objective 1E	Monitor membership expansion and healthcare facility representation; revise strategy for Goal 1 achievement if/as required.	31-Dec	0 - 25%
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
  - Workgroup mission:
    - Create a virtual environment where all regional healthcare provider types may connect to share common assets & information to foster regional collaboration
  - eCoalitions developed St. Louis Healthcare Subcommittee protype website
- Upcoming Activities
  - Coordinate workgroup/STARRS meeting to review website design & contract proposal
  - Determine next steps for goal achievement

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Attachment A1

Goal Development Plan Reports
2 – Support Technology

- Challenges or Barriers
  - None reported

- Next Meeting
  - TBD

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	76 - 99%
Objective 2D	Establish portal solution for subcommittee membership and verify resolution of critical gaps.	30-Sep	26 - 50%

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Goal Development Plan Reports
3 – Subcommittee Report

- Workgroup Highlights
  - Healthcare Subcommittee CY2021 Mid-Year Report submitted to Healthcare Coalition leadership & STARRS

- Next Steps
  - Collecting feedback, suggestions, & new content for CY2021 Final Report

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Attachment A1

Goal Development Plan Reports
3 – Subcommittee Report

- Challenges or Barriers
  - None to report
- Next Meeting
  - TBD

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	51 - 75%

Goal Development Plan Reports
4 – Subcommittee Administration

- Workgroup Highlights
  - DRAFT CY2021 Charter submitted for review, discussion, & approval
    - Discussion scheduled as "New Business"
  - Members participating on Healthcare Coalition Executive Committee Charter review workgroup to create linkages
- Upcoming Activities
  - Continue coordination with Healthcare Coalition Charter Workgroup to harmonize Charter & other administrative documents for effectiveness

Attachment A1

Goal Development Plan Reports
4 – Subcommittee Administration

- Challenges or Barriers
  - None to report
- Next Meeting
  - TBD

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	76 - 99%
Objective 4D	Verify all applicable coalition and healthcare subcommittee management materials are aligned for optimal administrative coordination for upcoming year.	31-Dec	51 - 75%

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
    - September & October
  - Submit monthly progress reports via electronic *Report Form*

Attachment A1

Workgroup Reports
Pediatric Surge Planning

- Workgroup Highlights
  - No meeting during this reporting period
- Upcoming Activities
  - SLCH hosting TEEX Pediatric Disaster Response & Emergency Preparedness course September 30 - October 1, 2021
    - Registration information available soon
- Challenges or Barriers
  - None to report
- Next Meeting
  - TBD

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Coalition Partner Updates
Public Health

- Sector Highlights
- Upcoming Activities
- Challenges
- Next Meeting

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Attachment A1

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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Attachment A1

Coalition Partner Updates EMResource

- Sector Highlights
- Upcoming Activities
- Challenges
- Next Meeting

Coalition Partner Updates Interoperable Communication

- Sector Highlights
- Upcoming Activities
- Challenges
- Next Meeting

Attachment A1

New Business
Healthcare Subcommittee 2021 Charter

- Current Status
  - Refer to Attachments C & C1 for details
  - Goal 4 workgroup submitted DRAFT *St. Louis Healthcare Subcommittee Charter* for review
    - All revisions to CY2018 version reflected via "Track Changes" & comments
  - Reformatted existing content into five (5) distinct sections
    - Overview
    - Participation
    - Structure
    - Meetings
    - Voting
  - General grammar, spelling, & wordsmithing revisions

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New Business
Healthcare Subcommittee 2021 Charter

- Revision Overview
  - Added Charter purpose & January 2021 mission statement

St. Louis Regional Healthcare Coalition
Healthcare Subcommittee
Charter

I. St. Louis Healthcare Subcommittee Overview

A. Charter Purpose

Define St. Louis Healthcare Subcommittee:

- Mission, scope, role, and authority
- Membership, partnership, responsibilities, and benefits
- Leadership and structure
- Meetings and business
- Voting and quorum
- Provisions

B. 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

C. Scope

All hospitals, healthcare organizations, and other qualified Centers for Medicaid and Medicare Services (CMS) facilities/provider types within the St. Louis Area Regional Response System (STARRS) geographic area, as identified below.

Missouri Jurisdictions	Illinois Jurisdictions
City of St. Louis	Madison County
Franklin County	Monroe County
Jefferson County	St. Clair County
Lincoln County	
Perry County	
Pike County	
St. Charles County	
St. Francois County	
St. Genevieve County	
St. Louis County	
Warren County	
Washington County	

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Attachment A1

New Business
Healthcare Subcommittee 2021 Charter

- Revision Overview
  - Added Charter purpose & January 2021 mission statement
  - Incorporated March 2021 revised participant definitions

II. **St. Louis Healthcare Subcommittee Participation**
Refer to Attachment A

A. Participating Organizations

1. Healthcare Organization is any organization engaged in the provision of direct healthcare services and treatment to St. Louis community
   - Not required to be licensed by CMS for membership eligibility
   - Not required to be affiliated with system for membership eligibility
2. Partner Organizations are any private sector or government agencies supporting healthcare organizations in St. Louis area, representing disciplines including, but not limited to:
   - Emergency Management
   - Emergency Medical Services (EMS)
   - Fusion Center
   - Higher Education
   - Public Health
3. Healthcare System is any consortium of healthcare organizations connected via joint management arrangement, contractual agreement, or corporate ownership structure.

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Attachment C

St. Louis Healthcare Subcommittee Charter
Charter

B. Member

1. Healthcare Subcommittee Member is a representative from a Healthcare Organization with at least fifty percent (50%) Regular Meeting attendance within a calendar year.
2. St. Louis community members seeking membership on Healthcare Subcommittee must submit electronic application to STARRS for review. Application and details available via STARRS Committee Website.

C. Partner

1. Healthcare Subcommittee Partner is representative from a Healthcare System or Partner Organization.
2. Healthcare Subcommittee Partners also include Healthcare Organization representatives not meeting minimum Member attendance requirements.

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New Business
Healthcare Subcommittee 2021 Charter

- Revision Overview
  - Added Charter purpose & January 2021 mission statement
  - Incorporated March 2021 revised participant definitions
  - Expanded participation benefits & responsibilities

D. Participation Benefits

Professionals participating on St. Louis Healthcare Subcommittee:

1. Collaborate with industry partners to strengthen organizational and regional healthcare emergency management.
2. Receive opportunities to advance healthcare emergency management capabilities via cross-functional planning, equipping, training, and testing.
3. Promote awareness and advocate for healthcare emergency management policy, funding, regulatory compliance, and performance solutions to elected officials and industry executives.
4. Gain advantages in organizational and agency regulatory/accreditation compliance via engagement with community-based healthcare emergency management entities.
5. Maximize emergency response/recovery outcomes and effectiveness via developed partnerships within regional network.

E. Participation Responsibilities

Professionals participating on St. Louis Healthcare Subcommittee:

1. Engage during Healthcare Subcommittee regular meeting and business discussions.

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Attachment C

ouis Healthcare Subcommittee Charter
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2. Participate in Healthcare Subcommittee preparedness programming, including training, planning workshops, learning seminars, and drills/exercises.
3. Have responsibility for organizational emergency management activity and share relevant program, operational, or other details with community partners for advancing St. Louis healthcare sector resilience.
4. Support regional incident response/recovery operations via information sharing, operational coordination, resource management, and other functions, as requested.

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Attachment A1

New Business
Healthcare Subcommittee 2021 Charter

- Revision Overview
  - Added Charter purpose & January 2021 mission statement
  - Incorporated March 2021 revised participant definitions
  - Expanded participation benefits & responsibilities
  - Clarified roles & structure
    - Added leadership eligibility, terms & transitions

1. Vice Chair supports Chair in performance of all leadership duties.
2. Vice Chair serves as Chair during absence and/or delegation situations.
3. Vice Chair presides over Leadership meetings.

C. Leadership Council

1. Leadership Council oversees Healthcare Subcommittee mission progress and RHCC coordination activities.
2. Leadership Council performs annual membership audit in January.

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Attachment C

Louis Healthcare Subcommittee Charter
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3. Leadership Council includes the following representatives:
   - Chair
   - Vice
   - RHCC Coordinator
   - STARRS Representative
4. Leadership Council may include ad hoc representatives such as coalition leaders, workgroup leaders, and external partners, as needed/requested.

D. Workgroups

1. Workgroups are established to coordinate actions around a specific capability, goal, or grant expense, in advance of Healthcare Subcommittee mission.
2. Workgroups may be established by Chair/Vice Chair designation or Member proposal.
3. Workgroups must include the following to be recognized and operational:
   - At least one (1) declared objective or deliverable
   - Identified Leader(s)
4. Workgroup Leaders are Members or Partners nominated and elected by Healthcare subcommittee.
5. Workgroup members are volunteers

E. Eligibility, Terms, and Transitions

1. Any Member may volunteer or be nominated for Chair or Vice Chair elections. Individuals must agree to nomination prior to election, as applicable.
2. Chair and Vice Chair elections occur during November Regular Meeting business.
3. Chair and Vice Chair each serve one (1) year terms aligned to a calendar year, with terms beginning in January of each year.
4. Leadership transition and annual goal planning occur during December, prior to new term start.
5. Chain and Vice Chain are validated by STARRS Board of Directors in February.

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New Business
Healthcare Subcommittee 2021 Charter

- Revision Overview
  - Added Charter purpose & January 2021 mission statement
  - Incorporated March 2021 revised participant definitions
  - Expanded participation benefits & responsibilities
  - Clarified roles & structure
    - Added leadership eligibility, terms & transitions
  - Established standard work & management for all meeting types

IV. **St. Louis Healthcare Subcommittee Meetings**

A. Regular Meeting

1. Regular Meeting occurs bimonthly on the second (2nd) Wednesday of alternating month, allowing six (6) occurrences within the calendar year.
   - January, March, May, July, September, November
2. Regular Meetings are scheduled with no less than ten (10) business day notice to participants.
3. Regular Meeting facilitated by Chair, following Robert's Rules of Order.
4. Regular Meeting purpose is to conduct standard business, including:
   - Project reporting and discussion
   - Content review and approval
   - Training and exercise opportunities
   - Regional partner highlights
   - Regulatory/accreditation survey experience/updates
5. Regular Meeting materials include agenda, previous meeting minutes, and previous meeting attendance sheet. Meeting material distribution occurs no less than seven (7) business days prior to meeting date.
6. Regular Meeting materials approved during standard business are distributed no more than fifteen (15) business days after approval to the following:
   - RHCC Executive Committee Chair
   - RHCC Coordinator
   - STARRS Executive Director

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Attachment A1

New Business
Healthcare Subcommittee 2021 Charter

- Revision Overview
  - Strengthened voting processes & measures via:
    - Verifying quorum standards
    - One (1) vote allocation for individual Healthcare Organizations
    - Defining primary & secondary voting officials
      - Chair, Vice, RHCC Coordinator
    - Detailing standard & alternative voting methods, including conditions
      - Voice
      - Show of Hands
      - Feedback Deadlines

V. St. Louis Healthcare Subcommittee Voting

A. Quorum

1. Quorum is achieved when at least fifty-one percent (51%) of approved Members participate in a Regular Meeting physically or virtually.
2. Quorum is required to conduct any approval vote or election during Regular and Special Meetings.

B. Vote Allocation

1. Healthcare Subcommittee Members are allocated one (1) vote to cast related standard business.
2. Only one (1) Member per individual Healthcare Organization may cast a vote.
3. Healthcare Subcommittee Partners may not vote during standard business.

C. Voting Process

1. Chair or Vice Chair conduct voting activities, in accordance with Regular Meeting facilitation.
2. RHCC Coordinator conducts voting activities when Chair or Vice Chair are ineligible, due to election candidate status or other potential conflict.
3. Voice voting is standard method for Members to cast votes.
4. Show of hands is alternative method for Members to cast votes when voting outcomes are undeterminable via voice voting or specifically requested for a particular vote.
5. Feedback deadlines may be used for Members and Partners to provide input/improvements to Healthcare Subcommittee content that does not require formal voting approval.

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Attachment C

St. Louis Healthcare Subcommittee Charter
Charter

D. Voting Measures

1. A simple majority of affirming votes is required to approve or elect the following:
   - Chair
   - Vice Chair
   - Goal/Workgroup Leader
   - Regular Meeting Minutes
   - Special Meeting occurrence
2. A two-thirds (2/3) majority of
   Subcommittee Charter revisio
3. Feedback deadlines for Memb
   seven (7) business days follow

New Business
Healthcare Subcommittee 2021 Charter

- Revision Overview
  - Added Structure & Standard Business Matrix to
    - Clearly define duties & terms for key leadership roles

Position	Description	Duties	Term
Chair	Provide overall Healthcare Subcommittee leadership.	• Produce and distribute Regular and Special Meeting materials • Preside over Regular and Special Meetings • Set and achieve annual goals, in support of mission • Maintain participant roster, attendance record, and communication directory • Oversee Workgroup progress and resolve barriers, as needed	One Year
Vice Chair	Support Chair in fulfillment of all leadership duties.	• Produce and distribute Leadership Meeting materials • Preside over Leadership Meetings • Serve as Chair during absence and/or delegation situations	One Year
Workgroup Leader	Lead actions focused on a specific capability, goal, or grant expense.	• Produce and distribute Workgroup Meeting materials • Preside over Workgroup Meetings • Perform actions necessary to achieve Workgroup objectives • Escalate challenges/barriers to Chair for resolution	Achievement of Workgroup Objectives
Leadership Council	Oversee mission progress and RHCC coordination activities.	• Complete annual membership audit in January • Preside over Leadership Meetings • Serve as Chair during absence and/or delegation situations	One Year

Attachment A1

New Business
Healthcare Subcommittee 2021 Charter

- Revision Overview
  - Added Structure & Standard Business Matrix to
    - Clearly define duties & terms for key leadership roles
    - Outline core functions, deliverables, & frequency of standard work

Month	Action	Description	Frequency	Responsibility
January	New Leadership Term Start	Declare annual goals and intended outcomes	Annually	Chair and Vice Chair
	Membership Audit	Review previous year attendance record to designate qualified voting members	Annually	Leadership Council
	Regular Meeting	Complete standard business, review goal development plan, and establish workgroups	Bi-monthly	Chair and Vice Chair
	Leadership Meeting	Oversight and RHCC coordination	Monthly	Vice Chair
February	New Leadership Confirmation	Official approval of new Chair and Vice Chair	Annually	STARRS Board
	Leadership Meeting	Oversight and RHCC coordination	Monthly	Vice Chair
	Workgroup Meeting	Coordinate goal-specific tactical activity	Monthly	Workgroup Leaders
March	Regular Meeting	Complete standard business and review member audit outcomes	Bi-monthly	Chair and Vice Chair
	Leadership Meeting	Oversight and RHCC coordination	Monthly	Vice Chair
	Workgroup Meeting	Coordinate goal-specific tactical activity	Monthly	Workgroup Leaders
April	Leadership Meeting	Oversight and RHCC coordination	Monthly	Vice Chair
	Workgroup Meeting	Coordinate goal-specific tactical activity	Monthly	Workgroup Leaders
May	Regular Meeting	Complete standard business	Bi-monthly	Chair and Vice Chair
	Leadership Meeting	Oversight and RHCC coordination	Monthly	Vice Chair
	Workgroup Meeting	Coordinate goal-specific tactical activity	Monthly	Workgroup Leaders
June	Leadership Meeting	Oversight and RHCC coordination	Monthly	Vice Chair
	Workgroup Meeting	Coordinate goal-specific tactical activity	Monthly	Workgroup Leaders
	Mid-Year Report	Summary of year-to-date progress/accomplishments	Biannually	Chair and Vice Chair
July	Regular Meeting	Complete standard business	Bi-monthly	Chair and Vice Chair
	Leadership Meeting	Oversight and RHCC coordination	Monthly	Vice Chair
	Workgroup Meeting	Coordinate goal-specific tactical activity	Monthly	Workgroup Leaders
August	Leadership Meeting	Oversight and RHCC coordination	Monthly	Vice Chair
	Workgroup Meeting	Coordinate goal-specific tactical activity	Monthly	Workgroup Leaders
September	Regular Meeting	Complete standard business	Bi-monthly	Chair and Vice Chair
	Leadership Meeting	Oversight and RHCC coordination	Monthly	Vice Chair
	Workgroup Meeting	Coordinate goal-specific tactical activity	Monthly	Workgroup Leaders
October	Leadership Meeting	Oversight and RHCC coordination	Monthly	Vice Chair
	Workgroup Meeting	Coordinate goal-specific tactical activity	Monthly	Workgroup Leaders
November	New Leadership Nominations	Submit recommendations for Chair and Vice Chair	Annually	Members
	Regular Meeting	Complete standard business, facilitate elections for new leadership team, final update on goal plan	Bi-monthly	Chair and Vice Chair
	Leadership Meeting	Oversight and RHCC coordination	Monthly	Vice Chair
	Workgroup Meeting	Coordinate goal-specific tactical activity	Monthly	Workgroup Leaders
December	Leadership Transition Meeting	Outgoing and incoming leadership teams exchange strategic vision, goal planning, and management processes for continuation of successful outcomes	Annually	Leadership Council Incoming Leaders
	Workgroup Meeting	Conclude goal-specific tactical activity	Monthly	Workgroup Leaders
	Goal Workplan Development	Define upcoming annual goals and objectives	Annually	Leadership Council

New Business
Healthcare Subcommittee 2021 Charter

- Next Steps
  - Review & discuss Healthcare Subcommittee 2021 Charter
  - Vote to adopt
    - Requires 2/3 Member approval under current & revised Charter
  - Continue coordination with Healthcare Coalition Executive Committee Charter review workgroup to create linkages between administrative documents

Attachment A1

Regional Initiatives Healthcare Coalition & SMOC

- Coalition Committee Highlights
  - Last meeting July 16, 2021
    - August meeting replaced with Charter workgroup meeting
  - Reviewed CY2020 & CY2021 grant deliverables
  - Reviewed SMOC mission & updated team on SOG revision progress
- Upcoming Activities
  - Continue coordination with appropriate partners
- Next Meeting
  - September 17, 2021

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Training & Exercise Subcommittee Report

- Subcommittee Highlights
- Current Status
  - *St. Louis Healthcare Training Newsletter – September*
    - Refer to Attachment D for details
    - Highlights education/training opportunities related to Healthcare EM & industry hazards
- Next Steps
  - Next meeting TBD

Training Newsletter
Healthcare: September 2021

STARRS
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.

Most 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

G300- ICS300 Intermediate Incident Command System

- September 22nd 11am-430pm, September 23rd 8am-5pm, September 24th 8am-4pm
- St. Louis County Office of Emergency Management
- https://unifiedcommand.formstack.com/forms/ics_course_registration

This course provides training for personnel who require advanced applications of the Incident Command System (ICS). Prerequisites: ICS 100, ICS 200, IS 700 & IS 800.

MGT 349 Pediatric Disaster Response & Emergency Preparedness

- Sep 30 - Oct 1, 2021 from 8 AM – 4:30 PM
- BJC/ St. Louis Children's Hospital
- https://sematraining.com/courses/1126/offerings/8145

This course prepares students to effectively, appropriately, and safely plan for and respond to a disaster incident involving children, addressing the specific needs of pediatric patients in the event of a community based incident.

L146- Homeland Security Exercise and Evaluation Program (HSEEP) Training Course

- October 13 – 15 2021 from 8 AM – 5 PM
- St. Charles Emergency Operations Center
- https://sematraining.com/courses/322/offerings/8141

This is an intermediate-level course designed to describe the core principles and processes of HSEEP, its standardized methodology, available resources, and practical skill development, which will assist in developing an HSEEP consistent exercise program.

G191-V-ICS/EOC Interface Workshop

- Oct 19 & Oct 20, 2021 from 8:30 AM- 12:30 PM (Virtual)
- https://sematraining.com/courses/1703/offerings/8122

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 reviews ICS and EOC characteristics, responsibilities and functions.

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Attachment A1

Training & Exercise Upcoming Opportunities

- St. Louis UASI THIRA/SPR 2021 Exercise Series
  - Five (5) virtual TTXs focused on specific mission areas & core capabilities
  - Cross-functional & cross-agency participation
  - Registration link: https://www.surveymonkey.com/r/THIRASPR
    - Deadline today
- Upcoming Organizational Training & Exercise Opportunities

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Grant Funding Update UASI, HPP, & PHEP

- Current Status
- Next Steps

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Attachment A1

Regulatory/Accreditation Survey Updates TJC New EM Chapter

- Current Status
  - Proposed new EM Chapter currently in Field Review for broader comments & input
  - SRP to review feedback & submit final revisions/recommendations to TJC
- Summary
  - Review, discussion, & editing within 4 phases aligned to key program elements
    - Leadership support & administration of EM programs
    - Program activities aligned to each EM phase
    - Program activities aligned to TJC six (6) critical EM areas
    - Outputs & outcomes effectiveness monitoring
  - Expands EM requirements in:
    - Continuity of Operations (COOP) & Crisis Standards of Care (CSC),
    - Staff education & training competence
    - Program effectiveness monitoring/evaluation – drills/exercises, reporting, & performance metric integration
- Next Steps
  - Anticipated implementation CY2022
  - New standards implementation likely to have positive effect on actual hospital disaster outcomes

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Regulatory/Accreditation Survey Updates Member Experience

- SSM St. Charles
- SSM De Paul

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Attachment A1

Open Discussion
National Preparedness Month – September 2021

- Weekly themes to celebrate & encourage emergency management
  - Make a Plan
  - Build a Kit
  - Cost-Efficient Preparedness
  - Youth EM Engagement
- CDC Webinar
  - #BringDownBarriers to Emergency Preparedness & Response
  - Sept 15 at 1200 hours CST
  - https://www.zoomgov.com/j/1600814729?pwd=Njc4YUxvYzNTSUZ5em9NOWF5TE1PUT09%20

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Open Discussion

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

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Attachment A1

Resources & Literature
ASPR TRACIE

- Express – August 2021
  - COVID-19 pediatric lessons
  - Support service role(s) during hospital disasters
  - Suicide & mental health management
  - HPP funding opportunity announcements

BARNES JEWISH Hospital BJC HealthCare

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Action Item Review

- Meeting Action Items

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Attachment A1

Next Meeting

- St. Louis Healthcare Subcommittee Meeting
  - Wednesday, November 10, 2021
    - 0930 – 1100 hours
    - Microsoft Teams
  - Activities include:
    - Chair & Vice-Chair elections
    - CY2021 outcomes review
    - CY2022 goal development

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THANK YOU!!

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Attachment A1

St. Louis Healthcare Coalition
Healthcare Subcommittee Regular Meeting
Wednesday, September 08, 2021 0930 - 1100 Hours
Attendance Report

#	First Name	Last Name	Email	Role	Join Time	Leave Time	Duration
1	Scott	Austermann	SA36369@bjc.org	Member	9/8/2021, 9:29:43 AM	9/8/2021, 10:39:58 AM	1h 10m
2	Nicholas	Blaes	EM94363@bjc.org	Member	9/8/2021, 9:29:40 AM	9/8/2021, 10:40:00 AM	1h 10m
3	Eric	Brandmeyer		Member	9/8/2021, 9:29:40 AM	9/8/2021, 10:43:03 AM	1h 13m
4	Jason	Campbell	jxc9312@BJC.org	Member	9/8/2021, 9:25:24 AM	9/8/2021, 10:40:34 AM	1h 15m
5	Rikia	Carter	rcarter@phcenters.com	Member	9/8/2021, 9:08:34 AM	9/8/2021, 10:32:27 AM	1h 23m
6	Billy	Chambers		Partner	9/8/2021, 9:29:49 AM	9/8/2021, 10:25:52 AM	56m 3s
7	Dale	Chambers	dale@stlstarrs.org	Partner	9/8/2021, 9:49:52 AM	9/8/2021, 10:39:57 AM	50m 4s
8	Rachel	Charney	rachel.charney@health.slu.edu	Member	9/8/2021, 9:30:33 AM	9/8/2021, 10:13:39 AM	43m 6s
9	Brenda	Chotrow	chotbm@mercy.net	Member	9/8/2021, 9:30:32 AM	9/8/2021, 10:39:57 AM	1h 9m
10	Gary	Christmann	Gary.Christmann@stlukes-stl.com	Member	9/8/2021, 9:25:33 AM	9/8/2021, 10:32:08 AM	1h 6m
11	Murrel	French	MLF1576@bjc.org	Member	9/8/2021, 9:28:45 AM	9/8/2021, 10:40:08 AM	1h 11m
12	Emma	Hooks	EFH9961@BJC.org	Member	9/8/2021, 9:23:54 AM	9/8/2021, 10:40:20 AM	1h 16m
13	Shawn	Icenhower	SI22394@bjc.org	Member	9/8/2021, 10:24:47 AM	9/8/2021, 10:40:00 AM	15m 12s
14	Nicholas	Kohlberg	nkohlberg@sccmo.org	Partner	9/8/2021, 9:30:34 AM	9/8/2021, 11:13:06 AM	1h 42m
15	Brian	Liedtke	BL19364@bjc.org	Member	9/8/2021, 9:26:27 AM	9/8/2021, 9:50:01 AM	23m 34s
16	Cynthia	Matthews-Snc	dmmullen@mrhsl.com	Member	9/8/2021, 9:31:18 AM	9/8/2021, 10:43:05 AM	1h 11m
17	Derek	McDonald	Derek.McDonald@va.gov	Member	9/8/2021, 9:33:34 AM	9/8/2021, 10:39:50 AM	1h 6m
18	Cody	Minks	Cody.Minks@ssmhealth.com	Member	9/8/2021, 9:29:28 AM	9/8/2021, 10:36:41 AM	1h 7m
19	Dennis	Mullen		Member	9/8/2021, 9:29:45 AM	9/8/2021, 10:40:06 AM	1h 10m
20	Samantha	Peterson	sam@stlstarrs.org	Partner	9/8/2021, 9:29:27 AM	9/8/2021, 10:40:10 AM	1h 10m
21	Vanessa	Poston	VP30235@bjc.org	Member	9/8/2021, 9:31:31 AM	9/8/2021, 10:40:19 AM	1h 8m
22	Helen	Sandkuhl		Member	9/8/2021, 9:25:15 AM	9/8/2021, 10:40:17 AM	1h 15m
23	Anna	Taylor	anna.taylor@wustl.edu	Partner	9/8/2021, 9:29:57 AM	9/8/2021, 10:37:41 AM	1h 7m
24	Erica	Timmer	EXT5687@bjc.org	Member	9/8/2021, 9:29:13 AM	9/8/2021, 10:40:18 AM	1h 11m
25	Horton	Tracy	Tracy.Horton@stlukes-stl.com	Member	9/8/2021, 9:42:56 AM	9/8/2021, 10:40:14 AM	57m 17s
26	Natalie	Yanko		Member	9/8/2021, 9:29:28 AM	9/8/2021, 10:36:41 AM	1h 7m
27	Brad	Zoref	brad@stlstarrs.org	Partner	9/8/2021, 9:29:59 AM	9/8/2021, 10:40:08 AM	1h 10m

Attachment A2

St. Louis Healthcare Subcommittee
2021 Goal Development Workplan

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	Workgroup Leader	Completion	Notes
Objective 1A	Coordinate with local/state partners to identify applicable healthcare organizations and facilities within subcommittee geographic scope.	31-May	A. Blevins	100%	
Objective 1B	Review, verify, and update current subcommittee membership roster.	31-May	A. Blevins	100%	
Objective 1C	Develop healthcare subcommittee one-page summary sheet with membership responsibilities, benefits, enrollment details, and FAQs.	31-May	A. Blevins	26 - 50%	Membership sheet content to be informed by new HCS Charter outlining responsibilities, benefits, & expectations of all participant types.
Objective 1D	Distribute subcommittee summary sheet to all eligible healthcare organizations.	30-Jun	A. Blevins	0 - 25%	
Objective 1E	Monitor membership expansion and healthcare facility representation; revise strategy for Goal 1 achievement if/as required.	31-Dec	A. Blevins	0 - 25%	
Objective 1F	Update contact information for all current and new subcommittee members.	30-Jun	A. Blevins	100%	

Goal 2	Deliver healthcare/hospital outcomes defined in St. Louis Healthcare Coalition Strategic Plan.				
	Description	Deadline	Workgroup Leader	Completion	Notes
Objective 2A	Develop and distribute electronic survey to determine and rank specific membership portal needs/features.	31-May	J. O'Brien	100%	
Objective 2B	Analyze and report membership portal survey results within during May meeting.	30-Jun	J. O'Brien	100%	
Objective 2C	Identify potential portal solutions that support/resolve critical needs, as defined by survey results.	30-Jun	J. O'Brien	100%	
Objective 2D	Establish portal solution for subcommittee membership and verify resolution of critical gaps.	30-Sep	J. O'Brien	76 - 99%	

St. Louis Healthcare Subcommittee
2021 Goal Development Workplan

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

Goal 4	Optimize healthcare subcommittee management via revision/alignment of applicable Charters, Bylaws, and other administrative materials.				
	Description	Deadline	Assigned Group/Leader	Completion	Notes
Objective 4A	Verify all applicable documents are included in subcommittee review/revision scope.	30-Jun	C. Minks	100%	
Objective 4B	Review current subcommittee Charter; document recommended edits and submit revised version to subcommittee for review/approval.	30-Jun	C. Minks	100%	
Objective 4C	Coordinate with HCC Coordinator and ESF-8 Committee Chairs to strengthen alignment of approved Healthcare Subcommittee Charter with applicable coalition/STARRS administrative documents; support revision as appropriate.	30-Sep	C. Minks	100%	Subcommittee leaders shared HCS Charter draft, submitted HCC revision recommendations, and collaborated with HCC Charter Workgroup during all scheduled meetings.
Objective 4D	Verify all applicable coalition and healthcare subcommittee management materials are aligned for optimal administrative coordination for upcoming year.	31-Dec	C. Minks	76 - 99%	

Training Newsletter
Healthcare: November 2021

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.

Most 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.

National Healthcare Coalition Preparedness Conference

- November 30 – December 2
- Orlando, Florida
- Register at: https://web.cvent.com/event/be04fb87-1ea3-4231-97f4-0ac69f6a7198/websitePage:0d83fcf6-9693-456f-8682-1d0ef8eb3a72

Re-connect in person with more attendees who work in emergency management, healthcare coalitions, volunteer 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.

G191-V-ICS/EOC Interface Workshop

- Dec 14 & 15 2021, from 830 – 1230 pm
- Virtual
- https://sematraining.com/courses/1703/offerings/8121

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 reviews ICS and EOC characteristics, responsibilities and functions and depends heavily on activities and group discussions to formulate an interface.

Pending! ICS 300 Intermediate Incident Command System

- January 10, 11, & 12
- Rock Community Fire Protection District
- Registration Pending!

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.

Pending! ICS400 Advanced Incident Command System

- February 28, March 1
- Rock Community Fire Protection District
- Registration Pending!

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).

HERT-PER-902: Hospital Emergency Response Training for Mass Casualty Incidents

- Multiple Offerings
- Center for Domestic Preparedness, Anniston, Alabama
- https://cdp.dhs.gov/training/course/PER-902

The Hospital Emergency Response Training for Mass Casualty Incidents (HERT) course addresses healthcare response at the operations level for the facility and its personnel. This three-day course prepares healthcare responders to utilize the Hospital Incident Command System — integrating into the community emergency response network while operating an Emergency Treatment Area as hospital first responders during a mass casualty incident involving patient contamination. The healthcare responders will determine and use appropriate personal protective equipment and conduct triage followed by decontamination of ambulatory and nonambulatory patients as members of a Hospital Emergency Response Team. Train the Trainer Course is also available for HERT.

HID PER-321: Barrier Precautions and Controls for Highly Infectious Disease

- Multiple Offerings
- Center for Domestic Preparedness, Anniston, Alabama
- https://cdp.dhs.gov/training/course/PER-321

This course is a four-day course designed to provide to provide emergency medical service, healthcare, and public health professionals with knowledge and practical experience in the barrier precautions and infection control guidelines and procedures for triaging, transporting, transferring, treating, and managing risk of transmission in persons with highly infectious diseases. This course provides practical application in the handling and treatment of persons with a highly infectious disease, develops critical thinking ability with regard to the decisions that must be effectively made to prevent providers, other patients, and visitor infections when handling and treating persons with a highly infectious disease, and provides knowledge and experience that aids in assessing the risk and reducing the potential for infection.

EMO-PER-267: Emergency Medical Operations for CBRNE Incidents

- Multiple Offerings
- Center for Domestic Preparedness, Anniston, Alabama
- https://cdp.dhs.gov/training/course/PER-267

The Emergency Medical Operations for CBRNE Incidents (EMO) is a four-day course that prepares responders to effectively respond to a chemical, biological, radiological, nuclear, or explosive (CBRNE) or mass casualty incident. The course provides classroom lectures, hands-on training, and culminates with a hands-on practical exercise that allows responders to implement the emergency-response knowledge and skills learned during the course.

AWR-336-W: Health Sector Emergency Preparedness Distance Learning Course

- Center for Domestic Preparedness
- Virtual
- https://cdp.dhs.gov/training/course/AWR-336-W

This course content is to provide training and resources to emergency management officials, healthcare coalitions, healthcare providers and suppliers. The course focuses on the general overview of emergency planning and preparedness; development of policies and procedures; creation of communication plans and training and exercises for healthcare entities.

Medical Response & Surge Exercise (MRSE) Situation Manual

Hospital Preparedness Program

September 2021

Attachment D

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 Cliffon 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 exercise[2]. Information about surge patients provided in MRSE materials is hypothetical in nature and will not reflect

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[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-capablities.pdf. Accessed August 2021.

[2] The Privacy Act of 1974. 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 capacity[3] 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:

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[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.

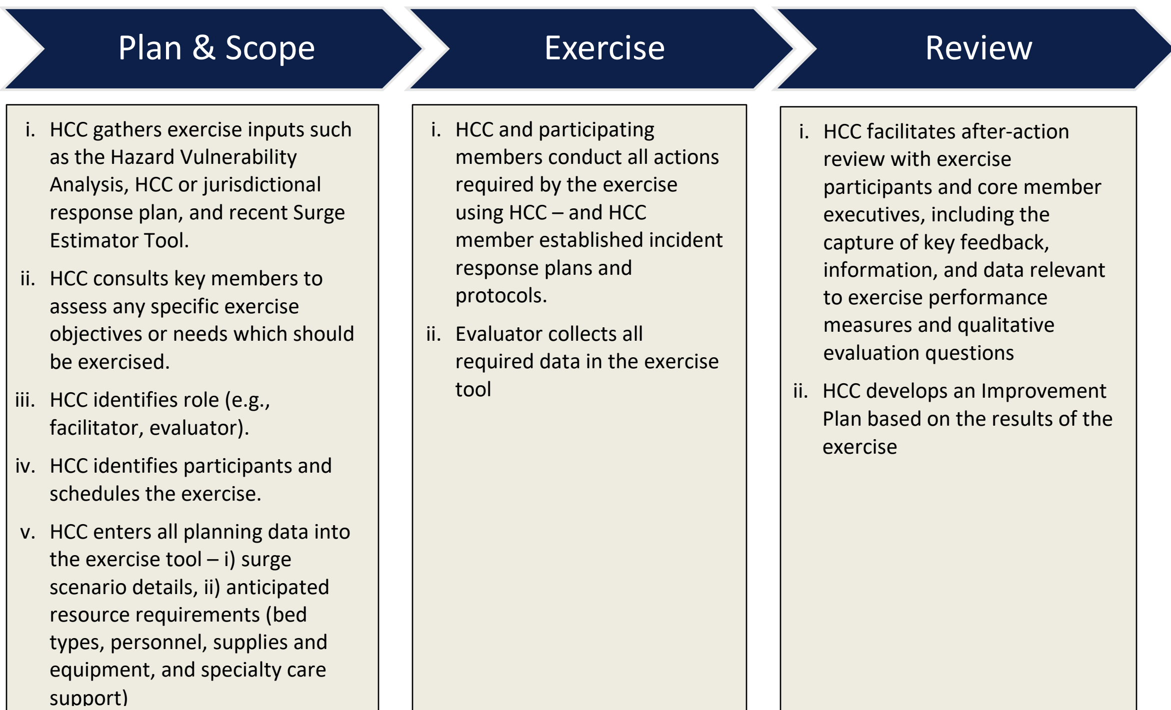
During the course of the MRSE functional exercise, participants will be asked to address topics such as alerts and notifications; situational assessment and information management; operational coordination; resource allocation and mobilization; workforce protection, patient movement and patient care; 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	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).
Exercise Facilitator	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).
Exercise Evaluator	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 *Phase I: Plan & Scope* to understand the exercise objectives, performance measures, and the exercise materials such as the SitMan, MRSE Evaluation Plan, and the accompanying tool.

Exercise Role	Role Description
Duty Officer (Notification System Representative)	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. 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.

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
Consulting HCC Members	Dear [*member name*], [*HCC name*] 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 [*response plan title*], 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 [*scenario description]*. 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. 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. Kind regards, [*Name*] [*RRC*] [*HCC name*]
Participant Invitation	Dear [*member name*], [*HCC name*] will conduct this year's Medical Response & Surge Exercise (MRSE) on [*expected date*] at [*time*]. The exercise is expected to last [*expected duration*]. The MRSE is an operations-based exercise required by the Hospital Preparedness Program (HPP) Cooperative Agreement. The exercise will follow the [*response plan title*], 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 [*scenario description]*. Based on the scenario we plan to exercise, we have identified [*member name*] as an essential participant in this this year's exercise. 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 [*date/time*]. [*instructions for how to participate in the exercise*] Kindly confirm your intention to participate by responding to this message with the name/s of the individual/s who will represent your organization. [*Name*] [*RRC*] [*HCC name*]

Attachment D

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.

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[4] Assistant Secretary for Preparedness and Response. 2017. 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, pharmaceuticals 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
Incident notification to all HCC members	*****EXERCISE | EXERCISE | EXERCISE | EXERCISE***** Incident Notification 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. We request you to acknowledge receipt of this notification by [*deadline*]. [*HCC Representative Name*] [*Title*] [*HCC name*]
EMS agencies – request availability of transport and other resources	*****EXERCISE | EXERCISE | EXERCISE | EXERCISE***** 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.** Please confirm the current number of the following resources you have available by [*deadline*]. • [*List of pre-identified, critical EMS resources*]. Kind regards, [*Name*] [*Exercise Facilitator*] [*HCC name*]
Clinical care members – current staffed bed census	EXERCISE | EXERCISE | EXERCISE | EXERCISE 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**

Communication	Sample Text
	the exercise. Please confirm the current number of staffed beds you have immediately available by the types below. Please respond by [*deadline*]. • 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). • *[List of additional pre-identified, critical bed types].* Kind regards, [*Name*] [*Exercise Facilitator*] [*HCC name*]
Clinical care members – resource availability (personnel and supplies and equipment)	EXERCISE | EXERCISE | EXERCISE | EXERCISE 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]*. 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.** If you receive [*number of patients expected at this facility*], 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 [*deadline*].** • *[List of pre-identified, critical personnel types required to manage patient surge].* • [*list of pre-identified, critical supplies and equipment required to manage patient surge*]. • Would you require HCC support in identifying alternative sources of these resources? If so, which? Kind regards, [*Name*] [*Exercise Facilitator or other title*] [*HCC name*]

Attachment D

Communication	Sample Text
Clinical care – confirm staffed bed availability	EXERCISE | EXERCISE | EXERCISE | EXERCISE 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.** Based on the number of patients expected at your facility, could you kindly note the following by [*deadline*]? 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 *and* 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? Kind regards, [*Name*] [*Exercise Facilitator or other title*] [*HCC name*]
Seeking additional resources from HCC member or other organization	**EXERCISE | EXERCISE | EXERCISE | EXERCISE** 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.** Please confirm the availability of the following resources to be shared with members

Communication	Sample Text
	of [*HCC name*] to accommodate the large-scale surge inpatients. Kindly reply by [*deadline*]. • [*list and quantity of resources required*]. Kind regards, [*Name*] [*Exercise Facilitator or other title*] [*HCC name*]

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)	ESF-8 provides the mechanism for coordinated federal assistance to supplement state, tribal, and local resources in response to the following: • 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. Reference: "Emergency Support Functions." Public Health Emergency. http://www.phe.gov/Preparedness/support/esf8/Pages/default.aspx#8. Accessed 6 Aug. 2020.
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 *prevention, protection, response,* and *recovery capabilities* 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.

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.

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.

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

Attachment D1

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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-capablities.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 exercise[22]. 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

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[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 capacity[3] 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	• Confirm your ability to attend the full MRSE exercise, including *Phase I Plan & Scope*, 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:
	   ▪ The MRSE Situation Manual
	   ▪ The MRSE Exercise Planning and Evaluation Tool
		N/A

Exercise Phase	Responsibilities	Evaluation Products
	▪ The MRSE Evaluation Plan (this document) • Review materials relevant to HCC response (including HCC Response Plan; policies and procedures)	
Phase I Plan & Scope	• 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 *Phase I Plan & Scope* is completed and that information on the *Phase I Plan & Scope* tab of the Exercise Planning and Evaluation Tool is completely and accurately filled in	Completed *Phase I Plan & Scope* tab in the Exercise Planning and Evaluation Tool
Phase II Exercise	• 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 *Phase II Exercise Initial Actions* and Phase *II Exercise Operations* tabs in the Exercise Planning and Evaluation Tool

Exercise Phase	Responsibilities	Evaluation Products
	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 • 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 *Phase III: After-Action Review* tab in the Exercise Planning and Evaluation Tool • Ensure the *Phase II Exercise Initial Actions* and *Phase II Exercise Operations* tabs are filled in fully and in accordance with the play of the HCC throughout the exercise	
Phase III After-Action Review	• Facilitate discussion during the AAR using the scripts and tables included in the *Phase III After-Action Review* 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 *Phase III After-Action Review* 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,	Completed *Phase III After-Action Review* tab in the Exercise Planning and Evaluation Tool

Exercise Phase	Responsibilities	Evaluation Products
	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. • 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 *Phase III After-Action Review* tab in the Exercise Planning and Evaluation Tool is filled out completely	
Phase III Improvement Planning	• Participate in HCC processes for improvement planning based upon strengths, challenges, and lessons learned documented in the *Phase III After-Action Review* tab • Exercise Evaluators will support the HCC in using the outputs of the Exercise Planning and Evaluation Tool *Phase III After-Action Review* tab 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 • Ensure that the *Phase III Improvement Plan* tab in the Exercise Planning and Evaluation Tool is filled out completely	Completed *Phase III Improvement Plan* tab in the Exercise Planning and Evaluation Tool Completed Exercise Planning and Evaluation Tool

Exercise Phase	Responsibilities	Evaluation Products
	• 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 PREPAREDNES 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

<table>
<tr><td>Numerator</td><td>Number of pre-identified, critical required personnel types that were fully met by your HCC and its members to manage patient surge

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.

Personnel Types
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)</td></tr>
<tr><td>Denominator</td><td>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.

Personnel Types</td></tr>
</table>

	• 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)

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	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 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

	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)

Denominator	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. **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 and neonatal ICU beds • Oncology unit beds • Other (describe below) **Pharmaceutical Supplies** • 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 **Non-pharmaceutical supplies and Equipment Types** • Blood products • Intravenous fluids • Infusion pumps • Ventilators • Bedside monitors • Airway suction (adult and pediatric) • Surgical equipment and supplies

	• Supplies needed to administer pharmaceuticals, blood products, and intravenous fluids • Other (describe below)

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	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. 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. • 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)
Denominator	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. (Select all that apply) • 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	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	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	Number of HCC core members with at least one executive that participated in the exercise AAR below: • Hospital • EMS

	• Public Health • Emergency Management
Denominator	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. • 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	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 *2017-2022 Health Care Preparedness and Response Capabilities* for more information about member types. • Hospital • Public Health • EMS • Emergency Management • Laboratory

	• Pharmacy • Long Term Care Facility • Nursing Home • Other (specify)
Denominator	Number of pre-identified, critical members of each type to manage patient surge: • 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	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? a. Joint Commission b. CMS c. PHEP d. EMS-related exercise requirements e. Other (please specify)
Incident Recognition	3. How is the HCC notified? 4. Identify Initial Incident Details a. What, When, Where b. Responding units c. Reported injuries (approx. # & type) 5. Identify Current Operating Conditions: a. Weather b. Traffic c. Other factors impacting operations
Notification	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	ESF-8 provides the mechanism for coordinated federal assistance to supplement state, tribal, and local resources in response to the following: • 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 Reference “Emergency Support Functions.” Public Health

Term	Definition
	Emergency. http://www.phe.gov/Preparedness/support/esf8/Pages/default.aspx#8. Accessed 6 Aug. 2020.
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, nongovernmental 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.
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 *prevention, protection, response,* and *recovery capabilities* 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

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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The Express: October 2021

This issue of *The Express* highlights the following new resources:

- Healthcare Coalition Engagement in COVID-19 Assessment (infographic)
- Next Generation HCCs: Learning and Evolving from COVID-19 (webinar)
- Managing the Nation's Blood Supply During the COVID-19 Pandemic (speaker series recording)
- Excess Mortality and COVID-19 Surges: Defining the Problem and Solutions (speaker series recording)
- Hospital and Fire Department Roles in Decontamination Incidents (technical assistance [TA] response)
- Facility Cleaning and Sanitation Guidelines (TA response)
- Hospital Surge of Patients with Behavioral Health Challenges during COVID-19 (TA response)
- Roles of Public Libraries in Emergency Response (TA response)

Please continue to access our COVID-19 Patient Surge and Scarce Resource Allocation page, 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 Coalition Engagement in COVID-19 Assessment

This infographic highlights findings from a multi-phased effort that included an

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online survey open to all healthcare coalitions (HCC) about various aspects of their response to the pandemic and eight focus groups with a subset of survey respondents. Access the full report for more information.

Next Generation HCCs: Learning and Evolving from COVID-19 (Webinar)

This webinar will highlight key findings from the Healthcare Coalition Engagement in COVID-19 Assessment project and how they can help inform future ASPR guidance and HCC planning, response, and recovery efforts. The webinar will take place Wednesday, December 8, 2021, at 2:30 PM ET. **Register today**!

Managing the Nation's Blood Supply During the COVID-19 Pandemic

Experts from the American Association of Blood Banks discuss the role of blood centers during disasters in general and specifically during the COVID-19 pandemic in this recording.

Excess Mortality and COVID-19 Surges: Defining the Problem and Solutions

In this recording, Dr. Sameer S. Kadri (Head, Clinical Epidemiology Section, Tenure Track Investigator, Critical Care Medicine Dept., NIH Clinical Center) discusses the role patient surge plays in mortality, shares a surge index formula, and explains how Medical Operations Coordinating Cells can help with patient loading.

Both of these recordings are part of the COVID-19 Healthcare Operations Speaker Series.

New ASPR TRACIE TA Responses

- Hospital and Fire Department Roles in Decontamination Incidents provides resources related to the responsibilities hospitals and fire departments have in managing hazardous materials decontamination incidents.
- Facility Cleaning and Sanitation Guidelines includes resources on general cleaning and sanitation of a facility that is being reopened for purposes such as hosting a monoclonal antibody COVID-19 treatment site. It also includes materials on preparing or modifying buildings for repurposing.
- Hospital Surge of Patients with Behavioral Health Challenges during COVID-19 includes comments from ASPR TRACIE Subject Matter Expert

Attachment E

Cadre members and resources related to managing a surge of hospital patients with behavioral health challenges during the COVID-19 pandemic.

- Roles of Public Libraries in Emergency Response provides links to resources related to the roles that public libraries can play in emergency response.

Subscribe to the Division of Critical Infrastructure Protection's Bulletins

ASPR's Division of Critical Infrastructure Protection (CIP) offers a variety of newsletters to keep stakeholders informed during emergency response and steady state. The newsletters inform stakeholders of the most significant issues facing the Healthcare and Public Health Sector including cybersecurity, healthcare supply chains, COVID-19, and more. If you are interested in receiving CIP newsletters, visit the CIP newsletter subscription webpage.

COVID-19 Clinical Rounds Are Back!

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.

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The Express: October 2021 (Update #2)

This issue of *The Express* highlights the following new resources:

- Healthcare Coalition Radiation Emergency Surge Annex Tabletop Exercise Toolkit
- Monoclonals and More: Issues and Opportunities with Early COVID-19 Treatment Options (webinar)
- New Training! Disaster Medicine: Sepsis

Coming soon: Issue 14 of *The Exchange*, featuring articles on the impact of civil unrest on healthcare facilities, workplace violence in healthcare, and changes that can be made to emergency departments to deter violence and increase staff, patient, and visitor safety.

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 Coalition Radiation Emergency Surge Annex Tabletop Exercise Toolkit

This toolkit template can be used by healthcare coalitions (HCCs) to enhance operational area awareness and capabilities to effectively address the needs of

Attachment E1

patients impacted by a radiological incident as part of a whole community emergency response framework. HCCs are not required to use this template, but it can be utilized to satisfy Funding Opportunity Announcement requirements for the Hospital Preparedness Program Cooperative Agreement. The template complements ASPR TRACIE's HCC Radiation Emergency Surge Annex Template. For more information, access our CBRN Resources Page and additional resources for HCCs.

Register Today—Monoclonals and More: Issues and Opportunities with Early COVID-19 Treatment Options (webinar)

In this webinar (November 12, 12:30-2:00 PM ET), speakers will review some of the most current recommendations for use of monoclonal antibodies (mAbs), upcoming therapies, and the challenges and opportunities that new therapies may pose in conjunction with mAb and other treatments (e.g., prioritization and distribution). Speakers will also highlight operational principles for a scaled strategy for use of these therapeutics in a scarce resource situation. **Register today!**

New Training! Disaster Medicine: Sepsis

Populations affected by disasters are exposed to a variety of health hazards such as trauma, burns, poor sanitation, and mass sheltering, all of which place them at increased risk of infection and sepsis. Under the austere, resource-limited conditions typical of disaster zones, the clinical identification and management of sepsis can be more challenging compared to normal operating conditions in conventional health care settings. This free training module (funded by BARDA) provides guidance to emergency health professionals on how to recognize, assess, and evacuate patients with or at risk of sepsis in the context of a disaster response.

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