SEMNDHC SURGE TEST 2019 Functional/Tabletop Exercise

After-Action Report / Improvement Plan 2017-2022

Exercise Date: March 7, 2019

Date Published: May 30, 2019

EXERCISE DESCRIPTION

Exercise Name	SEMNDHC SURGE TEST 2019 Functional/Tabletop Exercise
Exercise Date	March 7, 2019
Scope	This was a functional and tabletop exercise that was conducted on March 7, 2019 from 7:30am to 12:00pm at various hospitals, long-term care facilities, health departments, emergency management agencies, and ancillary partners across the Southeast Minnesota Disaster Healthcare Coalition. Exercise play focused on the evacuation of patients; however no actual patients were evacuated during the exercise. Additionally, this exercise included the SEMN Healthcare Multi-Agency Coordination Center (H-MACC) activation and a coalition conference call. (Improvement items related to the communication part of this exercise are covered in a separate AAR.)
Mission Area(s)	Response
HPP Capabilities	HPP #1 - Foundation for Health Care and Medical Readiness HPP #2 - Health Care and Medical Response Coordination HPP #4 - Medical Surge *Note: The six-core emergency management function areas defined by The Joint Commission were also considered for during the review of this exercise.*
Objectives	1. Test the ability of an evacuating facility and its coalition partners to rapidly shift into disaster mode. 2. Determine whether an evacuating facility knows whom to contact upon learning of the need to evacuate, and whether it can reach them at a moment's notice. 3. Assess coalition members' ability to communicate and coordinate quickly to find and match available beds and transportation resources with those needing to be evacuated. 4. Assess coalition member's ability to plan an evacuation/surge with existing on-site staff without excessive guidance or prompting from leadership. 5. Evaluate the ability of long-term care facilities to surge during a disaster. 6. Assess Local Public Health's ability to identify needs and provide assistance to discharged patients who receive County services. 7. Evaluate the patient data provided by the evacuation facility to EMS and receiving facility. 8. Assess Local Emergency Management's ability to assist with facility evacuations, patient transports, and related needs.

Threat or Hazard	Explosive device incidents causing a simulated evacuation of at least 20% (323 beds) of the healthcare coalition's 1,616 total staffed acute care beds.
Scenario or Incident Description	Detonation of a bomb in Mayo Clinic's Eisenberg Building with subsequent threats of another bomb in the Eisenberg Building as well as Olmsted Medical Center resulting in the need for full evacuation of both of these patient care buildings.
Sponsor	Department of Health and Human Services (DHHS) Assistant Secretary for Preparedness and Response (ASPR), SEMNDHC, and Mayo Clinic.
Participating Organizations	Participants by organization type is listed in Appendix B.
Point of Contact	Kristen Sailer, SEMN DHC Regional Healthcare Preparedness Coordinator ksailer@cemainc.com

EXECUTIVE SUMMARY

On March 7, 2019, various hospitals, long-term care centers (LTCs), EMS agencies, local health departments, local emergency management offices, and Southeast Minnesota Disaster Health Coalition's (SEMNDHC) Healthcare Multi-Agency Coordination Center (H-MACC) participated in a four-and-a-half-hour functional/tabletop exercise that tested evacuation and surge capabilities throughout the region, as a Coalition Surge Test (CST). The Department of Health and Human Services (DHHS) Assistant Secretary for Preparedness and Response (ASPR) grants require communities to conduct exercises to improve disaster response operations capabilities. Additionally, the Joint Commission requires hospitals and ambulatory care facilities to conduct exercises periodically. The Healthcare Preparedness Program (HPP) also requires periodic exercises to assess specific regional response capabilities. The region recognizes the need to understand expectations, roles, and responsibilities of work areas during an incident involving Evacuation. This CST is part of a comprehensive exercise plan.

The purpose of this CST was to ensure that the Healthcare Coalition (HCC) can transition quickly and efficiently into "disaster mode" and provide a more realistic picture of readiness than traditionally seen in pre-announced exercises. As required by the federal HPP grant, this CST involved a regional low- to no-notice surge exercise using the provided, standardized coalition surge tools.

Even though the CST did not include the actual movement of patients, the goal was to simulate the ability to evacuate at least twenty percent of the healthcare coalition's total staffed acute-care bed capacity to be absorbed at other healthcare facilities within the region. Twenty percent of the staffed acute care bed capacity within the southeast region equates to 323 beds. At the beginning of the CST, there were 319 patients at the two evacuating facilities. The two evacuating facilities were Mayo Clinic's Eisenberg Building as well as Olmsted Medical Center located in Rochester, Minnesota. This amounts to 18.6% of the total number (1,616) of staffed acute care beds in the coalition. During the CST, 74 (23.2%) of the patients at the two evacuating facilities were identified as being able to be discharged safely to home, and 245 (76.8%) were identified as being able to be evacuated to receiving facilities.

To meet the goal of evacuating a number of patients equal to 20% of the staffed acute care beds in the coalition, the goal was to simulate such an evacuation of 323 patients. While this target was not met within the 90-minute functional window of time during the CST s (i.e., by the stop time identified by federal requirement for the evacuation portion of the CST), coalition members exhibited excellent efficiency in assessing available staffed beds and coordinating interfacility transfer of the evaluated patients. This included not only movement of patients to other hospitals, but several long-term care centers (LTCs) as valued coalition member organizations. As a result of this CST, important strengths and areas for improvement were identified from a regional perspective.

ANALYSIS OF HPP CAPABILITIES

Alignment of exercise objectives and capabilities provides a consistent taxonomy for evaluation that transcends individual exercises to support preparedness reporting and trend analysis. Table 1 includes the exercise objectives, aligned capabilities, and performance ratings for each capability as observed during the exercise and determined by the evaluation team.

Table 1 Summary of Capability Performance

The following sections provide an overview of the performance related to each exercise or incident objective and the associated HPP Capability, highlighting strengths, and areas for improvement.

Objective	HPP Capability	P	S	M	U
1. Test the ability of an evacuating facility and its coalition partners to rapidly shift into disaster mode.	#1 Foundation for Health Care & Medical Readiness		X		
2. Determine whether an evacuating facility knows whom to contact upon learning of the need to evacuate, and whether it can reach them at a moment's notice.	#2 Health Care & Medical Response Coordination	X			
3. Assess coalition members' ability to communicate and coordinate quickly to find and match available beds and transportation resources with those needing to be evacuated.	#2 Health Care & Medical Response Coordination	X			
4. Assess coalition member's ability to plan an evacuation/surge with existing on-site staff without excessive guidance or prompting from leadership.	#4 Medical Surge		X		
5. Evaluate the ability of long-term care facilities to surge during a disaster.	#4 Medical Surge		X		
6. Assess Local Public Health's ability to identify needs and provide assistance to discharged patients who receive County services.	#4 Medical Surge	X			
7. Evaluate the patient data provided by the evacuation facility to EMS and receiving facility.	#4 Medical Surge		X		
8. Assess Local Emergency Management's ability to assist with facility evacuations, patient transports, and related needs.	#4 Medical Surge	X			

Ratings Definitions

Performed without Challenges (P): The targets and critical tasks associated with the capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws.

Performed with Some Challenges (S): The targets and critical tasks associated with the capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws. However, opportunities to enhance effectiveness and/or efficiency were identified.

Performed with Major Challenges (M): The targets and critical tasks associated with the capability were completed in a manner that achieved the objective(s), but some or all of the following were observed: demonstrated performance had a negative impact on the performance of other activities; contributed to additional health and/or safety risks for the public or for emergency workers; and/or was not conducted in accordance with applicable plans, policies, procedures, regulations, and laws.

Unable to be Performed (U): The targets and critical tasks associated with the capability were not performed in a manner that achieved the objective(s).

Surge Test Performance Measures

(Answers are in red and were documented using the ASPR Annual Coalition Surge Test exercise tool)

- Percent of HCC core member organizations participating in Coalition Surge Test.
  - Hospitals: 100.0% (11 of 11 Hospitals)
  - EMS Agencies: 92.3% (36 of 39 EMS Agencies)
  - EM Organizations: 16.7% (2 of 12 EM Organizations)
  - PH Agencies: 27.3% (3 of 11 PH Agencies)
- Percent of HCC core member organizations' executives participating After-Action Review.
  - Hospitals: 100.0% (11 of 11 Hospitals)
  - EMS Agencies: 2.6% (1 of 39 EMS Agencies)
  - EM Organizations: 8.3% (1 of 12 EM Organizations)
  - PH Agencies: 27.3% (3 of 11 PH Agencies)
- Percent of patients at the evacuating facilities that are identified as able to be:
  - discharged safely to home or LTC: 23.2% (74 of 319 patients)
  - evacuated to receiving facilities: 76.8% (245 of 319 patients)
- Time for evacuating facilities to report the total number of evacuating patients: 90 mins
- Percent of evacuating patients with an appropriate bed identified at a receiving health care facility in 90 minutes: 89% (284 of 319 patients)
- Time for receiving facilities to report the total number of beds available to receive patients: 90 mins
- Percent of evacuating patients with acceptance for transfer to another facility that have an appropriate mode of transport identified in 90 minutes: 89.0% (284 of 319 patients)
- Time to identify an appropriate mode of transport for the last evacuating patient: 90 mins

EVALUATION OF STRENGTHS AND AREAS FOR IMPROVEMENT

HPP Capability #1: Foundation for Health Care & Medical Readiness

1. Objective: Test the ability of an evacuating facility and its coalition partners to rapidly shift into disaster mode.

Gap Addressed: Disasters response needs testing.

The strengths and areas for improvement for each capability aligned to this objective are described in this section.

Strengths

The following strengths were identified during the exercise for this objective:

Strength 1: Evacuating facilities can immediately activate their emergency evacuation plans and teams. Receiving facilities (hospitals and LTCs) assessed the impact of the incident, including their ability to receive evacuated patients, and activate their emergency response systems if necessary.

Strength 2: The H-MACC can immediately activate to provide assistance and coordinate information needed to help manage evacuation and interfacility transfer decisions and resource needs.

Areas for Improvement

The following areas for improvement were identified during the exercise for this objective:

1.1. Area for Improvement: Meeting CST Goals

Reference: MYTEP

Analysis: The goal for this exercise was to simulate the evacuation of a number of patients equal to 20% of the staffed acute care beds in the coalition – i.e., 323 of the total 1,616 staffed beds region-wide. At the onset of the CST, there were 319 patients requiring assistance at the two evacuating facilities, of which 74 (23.2%) were discharged safely to home and 245 (76.8%) were evacuated to receiving facilities. While the goal of evacuating 323 patients was not met, critical capabilities were validated and important lessons were learned.

Recommendations:

1.1.1. Provide feedback to MDH and ASPR regarding adjusting the metrics to accommodate regional dynamics. It is not feasible to plan regional surge

exercises with other facilities when only one hospital has the capacity of the entire region in one facility.

1.2. Area for Improvement: Activation Process

Reference: H-MACC Guidelines

Analysis: While the ability to rapidly activate (or at least contemplate the need for activation) was reported by most hospitals and LTCs, it is unclear what decision-making criteria were used to make such decisions.

Recommendations:

1.2.1. Coalition healthcare partners should review their H-MACC activation process to ensure that consistent and well-defined variables are used to evaluate the need for activation of emergency response systems.

1.2.2. Coalition healthcare partners desiring to improve/update their EOPs with the H-MACC Guidelines should request copies of the H-MACC Guidelines.

HPP Capability #2: Health Care & Medical Response Coordination

2. Objective: Determine whether an evacuating facility knows whom to contact upon learning of the need to evacuate, and whether it can reach them at a moment's notice.

Gap Addressed: Communication plans should be tested regularly to ensure functionality.

The strengths and areas for improvement for each capability aligned to this objective are described in this section.

Strengths

The following strengths were identified during the exercise for this objective:

Strength 1: Participating hospitals and LTCs generally exhibited knowledge of whom to contact and how to contact them, in the event of an incident requiring evacuation.

Strength 2: The H-MACC plays an essential role in brokering multi-site communications to help make informed decisions as a coalition during a large-scale incident.

Areas for Improvement

The following areas for improvement were identified during the exercise for this objective:

2.1. Area for Improvement: Information Sharing

Reference: Regional Communications Plan

Analysis: While knowledge of whom to contact and how to contact them was generally good, a number of missed communications or erroneous communications occurred. In some cases, these issues occurred internally (e.g., discrepancies in numbers from Epic

reports, Surgery received no notification); in other cases, these issues occurred externally (e.g., LTC not receiving a return phone call from ATC, calls that went straight to voice mail with no return call).

Recommendations:

2.1.1. Coalition healthcare partners should review their EOP Communications Annex to ensure that a consistent process is articulated, including how different communications modalities are to be used for different purposes.

2.1.2. The regional communications plan should be developed and/or updated and shared with all regional partners.

3. Objective: Assess coalition members' ability to communicate and coordinate quickly to find and match available beds and transportation resources with those needing to be evacuated.

Gap Addressed: Coordinating across hospital systems under disaster conditions should be tested.

The strengths and areas for improvement for each capability aligned to this objective are described in this section.

Strengths

The following strengths were identified during the exercise for this objective:

Strength 1: Within 90 minutes, appropriate staffed beds were identified for 210 (85.7%) of the 245 patients requiring evacuation. Presumably, by the time the final 35 (14.3%) patients were being prepared for transport to a receiving facility, appropriate staffed beds would be identified for these remaining patients, as well.

Strength 2: EMS partners closely monitored the progression of the incident and rapidly reported their available transportation resources via MN Trac.

Areas for Improvement

The following areas for improvement were identified during the exercise for this objective:

3.1. Area for Improvement: EMS Resource Availability

Reference: SEMNDHC Medical Disaster Resources Guidelines

Analysis: Over the 90-minute functional exercise portion of the CST, an appropriate mode of transport was identified for only 284 (89%) of the 319 patients requiring evacuation. While transporting units would be able to return to the evacuating facilities to pick up and transport additional patients over time, an additional constriction that needs to be considered is distance: given the size of the region, depending upon the locations of the evacuating and receiving facilities, an outbound ambulance may not be able to return to

assist with another evacuated patient for potentially multiple hours. City and Mayo transportation was considered with approximately 170 patients being transported.

Recommendations:

3.1.1 Perform additional root-cause analysis to determine if more transport resources could be deployed in a real evacuation incident (pointing to perhaps an exercise artificiality) or if the numbers of available transport resources are indeed valid (pointing to a critical gap in real-world mass patient transport capacity).

3.1.2 Identify specific sources and numbers of additional and non-traditional means to transport patients during a major evacuation incident, for inclusion in SEMNDHC Medical Disaster Resources Guidelines.

HPP Capability #4: Medical Surge

4. Objective: Assess coalition member's ability to plan an evacuation/surge with existing on-site staff without excessive guidance or prompting from leadership.

Gap Addressed: Evacuations are rare occurrences. Plans need assessment.

The strengths and areas for improvement for each capability aligned to this objective are described in this section.

Strengths

The following strengths were identified during the exercise for this objective:

Strength 1: Based on exercise documentation received, it appears that most coalition partner organizations are relatively comfortable with coordinating needs for a major evacuation incident without excessive guidance or prompting from leadership.

Areas for Improvement

The following areas for improvement were identified during the exercise for this objective:

4.1. Area for Improvement: Reporting Patients/Beds

Reference: MN Trac, etc.

Analysis: Reporting of numbers of patients and the staffed beds required to accommodate them at receiving facilities was at times confusing. Internally, in the Mayo Clinic system, there were discrepancies in numbers from Epic reports. Externally, numbers of patients, transport resources, and beds available were sometimes reported differently, such as by telephone, email, MN Trac or other channels. Lack of a uniform reporting method may have hindered the decision-making process to coordinate patient evacuations.

Recommendations:

4.1.1. The SEMN DHC should review the Essential Elements of Information and determine if outreach should occur on the information required.

4.1.2. Regionally, a planning workshop should be considered to identify the elements of essential information necessary during a major incident requiring patient evacuations so that coalition partners can update their EOP Evacuation Annexes accordingly.

5. Objective: Evaluate the ability of long-term care facilities to surge during a disaster.

Gap Addressed: Long-term care surge capability needs to be assessed.

The strengths and areas for improvement for each capability aligned to this objective are described in this section.

Strengths

The following strengths were identified during the exercise for this objective:

Strength 1: Even though a long-term care surge capability assessment was not required, this activity was built into this CST, and four LTCs participated.

Areas for Improvement

The following areas for improvement were identified during the exercise for this objective:

5.1. Area for Improvement: LTC Preparedness.

Reference: MYTEP

Analysis: The four LTCs that participated in this CST appear to be at different stages of developing their emergency preparedness programs, in terms of emergency plans/policies, resource and contact lists, staff training, and exercises.

Recommendations:

5.1.1. Additional coalition training and exercise events focused specifically on developing and testing LTC preparedness capabilities will help shore up disparities in the region's level of LTC preparedness over time.

6. Objective: Assess Local Public Health's ability to identify needs and provide assistance to discharged patients who receive County services.

Gap Addressed: The impact of a large increase in patient discharge on a community has not been adequately assessed.

The strengths and areas for improvement for each capability aligned to this objective are described in this section.

Strengths

The following strengths were identified during the exercise for this objective:

Strength 1: During the CST, 74 (23.2%) of the 319 patients at the two evacuating facilities were identified as being able to be discharged safely to home. This significantly alleviated the burden on coalition partners to accommodate the more rigorous needs of patients needing evacuation to other healthcare facilities.

Strength 2: Local public health resources and capabilities vary throughout the region, but in general, it appears that local public health has the means necessary to provide assistance to patients discharged to their homes by working with their routine resources.

Areas for Improvement

The following areas for improvement were identified during the exercise for this objective:

6.1. Area for Improvement: Testing of PH Role

Reference: MYTEP

Analysis: More focused exercising of the role of local public health needs to be done to validate the strengths and opportunities for improvement relative to their role in providing assistance during a mass healthcare facility evacuation incident.

Recommendations:

6.1.1. Plan future CSTs to explore issues associated with discharged patients at a deeper level, including how information is exchanged between the evacuating facilities and local public health agencies, and building an action plan to meet these patients' needs based on actual, real-world resources available through the County to determine if there are any potential gaps.

7. Objective: Evaluate the patient data provided by the evacuation facility to EMS and receiving facility.

Gap Addressed: An improvement item from the last exercise indicated that receiving facilities are unsure what information will accompany an evacuating patient.

The strengths and areas for improvement for each capability aligned to this objective are described in this section.

Strengths

The following strengths were identified during the exercise for this objective:

Strength 1: Within 90 minutes, appropriate staffed beds were identified for 210 (85.7%) of the 245 patients requiring evacuation. Presumably, by the time the final 35 (14.3%) patients were being prepared for transport to a receiving facility, appropriate staffed beds would be identified for these remaining patients, as well.

Strength 2: EMS partners closely monitored the progression of the incident and rapidly reported their available transportation resources via MN Trac.

Areas for Improvement

The following areas for improvement were identified during the exercise for this objective:

7.1. Area for Improvement: Patient Data

Reference: EOP Evacuation Annexes

Analysis: More focused exercising of the information that will accompany an evacuating patient needs to be done to validate the strengths and opportunities for improvement relative to these needs during a mass healthcare facility evacuation incident. Specifically, what portions of medical records need to be provided? How is HICS Form 260 (Patient Evacuation Tracking Form) used? What other data needs to be provided to ensure an effective physician-to-physician handoff?

Recommendations:

7.1.1. Coalition healthcare partners should review their EOP Evacuation Annex to ensure that specific types of patient data are sent (as an evacuating facility) or requested (as a receiving facility) to improve the physician-to-physician handoff process.

7.1.2. Regionally, a planning workshop should be considered to identify the specific types of patient data necessary (in both the evacuating and receiving facility roles) during a major incident requiring patient evacuations so that coalition partners can update their EOP Evacuation Annexes accordingly.

8. Objective: Assess Local Emergency Management's ability to assist with facility evacuations, patient transports, and related needs.

Gap Addressed: Coordination with local emergency management for facility evacuations and mass interfacility transfers needs to be assessed.

The strengths and areas for improvement for each capability aligned to this objective are described in this section.

Strengths

The following strengths were identified during the exercise for this objective:

Strength 1: Local emergency management programs are capable of supporting a wide range of needs through the activation of local (tribal/county/city) EOCs.

Areas for Improvement

The following areas for improvement were identified during the exercise for this objective:

8.1. Area for Improvement: Testing of EM Role

Reference: MYTEP

Analysis: More focused exercising of the role of local emergency management needs to be done to validate the strengths and opportunities for improvement relative to their role in providing assistance during a mass healthcare facility evacuation incident.

Recommendations:

8.1.1. Plan future CSTs to explore issues associated with coordinating with local emergency management and local (tribal/county/city) EOCs at a deeper level, including how information is exchanged between the evacuating facilities and EOCs, coordinating patient evacuation needs with local fire/rescue services, controlling access/traffic with law enforcement, etc.

APPENDIX A: IMPROVEMENT PLAN

This IP has been developed for the Southeast Minnesota Disaster Healthcare Coalition as a result of the 2019 Surge Test Functional / Tabletop Exercise conducted on March 7, 2019.

Issue / Area for Improvement	Corrective Action	Capability Element[1]	POC/Agency	Start Date	End Date
HPP Capability #1: Foundation for Health Care & Medical Readiness					
1.1 Meeting CST Goals	1.1.1. Provide feedback to MDH and ASPR regarding adjusting the metrics to accommodate regional dynamics. It is not feasible to plan regional surge exercises with other facilities when only one hospital has the capacity of the entire region in one facility.	Planning (Exercises)	Kristen Sailer SEMN DHC RHPC	June 18, 2019	June 30, 2019
1.2 Activation Process	1.2.1. Coalition healthcare partners should review their H-MACC activation process to ensure that consistent and well-defined variables are used to evaluate the need for activation of emergency response systems.	Planning	Kristen Sailer SEMN DHC RHPC	June 18, 2019	June 30, 2020
	1.2.2. Coalition healthcare partners desiring to improve/update their EOPs with the H-MACC Guidelines should request copies of the H-MACC Guidelines.	Planning	Kristen Sailer SEMN DHC RHPC	June 18, 2019	June 30, 2020

1. Capability Elements: Planning, Skills/Training, Equipment/Technology
2. Please submit a copy of this AAR/IP to health.hpp@state.mn.us

Issue / Area for Improvement	Corrective Action	Capability Element[1]	POC/Agency	Start Date	End Date
HPP Capability #2: Health Care & Medical Response Coordination					
2.1 Information Sharing	2.1.1. Coalition healthcare partners should review their EOP Communications Annex to ensure that a consistent process is articulated, including how different communications modalities are to be used for different purposes.	Planning; Equipment/ Technology	Kristen Sailer SEMN DHC RHPC	June 18, 2019	June 30, 2020
	2.1.2. The regional communications plan should be developed and/or updated and shared with all regional partners.	Planning; Equipment/ Technology	Kristen Sailer SEMN DHC RHPC	June 18, 2019	June 30, 2020
3.1 EMS Resource Availability	3.1.1 Perform additional root-cause analysis to determine if more transport resources could be deployed in a real evacuation incident (pointing to perhaps an exercise artificiality) or if the numbers of available transport resources are indeed valid (pointing to a critical gap in real-world mass patient transport capacity).	Planning	Don Hauge SE EMS Director	June 18, 2019	June 30, 2020
	3.1.2 Identify specific sources and numbers of additional and non-traditional means to transport patients during a major evacuation incident, for inclusion in SEMNDHC Medical Disaster Resources Guidelines.	Planning	Kristen Sailer SEMN DHC RHPC Don Hauge SE EMS Director	June 18, 2019	June 30, 2020

Issue / Area for Improvement	Corrective Action	Capability Element[1]	POC/Agency	Start Date	End Date
HPP Capability #4: Medical Surge					
4.1 Reporting Patients/Beds	4.1.1. The SEMN DHC should review the Essential Elements of Information and determine if outreach should occur on the information required.	Planning	Kristen Sailer SEMN DHC RHPC	June 18, 2019	June 30, 2020
	4.1.2. Regionally, a planning workshop should be considered to identify the elements of essential information necessary during a major incident requiring patient evacuations so that coalition partners can update their EOP Evacuation Annexes accordingly.	Planning	Kristen Sailer SEMN DHC RHPC	June 18, 2019	June 30, 2020
5.1 LTC Preparedness	5.1.1. Additional coalition training and exercise events focused specifically on developing and testing LTC preparedness capabilities will help shore up disparities in the region's level of LTC preparedness over time.	Planning (Training & Exercises); Skills/Training	Kristen Sailer SEMN DHC RHPC	June 18, 2019	June 30, 2020
6.1 Testing of PH Role	6.1.1. Plan future CSTs to explore issues associated with discharged patients at a deeper level, including how information is exchanged between the evacuating facilities and local public health agencies, and building an action plan to meet these patients' needs based on actual, real-world resources available through the County to determine if there are any potential gaps.	Planning (Exercises)	Kristen Sailer SEMN DHC RHPC	June 18, 2019	June 30, 2020

Issue / Area for Improvement	Corrective Action	Capability Element[1]	POC/Agency	Start Date	End Date
7.1 Patient Data	7.1.1. Coalition healthcare partners should review their EOP Evacuation Annex to ensure that specific types of patient data are sent (as an evacuating facility) or requested (as a receiving facility) to improve the physician-to-physician handoff process.	Planning	Kristen Sailer SEMN DHC RHPC	June 18, 2019	June 30, 2020
	7.1.2. Regionally, a planning workshop should be considered to identify the specific types of patient data necessary (in both the evacuating and receiving facility roles) during a major incident requiring patient evacuations so that coalition partners can update their EOP Evacuation Annexes accordingly.	Planning	Kristen Sailer SEMN DHC RHPC	June 18, 2019	June 30, 2020
8.1 Testing of EM Role	8.1.1. Plan future CSTs to explore issues associated with coordinating with local emergency management and local (tribal/county/city) EOCs at a deeper level, including how information is exchanged between the evacuating facilities and EOCs, coordinating patient evacuation needs with local fire/rescue services, controlling access/traffic with law enforcement, etc.	Planning (Exercises)	Kristen Sailer SEMN DHC RHPC	June 18, 2019	June 30, 2020

APPENDIX B: EXERCISE PARTICIPANTS

Participating Organizations	
Regional	
SEMNDHC	Regional Public Health Preparedness Coordinator
SE EMS Regulatory Board	
Hospitals	
District One Hospital	Mayo Clinic Hospital – Rochester, Methodist Campus
MCHS Albert Lea & Austin	Olmsted Medical Center
MCHS Cannon Falls	Owatonna Hospital
MCHS Lake City	Saint Elizabeth's Medical Center
MCHS Red Wing	Winona Health
Mayo Clinic Hospital – Rochester, Saint Marys Campus	
LTCs	
Bremmer Suites - Good Shepherd Lutheran Services Rushford	Chosen Valley Care Center
Green Prairie Rehabilitation	Homestead at Rochester & The Rochester Rehab and Living Center
Heartland Hospice Rochester	Lake Winona Manor
Stewartville Care Center	
EMS Agencies	
Cannon Falls Ambulance	Northfield Hospital EMS
Chatfield Ambulance	Preston Emergency Services
Elgin Ambulance	Red Wing Fire Department
Eyota Ambulance	Rushford Ambulance
Lanesboro Ambulance	West Concord Fire Department & Ambulance
Lewiston Ambulance	Zumbrota Ambulance
Mayo Clinic Ambulance	
Local Public Health	
Olmsted County	Fillmore County
Winona County	
Local Emergency Management	
City of Rochester	

APPENDIX C: CAT TOOL

Exercise Tool

For HCCs from U.S. States, directly funded localities, Puerto Rico, and Guam

Annual Coalition Surge Test

Each health care coalition (HCC) must conduct an exercise using the Health Care Coalition Surge Test once annually to assess overall health care system response (low/no-notice exercise to test ability of HCCs to transition quickly into "disaster mode").

Please note that **this requirement applies to states, directly funded localities, Puerto Rico, and Guam**. Coalition Surge Test information is located at the following link: http://www.phe.gov/Preparedness/planning/hpp/Pages/coaltion-tool.aspx.

****ALL MANUALLY ENTERED RESPONSES MUST BE DIGITS ONLY****

#	Performance Measure	Data Point	
1	PM14: HCC core member **organizations** participating in Phase 1: Table Top Exercise with Functional Elements and Facilitated Discussion of the Coalition Surge Test.	Input the total number of HCC core member **organizations** participating (**digits only**):	
		Hospitals:	11
		Emergency Medical Services (EMS):	36
		Emergency Management (EM) organizations:	2
		Public Health Agencies:	3
2	PM15:HCC core member **organizations'** executives participating in Phase 2: After Action Review of the Coalition Surge Test.	Input the total number of HCC core member **organizations** with executives participating (**digits only**):	
		Hospitals:	11
		EMS:	1
		EM:	1
		Public Health Agencies:	3

3	PM16: Percent of patients at the evacuating facilities that are identified as able to be: a) discharged safely to home or b) evacuated to receiving facilities during Phase 1: Table Top Exercise with Functional Elements and Facilitated Discussion of the Coalition Surge Test.	Enter total number of patients at evacuating facilities identified as being able to be discharged safely to home during a Coalition Surge Test (or real world evacuation of at least 20% of coalition's beds) - 74 
		Enter total number of patients at evacuating facilities identified as being able to be evacuated to receiving facilities during a Coalition Surge Test (or real world evacuation of at least 20% of coalition's beds) – 245 
		Enter total number of patients at all evacuating facilities at the beginning of the Coalition Surge Test (or real world evacuation of at least 20% of coalition's beds) – 319 
		Enter total number of staffed acute care beds in the coalition - 1,616 
4	PM17: Time [in minutes] for evacuating facilities in the HCC to report the total number of evacuating patients.	Enter time in minutes for the last evacuating facility to report the total number of patients identified as able to be evacuated after start of a Coalition Surge Test (or real world evacuation of at least 20 percent of coalition's total beds) - 90  *(Enter "0" only if the CST has not yet been conducted.)* **Check this box if not complete in 90 minute Phase 1 exercise:** ☐
5	PM18: Number of evacuating patients with an appropriate bed identified at a receiving health care facility in 90 minutes.	Enter total number of beds identified at all receiving facilities at the end of the exercise during a Coalition Surge Test (or real world evacuation of at least 20% of coalition's beds) – 210 

6	PM19: Time [in minutes] for receiving facilities in the HCC to report the total number of beds available to receive patients.	Enter time in minutes for the last receiving facility to report the total number of beds available to receive patients after start of a Coalition Surge Test (or real world evacuation of at least 20% of coalition's total beds) - 90  *(Enter "0" only if the CST has not yet been conducted.)* **Check this box if not complete in 90 minute Phase 1 exercise:** ☐
7	PM20: Number of evacuating patients with acceptance for transfer to another facility that have an appropriate mode of transport identified in 90 minutes.	Enter total number of patients matched to a confirmed, appropriate mode of transport to their receiving facility at the end of the exercise (or real world evacuation of at least 20% of coalition's beds) – 10 
8	PM21: Time [in minutes] for the HCCs to identify an appropriate mode of transport for the last evacuating patient.	Enter time in minutes for an available and appropriate mode of transport to be identified for the last evacuating patient after start of a Coalition Surge Test (or real world evacuation of at least 20 percent of coalition's total beds) - 90  *(Enter "0" only if the CST has not yet been conducted.)* **Check this box if not complete in 90 minute Phase 1 exercise:** ☐

*For Territory and Freely Associated State HCCs **ONLY (excluding Puerto Rico and Guam)***

Annual Hospital Surge Test

The Awardees (American Samoa, Commonwealth of Northern Marianas, Federated States of Micronesia, Republic of Palau, Republic of the Marshall Islands, and U.S. Virgin Islands) must develop a surge scenario and use the Hospital Surge Test annually within hospitals, and include other partners (e.g., EMA, PH, EMS, etc.). Addressing gaps from risk assessments should be considered, as well as an evacuation component at least once during the project period. If FAA, U.S. Navy, or DOI plans an exercise during the project period, the islands should integrate.

Hospital Surge Test information is located at the following link:http://www.phe.gov/preparedness/planning/hpp/surge/Pages/default.aspx

#	Performance Measure	Data Point	
1	PM23: HCC core member **organizations** participating in the Command Center Tabletop and Emergency Department Tabletop of the Hospital Surge Test.	Input the total number of HCC core member **organizations** participating (**digits only**):	
		Hospitals:	7

		EMS:	1
		EM:	2
		Public Health Agencies:	3
2	PM24: HCC core member **organizations'** executives participating (in person or virtually) in the After Action Review of the Hospital Surge Test.	Input the total number of HCC core member **organizations** with executives participating (**digits only**):	
		Hospitals:	7
		EMS:	1
		EM:	1
		Public Health Agencies:	3
3	PM25: Number of ICU beds made available during the Hospital Surge Test.	Number of empty staffed ICU beds – 53	
		Number of ICU Patients (Red) Admitted from the ED – 0	
		Number of ICU Patients (Red) Transferred Out or Discharged – 0	
		Number of New ICU Treatment Spaces - 0	
		Number of total (empty or occupied) staffed ICU beds – 53	
4	PM26: Number of non-ICU beds made available during the Hospital Surge Test.	Number of empty staffed non-ICU beds – 83	
		Number of ICU Patients (Yellow) Admitted from the ED – 10	
		Number of ICU Patients (Yellow) Transferred Out or Discharged – 10	
		Number of New non-ICU Treatment Spaces - 0	
		Number of total (empty or occupied) staffed adult medical/surgical (non-ICU) beds – 83	

5	PM27: Emergency department beds made available during a Hospital Surge Test.	Number of regular treatment beds in the main part of the ED at the end of the exercise – 45
		Number of regular treatment beds in the main part of the ED at the beginning of the exercise - 45
6	PM28: Number of patients with a bed identified in the emergency department during the Hospital Surge Test.	Number of total regular treatment beds in the main part of the ED at the end of the exercise – 62
		Number of total emergent (Red) and urgent (Yellow) patients at the end of the exercise - 0