

Medical Response & Surge Exercise (MRSE) Situation Manual

Hospital Preparedness Program

July 2023

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, Director of the Office of Health Care Readiness (OHCR), who led development of the MRSE. ASPR would like to express sincere gratitude to OHCR 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, and Requirements (SPR) members Darrin Donato and Cliffon Smith; ASPR's Technical Resources, Assistance Center, & Information Exchange (TRACIE) Team; ASPR's Division of Exercise, Evaluation, and After Action (E2A2) Exercise Branch and Evaluation Branch, including Elizabeth Catarious, William Moore, Tschuna Patterson, Debjani Das, and Thomas Greer; Jon Krohmer and the US Department of Transportation, National Highway Traffic Safety Administration'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 MRSE Design Team members: David Csernak, Angela Krutsinger, Kevin Sheehan, Olugbadero Yerokun, Lauren Cuddy Egbert, Pete Telaroli, Aldemaro Alberto Algarra Gonzalez, Katherine Gorbach, Griffin Otto, and Jonathan Pearson, as well as Gryphon Scientific contributors Robert Stephan, Mark Kazmierczak, and Audrey Cerles.

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, a survey, and office hours. 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.

Table of Contents

ACKNOWLEDGEMENTS.....	1
1.0 INTRODUCTION	4
1.1 RELATED DOCUMENTS AND TOOLS	4
2.0 EXERCISE OVERVIEW.....	5
2.1 BACKGROUND	5
2.2 CONFIDENTIALITY	6
2.3 PURPOSE AND SCOPE	7
2.4 EXERCISE OBJECTIVES.....	7
2.5 EXERCISE OUTCOMES.....	8
2.6 EXERCISE STRUCTURE.....	9
2.7 EXERCISE PHASES.....	10
2.8 EXERCISE RULES.....	10
2.9 USING REAL-WORLD EVENTS IN LIEU OF THE MRSE	11
2.10 PARTICIPANT ROLES AND RESPONSIBILITIES.....	12
2.11 EXERCISE FACILITATION.....	13
3.0 PHASE I: PLAN & SCOPE	14
3.1 CONCEPTS & OBJECTIVES	14
3.2 PLANNING & COORDINATION	14
3.3 RESOURCE REQUIREMENTS.....	16
3.4 SURGE CAPACITY & THRESHOLD	16
4.0 SCHEDULING THE EXERCISE.....	19
5.0 PHASE II: EXERCISE.....	22
5.1 RESPONSE ACTIONS IN THE EXERCISE	22

5.2 EXERCISE INITIAL ACTIONS 23

5.2.1 Step 1: Start Exercise 23

5.2.2 Step 2: Activation 23

5.2.3 Step 3: Notification 23

5.2.4 Step 4: Mobilization..... 24

5.3 Exercise Operations 24

5.4 END EXERCISE 31

6.0 PHASE III: REVIEW (AFTER-ACTION DISCUSSION AND IMPROVEMENT PLANNING).....32

6.1 CONVENING EXECUTIVES FOR THE REVIEW 32

6.2 REVIEWING THE EXERCISE RESULTS 32

6.3 IMPROVEMENT PLANNING..... 34

6.4 MRSE EXERCISE FEEDBACK FORM 34

Appendix A: Crosswalk of Staffed Bed Types Between the Surge Estimator Tool (SET) and the Medical Response & Surge Exercise35

Appendix B: Glossary.....36

Appendix C: Guidance for Using a Real-world Incident in Lieu of the MRSE46

Phase I: Plan & Scope 46

Phase II: Exercise 47

Phase III: Review 47

Appendix D: Optional roles for non-core HCC members in the MRSE48

Appendix E: Alignment of ASPR’s Medical Response and Surge Exercise (MRSE) Design with the Homeland Security Exercise and Evaluation Program (HSEEP) Principles61

1.0 INTRODUCTION

The **Medical Response & Surge Exercise (MRSE)** was created by the U.S. Department of Health and Human Services (HHS) Administration for Strategic Preparedness and Response (ASPR). The exercise procedures and supporting materials described in the Situation Manual are consistent with updated Federal Emergency Management Agency (FEMA) Homeland Security Exercise and Evaluation Program (HSEEP) guidelines issued in 2020 (refer to Appendix E: Alignment of ASPR’s Medical Response and Surge Exercise (MRSE) Design with the Homeland Security Exercise and Evaluation Program (HSEEP) Principles). 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.”¹

The MRSE and this Situation Manual were produced with input, advice, and assistance from the OHCR MRSE Design Team (hereafter referred to as “Design Team”). This team included OHCR representatives as well as a number of emergency preparedness and response subject matter experts from federal, state, and private sector organizations.

This Situation Manual 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 process participants will use to establish the exercise scenario, exercise operations, and 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 Situation Manual.

For HPP recipients and HCCs requesting more information about this exercise and requirements of the HPP cooperative agreement, please contact your regional OHCR 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

¹ Homeland Security Exercise and Evaluation Program (HSEEP). [Homeland Security Exercise and Evaluation Program \(HSEEP\) \(fema.gov\). https://www.fema.gov/sites/default/files/2020-04/Homeland-Security-Exercise-and-Evaluation-Program-Doctrine-2020-Revision-2-2-25.pdf](https://www.fema.gov/sites/default/files/2020-04/Homeland-Security-Exercise-and-Evaluation-Program-Doctrine-2020-Revision-2-2-25.pdf). Accessed June 2023.

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 an HCC and guides the Exercise Evaluator (refer to section 2.10 below) through assisting during the exercise, gathering information, and facilitating the After-Action Review. The Evaluation Plan helps the Exercise Evaluator turn information collected during the exercise into a meaningful After-Action Report 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.
- **Real-World Incident and Evaluation Tool** – The Excel-based tool is primarily used by the HCC to document decisions and results of a real-world incident response. All required real-world incident data collection – including data for MRSE performance measures – should be completed in the Real-World Incident Reporting and Evaluation Tool.

2.0 EXERCISE OVERVIEW

2.1 BACKGROUND

ASPR's Office of Health Care Readiness (OHCR) advances the ability of the nation's health care system to prepare for, respond to, and recover from disasters and emergencies through the administration of cooperative agreements, training and technical assistance, evidenced-based research and promising practices, and strategic partner engagement that engages health care partners nationally to empower private health care to share ownership in preparing the nation's health care delivery system for disasters or emergencies. The Hospital Preparedness Program (HPP) is the primary source of federal funding for health care delivery system preparedness and response, by providing leadership and funding to states, territories, freely associated states, and eligible major metropolitan areas through its support for HCCs." 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. An effective medical surge response is dependent on the planning and response capabilities developed by HCCs, their members, and other partners. Addressing medical surge safely requires building capacity and capability.²

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).²

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.²

The MRSE is designed to examine and evaluate the ability of HCCs, their members, and other partners to support medical surge. Specifically, the MRSE helps HCCs evaluate their ability to provide patients the care they need at the right place, at the right time, and with the right resources during medical surge to decrease deaths, injuries, and illnesses resulting from medical surge.

2.2 CONFIDENTIALITY

All exercise participants should use appropriate guidelines to ensure proper control of information to 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

² Office of the Assistant Secretary for Preparedness and Response. [2017-2022 Health Care Preparedness and Response Capabilities](https://aspr.hhs.gov/HealthCareReadiness/HPP/Documents/2017-2022%20Health%20Care%20Preparedness%20and%20Response%20Capabilities.pdf). <https://aspr.hhs.gov/HealthCareReadiness/HPP/Documents/2017-2022%20Health%20Care%20Preparedness%20and%20Response%20Capabilities.pdf>. Accessed August 2023.

should be shared as a part of this exercise.³ Information about surge patients provided in the MRSE materials is hypothetical in nature and will not reflect 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 Situation Manual. 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 completing exercise objectives; 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 medical 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 percent of its staffed bed capacity⁴ and to assess the availability of staffed beds, supplies and equipment, and personnel across its membership.

2.4 EXERCISE OBJECTIVES

The exercise includes six required objectives. However, HCCs are encouraged to develop their own 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

³ [The Privacy Act of 1974](https://www.hhs.gov/foia/privacy/index.html). <https://www.hhs.gov/foia/privacy/index.html>. Accessed August 2021.

⁴ The required staffed bed types are included in this calculation. Required bed types include emergency department beds, general inpatient medical unit beds, ICU beds (SICU, MICU, CCU), post critical care beds (monitored/step down), and surgical unit beds (pre-op, post-op, procedural). HCCs have the option to include additional bed types in the calculation 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.

from HPP requirements.

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

1. HCC(s) engage coalition members and their executives to participate in the exercise and the After-Action Review within the HPP budget period.
2. HCC(s) effectively notify HCC members of an incident and facilitate ongoing information sharing during a community-wide emergency or disaster.
3. HCC(s) demonstrate their ability to assess and meet the critical personnel and resource needs (supplies, equipment, etc.) to manage patient surge during a community-wide emergency or disaster by the end of the MRSE.
4. HCC(s) demonstrate their ability to assess and meet the critical EMS personnel and resource needs to manage patient surge during a community-wide emergency or disaster by the end of the MRSE.
5. HCC(s) demonstrate their ability to reduce patient morbidity and mortality through appropriate patient placement during a large patient surge by assisting with the identification and coordination of available patient care resources by the end of the MRSE.
6. HCC(s) demonstrate their ability to successfully coordinate and execute all relevant response plans during a community-wide emergency or disaster.

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.

1. Improved HCC member engagement in preparedness and response planning.
2. Executive engagement in preparedness and response planning through participation in the MRSE and/or the After-Action Review.
3. Strengthened processes to coordinate and share information during a community-wide emergency or disaster.
4. Improved HCC capacity to assess the availability of and secure access to critical resources such as staffed beds, personnel, supplies and equipment, and patient transport during a community-wide emergency or disaster.

5. Improved HCC capacity to assess the availability of and secure access to critical EMS personnel and resource needs during a community-wide emergency or disaster.
6. Strengthened HCC preparedness to support appropriate patient placement during a large patient surge.
7. Improvement upon and/or validation of all applicable response plans and/or corrective actions taken to reduce patient morbidity and mortality during a community-wide emergency or disaster.

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 relevant to the selected scenario, to offer observations during the exercise, to make strategic and operational decisions, and to comply 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 After-Action Review.

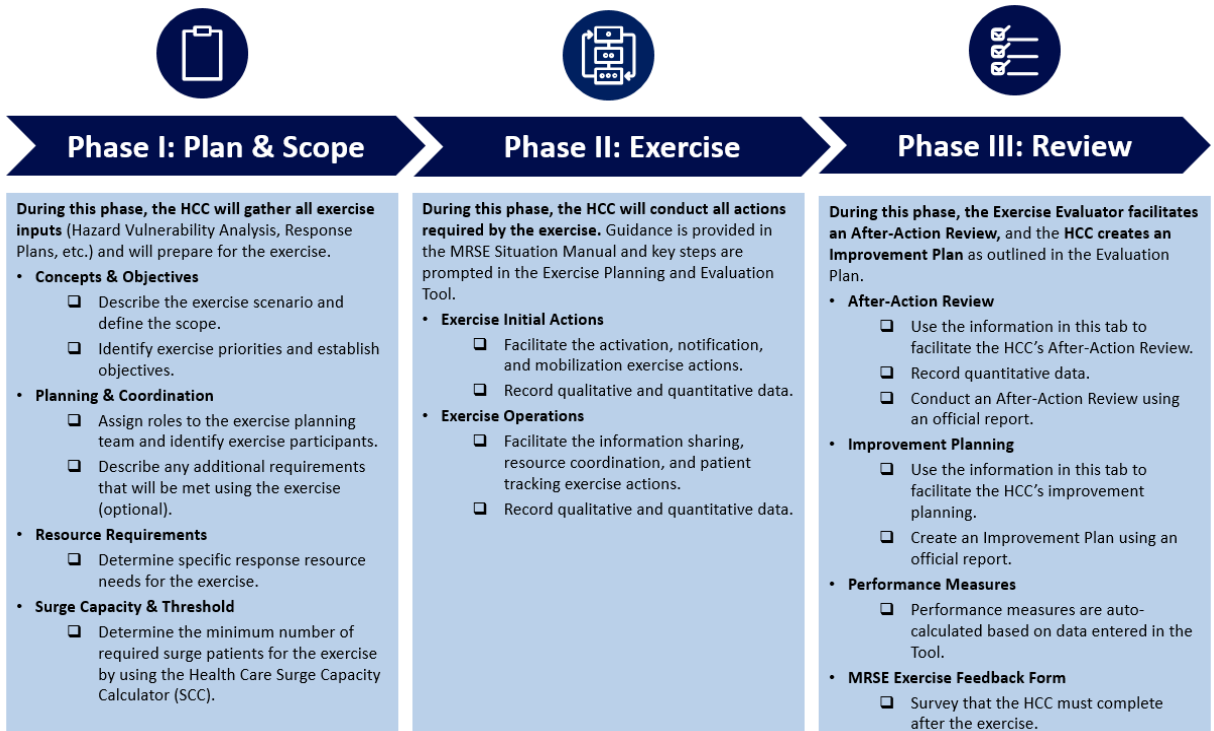
Note that HCCs also have the option of using the MRSE as a full-scale exercise, given that adequate time has been allocated to planning ahead of execution.

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 MRSE objectives are met in a reasonable amount of time and that the exercise runs smoothly. MRSE participants should:

- Use the HCC's 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 their role.
- Comply with real-world response procedures, as responses should be based on the

current capabilities of their facility or 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 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 MRSE. 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 complete the Real-World Incident Reporting and Evaluation Tool to respond to each 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 percent of the required staffed bed types. Note that HCCs have the option of including other scenario-specific staffed bed types in the 20 percent calculation (refer to section 3.4 in the Situation Manual).
- At least one of each of the HCC core member types must participate in the real-world incident response.
- At least one executive from each of the participating core member organizations must participate in the After-Action Review.
- 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 Real-World Incident Reporting and Evaluation Tool to document

the real-world incident and provide data required by HPP (e.g., performance measures).

- The HCC must submit an After-Action Report 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 must have a discrete beginning and end ('bookends') and not be 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 OHCR Field Project Officer and refer to Appendix C: Guidance for Using a Real-world Incident in Lieu of the MRSE.

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)	This is 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, the coalition membership, and other jurisdictional response plans.
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, 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 Role	Role Description
Exercise Facilitator	<p>This role will guide the participants through the exercise actions, ensuring all HPP-required exercise tasks are completed. The Exercise Facilitator should be a separately designated or delegated individual, but also serve as the RRC if no other individuals are available to fill the RRC role. It is generally recommended the RRC, Exercise Facilitator, and evaluator be different individuals given both the burden as well as best practice of the evaluator being an objective observer not involved in the implementation of the exercise actions. The Exercise Facilitator triggers the exercise incident response by contacting the Duty Officer (Notification System Representative).</p>
Exercise Evaluator	<p>This is 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 After-Action Review 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 Program (HSEEP) guidelines suggest the Exercise Evaluator be involved in the full lifecycle of the exercise, including <i>Phase I: Plan & Scope</i> to understand the exercise objectives, performance measures, and the exercise materials such as the Situation Manual, MRSE Evaluation Plan, and the accompanying tool.</p>
Duty Officer (Notification System Representative)	<p>The Duty Officer is the individual(s) designated in the relevant HCC or jurisdictional response plan for receiving notice of emergency incidents, triggering the HCC’s response plan, and determining the response level. Although some HCCs may not utilize this term or fund this role, the exercise refers to this role as the Duty Officer for simplicity. The HCC should utilize the same person or persons for this role as it would during a real-world event. This is a very limited role in the exercise and may be performed by an individual of the HCC’s choosing.</p>

2.11 EXERCISE FACILITATION

The Exercise Facilitator will guide the exercise. The Exercise Facilitator will lead exercise participants through a series of activities and discussions. 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 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 a minimum of 90 days before the beginning of the actual exercise. To assist HCCs with planning and coordination of the exercise, this phase has been divided into four sections, namely, Concepts & Objectives, Planning & Coordination, Resource Requirements, and Surge Capacity & Threshold. HCCs will use these sections to gather all exercise inputs (Hazard Vulnerability Analysis, Response Plans, etc.) to prepare for the exercise. 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 the exercise will be scheduled for a specific date. Note that 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 CONCEPTS & OBJECTIVES

HCCs will describe the exercise scenario and align it with hazards, risks, and threats from the HCC's most recent Hazard Vulnerability Assessment (HVA), provide information about health equity issues addressed in the scenario, describe public health agency and emergency management activities, identify exercise priorities, define the scope of the exercise, and establish the exercise objectives.

3.2 PLANNING & COORDINATION

Key roles such as the Exercise Facilitator, Exercise Evaluator, HCC Clinical Advisor, and Duty

Officer (Notification System Representative) will be assigned in this section.

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 MRSE, the HCC is encouraged to consult its members during the *Phase I-Concepts & Objectives* section 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, the HCC-defined scenario, the incident type, the 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 HCC can build these additional member needs into the MRSE as needed. HCCs should document any outputs needed by members to meet additional exercise 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.

HCCs will determine which of its member organizations will participate in the exercise, and all participating member organizations should be documented in the exercise tool. The number of invited member organizations to the exercise is used to calculate MRSE performance measures. HCCs will indicate which member organizations are critical participants for the exercise. A critical participant is defined as a member organization that is crucial to successfully respond to the exercise scenario.

CRITICAL PARTICIPANT – EXAMPLE

An HCC has chosen to include mass fatality as a priority to test for their exercise scenario. The HCC designs a scenario that includes an explosion in high-rise building that creates 1) a surge of patients in need of trauma and burn care and 2) the need for mass fatality management. The HCC has determined that to effectively respond to this scenario, it must include funeral homes in its response. The HCC will evaluate its coordination with funeral homes within its jurisdiction during the exercise. Therefore, the HCC will indicate that funeral homes invited to the exercise are critical participants because they are crucial contributors to the HCC's mass fatality response.

3.3 RESOURCE REQUIREMENTS

HCCs will determine specific response resource needs for the exercise. This section 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, the HCC will define the resources it anticipates being required to manage the surge. In addition to staffed bed types selected in the prior step, the resources include personnel, bed types, pharmaceuticals, medical supplies and equipment, patient transport units, and specialized response units. 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. Resources selected as 'Included (Critical)' are defined as being crucial to the HCC's ability to successfully respond to the exercise scenario. Resources selected as 'Included (Non-Critical)' are defined as being helpful but not required to respond to the exercise scenario.

3.4 SURGE CAPACITY & THRESHOLD

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 percent of its staffed bed capacity. In this section, the HCC will complete the Health Care Surge Capacity Calculator (SCC) by entering the total staffed beds within its member organizations by bed category. The SCC will automatically calculate the number of patients resulting from the

incident based on the number of staffed beds in the HCC (i.e., 20 percent of staffed beds required for the incident). Staffed bed types included in the calculation include the required medical surge beds (emergency department beds, general inpatient medical unit beds, ICU beds (SICU, MICU, CCU), post critical care beds (monitored/stepdown), and surgical unit beds (pre-op, post-op, and procedural), plus any additional surge beds relevant for the HCC's surge incident scenario as selected by the HCC. The surge capacity calculation is based on the various types of patient care beds located within the HCC, regardless of the type of facility in which they are located. This includes but is not limited to acute care, long-term care, and specialty care facilities. Staffed bed types are summarized in Table 2 below.

In addition, HCCs will enter the licensed and additional surge beds within its member organizations by bed category. HCCs can use this information for any future planning beyond the MRSE. The information provided in the SCC is intended to provide HCC Coordinators and Exercise Planners with an understanding of the current and potential surge capability within their jurisdiction. Completion of the Health Care Surge Capacity Calculator is required before moving forward with the exercise. Note that the HPP Surge Estimator Tool (SET) requirements are met with completion of this section and HCCs will not be required to complete the SET separately. 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 Inpatient Medical Unit Beds	Required for all exercises
ICU Beds (SICU, MICU, CCU)	Required for all exercises
Post Critical Care Beds(Monitored / stepdown)	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 ICU Beds	Based on surge type defined by the HCC
Neonatal ICU Beds	Based on surge type defined by the HCC
Oncology Unit Beds	Based on surge type defined by the HCC
Long Term Care Beds	Based on surge type defined by the HCC
Urgent Care Beds	Based on surge type defined by the HCC
Alternate Care Site 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. 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**

Total numbers of surge patients in the exercise = **200**

As an option, the HCC has chosen to include **additional staffed bed types (100 neonatal ICU staffed beds)** in the 20% calculation of its staffed bed capacity. Therefore, 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 neonatal ICU staffed beds = **20**

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

The health care surge capacity calculator (SCC) will automatically calculate the number of surge patients based on the number of staffed beds entered by the HCC.

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.

4.0 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	<p>Dear [member name],</p> <p>[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].</p> <p>HPP encourages HCCs to consult members regarding other exercise requirements which could be met by the MRSE (e.g., Joint Commission or Centers for Medicare & Medicaid). HCCs can incorporate member needs provided they do not change the core objectives of the MRSE or impede our ability to report certain data.</p> <p>If you would like to use the MRSE to serve other exercise needs you have, kindly send us a summary of your requirements, including specific documents or outputs you may require for compliance. We will attempt to build them into this year’s MRSE exercise.</p> <p>Kind regards,</p> <p>[Name] [RRC] [HCC name]</p>

Communication	Sample Text
Participant Invitation	<p>Dear <i>[member name]</i>,</p> <p><i>[HCC name]</i> will conduct this year’s Medical Response & Surge Exercise (MRSE) on <i>[expected date]</i> at <i>[time]</i>. The exercise is expected to last <i>[expected duration]</i>. The MRSE is an operations-based exercise required by the Hospital Preparedness Program (HPP) cooperative agreement. The exercise will follow the <i>[response plan title]</i>, focusing on response actions such as information sharing and resource mobilization for a large, community-wide surge incident. The incident we are planning to exercise is <i>[scenario description]</i>.</p> <p>Based on the scenario we plan to exercise, we have identified <i>[member name]</i> as an essential participant in this this year’s exercise.</p> <p>To satisfy HPP cooperative agreement requirements – all core HCC members (hospitals, emergency medical services, emergency management organizations, and public health agencies) are required participants. Further, HPP requires executives from core member institutions to participate in the After-Action Review, which is scheduled for <i>[date/time]</i>.</p> <p><i>[instructions for how to participate in the exercise]</i></p> <p>Kindly confirm your intention to participate by responding to this message with the name/s of the individual/s who will represent your organization.</p> <p><i>[Name]</i> <i>[RRC]</i> <i>[HCC name]</i></p>

5.0 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.⁵ 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.

5.1 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), or other appropriate and mandated plans (i.e., state, county, city, regional, etc.). 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. Stressing 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.
5. Exercise participants manage a series of challenges related to **ongoing**

⁵ Assistant Secretary for Preparedness and Response. 2017. [Healthcare Coalition Response Plan](https://asprtracie.hhs.gov/technical-resources/resource/4525/healthcare-coalition-response-plan). <https://asprtracie.hhs.gov/technical-resources/resource/4525/healthcare-coalition-response-plan>

situational awareness, information sharing, resource coordination, and patient tracking.

6. End exercise.

5.2 EXERCISE INITIAL ACTIONS

5.2.1 Step 1: Start Exercise

The Exercise Facilitator triggers the exercise incident response by initiating direct communication 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, iii) responding units, iv) a description of how weather and traffic conditions have impacted the response (e.g., road closures due to icy roads has caused EMS to take an alternate route, which is causing a delay in the response), and v) 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.

5.2.2 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.

5.2.3 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 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 Performance Measure 14).

5.2.4 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).

5.3 Exercise Operations

Once the HCC is mobilized, the members will review and confirm the anticipated resource needs documented during *Ph I-Resource Requirements*. They will confirm (by indicating availability in *Ph II-Exercise Operations*) or modify (in *Ph I-Resource Requirements*) 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. Updates should be made 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.

Allocate Patients to Facilities

The HCC will allocate surge patients to each participating clinical care member (receiving facility). In *Phase II: Exercise Operations*, the HCC will send each facility the total number

of patients to expect and document it in the Patient Surge Summary Table. The anticipated injuries are defined in the exercise scenario by the Clinical Advisor in *Phase I: Concepts & Objectives*. 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 need an appropriate, staffed bed in this exercise.

Sample communications for participating clinical care members (receiving facilities) 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 (receiving facilities) contacted, (ii) whether they responded by the deadline requested by the HCC (MRSE Performance Measure 15), and (iii) the staffed bed counts in their facility able to receive patients.

Confirm Availability of Personnel, Bed Types, Pharmaceuticals, Medical Supplies and Equipment . Either after or in the same communication as the staffed bed census request, the HCC will request participating clinical care members (receiving facilities) to assess the sufficiency of current availability of personnel, bed types, pharmaceuticals, medical supplies and equipment defined in *Ph I-Resource Requirements* (and reflected in *Ph II- Exercise Operations*). Once availability of resources has been determined at the different receiving facilities, the HCC will work with the facilities to determine the number of surge patients that each will receive, ensuring that sufficient resources are readily available for allocated patients.

Once patients are allocated to facilities, 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. The Exercise Evaluator should document the list of HCC members (aside from EMS, as described above) who were contacted with an initial information request about resources, ii) the number of HCC members contacted that responded by the deadline requested by the HCC (MRSE Performance Measure 15), and iii) whether or not sufficient quantities of every pre-identified critical resource type were available at all facilities in the quantities necessary due to patient allocation (MRSE Performance Measures 16 and MRSE Performance Measure 17). If one or more members reports insufficient availability of any one of the resource types for the number of patients allocated to them, that type should be noted as insufficient for managing the surge.

The subsequent steps, any facility with shortages should work with the HCCs to see if resources can be shared among facilities. They may also consider if they can discharge other patients or transfer patients to address the resource shortage.

Confirm Availability of EMS Resources (Patient Transport Units, and Specialized Response Units). The HCC begins by contacting participating EMS agencies to request current availability of pre-identified, critical EMS-related resources defined in *Ph I- Resource Requirements* (and reflected in *Ph II- Exercise Operations*). These EMS resources are required to triage and transport patients during the incident. Sample communications to EMS participants are provided in Table 4 below. The Exercise Evaluator should document i) the list of EMS agencies contacted about EMS related resources, ii) whether each responded within the requested amount of time (to contribute to MRSE Performance Measure 15), , and iii) the types and numbers of EMS resources offered to triage and transport incident patients (to contribute to MRSE Performance Measure 18). 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, 911 Center). The principal goal of this step is to document the availability of appropriate EMS-related resources required to triage and transport surge patients.

Support Resource Sharing if Required. 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 partners 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 Performance Measure 16 and MRSE Performance Measure 17). If a facility with one or more resource shortages cannot do this successfully and within an appropriate amount of time as determined by the HCC clinical advisor, that resource type should be noted as insufficient for managing the surge.

Patient Tracking

Transfer Patients if Required. If patients at one or more facilities do not have an appropriate, staffed bed, each facility may 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.

Confirm the Availability of Staffed Beds and All Other Resources for Patients and Finalize Patient Tracking. In this action, the HCC contacts all clinical care facilities receiving surge patients to determine final numbers for: i) number of existing inpatients at the facility in the beginning of the response, ii) the number of surge patients received and admitted for inpatient care, iii) the number of transfer patients received, iv) the number of patients discharged to accommodate surge patients, v) the number of patients transferred to another receiving facility to accommodate surge patients, vi) the number of surge and existing patients that did not receive an appropriate staffed bed at the receiving facility and/or transport within a reasonable amount of time, and vii) the number of existing patients and surge patients requiring admission for inpatient care that received an appropriate, staffed bed at the receiving facility within a reasonable amount of time. This information is used to make final updates to the patient tracking

table in the MRSE Exercise Evaluation and Reporting Tool on tab **Ph II-Exercise Operations**.

Table 4: Sample Communications for Initial Notifications and Information Requests – Phase II: Exercise

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

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

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

Communication	Sample Text
	<p>Note: this is an exercise so there are no actual surge patients, and no resources or patients are to be moved or otherwise affected during the exercise.</p> <p>Please confirm the availability of the following resources to be shared with members of [HCC name] to accommodate the large-scale surge inpatients. Kindly reply by [deadline].</p> <ul style="list-style-type: none"> • [list and quantity of resources required]. <p>Kind regards, [Name] [Exercise Facilitator or other title] [HCC name]</p>

5.4 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 is medically appropriate 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 After-Action Review 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 After-Action Review, 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.

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.

6.0 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. Data from the exercise will automatically populate in the ***Phase III: After-Action Review*** tab of the MRSE Evaluation and Reporting Tool. The ***Phase III: After-Action Review*** tab should be used as a guide to facilitate the HCCs official After-Action Review. The tab in the exercise tool **does not** replace the HCC's official After Action Report document. The tab will outline participant discussion topics including highlighting strengths and highlighting areas for improvement. The After-Action Review may also identify gaps in: (i) existing resources, roles, and responsibilities, (ii) notification and activation procedures, and (iii) information sharing coordination processes and protocols. The HCC should follow the official After-Action Review by creating an IP. *Guidance for both After-Action Review facilitation and documentation as well as IP creation is provided in the Exercise Planning and Evaluation Tool and, the MRSE Evaluation Plan, and in the [Homeland Security Exercise and Evaluation Program \(HSEEP\) guidance](#).*

6.1 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 official After-Action Review.* 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 After-Action Review. Once the review begins, the Exercise Evaluator will document which core member organizations were represented by at least one executive in the ***Phase III: After-Action Review*** tab of the MRSE Evaluation and Reporting Tool (MRSE Performance Measure 20).

6.2 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 After-Action Review. 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:

1. HCC(s) engage coalition members and their executives to participate in the exercise and the After-Action Review within the HPP budget period.
2. HCC(s) effectively notify HCC members of an incident and facilitate ongoing information sharing during a community-wide emergency or disaster.
3. HCC(s) demonstrate their ability to assess and meet the critical personnel and resource needs (supplies, equipment, etc.) to manage patient surge during a community-wide emergency or disaster by the end of the MRSE.
4. HCC(s) demonstrate their ability to assess and meet the critical EMS personnel and resource needs to manage patient surge during a community-wide emergency or disaster by the end of the MRSE.
5. HCC(s) demonstrate their ability to reduce patient morbidity and mortality through appropriate patient placement during a large patient surge by assisting with the identification and coordination of available patient care resources by the end of the MRSE.
6. HCC(s) demonstrate their ability to successfully coordinate and execute all relevant response plans during a community-wide emergency or disaster.

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 may summarize for participants during the After-Action Review, highlighting successes and gaps in the response from the perspective of patient placement.

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 After-Action Review 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.

6.3 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 After-Action Report to develop plans for HCC improvement, including corrective actions, timelines, and associated owners. These plans will be documented in the *Phase III-Improvement Plan* tab of the Exercise Planning and Evaluation Tool.

6.4 MRSE EXERCISE FEEDBACK FORM

In the Exercise Feedback form in the MRSE Exercise Evaluation and Reporting Tool, HCCs will provide observations, comments, and input that will be used by the Design Team to better prepare HCCs against threats and hazards. Any comments provided will be treated in a sensitive manner and all personal information will remain confidential. HCCs should keep comments concise, specific, and constructive.

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

The SET requirement, which is to help HCCs understand their thresholds and determine how much help would be needed from outside the coalition, has now been incorporated in the MRSE using the Health Care Surge Capacity Calculator (SCC) in *Phase I: Surge Capacity & Threshold*. The table below provides a crosswalk between the staffed 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 Inpatient 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 Report (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. Refer to Improvement Plan.
After-Action Review	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.
Alternate Care Site Beds	Additional surge beds to provide medical care for injured or sick patients or continue care for patients with chronic conditions in non-traditional environments.
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.

Term	Definition
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.
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 (refer to “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 (refer to “disaster” for important contrast between the two terms).
Emergency Department Beds	Licensed, staffed, or additional surge beds available to patients in the emergency department.
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.

Term	Definition
Emergency Medical Services (EMS)	<p>Services, including personnel, facilities, and equipment required to ensure proper medical care for the sick and injured from the time of injury to the time of final disposition (which includes medical disposition within a hospital, temporary medical facility, or special care facility; release from the site; or being declared dead). EMS specifically includes those services immediately required to ensure proper medical care and specialized treatment for patients in a hospital and coordination of related hospital services.</p>
Emergency Support Function-8 (ESF-8)	<p>ESF-8 provides the mechanism for coordinated federal assistance to supplement state, tribal, and local resources in response to the following:</p> <ul style="list-style-type: none"> • Public health and medical care needs. • Veterinary and/or animal health issues in coordination with the U.S. Department of Agriculture (USDA). • Potential or actual incidents of national significance. • A developing potential health and medical situation. <p>Reference: “Emergency Support Functions.” https://aspr.hhs.gov/legal/Pages/Emergency-Support-Functions.aspx. https://aspr.hhs.gov/legal/Pages/Emergency-Support-Functions.aspx. Accessed 24 Aug. 2023.</p>
Evacuation	<p>The organized, phased, and supervised withdrawal, dispersal, or removal of patients, personnel, and visitors from dangerous or potentially dangerous areas.</p>
Exercise	<p>An instrument to train for, assess, practice, and improve performance in <i>prevention, protection, response, and recovery capabilities</i> in a risk-free environment. Exercises can be used for: testing and validating policies, plans, procedures, training, equipment, and interagency agreements; clarifying and training personnel in roles and responsibilities; improving interagency coordination and communications; identifying gaps in resources; improving individual performance; and identifying opportunities for improvement.</p>

Term	Definition
Functional Exercise	A single- or multi-agency operations-based exercise designed to evaluate capabilities and multiple functions using a simulated response. Characteristics of a functional exercise include simulated deployment of resources and personnel, rapid problem solving, and a highly stressful environment.
General Inpatient Medical Unit Beds	Licensed, staffed, or additional surge beds for inpatient floor and observation beds that are in daily/routine operational use at the hospital.
General Pediatric Unit Beds	Licensed, staffed, or additional surge beds for the observation, diagnosis and treatment (including preventive treatment) of children and their illnesses, injuries, diseases and disorders by appropriate staff, space, equipment and supplies.
Hazard	Something that is potentially dangerous or harmful, often the root cause of an unwanted outcome.
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.

Term	Definition
Health care coalition (HCC) member	<p>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.</p>
Health care executive	<p>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.</p>
Health care facility	<p>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.</p>

Term	Definition
<p>Homeland Security Exercise and Evaluation Program (HSEEP)</p>	<p>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.</p>
<p>Intensive Care Unit (ICU) beds, including Surgical Intensive Care Unit (SICU), Medical Intensive Care Unit (MICU), and Critical Care Unit (CCU)</p>	<p>Licensed, staffed, or additional surge beds for intensive care in which there are specially trained nursing and supportive personnel and diagnostic, monitoring and therapeutic equipment necessary to provide specialized medical and nursing care to critically ill patients.</p>
<p>Improvement Plan</p>	<p>Identifies specific corrective actions, assigns them to responsible parties, and establishes targets for their completion.</p>
<p>Incident</p>	<p>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.</p>

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).
Labor and Delivery Unit Beds	Licensed, staffed, or additional surge beds for use the hospital’s labor and delivery services.
Long Term Care Beds	Licensed, staffed, or additional surge beds for patients with serious medical needs on an ongoing basis but not needing intensive care/ extensive diagnostic procedures.

Term	Definition
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).
Neonatal Intensive Care Unit (ICU) Beds	Licensed, staffed, or additional surge beds for the provision of comprehensive and intensive care for all contingencies of the newborn infant.
Oncology Unit Beds	Licensed, staffed, or additional surge beds for oncology patients whose conditions are of varying levels of acuity (for example, critical care, ward-level care, step down type care, etc.).
Participating	A member organization or executive is considered participating if they are physically or remotely connected to the exercise and After-Action Review in real time.
Partners	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.
Pediatric Intensive Care Unit (ICU) Beds	Licensed, staffed, or additional surge beds for intensive care in which there are specially trained nursing and supportive personnel and diagnostic, monitoring and therapeutic equipment necessary to provide specialized medical and nursing care to critically ill children.
Post Critical Care (Monitored/Stepdown) Beds	Licensed, staffed, or additional surge beds equipped with cardiac and other monitoring necessary for step-down or intermediate level care.
Psychiatric Unit Beds	Licensed, staffed, or additional surge beds for acute psychiatric, developmentally disabled or drug abuse patients receiving 24-hour medical care.

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.
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.
Surgical Unit Beds (Pre-op, Post-op, & Procedural)	Licensed, staffed, or additional surge beds within the surgical/procedural care areas. Pre-induction/ post-anesthesia/recovery and appropriate procedural beds (e.g., interventional, GI) should be counted toward this total. Selected 'swing', same day surgery or other beds that could increase ICU/inpatient surge may also be counted in this total if they can predictably be made available within hours – these should not be counted in the inpatient beds above. Procedural beds should include beds that allow full monitoring and care of patients undergoing minor procedures or sedation such as endoscopy or interventional radiology that are suitable for overflow critical care.

Term	Definition
Underserved Communities	Populations sharing a particular characteristic, as well as geographic communities, who have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life'; this definition includes individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. Individuals may belong to more than one underserved community and face intersecting barriers (Executive Order 13985 of Jan 21, 2021).
Urgent Care Beds	Licensed, staffed, or additional surge beds for patients that require medical care services for illnesses and injuries that are not life-threatening.

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 Situation Manual.

HCCs that will utilize information from a real-world incident are required to use the Real-World Incident Reporting and Evaluation Tool to report on program performance measures. 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 Real-World Incident Reporting and Evaluation 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 Real-World Incident Reporting 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 After-Action Report and associated IP. Each HCC should utilize the Real-World Incident Reporting and Evaluation Tool to guide its After-Action Review and improvement planning process.

Appendix D: Optional roles for non-core HCC members in the MRSE

Background

The MRSE is designed to be a community-wide functional exercise that incorporates the roles of various actors across the health care system. One central objective of MRSE's development was to increase the participation of HCC members beyond acute care hospitals. ASPR requires that at least two of each HCC's 'core' members (at minimum: two acute care hospitals, two EMS agencies, two public health agencies, and two emergency management agencies) participate in the MRSE and strongly encourages participation for all core members. However, HCCs may wish to encourage participation of a broader range of their member organizations to strengthen preparedness and response capabilities in their communities.

Below are optional activities that HCCs can include in their MRSE planning and execution for eight additional organization types (also called non-core HCC member types): blood centers; clinical laboratories; clinics and outpatient care, including Federally Qualified Health Centers; community care organizations; poison control centers; primary health care; long-term care and skilled nursing facilities; and urgent care.

Optional activities are based on the roles these organizations have played (or could play) in medical surge as illustrated in the health care, medical, and emergency management literature. For each exercise priority (emergency department and inpatient medical, out-of-hospital, pediatric care, trauma care, etc.), ASPR has proposed where these non-core HCC members may be most likely to play a role. For each non-core member type highlighted in this appendix, sample activities are provided for Phase I: Plan & Scope and Phase II: Exercise. Optional qualitative questions are provided for Phase III: Review. HCCs are welcome to include additional non-core members in their exercise and HCCs may generate additional activities and questions even for the non-core members highlighted below.

Many of the non-core HCC member types are also subject to emergency preparedness

exercise requirements under the CMS Emergency Preparedness Rule.^{6 7} Wherever possible, HCCs should attempt to align their MRSE implementation to the needs of their members, including assisting them to use the MRSE to meet other exercise requirements such as those from CMS.

Suggested Non-Core Member Types for Outreach Based Upon Exercise Priorities for the MRSE Scenario

Table 5 below outlines suggested non-core member types for outreach based upon the exercise priorities of the medical surge scenario the HCC selects for the MRSE. The list of non-core members for each exercise priority is not exhaustive, and ASPR encourages HCCs to include non-core members as much as possible in ways that support community-wide responses.

Table 5: Suggested Non-Core Members for Outreach by Exercise Priority

MRSE Exercise Priorities	Suggested Non-Core Members
Emergency Department and Inpatient Medical	<ul style="list-style-type: none"> • Blood centers • Clinics and outpatient care, including Federally Qualified Health Centers (low acuity patients only) • Urgent care (low acuity patients only)
Out-of-Hospital Response / Interagency Coordination	<ul style="list-style-type: none"> • Community care organizations • Long-term care and skilled nursing facilities • Primary health care
Establishing an Alternate Care System	<ul style="list-style-type: none"> • Long-term care and skilled nursing facilities • Primary health care

⁶ Quality, Safety & Oversight Group Centers for Medicare & Medicaid Services. CMS Emergency Preparedness Rule. What’s New based on the Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction Final Rule. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/CMS-Understanding-the-EP-Final-Rule-Update-BRIII-2019.pdf>

⁷ Quality, Safety & Oversight Group Centers for Medicare & Medicaid Services. Updated Guidance for Emergency Preparedness-Appendix Z of the State Operations Manual. March 2021. <https://www.cms.gov/files/document/qso-21-15-all.pdf>

Pediatric Care	<ul style="list-style-type: none"> • Clinics and outpatient care, including Federally Qualified Health Center • Community care organizations • Urgent care
Chemical/Radiation	<ul style="list-style-type: none"> • Blood centers • Clinical laboratories • Clinics and outpatient care, including Federally Qualified Health Center • Poison control centers • Urgent care
Trauma Care	<ul style="list-style-type: none"> • Blood centers
Behavioral Health Needs Response	<ul style="list-style-type: none"> • Clinics and outpatient care, including Federally Qualified Health Center • Community care organizations • Urgent care
Infectious Disease Outbreak and Surge Response	<ul style="list-style-type: none"> • Clinical laboratories • Clinics and outpatient care, including Federally Qualified Health Center • Community care organizations • Urgent care
Distribute Medical Countermeasures	<ul style="list-style-type: none"> • Clinics and outpatient care, including Federally Qualified Health Center • Community care organizations • Long-term care and skilled nursing facilities • Poison control centers • Primary health care • Urgent care
Health Care Facility Evacuation	<ul style="list-style-type: none"> • Long-term care and skilled nursing facilities
Communications Disruption / Failure	<ul style="list-style-type: none"> • Clinics and outpatient care, including Federally Qualified Health Center • Community care organizations • Primary health care • Long-term care and skilled nursing facilities • Poison control centers • Urgent care
Health Equity and Vulnerable/At-Risk Populations	<ul style="list-style-type: none"> • Primary health care • Long-term care and skilled nursing facilities • Community care organizations • Clinics and outpatient care, including Federally Qualified Health Center

Suggested Activities to Incorporate Non-Core Members

For non-core HCC members targeted for MRSE participation, HCCs can conduct the following activities during Phase I: Plan & Scope:

- Identify the type/s of non-core members who should participate based upon the selected exercise priorities for the MRSE surge scenario,
- Determine the number of or particular facilities and organizations for outreach based upon HCC and facility response plans where relevant,
- Review ASPR TRACIE’s materials regarding exercise requirements (e.g., CMS Final Rule, Joint Commission, etc.) applicable to the non-core members that the HCC will reach out to with the goal of increasing participation in MRSE,^{8 9}
- Contact identified non-core HCC members to introduce the MRSE and invite them to participate; confirm their exercise requirements and determine if the MRSE could be adapted to meet each member’s requirements without changing the essential elements (e.g., collecting all data for associated performance measures),
- Determine how each non-core member type will participate using the list of optional activities in table 6, below.

For non-core HCC members targeted for MRSE participation, HCCs can conduct the exercise activities detailed in Table 6, below. HCCs can add optional qualitative discussion questions to their After-Action Review to evaluate their engagement with and the performance of the non-core members.

Table 6: MRSE Activities to Incorporate Non-Core Members

Blood centers
<p>Phase I: Plan & Scope</p> <ul style="list-style-type: none"> • Quantify blood needs during the exercise in consultation with HCC Clinical Advisor • Identify how the HCC expects blood centers to participate (i.e., which of the activities in Phase II will be included in the MRSE implementation)

⁸ Provider and Supplier Types Covered by the CMS Emergency Preparedness Rule. 2016.

<https://files.asprtracie.hhs.gov/documents/aspr-tracie-ta-cms-rule-provider-type-definitions.pdf>

⁹ Provider- and Supplier-Specific Resources. <https://asprtracie.hhs.gov/cmsrule#provider-and-supplier-specific-resources>

Phase II: Exercise

- Contact blood centers to identify sources for blood quantity and type estimates based on exercise casualties and advice from HCC Clinical Advisor
- Contact blood center members to assess sufficiency of blood supply based on hazard
- Contact blood centers to determine how many have sufficiency of backup energy for all critical equipment
- Assess availability of space, staff, and supplies to simulate stand up of blood collection sites (site selection, staff availability, equipment, public communications plan) to address unmet blood needs

Phase III: Review

- Optional qualitative discussion questions:
 - Were blood supply resource needs met?
 - Did all participating blood centers have sufficient backup energy for critical equipment?
 - What adaptations were made to the MRSE to include blood center participation?
 - What communication system was used to alert and communicate with participating blood centers?
 - Was communication effective and efficient?
 - Were roles and responsibilities clear among participating blood centers and with other participating facilities/organizations?
 - Was there direct engagement between participating blood centers and required member participants (e.g., hospitals or EMS)?
 - What was the level of engagement with participating blood centers in the three phases of the exercise?
 - How will the MRSE change the extent to which blood centers participate in future HCC activities?
 - What feedback should be provided to blood centers based on this implementation of the MRSE?

Clinical laboratories

Phase I: Plan & Scope

- In conjunction with the Clinical Advisor, quantify number of tests required (including on-going surveillance monitoring needs)
- Identify how the HCC expects clinical laboratories to participate (i.e., which of the activities in Phase II will be included in the MRSE implementation)

Phase II: Exercise

- Contact lab members to determine total capacity of jurisdiction to meet diagnostic testing needs
- Contact lab members to determine how many have sufficiency of key supplies, equipment, and backup energy for all critical equipment

Phase III: Review

- Optional qualitative discussion questions:
 - Were all testing needs met by participating clinical laboratories?
 - What adaptations were made to the MRSE to include the participation of clinical laboratories?
 - What communication system was used to alert and communicate with participating clinical laboratories?
 - Was communication effective and efficient?
 - Were roles and responsibilities clear among participating clinical laboratories and with other participating facilities/organizations?
 - Was there direct engagement between participating clinical laboratories and required member participants (e.g., hospitals or EMS)?
 - What was the level of engagement with participating clinical laboratories in the three phases of the exercise?
 - How will the MRSE change the extent to which clinical laboratories participate in future HCC activities?
 - What feedback should be provided to clinical laboratories based on this implementation of the MRSE?

Clinics and outpatient care, including Federally Qualified Health Centers

Phase I: Plan & Scope

- In conjunction with the Clinical Advisor, identify characteristics of at-risk patients for the selected hazard (e.g., aged, diabetic, etc.)
- Identify how the HCC expects clinics and outpatient care to participate (i.e., which of the activities in Phase II will be included in the MRSE implementation)

Phase II: Exercise

- Contact clinics to identify and/or quantify chronic care or other at-risk populations under their care

- Assess clinic functioning based on the exercise hazard scenario (e.g., utility failure, protracted incident, surge in impact to chronic care patients, etc.)
- Request clinics to communicate key health promotion or protection messaging to the population based on the hazard
- Assess availability of clinic staff to support mobile health force in conjunction with community care in their jurisdiction

Phase III: Review

- Optional qualitative discussion questions:
 - Were contacted clinics able to quantify and identify requested populations during the exercise?
 - Did contacted clinics have the capacity to conduct health promotion and/or health protection messaging to select patients?
 - Were contacted clinics able to provide staff to support community care interventions?
 - What adaptations were made to the MRSE to include the participation of clinics?
 - What communication system was used to alert and communicate with participating clinics?
 - Was communication effective and efficient?
 - Were roles and responsibilities clear among participating clinics and with other participating facilities/organizations?
 - Was there direct engagement between participating clinics and required member participants (e.g., hospitals or EMS)?
 - What was the level of engagement with participating clinics in the three phases of the exercise?
 - How will the MRSE change the extent to which clinics participate in future HCC activities?
 - What feedback should be provided to clinics based on this implementation of the MRSE?

Community care organizations

Phase I: Plan & Scope

- In conjunction with the Clinical Advisor, identify characteristics of at-risk patients for the selected hazard (e.g., aged, diabetic, etc.) and patients with care access challenges
- Identify how the HCC expects community care to participate (i.e., which of the activities in Phase II will be included in the MRSE implementation)

Phase II: Exercise

- Contact community care to identify and/or quantify chronic care or at-risk populations under their care
- Assess community care's capacity to reach local population with health promotion or health protection messaging
- Utilize community care centers to deliver appropriate care to populations relevant to the hazard, including door-to-door and home-based care
- Assess availability of space, staff, and supplies to simulate set up of alternate care sites or mass prophylaxis sites in conjunction with hospitals, public health, and jurisdictional health authorities

Phase III: Review

- Optional qualitative discussion questions:
 - Were community care organizations able to quantify and identify requested populations during the exercise?
 - Did community care organizations have the capacity to conduct health promotion and/or health protection messaging to select patients?
 - Were community care organizations able to provide staff to support community care interventions?
 - What adaptations were made to the MRSE to include the participation of community care organizations?
 - What communication system was used to alert and communicate with participating community care organizations?
 - Was communication effective and efficient?
 - Were roles and responsibilities clear among participating community care organizations and with other participating facilities/organizations?
 - Was there direct engagement between participating community care organizations and required member participants (e.g., hospitals or EMS)?
 - What was the level of engagement with participating community care organizations in the three phases of the exercise?
 - How will the MRSE change the extent to which community care organizations participate in future HCC activities?
 - What feedback should be provided to community care organizations based on this implementation of the MRSE?

Long-term care and skilled nursing facilities

Phase I: Plan & Scope

- Identify how the HCC expects long-term care and skilled nursing members to participate (i.e., which of the activities in Phase II will be included in the MRSE implementation)

Phase II: Exercise

- Contact facilities to collect current staffed bed availability
- Assess facility capacity to receive lower acuity patients from incident site or from acute care hospitals (surge or existing), placing them in appropriate staffed beds
- Contact facilities to quantify or source supplies, staff, or other resources if there are shortages at hospitals
- Assess availability of space, staff, and supplies to simulate set up of alternate care sites or mass prophylaxis sites in conjunction with hospitals, public health, and jurisdictional health authorities

Phase III: Review

- Optional qualitative discussion questions:
 - Were long-term care and skilled nursing facilities able to provide resources to other HCC members to meet the needs of medical surge patients?
 - Did long-term care and skilled nursing facilities have sufficient resources available to serve as an ACS or mass prophylaxis site?
 - What adaptations were made to the MRSE to include the participation of long-term care and skilled nursing facilities?
 - What communication system was used to alert and communicate with participating long-term care and skilled nursing facilities?
 - Was communication effective and efficient?
 - Were roles and responsibilities clear among participating long-term care and skilled nursing facilities and with other participating facilities/organizations?
 - Was there direct engagement between participating long-term care and skilled nursing facilities and required member participants (e.g., hospitals or EMS)?
 - What was the level of engagement with participating long-term care and skilled nursing facilities in the three phases of the exercise?
 - How will the MRSE change the extent to which long-term care and skilled nursing facilities participate in future HCC activities?
 - What feedback should be provided to long-term care and skilled nursing facilities based on this implementation of the MRSE?

Poison control centers

Phase I: Plan & Scope

- Identify how the HCC expects clinics and outpatient care to participate (i.e., which of the activities in Phase II will be included in the MRSE implementation)
- In conjunction with the Clinical Advisor and one (or more) poison center member, identify the antidotes and quantities needed for the exercise hazard

Phase II: Exercise

- Contact poison control to calculate antidote quantity and type needs based on exercise hazard
- Contact poison control to assess sufficiency of antidote supply based on hazard
- Contact poison control to determine how many have sufficiency of backup for scaling a call center to provide information to the public.
- Assess space, staff, and supplies available at poison control for simulating stand up of call center; option to create virtual call center with staff working from home

Phase III: Review

- Optional qualitative discussion questions:
 - Was the poison control center able to provide information related to antidotes, antidote quantity, or other needs to inform the medical surge response?
 - Did the poison control center have backup energy for equipment required to operate a call center?
 - Can the poison control center operate a virtual call center at scale for the public and establish hotlines for providers if required?
 - What adaptations were made to the MRSE to include the participation of the poison control center?
 - What communication system was used to alert and communicate with the poison control center?
 - Was communication effective and efficient?
 - Were roles and responsibilities clear among participating poison control centers and with other participating facilities/organizations?
 - Was there direct engagement between the poison control center and required member participants (e.g., hospitals or EMS)?
 - What was the level of engagement with the poison control center in the three phases of the exercise?

- How will the MRSE change the extent to which poison control centers participate in future HCC activities?
- What feedback should be provided to poison control centers based on this implementation of the MRSE?

Primary health care

Phase I: Plan & Scope

- Identify how the HCC expects primary care members to participate (i.e., which of the activities in Phase II will be included in the MRSE implementation)

Phase II: Exercise

- Contact primary care to identify/quantify at-risk populations and those with access-to-care challenges
- Assess availability of primary care staff to simulate set up alternative care sites or vaccine/MCM distribution sites in collaboration with hospitals, public health, and jurisdictional health authorities
- Contact primary care to assess their systems for communicating key health promotion or health protection messaging to the population based on the hazard
- Assess availability of primary care staff to support mobile health force in conjunction with community care

Phase III: Review

- Optional qualitative discussion questions:
 - Were primary care providers able to quantify and identify requested populations during the exercise?
 - Did primary care providers have the capacity to conduct health promotion and/or health protection messaging to select patients?
 - Were primary care providers able to provide staff to support community care interventions?
 - What adaptations were made to the MRSE to include the participation of primary care providers?
 - What communication system was used to alert and communicate with primary care providers?
 - Was communication effective and efficient?
 - Were roles and responsibilities clear among participating primary care providers and with other participating facilities/organizations?
 - Was there direct engagement between primary care providers and required member participants (e.g., hospitals or EMS)?

- What was the level of engagement with primary care providers in the three phases of the exercise?
- How will the MRSE change the extent to which primary care providers participate in future HCC activities?
- What feedback should be provided to primary care providers based on this implementation of the MRSE?

Urgent care

Phase I: Plan & Scope

- Identify how the HCC expects urgent care members to participate (i.e., which of the activities in Phase II will be included in the MRSE implementation)

Phase II: Exercise

- Contact urgent care to quantify staffed bed availability by type and/or availability of other critical resources
- Simulate transfer lower-acuity patients from incident site and/or hospitals to urgent care facilities; confirm transport availability with EMS

Phase III: Review

- Optional qualitative discussion questions:
 - Were urgent care providers able to report bed availability?
 - Did contacted urgent care providers have the ability to receive lower-acuity patients during the medical surge?
 - What adaptations were made to the MRSE to include the participation of urgent care providers?
 - What communication system was used to alert and communicate with urgent care providers?
 - Was communication effective and efficient?
 - Were roles and responsibilities clear among participating urgent care providers and with other participating facilities/organizations?
 - Was there direct engagement between urgent care providers and required member participants (e.g., hospitals or EMS)?
 - What was the level of engagement with urgent care providers in the three phases of the exercise?
 - How will the MRSE change the extent to which urgent care providers participate in future HCC activities?
 - What feedback should be provided to urgent care providers based on this implementation of the MRSE?

Optional Performance Measures for Phase III: Review

HCCs have the option to use the performance measures below to help evaluate non-core HCC member participation in the response. Note that these performance measures are ***not required*** as part of the annual MRSE data reported to ASPR.

Sample cross-cutting performance measures:

- Percent of invited non-core HCC members who participated in the MRSE
- Percent of invited non-core HCC members who acknowledged the initial emergency notification (adapted from PM 14)
- Percent of invited non-core HCC members who responded to the initial information request (adapted from PM 15)
- Percent of participating non-core HCC members who used the MRSE to meet other exercise requirements (e.g., CMS Emergency Preparedness Rule)
- Percent of invited non-core HCC members who participated in the After-Action Review (adapted from PM 20)

Appendix E: Alignment of ASPR’s Medical Response and Surge Exercise (MRSE) Design with the Homeland Security Exercise and Evaluation Program (HSEEP) Principles

The purpose of this appendix is demonstrating how the three exercise phases of the Medical Response and Surge Exercise (MRSE) are consistent with the Federal Emergency Management Agency (FEMA) Homeland Security Exercise and Evaluation Program (HSEEP) doctrine. HSEEP doctrine provides an overarching structure that exercises should follow to offer value to the preparedness and response operations they evaluate. HSEEP doctrine offers “a set of fundamental principles for exercise programs, as well as a common approach to program management, design and development, conduct, evaluation, and improvement planning.”¹⁰ The MRSE has been designed to enable health care coalitions (HCCs) to flexibly design, exercise, learn, and improve from their crafted scenario in alignment with HSEEP principles and processes. Consistency with HSEEP principles and use of HSEEP resources is advised for all HCCs conducting the Medical Response and Surge Exercise (MRSE).

Refer to **Table 5**, below, for the elements of MRSE design that align the exercise with the fundamental principles of HSEEP.

Table 5. Crosswalk of HSEEP Fundamental Principles with the MRSE

HSEEP	MRSE
<p>Senior Leader Guidance. <i>The early and frequent engagement of senior leaders is the key to the success of any exercise program. Senior leaders provide the overarching guidance and direction for the exercise and evaluation program as well as specific intent for individual exercises.</i>¹¹</p>	<p>HCC leadership, with leadership of participating facilities, determines who will play key exercise roles. These leaders provide operational, clinical, facilitation, and evaluation guidance during the exercise. Executives of participating facilities and organizations are strongly encouraged to participate in all phases of</p>

¹⁰ [Homeland Security Exercise and Evaluation Program \(HSEEP\) \(fema.gov\)](https://www.fema.gov/hseep). Accessed 3/23/23.

¹¹ Ibid

	<p>the exercise process. At least one executive from all participating HCC core member facilities and organizations (acute care hospitals, Emergency Medical Services (EMS), emergency management agencies, and public health agencies) is expected to participate in the after-action review (refer to sections 3.2 and 6.1).</p>
<p>Informed by Risk. <i>Identifying and assessing risks and associated impacts helps jurisdictions/organizations identify and evaluate priorities, objectives, and capabilities through exercises.</i>¹²</p>	<p>HCCs are expected to exercise using a scenario that aligns with one of their top five hazards identified in their Hazard Vulnerability Assessment. HCCs conduct their exercise realistically, using their own systems, processes, and plans, to identify gaps and challenges in meeting exercise objectives (refer to section 3.1).</p>
<p>Capability-Based, Objective-Driven. <i>Jurisdictions/Organizations can use exercises to evaluate current capability levels/targets and identify gaps. Exercises focus on assessing performance against capability-based objectives.</i>¹³</p>	<p>The MRSE enables ASPR and individual HCCs to evaluate HCCs’ ability to manage medical surge, leading to reduced morbidity and mortality during a response. HCCs aim to fulfill the objectives of meeting their space, staffing, supplies, and system needs to manage medical surge, placing all patients in appropriate beds with transport where required. HCCs designate additional objectives they would like to test specific to their coalition’s risks, needs, or new opportunities. ASPR expects HCCs to use identified areas of improvement to improve plans, operations, and goals for the next</p>

¹² Ibid

¹³ Ibid

	year’s budget period (refer to section 3.1).
<p>Progressive Exercise Planning Approach. <i>A progressive approach includes the use of various exercises aligned to a common set of program priorities and objectives with an increasing level of complexity over time. Progressive exercise planning does not always imply a linear progression of exercise types.</i>¹⁴</p>	<p>HCCs must meet a minimum threshold for patient surge to ensure the exercise effectively challenges and stresses the health care delivery system regardless of their current capacity. HCCs are encouraged to exercise with increasing difficulty and complexity over time by including new or additional priorities, partners, and objectives. The MRSE is flexible, allowing HCCs to build a progressive multi-year exercise program linked to their identified hazards, risks, capabilities, and areas of improvement (refer to section 3.4).</p>
<p>Whole Community Integration. <i>The use of HSEEP encourages exercise planners, where appropriate, to engage the whole community throughout program management, design and development, conduct, evaluation, and improvement planning.</i>¹⁵</p>	<p>The MRSE encourages participation of all HCC members and supporting community partners. ASPR has provided additional guidance regarding how HCCs may seek to expand integration of non-core members (including long-term care, blood banks, poison control, community care, and other members) into exercise play. ASPR intends the after-action review and Improvement Plan (IP) processes to be contributed to by all exercise participants (refer to sections 3.2, 6.0, and Appendix D).</p>
<p>Common Methodology. <i>HSEEP includes a</i></p>	<p>The MRSE is consistent with HSEEP’s</p>

¹⁴ Ibid

¹⁵ Ibid

*common methodology for exercises across all mission areas. The methodology enables jurisdictions/organizations a shared understanding of program management, design and development, conduct, evaluation, and improvement planning and fosters exercise-related interoperability and collaboration.*¹⁶

common methodology. The MRSE documentation and tools establish the key phases of the exercise, as well as expectations for the scale of the exercise, exercise roles, and patient tracking and reporting requirements. Although the MRSE allows for HCCs to exercise different scenarios across very different HCC demographics, sizes, and geographies, a minimum threshold for the scale of the medical surge combined with common data collection standards enable national-level evaluation (refer to sections 3.0, 4.0, and 5.0).

ASPR’s expectation of the AAR and IP process includes that HCCs will use findings and corrective actions as a means to strengthen HCC collaboration, planning, and preparedness (refer to section 6.0).

The MRSE and the HSEEP Exercise Cycle

The lifecycle of preparing for, conducting, and learning from the MRSE mirrors the HSEEP Exercise Cycle (**Figure 1**). The first phase of the MRSE, the Plan & Scope phase, is aligned with Design and Development. MRSE’s Exercise phase aligns with the Conduct component of the HSEEP Exercise Cycle. The Evaluation and Improvement Planning components of the HSEEP Exercise Cycle are supported via the MRSE’s final phase, Review, which facilitates learning via an after-action review. Insights from the after-action review documented in the AAR are reflected in HCC IPs. HCCs are expected to

Figure 1: HSEEP Exercise Cycle



¹⁶ Ibid.

incorporate the necessary corrective actions for improvement into HCC preparedness and response plans, annual work plans, trainings, and future exercises. HCCs conducting the MRSE are encouraged to learn more about HSEEP via HSEEP videos,¹⁷ webinars,¹⁸ and training.¹⁹ Downloads of all HSEEP templates are also available on FEMA’s Preparedness Toolkit website.²⁰

HSEEP doctrine is organized by the HSEEP Exercise Cycle and is described in six chapters. Refer to **Table 2**, below, to learn how HSEEP practices and processes are reflected in the MRSE.

Table 6: HSEEP and MRSE Process Crosswalk

Chapter Number & Name	HSEEP Practices and Processes	Reflection in the MRSE
1. HSEEP Fundamentals	This chapter describes the basic principles of HSEEP.	MRSE consistency with HSEEP principles is detailed above (refer to Table 5).
2. Program Management	This chapter provides guidance for overseeing exercises over time. Effective program management includes establishing multi-year priorities; for this an Integrated Preparedness Planning Workshop (IPPW) and a multi-year Integrated Preparedness Plan (IPP) are used. In HSEEP Design and Development, of an Integrated Preparedness Planning Workshop (IPPW) is used	Many of the program management needs of the MRSE are fulfilled by ASPR’s Hospital Preparedness Program (HPP). ASPR outlines the multi-year priorities for HCC development, manages program reporting at the federal level, and conducts national-level evaluation using MRSE data. Additionally, HCCs

¹⁷ [HSEEP Training Videos - YouTube](#)

¹⁸ [Connect Event Catalog \(connectsolutions.com\)](#)

¹⁹ [EMI | National Standard Exercise Curriculum | HSEEP \(fema.gov\)](#)

²⁰ [About - HSEEP Resources - Preparedness Toolkit \(fema.gov\)](#)

	<p>to establish the framework for the exercise program and the foundation of individual exercises. These workshops are a chance to coordinate for whole-community participation, align efforts, efficiently and effectively use resources, and avoid overburdening exercise participants. An Integrated Preparedness Plan is used to iteratively build jurisdictional/organizational capabilities.</p>	<p>are expected to include identified gaps and corrective actions from the MRSE (refer to section 6.0) into their multi-year training and exercise plans, annual work plans, and budgets through the HPP cooperative agreement. While less directly overseen by ASPR, supporting HCC-level learning, including engaging senior leaders at the facility/organizational level is a significant priority for HPP. Each HCC maintains a preparedness plan and a response plan which is to be activated, tested, and improved upon through the exercise. HCCs are likewise expected to manage their exercise budget, staffing, and resources as part of the HPP cooperative agreement.</p>
<p>3. Exercise Design and Development</p>	<p>This chapter describes the methodology for developing exercise objectives, conducting planning meetings, developing exercise documentation, and planning for the exercise and its evaluation. A series of exercise meetings are suggested with key considerations and activities for each. These meetings include the Concept & Objective Meeting to</p>	<p>In the Plan and Scope phase of the MRSE, HCCs will assess their specific threats and hazards, establish their objectives, develop the scenario, identify resources, and determine the scale of patient surge and response (refer to section 3.0). While fewer initial meetings may be needed based on the exercise structure and</p>

	<p>begin the process; the Initial Planning Meeting to refine the scope, objectives, and initial exercise details; the Midterm Planning Meeting to develop the exercise scenario; the Master Scenario Events List (MSEL) Meeting to establish responsibilities, key injects, and timeline; and the Final Planning Meeting to finalize coordination and documentation.</p>	<p>resources provided by ASPR, ASPR encourages HCCs to use HSEEP-outlined meetings as needed to plan their MRSE. HCCs must also assign the Exercise Director, Exercise Evaluator, the HCC Clinical Advisor, and the Duty Officer on their exercise planning team, as well as solicit for and prepare HCC members to participate fully. While some required exercise documentation is MRSE-specific, HCCs are encouraged to leverage other suggested document templates provided via HSEEP (e.g., press releases, waiver forms, player handouts, etc.). At the end of the Plan and Scope phase of the MRSE, HCCs should have the information and decisions made documented in <i>Chapter 3: Exercise Design and Development</i>.</p>
<p>4. Exercise Conduct</p>	<p>This chapter provides guidance on conducting the exercise by exercise type.</p>	<p>Although the MRSE is designed to be a functional exercise, HCCs have the option to conduct the MRSE as a full-scale exercise. HSEEP provides guidance regarding the elements of each exercise type, the considerations that should be included, and activities that</p>

		<p>support the exercise, including the required roles. To begin the exercise, the MRSE requires an Exercise Facilitator and a Duty Officer (refer to section 5.2). Positions outlined for operations-based exercise control structures in the HSEEP doctrine are welcomed but are not strictly required for the MRSE.</p>
<p>5. Exercise Evaluation</p>	<p>This chapter provides the approaches to exercise evaluation through data collection, analysis, and development of an After-Action Report (AAR). The chapter focuses on selecting an evaluation team and developing the evaluation methodology and aligned documentation (including Facilitator/Evaluator Handbook, the Controller/Evaluator Handbook, the Evaluation Plan, the Exercise Evaluation Guide, and the Participant Feedback Form). Potential data collection and analysis methods are outlined. The chapter also describes conduct of the After-Action Meeting to finalize the AAR and IP.</p>	<p>ASPR has provided a tool for documenting qualitative and quantitative data during exercise play. ASPR has created performance measures for the MRSE that speak to the ability of HCCs to meet the exercise objectives. Standardized data collection enables HCCs to evaluate their performance and allows ASPR to evaluate performance at the national level. The MRSE requires an Exercise Evaluator, though other positions encouraged by HSEEP are welcomed. The tool prepopulates relevant information into the facilitator guide for the after-action review that is intended to help the facilitator drive the after-action review and IP processes. A formal AAR and IP must be produced by HCCs using</p>

		exercise data after the exercise (refer to section 6.0).
<p>6. Improvement Planning</p>	<p>This chapter addresses creating corrective actions to document in the exercise Improvement Plan and the process of tracking corrective actions to resolution. The guidance outlines how to establish corrective actions that are specific, measurable, achievable, relevant, and time-bound (SMART) and ways to track corrective actions and support continuous improvement.</p>	<p>ASPR fully supports the guidance provided by HSEEP documentation on improvement planning (refer to section 6.3). HCCs are expected to write SMART corrective actions, to assign responsibility of tasks associated with those actions to specific people for accountability, and to track corrective actions to completion. HCCs are encouraged to include these corrective actions in their annual work plans and budgets as well as validate that the corrective actions have been addressed through subsequent MRSEs.</p>