EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

(East Palestine, Ohio Train Derailment on 2/3/2023: NTSB [https://www.ntsb.gov/investigations/Pages/RRD23MR005.aspx] "Overhead view of derailment and early fire. (Courtesy of Eric's Train Yard.)")

Medical Response and Surge Exercise (MRSE)

Situation Manual (SitMan)
Thursday, November 21, 2024

Welcome to the Los Angeles County Emergency Medical Services (EMS) Agency, Medical Response and Surge Exercise (MRSE). The 2024 MRSE will focus on surge and the Los Angeles County Burn Surge plan.

Supported by the U.S. Administration for Strategic Preparedness and Response (ASPR), Hospital Preparedness Program (HPP), and the Los Angeles County Healthcare Coalition (HCC) the MRSE is an annual requirement of the HPP cooperative agreement.

The MRSE is an operational-based exercise designed to examine and evaluate the ability of HCC and other stakeholders to support medical surge. Placing stress on the health system is important for testing current response systems, identifying gaps in preparedness, and informing improvement planning by facilitating program grant requirements and Healthcare Coalition (HCC) priorities.

This Situation Manual (SitMan) provides exercise participants with all the necessary tools for their roles in the exercise. Some exercise material is intended for the exclusive use of exercise planners, facilitators, and evaluators, but players may view other materials that are necessary to their performance. All exercise participants may view the SitMan.

EXERCISE OVERVIEW

Exercise Name	Medical Response and Surge Exercise (MRSE)
Exercise Date	Thursday, November 21, 2024
Scope	The MRSE is an operations-based exercise for Hospital Preparedness Program fund recipients and Healthcare Coalition (HCC) members. The exercise will test burn surge plans, communication processes, patient decompression coordination to support surge efforts, shelter-in-place, and evacuation plans. Command center activation is encouraged. There will be no actual movement of patients. Play will take place in the live ReddiNet system. The exercise will begin at 8:00 am and end at 12:00 pm. Participating facilities who chose to end sooner than 12:00 pm may do so if all objectives and associated tasks are achieved. There will be no request for mandatory County wide polls or resource requests after 11:00 am to provide participants the opportunity to end sooner if able.
ASPR Core Capabilities	Capability 1. Foundation for Health Care and Medical Readiness Capability 2. Health Care and Medical Response Coordination Capability 3. Continuity of Health Care Service Delivery Capability 4. Medical Surge
FEMA Mission Areas	FEMA National Preparedness Goal: Five Mission Areas (Prevention, Protection, Mitigation, Response, and Recovery)
FEMA Core Capabilities	• Planning • Operational Coordination • Operational Communication • Public Health, Healthcare, and Emergency Medical Services
PHEP Capabilities	Capability 3: Emergency Operations Coordination • **Function 1**: Conduct preliminary assessment to determine the need for activation of public health emergency operations • **Function 2:** Activate public health emergency operations • **Function 3**: Develop and maintain an incident response strategy • **Function 4**: Manage and sustain the public health response • **Function 5**: Demobilize and evaluate public health emergency operations

Goals and Objectives	The MRSE is designed to examine and evaluate the ability of HCCs and other stakeholders to support medical surge. In addition, the exercise will test the Los Angeles County Burn Surge Plan, communication processes, patient destination coordination to support surge efforts, shelter-in-place plans, and evacuation plans.
Threat/Hazard	Burn
Scenario	*A freight train carrying hazardous material derailed at a location near your facility. Several railcars were damaged and released a gaseous substance into the air. A subsequent explosion occurred with a brief fireball that had a horizontal expansion (approximately two blocks in one direction) that resulted in multiple persons attending a mass gathering event with burn injuries. The estimated number of persons with burns and other injuries is approximately 1,700. Approximately 800 plus persons sustained burns and minor injuries. Several railcars are fully engulfed and a smoke plume, presumed toxic, is traveling in a North-East direction. Evacuation and Shelter-in-Place advisories are currently in effect.*
Sponsor	Los Angeles County Emergency Medical Services (EMS) Agency, Hospital Preparedness Program
Participating Organizations	• Amateur Radio Emergency Services • Ambulatory Surgery Centers • Clinics • Dialysis Centers • Home Health and Hospice • Hospitals • Long Term Care Facilities • Los Angeles County Department of Mental Health • Los Angeles County Emergency Medical Services Agency • Los Angeles County Fire Department • Los Angeles County Office of Emergency Management • Provider Agencies (Private) • Public Health (Long Beach, Pasadena, Los Angeles County) • Urgent Care Centers
Point of Contact	Darren Verrette Disaster Program Manager Los Angeles County Emergency Medical Services Agency 10100 Pioneer Blvd. Santa Fe Springs, CA 90670

GENERAL INFORMATION

Exercise Objectives and Capabilities

The MRSE is designed to examine and evaluate the ability of HCCs and other stakeholders to support medical surge. The MRSE is a functional exercise and has very specific surge capacity requirements and data collection elements. HCC must surge to 20% of staffed beds by five (5) required bed types:

1) Emergency Department
2) General Medicine
3) Surgical
4) Burn Floor Beds
5) Burn ICU

The MRSE includes six (6) required objectives for the Health Care Coalition. The Core Capabilities are from the U.S. Administration for Strategic Preparedness and Response, 2017-2022 Health Care Preparedness and Response Capabilities guide. [2017-2022 Health Care Preparedness and Response Capabilities (phe.gov)]

Health Care Coalition (HCC) Objectives:

Exercise Objective	Core Capability
Assess an HCC's capacity to support a large-scale, community-wide medical surge incident	Capability 4. Medical Surge
Evaluate a multitude of coalition preparedness and response documents and plans, including specialty surge annexes, transfer agreements, coordination plans with other state HCCs, and other relevant plans.	Capability 1. Foundation for Health Care and Medical Readiness
Evaluate coalition members' ability to communicate and coordinate quickly to find andmatch available staffed beds, transportation, supplies and equipment, and personnel during a large-scale surge incident	Capability 2. Health Care and Medical Response Coordination
Assist HCCs and their members with improvement planning based on MRSE outcomes	Capability 1. Foundation for Health Care and Medical Readiness
Serve as a data source for performance measure reporting required by the HPP Cooperative Agreement	Capability 1. Foundation for Health Care and Medical Readiness

Exercise Objective	Core Capability
Provide a flexible exercise which could be customized to meet the needs and/or exercise requirements of HCCs	Capability 1. Foundation for Health Care and Medical Readiness

Exercise Objectives by Sector

Amateur Radio Emergency Services (ARES) Objectives:

Exercise Objective	Core Capability
Maintain voice and digital communications for 911 receiving hospital partners and the Medical Alert Center	Capability 2. Health Care and Medical Response Coordination
Provide an internet independent network for delivery of hospital HAvBED and Resource Request spreadsheets to the Medical Alert Center	Capability 2. Health Care and Medical Response Coordination
Provide color coded hospital service level	Capability 2. Health Care and Medical Response Coordination

Ambulatory Surgery Center Objectives:

Exercise Objective	Core Capability
Maintain awareness of the common operating picture	Capability 2. Health Care and Medical Response Coordination
Activate the Incident Command System (ICS) and the facility's Command Center (if applicable)	Capability 2. Health Care and Medical Response Coordination
Determine the facility's priorities for ensuring key functions are maintained	Capability 3. Continuity of Health Care Service Delivery
Evaluate capabilities and resources for a burn surge event	Capability 4. Medical Surge
Plan for the activation of mental and behavioral health services for all staff members	Capability 3. Continuity of Health Care Service Delivery

Exercise Objective	Core Capability
Medical and Health Operational Area Coordinator (MHOAC) Communications and Resource Requesting	Capability 1. Foundation for Health Care and Medical Readiness

Clinic Objectives:

Exercise Objective	Core Capability
Maintain awareness of the common operating picture	Capability 2. Health Care and Medical Response Coordination
Activate the Incident Command System	Capability 2. Health Care and Medical Response Coordination
Determine the (clinic or urgent care) priorities for ensuring key functions are maintained	Capability 2. Health Care and Medical Response Coordination
Evaluate capabilities and resources for burn surge incident	Capability 4. Medical Surge
Ensure processes and procedures are in place to provide appropriate Personal Protective Equipment (PPE), psychological first aid	Capability 2. Health Care and Medical Response Coordination
Medical and Health Operational Area Coordinator (MHOAC) Communications and Resource Requesting	Capability 1. Foundation for Health Care and Medical Readiness

Dialysis Center Objectives:

Exercise Objective	Core Capability
Maintain awareness of the common operating picture	Capability 2. Health Care and Medical Response Coordination
Activate the organization's Emergency Operations Plan (EOP) Determine the facility's priorities for ensuring key functions are maintained throughout the emergency	Capability 2. Health Care and Medical Response Coordination

Exercise Objective	Core Capability
Determine the organization's priorities for ensuring key functions are maintained	Capability 3. Continuity of Health Care Service Delivery
Ensure processes and procedures are in place throughout response to provide appropriate Personal Protective Equipment (PPE), psychological first aid	Capability 3. Continuity of Health Care Service Delivery
Medical and Health Operational Area Coordinator (MHOAC) Communications and Resource Requesting	Capability 1. Foundation for Health Care and Medical Readiness

Emergency Medical Services (EMS) Agency / MAC / MHOAC Objectives:

Exercise Objective	Core Capability
Communication	Capability 2. Health Care and Medical Response Coordination
Situational Awareness	Capability 2. Health Care and Medical Response Coordination
Burn Surge	Capability 4. Medical Surge
Coordinate Resources	Capability 2. Health Care and Medical Response Coordination
Incident Management	Capability 3. Continuity of Health Care Service Delivery

Home Health Hospice Objectives:

Exercise Objective	Core Capability
Maintain awareness of the common operating picture	Capability 2. Health Care and Medical Response Coordination
Activate the Emergency Operations Plan (EOP) and Continuity of Operations (COOP) Plan	Capability 2. Health Care and Medical Response Coordination

Exercise Objective	Core Capability
Activate and implement Surge plan	Capability 4. Medical Surge
Medical and Health Operational Area Coordinator (MHOAC) Communications and Resource Requesting	Capability 1. Foundation for Health Care and Medical Readiness

Hospital Objectives:

Exercise Objective	Core Capability
Maintain awareness of the common operating picture	Capability 2. Health Care and Medical Response Coordination
Alert and notify Incident Management Team or Hospital Command Center staff of incident	Capability 2. Health Care and Medical Response Coordination
Activate the Hospital Command Center	Capability 2. Health Care and Medical Response Coordination
Develop an incident action plan	Capability 2. Health Care and Medical Response Coordination
Assess the hospital's ability to activate Burn surge / patient surge response plans	Capability 4. Medical Surge
Medical and Health Operational Area Coordinator (MHOAC) Communications and Resource Requesting	Capability 1. Foundation for Health Care and Medical Readiness

Long Term Care Objectives:

Exercise Objective	Core Capability
Maintain awareness of the common operating picture	Capability 2. Health Care and Medical Response Coordination

Exercise Objective	Core Capability
Activate the Emergency Operation Plan (EOP) and policies related to the incident	Capability 2. Health Care and Medical Response Coordination
Implement the Nursing Home Incident Command System (ICS)	Capability 3. Continuity of Health Care Service Delivery
If shelter in place and/or activate surge plans, provide minimum standard of care	Capability 3. Continuity of Health Care Service Delivery
If evacuation provide patients with at least a minimum standard of care	Capability 3. Continuity of Health Care Service Delivery
Plan for the Activation of Mental and Behavioral Health Services	Capability 3. Continuity of Health Care Service Delivery
Medical and Health Operational Area Coordinator (MHOAC) Communications and Resource Requesting	Capability 1. Foundation for Health Care and Medical Readiness

Los Angeles County Office of Emergency Management:

Exercise Objective	Core Capability
Simulate activating the Emergency Operations Center (EOC) within	FEMA Core Capability: Operational Coordination
Simulate activating the Incident Command System (ICS	FEMA Core Capability: Operational Coordination
CEOC will notify the Department DOCs that the CEOC is activated and available to support ongoing response efforts	FEMA Core Capability: Operational Coordination
Gather, organize, and document incident situation and resource information received	FEMA Core Capability: Operational Coordination
Ensure that OARRS is available to the DOCs	FEMA Core Capability: Operational Coordination

Los Angeles County Department of Mental Health:

Exercise Objective	Core Capability
Activate DOC and send an agency representative to the MCC	FEMA Core Capability: Public Health, Healthcare, and Emergency Medical Services
Simulate testing rapid response outreach team or available services to clinical/field personnel	FEMA Core Capability: Public Health, Healthcare, and Emergency Medical Services
Test activation of Family Assistance Center	FEMA Core Capability: Public Health, Healthcare, and Emergency Medical Services

Provider Agency Objectives:

Exercise Objective	Core Capability
Maintain awareness of the common operating picture	Capability 2. Health Care and Medical Response Coordination
Alerts and Notifications	Capability 2. Health Care and Medical Response Coordination
Implement Plan	Capability 4. Medical Surge
Implement FOAC for mutual aid back up providers	Capability 4. Medical Surge
Medical and Health Operational Area Coordinator (MHOAC) Communications and Resource Requesting	Capability 1. Foundation for Health Care and Medical Readiness

Public Health Objectives:

Exercise Objective	Core Capability
Establish situational awareness with health and medical stakeholders/MHOAC	Capability 2. Health Care and Medical Response Coordination
Determine need as to whether-or-not to activate formal ICS organization	Capability 2. Health Care and Medical Response Coordination
Coordinate ongoing situational awareness and establish information sharing plan	Capability 2. Health Care and Medical Response Coordination

Urgent Care Center Objectives:

Exercise Objective	Core Capability
Maintain awareness of the common operating picture	Capability 2. Health Care and Medical Response Coordination
Activate the Incident Command System	Capability 2. Health Care and Medical Response Coordination
Determine the (clinic or urgent care) priorities for ensuring key functions are maintained	Capability 2. Health Care and Medical Response Coordination
Evaluate capabilities and resources for burn surge incident	Capability 4. Medical Surge
Ensure processes and procedures are in place to provide appropriate Personal Protective Equipment (PPE), psychological first aid	Capability 2. Health Care and Medical Response Coordination
Medical and Health Operational Area Coordinator (MHOAC) Communications and Resource Requesting	Capability 1. Foundation for Health Care and Medical Readiness

Table 1. Exercise Objectives and Associated Capabilities

Participant Roles and Responsibilities

The term *participant* encompasses many groups of people, not just those playing in the exercise. Groups of participants involved in the exercise, and their respective roles and responsibilities, are as follows:

Players. Players are personnel who have an active role in discussing or performing their regular roles and responsibilities during the exercise. Players discuss or initiate actions in response to the simulated emergency.

Controllers. Controllers plan and manage exercise play, set up and operate the exercise site, and act in the roles of organizations or individuals that are not playing in the exercise. Controllers direct the pace of the exercise, provide key data to players, and may prompt or initiate certain player actions to ensure exercise continuity. In addition, they issue exercise material to players as required, monitor the exercise timeline, and supervise the safety of all exercise participants.

Simulators. Simulators are control staff personnel who deliver scenario messages representing actions, activities, and conversations of an individual, agency, or organization that is not participating in the exercise. They most often operate out of the Simulation Cell (SimCell), but they may occasionally have face-to-face contact with players. Simulators function semi-independently under the supervision of SimCell controllers, enacting roles (e.g., media reporters or next of kin) in accordance with instructions provided in the Master Scenario Events List (MSEL). All simulators are ultimately accountable to the Exercise Director and Senior Controller.

Evaluators. Evaluators evaluate and provide feedback on a designated functional area of the exercise. Evaluators observe and document performance against established capability targets and critical tasks, in accordance with the Exercise Evaluation Guides (EEGs).

Observers. Observers visit or view selected segments of the exercise. Observers do not play in the exercise, nor do they perform any control or evaluation functions. Observers view the exercise from a designated observation area and must remain within the observation area during the exercise. Very Important Persons (VIPs) are also observers, but they frequently are grouped separately.

Support Staff. The exercise support staff includes individuals who perform administrative and logistical support tasks during the exercise (e.g., registration, catering).

Exercise Guidelines

- This exercise will be held in an open, no-fault environment wherein capabilities, plans, systems, and processes will be evaluated. Varying viewpoints, even disagreements, are expected.
- Respond to the scenario using your knowledge of current plans and capabilities (i.e., you may use only existing assets) and insights derived from your training.
- Decisions are not precedent setting and may not reflect your jurisdiction's/ organization's final position on a given issue. This exercise is an opportunity to discuss and present multiple options and possible solutions.

- Problem-solving efforts should be the focus. Areas of opportunities can help improve [focus area] and result in action items.
- The assumption is that the exercise scenario is plausible, and events occur as they are presented. All players will receive information at the same time.

Data Elements and Information Sharing

The exercise will test burn surge plans, communication processes, patient decompression coordination to support surge efforts, shelter-in-place, and evacuation plans.

Participating Medical and Health facilities will communicate with the Medical Alert Center (MAC) or the Medical Coordination Center (MCC) to maintain situational awareness, share information, assess resource availability, and support the identification and sharing of resources. Communication with the MAC or MCC should follow the normal communication procedures according to the EMS Agency's Communication Plan available at https://file.lacounty.gov/SDSInter/dhs/206683_Communication.pdf unless informed of alternative channels.

The MAC will initiate the Start of the Exercise (StartEx) at 08:00 hours via ReddiNet messaging to all Healthcare Facilities in ReddiNet for the following sectors:

- Ambulatory Surgery Centers
- Clinics
- Dialysis
- Home Health / Hospice
- Hospitals
- Long Term Care
- Provider Agencies
- Urgent Care

All participating facilities will acknowledge receipt of the ReddiNet message and begin exercise activities according to sector specific objectives and the Master Scenario Event List (MSEL). The MSEL will prompt specific actions throughout the exercise to support play across all sectors of the HCC.

Calculating the Scale of the Surge

The MRSE requires Healthcare Coalitions (HCC) to surge to 10% of their staffed bed capacity. Staffed beds are those beds that are equipped and available for patient use, including beds that are vacant and beds that are occupied. The HCC has determined that it has 17,000 staffed beds of the five required types.

Staffed bed types are summarized in the Tables below

Staffed Bed Type	Calculation
Emergency Department Beds	Required
General Medical Unit Beds	Required
ICU beds (SICU, MICU, CCU)	Required
Burn Floor Beds	Required
Burn ICU	Required

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

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

Table 3: Crosswalk between bed types and the equivalent in the MRSE.

Patient Allocation

The Healthcare Coalition (HCC) must surge to 10% of its staffed bed capacity. Los Angeles County has 17,000 staffed beds. (17,000 multiplied by 10% = 1,700 surge patients).

The HCC consists of 69 Acute Care Hospitals that have Emergency Departments and 11 Acute Care Hospitals that do not have Emergency Departments.

68 of the 69 Acute Care Hospitals with an Emergency Department (9-1-1 receiving) will receive 25 surge patients each, 20 by EMS (ReddiNet MCI Module) and 5 walk-in patients. Catalina Island Medical Center will receive 10 surge patients in total by EMS (ReddiNet MCI Module).

The 11 Acute Care Hospitals without an Emergency Department (Non 9-1-1 receiving) will receive a minimum of three (3) to a maximum of five (5) walk-in patients with minor burn injuries from the incident. The facility can select to receive either three (3), four (4), or five (5) walk-in patients with minor burn injuries. In addition, they will receive ten (10) in-patients to support hospital decompression efforts.

The MAC will initiate a ReddiNet MCI poll for the 69 acute care hospitals with emergency departments (9-1-1 receiving). Each facility will respond to the poll and enter their bed availability data into ReddiNet. The MAC will then assign either one or two ambulances to each of the acute care hospitals. Each facility will arrive the ambulance(s) and update the MCI victim list in ReddiNet with all 25 patients (EMS and walk-in) from the incident in their emergency department.

Patient Allocation: Burn Surge

The 15 trauma centers in Los Angeles County are the designated Burn Resource Centers (BRC). Each BRC can take up to 20 major/critical burn patients. Each BRC maintains a cache of pharmaceuticals, medical supplies, and equipment to manage burn patients. In addition, each BRC is required to provide burn care training to designated clinical staff in the facility.

Out of the 1,700 surge patients needed for the MRSE, we will have a total of 840 burn victims. Out of the 840 burn victims, 354 will be classified as major/critical burn victims and the remaining 486 will be classified as minor burn victims.

As previously mentioned, 68 of the 69 acute care hospitals will receive 25 surge patients and Catalina Island Medical Center will receive 10 surge patients. Each of the 15 BRCs will receive 20 burn victims out of the 25 surge patients each with major/critical burns. Each of the remaining 54 acute care hospitals (non-BRC) will receive 10 burn victims, 1 of the 10 burn patients will have major/critical burns and the remaining 9 will have minor burn injuries.

Patient Allocation: Hospitals

Before the exercise, all hospitals will choose the victims from the victim list based on the above and following categories and quantities.

All hospitals with emergency departments will select 25 patients from the victim list except Catalina Island Medical Center who will select 10 patients from the victim list.

Burn Resource Centers (Trauma Centers) must select at least 20 major/critical burn patients, and the remaining 5 victims (patients) can be chosen freely.

All other acute care hospitals with emergency departments must select 1 major/critical burn patient, 9 minor burn patients, and the remaining 15 victims (patients) can be chosen freely.

Hospitals without emergency departments will select either three (3), four (4), or five (5) walk-in patients from the incident. In addition, they will select ten (10) patients of their choice from the hospital patient list. These patients will not be assigned via ReddiNet, and it is not mandatory to add them to the MCI victim list. The person(s) on site preparing for the exercise will create injects to simulate patient arrival.

Patient Allocation: Clinics and Urgent Care Centers

Participating clinics and urgent care facilities have the option to choose the number of walk-in patients they wish to receive to fulfill their objectives. It is advisable to receive at least 1 walk-in patient but no more than 10 walk-in patients from the incident. These patients will not be assigned to clinics via ReddiNet, and it is not mandatory to add them to the MCI victim list. The person(s) on site preparing for the exercise will create injects to simulate patient arrival.

Before the exercise, each participating clinic and urgent care must download the victim list and select the (1 to 10) patient(s) of their choice from the burn clinic category.

Patient Allocation: Long Term Care Centers and Home Health / Hospice

Long-term care (LTC) and Home Health / Hospice (HHH) facilities taking part in the exercise will be allocated ten (10) patients to assist in relieving the pressure on hospitals. These patients will not be assigned to facilities through ReddiNet, nor will it be necessary to add them to any patient list on ReddiNet. The person on site preparing for the exercise will create injects to simulate patient arrival.

Before the exercise, each participating LTC and HHH facility must download the hospital patient list and choose 10 patients of their choice from the list.

Patient allocation summarized in table below

	Number of surge patients from incident with Major/Critical Burns injuries arriving by EMS	Number of surge patients from incident with Minor Burn injuries arriving by EMS	Other surge patients from incident arriving by EMS	Number of walk-in patients from Incident	Decompression patient transfers to: • Hospitals without ED • HHH • LTC	Total number of Patients
Trauma Center / Burn Resource Center (15)	20	0	0	5	0	25
Acute Care Hospital (53)	1	9	10	5	0	25
Catalina Island Medical Center	1	9	0	0	0	10
Hospitals without Emergency Departments (11)	0	0	0	*3-5	10	*13 -15
Clinics and Urgent Care Centers	0	0	0	**1-10	0	**1 -10
Home Health Hospice	0	0	0	0	10	10
Long Term Care	0	0	0	0	10	10

*Table 4: Patient allocation table. *Hospitals without Emergency Departments will receive a minimum of three (3) to a maximum of five (5) walk-in patients with minor burn injuries. **Clinics and Urgent Care Centers have the option of receiving up to 10 walk-in patients with minor burn injuries. These patients are in addition to the 10% patient surge.*

Staffed Bed Availability: Hospital Capacity Survey

All participating HPP Hospitals will participate in the "Hospital Capacity Survey" in the ReddiNet assessment module. The deadline to submit the data is the end of the next business day following the conclusion of the exercise. The following data elements are required:

Start of Exercise (Prior to Patient Surge Data):

i) Number of staffed beds (includes both vacant and occupied beds) at the beginning of the exercise, prior to receiving patients, for the five (5) required bed types only *(see Table 2 on page 14 for the five (5) required bed types)*

ii) Number of existing in-patients (census) at the beginning of the exercise, prior to receiving patients

iii) Number of existing in-patients who could be safely discharged to accommodate surge patients (decompress)

During and Post Exercise (Patient Surge Data):

iv) Number of surge patients requiring admission for inpatient care based on triage assessment

v) Number of surge patients requiring outpatient care who will not be admitted based on your triage assessment (discharged from ED)

vi) Number of existing in-patients and surge patients requiring admission for inpatient care with an appropriate staffed bed and after safe discharge of patients from the original patient census.

Exercise Assumptions and Artificialities

In any exercise, assumptions and artificialities may be necessary to complete play in the time allotted and/or account for logistical limitations. Exercise participants should accept that assumptions and artificialities are inherent in any exercise and should not allow these considerations to negatively impact their participation.

Assumptions

Assumptions constitute the implied factual foundation for the exercise and, as such, are assumed to be present before the exercise starts. The following assumptions apply to the exercise:

The exercise is conducted in a no-fault learning environment wherein capabilities, plans, systems, and processes will be evaluated.

The exercise scenario is plausible, and events occur as they are presented.

Exercise simulation contains sufficient detail to allow players to react to information and situations as they are presented as if the simulated incident were real.

Participating agencies may need to balance exercise play with real-world emergencies. Real-world emergencies take priority.

Artificialities

During this exercise, the following artificialities apply:

- Some hospitals will be disproportionately impacted more than others. For example, the 10% staffed bed capacity of Ronald Reagan UCLA (RR UCLA) is a larger number compared to the 10% staffed bed capacity of Emanate Foothill Presbyterian (FHP) Hospital. Sending 25 surge patients to RR UCLA is less than their 10% surge capacity, while sending 25 surge patients to FHP is greater than their 10% surge capacity.
- Exercise communication and coordination is limited to participating exercise organizations, venues, and the SimCell
- Only communication methods listed in the Communications Directory are available for players to use during the exercise.

Exercise Evaluation

Evaluation of the exercise is based on the exercise objectives and aligned capabilities, capability targets, and critical tasks, which are documented in Exercise Evaluation Guides (EEGs). Evaluators have EEGs for each of their assigned areas. Additionally, players will be asked to complete participant feedback forms. These documents, coupled with facilitator observations and notes, will be used to evaluate the exercise, and compile the After-Action Report (AAR)/Improvement Plan (IP)

MODULE 1: MCI INITIATION AND NOTIFICATION

Scenario

November 21, 2024:

A freight train carrying hazardous material derailed at a location near your facility.

Several railcars were damaged and released a gaseous substance into the air.

A subsequent explosion occurred with a brief fireball that had a horizontal expansion approximately two blocks in one direction that resulted in multiple persons attending a mass gathering event with burn injuries.

Fire and HAZMAT are on scene of the incident.

First responders reported the estimated number of persons with burns and other injuries is approximately 1,700.

Approximately 800 plus attendees sustained burn injuries.

Many others sustained minor burns and minor injuries.

Several railcars are fully engulfed, and a smoke plume, presumed toxic, is traveling in a North-East direction.

News crews respond to the scene and begin broadcasting.

First responders began triaging the victims in the Immediate, Delayed, and Minor categories and are preparing patients for transport to local hospitals.

HAZMAT reported Evacuation and Shelter-in-Place advisories are currently in effect.

Upon receiving the ReddiNet MCI notification and hearing the emergency news broadcast, hospital leadership began mobilization of the command center (incident management team) and preparing for the influx of patients to the Emergency Department. (*Implement your burn surge plan. Hospitals begin your MRSE action items.*)

Instructions

1. You have **20-30 minutes** to consider the questions in this module.
2. **Participants are not required to address every assigned question.** Take a moment to review the questions in their entirety and then focus on the critical issues of major concern for your group at this point in the exercise.
3. Elect a spokesperson and a scribe/note taker for your group to discuss the group's findings after each module and document them.
4. Groups should work to identify any additional questions, critical issues, or decisions they feel should be addressed at this time. **Each participant should record their thoughts, issues, and questions on the provided Participant Feedback Form.**
5. Make decisions using the information provided and your best judgment of how to proceed.

Key Issues

- MCI Initiation
- Notification
- Surge Plan Activation

Questions

Based on the information provided, participate in the discussion concerning the issues. Identify any critical issues, decisions, requirements, or questions that should be addressed at this time.

The following questions are provided as suggested subjects that you may wish to address as the discussion progresses. These questions are not meant to constitute a definitive list of concerns to be addressed, nor is there a requirement to address every question.

1. Does your organization have an emergency preparedness plan to address potential burn surge issues?
2. If so, does that plan address appropriate training and equipment, referral and transfer to burn centers, and ability to hold and stabilize patients when necessary?
3. If victims from the incident walk into your facility, does your organization have a plan to address potential burn injuries?
4. If so, does that plan address appropriate training and equipment, referral and transfer to tertiary centers or burn ceners, and ability to hold and stabilize patients when necessary?
5. If receiving in-patients from another facility to support a surge, what emergency procedures are available to expedite the intake process?
6. What resources such as action planning procedures and forms are used to document and guide the response and recovery process?
7. What is your process for receiving and disseminating critical information (Situational Reports) internally and externally with government and non-government partners?
8. What is the process and format for submitting situation reports from the field or local level to the Medical and Health Operational Area Coordinator (MHOAC) Program?
9. How do you, at the field or local level, receive situation updates and other information from the Medical and Health Operational Area Coordinator (MHOAC)?
10. What redundant communication systems are in place for use in incidents like this (e.g. CAHAN, ReddiNet, WebEOC, etc.)? If these systems exist, how are they tested?
11. How will you communicate your situation status to your staff and with external agencies?
12. What information should be released to the public? How will that information be released? How will you communicate with and address the requirements of persons with disabilities and others with access and functional needs (e.g., non-English speaking, seniors, homeless, and homebound)? How do you utilize local media, social media and other resources?

13. How are you utilizing local emergency medical services, ambulance providers, law enforcement and other emergency management resources to aid your efforts?
14. How do you plan for and respond to staffing needs when staff are unable to access your facility?
15. Do you have MOU's or other agreements with other agencies to share resources in a disaster?

Additional Discussion Questions to Consider

16. How do you track your staff who may be evacuated from their homes or sheltering-in-place?
17. How do you notify the family of patients your facility is evacuating or sheltering in place?
18. Do healthcare providers have a policy or plan for requesting an 1135 waiver?
19. How does your facility shelter in place for a hazardous materials incident?
20. Do you have continuity plans in place with key vendors to provide services/deliveries when access to the facility is limited?

MODULE 2: RECOVERY (OPTIONAL)

Scenario

Hours after the initial incident.

There are many family members flooding local hotlines, and healthcare organizations, asking for information about loved ones who either worked or were treated at the nearby medical facility.

The hotlines established by the county are flooded with phone calls from members of the public seeking information, resources, or just someone to talk to about the incidents.

Staff at the incident scene, and at receiving facilities, along with in the Command and Operations Centers, and first responders in the area are deeply affected by the events. Some are showing signs of exhaustion, while others are quiet and isolated. Some are showing signs of stress. There is a need for additional mental and behavioral support. Some staff/responders had family members or friends involved in the incidents.

There are concerns about those with pre-existing disorders, acute syndromes, or mental health conditions, with a potential worsening due to the trauma of these events.

Conversely, medical personnel, law enforcement, and first responders from other healthcare facilities and jurisdictions have flooded the area with offers of volunteering and donations. It is unclear who is managing volunteers and donations.

Key Issues

- **Recovery**
- **Family Assistance**
- **Mental Health / Wellness Support**

Instructions

1. You have **20-30 minutes** to consider the questions in this module.
2. **Participants are not required to address every assigned question.** Take a moment to review the questions in their entirety and then focus on the critical issues of major concern for your group at this point in the exercise.
3. Elect a spokesperson and a scribe/note taker for your group to discuss the group's findings after each module and document them.
4. Groups should work to identify any additional questions, critical issues, or decisions they feel should be addressed at this time. **Each participant should record their thoughts, issues, and questions on the provided Participant Feedback Form.**
5. Make decisions using the information provided and your best judgment of how to proceed.

Questions

Based on the information provided, participate in the discussion concerning the issues raised in Module 1. Identify any critical issues, decisions, requirements, or questions that should be addressed at this time.

The following questions are provided as suggested subjects that you may wish to address as the discussion progresses. These questions are not meant to constitute a definitive list of concerns to be addressed, nor is there a requirement to address every question.

1. How would your facility coordinate with law enforcement and state/federal partners to assist in evidence collection and protection? What about interviewing of patients?
2. Would your facility set up a Family Information Center? Would your facility play a role in working with a Family Assistance Center if one were set up by the county? If so, what role would your facility play? Would the hospital anticipate fielding inquiries from concerned individuals seeking out their friends, family and/or loved ones?
3. Does your health care coalition have mental health experts or teams that can be utilized if your facility needed additional resources? How would you request these resources?

4. Who is responsible for updating the Incident Action Plan each operational period? What would your objectives be for the next operational period?
5. Consider that you may have limited staff and resources in the coming days and weeks. How would your facility prioritize essential functions to continue to provide quality care to your patients? Would your Continuity of Operations Plan be activated? If so, how and when?
6. How would your organization accept volunteer practitioners to assist with caring for your patients? Do you have a policy/procedure in place? What sorts of identification do you require and how will you validate that the staff are competent to practice at your facility?
7. Who determines when a lockdown or shelter in place order is no longer necessary? How is the order communicated to staff, patients, family of patients, and volunteers?
8. What types of broader, community-based behavioral support services will be available to the public in the days, weeks, and even months following these incidents? Will there be services such as crisis hotlines, counseling, self-help tips, social media resources, educational materials, and/or text messages?
9. What steps will be taken to ensure that your organization's staff feel safe when returning to work? How would your organization ensure that the public feels safe to return to your facility?
10. What are your center's priorities for ensuring key functions are maintained throughout the response and recovery phases from an incident, including the care of existing and new patients?
11. How would your center demobilize operations after evacuating, re-locating, or receiving a surge of patients? How would your center coordinate with the Medical and Health Operational Area Coordinator, health care coalition partners, emergency medical services, and the local Emergency Operations Center to return to normal operations?
12. How would your agency continue to receive and vet information in order to provide situational awareness during the incidents? What jurisdictional partners would you work with (e.g., Joint Information Center, Emergency Medical Services system partners, Medical and Health Operational Area Coordinator program)?
13. What agency positions are responsible for compiling information and completing assessments and/or situational reports related to the incident? If the incident is

prolonged, how often are these required for local, regional, state and/or federal partners?

14. What types of broader, community-based behavioral support services will be available to your employees in the days, weeks, and even months following these incidents?
15. Would your agency play a role in working with the Family Assistance Center if one were activated? If so, what role would your agency play? Would you anticipate fielding inquiries from concerned individuals seeking out their friends, family and/or loved ones?
16. What are your agency's priorities for ensuring key functions are maintained throughout the response and recovery phases from an incident?

APPENDIX A: EXERCISE SCHEDULE

Note: Because this information is updated throughout the exercise planning process, appendices may be developed as stand-alone documents rather than part of the SitMan.

Date	[Insert Date]
[Time]	[Player Check-In]
[Time]	[Exercise Briefing]
[Time]	[Start Exercise]
[Time]	[Capture Initial Data Elements]
[Time]	[Objectives]
[Time]	[Objectives]
[Time]	[Capture Ending Data Elements]
[Time]	[End Exercise]
[Time]	[Hot wash]
[Time]	[Closing Comments]

APPENDIX B: EXERCISE PARTICIPANTS

Participating Organizations
County
Medical Alert Center
[County Participant]
[County Participant]
City
[City Participant]
[City Participant]
[City Participant]
[Jurisdiction A]
[Jurisdiction A Participant]
[Jurisdiction A Participant]
[Jurisdiction A Participant]
[Jurisdiction B]
[Jurisdiction B Participant]
[Jurisdiction B Participant]
[Jurisdiction B Participant]

APPENDIX C: RELEVANT PLANS

- Los Angeles County Burn Resource Manual
  https://drive.google.com/file/d/1Q_cm_MeG06Cfz2ZlfO964noyiarUDyeB/view

APPENDIX D: ACRONYMS

Term	Definition
AAR / IP	After-Action Report / Improvement Plan
ESF-8	Emergency Support Function – 8 (Medical and Health)
HCC	Health Care Coalition
MAC	Medical Alert Center
MRSE	Medical Response and Surge Exercise