Lauren Egbert: Today's meeting is going to be recorded, so Pete has just started our recording for us. And I see that we have a few more folks in the waiting room, so we're going to admit those folks and then I'm going to pass it over to Jennifer Hannah is going to open our call today. Wonderful, and all have been admitted. Thank you, Jennifer.

Jennifer Hannah: Great, thank you, Lauren and Pete. Good afternoon, everyone. Thank you for joining us today. I am Jennifer Hannah, Deputy Director for ASPR’s National Healthcare Preparedness Programs Branch or NHPP.

It is my pleasure to be with all of you today and discuss the work that has gone into redesigning the Coalition Search Test and Hospital Surge Test into what we are now calling the Medical Response and Surge Exercise or MRSE. Next slide, please.

First, I would like to introduce today's speakers who are part of the MRSE design team and also are members of the NHPP branch. The first presenter is Angela Krutsinger, who is the Acting Field Project Officer Supervisor for Regions 1, 3, 4, 7, and 8. The second presenter is Kevin Sheehan, who serves as a Captain in the US Public Health Service and is also a Field Project Officer for Region 9. Our final presenter is David Csernak, the Acting Field Project Officer Supervisor for Regions 2, 5, 6, 9, and 10. And now I will hand it over to Angela Krutsinger to continue with the presentation.

Angela Krutsinger: Thank you Jennifer and good afternoon everyone. Let's quickly review our agenda for today's call. First we'll provide a brief background as to why the CST and HST have been refreshed to create the MRSE. Next we'll walk through an overview of the exercise steps and instructions. Afterwards we'll review changes that have been made to the exercise performance measures. Then we'll highlight a few sections of the MRSE supporting documents, and finally we'll open it up for questions and answers. Next slide, please. Thank you.

In response to feedback from Health Care Coalitions, recipients, and Field Project Officers, we at ASPR HPP wanted to move the CST and HST requirement from a check-the-box test to a more useful and much more flexible surge exercise tool that we hope will be much more helpful for everybody, using the feedback and information that we've received from the last several years of the CST and HST, as well as real-world responses.

Dave and Kevin will talk more about the specifics on later slides, but the CST and HST have been refreshed to create the MRSE with a lot of help from a lot of people. The design team is comprised of the following organizations: the ASPR National Healthcare Preparedness Programs Branch, the Office of Strategy, Planning, Policy, and Requirements (SPPR) Evaluation Branch. Deloitte Consulting has been a key partner with us, as well as Gryphon Scientific.
Subject matter expertise and review is provided by ASPR’s Exercise Branch, ASPR TRACIE, select Hospital Associations, and the US Department of Transportation’s Office of EMS, and other partners, including ASPR HPP Field Project Officers and the HCCs who piloted these tools for us. And we can’t thank enough the HCCs who participated in the short-notice pilot of the MRSE: Colorado’s West Region Health Care Coalition and South Dakota’s Health Care Coalition, as well as all of those HCCs and recipients who provided feedback on the draft documents during these very busy times. Next slide please.

The MRSE is an operations-based exercise designed to examine and evaluate the capabilities and functions of Health Care Coalitions and their members to support medical surge response. The MRSE officially replaces the Coalition Surge Test and Hospital Surge Test as an annual requirement of the Hospital Preparedness Program Cooperative Agreement.

In accordance with guidance provided throughout the budget year, as of our current HPP budget year three, (which started July 1 of 2021 and this year ends June 30 of 2022), HCCs must complete the MRSE annually, starting this budget period (three) and moving forward.

In the past there was a separate requirement of the HST for hospitals located in approved jurisdictions or officially classified as an isolated frontier hospital. Now everyone uses the MRSE, and those previously classified for the HST must also develop a surge scenario and exercise annually utilizing the MRSE.

Data from the MRSE must be submitted by HCCs and isolated frontier hospitals into the Coalition Assessment Tool (the CAT). HCCs are required to submit MRSE performance measure information into the CAT and to upload the MRSE Exercise Planning and Evaluation Tool into the CAT, as well. I will now pass it over to Kevin Sheehan. Kevin.

Kevin Sheehan: Hey, thank you Angela and good afternoon everyone. The three large, biggest muscle movement changes we have in the MRSE versus the CST are increased flexibility, expanded engagement, and increased options for you as Health Care Coalitions. We have over 500 people on this call and a lot of interest in this exercise, so I wanted to really, you know, review our changes and let you understand that there’s some greater flexibility is for you. We’re interested not just an evacuation scenario any longer, you can determine your objectives and your scenario we are giving you a greater flexibility to look at your HVAs, your surge estimators, your various response plan surge annexes, and determine for yourself what flexibilities you want to exercise and what options you are looking to exercise for your coalition.

Our engagement we anticipate: as you know, with the CST it was really an evacuation hospital as well as a receiving hospital, and some other members of your coalition didn’t have much of a role other than just observing and participating, so we hope there’ll be more options for you and for engaging other coalition partners. And the other thing we’re really interested in asking you about are resource requests. On the CST, we did not ask questions about resource requests, but for the MRSE, we are going to ask you resource request questions, and that will be in the early phases of stage one or phase one of the exercise. The other options we envision will be that you will determine, working with your clinical advisor and other partners, what resource demands you may have on the coalition, depending on your different scenarios.
And the MRSE will adapt to meet other exercise requirements for your coalition members. If there’s a possibility for you to integrate the MRSE into other exercises or other exercises into the MRSE to meet other types of requirements such as CMS, that’s up to the coalitions and your members to determine – you know how best to make that happen. We are removing the no-notice and 90 minute requirement within the CST, so again, there is no no-notice there is no low-notice, requirement, but if you still want to exercise with low notice, feel free to do so. And there’s no time limit anymore on the exercise. We’re still focusing on coordination, communication, and resource sharing. We anticipate the major benefits of these changes will be strengthening your partnerships and capabilities by aligning your various plans and, hopefully, reducing burden on your members by consolidating exercises together. Next slide, please.

Criteria for real world events: as we allowed in the CST, we encouraged all of you, if you did have a real world event, to use that as your exercise, to use that real world response in lieu of conducting your Coalition Surge Test. We’re going to obviously allow that to happen here again with MRSE.

Real world surge incident: we do want this to be a challenging exercise for the coalitions, we do want coalitions to stress your health care system, so we are requiring that the 20% of the staffed beds be impacted depending on your different surge scenario. We are looking at ED beds, general medical beds, ICU, step down, post critical care and surgical beds. All those will be combined and we'll discuss those more and the tools later in the presentation.

One of your coalition core members should participate in the real world incident. And the other thing we really want is executives, we still are asking executives participate in the after action review they don’t necessarily have to participate in the exercise itself, but in the after action review process. With relieving the low-notice no-notice component, we hope there’ll be more opportunity for executives to free up their schedule to come and participate in both the after action review and, if possible, the actual exercise itself.

Coalitions will be able to capture data points required to report all the performance measures, and Dave’s going to walk us through the performance measures. And coalitions must submit their AAR and Improvement Plan after a real world event with the reporting requirements of the cooperative agreement for both exercises and real-world events. One of the things we’ve thought through, talked about was: ‘what type of real world event are we looking at?’ We know that we are all busy - you guys have been very busy over the last two years with COVID. We understand the hospital impacts of COVID. We've waived the CST requirement for the last two years. But when we are looking at having a surge incident, it really should have a beginning and an end. It should be somewhere in the area of not longer than a week.

But we really are interested in working with you. If you do have a real world event, we’re asking the coalitions to contact the recipients and their Field Project Officers to discuss using your real world event lieu of the MRSE requirement. Next slide please.

Our exercise outcomes: we have four exercise outcomes that we are interested in and you obviously can add to the outcomes that you’re interested in for your respective coalition. We want you to validate and socialize all relevant plans, and not just your Health Care Coalition plans - we know you all have Health Care Coalition response plans, but in each of your jurisdictions, you have numerous plans of which you
have to work within. So one of the things we want you to do is to obviously validate all those plans within your coalition.

We are interested in having you become better prepared to respond to a medical surge resulting from any type of incident, not just an evacuation incident. As you know, this past year we’ve had hospitals in California evacuated due to the wildfires, we have had hospitals in Louisiana evacuated due to hurricanes, we’ve had other incidents with regard to our tornadoes in the Midwest, but there are still other types of incidents we want folks to get prepared for. We’re interested in having you improve your resource coordination with your coalitions, across multiple coalitions, and statewide.

And the fourth outcome we’re looking for is strengthening coalition coordination and communication across both the community that you work within, in your state, and hopefully increasing your overall preparedness. Next slide, please.

We've gone through our exercise roles. We’re interested in identifying a few roles here. There obviously will be more roles as you put your exercise together, but here are some of the key players who we wanted to identify. The Readiness and Response Coordinator: we saw that many of you on the phone are, as you know, the Readiness and Response Coordinator for your coalition. We envision you having the lead role for planning and preparing for this exercise. We’re asking your Clinical Advisors to participate, even from the beginning, in helping you identify the scenarios, providing some clinical guidance, determining impacts and injuries to patient, and in triage and those types of things – as well as identification of medical types of resources you may need.

The Exercise Facilitator and the Exercise Evaluator are two important roles. These folks need to be involved early, at the beginning. They need to be very familiar with all the documents that Dave Csernak is going to go over in a little bit so that the facilitators can really guide this exercise through. And I know you may have an Exercise Facilitator that's perfect for you and that's fine. We’re not dictating who the Exercise Facilitator is, but we really want that person or persons involved early on. The Exercise Evaluator must be the one who really understands the documentation and the tool that we are asking you to use and fill out throughout the exercise, because after the exercise those tools will be completed, updated, and then you will upload as coalition members into the Coalition Assessment Tool.

And then obviously we’re interested in notification and using your existing notification systems. However, whatever your notification system is during a real world event or on game day, please use it during the exercise as well. That’s all I have on this one.

The next one is resource management. We’re interested in identifying both critical and non-critical resources across all coalition members. This is intended to improve coalitions’ overall understanding of resource needs from all members by reviewing plans and maintaining situational awareness throughout the exercise and the execution of the exercise and of your activations in your plans. It’s understood that the coalition’s role is not to identify and secure every needed resources during a response, but that their roles is to support their members, especially the four core members, by assisting them with identifying and correcting gaps in their respective resource requirements. We understand that some coalitions are able to stockpile and provide resources as needed during a response, and others do not have that capability. Therefore, whatever your normal everyday response for requesting resources, whether that’s within the coalition, within your neighboring coalition, or within your state or other partners – obviously we’re asking you to play an exercise as you would in any type of game-day event. Next slide please.
We have three phases of the MRSE. The MRSE is a functional exercise and is a coalition-based operations-based exercise. No patients or actual resources will be moved. The MRSE, as I mentioned earlier, should challenge the coalition and stress the overall surge capacity of the health care system. The MRSE follows three phases: phase one, the plan and scope phase; phase two, the exercise phase; and phase three is the review phase with the hotwash, AAR, and discussion of validating strengths, identifying areas of improvement, and highlighting lessons. Next slide please.

Phase One: The MRSE is designed to be flexible, to meet your coalition’s tailored needs, and this is when you work with your members to identify objectives and scenarios that are most needed in your HCC. I know many of you. And your phase one, your plan and scope phase, for all your exercises, you do that very effectively. Now, with some additional flexibilities this may take on a different approach. We are looking at this from a whole different perspective because it is not just your evacuation scenario any longer, but there are other opportunities to exercise various types of vulnerabilities that you may have within your coalition. We are interested in you at least looking within your top five vulnerabilities and exercising and trying to get prepared to better respond to one of those type of events that you may have in your coalition.

We are looking for you to report only staffed beds, similar to how it was done in the CST. The clinical advisor designee should be providing details regarding patient injuries from the incident to be used in phase two of the exercise. So in phase two coalitions are expected to follow their initial response actions and their coalition response plans, the list of patient’s injuries used to determine triage and decisions on where patients should be transported depending on availability.

HPP wants all coalitions to exercise as it would, as I mentioned, on game day, identify bed space within the coalition and, if needed, outside their coalition. This is where the resource identifier in phase one will be requested. Next slide please.

Phase three. This is your typical AAR After Action Improvement Plan process. Coalitions are expected to engage your executives to bring them into the discussion. And hopefully, those executives will be able to make decisions. We do have a definition of what we classify as an executive in the glossary of the Situation Manual and I will read what that definition is now because I know we've been asked that question and a couple of others on other presentations on this. An health care executive is a decision maker for his or her respective organizations and should have decision-making power that includes, but not limited to, allocating or reallocating resources, changing staffing roles and responsibilities, and modifying business processes in his or her organization. Typical titles include CEO, COO, CMO, Chief Clinical Officer, the CNO, or state or local Director of Public Health, Director of Emergency Management, Administrator on Duty, or Chief of EMS, among others. We envision that you as coalition leads will determine. You understand who your executives are within your coalition and how to best bring them to the table to help them understand any challenges that you may have within the exercise and to make decisions and to assess resource requests if needed.

So I cannot emphasize enough that these three documents that David and we're going to go over - and the three phases of the exercise - are very important for everybody to read. They will help you walk through this. We know many of you have extensive experience on exercises. I know there's a couple of my colleagues I work with out here in region nine who have put on hundreds of exercises, and so we hope that walking through this it gives you a good start, and if you have any questions on any of this as we move forward and get better prepared, you ask your Field Project Officer to help and assist. I know
that we, as the exercise design team are here throughout this process to help you as well. I’m going to turn the briefing over to Dave Csernak to present our new performance measures and go over our three exercise documents. Thank you, Dave.

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**Dave Csernak:** Thank you, Kevin, and good afternoon everyone. We can take the next few minutes to discuss the new MRSE performance measures, as well as the supporting tools. So, as you can see, many of the old performance measures were focused on specific details such as patient numbers, bed numbers, and the time required to complete certain tasks. And, as you can see, many of these performance measures have been discontinued or replaced with updated performance measures. Of the remaining three performance measures, two focus primarily on HCC member participation and the third on identification of a receiving facility. Next slide please.

The MRSE will now utilize a total of only eight comprehensive performance measures, which is down from twelve, that will apply universally to all Health Care Coalitions. These performance measures have been updated to focus on three specific areas. First, the Health Care Coalition’s ability to effectively communicate with its members during a response. Second, the Health Care Coalition’s ability to support and assist members with critical resource identification and management. And third, Health Care Coalition member participation in both exercise and the AAR/IP process. It is our hope that these performance measures will assist Health Care Coalitions, their members, and other participating jurisdictions with both strengthening and aligning their preparedness and response plans.

One additional item of note: we’re not expecting Health Care Coalitions to report high percentages on all performance measures. Ideally, we’re encouraging Health Care Coalitions to work with NHPP regional staff to select challenging scenarios that will yield greater benefit to all coalition members. Next slide please.

The MRSE toolkit is comprised of three required tools to support HCCs as they complete the exercise. Number one on your screen is a Situation Manual or SitMan. This is the core document that describes the purpose of the MRSE and MRSE operations. As the core document, the overall goal of the Situation Manual is to provide explicit detail that will help all coalition exercise planners and participants perform their required actions for each of the three exercise phases. It also provides sample language that the coalitions can use as they coordinate beds, personnel, and supplies and equipment throughout the exercise.

Item number three on your screen is the Evaluation Plan. It not only provides the qualifications to consider when assigning an Exercise Evaluator but walks the Exercise Evaluator through collecting data during the exercise and facilitation of the After Action Review.

Starting on page 15, it provides a detailed performance measure implementation guide so that Health Care Coalitions and recipients are able to clearly understand each performance measure. This includes the operational intent, the numerators and denominators for that measure, and, finally, the calculation utilized for each of the performance measures.

Finally, item number two on your screen is the Exercise Planning and Evaluation Tool. Lauren, can you please bring up the tool on your screen?
Dave Csernak: Thank you. So while Lauren is bringing up the tool for you to see, this tool is basically designed to move your coalition through the exercise, from start to finish. It is designed to collect data for each phase of the exercise, and it serves as the primary place where exercise data will be recorded and documented so there'll be no need to document the information in multiple locations. Data from different exercise phase sections will auto-populate into the after action review section, as well as into the performance measures section, making review of the exercise that much easier for you.

The tool will automatically calculate your performance measures, using the data points you enter during the exercise. Health Care Coalitions will copy their final performance measures, the numerators and denominator, from the tool and simply paste them directly into the CAT once complete.

So just for everyone's awareness, due to federal compliance regulations we were tasked with converting our original Excel-based tool into a functional PDF format. This will allow us to post the entire exercise toolkit in its entirety on PHE.gov, as well as a full copy of the toolkit within the HPP CAT. ASPR Communications is in the final review process of this new PDF document, and we expect to have it available to you in the coming days. If your coalition requires access to this tool in the immediate future, please contact your regional HPP Project Officer and we can work with you to initiate your exercise. The exercise toolkit will be evaluated and updated on an annual basis based on HCC feedback. HPP program requirements and additional tools will be considered for future inclusion in the toolkit.

Okay, and next slide for me. Okay, so, our next steps. In the coming weeks, NHPP will take the following actions to provide additional support for those coalition's conducting MRSE: 1) final publication of the official Situation Manual, Evaluation Plan, and Exercise Planning and Evaluation Tool, 2) we will additionally publish a MRSE FAQ document, and finally, we're going to transition our MRSE design team to a MRSE support team, which will be available throughout the year to collect feedback and provide additional technical assistance to every coalition, as they work through this process. The MRSE materials will be located on the link shown on this slide. And next slide please.

Finally, the part we've all been looking forward to: our Q&A session. So at this time we're now going to open up this presentation for general Q&A. In order to submit a written question, feel free to utilize the chat icon below. If you would like to ask a question verbally, as Lauren explained in the beginning of the call, simply raise your hand and we will recognize you, at which time you can then unmute your question - or unmute yourself and ask the question.

In order to address questions that have been asked in the chat throughout the presentation we’re going to start with those written questions first in order to get us moving. I'm going to turn it over to Pete to read through the questions in the chat.

Pete Telaroli: Thank you, Dave. So the first question is from Darren Pruitt out of New York, New York City HCC. And the question is: are the six required objectives at the overall concept level, or are they meant to be at the exercise level? Not the smart objectives. And this is asked at the very beginning.
Dave Csernak: Kevin, would you like to take that question?

Kevin Sheehan: As you mentioned, we have six objectives and four outcomes that we are looking at. We want all coalitions to hopefully include those objectives in the exercise, but if the coalition is interested in modifying or including other objectives we’re completely open to those types of changes to those objectives. Is that helpful? Any other thing to add, Dave or Angela?

Angela Krutsinger: You covered it, Kevin.

Kevin Sheehan: OK.

Pete Telaroli: The next question I have is: when the CST is suspended, will we continue to write the remaining annexes and use the remaining surge test MRSE exercises to base exercises on to test the annexes remaining?

David Csernak: So I can, I can address this question. So the annex requirement is a separate requirement within the FOA for the coalitions. Now the MRSE can be utilized to evaluate scenarios based on each of those annexes moving forward. However, the MRSE does not replace the annex the specialty surge annex requirement and each coalition is still going to be required to complete each of the five annexes and validate each of those five annexes via an exercise that can be a facilitated discussion a tabletop or a functional exercise. So the MRSE can test those scenarios, but it does not replace them. They are separate and will remain in place. Hope that answers the question.

Pete Telaroli: Thank you. Okay, and the next questions are about where we can find some of the tools. So one is: has the Evaluation Plan been added to the CAT? Last I checked, only the SitMan and eval tool were posted.

And Dave, I’m happy to just take that. So in the CAT in the help and guidance section, we have currently the SitMan and the Evaluation Plan posted. We have not yet posted the evaluation tool, because as Dave mentioned it’s going to be undergoing the compliance changes. So I’d be happy to send around post this meeting, the link to the documents in the tab.

David Csernak: Thanks, Pete.
Pete Telaroli: You're welcome.

Another question’s related: where can I find the MRSE Planning and Evaluation Tool and, again, I think that will be posted to PHE.gov once it undergoes its compliance check and it will be posted to the CAT, as well, once that is finalized.

The next question: will we be able to add additional facilities to the PDF, such as long term care facilities?

David Csernak: Angela or Kevin, would you like to take that question?

Angela Krutsinger: Sure.

David Csernak: Go ahead, Angela.

Angela Krutsinger: Sure, yeah. Yes, yes, you will be able to add the additional facilities to the PDF. That’s one of the things that they’re currently working on with the transition from the Excel document, as well. So yes, you will be able to.

Pete Telaroli: OK, the next question that I have: we are planning our annual medical surge exercise on April 2022. The exercise was postponed in April 2020 and October 2021 due to COVID. What happens if we get another surge next year, like the one this summer?

David Csernak: Kevin, would you like to address that one?

Kevin Sheehan: At this time, we are not anticipating waving this requirement in year three. We've waved it the last two years. And we do anticipate that you know, we know there's other risks, other challenges out there. But if we do face something similarly as we faced, we will obviously come back together as a leadership team and as ASPR HPP to discuss this, if need be.

But right now we're not anticipating waving this at all before for the rest of the year. But that's an excellent point of view. We will, we'll address that if that is the case. We will look at what the challenges are and kind of where we're at on the COVID response. Thanks for that question.
Pete Telaroli: Okay. Next question: will we be required to evacuate 20% of staffed beds or licensed beds? As public health and facilities implement the vaccine mandate and terminate staff I foresee our bed capacity decreasing in our region.

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David Csernak: So I can start on this one, and then Kevin or Angela if you have anything to add. So the MRSE no longer requires an exercise or the exercise to be an evacuation-based scenario. The scenario that you will exercise is decided by the coalition based on your HVA. It can be an exercise scenario, or it can be any other incident that generates a medical surge.

Of the 20%, we are basing our numbers and the calculations off of current staffed beds. So, while there is discrepancy sometimes between licensed beds and staffed beds we want it to be clear that we are looking at current staffed bed numbers. And we realize, too, that with the ongoing COVID response, that hospital and health care staffing is in continual flux. And as a result, many facilities are unable to staff every bed that's currently in their facility. So to take that factor into account, while planning and executing this exercise, we decided to focus solely on current staffed bed numbers for conducting and calculating the 20% requirement needed to complete the exercise. Kevin or Angela, did you have anything else you'd like to add?

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Kevin Sheehan: No Dave, I think I’d just make sure that people are aware that as we are asking when we asked you for bed availability, as we did in their coalition surge test, its staffed beds not license beds. We know that there’s a difference there, and so we didn't want that to be confusing to anybody. So the, the documents that you will have will clearly identify staffed beds - not licensed beds.

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Pete Telaroli: Okay, thank you. Next question: our jurisdiction has seven HCCs. Do they need to perform seven different MRSEs or can we combine them into one?

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David Csernak: At this time I’m going to say, the answer to that would most likely be no, that the exercise is going to need to be completed moving forward. We’re not looking to go back into BP2 in order to complete the exercise.

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Pete Telaroli: Okay, thank you. Next question: our jurisdiction has seven HCCs. Do they need to perform seven different MRSEs or can we combine them into one?
**Angela Krutsinger:** So we built this flexibility, so that you know, based on feedback that we’ve received in the past where states have liked to exercise the HCCs together and be able to do that. I believe that you would still need to do the MRSE for each HCC, but you can exercise them together.

Dave, Kevin, did you have anything to add for that?

**Kevin Sheehan:** Yeah, this is Kevin. The performance measures are Health Care Coalition based. So each coalition would have to answer to their own performance measure questions. We’re interested in not, you know, having coalitions stress their health care system. If there’s a way that their coalitions can effectively exercise together at one time and kind of make that happen, we’re not against that. We encourage that, because on game day we do see that there’s a large event that you would be asking your other coalitions adjacent to you and your state partners to help provide resources and to assist you at that time. So it does make sense to do that.

Again, we really would like for you to at least talk through this with your recipients, your state health leads, your FPO, so that everyone’s clear on what the expectation is and how you’re going to report performance measures for that type of event. Thank you.

**Pete Telaroli:** Okay. Next question that I have is: how does the MRSE define ‘incident management team?’ In the Omaha Metro HCC, we don't have a traditional IMT we have what we call the OM HCC Representative Model.

**David Csernak:** So the MRSE tool doesn’t specifically define incident management team internally, but what it does do is it references Health Care Coalition’s preparedness and response plans, as well as their other jurisdictional plans. So when executing the MRSE exercise, we highly encourage you to utilize your current plans. Your coalition’s preparedness plan, your response plans, your current structures, as well as your jurisdictional partners’ plans and their structures, to successfully complete the exercise. So if your structure is unique to your jurisdiction, then that is the structure that you should use to be most successful.

**Pete Telaroli:** Okay. Next question. This is a multi-question. So one: is the MRSE an annual requirement? When will it be due? And is COVID response an alternative to a separate MRSE exercise?

**Angela Krutsinger:** I’ll go ahead and take this one, Dave.

Yes, it is an annual requirement and the first one is due by the 30th of June of 2022, which is the end of the BP3 period. And yes, you may use COVID response as your surge exercise, but you need to have a specific period of time related to that. A good example would be if your HCC saw a tremendous spike in pediatric surge patients in this current week, then you could use this week of the pediatric surge to complete your MRSE.
Dave, Kevin, anything to add?

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Kevin Sheehan: No, Angela, I don’t think so. That that was a good review.

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Pete Telaroli: OK. The next question is: if we are doing an evacuation scenario, in planning anticipated resources, is that for the hospitals evacuating or for those receiving?

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Kevin Sheehan: This is Kevin. I can take this.

For that scenario, it would be for both. It would be not only be for what the hospital would need in terms of how to evacuate resources to evacuate that hospital, but also your EMS resources you would need to transport those patients from one hospital to another. Again, there’s no actual patients being moved and no actual activation of EMS units to that facility, but it's working collectively with your evacuating facilities, your receiving facilities, and your EMS partners to try to identify those staffed beds, where they could be moved to. So resources could be on both evacuating hospital, the receiving hospitals, maybe they need staffing as well, obviously if you’re going to accept new patients there’s going to be staffing challenges, perhaps, and then the EMS as well. Dave, Angela anything in addition to add to that?

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Angela Krutsinger: No, I thought that was comprehensive. Thank you Kevin.

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David Csernak: Thanks, Kevin.

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Pete Telaroli: Next question: previously with the CST, the expectation was to exercise all hospitals within the HCC over the course of five years. Does this requirement restart with the start of the MRSE?

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Kevin Sheehan: Yeah this is Kevin. I'll take that again. No, it does not. There is no requirement for each hospital to evacuate, in fact, new scenarios may not be completely hospital based at all, depending on what that is. So it’s really that we're asking coalitions to have a greater role and responsibility to identify your individual scenarios. Again work with your members, your partners, not just your hospital, your long term care, your, you know, other surgical centers things that they may be interested in exercising. And you have kind of an open slate, you have a, you know, a clear canvas to create the type of exercise you need to get yourself better prepared and to help your members do that. So if you do want to, I know there are some coalitions who said, hey I’ve done a couple of, or a third, or two thirds, of my hospitals have gone through the evacuation process and I’m interested in having the last third go through that it. Is that still something we can do to meet the MRSE requirements? And the answer is absolutely you can do that. You can have a no notice exercise, or you can have a full notice exercise.
Again we encourage you to work with your partners and your members, and you know - what is the best fit for you? 326 coalitions in the country - you all have very, you know, different needs and we’re looking forward as a program, as a national program, to really get some different ideas and innovative ways that you approach different challenges in different situations.

Anything else to add, team members, folks?

Pete Telaroli: Okay. Next question: does the 20% staffed bed requirement include the entire bed count for the HCC as the denominator?

David Csernak: So I’ll start with this one and then Kevin, since you briefed part of this on one of your slides, feel free to chime in as well. So the 20% bed count is specific to the coalition itself. It’s looking at the current staffed beds within the coalition, but it is, however, looking only at specific bed types based on the scenario. There are specific bed types identified that are required for all scenarios. Then there are other bed types that can be added on and selected by the coalition based on the scenario.

By adding those additional bed types, it does change the total number of beds that you might be looking at, but by only requiring certain beds to be included in all exercise, it limits the number of staffed beds that may be utilized by the coalition in the facilities during the exercise based on the scenario. For example, if the scenario is a trauma-based scenario you don’t necessarily need to include labor and delivery type of beds or mental health, inpatient mental health beds, in that 20% calculation. However, if your scenario does potentially include patients that would utilize a specialty type of unit in your facility, then you would include those beds in your calculation.

Kevin did you have anything further to add on this one?

Kevin Sheehan: No, I mean I wanted to reiterate that the five bed types that you have to address in every scenario include your ED, your general medical beds, ICU, any post critical care step down unit beds, and your surgical beds, but if you have a pediatric surge event that you’re interested in exercising as well, in addition to those, those are options for you as well, or burn beds or site beds, or other types of challenges within your coalition. Our tool, and when you get that will help you put in your bed type numbers for your coalition of those bed types, and then you can kind of identify your surge and what that should be.


Pete Telaroli: Okay. Next question: due to limited services in rural portions of various states, often manned by volunteer agencies, will HCC be able to utilize a SIM cells to role play for them based on their capabilities?
Kevin Sheehan: Yeah this is Kevin. Yeah, absolutely. If that’s, if you have that ability to create a SIM cell to do that, by all means. If you only have the ability to have a facilitator walk your coalitions through that that’s great. As, as you know, we have some coalitions with hundreds of members. We have one coalition in region nine out here with 80 different hospitals and we have some coalitions with two hospitals. So there are different levels of, you know, partners and different abilities to staff and exercise them collectively as a coalition. So if you want a SIM cell, you have the ability to do that, by all means... it sounds like a great opportunity.

David Csernak: I would just add to be cautious of overutilization have of a SIM cell during the actual exercise. If members of the coalition are unavailable to participate on the given exercise day, for various reasons, if a facility is currently overwhelmed and unable to participate, then that is something that actually should be taken into account during execution of the exercise. If the facility is stating that they cannot actually accept any patients on a given day, we shouldn't simulate sending them something that they can't actually handle. Additionally, organizations such as EMS - we've definitely increased the role of EMS in both the planning and the execution aspect of this exercise, which many EMS organizations have looked at very positively and are excited to engage at a higher level.

We don’t necessarily need to have every EMS supervisor participate during the actual exercise, but if they engaged during the planning phase on the day the exercise, they can utilize a SIM Cell to relay and communicate real time availability units in service and their capabilities to help support the incident response, rather than trying to communicate real time over to the EMS Dispatch Center. So SIM cells are great but we're still looking for that real time communication and coordination as much as possible.

Pete Telaroli: Thank you Dave. So one thing that there's been a couple of comments on is just related to burden on HCCs with the ongoing pandemic, and so I was wondering if, you know, Dave and Kevin and Angela if there just some thoughts or some items you might want to share related to take HCC burden with everything that's going on these days.

David Csernak: Kevin, would you like to start off on this one, and before you answer I know it is coming up on the top of the hour so we’re going to make this our final question right now of the presentation.

However, we are going to record each of the questions that have been answered into the chat. So, if you have any additional questions you'd like to get in now please do so and we'll make sure we take all those into account and get answers to those questions back when we finalize the FAQ document. So with that said Kevin would you like, to take...

Kevin Sheehan: Yeah, you know due to COVID we've waived the coalition exercise requirement for the last two years, and as I mentioned in my portion of the presentation, that obviously we still have other types of hazards. And as HPP, the only federal source of funding for health care preparedness, not public health preparedness, we still feel that there's a number of - obviously this past year and I mentioned the hurricane and the wildfire evacuations, amongst other types of risks to the health care system - to
continue to be prepared for, not just for COVID, but for all hazards that we anticipate that we have seen over the last couple years and we continue to see moving forward.

The other person asked a question earlier about what if we have another surge, what does that mean, what can we do? Well at this point we're not anticipating lifting this requirement, but if we do have any other type of surge event we'll obviously work with miss Jennifer Hannah and the leadership at ASPR and we'll determine the best course moving forward for everyone who participates in the Hospital Preparedness Program. Thanks, that's all I have.

00:52:32.700 --> 00:52:34.860

David Csernak: Thanks Kevin, Angela did you have anything you wanted to add?

00:52:36.990 --> 00:52:39.540

Angela Krutsinger: No, I think Kevin answered that question for us.

00:52:42.000 --> 00:52:56.280

David Csernak: Excellent. Thank you. Well at this time, this will wrap up our general Q&A session.

Again, thank you all for the questions and we will continue to work to address additional questions that are being entered into the chat. So at this time, I'd like to turn this back over to the presentation coordinators and Jennifer Hannah for final closing thoughts. Thank you.

00:53:05.100 -- 00:53:56.64

Jennifer Hannah: Great. Thanks Dave, Angela, and Kevin, and also thanks to Pete and to Lauren for helping to facilitate this call. And we want to thank all of you that participated on today's call for the for the great questions that you have asked. And if your question was not answered during the call, they will be captured and be included in the in the FAQ document, but keep those questions coming and we'll make sure that we answer them.

But again, thank you to everyone for taking the time to meet with us today. As always, we would love to hear from all of you, and if you would like to share how you are using cooperative agreement funding to make an impact on your community, please fill out our story from the field submission form and send a quick note to your project officer or email the http@hhs.gov mailbox. Please stay in touch with ASPR by visiting our website@www.PHE.gov or by following us on social media at the handles shown on this slide. Thank you again and have a great day.

00:56:44.010 -- 00:56:46.710

Lauren Egbert: Alright, we're just going to take a moment here and we're going to remove folks who are finished with the webinar from this meeting.