Operation Safe Corridor Kickoff

After-Action Report/Improvement Plan

Draft report November 16, 2015

The After-Action Report/Improvement Plan (AAR/IP) aligns exercise objectives with preparedness doctrine to include the National Preparedness Goal and related frameworks and guidance. Exercise information required for preparedness reporting and trend analysis is included; users are encouraged to add additional sections as needed to support their own organizational needs.

EXERCISE OVERVIEW

Exercise Name	Operation Safe Corridor Kickoff
Exercise Dates	November 9-10, 2015
Scope	This exercise is a workshop, planned for two (2) hours at Moore FirstHealth and Duke Regional Hospital. Exercise play is limited to discussion of exercise cycle objectives and core capabilities.
Mission Area(s)	Response
Core Capabilities	Public Health and Mass Care
Objectives	1) Build involvement in the entire process of enhancing surge capacity throughout the region – especially for the Tabletop exercises to be held in January. 2) Gather information from participating organizations on their concerns and capabilities regarding surge. 3) Build relationships among participating agencies.
Threat or Hazard	Patient Surge
Scenario	hurricane-related evacuation of healthcare facilities in eastern North Carolina
Sponsor	Triangle Healthcare Coalition
Participating Organizations	Triangle Healthcare Coalition For a full list of agencies, see Appendix B.
Point of Contact	Rick Christ, MEP, Crisis Prevention & Response, Inc., 540-239-6497, Richard.Christ@YourCrisisTeam.com

ANALYSIS OF CORE CAPABILITIES

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

Table 1. Summary of Core Capability Performance

Objective	Core Capability	Performed without Challenges (P)	Performed with Some Challenges (S)	Performed with Major Challenges (M)	Unable to be Performed (U)
1) Build involvement in the entire process of enhancing surge capacity throughout the region – especially for the Tabletop exercises to be held in January.	A strong regional healthcare coalition	**P**			
2) Gather information from participating organizations on their concerns and capabilities regarding surge.	Understanding the concerns of coalition stakeholders	**P**			
3) Build relationships among participating agencies.	Facilitating Mutual Aid relationships	**P**			

Ratings Definitions:

- Performed without Challenges (P): The targets and critical tasks associated with the core capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws.
- Performed with Some Challenges (S): The targets and critical tasks associated with the core capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws. However, opportunities to enhance effectiveness and/or efficiency were identified.
- Performed with Major Challenges (M): The targets and critical tasks associated with the core capability were completed in a manner that achieved the objective(s), but some or all of the following were observed: demonstrated performance had a negative impact on the performance of other activities; contributed to additional health and/or safety risks for the public or for emergency workers; and/or was not conducted in accordance with applicable plans, policies, procedures, regulations, and laws.
- Unable to be Performed (U): The targets and critical tasks associated with the core capability were not performed in a manner that achieved the objective(s).

The following sections provide an overview of the performance related to each exercise objective and associated core capability, highlighting strengths and areas for improvement.

OBJECTIVE 1: Build involvement in the entire process of enhancing surge capacity throughout the region – especially for the Tabletop exercises to be held in January.

CORE CAPABILITY 1: **A strong regional healthcare coalition**.

STRENGTHS

Strength 1: More than 60 people attended the two events – 33% of those invited – representing over 1200 combined years of experience in preparedness.

Strength 2: Attendees participated vigorously throughout the process.

Strength 3: Attendees volunteered to continue participation in the exercise cycle.

AREAS FOR IMPROVEMENT

Area for Improvement 1: It's important to continue the communication between the coalition and attendees. Bi-weekly communications will help maintain interest and involvement, and will provide opportunities to continue to educate the stakeholders, listen to them, and build preparedness.

Let's send out, this week, a list of participants with contact information, along with the overall summary notes from this AAR (in Objective 2 below), and a feedback form inviting their participation in the exercise process.

Area for Improvement 2: Those who were invited but who did not attend, and those who are stakeholders but who have not yet become known to the Triangle Coalition, must be recruited for participation.

Area for Improvement 3: The Incident Command System must be fully implemented. This will:

- Manage the span of control among participants.
- Support current momentum by allowing more stakeholders to participate in a meaningful way.
- Firmly assign responsibilities for communication among stakeholders (via a Public Information Officer).

Please see our suggested ICS Organization Chart attached.

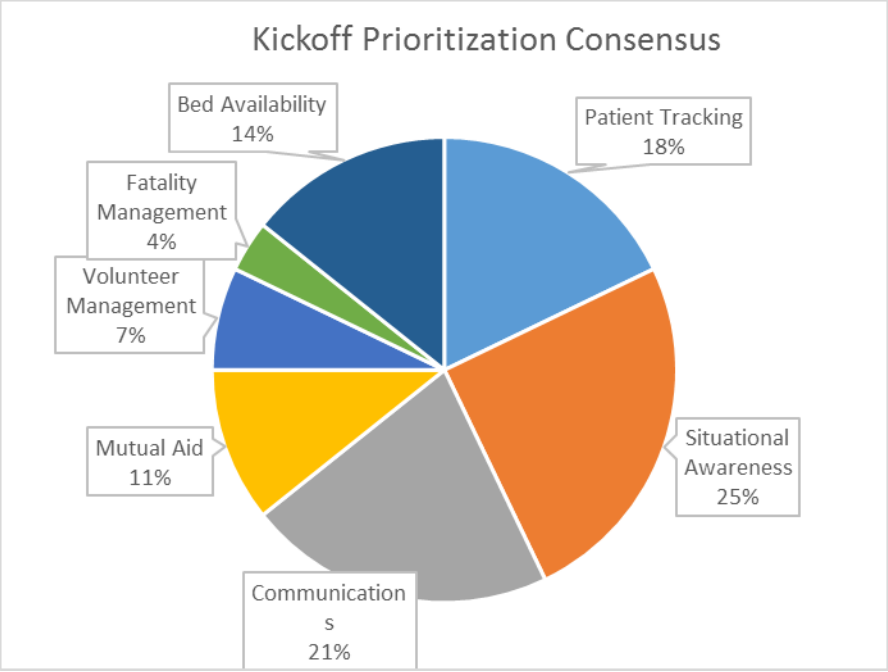
OBJECTIVE 2: **Gather information from participating organizations on their concerns and capabilities regarding surge.**

CORE CAPABILITY 2: **Understanding the concerns of coalition stakeholders**

STRENGTHS

Strength 1: Each attendee had the opportunity to work in small groups to rank the exercise cycle capabilities and offer plans, policies and procedures to meet that capability.

Strength 2: Dozens of comments on the exercise capabilities were recorded, and suggestions for follow-up were made. They follow this page.



Priorities as ranked by participants (based on the numerical ranking of capabilities)

AREAS FOR IMPROVEMENT

Area for Improvement 1: There is great concern among the stakeholders regarding their comfort level with the capabilities called for. They are seeking further training and direction.

Area for Improvement 2: Many of the participants have ideas for processes and contacts with additional information that should be solicited as a part of the exercise cycle.

PARTICIPANT NOTES BY CAPABILITY:

Patient Tracking

- There are dozens of patients that transfer from one hospital to another on a daily basis within North Carolina – what systems are in use now, and how can any of them be scaled to manage a large transfer of patients?
- Must begin at point of origin.
- Must be fast, widely available and easy to use.
- System needs to identify who went where and how. (Consider family notification element – destination information must come back to sending institution)
- Packaging of patient information (medical history, meds, etc.) – how does it "move"?
- In the event of an emergency evacuation, the data will be presented verbally by someone in the patient care of the sending institution, e.g. an RN. In a more planned event, the charts and data can be printed. If there were a common database of patient data, the patient information could be sent electronically with the patient (on a flash drive) or in advance (via Electronic Data Interchange).
- This is really a statewide issue that needs a statewide solution. Ideally, a national standard, because patients may be transferred to Virginia or South Carolina as well as within North Carolina
- Patient tracking must be considered with Bed Availability – Bed availability at the receiving hospital dictates the destination of the patient data.
- Who is responsible for overall tracking of patients?
- There are several entities involved:
    - the sending institution
    - the receiving institution
    - the transportation entity
    - the "space broker" – healthcare coalition or other entity that determines the receiving institution
- What is the "official" tracking system? (does one exist?)
    - How do we use it? (training needed)
    - Who is ultimately making the decision of where patients are going?
- National Disaster Medical System (NDMS) has a patient tracking system (JPATS) (In the event of an NDMS incident, pt. evacuation would be coordinated at federal level, as a result of a request at the state level. IRCT [Incident

Response Coordination Team].) Hospital creates paper chart → chart w/ pt.) This was considered, but is not an option for our use.

Situational Awareness

- What to use during the first 12 hrs. (real time) – most people indicated they contact other resources using cell phones or radio, and don't update WebEOC until many hours into an incident.
- Fusion issue between EM & Hospital WebEOC (access issues) – there are two WebEOC systems in use in NC that do not talk to each other. Who has access to WebEOC? (Example: VA hospitals in NC do not have access to WebEOC. Multiple versions: state, local, healthcare, etc.)
- Need WebEOC education.
- What is your local Emergency Op Plan?
- Procedures to open hospital EOC (Who has the key? Isn't there a binder for that?)
- Policies/Plans related to Situational Awareness
- Need for NIMS training
- Situational Awareness must be considered with communications
- There are a lot of tools to gather the data, but there is no mechanism for gathering the data and sharing it.
- Bridge the information / translation gap. (Each organization has "their" way of gathering data. Identify unified/standardized process.
- How do we communicate with our volunteers? (and other agencies)
- What other resources are available to participate.
- Who ultimately manages the incident? What command role does the healthcare coalition play in managing an incident, or is it merely an information resource to some other incident command system?

Redundant Communications Processes

- Need for Contact lists
- What are the procedures for communicating with other agencies?
- Development of how information is shared – verbally, via email, etc.
- Situational Awareness must be considered with communications
- Integration of information.
- Multi-agency access to a unified data collection point.
    - Training needed – WebEOC, SMARTT

Mutual Aid Agreements/Requests

- Standardization / Typing – there are few if any standards for hospital bed typing
- What are needs? Who meets what needs?
- Who do you call when you are overwhelmed?
- What agreements are ALREADY in place?
    - Updating agreements
    - Establish new agreements
- What bridges need to be built?
- Who has what “toys” – equipment and systems?
- Assessing (realistic) availability of beds
- Who is responsible for updating the “Status Board”
- What is the real-time method for gathering this intel? (phone, digital, etc.?)

Volunteer Management/Safety

- Who will be responsible for overall volunteer management?
- What system will be used for tracking/vetting?
- What are educational needs for such a system?

Bed Availability Coordination

- Who has what (numbers and typing)? (see situational awareness)
- Standardized “typing” of beds (i.e.: vents, “big boy beds”, etc.)
- SMARTT is a work in progress.
- Unified system (hospital, EMS, etc.)
- Updating – real time? Currently data is updated daily
- Patient tracking must be considered with Bed Availability

PARTICIPANT NOTES BY DISCIPLINE

Public Health

- 1st Communication
    - Alternate Communications for locals
    - VIPER training
    - Continue to foster EOC presence/relationship
    - Emily Earnest (Orange County PH & MRC coordinator) mentioned a system called Patagonia. She says it and email are primary methods of communication with volunteers.

- 2nd Situational Awareness
    - (State PH has view only WebEOC access --> taps local resources for intel.)
    - WebEOC is a tool that Public Health people need more access to, and training on.
    - Local tracks broad SA (shelters, fatality mgmt.)
    - Fatality Mgmt. falls squarely on Local PH shoulders (top 3)
    - Frequently exercises Points of Distribution
    - Some localities may need to EMAC for volunteer mgmt. (VOAD? MRC?)
    - Rachel Arthur (CPR) said the state EM has a contract with Salamander, a software package that can produce scan-able ID tags quickly and track the human or physical assets associated with each ID tag.
- 3rd Mutual Aid

EMS

- 1st Situational Awareness & Communications go hand-in-hand
- 2nd Mutual Aid
- 3rd Patient Tracking (Who can absorb pts? Where are we going?)

Emergency Management

Situational Awareness

- This Event
- The Planning Process (include your neighbors – your neighbor may already be trying to solve the same problem).

Community Health

1st Patient Tracking

- Concerns about bed typing / availability

2nd Situational Awareness

- Who does what?
- Learning about local emergency plans
- Who do we contact locally – for what?
- VIPER training needed.
- Primary communications are by phone.

American Red Cross

- Contributing sheltering, feeding, health services volunteers.
- Activated by county EM
- Depending on the county may/may not have access to WebEOC.

Long Term Care

1st Situational Awareness

- In times of crisis → reaches out to other LTCs, especially within the same corporation

2nd Patient Tracking

National Guard

- Resources:
  - Trained personnel
  - "Lots of stuff" (challenge is matching up availability of personnel & need.)
- Process: Request from county → state to mobilizes based on location & resource availability.
- National Guard & Title X provides ability to use DOD military assets for transportation and other needs.

OBJECTIVE 3: **Build relationships among participating agencies.**

CORE CAPABILITY 3: **Facilitating Mutual Aid relationships**.

STRENGTHS

Strength 1: There were many one-on-one and small group discussions wherein participants exchanged contact information and ideas, and plan to continue direct discussion of preparedness activities.

Strength 2: Attendees understood that there were people in their locality who had shared vision. They plan to reach out and form or strengthen relationships.

AREAS FOR IMPROVEMENT

Area for Improvement 1: The Triangle Coalition is in the unique position of bringing together local, state and federal stakeholders to increase healthcare preparedness in the region. Building and publishing lists, and facilitating additional meetings and trainings, will build a stronger coalition, and will build stronger individual relationships within the region.

APPENDIX A: IMPROVEMENT PLAN

Core Capability	Issue/Area for Improvement	Corrective Action	Primary Responsible Organization	Point of Contact	Start Date	End Date
Core Capability 1: A strong regional healthcare coalition	Continue communication	Develop bi-weekly communications schedule	Triangle Healthcare Coalition (THC)	PIO	11/16/15	12/1/15
		Implement bi-weekly communications	THC	PIO (with CPR)	12/1/15	ongoing
	Continue outreach and recruitment	Actively identify & recruit LTC, Comm. Health, and other stakeholders not on current list	THC	PIO	12/1/15	12/31/16
	Manage span of control	Fully implement exercise planning ICS	THC	Pokey Harris	11/16/15	11/31/15
Core Capability 2: Understanding the concerns of coalition stakeholders	Training needs	Develop NIMS training schedule	THC	Pokey Harris	12/1/15	6/30/16
	Process concerns	Develop/refine processes for each capability	THC	Pokey Harris	11/16/15	1/31/16
Core Capability 3: Facilitating Mutual Aid relationships	Build and publish lists of mutual aid participants	Identify all key players	THC	Pokey Harris	12/1/15	6/30/16
		Publish lists	THC	Pokey Harris	12/1/15	6/30/16
		Develop/Maintain process to update data.	THC	Pokey Harris	12/1/15	6/30/16

APPENDIX B: EXERCISE PARTICIPANTS

Participating Organizations
Federal
US Dept. of Veterans Affairs
American Red Cross
State
NC Community Health Center Assoc.
NC Department of Agriculture & Consumer Services
NC PHP&R
North Carolina National Guard
Virginia Department of Health
Regional/Local
Alamance County EMS
CAP-RAC - WakeMed Health & Hospitals
Chatham County Public Health Department
Cone Health
Cumberland County Department of Public Health
Duke Hospital
Duke Medicine
Duke Raleigh Hospital
Durham Co EM
Durham County EMS
Durham Regional Hospital
FirstHealth Moore Regional Hospital
FirstHealth of the Carolinas, Richmond
Harnett County Emergency Management
Harnett County EMS
Johnston County Emergency Services
Johnston County Public Health
Maria Parham Medical Center
Mid Carolina Regional Operations (RAC)
North Carolina Specialty Hospital
Orange County Health Department
Peak Resources Treyburn

Person County EMS
Rex Healthcare
Richmond County Emergency Services
Robeson County Health Department
SERAC
Stedman-Wade Health Services, Inc.
UNC Healthcare
Wake Medical Cary Hospital
Warren County EMS