



Acute Care Hospital Evacuation & Patient Surge Tabletop Exercise

Situation Manual
November 2, 2017

PREFACE

The Eastern Virginia Healthcare Coalition Acute Care Hospital Evacuation & Surge Tabletop Exercise (TTX) is sponsored by the Eastern Virginia Healthcare Coalition (EVHC). This Situation Manual (SITMAN) was produced with input, advice, and assistance from the EVHC staff and, which followed guidance set forth by the U.S. Department of Homeland Security (DHS) Homeland Security Exercise and Evaluation Program (HSEEP).

The EVHC Acute Care Hospital Evacuation & Surge Tabletop Exercise TTX SITMAN provides exercise participants with the information needed to engage in the exercise.

The EVHC Acute Care Hospitals Evacuation & Surge TTX is an unclassified exercise. Control of exercise information is based on public sensitivity regarding the nature of the exercise rather than actual exercise content. 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 this SITMAN.

All exercise participants should use appropriate guidelines to ensure proper control of information within their areas of expertise and protect this material in accordance with current directives. Public release of exercise materials to third parties is at the discretion of the EVHC.

HANDLING INSTRUCTIONS

1. The title of this document is the *EVHC Acute Care Hospitals Evacuation & Surge Situation Manual (SITMAN)*.
2. Information gathered in this SITMAN is designated as For Official Use Only (FOUO) and should be handled as sensitive information that is not to be disclosed. This document should be safeguarded, handled, transmitted, and stored in accordance with appropriate security directives.
3. At a minimum, the attached materials will be disseminated strictly on a need-to-know basis and, when unattended, will be stored in a locked container or area that offers sufficient protection against theft, compromise, inadvertent access, and unauthorized disclosure.
4. For more information about the exercise, please consult the following points of contact:

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EXERCISE OVERVIEW

Exercise Name	Acute Care Hospital Evacuation & Patient Surge TTX
Exercise Dates	November 2, 2017 from 9:30 am to 12:30 pm
Scope	This exercise is a table top exercise planned for three hours at the Tidewater EMS Council Office in Chesapeake.
Core Capabilities Tested	Healthcare and Medical Response Coordination Continuity of Healthcare Service Delivery Medical Surge
Objectives	<ol style="list-style-type: none">1. Implement HICS2. Demonstrate patient destination planning3. Patient tracking4. Patient movement5. Resource management6. Communications7. Medical Surge
Threat or Hazard	Event: Gas pipeline explosion causing loss of vital utilities for 2-4 weeks.
Scenario	A 30” main natural gas pipeline has exploded cutting off potable water, electric power and sewer service to the hospital for a minimum of two weeks.
Sponsor	Eastern Virginia Healthcare Coalition (EVHC)
Participating Organizations	A list of participating organizations can be found in Annex A of this document.
Point of Contact	Mr. Glenn McBride, Regional Healthcare Coordinator, Eastern Virginia Healthcare Coalition, mcbride@vaems.org , (757) 963-0632

INTRODUCTION

Background

Hospitals and other healthcare facilities and organizations are dependent upon public utilities such as electric power, potable water and sewer services to provide healthcare services to their patient populations. Without these utilities patient care is compromised. The San Bruno pipeline explosion of September 9, 2010 demonstrated just how much havoc and damage can be caused by a pipeline explosion.

If critical utilities are lost from a pipeline explosion or other disaster such that patient care is jeopardized for an extended period, plans must be in place to support a partial or total evacuation of the facility.

Purpose

The purpose of this exercise is to provide participants with an opportunity to evaluate current response concepts, plans, and capabilities for a response to a disaster or other event that would require a partial or full evacuation of the facility, early discharge and/or the transfer of patients to another appropriate facility. The exercise will evaluate the response by acute care hospitals using their current policies, plans and procedures to manage the incident. Patient tracking, patient transportation, the overall patient movement (internal and externally to receiving facilities); staff and family notifications and regional communications will also be evaluated.

Scope

This exercise emphasizes the ability of participating acute care hospitals in southeastern Virginia to effectively evacuate or receive patients from an evacuating facility.

Health Care Preparedness and Response Capabilities

The *2017-2022 Health Care Preparedness and Response Capabilities* document outlines the high-level objectives that the nation's health care delivery system, including health care coalitions (HCCs) and individual health care organizations, should undertake to prepare for, respond to, and recover from emergencies. These capabilities illustrate the range of preparedness and response activities that, if conducted, represent the ideal state of readiness in the United States. The Assistant Secretary for Preparedness and Response recognizes that many public and private entities must come together to ensure community preparedness. There is a shared authority and accountability for the health care delivery system's readiness that rests with private organizations, government agencies and Emergency Support Function-8 (EFS-8, Public Health and Medical Services) lead agencies. To that end the Eastern Virginia Healthcare Coalition serves an important communication and coordination role in the region.

These health care preparedness and response capabilities provide the foundation for development of the exercise design objectives and scenario. The purpose of this exercise is to measure and validate performance of these capabilities and their associated critical tasks.

The following core capabilities will be evaluated by this exercise as specified in the exercise objectives. The selected core capabilities are:

- Health Care and Medical Readiness Coordination
- Continuity of Health Care Service Delivery
- Medical Surge

Exercise Objectives

The following exercise objectives describe the expected outcomes for the exercise. The objectives are linked to core capabilities, which are distinct critical elements necessary to achieve the specific mission area(s). Exercise design objectives focus on improving understanding of a response concept, identifying opportunities or problems, and achieving a change in attitude. This exercise will focus on the following design objectives:

- **Objective #1 Incident Command:** Demonstrate the ability to implement the Healthcare Incident Command System (HICS) to effectively respond to evacuation and medical surge event.
- **Objective #2 Patient Destination Planning:** Demonstrate the ability to utilize hospital plans and resources to efficiently locate receiving facilities appropriate for each patient's level of acuity.
- **Objective #3 Patient Tracking:** Demonstrate the ability to utilize the hospital's plan to track patients from current area of care to the receiving facility using the Virginia Healthcare Alerting and Status System (VHASS) and other communication tools.
- **Objective #4 Patient Movement:** Demonstrate the ability to utilize hospital plans to identify and obtain sufficient patient transportation resources to efficiently relocate evacuating patients to receiving facilities appropriate for each patient's level of acuity.
- **Objective #5 Resource Management:** Demonstrate the ability to recognize current and future resources needs and request, mobilize, and manage assets and resources.
- **Objective #6 Communications:** Demonstrate the ability to notify and communicate with the appropriate agencies, organizations and personnel to effectively respond to and manage the incident.
- **Objective #7 Medical Surge:** Demonstrate the ability manage an influx of patients in response to an evacuation of another acute care hospital.

Exercise Structure

This tabletop exercise (TTX) will be a facilitated exercise. Players will participate in the following two modules:

- Module 1: Incident Response & Evacuation Planning
- Module 2: Evacuation & Patient Surge Operations

Each module begins with an update that summarizes key events occurring within the specified time frame. After the updates, participants review the situation, engage in discussion and respond to the questions provided.

Exercise Guidelines

- This TTX will be held in an open, low-stress, no-fault environment. Varying viewpoints, even disagreements, are expected.
- Respond on the basis of 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 organization's final position on a given issue. This exercise is an opportunity to discuss and present multiple options and possible solutions.
- Issue identification is not as valuable as suggestions and recommended actions that could improve response and preparedness efforts. Problem-solving efforts should be the focus.

Assumptions and Artificialities

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

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

During this exercise, the following apply:

- The scenario is plausible, and events occur as they are presented.
- There is no hidden agenda, and there are no trick questions.
- All players receive information at the same time.

Module Discussions

Based on the information provided, participate in the discussion concerning the issues raised in each module. Identify any additional requirements, critical issues, decisions, or questions that should be addressed during each module discussion.

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

POST-EXERCISE AND EVALUATION ACTIVITIES

Debriefings

Post-exercise debriefings aim to collect sufficient relevant data to support effective evaluation and improvement planning.

Hot Wash

At the conclusion of exercise play, a facilitated Hot Wash will allow players to discuss strengths and areas for improvement, and for facilitators to seek clarification regarding player actions and decision-making processes. All participants should attend.

Evaluation

Participant Feedback Forms

Participant Feedback Forms provide players with the opportunity to comment candidly on exercise activities and exercise design. Participant Feedback Forms will be collected at the conclusion of the Hot Wash.

Facilitator Notes

Facilitators are asked to take notes on the module discussions and table report-outs. Facilitators will submit their notes electronically via e-mail to the Exercise Director no later than Wednesday, November 8, 2017. These notes, coupled with Participant Feedback Forms and Hot Wash notes, are used to evaluate the exercise and compile the After-Action Report (AAR).

After-Action Report

The AAR summarizes key information related to evaluation. The AAR primarily focuses on the analysis of core capabilities, including capability performance, strengths, and areas for improvement. AARs also include basic exercise information, including the exercise name, type of exercise, dates, location, participating organizations, mission area(s), specific threat or hazard, a brief scenario description, and the name of the exercise sponsor and POC.

Improvement Planning

Improvement planning is the process by which the observations recorded in the AAR are resolved through development of concrete corrective actions, which are prioritized and tracked as a part of a continuous corrective action program.

After-Action Meeting

The After-Action Meeting (AAM) is a meeting held among decision- and policy-makers from the exercising organizations, as well as the Lead Evaluator and members of the Exercise Planning Team, to debrief the exercise and to review and refine the draft AAR and Improvement Plan (IP). The AAM should be an interactive session, providing attendees the opportunity to discuss and validate the observations and corrective actions in the draft AAR/IP.

Improvement Plan

The IP identifies specific corrective actions, assigns them to responsible parties, and establishes target dates for their completion. It is created by elected and appointed officials from the organizations participating in the exercise, and discussed and validated during the AAM

PARTICIPANT INFORMATION AND GUIDANCE

Exercise Rules

The following general rules govern exercise play:

- Real-world emergency actions take priority over exercise actions.
- Exercise players will comply with real-world emergency procedures, unless otherwise directed by the control staff.
- All communications with persons outside this room, including written, radio, telephone, and e-mail, during the exercise will begin and end with the statement **“This is an exercise.”**

Players Instructions

Players should follow certain guidelines before, during, and after the exercise to ensure a safe and effective exercise.

Before the Exercise

- Review appropriate organizational plans, procedures, and exercise support documents.

During the Exercise

- Respond to exercise events and information as if the emergency were real, unless otherwise directed by an exercise controller.
- Do not engage in personal conversations with controllers, evaluators, observers, or media personnel. If you are asked an exercise-related question, give a short, concise answer. If you are busy and cannot immediately respond, indicate that, but report back with an answer as soon as possible.
- Parts of the scenario may seem implausible. Recognize that the exercise has objectives to satisfy and may require incorporation of unrealistic aspects. Every effort has been made by the exercise’s trusted agents to balance realism with safety and to create an effective learning and evaluation environment.

After the Exercise

- Participate in the Hot Wash with your controllers and evaluators at the designated location.
- Complete the Participant Feedback Form. This form allows you to comment candidly on emergency response activities and exercise effectiveness. Provide the completed form to a controller or evaluator.
- Provide any notes or materials generated from the exercise to your controller or evaluator for review and inclusion in the AAR.

EXERCISE SCHEDULE

Time	Activity
0930	Welcome and Exercise Briefing
0945 – 1030	Module 1 Discussion
1030 – 1100	Table Report-outs
1100 – 1145	Module 2 Discussion
1145 – 1215	Table Report-outs
1215 – 1230	Debrief and Hot-wash
1230	Exercise complete

MODULE 1: INCIDENT RESPONSE & EVACUATION PLANNING

November 2, 2017: 1630 Hours

A 30-inch (76 cm) diameter steel natural gas pipeline exploded into flames in the Stockley Gardens residential neighborhood, approximately 1855 ft (565 m) northeast of the Children's Hospital of the King's Daughters (CHKD). The loud roar and shaking led some hospital staff, patients and residents of the area, first responders, and news media to initially believe that it was an earthquake or that a large jetliner had crashed. The shaking was felt in the hospital and numerous windows on the northeast side of several Eastern Virginia Medical Center buildings were blown out by the blast wave. The United States Geological Survey registered the explosion and resulting shock wave as a magnitude 1.0 earthquake. Eyewitnesses reported seeing "a ball of fire more than 1,000 feet high".

November 2, 2017: 1635 Hours

The blast instantly knocked out the electrical power and blew out windows on the upper floors of the northeast side of CHKD buildings. The hospital is now running on generator power. Numerous cars in the parking lot have blown out windows. Car alarms are blaring on many of the cars parked on the street and in the hospital parking garage. Fortunately NO major injuries to patients, visitors or staff have been reported. People in the hospital can see many homes and buildings on fire. Numerous sirens can be heard as first responders are in route to the scene.

November 2, 2017: 1637 Hours

Additional damage reports are coming in from various locations in the hospital. Several calls have been received reporting there is no water coming out of the faucets. The cafeteria kitchen reports that there is no water coming from the faucets. The decision is made to stand up the Hospital Command Center.

November 2, 2017: 1718 Hours

Facilities staff have completed a structural damage assessment of the hospital. Much of the glass on the northeast side of the building, mostly patient rooms and administrative offices have been blown out or are cracked. Reports are being received in the Hospital Command Center that sewage is backing up into the toilets in multiple bathrooms and sinks on the first floor. Facilities is currently conducting a damage assessment of the medical gases system.

The phone is ringing off the hook as patient family members, off-duty staff and the media want information about the situation.

November 2, 2017: 1723 Hours

The Hospital Command Center receives a call from the Mr. Jim Redick, the City of Norfolk's Emergency Manager. The emergency manager states that the cause of this incident appears to be a gas main explosion. He reports that the explosion and subsequent fires have caused severe and extensive damage to critical infrastructure in the area. The explosion has damaged the water main, the main sewer line, electrical transformers and service lines that service the hospital. Only CHKD is affected as there lines feed the hospital from the main distribution lines located at the incident scene. It will be hours before the gas line can be secured and all of the fires extinguished. Initial damage assessments conducted by the city reveal that the hospital will be without power, potable water and sewer for at least two weeks.

The cafeteria kitchen reports that the floor drains in the kitchen are backing up into the food preparation area.

Access to the hospital via Colley Avenue is closed as Colley Avenue between Brambleton Avenue and Baldwin Avenue is closed due to the incident. The Eastern Virginia Medical Center Campus can only be accessed via the entrances on Brambleton Avenue and Gresham Drive, or via Hampton Boulevard and Raleigh Avenue. An emergency shelter has been opened to house the residents of Stockley Gardens until the incident scene is secured.

Key Issues

- The hospital is now on emergency power.
- There are reports from multiple locations throughout the hospital that no water is coming out of the faucets.
- There are several reports of sewage and floor drains backing-up into first floor bathrooms. Floor drains are backing up in the kitchen.
- A preliminary structural damage assessment shows 22% of patient rooms, administrative and clinic areas are the northeast side of the buildings uninhabitable due to window damage.
- Local emergency management officials have notified the hospital that both the hospital and surrounding neighborhood will be without potable water, electric and sewer for a minimum of two weeks while extensive repairs are made.
- Road access to the hospital is limited.
- Patient family members and media are calling the hospital for information.

CHKD Initial Incident Response Questions

1. Who decides if your Hospital Incident Command System is activated? Who decides if the Hospital Command Center is opened? What is the activation process? How quickly can it be activated? Which positions would be staffed?
2. Would the hospital consider evacuation at this point? Who would make this decision? What are the critical factors used in making this decision?
3. What hospital plans, if any, would be activated?
4. Would your hospital close to new patients at this point?
5. How will you keep yourselves current regarding the event?
6. What notifications, if any, would you make and to whom?
7. Who would manage an influx of telephone calls from patient family members, staff and the media asking about the hospital? Who will monitor and responds to social media inquiries?

CHKD Evacuation Planning Questions

1. What is your current inpatient and TCI census by bed type?
2. How many of those patients, by bed type, can be discharged to home?
3. How many patients, by bed type, will require care at another pediatric specialty hospital?
4. How many patients, by bed type, can be transferred to an acute care hospital?
5. Who determines which patients are assigned/transferred to specific hospitals?
6. Who determines what type of transportation resource needed for each patient? (ALS, BLS or neonatal/pediatric ambulance, etc.)
7. Using the CHKD Neonatal/Pediatric Ambulances and other CHKD transportation contracts how many of your patients can you transport WITHOUT the use of 911 Emergency Medical Services ambulances or other commercial ambulance or transportation services?
8. How long do you estimate it would take to discharge or evacuate all of your patients?
9. What other actions would you take at this point?
10. In real life, would you evacuate and close your facility if you were without potable water, sewer service for at least two weeks?

Questions – All Other Acute Care Hospitals

1. How would you be notified that this incident has occurred?
2. How would you be notified that CHKD was going to evacuate?
3. What notifications, if any, would you make and to whom?
4. Who determines if your hospital will accept pediatric patients from CHKD and into what hospital service (i.e. orthopedics, etc.)
5. What is your current patient census by bed type?
6. Can your hospital accept pediatric patients? Do you have any limitation on your pediatric services such as neonatal ICU?
7. What hospital plans, if any, would be activated if your facility agreed to accept an influx of patients from CHKD?
8. Does your hospital Emergency Operations Plan include the facility's response to a medical surge?
9. Would your Hospital Command Center be opened? If yes, then what is the activation process? How quickly can it be activated? Which positions would be staffed?
10. Would you need additional staff or other resources to support the arrival, assessment and placement of these patients? If so, what do you need and from whom?
11. Would you require any pediatric specialty patient care equipment or pharmaceuticals to treat these patients? Are these resources immediately available?
12. How will you keep yourselves current regarding the event?
13. How will you handle any telephone inquiries, media requests
14. What other actions would you take at this point?

MODULE 2: EVACUATION AND MEDICAL SURGE OPERATIONS

November 2, 2017: 1835 Hours

Colley Avenue between Brambleton Avenue and Baldwin Avenue remains closed as firefighters are actively fighting many residential structure fires caused by the explosion. The gas leak is still on fire and has not yet been secured by the gas company due to the serious damage to the pipeline in the area.

Vehicle access to the area is limited and roads are congested with re-routed traffic. The Eastern Virginia Medical Center Campus can only be accessed via the entrances on Brambleton Avenue and Gresham Drive, or via Hampton Boulevard and Raleigh Avenue. Hospital staff, ambulances, patients and visitors are having difficulty getting on and off of the Eastern Virginia Medical Center campus.

Additional conversations with local Emergency Management officials reveal that infrastructure damage is worse than expected. Repairs to all vital utilities take at least two – three weeks, probably more. The Emergency Manager also informs the hospital that all of Norfolk Fire-Rescue's ambulances are currently engaged in the response to the incident or are answering other 911 calls.

November 2, 2017: 1839 Hours

The CHKD Hospital Incident Commander (IC) has decided to evacuate all of their patients citing the lack of food preparation, potable water and sewer services. Other area hospitals are seeing reports of the incident and possible CHKD evacuation on the television news and from EMS personnel bringing patients to the various hospitals. CHKD contact Norfolk Emergency Management officials to tell them of their decisions to evacuate and request whatever assistance that they can provide.

November 2, 2017: 1845 Hours

The CHKD Liaison Officer is contacted by a Norfolk Emergency Management official. They inform CHKD that Norfolk Fire-Rescue will send one Fire-Medic to assist with coordinating the hospital's evacuation and serve as the Transportation Officer at the hospital. Norfolk Fire-Rescue needs to know where, and to whom, the assigned Fire-Medic should report to. Norfolk Fire-Rescue has cleared one ALS ambulance and has staffed the Mass Casualty Evacuation and Transportation Unit (MCETU) to assist with the evacuation if needed. The city has also two Hampton Roads Transit busses on call to assist with the evacuation if need.

Key Issues

- The hospital has decided to evacuate all inpatients that cannot be discharged to home.
- Bed status availability for other acute care hospital is needed to arrange for the transfer of CHKD patients.
- Transportation contracts must be activated to transfer patients to their receiving facilities using appropriate means of transportation. Emergency management has contacted you with evacuation support services. Your evacuation can now begin.
- One ALS ambulance, one MCETU and two Hampton Roads Transit busses are available to assist you.
- You have one additional shift of personnel as many of your staff remained at the hospital when they heard the explosion and many other staff personnel self-reported to the hospital when they heard of the explosion.

CHKD Evacuation Questions

1. Now that the evacuation can proceed, what notifications will you make? How will these notifications be made?
2. How will you find destinations for your evacuating patients?
3. How will you obtain bed status availability at other hospitals?
4. Would any additional positions need to be filled in the Hospital Command Center to carry out the evacuation?
5. Who is responsible to prepare your patients and their families for the evacuation?
6. Where on campus will you stage ambulances and other vehicles waiting to pick up patients?
7. Where is the designated CHKD pick-up location for ambulances and other vehicles?
8. How will you track patients as they move from CHKD to each receiving destination, and confirm that they have arrived safely?
9. How will you notify patient family members about the evacuation? Does anyone else need to be notified?
10. How will you transfer medical information regarding the patient to the receiving facility? Will any pharmaceuticals need to be sent with any of the patients? Will any durable medical equipment be sent with any of the patients?

Questions – All Receiving Acute Care Hospitals

1. How would you receive notice of the CHKD closure and evacuation preparations?
2. Who would receive that notice?
3. Does your Emergency Operations Plan (EOP) outlining how to manage a patient surge from other inpatient facilities?
4. Is a receiving physician required to accept patients transferred from another hospital during an emergency or disaster?
5. Who would meet and receive all patients being transferred into your hospital? What staff members are needed to receive these patients?
6. Where would you want EMS agencies and other transportation services to deliver these patients? Would they be brought to the Emergency Department?
7. What medical information do you need on each of the incoming patients to provide for continuity of care?
8. What information do you need for billing and payment purposes?
9. Would you stand up your Hospital Command Center to manage the surge of patients? Who makes that decision during normal working hours? Who make the decision after normal working hours, on weekends and holidays?
10. How will you track arriving patients?
11. What documentation will the families or guardians of the arriving patients need to complete?
12. Would you call in any additional staff at this point? If yes, who would be called in?

Appendix A: Exercise Participants

Participating Organizations
Regional
Eastern Virginia Healthcare Coalition (EVHC)
Hampton Roads Metropolitan Medical Response System (HRMMRS)
Peninsulas Emergency Medical Services Council (PEMS)
Regional Healthcare Coordinating Center – Southside (RHCC)
Tidewater Emergency Medical Services Council, Inc. (TEMS)
Virginia Department of Health
Norfolk Health Department
Virginia Department of Health – Eastern Region
Western Tidewater Health District
Acute Care Hospitals
Chesapeake Regional Healthcare
Children’s Hospital of the King’s Daughters
Naval Medical Center Portsmouth
Riverside Health System
Sentara Health System
Sentara Norfolk General Hospital
Long Term Care Facilities
Atlantic Shores
Concordia Transitional Care and Rehabilitation Nansemond Pointe
Princes Anne Health & Rehabilitation Center
Other Organizations
Fusion Ex
Hampton Roads Planning District Commission

Appendix B: Acronyms

Acronym	Term
AAM	After Action Meeting
AAR	After Action Report
ALS	Advanced Life Support
BLS	Basic Life Support
CHKD	Children’s Hospital of the King’s Daughters
DHS	U.S. Department of Homeland Security
EMS	Emergency Medical Services
ESF	Emergency Support Function
EVHC	Eastern Virginia Healthcare Coalition
FOUO	For Official Use Only
HCC	Health Care Coalition
HICS	Healthcare Incident Command System
HSEEP	Homeland Security Exercise and Evaluation Program
IC	Incident Commander
ICU	Intensive Care Unit
IP	Improvement Plan
MCETU	Mass Casualty Transportation and Evacuation Unit
POC	Point-of-Contact
VDH	Virginia Department of Health
VHASS	Virginia Healthcare Alerting and Status System
SITMAN	Situation Manual
TCU	Transitional Care Unit
TTX	Tabletop Exercise