Situation Manual
(SitMan)

Shelter-In-Place/ Evacuation Tabletop Exercise

Long Term Care Facility

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Preface

The District One Regional Medical Response Coalition (D1RMRC) sponsors the Long Term Care Facility (LTC) Shelter-In-Place/Evacuation Tabletop Exercise. This Situation Manual (SITMAN) was produced with input, advice, and assistance from the LTC Shelter-In-Place/Evacuation exercise planning team.

The LTC Shelter-In-Place/Evacuation Tabletop Exercise (TTX) Situation Manual (SITMAN) provides exercise participants with all the necessary tools for their roles in the exercise. It is tangible evidence District Long Term Care Facilities commitment to ensure patient and employee safety through collaborative partnerships that will prepare organizations to respond to any emergency.

The LTC Shelter-In-Place/Evacuation TTX is an unclassified exercise. The control of information is based more on public sensitivity regarding the nature of the exercise than on the actual exercise content. Some exercise material is intended for the exclusive use of exercise planners, Facilitators, and Evaluators, but Players may view other materials deemed necessary to their performance. All exercise participants may view the SITMAN.

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

Handling Instructions

1. The title of this document is *LTC Shelter-In-Place/Evacuation Tabletop Exercise (TTX) Situation Manual (SITMAN).*

2. The information gathered in this SITMAN is *For Official Use Only (FOUO)* and should be handled as sensitive information not to be disclosed. This document should be safeguarded, handled, transmitted, and stored in accordance with appropriate security directives. Reproduction of this document, in whole or in part, without prior approval from the Long Term Care Facility is prohibited.

3. At a minimum, the attached materials will be disseminated only on a need-to-know basis and when unattended, will be stored in a locked container or area offering sufficient protection against theft, compromise, inadvertent access, and unauthorized disclosure.

4. For more information, please consult the following point of contact (POC):

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Introduction

A. Background

The current OASPR Hospital Preparedness Program grant cycle requires regions to conduct exercises that involve, among other priorities, shelter-in-place and evacuation components. District 1 organizations recognize the need to understand the issues associated with an incident that creates the need for a LTC to shelter in place or evacuate (partially or fully). Regional entities also recognize the need to understand expectations, roles, and responsibilities of response agencies during an incident involving LTC sheltering in place or evacuation.

Of the many potential disasters faced today, natural disasters are still among the highest risks for Michigan. In particular, those disasters that impact the hospital infrastructure, directly or indirectly, have the potential to create a need for LTC(s) to make a decision to implement shelter-in-place and/or evacuation plans.

B. Purpose

The purpose of the tabletop exercise is to provide a forum for LTC(s) and Region 1 organizations to participate in a facilitated discussion of their roles, responsibilities, and anticipated activities in response to scenario events. During the tabletop exercise, Players will discuss shelter-in-place and evacuation plans, community response agencies roles and responsibilities, and coordination and control activities.

The purpose of this exercise furthermore is to provide participants an opportunity to evaluate current response concepts, plans, and capabilities for an incident involving a hospital's sheltering in place and evacuation. Through the exercise process, the Exercise Planning Team also seeks to identify areas that require additional planning, training, and/or exercising to improve organizational and community readiness and resiliency.

C. Scope

The scope of play for the LTC Shelter-In-Place/Evacuation Tabletop Exercise involves a discussion-based activity. The format of the exercise may include small-group discussions and caucus sessions based on defined questions. An exercise Facilitator will manage the flow of the exercise by presenting a scenario in multiple modules. Players will have an opportunity to both respond to the defined questions and discuss topics freely within an established time frame.

Expected tabletop participants may include, but are not limited to Long Term Care Facilities, other (patient-receiving) hospitals, Medical Control Authority, EMS agencies, emergency management agencies, public health agencies, and District 1 Regional Medical Coordination Center (D1RMCC) staff. The tabletop exercise will

seek to clarify roles and responsibilities while identifying issues surrounding the LTC(s) plans for sheltering in place and evacuation in the context of a prolonged power outage.

D. Target Capabilities

The National Planning Scenarios and the establishment of the National Preparedness Priorities have steered the focus of homeland security toward a capabilities-based planning approach. Capabilities-based planning focuses on planning under uncertainty, since the next danger or disaster can never be forecast with complete accuracy. Therefore, capabilities-based planning takes an all-hazards approach to planning and preparation, which builds capabilities that can be applied to a wide variety of incidents. Communities and organizations use capabilities-based planning to identify a baseline assessment of their homeland security efforts by comparing their current capabilities against the Target Capabilities List (TCL) and the critical tasks of the Universal Task List (UTL). This approach identifies gaps in current capabilities and focuses efforts on identifying and developing priority capabilities and tasks for the community and response organizations.

The capabilities listed below have been selected by the Exercise Planning Team. These capabilities provide the foundation for development of the exercise objectives and scenario, as the purpose of this exercise is to measure and validate performance of these capabilities and their associated critical tasks:

- Citizen [Patient] Evacuation/Shelter-In-Place (Hospital)
- Medical Surge
- Planning

E. Exercise Objectives

Exercise design objectives are focused on improving understanding of a response concept, identifying opportunities or problems, and/or achieving a change in attitude. The exercise will focus on the following design objectives selected by the Exercise Planning Team:

1. *Resource Coordination.* Determine strengths and weaknesses in current plans governing the coordination and integration of various response resources. Identify critical issues and potential solutions.
2. *Preparedness.* Determine preparedness gaps for incidents involving LTC shelter-in-place and evacuation operations.
3. *Response.* Determine capabilities and limitations of community response agencies to support LTC shelter-in-place and evacuation operations.

F. Participants

Players are LTC and response agency personnel who have an active role in responding to incidents involving LTC shelter-in-place and/or evacuation activities. Players discuss various topics based on a presented scenario, posed questions, and free-play discussion among participants. Players respond to scenario events based on expert knowledge of their agency or organization's response assets and current plans and procedures.

Observers view all or selected portions of exercise play. Observers do not participate in exercise play or in exercise control functions.

Facilitators provide scenario information, pose questions, and guide discussion. Facilitators may prompt or initiate certain Player discussions to ensure exercise continuity and flow in order to meet exercise objectives.

Evaluators collect discussion information for use in an After Action Report/ Improvement Plan (AAR/IP).

G. Exercise Structure

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

- Module 1: Initial Incident
- Module 2: Extended Incident

Each module begins with an update that summarizes the key events occurring within that time period. Following the updates, participants review the situation and engage in small-group discussions and caucus sessions to address appropriate response issues.

- Module 1: Initial Incident (Shelter-In-Place Focus)
  - Scenario Presented
  - Caucus Session

- Module 2: Extended Incident Extended Incident (Evacuation Focus)
  - Scenario Presented
  - Small Group Discussion
  - Caucus Session

Time	Activity
0830	Player Registration *
0900	Introduction/Background
0915	Module 1 Scenario Presented
0930	Caucus Session
1015	Module 2 Scenario Presented
1030	Small Group Discussion
1130	Break
1145	Caucus Session
1230	End of Exercise; Begin Player Debrief
1300	End Player Debrief; Adjourn

* Light snacks and beverages will be available at arrival.

H. Exercise Guidelines

This is an open, no-fault, stress-free environment. There is no single "right" response to scenario events. Varying viewpoints, even disagreements, are expected. Open discussion is encouraged.

Respond as if exercise events are real, using existing plans, procedures, equipment, and other response assets. Yet, the organization's positions or policies do not limit you. Make your best decision based on the circumstances presented.

Respond based on your knowledge of current plans and capabilities (i.e., you may use only existing assets) and insights derived from training.

Decisions are not precedent-setting and may not reflect your final position on a given issue. This 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 prevention, mitigation, preparedness, response, and recovery efforts. Problem-solving efforts should be the focus.

Assume the scenario and exercise activities are real. If parts of the scenario seem implausible, do not complain. Recognize that the exercise has objectives that must be satisfied and may require doing things that may not be as realistic as we would like.

The situation updates, written material, and resources serve as the basis for discussion. There are no situational injects.

The tabletop exercise is an opportunity to clarify roles and responsibilities, policies and procedures, and capabilities and limitations. It is not a forum for "developing" plans. For discussions that get bogged down with planning details, Evaluators will note the issue and Facilitators will guide the discussion toward a new topic. Any identified planning, training, or exercising need will be documented for inclusion into an after action report and improvement plan.

I. Assumptions and Artificialities

In any exercise a number of assumptions and artificialities may be necessary to complete play in the time allotted. During this exercise, the following apply:

- The scenario is plausible, and events occur as they are presented.
- There is no "hidden agenda", nor any trick questions.
- Surrogates may be playing in place of some key decision makers. The surrogates, in most instances, will be junior to the principals they represent. Thus, the surrogates' actions during the exercise may not depict the same actions that might be taken by their respective principals.
- The tabletop exercise will be played in accelerated time to meet exercise objectives and to create a 96-hour scenario.
- All Players receive scenario information at the same time.

Module 1: Initial Incident
(Response: Shelter in Place)

A. Scenario

The Lansin

Sunday, September 12, 2010

Blackouts of 2010!

On September 11, 2010, severe storms passed through the Midwest causing major power outages to many communities. Much of the service area was back online by the afternoon of September 13, however many communities had utilized contingencies to self-sustain during the outages of September 11 and 12.

During the early morning hours on September 13, multiple F4 tornadoes touched down in northern Ohio, causing extensive damage to property and infrastructure. The tornadoes caused catastrophic damage to

FirstEnergy control area in Ohio, Cleveland Public Power, Toledo Edison, and Ohio Edison. Many of the facilities were completely destroyed, it is not expected that the electrical grid can handle the significant damage. As a result of the destruction, the electrical grid has experienced cascading failures at multiple major distribution centers and production facilities extending throughout much of Michigan, including District 1.

DTE, Consumers Power, and other area providers all have lost the ability to susta

September 2-4, 2010

On September 2, severe storms passed through the Midwest causing major power outages to many communities. Much of the service area was back online by the afternoon of September 3, however many communities had utilized contingencies to self-sustain during the outages during the preceding 36 hours.

During the early morning hours on September 4, multiple F4 tornadoes touched down in northern Ohio, causing extensive damage to property and infrastructure. The tornadoes caused catastrophic damage to FirstEnergy control area in Ohio, Cleveland Public Power, Toledo Edison, and Ohio Edison. Many of the facilities were completely destroyed; it is not expected that the electrical grid can handle the significant damage. As a result of the destruction, the electrical grid has experienced cascading failures at multiple major distribution centers and production facilities extending throughout much of Michigan, including District 1.

DTE, Consumers Power, and other area providers all have lost the ability to sustain power and have experienced loss of service due to the event that occurred in Northern Ohio. Initial reports from the providers indicate that it could be a couple of days before service is restored throughout the mid and southern Michigan area of operations.

September 5, 2010

Updates from the power companies indicate that the power outage does not appear to be fixable in the near future. The power companies still cannot provide an exact timeframe for the outage or when electrical service will be back online. Hospitals throughout District 1, as in adjoining regions in Michigan and Ohio, are experiencing a small increase in patients requesting service due to the power outage. Several hospital facilities maintenance departments are reporting that their hospitals may not have enough fuel to operate their generators beyond the next 48-72 hours. Additionally, area media reps have requested to know if hospitals around the district will be able to remain open if the power outage continues, and at what point would operations cease. Hospitals within District 1 each possess generators that enable them to maintain core medical services for their patients, for at least the time being.

B. Key Issues

- No municipal power to any hospitals within District 1.
- Patient surge at hospitals.
- Fuel delivery delay/shortage.

C. Definition

Shelter-in-Place: The process of staying where you are and taking shelter, rather than trying to evacuate. (Source: www.ready.gov, http://www.ready.gov/america/other/glossary.html, accessed June 17, 2010.)

D. Questions

Based on the information provided, participate in the discussion concerning the provided scenario. Identify requirements, critical issues, decisions, and/or questions related to hospital shelter-in-place that should be addressed at this time.

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

Command

1. Would the LTC Command Center be activated at this point? If so, what is the activation process, and how long would it take? What is the staffing model at this point in the scenario?
2. Will the LTC activate access control or lock down procedures?
3. Does your LTC have a plan to communicate with the local EOC about the situation status, critical issues and request assistance? Would your LTC be implementing this plan at this point? Who in your hospital would activate this plan?
4. Does your LTC have a plan to modify contingency staff utilization and provide staff support (i.e., childcare contingency plan for staff, staff transportation needs, etc.)? Would your LTC be implementing this plan at this point? Who in your hospital would activate this plan?
5. Does your LTC have procedures to communicate situation and safety information to staff, family & visitors?

Medical Care Branch

1. What are the critical patient care issues that could result from this scenario?
2. From a patient care perspective, what triggers may drive you to request activation of the LTC(s) disaster response protocols?

3. How will the LTC address self-presenting patients who arrive at the LTC to seek emergency care during shelter-in-place operations?
4. How does implementing the LTC(s) shelter-in-place plan impact staffing resources?
5. How would MIHAN be used at this time at your facility?
6. Will the LTC be on "diversion" status if shelter-in-place plans are implemented?
7. Who in your LTC would activate this plan?
8. What plans does the LTC have to obtain supplies during shelter-in-place operations?

Infrastructure Branch

1. What are the critical infrastructure issues that could result from this scenario?
2. What is the most critical system of concern to ensure the LTC maintains the capability to shelter in place?
3. From a facility infrastructure perspective, what triggers may drive a request to activate the LTC(s) disaster response protocols?
4. Does your LTC I have plans for loss of power or loss of other utilities and services? If so, would your LTC be implementing this plan at this point? Who in your LTC would activate this plan?
5. Does your facility have MOUs with fuel suppliers to ensure a supply of fuel for emergency generators and vehicles, if needed?
6. Does your LTC have procedures to communicate situation and safety information to staff?
7. Does the LTC participate in the National Communication System's Telecommunication Service Priority (TSP)? Government Emergency Telecommunications Service (GETS)?
8. What mitigation strategies have been put in place to reduce the risk to the facility for this type of scenario?
9. What mitigation strategies should be put in place to reduce the risk to the facility for this type of scenario?
10. Does your LTC have procedures to monitor environmental issues (bio waste disposal) and water safety?
11. Does your LTC have a plan and back up (redundant) communication systems to maintain communications with off-site facilities?
12. Does your LTC have a plan and back up (redundant) communication systems to maintain communications with the local EOC?
13. Are key personnel adequately trained to use these redundant communication systems? Is this equipment accessible and viable (programming, batteries, installation, etc.) to rapidly put into use?

Emergency Operations Center (EOC)

1. Will the county Emergency Operations Center (EOC) be activated at this point?
2. If the county EOC is activated, what support can the EOC provide to the LTC(s) implementing shelter-in-place plans?

3. If the county EOC is not activated at this point, what triggers within the community, and LTC(s) specifically, would result in partial EOC activation? Full EOC activation?
4. What type of impact would this scenario have on the ability of emergency management/EOC to provide support to impacted LTC(s)? Casualty Transport System/EMS agencies?
5. What mechanisms does the EOC have in place to address any resource needs that the LTC, Regional Medical Coordination Center, or Casualty Transportation System may need in this type of scenario?
6. Given the area's power supply issues under this scenario, does the EOC have a plan to sustain its own operations for multiple operational periods?
7. What disciplines/roles would be essential to staff the EOC at this point? How will these individuals be contacted/how will they contact the EOC?
8. Does your EOC have a plan and back up (redundant) communication systems to maintain communications with area agencies?
9. Are your EOC personnel adequately trained to use these redundant communication systems? Is this equipment accessible and viable (programming, batteries, installation, etc.) to rapidly put into use?

Regional Medical Coordination Center (RMCC)

1. Will the Regional Medical Coordination Center be activated at this point? If so, what are the activation triggers, and how would this process work, under this type of scenario?
2. What capabilities does the Regional Medical Coordination Center have to support LTC(s) that implement shelter-in-place plans?
3. What is the operational role for the Regional Medical Coordination Center at this point?
4. Given the area's power supply issues under this scenario, does the RMCC have a plan to sustain its own operations for multiple operational periods?
5. Given the scenario, who would staff your RMCC at this point? How would these individuals be notified/requested to report to the RMCC? Where would they set up operations?

Module 2: Extended Incident
(Response: Evacuation)

A. Scenario

September 6, 2010

Unseasonably hot temperatures have occurred throughout most of the Midwest. Despite this added complication, power has been restored to multiple areas in the district, adjoining regions, and northern Ohio, including various hospitals. Long Term Care Facilities remain without power, whereas power to some area hospitals have been restored. Local emergency management is announcing that the local power company has indicated that services will not be restored for at least an additional 72 hours. The local health department has indicated that there will be a restriction for water use due to dangerously low pressure in the municipal water supply system. The County waste management engineers are attempting to evaluate how the power outage is impacting the system and have advised all users of reductions in the ability to support operations.

In general, internal reports from the hospitals around the region indicate shortages of critical supplies in many of the departments, in particular for surgery, obstetrics, intensive care, emergency room, and pediatrics. Some hospitals are getting low on many essential supplies and department managers are not sure how long operations can be continued without resupply and continued auxiliary power usage. In multiple hospitals across the region, facilities maintenance reports that the fuel for the generators will be expended in the next 24 hours without resupply or reduction in consumption.

The Ingham County Emergency Operations Center and the District 1 Regional Medical Coordination Center have been activated to support response operations. The County has declared a state of emergency. The Governor has declared a state of emergency for affected areas and has submitted a request for a Presidential disaster declaration. The Presidential decision is pending. Local emergency response is focused on returning electricity to the community, opening transportation routes, and providing services to special-needs population groups.

September 7, 2010

Reports from local emergency management indicate that fuel suppliers have a limited ability to support local refueling operations due to limited fuel resupply at their end. Emergency management requests all users to conserve fuel at all costs with the limited supply having been identified. Additionally, emergency management reaffirms the criticality of the water supply in the city and has restricted use to only essential usage.

General suppliers have contacted both emergency management and the LTC to indicate their inability to continue with full operations because of the lack of fuel and general logistical deficiencies in the supply chain. They do not specifically know when they will be operational, but do not anticipate returning to normal operations for the next 48-72 hours.

The media is reporting that the community is critically low on essential supplies and has been distributing the alert/warning messages from emergency management to the public. Yet, LTC(s) are still seeing a surge of patients presenting to the LTC(s) for various needs related to the power outage. The media has requested to know the status of area LTC(s) and how long can the hospitals continue operations in the current environment.

While some have regained power as stated, nearly half of the hospitals around District 1 have lost both city power feeds. Hospital command center staff and administrators for these hospitals are contemplating total facility evacuations within the next operational period, and have reached out to assess other area facilities that may be willing and able to accept transfer of the impacted patients. Another three hospitals in the tri-county area have only one municipal power feed that is functioning. These hospitals are only cautiously optimistic about full power restoration, and are hesitant to consider accepting even limited transfers.

Hayes Green Beach's generators will be out of fuel in the next 24 hours if refueling does not occur. Several hospitals have experienced mechanical generator failure, which has impacted the hospital's ability to sustain patient care within the hospital. Multiple departments in these impacted hospitals are also reporting that they are out of critical supplies and can no longer support basic functions; they are seeking guidance from the Hospital Command Center. At these hospitals, the food service unit does not have the ability to feed patients beyond the next 24-hour period; they are especially concerned about patients with specific dietary needs.

Overall, the impact involves more than 4 million people without electricity, most of them in Lower Michigan. Over the past few days, Medical First Responders (MFR)/Emergency Medical Service (EMS) agencies have experienced a surge of runs.

B. Key Issues

- No municipal power to half the LTC(s) within District 1.
  - Fuel delivery delays impacting emergency generator capabilities.
  - Mechanical failure of generators at many hospitals is resulting in the inability to sustain patient care operations.
- Only single power feeds are functional for five other D1 hospitals.
- Low critical supplies at all LTC(s).
- MFR/EMS agency patient inundation.

- Local Emergency Operations Centers have been activated to support response operations.
- The D1 Regional Medical Coordination Center has been activated to support response operations.

C. Definition

Evacuation: The process of leaving a potentially dangerous area. (Source: www.ready.gov, http://www.ready.gov/america/other/glossary.html, accessed June 17, 2010.)

D. Questions

Based on the information provided, participate in the discussion concerning the provided scenario. Identify requirements, critical issues, decisions, and/or questions related to hospital shelter-in-place that should be addressed at this time.

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

Command

1. How does the LTC interface with the county Emergency Operations Center to provide/obtain situational awareness, submit resource requests, and ensure the EOC is aware of the LTC(s) capabilities, limitations, and needs?
2. What does the Federal Disaster Declaration mean for your agency?
3. Does your LTC plan for demobilization and system recovery during response?
4. How is the LTC Command Center staffed at this point in the incident? How would you prepare to staff for a possible extended activation? Is your current staffing protocol sufficient to support extended activation? If not, how might this be remedied?
5. What mutual-aid agreements (MAAs) or memoranda of understanding (MOUs) do you currently have in place that could be utilized for this response? Would mutual aid be requested at this point? If so, from whom?
6. How is available patient bed space at alternative care sites (i.e., other hospital properties, other hospitals, acute care centers) identified? How are these alternative care sites notified about the need for "evacuating" (your) LTC patients?
7. How does the LTC interface with the Regional Medical Coordination Center to provide/obtain situational awareness, submit resource requests, and ensure the Regional Medical Coordination Center is aware of the hospital's capabilities, limitations, and needs?

8. Does your facility have a plan to manage an increase in numbers of people presenting to the facility for non-medical, general assistance (food, medicine, adult briefs)?
9. What documentation needs to be initiated for the incident and future cost reimbursement submission?
10. What documentation needs to be initiated for the incident and future cost reimbursement submission?

Medical Care Branch

1. How will you track patients to be evacuated?
2. From a patient-care perspective, what are the critical issues that could result from having to implement patient evacuation?
3. What types and numbers of staff are needed to support patient evacuation?
4. How will the LTC address self-presenting patients who arrive at the LTC to seek emergency care during evacuation operations?
5. Are there any atypical patient transfer issues associated with mass-patient evacuation versus routine patient transfers?
6. Would you use EMResource at this time? If so, who would be using it and how would it be utilized?
7. What documentation needs to be initiated for the incident and future cost reimbursement submission?

Infrastructure Branch

1. What are your primary security concerns, for staff, patients, and visitors? What steps should be taken to address these safety concerns? What resources may be required?
2. What challenges will you face if the scenario continues the next three days without any improvement? What are some potential action plans to address the challenges?
3. Does your LTC have procedures to regularly evaluate infrastructure and operational needs and implement appropriate actions to meet the needs?
4. Does your LTC possess sufficient types and quantities of equipment and supplies (stair chairs, sleds, blankets, etc.) to support evacuation of all non-ambulatory patients? Are key personnel adequately trained on how to utilize this equipment?
5. Has the LTC mapped out ingress and egress routes for the safe evacuation of patients, both horizontally and vertically? Do these plans address flow of personnel and patients through narrow corridors/stairwells, to mitigate potential traffic “bottlenecks”?
6. From an infrastructure perspective, what are the critical issues that could result from having to implement patient evacuation?
7. Does your LTC have procedures to perform damage assessment (interior and exterior), evaluate infrastructure operations needs, initiate repair plan, contract for needed repair assistance, and re-evaluate need for evacuation (partial or complete)?

8. Does your LTC have procedures for prioritizing service restoration activities?

Emergency Operations Center (EOC)

1. Would alternative care centers be activated to support evacuated hospitals? If yes, how long would it take to activate a site? How many patients could be housed at alternative sites? What infrastructures impact these sites ability to support patient care?
2. Will the county Emergency Operations Center (EOC) be activated at this point?
3. If the county EOC is activated, what support can the EOC provide to the LTC(s) implementing evacuation plans?
4. How are Casualty Transportation System assets coordinated to support LTC evacuation?
5. Does the EOC have a process to obtain disaster relief workers via the MI-Volunteer Registry?
6. What type of impact would this type of scenario have on the ability of emergency management/EOC to provide support to impacted LTC(s)?
7. What is the role of the EOC for supporting patient tracking during LTC evacuation? What is the role of the EOC for supporting family reunification for transferred patients?
8. What mechanisms does the EOC have in place to address any resource needs that the LTC, Regional Medical Coordination Center, or Casualty Transportation System may need in this type of scenario?
9. What documentation needs to be initiated for the incident and future cost reimbursement submission?

Regional Medical Coordination Center (RMCC)

1. What capabilities does the Regional Medical Coordination Center have to support LTC(s) that implement evacuation plans?
2. What capabilities does the Regional Medical Coordination Center have to support LTC(s) that perform as patient receiving hospitals?
3. What is the operational role for the Regional Medical Coordination Center at this point?
4. What documentation needs to be initiated for the incident and future cost reimbursement submission?

Appendix A: Acronym List

AAR	After Action Report
AAR/IP	After Action Report/Improvement Plan
ACC	Acute/Alternative Care Center
ACS	Alternative Care Site
CHECC	Community Health Emergency Coordination Center
ED	Emergency Department
EPT	Exercise Planning Team
EMD	Emergency Management Department/Division
EMS	Emergency Medical Services
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
ER	Emergency Room
EXPLAN	Exercise Plan
FSE	Full-Scale Exercise
DIP	Defend In Place
HCC	Hospital Command Center
LTC	Long Term Care Facility
HICS	Hospital Incident Command System
HIMT	Hospital Incident Management Team
HSEEP	Homeland Security Exercise and Evaluation Program
IC	Incident Commander
ICS	Incident Command System
IMT	Incident Management Team
JIC	Joint Information Center
MCC	Medical Coordination Center
MDCH-OPHP	Michigan Department of Community Health – Office of Public Health Preparedness
MEMS	Modular Emergency Medical System
MFR	Medical First Response
PIO	Public Information Officer
POC	Point of Contact
SEOC	State Emergency Operations Center
SIMCELL	Simulation Cell
SIP	Shelter In Place
SITMAN	Situation Manual
SOP	Standard Operating Procedure
TTX	Tabletop Exercise