



FIFA World Cup '26 Special Event WA State MCI Surge “Confluent Goal” Virtual Tabletop Exercise

After Action Report/Improvement Plan

Approved as of 6/11/2026

Updated as of 9/15/2026

Executive Summary

The Northwest Healthcare Response Network (NWHRN), the healthcare coalition for most of Washington State, hosted the annual Administration for Strategic Preparedness and Response (ASPR) Medical Response and Surge Exercise (MRSE). The 4.5-hour virtual tabletop exercise was held on May 6, 2026. Because of the FIFA World Cup activities taking place in Washington State NWHRN was allowed to alter normal MRSE exercise requirements and create a “special event” MRSE exercise using the World Cup games and activities as a backdrop for the exercise. Core functions included in the exercise were: Information Sharing; Specialty care Planning and Coordination; Respond; and Resource Management.

This year’s exercise included over 200 participants from 110 organizations, agencies or entities across 8 of Washington State’s 9 Public Health regions along with “Region 0” representing State and Federal partners and any other organizations that didn’t fit into the “region” model. The regional partners went to breakout rooms for Modules 1 and 2 where two separate significant mass casualty incidents were introduced in their region, with 2 to 8 hours separating the two incidents. Following those modules each region gave a report-out of the incidents that had occurred in their regions and the high-level discussions for their response. With the two scenarios for “Region 0” there were a total of 18 different mass casualty scenarios that occurred across the state. Through the report-outs each of the regions and the Region 0 partners learned, for the first time, what was happening in the other regions. Following the report-outs Module 3 featured a discussion with all participants together addressing the multiple mass casualty incidents “occurring around the state” and activation of the new State Mass Casualty Incident Annex designed for state level partners to support multiple mass casualty incidents through coordination and resource management.

The exercise was kicked off the day before with a communications drill, testing the use of Alert Media and WATrac for sending out messaging and receiving responses. Those responses were then tabulated. The exercise was rounded out with a Participant Feedback Survey that went to participants. A separate participant survey was sent to hospital and EMS partners with a resource management and supply chain survey evaluating the available resources within the state to respond effectively to the exercise mass casualty scenarios. Both the communications and resource and supply chain portions of the exercise were specific requirements of the ASPR MRSE exercise.

Many participants shared positive feedback on the exercise saying that they really liked the opportunity to discuss response actions with their regional partners. Newer responders were learning from the experiences of more seasoned responders. Ideas were being shared and critical conversations around response limitations were being had. There were some negative aspects to the exercise, that it was either too long or not long enough, that there was more to

discuss or that critical partners were not present. These are all foreseeable aspects to exercise design, particularly for such a large and diverse group of participants.

Through discussions held during this exercise the following major strengths and areas for improvement were identified:

Strengths

- Critical thinking skills, cooperation and coordination were demonstrated which helped identify realistic operational impacts
- More experienced responders sharing knowledge with less experienced responders
- Taking the Level 1 trauma center out of play really forced regional hospitals to focus on regional assets and less traditional capabilities
- Participants demonstrated clear awareness of the systems to request additional resources and potential operational constraints in receiving / deploying those resources

Areas of Opportunity

- Blood centers were not connected into incident management response mechanisms to know when and where mass casualty incidents were occurring, slowing down the delivery of critical blood products for trauma care
- Concerns around patient tracking and information sharing logistics, guidelines and parameters for connecting injured patients, hospitals, call centers, Family Reception Centers and those looking to reunite with missing individuals
- Hospitals that don't traditionally manage specialty care patients (peds, burn, etc.) want more support resources for providing specialty care when transfers are not possible
- Misconceptions about the DMCCs capabilities and responsibilities during incident response
- International visitors may be unfamiliar with US healthcare delivery and insurance requirements, which may cause frustration and delays in care delivery
- Sending “all pediatric ages” to a designated pediatric facility may overwhelm the facility when some “older” pediatric patients may receive appropriate care at facilities that are not specifically pediatric facilities, thus making resources more available at the designated pediatric facility
- Patient identification bands, used by EMS and hospitals, are not standardized and don't scan into hospital electronic health records or into the WATrac patient tracking module

The balance of this After Action Report discusses findings from the exercise in more detail.

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Exercise Overview

Exercise Name	FIFA World Cup 26 WA State MCI Surge “Confluent Goal” TTX
Exercise Date	Wednesday, May 6, 2026, 8:00am-12:30pm
Purpose	NWHRN, healthcare partners and others will test the new statewide mass casualty plan and other healthcare response plans ahead of World Cup 2026 fan gatherings in multiple locations across the state.
Scope	A single, 4.5-hour operations-focused virtual tabletop discussion exercise with breakouts for different regions to work together and report out. The exercise will include two separate exercise segments completed independently from the virtual TTX to test resource management and communications.
Parameters	A series of different scenarios related to the collective healthcare community response for large mass casualty incidents with differing threats occurring in and around the FIFA World Cup 2026 fan sites in Washington State The ability to coordinate moving patients from the field to appropriate points of care along with patient placement and load balancing across the state during large mass casualty incidents
Plans to be tested	NWHRN Emergency Operations Base Plan NWHRN Burn Surge Annex NWHRN Chemical, Radiation and Nuclear Emergency Surge Annex NWHRN DMCC Framework Annex NWHRN Patient Movement Annex NWHRN Pediatric Surge Annex NWHRN Response Operations Annex Washington State Healthcare Mass Casualty Incident MCI Annex NWHRN EMS Patient Movement Escalation Framework for WA State
Capabilities	Healthcare Preparedness Capabilities: Capability 2: Health Care and Medical Response Coordination Capability 3: Continuity of Health Care Service Delivery Capability 4: Medical Surge CMS Emergency Preparedness: Community Participation
Objectives	WC26 Objectives (revised 2.26.2026) 1. HCC and partners articulate response to a variety of potential mass casualty scenarios with World Cup 2026 fans, game venues, and fan

Exercise Name	FIFA World Cup 26 WA State MCI Surge “Confluent Goal” TTX
	sites across Washington State including responses for clinical and social threats (burn, pediatrics, chemical or radiation injuries, civil disobedience, an international population), and possible concurrent incidents across the state. 2. HCC and partners discuss DMCC patient distribution and coordination concerns during mass casualty incidents or concurrent incidents across WA state for a variety of scenarios crossing jurisdictions including triggers and activation of State DMCC or RMOCC for patient placement and load balancing. 3. HCC and partners articulate use of the EMS Patient Movement Escalation Framework for Washington State when the need for patient care overwhelms the area’s capacity or capability for providing care and EMS resources for moving patients is significantly challenged. 4. HCC and partners convey and tabulate their supply chain/resource management capabilities and needs during different significant mass casualty incident scenarios. 5. HCC and partners participate in critical communications processes related to the World Cup 2026 Special Event in Washington State with 75% accuracy for successful delivery and receipt of messages.
Threat/Hazard	Mass casualty incidents
Scenario	Large mass casualty incidents with a variety of injury causes, some incidents are associated with multiple international soccer championship locations within Washington State and other incidents are not.
Exercise Modules	Virtual Synchronous Modules 1. Initial incidents per Region 2. Compounding incidents per Region 3. State resource coordination Separate Asynchronous Modules 4. Supply chain/resource management capabilities and needs 5. Critical communications processes
Sponsor	Northwest Healthcare Response Network
Participant Types	• Air Medical Transport • Ambulatory Surgery Centers • Blood Centers • Clinics • Communications • Dialysis, ESRD Network

Exercise Name	FIFA World Cup 26 WA State MCI Surge “Confluent Goal” TTX	
	• Disaster Medical Coordination Center (DMCC) • Emergency Management • Fire / EMS • Federal • Healthcare Coalitions • Hospital Association • Hospitals • Local Government • Local Health Jurisdictions • Long Term Care, Skilled Nursing Facilities, Home Health, Assisted Living • State • Transportation (other than EMS)	
Breakout Groups	Region 1 Region 2 Region 3* Region 5 Region 6 Region 7 Region 8 Region 9 Region 0 (Federal, State, NWHRN, etc.) *Participants from Region 4 Healthcare Alliance Coalition will join Region 3 as observers	
Points of Contact	Jennifer Lord, MS, CEM, MEP Planning, Training and Exercise Manager Northwest Healthcare Response Network Jennifer.Lord@nwhrn.org	Michael Halfen, MS, CEM Operational Planning Coordinator Northwest Healthcare Response Network Michael.Halfen@nwhrn.org

Analysis of Capabilities

Aligning exercise objectives and 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 capabilities, and performance ratings for each capability as observed during the exercise and determined by the evaluation team.

MRSE-Specific Objective	Capability	Performed without Challenges (P)	Performed with Some Challenges (S)	Performed with Major Challenges (M)	Unable to be Performed (U)
HCC's engage healthcare partners and their executives to participate in the exercise and the After-Action Review within the HPP budget period			S		
HCC's effectively notify HCC health care partners of an incident and facilitate ongoing information sharing during a community wide emergency or disaster		P			
HCC demonstrate their ability to assess and meet critical resource needs (personnel, supplies, equipment, etc) to manage patient surge during a community-wide emergency or disaster by the end of the MRSE			S		
HCC demonstrate their ability to reduce patient morbidity and mortality through appropriate patient placement during a large patient surge by assisting with the identification and coordination of available patient care resources by the end of the MRSE		P			

NWHRN-Specific Objective	Capability	Performed without Challenges (P)	Performed with Some Challenges (S)	Performed with Major Challenges (M)	Unable to be Performed (U)
HCC and partners articulate response to a variety of potential mass casualty scenarios with World Cup 2026 fans, game venues, and fan sites across Washington State including responses for clinical and social threats (burn, pediatrics, chemical or radiation injuries, civil disobedience an international population), and possible concurrent incidents across the state.	Healthcare and Medical Response Coordination Medical Surge		S S		
HCC and partners discuss DMCC patient distribution and coordination concerns during mass casualty incidents or concurrent incidents across WA state for a variety of scenarios crossing jurisdictions including triggers and activation of State DMCC or RMOCC for patient placement and load balancing	Healthcare and Medical Response Coordination Medical Surge		S S		
HCC and partners articulate use of the EMS Patient Movement Escalation Framework for Washington State when the need for patient care overwhelms the area’s capacity or capability for providing care and EMS resources for moving patients is significantly challenged.	Healthcare and Medical Response Coordination Medical Surge		S S		
HCC and partners convey and tabulate their supply chain/resource management capabilities and needs during different significant mass casualty incident scenarios.	Continuity of Health Care Service Delivery		S		

NWHRN-Specific Objective	Capability	Performed without Challenges (P)	Performed with Some Challenges (S)	Performed with Major Challenges (M)	Unable to be Performed (U)
HCC and partners participate in critical communications processes related to the World Cup 2026 Special Event in Washington State with 75% accuracy for successful delivery and receipt of messages.	Healthcare and Medical Response Coordination		S		

Table 1. Summary of Core Capability Performance

Ratings Definitions:

Performed without Challenges (P): The targets and critical tasks associated with the 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 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 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 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 capability, highlighting strengths and areas for improvement.

MRSE-Specific Objectives

Objective 1

HCC’s engage healthcare partners and their executives to participate in the exercise and the After-Action Review within the HPP budget period

Objective Completed: No

Analysis: The parameters of our exercise did not specifically require executives to participate. Many did, though the focus was more on the frontline staff who would operationalize a response.

Objective 2

HCC’s effectively notify HCC health care partners of an incident and facilitate ongoing information sharing during a community wide emergency or disaster

Objective Completed: Yes

Objective 3

HCC demonstrate their ability to assess and meet critical resource needs (personnel, supplies, equipment, etc.) to manage patient surge during a community-wide emergency or disaster by the end of the MRSE

Objective Completed: No

Analysis: A targeted survey was used, following the exercise to assess availability of specific resources. Partners that did respond provided requested information, though the availability was much lower than the actual need. Not many participants engaged in the targeted survey

Objective 4

HCC demonstrate their ability to reduce patient morbidity and mortality through appropriate patient placement during a large patient surge by assisting with the identification and coordination of available patient care resources by the end of the MRSE

Objective Completed: Yes

NWHRN-Specific Objectives

Objective 1

HCC and partners articulate response to a variety of potential mass casualty scenarios with World Cup 2026 fans, game venues, and van sites across Washington State including responses for clinical and social threats (burn, pediatrics, chemical or radiation injuries, civil disobedience, an international population), and possible concurrent incidents across the state.

Capability: Healthcare and Medical Response Coordination

Strengths

The (full or partial) capability level can be attributed to the following strengths:

Strength 1: Participants had a strong understanding of the availability and limitations of the region’s resources, including specialty resources

Strength 2: Identifying what a big MCI would look like for all agencies and our community

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Areas for Improvement 1: Blood Centers are not connected into incident management response mechanisms to know when and where mass casualty incidents are occurring, slowing down the delivery of critical blood products for trauma care.

Analysis:

The immediate availability of blood and blood products during a mass casualty incident can be critical to saving lives. Through scenarios and discussions raised in this exercise it was identified that the blood centers have not been included in the State ESF-8 incident management or response plans. Having advanced notice, particularly in a large incident or multiple incidents, will help blood centers to lean forward in the preparation and delivery of blood products to trauma centers. Use of the WATrac Tracking and Alert System by blood centers might be another tool for developing situational awareness. Unsure whether blood centers have access to WATrac.

There was discussion about different ways to quickly distribute blood products during a disaster when road infrastructure may be impacted. Could air medical helicopters be used to quickly distribute supplies? Is it possible for local or regionally located hospitals to share

current supplies with facilities that had a critical need? What regulations or requirements would govern that sharing? The concept of a “Blood Coalition” was mentioned. The Prehospital Blood Transfusion Coalition is a multidisciplinary initiative to support the delivery of blood products to patients in the pre-hospital setting. Is there an established process or mutual aid agreements for the sharing of blood products between facilities within Washington State?

Area for Improvement 2: Additional resources to support large mass casualty incidents, besides what is normally at hand, may be available in the community or region but are not well communicated or coordinated.

Analysis: A large mass casualty incident may quickly outstrip resources at hand, whether staff, stuff, or space. These resources may be available in the community or region but may not have been organized, coordinated or catalogued.

While many of the suggestions below are facility-specific, the Northwest Healthcare Response Network would assist and support these activities by being a source for information, situational awareness and coordination.

Staff

When thinking about augmenting ‘staff’, calling back off-duty staff is the first action for bringing in help as they are already employed by the organization and familiar with the processes and procedures.

Pre-credentialed medically trained personnel may be available through a local Medical Reserve Corps (MRC). The State’s WAserv system is another potential resource for pre-credentialed individuals who are medically trained. Both MRC and WAserv require certain criteria to be met before activation and mobilization. Federal level resources for healthcare personnel also exist though their requirements for activation and lead time for deployment are much longer and complicated than accessing local resources. The use of waivers may allow a medical provider to stretch their areas for practice which could help expand the ability to provide care for patients.

A potential and untapped resource for personnel might be from other healthcare organizations with similarly trained staff, that could assist in a significant disaster response. Pre-credentialing and Memorandums of Understanding (MOU) or Memorandums Aid Agreements (MAA) would need to be established beforehand.

The use of TeleHealth could provide expanded knowledge to healthcare providers that have to manage a specialty care patient that they might normally transfer out to a facility with

the specialized care capabilities. During a significant mass casualty incident, it is quite likely that local healthcare providers would need to treat specialty care patients when they might not have the expertise or supplies for providing such care. Being able to consult with specialty care physicians would significantly expand the specialty care available to patients across the state during a disaster.

Plans may already be in place with hospitals for augmenting staff. If so, there may need to be further education on these established capabilities in advance of a disaster.

Stuff

The potential to exhaust supplies for providing care to patients during a large mass casualty incident is quite likely. Even with pre-established resupply agreements with medical suppliers, it will take time for those supplies to arrive. Other healthcare facilities in the surrounding area may be sources of immediate supplies and want to share what they currently have on hand. While it may be possible to put out a request to nearby partners for supplies to be immediately shared it may be best to discuss supply sharing agreements ahead of a mass casualty incident.

Easing restrictions on testing requirements, such as for infectious diseases, may ease the burden on the numbers, duration and staff time for testing and monitoring, particularly for very low-level risk patients. However, with the recent surge in worldwide infectious diseases (Ebola, Hanta Virus, Measles, etc.) it may not be advisable at this time to ease restrictions on infectious disease testing.

Space

Through the exercise discussions it seemed evident that established plans for providing care for green-triaged patients may not have been well understood. There was discussion around transportation for green-triaged patients from the scene thus saving ambulances for transporting more critically injured patients. To reserve the resources of the Emergency Department for those needing acute care, green-triaged patients would be directed to locations delivering more appropriate levels of non-acute care. Where those locations were seemed up for discussion. Use of ambulatory clinics or urgent care locations that may not be affiliated with the hospital would likely require an MOU to be utilized for receiving and treating green-triaged patients during a mass casualty incident.

Depending on the number of critically injured, the hospital may need to expand patient care areas within the hospital. Waivers may be necessary for expanding the use of restricted spaces.

Area for Improvement 3: International visitors may be unfamiliar with US healthcare delivery and insurance requirements, which may cause frustration and delays in care delivery.

Analysis: While some international visitors may be familiar with the customs, practices and requirements around delivery of healthcare in the US, it is quite likely there will be international visitors that are unfamiliar and unprepared for how differently healthcare is managed and delivered here as compared with their home countries. This may lead to frustrations and delays in receiving care. Likewise, US healthcare providers may not be familiar with the expectations of international visitors regarding healthcare delivery which may cause frustration on the part of the local healthcare staff and potentially delay delivery of healthcare.

Customs and practices for the delivery of healthcare in the US need to be clearly and frequently communicated in a variety of languages, or the near-universal language of images and drawings for international visitors. Conversely, education for US healthcare staff regarding understanding an international visitor’s confusion and frustration may help ease the stress on both sides.

Area for Improvement 4: Concerns relating to patient tracking and information-sharing logistics, guidelines and parameters for connecting injured patients, hospitals, call centers, Family Reception Centers and those looking to reunite with missing individuals.

Analysis: The flow of information necessary for reconnecting patients with those that might be missing them in a disaster is unclear. With the Washington 211 system taking calls to receive inquiries from those seeking missing people and sharing those inquiries with healthcare facilities and patients themselves has not been tested. The Health Insurance Portability and Accountability Act (HIPAA) is very strict with patient privacy and information sharing. Clear pathways for information flow need to be established and communicated to both 211 call takers, healthcare entities caring for patients and the entities within the state managing the Family Reception Sites.

Area for Improvement 5: Some patients from a disaster may get ‘lost’ when they bypass the normal patient transportation, documentation and accountability processes.

Analysis: The ability to do patient tracking is accomplished through the WATrac reporting system. Patient data entry starts at the hospital Emergency Department. EMS may have

their own patient tracking capabilities, but they may not be universal and are unconnected to the WATrac Patient Tracking or hospital patient chart capabilities.

If patients may be delivered to locations other than the Emergency Department or may arrive at a hospital distant from the incident scene it may be challenging to accurately account for everyone that was involved in the incident.

There have been efforts in the past for EMS to begin the patient accountability process in the field with uniquely numbered patient ID bands. There were requests, again, through this exercise to explore reinstituting patient ID bands for EMS. If the bands were able to sync with hospital patient charting systems (i.e., Epic) that would make connecting the EMS band unique identifiers with hospital chart unique identifiers easier. If both those unique identifiers could be connected through the WATrac Patient Tracking application that would further the synthesis of information.

Capability: Medical Surge

Strengths

The (full or partial) capability level can be attributed to the following strengths:

Strength 1: Critical thinking skills, cooperation and coordination were demonstrated which helped identify realistic operational impacts

Strength 2: Sharing real-life MCI experiences helped educate those responders who may not have had a real-world MCI response

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Area for Improvement 1: In a disaster patients may seek “medical care” wherever they perceive healthcare to be available which may mean patients present at facilities that are not equipped or capable of providing the level of medical care they actually need.

Analysis: When impacted by a mass casualty incident it may be possible patients seek medical care at the nearest location that looks like it offers medical care. The possibility exists that the facility they arrive at may not be equipped to appropriately care for the patient depending on the extent of their injuries. Until the patient can be transferred to a more appropriate location for receiving care staff at the initial location still need to provide

care for the patient. This may mean training ambulatory clinic, outpatient or urgent care staff in providing basic trauma care while awaiting EMS transport.

Areas for Improvement 2: Hospitals that don’t traditionally manage specialty care patients (peds, burns, etc.) want more resources of support for providing specialty care when normal transfers are not possible.

Analysis: When it might not be possible to transfer out a patient who needs a higher level of care it would be very helpful to local practitioners to be able to “phone a friend” and speak with a specialist to provide guidance on patient care for specialty care patients. While some facilities and individuals may know how to access these teleconsult resources it does not appear that many know the resources exist. Re-communicating these specialty care resources could support facility and staff preparedness for managing specialty care patients beyond normal timeframes.

Pediatrics

There are several resources for accessing highly specialized pediatric care capabilities including the Western Regional Alliance for Pediatric Emergency Management (WRAP-EM) and the Pediatric Toolkit documents available on the NWHRN website. These resources and documents may need higher visibility particularly for smaller, less well-resourced facilities.

One recommendation made during the exercise was to sort pediatrics by age and ability of a facility to provide care. For example, if a hospital can safely provide acute care to middle and older pediatric patients then a Children’s hospital would be able to provide care for the younger pediatrics and those that need specific pediatric care capabilities and resources. This may take educating physicians and hospitals for what ages they can safely provide care for and in what care setting. This also requires education for EMS and the DMCC’s when decisions are being made for pediatrics of different age groups and care needs.

Of special note when treating pediatrics contaminated in a nerve agent chemical exposure: The Chempack antidotes that are distributed around the state and available to both EMS and hospitals, for quick distribution, do not carry specific pediatric doses. The medication in their caches are all adult dose or multi-dose vials. Pediatric doses must be calculated for weight and drawn up from the multi-dose vials, which would happen at the hospital.

Burns

Caring for patients with burn injuries, whether thermal, chemical or radiological, can be very challenging. Harborview Medical Center is a burn center and can provide resource information for practitioners caring for burn patients. Similar to pediatric resources,

teleconsult resources are available when addressing burn patients. In addition to Harborview Medical Center’s Burn capabilities the Western Regional Burn Disaster Consortium is another resource. The availability of these resources to support clinical care and decision-making may not be well communicated and might benefit from a concentrated information campaign.

A reference was made during the exercise debrief to the successful deployment of burn push-packs within a southern state. The burn push packs contained supplies necessary for providing care for burn patients and could be useful for facilities that don’t normally provide care for burn patients. Establishing similar burn push-packs may help healthcare providers in Washington in providing burn care during a disaster.

Behavioral Health

Emotional trauma, even for someone not physically injured by a disaster may still have a debilitating impact on the individual and any point in the disaster cycle. More training for peer recognition and support and professional level training needs to continue taking place. The concept and skills for behavioral health support need to be included in mass casualty response plans and training. Behavioral health support can be provided by non-healthcare specific personnel. Public Health, Medical Reserve Corps (MRC) and Non-Governmental Organizations (NGO) providing support in disaster (such as the American Red Cross and others) are excellent personnel to train in behavioral health support as they work with individuals experiencing disaster (including those that have secondary impact from a disaster and who may not have actually witnessed the disaster but may still be impacted by it.) Providing training and materials to a wide variety of responders will help in spreading the capability and awareness.

Behavioral health support is not just limited to the ‘victims’ of the disaster. Responders can also have their behavioral health significantly impacted by responding to disaster. It is recommended that individuals with specialized training in responder behavioral health support work with responders needing support. Though individuals trained in basic behavioral health support can help recognize signs of struggle and urge individuals to seek a higher level of professional support.

Courses and materials for training individuals in behavioral health support need to be ongoing and made available across the state.

Decontamination Capabilities

The potential for individuals to be contaminated with harmful substances can be quite high in mass casualty incidents. The contaminant will dictate the type and level of decontamination needed. It is important for healthcare to work with Fire Departments and

HazMat units when identifying the contaminant and potential health impacts. There are state resources that can assist with identification and management of contaminants – the 10th Civil Support Team, part of the National Guard. With hospitals increasingly having given up their Decon trailers (provided through federal funding and having exceeded their life expectancy) the ability for a hospital to provide decontamination for a large number of individuals may be difficult. Most hospitals can decontaminate one or two patients at a time in a brick-and-mortar shower area. Some hospitals have exterior built-in shower curtains and piping allowing for decontamination of multiple people at a time. Some facilities may depend on their local Fire Departments for assistance with decontamination. However, there is the potential that the Fire Department staff will be busy responding to emergencies in the community and unable to support decontamination at the hospital. Hospitals are advised to assess their decontamination capabilities and resources and build a plan based on what is available to them.

Interpreter Capabilities

Hospitals have specific requirements for providing interpreter services for patients and their families that may require interpreters with specialized medical interpreter training. During a declared disaster, particularly when there may be a surge of international individuals allowing the relaxation of interpreter requirements may help facilitate basic care delivery.

Consideration for Service Animals

Since service animals are indispensable to the person they serve it is important to consider the care needs of the service animals at the same time as care for the person. Establishing contact with veterinarians that provide care for service or working animals can go a long way in supporting the person’s care journey as well as providing medical care for an injured animal. Hospitals may want to consider identifying resources for care for service or working animals.

Objective 2

HCC and partners discuss DMCC patient distribution and coordination concerns during mass casualty incidents or concurrent incidents across WA state for a variety of scenarios crossing jurisdictions including triggers and activation of State DMCC or RMOCC for patient placement and load balancing.

Capability: Healthcare and Medical Response Coordination

Strengths

The (full or partial) capability level can be attributed to the following strengths:

Strength 1: Cross jurisdiction communications

Strength 2: More experienced responders sharing knowledge with less experienced responders

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Area for Improvement 1: There may be misconceptions about the DMCC’s capabilities and responsibilities during incident response.

Analysis: During the exercise discussions participants ascribed attributes of Incident Management to the DMCC’s. This included the ability to communicate critical information to medical facilities during a disaster or directing the use of resources. Although DMCC’s do communicate between EMS and hospitals, the information they are communicating concerns destination assignments for different patients and their triage levels. Other information related to critical situational awareness or resource management is more likely to come from the Northwest Healthcare Response Network healthcare coalition or the Washington State Department of Health. Managing expectations for the roles of the DMCC’s and the Northwest Healthcare Response Network would help to better align responder expectations.

Areas for Improvement 2: The mechanics for patient placement coordination across jurisdictional boundaries is unclear, including across international boundaries.

Analysis: Most of the time there is enough bed availability within the region so that the DMCC can make destination decisions within the region. When bed availability has been

exceeded there may be need for cross jurisdictional placements. While this may be accomplished for a patient here and there, the process for coordinating with neighboring DMCC’s for patient placement has not been smoothly worked out.

Areas for Improvement 3: Much more difficult and time-consuming to locate beds for transfer patients who may need specialty care without the resources and capabilities of the Washington Medical Coordination Center (WMCC) which lost funding.

Analysis: When a patient is at a smaller hospital and needs specialty care, a physician must make the calls to locate a bed and a physician willing to take over care of the patient. Specialty care capabilities can be few and far between which requires time spent trying to locate open beds and physicians able and willing to accept the patient. This takes time away from patient care for the physician working on the transfer placement.

When a patient is transferred between one facility and another there needs to be physician-to-physician handoff.

Areas for Improvement 4: Lack of understanding for the distinction between who places patients from the field and who places in-patients being transferred between facilities.

Analysis: Generally emergency responders and hospitals understand that the DMCC makes placement decisions for patients coming from an incident (in the field) to an emergency department for care. When it comes to making placement decisions for in-patients (patients already admitted to the hospital) many assume that it is also the DMCC that makes those decisions. Though the DMCC can see in-patient bed availability through WATrac, the information may not be reliable as bed assignments are being made constantly and generally managed by a hospital or healthcare system’s Transfer Center or Mission Coordination Center (or the function referred to by another name.) In a large-scale incident when there is a need to move multiple in-patients the Regional Medical Operations Coordination Center (RMOCC) would be activated through NWHRN’s Healthcare Emergency Coordination Center (HECC). The role of the RMOCC Medical Director is to contact the ‘Transfer Centers’ to determine capacity and capability for accepting transferring patients. The RMOCC Medical Director facilitates the physician handoff necessary for transferring care of a patient. These are activities outside the responsibilities of the DMCC. Education may be needed for emergency responders and others regarding the difference in responsibilities and capabilities between the DMCC and RMOCC when moving patients during a disruption.

Capability: Medical Surge

Strengths

The (full or partial) capability level can be attributed to the following strengths:

Strength 1: Having some of the largest hospitals taken out of the equation and simultaneous events in multiple regions really forced us to focus on regional assets and less traditional capabilities

Strength 2: Identifying what a big MCI would look like for all agencies and our community

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Area for Improvement 1: Sending “all pediatric ages” to a designated pediatric facility may overwhelm the facility when some ‘older’ pediatric patients may receive appropriate care at facilities that are not specifically pediatric facilities, thus making resources more available at the designated pediatric facility

Analysis: Generally, it is advisable to send pediatric patients to facilities that are prepared to care for pediatrics. However, when there is a mass casualty incident involving pediatric patients, it may be a better use of resources to further define pediatric patients by development size, age, and level of care needed. Adult hospitals and physicians can treat pediatrics to a certain degree, particularly if the pediatric is more developed, at the older end of being considered a ‘pediatric’ and without care needs that would be best managed in the pediatric acute care setting. Making these distinctions on how pediatric resources are best used in a disaster could help provide pediatric-specific care for those pediatric patients most in need of those resources and skills.

Establishing the parameters for adjusting where different ‘pediatrics’ are sent for treatment during a mass casualty incident would take agreements from pediatric and adult physicians and hospitals in advance of a disaster. This would require education for DMCC’s and EMS for these altered criteria.

Pediatric facilities are suggested to consider that adults arriving with their children to a pediatric facility may need to provide urgent care for an adult and to build in that awareness and capability into the pediatric facility’s emergency planning.

Objective 3

HCC and partners articulate use of the EMS Patient Movement Escalation Framework for Washington State when the need for patient care overwhelms the area’s capacity or capability for providing care and EMS resources for moving patients is significantly challenged.

Capability: Healthcare and Medical Response Coordination

Strengths

The (full or partial) capability level can be attributed to the following strengths:

Strength 1: Participants demonstrated clear awareness of the systems to request additional resources and the potential operational constraints in receiving and deploying those resources

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Areas for Improvement 1: The patient identification bands or tags that EMS and hospitals currently use are not standardized, they are not scannable into WATrac, nor do they sync with hospital electronic medical records which increase concerns around patient identification information and accuracy with patient tracking.

Analysis: Many EMS agencies around the state use patient identification bands on their mass casualty patients. These bands have a unique identifier bar code on them meant to help with patient identification and tracking. Many bands have separate, removable bar codes meant to be placed on patient record paperwork to assist with patient accountability, particularly when the patient’s name may not be known. Now that patient health records are mostly electronic there needs to be a way to scan the unique identifier into the electronic health record and into WATrac for the Patient Tracking module. There have been attempts in the past to introduce a standardized patient identification band with EMS across the state. However, either the bands themselves weren’t useful, or EMS agencies were not consistent with their use. Hospitals would like these unique identifier bands to connect with their electronic health record systems. Data entry mistakes would be lessened by staff not having to manually enter the information. There were several requests throughout this exercise discussion to find and establish a standardized patient identification band that would scan into WATrac and electronic health records.

Area for Improvement 2: The process for repatriation of Canadian patients back across the border is not well understood.

Analysis: Coordination planning across the US/Canadian border for EMS mutual aid has been in process for several years. It would allow EMS crews from either country to cross the border to provide EMS care for patients when the ambulance from the crossing country could reach the patient before ambulances from the host country could arrive. It would be worth exploring how Canadian patients, injured in the US would be repatriated to Canada, and vice versa for US patients injured in Canada. Is there a handoff at the border so that crews don’t actually cross the border or are there agreements for ambulances to transport across the border to a specified facility or location? Having a better understanding of the processes and agreements would provide EMS with a clearer understanding of their responsibilities.

Capability: Medical Surge

Strengths

The (full or partial) capability level can be attributed to the following strengths:

Strength 1: Sharing of information and experience between responders

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Area for Improvement 1: Use of alternate forms of transportation for moving green-triaged patients could free up some EMS resources.

Analysis: The number of green-triaged patients involved in a mass casualty incident usually far outnumber the numbers of yellow- and red-triaged patients. Green-triaged patients may not need the capabilities of a basic life support (BLS) ambulance and could safely be transported from the scene to locations for care using alternate forms of transportation, such as transit buses, school buses, vans or other multi-passenger moving vehicles. People being transported on these alternate vehicles would need medical supervision, with an individual with medical training overseeing the patients during transport. Many Assisted Living Facilities have vans they use for ‘resident’ outings which could be used. Memorandums of Understanding would need to be established with public transit or school bus companies for having their vehicles and drivers participate in a mass casualty patient movement activity. Medical Reserve Corps personnel or other similar personnel, if available,

could provide medical oversight during transport. Use of these alternate transportation methods could free up the BLS and Advanced Life Support (ALS) ambulances for treating and transporting patients with more severe injuries which is a better use of available resources.

Area for Improvement 2: Use of telehealth or teleconsultation could help to minimize the need for ambulances to transfer patients, particularly over long distances.

Analysis: If the healthcare system can support keeping a patient near their home and family it can go a long way to supporting the recovery of that patient and minimize the stress on the family. With patients needing specialty care that may not be available at the facility where the patient is currently located EMS would be required for transporting the patient to a specialty care receiving facility which could be hours away. The availability of telehealth or teleconsult services makes the knowledge of a specialist available to the local hospital to support ongoing local care. This then eases the burden on EMS services which then supports the ability of those EMS services to provide more localized care and transportation. Hospital administrations are encouraged to explore the telehealth and teleconsult capabilities and resources for extending care delivered in their facilities without the need for transfers to distant facilities.

Objective 4

HCC and partners Convey and tabulate their supply chain/resource management capabilities and needs during different significant mass casualty incident scenarios.

Capability: Continuity of Health Care Service Delivery

Strengths

The (full or partial) capability level can be attributed to the following strengths:

Strength 1: The survey was delivered as part of the participant feedback survey after the conclusion of the exercise, making it easier for the selected participants to complete the requested resource management information.

Strength 2: Though the collected information indicated that there would not be enough resources within the Network service area, the information corroborated the general feeling that during a mass casualty incident within the service area there would not be enough resources.

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Areas for Improvement 1: Low participation in the resource management survey diminishes the accuracy of the information.

Analysis: About 20% of survey recipients completed the supply chain and resource management survey that was included with the exercise participant survey after the exercise. The information received indicated there would not be enough resources within the state to support providing critical patient care in the aftermath of a significant mass casualty incident.

Objective 5

HCC and partners participate in critical communications processes related to the World Cup 2026 Special Event in Washington State with 75% accuracy for successful delivery and receipt of messages.

Capability: Healthcare and Medical Response Coordination

Strengths

The (full or partial) capability level can be attributed to the following strengths:

Strength 1: Participants were able to receive and reply to messaging across several different communication platforms.

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Areas for Improvement 1: Response rate for Alert Media emails announcing the start of the exercise was 58% meaning that just over half of the emails sent were responded to diminishing the possible reach during an emergency.

Analysis: Of the 465 recipients that were sent the email communication regarding the exercise taking place the next day 197 individuals did not respond to the email. That equals 42% of the emails not being responded to. It is unknown whether this response rate was due to individuals being away from their email or whether the email addresses were incorrect or outdated. Exercise registrants included their email addresses in the registration. For registrants that were not already in the Networks contact management system the email

addresses supplied as part of registration were used. There was at least 1 instance of an email having been entered incorrectly into the registration. It may be worthwhile investigating whether the 197 non-respondents were already in the contact management system, indicating a higher likelihood that the email address was correct. Validating and maintaining the information in the contact management system is vital to the Network’s ability to connect with partners during an emergency or disruption.

Area for Improvement 2: Response rate for the WATrac alerts was mixed, diminishing the possible reach during an emergency.

Analysis: When looking at the breadth of agency types that received the WATrac alert about the exercise which included a request to updated beds for the exercise, the response rate appears to be very low at 14%. When digging down into the data there are much brighter spots. For example, of the 105 notified hospitals 75 acknowledged receipt of the alert, or 71%. Of the 38 Local Health Jurisdictions notified, 18 acknowledged receipt or 48%. For First Responders 210 were notified and 18 acknowledged receipt of the notification representing 99%. Of the Long Term Care partners numbering 549 receiving notification, 41 acknowledged receipt or 8%.

The discrepancies in response rate may be attributable to several factors: The alerts can arrive by text message and /or email. Acknowledgement requires signing into the WATrac system. If someone doesn’t remember their login or password that could frustrate them, limiting participation. Additionally, if the person receiving the alert is away from their phone or computer it is possible they may not receive the alert in a timely manner. This may happen because many healthcare workers may be away from their computers providing patient care or they may not be allowed to carry their phones with them while working with patients. The overarching concern is that staff may not understand that acknowledgements are tracked, making their act of acknowledgement all the more important. Communicating the importance of acknowledging alerts to users is important as it signals our ability to quickly communicate urgent information that they need to act upon.

Appendices

Appendix A: Improvement Plan

This IP is developed for the Northwest Healthcare Response Network as a result of the Confluent Goal MCI virtual tabletop exercise conducted on May 6, 2026.

*Planning, Organizing, Equipment, Training, Exercising

Issue/Improvement	Improvement Action	Capability Element*	Primary Responsible Org/ Point of Contact	Status/ Complete Dates
Healthcare and Medical Response Coordination				
Obj 1: Blood Centers not connected into the Incident Management response mechanisms to know when and where mass casualty incidents are occurring, slowing down the delivery of critical blood products for trauma care.		Organizing		
Obj 1: Additional resources available for a mass casualty incident response within a community or region are not well communicated or coordinated		Planning		
Obj 1: International visitors may be unfamiliar with US healthcare delivery and insurance requirements, which may cause frustration and delays in care delivery		Planning		
Obj 1: Concerns around patient tracking and information-sharing logistics, guidelines and parameters		Planning		

for connecting injured patients, hospitals, call centers, Family Reception Centers and those looking to reunite with missing individuals				
Obj 1: Some patients from a disaster may get ‘lost’ when they bypass the normal patient transportation, documentation and accountability processes		Planning		
Obj 2: There may be misconceptions about the DMCC’s capabilities and responsibilities during incident response		Training		
Obj 2: The mechanics for patient placement coordination across jurisdictional boundaries is unclear, including across international boundaries.		Planning		
Obj 2: Much more difficult and time-consuming to locate beds for transfer patients who may need specialty care without the resources and capabilities of the Washington Medical Coordination Center (WMCC) which lost funding		Organizing		
Obj 2: Lack of understanding for the distinction between who places patients from the field and who places in-patients being transferred between facilities		Training		
Obj 3: The patient identification bands or tags that EMS and hospitals		Equipment		

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use are not standardized, they are not scannable into WATrac, nor do they sync with hospital electronic medical records which increase concerns around patient identification information and accuracy with patient tracking				
Obj 3: The process for repatriation of Canadian patients back across the border is not well understood		Training		
Obj 5: Response rate for Alert Media emails announcing the start of the exercise was 58% meaning that just over half of the emails sent were responded to, diminishing the possible reach during an emergency		Organizing		
Obj 5: Response rate for the WATrac alerts was mixed, diminishing the possible reach during an emergency		Organizing		
Continuity of Health Care Service Delivery				
Obj 4: Low participation in the resource management survey diminishes the accuracy of the information		Organizing		
Medical Surge				
Obj 1: In a disaster patients may seek "medical care" wherever they perceive healthcare to be available which may mean patients present at facilities that are not equipped or		Planning		

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capable of providing the level of medical care they actually need.				
Obj 1: Hospitals that don’t traditionally manage specialty care patients (peds, burns, etc.) want more resources of support for providing specialty care when normal transfers are not possible		Planning		
Obj 2: Sending “all pediatric ages” to a designated pediatric facility may overwhelm the facility when some ‘older’ pediatric patients may receive appropriate care at facilities that are not specifically pediatric facilities, thus making resources more available at the designated pediatric facility		Planning		
Obj 3: Use of alternate forms of transportation for moving green-triaged patients could free up some EMS resources		Planning		
Obj 3: Use of telehealth or teleconsultation could help to minimize the need for ambulances to transfer patients, particularly over long distances		Planning		

*Planning, Organizing, Equipment, Training, Exercising

Appendix B: Exercise Participants

Participating Organizations	
ARES Amateur Radio	MultiCare Good Samaritan Hospital
Asotin County Health Department	MultiCare Mary Bridge Children’s Hospital
Astrum Health	MultiCare Tacoma General Hospital
Bainbridge Island Health & Rehab	North Olympic Healthcare Network
Belmont Terrace	Northwest Eyelid & Orbital Specialists
Benton Franklin Health District	Northwest Healthcare Response Network
Bloodworks Northwest	Northwest Orthopaedic Specialists
Central Washington University	Olympia Orthopaedic Associates
Chelan Douglas Health District	Orchard Park Health Care Rehab
City of Mercer Island	PeaceHealth St Joseph Hospital
Clark County	PeaceHealth United General Med Ctr
Coalition on Inclusive Emergency Planning	Pierce County Emergency Management
Columbia Basin Hospital	Proliance Puget Sound Surgery Center
Columbia County Public Health	Proliance Surgeons
Columbia Lutheran Home	Prosser Memorial Health
Columbia River Eye Surgery Center	Protean Preparedness WRAP-EM
Common Spirit St Anne Hospital	Providence
Common Spirit St Francis Hospital	Providence Hospice Spokane
Common Spirit St Joseph Medical Center	Providence Regional Med Ctr Everett
Common Spirit St Michael Medical Center	Providence St Peter Hospital
Community in Motion	Puget Sound Transitional Care
Confluence Health	Regency Harmony House
Cowlitz County Dept of Emergency Mgt	Samaritan Healthcare
Cybersecurity & Infrastructure Security Agen.	Sea Mar Community Health Centers
Digestive Disease and Endoscopy Center	Seattle Children’s Hospital
ENT Center	Seattle Human Services Department
EvergreenHealth-Kirkland	Seattle Roots Federally Qualified Health Ctr
EvergreenHealth-Monroe	SharpeVision, PLLC
Eye Associates Surgery Center	Skagit Regional Health
Fairchild Air Force Base	Skagit Regional Health – Cascade Valley Hosp
Fircrest Rural Health Clinic	Smoky Point Behavioral Hospital
Fred Hutch Cancer Center	Snohomish County Emergency Management
Garfield County Public Health District	Snohomish County Human Services
Gig Harbor Fire & Medic One	Sound Transit
Grant County Health District	Spokane Regional Health District
Grays Harbor Community Hospital	Swedish Health System Seattle
Harbor Regional Health	Tacoma Pierce County Health Department
Hopelink Mobility Management	Telecare
Horizon Hospice and Palliative Care	Thurston County Emergency Management

International Community Health Services	Thurston County Public Health
Island Health	US Army
Jeffcom 911 Communications	UW Medicine Burn Center
Kaiser Permanente	UW Medicine Harborview Med Ctr
King County Emergency Management	UW Medicine Montlake
King County Metro Access	Valley Medical Center
Kitsap Public Health District	WA Department of Health
Kittitas County Public Health	WA Department of Social & Health Services
Kittitas Valley Healthcare	WA Emergency Management Division
Klickitat Valley Health	WA Military Dept 10th Civil Support Team
Lincoln County Public Health	Walla Walla Co Dept of Community Health
Linden Grove Health Center	Walla Walla Co Emergency Management
Lynnwood Post-Acute Rehabilitation	Western Regional Alliance for Pediatric EM
Marianwood Health and Rehabilitation	Western WA Med Svcs Emergency Comms
Milton Freewater Health and Rehabilitation	Whatcom Co Sheriff’s Office Div of Em Mgt
MultiCare Auburn Medical Center	Whatcom County
MultiCare Covington Medical Center	Willapa Harbor Hospital
MultiCare Deaconess Hospital	

Appendix C: Evaluation of Exercise Design, Logistics and Conduct

This section provides an analysis of the exercise design, logistics and conduct.

Aspect: Exercise Concept and Foundation

Strengths

The partial capability level can be attributed to the following strengths:

Strength 1: The scenarios were well thought out, timely and relevant

Strength 2: Good initial planning

Strength 3: Good use of limited time for the number of participants, the scenarios and the discussions

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Areas for Improvement 1: Active participants seemed narrow to EMS and hospitals, with other participants not sure how to engage or participate

Analysis: The structure and requirements of the Medical Response and Surge Exercise (MRSE) that was a coalition grant requirement part of this exercise somewhat narrowed the exercise parameters to EMS patient movement and hospital surge response. Fortunately, coalitions were allowed, this year, to create a ‘special event’ exercise around the World Cup activities which allowed some flexibility in the exercise design. Future exercises are likely to be more narrowly focused specifically on hospital evacuation and surge response for hospitals and EMS. Other exercises might allow for wider organization types to participate more broadly.

Aspect: Announcement of Exercise, Registration

Strengths

The partial capability level can be attributed to the following strengths:

Strength 1: Appreciated the virtual option for the exercise

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Areas for Improvement 1: It was not clear to registrants that their registration confirmation email contained a unique user link to the meeting with many people disregarding the registration confirmation email only to discover they couldn’t enter the Zoom meeting.

Analysis: When the Zoom meeting was set up registration was required as a way for exercise organizers to know who was attending, from what organization, what organization type and from what Region within the state. It was unknown at that time that requiring registration would establish a unique link for each registrant. Many people didn’t understand that the confirmation email they received contained their unique link, so just disregarded the email. When this was discovered, communication went out to registrants to look for their confirmation email or request the email be resent. The Exercise logistics team built in extra staff tasks to remind registrants they needed their unique link and to send out requested confirmation emails to those that didn’t have theirs. This definitely added complexity and frustration on the part of the exercise staff and exercise participants.

Area for Improvement 2: No text blast that the exercise had started.

Analysis: Exercise participants that have participated in the MRSE exercise in the past are familiar with receiving blast text and email messages that signal the start of the exercise. With this year’s exercise being a MRSE ‘special event’ exercise it did not follow the usual format. The communications portion of the exercise (the blast texts, emails and WATrac communications) were sent out the day before the exercise (reminding people about the unique link for access to the exercise) and the day of the exercise through WATrac with an alert that the exercise had started and a bed update request. Next year’s exercise is likely to be a more traditional MRSE exercise encompassing these more familiar aspects of the exercise.

Aspect: Exercise Conduct

Strengths

The partial capability level can be attributed to the following strengths:

Strength 1: Participants particularly appreciated being able to exercise with their regional partners for Modules 1 and 2 before working with all participants in Module 3

Strength 2: The large turnout made for a lot of diverse perspectives with the right people involved for the scenarios presented.

Strength 3: The facilitators were terrific and kept the discussions moving along well.

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Areas for Improvement 1: Some critical partners were missing from some of the regional breakout rooms, making thorough discussion difficult

Analysis: It was challenging to communicate the exercise invitation to every possible participant type across the state. Different strategies were used for sharing the information about the exercise and the invitation to register. With this year’s exercise being a non-traditional MRSE exercise the possible participants were broader than normal, which added to the difficulty in adequately reaching potential participants. With next year’s exercise likely to be a more traditional MRSE exercise there will be a narrower participant group making it easier to communicate the invitation to participate.

Area for Improvement 2: Participants wanted more visuals and documentation supporting the exercise.

Analysis: Normally, for a tabletop exercise a Situation Manual is created and distributed to participants. The Situation Manual includes all the information about the scenarios and a list of potential questions for discussion. With the complexity of 9 breakout rooms with a total of 18 scenarios within Modules 1 and 2 it was more challenging to prepare and distribute a Situation Manual. More time will be built into the exercise design schedule for future exercises to ensure there is time to complete documentation for participants.

Area for Improvement 3: Use of “white board” to visually capture important points from the discussion. Desire for actionable processes to come from the scenarios and discussions

Analysis: Using an electronic ‘white board’ (a feature of many virtual meeting platforms) would have been beneficial it was not a tool that was considered. Additional Facilitator and Scribe training would have been necessary for implementing this capability during Confluent Goal. It will be considered for future exercises.

Area for Improvement 4: Participants wanted more detail for the patients, particularly the red- and yellow-triaged patients.

Analysis: Some exercise participants wanted more detail about the signs and symptoms of the red- and yellow-triaged patients to use when making transport and destination decisions. Providing this level of detail was outside the scope and parameters of this year’s exercise. Future exercises may contain more patient details to aid decision making.

Appendix D: Participant Survey “Things I liked” and “Things I didn’t like”

Things I liked	Things I didn’t Like
• Diversity of participants from across the state • Demonstrated Collaboration and Cooperation • Breadth of scenarios increased knowledge sharing across the state • Exercise format with regional breakout rooms before whole group discussions • Learning from other’s experiences • Virtual format allowed for broader participation • Plausible scenarios • Active participation • Knowledgeable facilitators	• Some critical partners were missing or underrepresented • Need definitions for jargon • Non-emergency responder entities unsure how to help or engage to support a big MCI • Issues with exercise duration • Wanted more time working in the regional breakouts • Individualized Zoom links were problematic • Needed more resources for Facilitators and Scribes related to managing the technical aspects of their breakout rooms • Future exercises to examine communications outages and be less operational/tactical

Appendix E: Things I learned that I will take back to my organization

• Encouraging creative problem solving • Streamlining response procedures • Foster better understanding between hospitals, EMS, and Fire for medical care delivery challenges and constraints • More exercises • Installation and use of redundant communication • Foster collaboration between different types of entities to support each other in disaster • Increase ability to care for pediatrics or other specialty care needs • Cross-training staff in emergency procedures and capabilities • Emergency messaging to staff • Fostering better cross jurisdiction knowledge with partners to help support each other in disaster • Increasing situational awareness and information-sharing • Develop and implement scarce resource planning • Develop alternate patient transport capabilities
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Appendix F: What NWHRN can do to further support my organization

- More exercises like this one and meeting hosting
- More support for resource requesting
- More support for resource requesting and availability
- Information about how Medical Reserve Corps (MRC's) could support local response
- Training for MCI communication and creating “helicopter” view
- Develop redundant communications for NWHRN not dependent on cell, landline or internet-based technologies
- Foster coordination and sharing best practices between agencies
- Increasing situational awareness for partners regarding disaster activations

Appendix G: Partner plans that would be helpful for future responses

- Plan sharing
- Klickitat county
- NWHRN
- Regional hospitals
- EMS districts
- Hospital surge plans
- Dispatch and communications as they apply between fire, EMS and hospitals
- Okanogan Emergency Management and local Ems for Chelan, Douglas and Okanogan County
- Radio communications and interoperability that crosses regions
- Below Lewis County is an unknown. Include OHSU (and other Oregon facilities) in these discussions may be helpful. Worry that south Lewis County and below feels unsupported
- Train our CERT in collaboration with our healthcare providers to assist them
- Mass fatality plans for Whatcom County would be really helpful
- Whatcom County and Snohomish County MCI plans
- Police, Fire, Schools and other facilities
- We need to compare local and regional plans to see what is overlap/missing in the plans
- Capital Medical Center and St Peter Hospital

Appendix H: Recommendations for future exercises

- Rural-based scenario (ie overwhelming MCI related to bus crash, hazmat incident, train derailment in small town) and how responder response and patient transport can be achieved from rural to metro when resources are scarce in rural settings
- Include telecommunications internet failure/overload
- Regional in-person functional exercises
- Continue to provide facilitated breakout sessions by region
- More information about numbers, availability and location of ambulances and other emergency vehicles
- Wildfires big power/phone outages, big cyber-attack, large earthquake
- Ensure broader participation – hard to make decisions during an exercise when critical participants are not there
- Floods, fires, power failures

Appendix G: Abbreviations

AAR-IP	After Action Report – Improvement Plan
ALS	Advanced Life Support
ASPR	Administration for Strategic Preparedness and Response
BLS	Basic Life Support
DMCC	Disaster Medical Coordination Center
EMS	Emergency Medical Services or System
ESF-8	Emergency Support Function – 8 Public Health & Medical
FIFA	Fédération Internationale de Football Association
FOUO	For Official Use Only
HCC	Health Care Coalition
HECC	Healthcare Emergency Coordination Center
HIPAA	Health Insurance Portability and Accountability
MCI	Mass Casualty Incident
MOU	Memorandum of Understanding
MRC	Medical Reserve Corps
MRSE	Medical Response and Surge Exercise
NGO	Non-Governmental Organization
NWHRN	Northwest Healthcare Response Network
OHSU	Oregon Health & Science University
RMOCC	Regional Medical Operations Coordination Center
TTX	Tabletop Exercise
US	United States
WMCC	Washington Medical Coordination Center
WRAP-EM	Western Regional Alliance for Pediatric Emergency Management

