Coalition Surge Test

An Exercise for Assessing and Improving Health Care Coalition Readiness

HANDBOOK FOR PEER ASSESSORS AND TRUSTED INSIDER

JANUARY 2017

PREFACE

The Coalition Surge Test (CST) includes a user-friendly peer assessment low/no-notice exercise that helps health care coalitions identify gaps in their surge planning. Low/no-notice exercising is important in assuring that health care coalitions can transition quickly and efficiently into “disaster mode” and provide a more realistic picture of readiness than pre-announced exercises. The exercise is designed to be challenging and is intended to support continuous improvement.

The audience for this document is the small assessment team that plans and administers the CST and a “trusted insider” (i.e., a member of the assessed coalition who agrees to assist in planning). Because of the nature of low/no-notice exercises, the players will receive most of their instructions from the assessment team on the day of the CST. This document briefly describes the motivation behind the CST, the resources it requires, and instructions on how to use it. Detailed step-by-step instructions, along with data collection and reporting tools, are provided in two accompanying Microsoft Excel tools.

Development of the CST was sponsored by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response. The exercise was developed by the RAND Corporation and was informed by pilot tests at four health care coalitions. ASPR encourages awardees and HCCs to consult their field project officer to receive technical assistance and resources for completing the CST.

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ABBREVIATIONS

Acronym	Definitions
EMS	emergency medical services
EVAC	evacuating facility assessor
FAQs	frequently asked questions
LEAD	lead assessor
POC	point of contact
RHCC	regional health care coordination center
WebEOC	web-based emergency operations center

Introduction

The Coalition Surge Test (CST) is a user-friendly peer assessment low/no-notice exercise that health care coalitions can use to identify gaps in their surge planning. Use of the CST is a Hospital Preparedness Program (HPP) requirement and can be initiated by any member of a coalition.

The CST scenario involves simulated evacuation of at least 20 percent of a health care coalition's acute-care bed capacity or other patient care facilities and take four or five hours from start to finish. It is designed to support coalitions in identifying strengths, gaps, and corrective actions. While facility evacuations are perhaps not the most common type of surge situation, they have happened several times during natural disasters (e.g., Hurricane Sandy) and usually involve enough patients to stress entire coalitions, which is a key purpose of this exercise.

The Coalition Surge Test is a user-friendly peer assessment low/no-notice exercise that helps coalitions identify gaps in their surge planning.

The CST is designed for use by peer assessors selected by the coalition—anyone with enough coalition expertise to provide meaningful feedback, but with enough distance to provide an objective assessment, may make a suitable peer assessor. The CST is also designed to work in a broad range of coalitions, including those that do not play an active, coordinating role during responses.

This handbook provides a *brief* overview of the Coalition Surge Test, the capabilities it tests, key features, and staff and resource requirements. Detailed information needed to run the CST (including step-by-step instructions, scripts, and data collection tools) is provided in Excel tools, described below.

Overview. The CST tests a coalition's ability to work in a coordinated fashion to find appropriate destinations for patients in a simulated evacuation of up to three patient care facilities. The entire CST will last approximately four or five hours and proceeds as follows:

- ***Phase 1: Table Top Exercise with Functional Elements and Facilitated Discussion (180-210 minutes).*** The exercise during the first phase lasts 90 minutes, but a 60-minute advance warning is given before the exercise begins. Specifically, at T minus 60 (i.e., 60 minutes before the official exercise start time), the assessment team calls the evacuating patient-care facilities to inform them that they need to stand up their hospital command centers. After this notification (and during the 60 minutes prior to start of the exercise), an assessment team of one or (optionally) two assessors arrives at each evacuating facility to inform leadership of the need to evacuate within approximately four

hours (assessors may add scenario details relating to the reason for the evacuation but should encourage players to accept the need to evacuate and not spend time questioning the decision to do so). Evacuating facilities are instructed to take a current patient count and to work (using whatever communication mechanisms it would during a real evacuation) to find appropriate destinations and transportation for each patient. However, there will be ***no movement of actual patients***. A patient will be considered "placed" when (1) there is verbal or written (i.e., email) agreement from another facility that it can provide an appropriate destination for the patient, and (2) players have identified appropriate transportation assets that could move patients to their new locations. The exercise ends when all patients are placed or after 90 minutes, whichever comes first.[1]

After a break (which can be up to several hours), the participants will join a facilitated discussion that explores issues raised during the exercise, including more detailed transportation planning, the capacity of receiving hospitals, patient tracking and public information, the needs of at-risk patients, and continuity of operations. Players may remain at their duty stations and participate via teleconference, web-based emergency operations center (WebEOC), or another communication platform.

- ***Phase 2: After Action Review (30–45 minutes).*** An after action review concludes the CST and consists of an assessment of strengths and weaknesses and corrective action planning. Ideally this should occur immediately after Phase 1, but it can be scheduled for a later date to maximize health care executive participation. If the after action review is scheduled in advance of the CST taking place, it may or may not occur on the same day as the CST. This phase should be conducted as soon as possible after Phase 1 and ideally the same day, but must occur within 30 days of Phase 1.

"Low/No-Notice" Features of the Exercise. The exercise is designed to test the coalition's ability to respond to a significant incident without prior notice. This helps reduce the temptation to ensure that the "A-team" is on duty during the exercise. Moreover, it helps prepare coalitions for incidents (e.g., transportation accidents, bombings) that occur without prior warning. Thus, members of the coalition should be notified that an exercise will occur within a two-week window, but they will not know the exact date and time. Assessors will select which facilities will play the role of "evacuating" facilities, but they should not divulge this information to coalition members. As a result, facilities will *not* know ahead of time whether they are playing the role of "evacuating" or "receiving" facility. Moreover, no attempt should be made ahead of time to determine which coalition partners the evacuating facility/facilities will call for help.

[1] Note that the purpose of counting placed patients is increase realism and seriousness of play by forcing players to communicate about specific patients, locations, and assets. Given the simplifications built into the exercise, therefore, the numbers produced by the exercise should be regarded only as approximations.

Indeed, an important purpose of the exercise is to see whether the evacuating facility knows whom to call and whether it is able to communicate with them at a moment's notice. Initially, coalitions may wish to run the exercise during "normal business hours." Over time, however, they may wish to try running it during evenings, weekends, and holidays.

In short, the exercise is designed to be challenging. Some coalitions may not be able to launch and complete the exercise in the allotted time. However, struggling with a challenging exercise may be more helpful in the long run than succeeding with an easier exercise. The exercise is not intended to assess individual performance or compliance with federal or other requirements. This is underscored by the decision to have coalitions select their own peer assessors, instead of using outside assessors. Select assessors who you trust and who can provide tough but constructive feedback.

Applicable to Coalitions Without Active Response Role. Some coalitions have regional command or coordination centers designed to play an active role during a response, but others do not. As noted above, evacuating facilities should act as they would during a real evacuation to find spaces, whether this involves coordinating with a coalition command center, reaching out to receiving facilities individually, or otherwise.

Capabilities Tested. The exercise simulates a hospital/facility evacuation, but its ultimate goal is to use this scenario to test a set of more generally applicable capacities, including emergency operations coordination, information-sharing, and medical surge capacity. More specifically, it tests the following:

- the ability of an evacuating facility and its coalition partners to rapidly shift into disaster mode
- whether an evacuating facility knows whom to contact upon learning of the need to evacuate, and whether it can reach them at a moment's notice
- coalition members' ability to communicate and coordinate quickly to find and match available beds and transportation resources with those needing to be evacuated (this may or may not involve an activated coalition command center)
- the coalition's ability to perform these tasks with existing on-site staff without excessive guidance or prompting from leadership.

Resources Required. The exercise requires the following players, peer assessors, and resources:

- *Trusted insider*. A "trusted insider" will serve as an internal point of contact (POC) for the coalition. Once the coalition has decided to run the exercise, this person should have the authority to recruit peer assessors, ensure that the necessary permissions have been

obtained, and ensure that peer assessors have access to evacuating facilities and (if relevant) to the regional health care coordination center (RHCC). The trusted insider will know the exact date and time of the exercise but should not divulge it to other coalition members or staff.

- *Players*. The table top exercise portion of the exercise requires each evacuating facility to involve a minimal complement of personnel to staff the facility's command center. Players will be asked to obtain a current patient count and to work with coalition partners to identify appropriate destinations and transportation for all patients. Other players include whomever the evacuating facility (or facilities) chooses to contact after the start of the low/no-notice exercise, as well as emergency medical services (EMS) or other entities responsible for patient transport. In some (but not all) coalitions, this may include staff in a coalition command center or other regional coordination center, state or local public health and emergency management agencies, and others. As a result, it may not be possible to predict with certainly who will participate in the exercise. Each facility contacted to place evacuating patients will need to provide at least one staff member who can respond authoritatively to evacuating facility requests to place patients. Note that the need to judge the "appropriateness" of destinations will require at least some players with strong clinical backgrounds. These players should also participate in the facilitated discussion portion of the exercise (via teleconference, WebEOC, or another platform). In addition, coalitions should include any other partners needed to have a robust discussion of the topics described in the three "Discussion" tabs found in the LEAD Excel tool.

Table 1. Personnel Required

Players	Peer Assessors
• Minimal complement of command staff at each evacuating facility • One senior staff member at each facility receiving simulated patients • EMS/patient transport staff	• A LEAD assessor in the regional coordination center or other appropriate location • An EVAC assessor at each evacuating facility • A Trusted Insider who serves as an internal point of contact for the coalition

Peer assessors. The exercise requires an evacuating facility assessor (EVAC) at each evacuating facility to observe activity during the 90-minute table top exercise. In addition, a lead assessor (LEAD) is needed to launch the exercise (see below) and facilitate the discussion in Phase 1. The LEAD assessor works with the trusted insider to identify the best location from which to execute these functions. For instance, if the coalition plans call for standing up a regional command center, the LEAD should be stationed there. *The LEAD assessor may recruit someone to assist with the note-taking and logistics, especially during the facilitated discussion.*

No assessors are required for facilities that receive patients or for organizations providing transportation.

The peer assessors should be available to accommodate any last-minute planning immediately before the exercise and continued conversations afterwards. The assessment team is responsible for selecting the exact date and time of the exercise. As noted above, in order to maximize the "surprise" element, the *assessment team should not divulge the date and time to anyone in the coalition*. However, they should work with the trusted insider (see below) to identify a two-week window that can be shared with coalition members.

- *Laptop computers*. Each LEAD and EVAC assessor needs a laptop to operate the Excel tools provided (see below). The devices should be capable of running Excel "off-network" in order to ensure full functionality during the exercise. In addition, for each evacuating facility, EVAC should provide printed paper copies of three simple tables (described below) to facility command staff.

- *Physical space for the facilitated discussion*. While many participants may join by phone or information sharing platforms, coalitions may wish to convene at least some of the players in a single location (e.g., a coalition command center). Be mindful of the fact that some command centers are arranged in rows, which might make face-to-face discussion difficult. If this is the case, you may wish to select a different location for the discussion.

Tools and Training Materials. Table 2 provides a complete list of tools and materials provided with the Surge Test.

Table 2. Tools and Materials Included in the Surge Test

Before the Exercise	During the Exercise
• Handbook for Peer Assessors and Trusted Insider (this document) • Preparation Checklist for the Trusted Insider (Appendix A of this document)	• LEAD Tool: Excel tool for LEAD assessor • EVAC Tool: Excel tool for EVAC assessors (one per evacuating facility)

- *Handbook for Peer Assessors and Trusted Insider.* This is the document you are reading right now, which provides an introduction and overview of the exercise. It will be useful to the trusted insider and other coalition partners, members of the assessment team, and anyone else interesting in learning about the exercise. However, this manual is intended to provide only the "big picture" of the exercise. Detailed directions on running the exercise and collecting data are contained in to the Excel tools described below.
- *Preparation Checklist for the Trusted Insider*. This document (located in Appendix A in this handbook) describes what the trusted insider should do to facilitate the CST. Most importantly, the trusted insider selects an assessment team and works with LEAD to identify a two-week (or longer) window during which the exercise may occur and provides a list of

patient care facilities to the assessment team, along with information on the number of beds and (if possible) an average daily patient count. The assessment team will use this information to decide which hospitals will be selected to serve as "evacuating" hospitals. Others may be asked during the exercise to serve as "receiving facilities."

- *LEAD and EVAC Excel tools.* The Excel tools are used by the peer assessors before and during the exercise itself. Each tool includes sequentially organized tabs that may be viewed by clicking on each tab's name at the bottom of the screen. Each Excel tool includes the following components:

    - *Overview*. This tab contains a summary of the overall flow of the exercise and details how each assessor's activities relate to what the other assessors are doing.

    - *Preparation*. This tab contains a checklist that tells assessors exactly what they need to do to prepare for the exercise, whom they need to work with, and when they need to do it.

    - *Sequentially organized tabs for each part of the exercise*. The remaining tabs contain detailed instructions for each phase of the exercise, including the table top exercise, facilitated discussion, and After Action Review. The tools provide detailed checklists, scripts (to be used when assessors must communicate information to players), places to enter data, and simple data displays.

Before the Exercise

Preparation for the exercise should normally begin one to six months before the exercise. As noted above, the Excel tools and materials described above provide detailed checklists to guide pre-exercise planning. The purpose of this section is not to repeat all the information in the checklists, but to provide a short narrative describing the most important activities. Readers should consult the Excel tools for more detailed instructions.

The trusted insider identifies the assessment team and informs the coalition of the upcoming low/no-notice exercise. The trusted insider will inform coalition members that a low/no-notice exercise is coming, but he or she should not divulge the exact date and time. Appendix B provides a brief communication template that describes the general requirements of the exercise, but without divulging details that might compromise the exercise's low/no-notice character. Next, the trusted insider will create two lists and share them with the assessment team:

- *Evacuating facilities*. The trusted insider creates a list of patient care facilities (e.g., hospitals, skilled nursing facilities) that could play the role of evacuating facilities during the exercise. Select facilities that are likely to produce enough evacuating patients to

stress the whole coalition (i.e., totaling 20 percent of the coalitions total acute care beds). Identify backup facilities as well, in case some decline to participate when called. Include information on bed count and average daily patient count, which might help the assessment team select evacuating facilities. The LEAD Excel tool provides a table for organizing this information.

- *Participants for the facilitated discussion.* The Trusted Insider assembles contact information for all coalition partners who should be involved in the facilitated discussion. The list should include all personnel needed to have a robust discussion of transportation planning, ensuring the capacity of receiving facilities, patient tracking and public information, needs of at-risk patients, and continuity of operations. The LEAD tool provides a table for organizing this information. The trusted insider will use this list to contact facilitated discussion participants immediately after the evacuating facilities have been notified.

The assessment team plans (*but does not divulge*) exercise details. The assessment team (led by the LEAD assessor) will use facility information provided by the trusted insider to identify a facility (or set of facilities) whose evacuation would adequately stress the coalition. As a rule of thumb, assessors should seek to identify facilities whose evacuation would surge the coalition to 20 percent above normal acute-care bed capacity.[2] The LEAD tool assists in selecting a specific exercise time and date and identifying evacuating facilities. The LEAD assessor is also responsible for ensuring that other assessment team members have access to exercise tools and for convening a "check-in" meeting with the assessment team and the trusted insider approximately one week before the exercise.

The LEAD assessor and trusted insider select a location from which they can observe and facilitate the exercise. LEAD should work with the trusted insider to identify an appropriate location for running the facilitated discussion and After Action Review, and both parties should assemble at that location 60 minutes before the start of the table top exercise. If the coalition's plan calls for standing up a regional command center, LEAD assessor should be positioned there.

During the Exercise

Immediately Before the Exercise. Assessment team members should assemble at their locations for the exercise. Specifically:

- Each EVAC assessor should be stationed near the hospital or other facility that has been selected to play the role of "evacuating facility" (there should be one EVAC

[2] For instance, if the total acute-care bed capacity of patient care facilities in the coalition is 100, the exercise should seek to "evacuate" a hospital with at least 20 acute-care beds.

assessor for each evacuating facility).

- The LEAD assessor and trusted insider should be stationed at the chosen location (see "Before the Exercise" above), and both should assemble at that location 60 minutes before the start of the table top exercise.

The two groups of assessors should verify that they can maintain telephone and text contact with each other and go over any last-minute details that need to be resolved before the exercise.

Initiating the Table Top Exercise Portion of the Exercise. The LEAD assessor places a telephone call to a POC at each selected evacuating facility and informs him or her that the exercise will begin in 60 minutes (however, the assessor should instruct the evacuating facility not to begin exercise play until the assessment team arrives). If the first facility declines, LEAD should call another facility on the list provided by the trusted insider.

Upon establishing contact with the evacuating facility POC and confirming participation, LEAD will call or text each EVAC assessor and instruct him or her to proceed to the evacuating facility/facilities. Upon arriving, each EVAC will meet the facility POC and proceed to the hospital/facility command center. Once in the command center, each EVAC will deliver spoken instructions to the assembled players (using a script provided in the EVAC tool) and provide three simple Microsoft Word worksheets (accessed by double-clicking the Word icon at the bottom of the "Preparation" tab in the EVAC tool) that the hospital will use to record its current patient count, destinations, and transportation for patients. Each EVAC will answer any questions and then press the Start button in the EVAC tool, which will start the 90-minute exercise clock.

If the facility does not contact a regional coordinating center, the assessment team should make no attempt to encourage them to do so.

Notifying Players of the Time for the Facilitated Discussion. After LEAD notifies the evacuating facility (or facilities), he or she will instruct the trusted insider to make contact with a predetermined group of coalition members, informing them that an exercise has begun and inviting them to participate (via conference call, WebEOC, or other platform) in the facilitated discussion at a designated time. The notification can be made by group email, group text, or telephone, at the discretion of the coalition insider. The facilitated discussion may be scheduled immediately following the table top exercise or later in the day. The trusted insider should advise on which approach is likely to result in high attendance.

Key Activities During the Table Top Exercise. Once play has begun, the evacuating facility should focus on contacting the coalition members it would contact in a real evacuation scenario. Each EVAC can answer procedural questions but should otherwise sit back and observe throughout the 90-minute duration. During the table top exercise, each EVAC should

record observations about the evacuating facility activities using a qualitative checklist provided in the EVAC tool. *If the facility does not contact a regional coordinating center, the assessment team should not attempt to encourage them to do so.*

Activities During the Facilitated Discussion Portion of the Exercise. After the table top exercise has ended and players have called into the conference line at the designated time for the facilitated discussion, LEAD will explain (using a script in the Excel tool) that this phase of the exercise will review key patient placement and transportation decisions made during the table top exercise and conduct a deeper discussion of several issues related to those decisions. The discussion proceeds in three parts. First, LEAD asks the evacuating facilities to briefly review (1) their patient count at the beginning of the exercise and (2) which facilities agreed to take their patients. Other players are invited to note discrepancies, and this is followed by a guided discussion that involves all participants. Next, LEAD asks for similar information about transportation of patients, again followed by a broader discussion among participants. Finally, the discussion turns to patient tracking and communication, at-risk populations, and continuity of operations.

During the facilitated discussion, each EVAC should note strengths and gaps in performance and should be prepared to share observations during the After Action Review.

After Action Review. Ideally, immediately after Phase 1 of the exercise, LEAD will facilitate an After Action Review, but this review can be scheduled for a later date to maximize health care executive participation. If the After Action Review is scheduled in advance of the exercise taking place, it may or may not occur on the same day as the exercise. This phase should be conducted within 30 days of the Coalition Surge Test. The LEAD Excel tool provides a brief summary of the objectives of the exercise, a summary of patient movement during the table top exercise, and a discussion outline. During the discussion, LEAD will invite the EVAC at each evacuating facility to provide insights observed from his or her vantage point. Similarly, the input of the players directly involved in the exercise will be critical in determining the reasons behind the strengths and weaknesses of the response efforts, as well as potential lessons learned and corrective actions.

After the Exercise

Assessors and players are encouraged to use learnings from the After Action Review in preparing a written after-action report on the exercise. The “After Action Review” tab of the LEAD tool contains a link to a simple after-action report template.

Things to Keep in Mind

We highlight a few important things to keep in mind throughout the exercise:

- ***Avoid excessive prompting.*** In order to simulate a true surge event, players should be allowed to act exactly as they would should such an event occur. As such, assessors and the trusted insider should avoid prompting the players during the exercise. Assessors will be encouraged to give feedback during the After Action Review.

> **Peer Assessors:** Throughout the exercise, avoid prompting, note vague statements for the After Action Review, and deliver text in the tool that is marked "read" verbatim.

- ***Note vague or inconsistent statements/actions for follow-up during the After Action Review.*** In addition to collecting the data listed in the Excel tools, peer assessors should remain on the lookout for vague or unrealistic statements. For example, a general claim that school buses could be used to transport ambulatory patients might warrant additional discussion at some point during the exercise to ascertain whether formal agreements are in place between the school system and coalition members. Use your professional judgment and experience in identifying claims that seem worth additional scrutiny.

- ***Deliver text marked "read" verbatim.*** It is very important to read any text in the tool that is marked "read" verbatim. In many cases, this text conveys critical assumptions that will make it easier for the players to respond to the scenario. Because reading scripts can be awkward for highly trained professionals, we have tried to limit their length and use them only when absolutely necessary. In other parts of the exercise, assessors are invited to customize the material based on the flow of the discussion.

Appendix A: Preparation Checklist for the Trusted Insider

Below is a checklist to be used by the trusted insider to prepare for the Coalition Surge Test. Checklists for the LEAD and EVAC assessors are provided in the accompanying Excel tools.

TIME FRAME	ACTIONS
One to six months before the CST	☐ Get the necessary approvals to run the CST. ☐ Notify coalition members of the CST and the two-week window during which it will happen (see Appendix B for sample notification). - Do not divulge the specific date and time or any information about which facility/facilities will be evacuating. - Assist with key planning considerations, such as other exercises or major local activities that LEAD/EVAC should be aware of when setting the date and location. ☐ Recruit peer assessors (LEAD, EVAC). - Provide this handbook and Excel tools to each assessor. - Consider recruiting optional additional assessors to assist with note-taking. ☐ Provide a list of patient care facilities to LEAD to help select evacuating facilities. - Provide supporting information (e.g., bed counts, average daily patient count) that will help ensure that the selected facilities can produce enough patients to stress the coalition. ☐ Assemble a list of participants (and their contact information) for the facilitated discussion phase of the exercise. - Assemble contact information, including backup numbers where possible, for the day of exercise. Bring a copy of the list the day of the exercise so you can notify participants of the facilitated discussion time and call-in logistics. - Select individuals who can address capacity of receiving facilities, transportation planning, at-risk patients, patient tracking/communication, and continuity of operations. - See specific discussion topics provided in the “Discussion” tabs of the LEAD tool. ☐ Arrange to use a call-in number, WebEOC, or other platform to host the facilitated discussion phase of the exercise. ☐ Be available to assist the assessment team, as needed.
At least one week before the CST	☐ Communicate with the assessment team to: - Finalize the exact date and time of the exercise (within the two-week window). - Review roles and responsibilities. - Assist in finalizing the list of evacuating facilities (and backups). - Plan how assessors will travel to relevant facilities (including contingency plans in case a facility declines to participate).

Appendix B: Sample Notification for Coalition Partners

Sometime within the next [two] weeks, the [name of coalition] will run a four-hour low/no-notice coalition surge test that will focus on communication and cooperation between members. Low/no-notice exercises do a better job of simulating the reality of rapid-onset incidents than other exercises and are encouraged by the U.S. Department of Health and Human Services Hospital Preparedness Program (who sponsored the development of this exercise).

The exercise will consist of three parts:

Phase 1. A 180-minute simulated table top exercise with functional elements that plays out in real time and facilitated discussion.

Phase 2. A 30- to 45-minute After Action Review to debrief. This phase should be conducted within 30 days of the Coalition Surge Test.

Your institution may or may not be asked to participate in the real-time Phase 1, and the degree of participation will vary considerably across participants. Your facility may be contacted at any time during the 90 minutes of real-time play.

After the table top exercise is a facilitated discussion designed to cover aspects of the scenario not covered in the real-time phase and to give coalition members who were not involved in real-time play a chance to participate. All coalition members are encouraged to participate in this call. Shortly after the table top exercise begins, each coalition member's predesignated point of contact will receive notification (via phone, text, or email) of the exact time that the conference call will begin and how to call in to participate. (Note that the conference call may not directly follow the real-time play.) The facilitated discussion will last 90 minutes, and a 45-minute After Action Review debrief (Phase 2) will follow as soon as possible, scheduled for a time when your executives are able to participate. This phase should be conducted within 30 days of the Coalition Surge Test.

In order to maintain the element of surprise, coalition members will not know the exact date and time of the exercise, what the scenario is, or what their role in the exercise will be. There will be no moulaged patients, and real patients will not be moved or otherwise disturbed. The exercise is designed to provide a robust test of how well a coalition can function in an emergency situation, while minimizing the burden on participants.

Your institution's participation is greatly appreciated. Please contact [name] at [e-mail address] or [extension] if you have questions or concerns.

Sincerely,

[name and title]