Mid-South
Emergency Planning Coalition

Non-Hospital Tabletop Exercise

After-Action Report/Improvement Plan

November 13, 2025

The After-Action Report/Improvement Plan (AAR/IP) aligns exercise objectives with preparedness doctrine to include the National Preparedness Goal and related frameworks and guidance. Specific to this report, the exercise objectives align with the Administration for Strategic Preparedness and Response's (ASPR) National Guidance for Healthcare Preparedness and the Hospital Preparedness Program Measures. Exercise information required for preparedness reporting and trend analysis is included; users are encouraged to add additional sections as needed to support their own organizational needs.

EXERCISE OVERVIEW

Event Name	Mid-South Emergency Planning Coalition Non-Hospital Tabletop Exercise
Exercise Dates	November 13, 2025
Scope	A discussion-based tabletop exercise conducted by the Mid-South Emergency Planning Coalition (MSEPC), engaging non-hospital healthcare partners (dialysis centers, long-term care/skilled nursing, assisted living and other residential facilities, ambulatory surgery centers, home care, hospice, outpatient physical therapy), EMS, public health, and emergency management. The scenario focused on a prolonged severe winter weather event with extreme cold, ice accumulation, power outages, water pressure issues, and hazardous roads impacting non-hospital healthcare service delivery.
Mission Area(s)	Response and Recovery
Core Capabilities, Objectives, and Activities	**Capability 2: Healthcare and Medical Response Coordination** ***Objective 1:*** Develop and coordinate healthcare organization and healthcare coalition response plans. ***Objective 3:*** Coordinate response strategy, resources, and communications. **Capability 3: Continuity of Healthcare Service Delivery** ***Objective 3:*** Maintain Access to Non-Personnel Resources during an Emergency ***Objective 5:*** Protect Responders' Safety and Health ***Objective 6:*** Plan for and Coordinate Healthcare Evacuations and Relocation **Capability 4: Medical Surge** ***Objective 1:*** Plan for a Medical Surge ***Objective 2:*** Respond to a Medical Surge
Exercise Objectives	1. Review existing winter weather preparedness, shelter-in-place, evacuation, and continuity-of-operations plans for non-hospital healthcare organizations. 2. Identify gaps in transportation, communication, and resource management (power, water, generators, fuel) during prolonged extreme cold and hazardous travel conditions.

	3. Clarify roles and incident command structures among facilities, EMS, public health, emergency management, and the coalition during a regional winter weather incident. 4. Validate assumptions in existing Emergency Operations Plans (EOPs) regarding shelter-in-place, evacuation, and re-entry for non-hospital providers. 5. Identify specific changes needed in facility EOPs and coalition processes to better support non-hospital partners for future winter weather events.
Threat or Hazard	Severe winter weather: extreme cold, negative windchills, prolonged sub-freezing conditions, ice accumulation on roads and power lines, power outages, generator failure, water pressure loss, and hazardous travel.
Scenario	Explosion at a local chemical manufacturing plant. The plant is adjacent to areas populated with office buildings, retail spaces, and schools.
Sponsor	Mid-South Emergency Planning Coalition
Participating Organizations	Non-hospital healthcare facilities (dialysis centers, long-term care/skilled nursing, assisted living and other residential facilities, ambulatory surgery centers, home care, hospice, outpatient PT), EMS agencies, public health departments, emergency management agencies, and other coalition healthcare partners. Included in Appendix B.
Points of Contact	Heather Burton Fortner, Board Chair Mid-South Emergency Planning Coalition hfortner@midsouthepc.org Sandiyan AL Hayali, Vulnerable Populations Coordinator Mid-South Emergency Planning Coalition salhayli@midsouthepc.org

ANALYSIS OF HEALTHCARE PREPAREDNESS CAPABILITIES

Aligning exercise objectives and healthcare preparedness capabilities allows for a more consistent approach to exercise evaluation to support preparedness reporting and trend analysis. The table below includes the exercise objectives, aligned core capabilities, and performance ratings for each core capability as observed during the exercise and determined by the evaluation team.

Objective	HPP Capability	Performance Rating
Review existing winter weather preparedness, shelter-in-place, evacuation, and continuity-of-operations plans for non-hospital healthcare organizations.	Capability 2 Capability 3	S – Most organizations have EOPs and winter weather procedures, but activation tends to be reactive; specific details for water loss, long-term generator operations, and evacuation of high-acuity outpatients are inconsistently documented.
Identify gaps in transportation, communication, and resource management (power, water, generators, fuel) during prolonged extreme cold and hazardous travel conditions.	Capability 2 Capability 3 Capability 4	S – Participants identified gaps in transportation for dialysis and other high-risk patients, lack of mass-notification systems, limitations in generator capacity, and challenges securing alternate water supplies.
Clarify roles and incident command structures among facilities, EMS, public health, emergency management, and the coalition during a regional winter weather incident.	Capability 2	P - Regional/district leadership structures and facility ICS concepts are generally well understood; roles for public health, EM, EMS, and MSEPC in information sharing and resource coordination are clear.
Validate assumptions in existing Emergency Operations Plans (EOPs) regarding shelter-in-place, evacuation, and re-entry for non-hospital providers.	Capability 2 Capability 3 Capability 4	M – Facilities can shelter-in-place and evacuate conceptually but face difficulty with generator failure, frozen plumbing, hazardous travel, and lack of detailed procedures for tracking patients, belongings, and staff/visitors.
Identify specific changes needed in facility EOPs and coalition processes to better support non-hospital partners for future winter weather events.	Capability 2 Capability 3	P – Participants generated concrete, actionable improvements: stronger documentation, improved tracking processes, expanded

		training, deeper use of the coalition, and more structured engagement of non-traditional partners such as ride-share and community 4x4 groups.

Ratings Definitions:

- Performed without Challenges (P): The targets and critical tasks associated with the healthcare preparedness 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 healthcare preparedness 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 healthcare preparedness 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 healthcare preparedness capability were not performed in a manner that achieved the objective(s).

EXERCISE FINDINGS

Questions utilized during the exercise are included below along with an abbreviated list of comments made during the discussion held as part of the exercise. A more complete evaluation of the overall strengths and areas of improvements specific to our participating organizations are included in the following section.

Module 1: Discussion Questions

For All Facilities / Agencies

How will this affect your organization from an Administration standpoint? Clinical standpoint?

- **Administration**
  - Immediate focus on **transportation and access** for staff and patients (salting sidewalks, clearing lots, arranging transport).
  - Consideration of **delayed opening, early closure, or full closure** of clinics and surgery schedules based on forecast severity.
  - Discussion of **staffing flexibility**, including shifting staff between sites based on where they live and which facilities can safely open.
- **Clinical**
  - Prioritization of **life sustaining treatments**, particularly **dialysis** and other time sensitive therapies.
  - Evaluation of which appointments/procedures can safely be **rescheduled or shortened** if conditions worsen.
  - Assessment of **homebased options** for some treatments, recognizing training and equipment limitations.

What are your triggers for activating your EOP?

- Forecast alone usually does **not** trigger EOP activation.
- Key triggers include:
  - **Actual or imminent loss of utilities** (power, water, HVAC).
  - **Travel advisories** and inability of staff/patients to safely reach the facility.
  - Anticipated **evacuation or shelter in place** for more than a short duration.

What does activating incident command look like?

- Most organizations adapt existing **regional/district leadership structures** to fill ICS roles rather than standing up a separate structure.
- Facility administrators and medical directors typically form the **command group**, supported by maintenance, HR, and clinical leads.
- Formal ICS language (IC, Ops, Planning, Logistics, Finance) is known but applied with varying depth across organizations.

What are you communicating with staff, patients, families, volunteers – and how?

- **Staff** – Primarily **phone calls and text messages**; some use:
  - A **HIPAA compliant platform** for leadership communication.
  - A **separate app** for broader staff notifications.
  - Few have true **mass notification** (autodial/text) systems in place.
- **Patients / Residents / Families** –
  - Facilities maintain a **dedicated phone number** or message line for status.

    - Staff perform **manual call downs** to notify patients of closures or schedule changes.
    - Clear messaging is needed to manage **family expectations** about coming to pick up loved ones in dangerous conditions.
- **Volunteers** – Usually notified through the same channels as staff, though many facilities would **suspend volunteer activities** during severe weather.

What are your policies for staff scheduling and recall? Who is responsible?

- Leadership teams (administrator, clinical manager) determine **modified schedules**, on-call expectations, and **who reports to which site**.
- **Recall** is handled via the same call/text/app methods; formal tiered recall lists are **not common**.
- Responsibilities break down roughly as:
    - **Command/Administration:** global decisions, communication with EM/coalition/state.
    - **Clinical leadership/Medical Director:** patient prioritization, clinical standards of care.
    - **Maintenance/Engineering:** generators, utilities, building systems.
    - **Scheduling/HR:** staffing, payroll, sheltering staff if they must stay on-site.

For Nursing Homes and other Residential Facilities:

What is your shelter-in-place preparations?

Preparations focus on keeping residents in the building, leveraging existing fire/smoke compartments and internal safe zones rather than external shelters.

What facility concerns would you have in this scenario?

- Potential loss of power, heat, or water for extended periods.
- Evacuating frail residents into subzero conditions without robust external shelter options (e.g., heated tents).
- Balancing family pressure to remove residents with safety concerns and road conditions.

For Surgery Centers:

What are your procedures to prepare for impending weather? (Resources, travel, etc. for Staff and Patients)

- Review next-day and multi-day surgical schedules and identify which cases can be rescheduled.
- Stop scheduling non-urgent elective cases once severe winter weather is predicted.

What are your triggers for implementation of those procedures?

- NWS watches/warnings expected ice accumulation, and anticipated power issues.
- Local EM travel advisories and staff's ability to arrive safely.

EMS and Emergency Management

What actions are you taking to prepare?

- Assess system-wide call volume expectations and staffing.
- Plan for targeted wellness checks and limited high-priority transports, recognizing they cannot be primary transport for all dialysis/LTC patients.
- Coordinate with MSEPC, public health, and hospitals on situational awareness and resource needs.

For Home Care and Hospice:
Policies for staff/patient personal preparedness and road checks?

- Staff are encouraged to maintain personal preparedness (fuel, clothing, phone charging, food).
- Agencies emphasize pre-event patient education on having medications, backup power for essential devices, and a plan if staff cannot reach them.
- Road conditions are typically checked using state/local reports and EM advisories; visits may be reprioritized or converted to phone check-ins when travel is unsafe.

Dialysis:
Procedures to prepare for impending weather and triggers for implementation?

- Prioritize dialysis patients who are most vulnerable if treatments are missed; adjust schedules to bring patients in early (before storm) when possible.
- Arrange transportation support (internal transport, coordination with families, community partners).
- Triggers include weather alerts, closure of usual transport services, and anticipated power/water disruptions at the clinic.

Module 2 – Shelter in Place

For All Facilities / Agencies
Immediate actions, concerns, and priorities (Admin, Clinical, Maintenance)?

- **Administration**
  - Decide whether to **finish ongoing treatments** and stop new starts.
  - Consider **partial or full closure** while ensuring care for critical patients/residents already on site.
- **Clinical**
  - **Triage and prioritize** high-risk patients (e.g., dialysis schedule, oxygen-dependent residents).
  - Coordinate with hospitals for **transfers** when facility infrastructure is at risk.
- **Maintenance**
  - Switch essential systems to **generator power**, if available.
  - Use **extension cords and portable heaters** to consolidate services into powered zones.
  - Monitor for **water pressure loss** and plan for temporary water solutions (tankers, bladders, holding tanks).

Policies to recall staff if needed?

- Recall uses **phone, text, and app-based group messages**.
- Staff may be directed to **whichever facility they can safely reach**, rather than their usual home facility.
- Few formal, written **tiered recall systems** exist, which participants recognized as a gap.

EOP activation and Command Center location?

- Many organizations **activate the EOP** when power is lost or when icy roads severely limit access.
- Command roles are often coordinated from **regional/district offices**, sometimes virtually, rather than via a single physical command room at each site.

- Some organizations rely on electronic access (intranet/shared drives) for plans, which may be impacted by **loss of Wi-Fi** during outages.

Impact on pharmaceutical supplies?

- Generators typically support **medication refrigerators and pharmacies**, but some facilities worry about **fuel duration** and **delayed generator replacement** (up to ~6 hours for a temporary unit).
- The greater risk comes from **delivery disruptions** due to road conditions, not short-term storage failure.

Preventive measures for frozen/burst water lines?

- Facilities expect possible **water pressure loss** and discuss the need for **water tankers, bladder tanks, or holding tanks** if municipal supply fails.
- Concrete measures like **heat tracing and piping insulation** are variably implemented and not always detailed in the EOP.

Are you making notifications to external partners?

- Requests to **EMA, EMS, public health, state agencies, and MSEPC** are typically routed through higher-level managers to avoid duplication.
- Coalition engagement is especially important for **bed availability** and for understanding regional utility impacts.

Nursing Homes & Other Residential Facilities

Maintaining temperature, lighting, and fire/life safety; generator details; partners for power loss?

- Use **generators** for heating critical spaces and emergency lighting, consolidating residents in fewer areas where possible.
- Participants acknowledged gaps in **written procedures** for keeping fire alarms and sprinkler systems functional in extreme cold (e.g., preventing frozen sprinkler lines).
- Generator fuel duration and **quick connect configurations** are not always clearly documented; some facilities know replacement generators can take up to **six hours** to arrive.
- External partners include **utility providers, EMA, EMS, fire services, generator vendors, and the coalition**; community groups (e.g., Jeep or 4x4 clubs) may assist with staff/patient transport.

Surgery Center:

What arrangements do you have in place to ensure your patients receive care if you are unable to meet their needs?

- If power is lost mid-procedure, cases are **completed on generator power** when safe.
- Elective cases are postponed; urgent cases may be **diverted to hospitals**.
- Postoperative follow-up plans are coordinated with **partner hospitals or other centers** in the network.

EMS and Emergency Management

What are your current actions and procedures at this point in the response?

- EMS maintains **priority responses** and performs **wellness checks** when requested by facilities/home care.
- EM and public health support **information sharing**, **public messaging**, and working with the MSEPC and MedCom for coordination of **bed availability**.

How would you establish contact with healthcare facilities?
Satellite phones are discussed as a backup, but there is uncertainty about **who should own them, who to call, and how they integrate** with other systems.

For Home Care and Hospice:
What is your policy for checking on patients during the storm?
Agencies conduct phone wellness checks when travel is unsafe and coordinate with EMS or EM for high-risk patients who cannot be reached.
How do you handle patients who need daily care but you are unable to reach them?
Plans emphasize pre-identifying critical patients (ventilator, oxygen, complex wound care) and ensuring they have backup power and supplies in advance.

For Dialysis, Surgery Centers, and Outpatient PT:
What arrangements do you have in place to ensure your patients receive care if you are unable to meet their needs?
Dialysis centers focus on early treatments before the storm and coordinated transport when possible.
If treatments must be missed, patients are prioritized based on clinical risk, and alternative sites may be used if open.
Outpatient PT visits are usually rescheduled; high-priority patients may switch temporarily to home exercise with telephonic follow-up.

Module 3 – Continuity of Operations & Evacuation

For All Facilities / Agencies
EOP site map, shut-off locations, and water valve procedures?

- Many EOPs technically include **site maps and shut-off locations**, but practical knowledge often resides with a few maintenance staff ("**tribal knowledge**").
- Written, step-by-step procedures that non-maintenance staff can follow in an emergency are rarely in place.

External partners list, triggers, and backup communication?

- Contact lists for **EMA, EMS, fire, state surveyors, coalition, generator vendors** exist but may be stored on systems that require **Wi-Fi/intranet**, which may be unavailable during outages.
- Triggers for contacting external partners include:
  - **Unsafe building** (loss of power, water, or heat).
  - **Generator failure** with no short-term fix.
  - Decision to **evacuate** residents/patients.
- Primary communication is via **phones and email**; alternates (sat phones, radios) are not uniformly available or integrated into EOPs.

EMS and Emergency Management
Resources and limitations for assisting with evacuation?

- EMS can provide **limited ambulance capacity** for the most critical patients but cannot be the main evacuation method.

- Other resources might include **fire department apparatus, specialty buses (e.g., MATA buses), nonemergency transport vendors, and community partners**.
- Capacity is constrained by **simultaneous system-wide demand and hazardous roads**.

Nursing Homes & Other Residential Facilities

Notifying partners of evacuation and finding placements; transportation; tracking; alternate care sites

- Facilities notify **regional/district leadership, EMA, the coalition, and state agencies** that an evacuation is needed.
- Family members may be given a **time window** to pick up residents; thereafter, the facility is responsible for moving residents to receiving facilities.
- Transportation arrangements vary:
  - **Non-emergency medical transport, fire department support, specialty buses, and community 4x4 volunteers**.
  - EMS is reserved for **high acuity** residents.
- Tracking:
  - Most facilities rely on **manual paper lists or basic spreadsheets** to record destinations and resident status.
  - There is limited ability to **track staff** who accompany residents and almost no formal process for **visitor tracking**.
- Alternate care:
  - Receiving sites are usually other LTC facilities or hospitals identified via **coalition/state coordination**.
  - Detailed supply lists (food, oxygen, meds, linens, equipment) for establishing a non-traditional alternate care site are not well defined.

Surgery Centers

What arrangements, if any do you have in place with other facilities or providers to receive patients in the event you have limitations or cessation of operations?

- Patients who were under anesthesia would be stabilized and transferred as necessary; elective patients would be rescheduled or **diverted to partner hospitals**.
- Some corporate systems have implicit expectations that **nearby hospitals or sister centers** will receive patients, but formal **MOUs** are often lacking or not widely known by staff.

Home Care and Hospice

What are your procedures in tracking patients if they must evacuate their home?

- Agencies try to maintain updated **patient rosters with destination information**, but methods are often manual.
- Coordination with **receiving family, shelters, or facilities** is ad hoc and not standard across agencies.

For Dialysis:

What arrangements, if any do you have in place with other facilities or providers to receive patients in the event you have limitations or cessation of operations?

Dialysis organizations attempt to **shift patients to other clinics** within the network that remain operational.

What actions do you take to ensure patients are treated in a timely manner?

When capacity is exceeded, medical directors prioritize patients who cannot safely miss another treatment, while those with more reserve may be delayed.

What limitations do you have?

Transport limitations, hazardous roads, and lack of patient tracking tools significantly hinder timely treatment.

Module 4 – Recovery

For All Facilities / Agencies

Steps for transitioning back into the facility once given all-clear?

- Confirm **structural integrity**, power, water, HVAC, and fire protection systems.
- For facilities that evacuated, obtain **state or regulatory clearance** if required before re-occupancy.
- **Re-activate EOP demobilization procedures**, including staff scheduling, restocking supplies, and environmental cleaning.
- Address **backlogs of critical treatments** (e.g., dialysis) and prioritize patients most impacted by missed visits.

How will you ensure transportation for patients to return?

- Resume normal **transport vendors** where possible.
- Use **family vehicles, ride-share services (Uber/Lyft), and community volunteers** while roads remain partially hazardous.
- Coordinate with EM/coalition if **additional transport resources** are needed.

If unable to return, what are next steps (staff, operations, repairs, notifications)?

- Maintain or expand **operations at alternate sites**.
- Begin **repairs and long-term recovery** (insurance, contractors, utility coordination).
- Reassign staff, adjust schedules, and notify **EMA, state agencies, coalition, patients, and families** of extended closure.

If a patient evacuated from home, how do you make sure they can return?

- Confirm **home utilities** (power, heat, water) are safe and functioning.
- Ensure patient has **necessary equipment, meds, supplies, and backup power** (battery packs) upon return.
- Coordinate with **EMS or community partners** if equipment delivery or special transport is required.

How are patients notified that you are returning to normal operations?

- Use the **dedicated facility phone line**, manual call downs, and existing apps or messaging systems.
- Some organizations plan to develop **standardized message templates** for closure and re-opening to streamline future communications.

Final Discussion & Questions

During the hotwash, participants shared the following reflections:

- Was this helpful?
  - Yes. The exercise helped organizations **compare approaches**, identify **gaps in transport and communication**, and understand how critical non-hospital services (especially dialysis) fit into a regional response.
- Meaningful takeaway:
  - The region relies heavily on **non-traditional partners** (Uber/Lyft, community 4x4 groups) and **coalition support** to move patients during severe winter weather.
- Area of improvement identified:
  - Need for **better documentation** (EOP details, utility shutoffs, recall procedures), **staff cross training**, and **more efficient patient/staff tracking**.
- One thing learned:
  - Greater appreciation of **generator limitations**, **water system vulnerabilities**, and the steps needed to **notify the state and coalition** in prolonged outages.
- Future trainings/exercises requested:
  - Sessions on **CMS emergency preparedness**, **less common but high impact scenarios** (long-term water loss, simultaneous utility failures), and **communication/mass notification tools**.
- Topics of concern for future exercises:
  - **Water pressure failure**, **total communications outages**, ensuring continuity of **dialysis and other life sustaining outpatient services**, and detailed **long-term evacuation and reentry** planning.

STRENGTHS AND AREAS OF IMPROVEMENT

Several issues common to most or all the participating facilities were reported as part of the exercise discussion. Since these items represent trends across the entire region, the HCC may wish to consider addressing these in a more strategic approach to improving capabilities for all member healthcare organizations.

STRENGTHS

Across the region, participating organizations demonstrated a strong understanding of incident command and leadership structures, enabling them to activate EOPs in a structured way and manage events with clear decision-making authority. Facilities showed a commitment to maintaining life-sustaining services such as dialysis, including a willingness to adjust schedules, reprioritize patients, and coordinate with hospitals to protect those at highest risk.

Many organizations already have generator coverage for key systems—including pharmacy storage, medication refrigerators, and food service—which provides a solid base for shelter-in-place operations during power outages. The exercise also highlighted robust interagency collaboration between non-hospital facilities, EMS, emergency management, public health, and the healthcare coalition; staff reported a strong willingness to take on additional responsibilities and support each other during emergencies.

Finally, although mass-notification tools are still limited, facilities are actively using multiple communication channels—phone calls, text messages, internal apps, and dedicated status lines—to keep staff and patients informed during severe winter weather.

AREAS OF IMPROVEMENT

The exercise also revealed several important opportunities to strengthen preparedness. Many EOPs do not yet fully address prolonged water loss, generator failure, or extended utility outages, and critical procedures—such as how to shut off utilities or execute evacuations—are sometimes known only to a few individuals rather than being clearly documented and accessible to all staff.

Communication and mass-notification remain heavily dependent on manual call-downs for both staff and patients, with few automated tools or standardized message templates available to speed information sharing. Transportation for high-risk patients, particularly those requiring dialysis or other high-acuity outpatient services, is a significant vulnerability during region-wide winter weather, as dedicated transport resources are limited and often supplemented by ad hoc community support.

Participant feedback underscored that real-time tracking of patients, staff, and visitors during evacuations is still largely manual and slow, complicating coordination with receiving facilities and timely updates to families. In addition, facilities identified the need for better understanding of generator fuel endurance, replacement timelines, quick-connect capabilities, and protections against frozen pipes and sprinkler systems to improve overall utility and infrastructure resilience.

Finally, ongoing training and cross-training are needed to counter staff turnover and varying experience levels; regular education on EOPs, ICS roles, evacuation procedures, and backup communications will be essential to maintain readiness across all non-hospital partners.

APPENDIX A: ACRONYMS

Acronym	Term
AAR	After Action Report
ASPR	Assistant Secretary of Preparedness and Response
EOP	Emergency Operating Procedure
EM	Emergency Management
EMS	Emergency Medical Services
HCC	Health Care Coalition
HPP	Hospital Preparedness Program
HRTS	Healthcare Resource Tracking System
HSEEP	Homeland Security Exercise and Evaluation Program
ICS	Incident Command System
IP	Improvement Plan
MSEPC	Mid-South Emergency Planning Coalition
OEM	Office of Emergency Management

APPENDIX B: EXERCISE PARTICIPANTS

Participating Organizations
Healthcare Coalitions
Mid-South Emergency Planning Coalition
Public Health
Shelby County Health Department
Emergency Management
City of Memphis Office of Emergency Management
Emergency Medical Service (EMS)
Memphis Fire Department
Vital medical transportation
Acadian Ambulance Service of Tennessee
Ambulatory Surgery Center
Campbell Clinic Surgery Center – Germantown
Campbell Clinic Surgery Center – Midtown
East Memphis Surgery Center
Memphis Surgery Center
OrthoSouth Surgery Center
UroCenter Surgery Center/East Memphis Surgery Center
Radiosurgical Center of Memphis
Dialysis Centers
Davita Stateline
DaVita Airways
Davita Capelville
Davita-Renal Care of Midtown Memphis
Fresenius Kidney Care Community Memphis 100271
Fresenius Kidney Care East 1775
Fresenius Kidney Care Germantown 4771
Fresenius Kidney Care North 4002
Fresenius Kidney Care- Raleigh Bartlett 9585
Fresenius Kidney Care Summer 6758
Fresenius Medical Care, Ridgeway 7553
Fresenius Whitehaven 4001
Fresenius Tipton County clinic 1541
Fresenius Millington clinic 6760
Fresenius Medical Care Midtown Memphis clinic 4000
Fresenius Medical Care Bartlett Clinic 6198
Fresenius Medical Care Graceland Clinic 1838

Fresenius Medical Care South Airways Clinic 9257
Fresenius Kidney Care Mt Moriah Home Therapies Clinic 6856
Fresenius Kidney Care Central Memphis 8699
Hospice/Home Health
Meritan Home Health
No Place Like Home Health Care
Long Term Care/ Assisted Living
Ave Maria Home
Kirby Pines
The village at Germantown
Memphis Jewish Home & Rehab
NHC Healthcare Somerville
The King's Daughters and Sons Home

APPENDIX C: IMPROVEMENT PLAN

This IP has been developed specifically for the Mid-South Emergency Planning Coalition as result of the Non- Hospital Tabletop Exercise conducted on November 13, 2025.

MSEPC accepts responsibility for assuring that the improvement plan issues identified will be integrated into an exercise in the next budget period.

Issue/Area for Improvement	Corrective Action	Capability Element[1]	Start Date	Completion Date
Limited mass-notification capabilities for staff and patients during severe weather.	Evaluate and implement scalable communication tools (e.g., mass text/phone systems, automated call trees) for staff and patient contact. Develop and share standard closure and reopening message templates region-wide. MSEPC to host trainings on messaging and information sharing.	Communications, Training	2026	Initial tools and templates by June 30, 2026; reviewed annually.
Incomplete documentation of EOP details and utility procedures, including shut-offs, generator operations, and staff recall.	Revise facility EOPs to include clear step-by-step procedures with diagrams for power and water shut-offs, generator operation, and staff recall. MSEPC will provide an EOP checklist and coordinate peer review sessions among members.	Planning, Training	2026	First revision cycle by June 30, 2026; ongoing updates thereafter.
Lack of standardized real-time tracking for patients, staff, and visitors during evacuation and re-entry.	Identify or refine a common tracking tool (paper or electronic) that non-hospital facilities can use. Provide coalition training and incorporate tracking into future drills and exercises.	Patient Movement, Information Management	2026	Pilot tracking tool in next exercise; full adoption target date December 31, 2026.

[2]Capability Elements are: Planning, Organization, Equipment, Training, or Exercise.