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Exercise Evaluators	Location		
	UC	MCP	RSP
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The statement that “*It is a common defect in man to not make any provision in the calm against the tempest*”¹ still applies some five hundred years later, however, not to organizations that participated in all or some of the exercises covered by this report. They include:

- American Red Cross, Oregon Trail Chapter; Portland, Oregon
- David Douglas School District and High School; Portland, Oregon
- University of Portland Dept. of Public Safety and School of Nursing; Portland, Oregon
- Partner County Health Departments from throughout Oregon
- Clark County Health Department; Vancouver, Washington
- Multnomah County: Health Department; County Human Services Department; County

¹ Nicollo Machiavelli, *The Prince*, 1513

Management Department, Office of Emergency Management

- City of Portland: Bureaus of Fire and Rescue and Police; Office of Emergency Management; and mutual aid through Clackamas County's Boring Fire District and the Port of Portland Fire and Rescue
- Oregon Department of Human Services, Public Health Division
- United States Environmental Protection Agency; local and regional incident management team members
- United States Department of Energy, and organizations comprising Federal Radiological Monitoring and Assessment Center teams
- Federal Bureau of Investigation; local office

David Douglas High School Principal Randy Hutchinson provided the facility and organized faculty, staff, student staff volunteers, and a thousand student actor 'clients' for the Rapid Screening Point. Public Safety Director Harold Burke-Sivers and Events Director Bill Reed arranged many details to host the Medical Care Point and a Federal Medical Station demonstration unit at the University of Portland. Portland Fire and Rescue volunteer coordinator June Vining and her staff recruited Medical Care Point 'patients.' University of Portland School of Nursing instructor Lori Chorpenning arranged volunteer staff for both operations, and dozens of 'patients' for the Medical Care Point. American Red Cross Oregon Trail Chapter volunteers and partner organizations provided food and beverages to responders at all venues. Clark County Health Department, our neighbor across the Columbia River, provided exercise evaluators, controllers, and Emergency Preparedness Coordinator Richard Konrad who once again served as ICS Coach for the Unified Command. He was joined by USDOE contracted coaches Chuck Mills, Tim Deal, and Ron Cantin of Emergency Management Services Inc.

About 1,300 volunteers generously performed community service as 'patients' at the Medical Care Point and 'clients' at the Rapid Screening Point. They challenged and built the experience of the emergency responders. Exercise controller Capt. Michael Hicks RN) of the Oregon National Guard fully applied his military leadership experience to prepare 'patients' and 'clients' at both operations with the assistance of controller Jeff Sargent of the Oregon Federal Executive Board. Controller Maria Maribona of Clark County facilitated VIP visitors and media.

Many thanks to all contributing organizations, their representatives, and volunteers!

EXECUTIVE SUMMARY

This is a report on three Oregon venues that were part of the fourth full-scale Top Officials Exercise (T4) mandated by the United States Congress. The venues are:

- Health/Environmental Unified Command (UC) activities at an Incident Command Post (ICP) conducted tactical health and environmental operations away from the scene of the blast;²
- Medical Care Point (MCP) field emergency medical facility for relieving pressure from an overwhelmed hospital emergency room;
- Rapid Screening Point (RSP) for mass screening of possible radiation exposure, referral of those suffering significant exposure, decontamination, initial mental health treatment, and registering those exposed for follow-up.

These public health and medical operations were arranged by the Multnomah County Health Department in cooperation with many partner jurisdictions and organizations. This report summarizes activities at these exercise venues, outlines objectives, and analyzes results, strengths, and weaknesses. Other exercise documentation such as time lapse videos of the MCP and RSP, participant guides, and preparation documents are available online at <http://www.mchealth.org/emergprep/topoff/index.shtml>. Activities at many other related T4 venues are covered in other after action reports. These other venues include the Portland blast scene Unified Command, hospitals, and jurisdictional and departmental emergency operations/coordination centers in Oregon, Guam, Arizona, and elsewhere.

The Oregon scenario relevant to the scope of this report is as follows:

The explosion at the blast scene near Portland's Steel Bridge quickly added hundreds of casualties to regional hospital emergency rooms, emergency rooms that normally operate near capacity. The related release of radioactive material was dispersed in an airborne plume to the east over or near Interstate 84. Contamination data was initially uncertain and was clarified over the four days of the exercise. However the release increased anxiety in the community, amplified mental health and physical concerns, caused tens of thousands of persons to self-evacuate, placed further pressure on the medical system, and would have long-term public health and environmental impacts.

The UC, MCP, and RSP were large, complex operations that were quickly established. The UC developed over the course of four days of operations as more Incident Commanders and their resources came together. The MCP and RSP were tactical operations that would ordinarily be

² Another UC led fire, rescue, and law enforcement operations near the site of the simulated release of radioactive material.

ordered and supported by a superior IC/UC. After a two-hour set up, the MCP and RSP operated for two-hours, and served 300 patients and 1,000 clients, respectively. The UC simulated the operation of other MCPs and RSPs.

Excellent technical experts led and staffed the operations at the Incident Command Post. Most were trained through intermediate ICS levels (ICS 300); some had experience operating at that level, and many ICS processes and jobs were done well. However, the challenges of the operations and the diversity of staffing strained the organization as the Unified Command grew from two to six persons with frequent leadership and staff additions and turnover during 4 days of operation. The Portland T4 scenario by itself was a Type 1 incident as defined by the National Incident Management System; that is a large, complex incident of national significance. The great majority of responders did not have the position-specific training and experience to apply ICS processes at high proficiency. Coaches and more experienced responders could barely keep ahead of the many demands on their time. This same situation may have also existed in other response organizations.

The result was that:

- critical ICS functions (primarily Public Information, Planning, Logistics, and Finance/Administration) did not fully support tactical operations (such as the real and simulated MCP and RSP operations);
- communications between these organizations and with other organizations and/or officials was insufficient to support required decisions, support, and coordination activities between organizations.

These shortfalls were revealed by the quality and substance of documents and information displays developed during planning cycles. Products did not have the detail needed to assure that operational objectives would be fully supported and achieved during the next operational periods.

Recommendations include:

- identify a reasonably high level of performance expected of Incident Command System (ICS) positions and teams;
- build capabilities to those levels;
- confirm those capabilities by a position credentialing system and exercise evaluation; and
- obtain the support of more capable incident management teams when the incident exceeds a local/regional team's capacity.

T4 stimulated a broad range of individual and organizational improvements that advanced general Incident Command System knowledge and experience, contingency plans, and jurisdictional and organizational relationships during emergencies.

SECTION 1: EXERCISE OVERVIEW

Exercise Details

Scope of Report. This After Action Report (AAR) covers three significant health, medical, and environmental venues that were part of Oregon’s participation in the national Top Officials Exercise (also referred to as TOPOFF 4 or T4):

- Health/Environmental Unified Command (UC);
- Medical Care Point (MCP); and
- Rapid Screening Point (RSP).

Exercise documentation such as time lapse videos of the MCP and RSP, participant guides, and preparation documents are available at <http://www.mchealth.org/emergprep/topoff/index.shtml>. This report does not cover other metro Portland venues in Oregon and Washington including hospitals, emergency operation centers, and the Unified Command at the Portland ‘blast site.’ Nor does it cover T4 activities in Guam, Arizona, Washington, D.C. and elsewhere.

Exercise Name	Top Officials Exercise (also known as TOPOFF 4 or T4)
Type of Exercise	Full-scale national exercise, incidents in two states and a territory
Exercise Start	October 16, 2007, ~0900 PDT
Exercise End	October 19, 2007, ~1400 PDT
Duration	4 days (of response operations in Oregon venues)
Location/Dates	Unified Command (UC) at Multnomah County Health Department from exercise start to end Medical Care Point (MCP) at University of Portland Chiles Center on October 17 Rapid Screening Point (RSP) at David Douglas High School’s South Gym on October 18

Sponsor. The Federal Emergency Management Agency of the U.S. Department of Homeland Security was the national sponsor. Multnomah County Health Department was the host/lead designer of the three venues detailed in this report. Many partner organizations contributed to the design or participated in these exercises.

Program. The City of Portland administered funding sources dedicated to T4 support, however, many organizations used other operating and preparedness related funds. For example local public health participation was mostly supported by county general funds and U. S. Centers for Disease Control Public Health Preparedness Program funds, with hope for some reimbursement from T4 funding sources.

Capabilities. General capabilities exercised were communications, mass care, onsite incident management, triage and pre-hospital treatment and emergency public information and warning.

Mission	Public Health/Medical/Environmental Emergency Response
Scenario Type	Radiological Dispersal Device “Dirty Bomb”

Exercise Planning Team; Participating Organizations and Resources

Unified Command (UC)

A very large Oregon venue planning team and a ~5-8 person Public Health/Medical Workgroup planned the overall exercise environment that the Health/Environmental Unified Command operated in.

The number of organizations represented at the Incident Command Post grew as the Unified Command evolved over four days. The operation began with the local public health incident management team and a Federal Bureau of Investigation agent, and expanded as the U.S. Environmental Protection Agency, U. S. Department of Energy, Oregon Public Health Division, and Portland Fire and Police joined this Unified Command. Numbers of daily participants including minimally staffed evening shifts (5-7 players) were as follows:

- Players ~95 at start; ~125 at peak; ~45 at end
- Controllers/Evaluators 1-3 per shift
- Observers periodic visits
- Victim Role Players none

Medical Care Point (MCP)

The MCP exercise was designed with representatives of key participating agencies listed in Table 1. MCP resource totals were:

- Players ~150
- Controllers 6
- Evaluators 5
- Exercise Staff ~8
- Observers ~110 (~90 in a VIP observer group)
- Patient Role Players ~200 (many processed more than once)

Table 1 shows organization resources and lead planning representatives.

Table 1: Medical Care Point Organizations/Resources and Lead Planner

Participating Agencies/Resources	Lead Planner or Point of Contact
University of Portland Department of Public Safety <ul style="list-style-type: none"> ○ Various officers and staff [5 persons] School of Nursing <ul style="list-style-type: none"> ○ faculty and seniors in MCP [~15 persons] [~40 of the ~200 total actor “patients”] 	Harold Burke-Sivers, Director Bill Reed, Events Director Lori Chorpenning, Instructor
Portland Fire and Rescue Bureau (PFB) <ul style="list-style-type: none"> ○ Batt. Chief (recon squad added) ○ CBRNE Rig ○ 1 Truck scheduled (actually 2) ○ 3 Engines scheduled (actually 4) 	Captain Mike Glenn Lieutenant Lonnie Fuller
U. S. Health & Human Services <ul style="list-style-type: none"> ○ Oregon and Washington Disaster Medical Assistance Teams (DMAT) [~70 persons] 	Captain Andrew Stevermer
Various Metro Portland Hospitals <ul style="list-style-type: none"> ○ Single resource medical staff [~15 persons planned, none available] 	Al Rhodes, Providence Hospitals John Reid, Legacy Hospitals
Multnomah County: Health Department Human Services Department <ul style="list-style-type: none"> ○ County Behavioral Health Response Team [~5 persons planned, actually ~8 persons] ○ Pacific Univ. behavioral health students [~5 persons planned, actually ~35] 	James Spitzer, Emergency Preparedness Manager Sean Derrickson, Mental Health Supervisor
Partner County Health Departments <ul style="list-style-type: none"> ○ Single resources health staff [~3 persons] 	Robin Holm, Multnomah County Emerg. Prep. Assoc.
Port of Portland Fire Department <ul style="list-style-type: none"> ○ CBRNE Rig [~4 persons] 	Via Portland Fire Bureau planners
Boring Fire District 59 (Clackamas Co.) <ul style="list-style-type: none"> ○ CBRNE rig [3 persons] ○ Batt. Chief Unit [~1 person] 	Via Portland Fire Bureau planners
Oregon Air National Guard <ul style="list-style-type: none"> ○ Medical Team [~3 persons] 	Captain Michael Hicks
American Red Cross Food Services [~5 persons]	Deborah Mills

Rapid Screening Point (RSP)

The author designed the RSP exercise in consultation with representatives of key participating agencies. These representatives and the resources contributions are listed in Table 2. RSP resource totals were:

- Players ~126
- Controllers 4
- Evaluators 4
- Exercise Staff ~10
- Observers ~150 (~90 in a VIP observer group)
- Client Role Players ~600 entered process, total of 1,000 arranged

Table 2 shows organization resources and lead planning representatives.

Table 2: Rapid Screening Point Organizations/Resources and Lead Planner

Participating Agencies [#s of persons]	Lead Planner or Point of Contact
David Douglas High School <ul style="list-style-type: none"> ○ [~35 Volunteer Staff] (30 RSP staff, ~5 exercise staff) ○ [~1000 actor clients] 	Randy Hutchinson, Principal
Portland Fire and Rescue Bureau <ul style="list-style-type: none"> ○ [5 persons] 	Captain Mike Glenn
Multnomah County and Health Department and various regional partner health depts. <ul style="list-style-type: none"> ○ [~12 persons] 	Robin Holm, Emerg. Prep. Associate
Partner County Health Departments <ul style="list-style-type: none"> ○ Single resources health staff ○ [~3 persons] 	Robin Holm, Emerg. Prep. Associate
Multnomah County Human Services and Pacific University (PU) <ul style="list-style-type: none"> ○ [~8 County staff] ○ [~35 PU students] 	Sean Derrickson, Mental Health Supv.
University of Portland School of Nursing <ul style="list-style-type: none"> ○ [~8 persons] 	Lori Chorpenning, Instructor
Oregon Air National Guard medical team <ul style="list-style-type: none"> ○ [3 persons] 	Captain Michael Hicks
Oregon Public Health Radiological Protection Services <ul style="list-style-type: none"> ○ [~8 persons] 	Justine Spence
Federal Radiological Monitoring and Assessment Center <ul style="list-style-type: none"> ○ [~6 persons] 	Player action during exercise
U. S. Coast Guard (added day before) <ul style="list-style-type: none"> ○ [2 persons] 	none
U.S. Environmental Protection Agency <ul style="list-style-type: none"> ○ [~5 persons] 	Dan Hiester, On Scene Coordinator
American Red Cross Food Services <ul style="list-style-type: none"> ○ [~4 persons] 	Deborah Mills

SECTION 2: EXERCISE PURPOSE, DESIGN, CAPABILITIES, ACTIVITIES AND SCENARIO SUMMARY BY VENUE

Health/Environmental Unified Command (UC)

UC Purpose and Design. Within minutes of the report of an explosion an ‘off-scene’ health Incident Command formed at the Multnomah County Health Department to plan likely health and medical operations that likely would be needed in addition to the initial response to the blast scene. Fire, law enforcement, emergency medical resources, and other disciplines responded to the blast scene. A few public health resources including an Incident Commander were integrated into the ‘on-scene’ Unified Command to help manage the mass casualty response, relationships to the hospitals, and to provide situational awareness back to the Incident Command at the Health Department. However, limited support facilities at the blast scene were not appropriate to support responses to broad public health impacts. Therefore, the health Incident Command was an important component of overall response operations. As critical blast scene operations scaled down, the health Incident Command evolved into a Unified Command comprised of six Incident Commanders dealing with most issues, except for the continuing law enforcement investigation, and continuing operations and security of the blast scene.

T-4 design objectives for the ‘off-scene’ Incident/Unified Command were:

1. Inform public health, hospitals, emergency medical services, and emergency management sectors across the region.
2. Develop and support risk communications to the public and external and internal partners.
3. Coordinate, lead, and manage regional public health and medical aspects of the incident.
4. Integrate with the larger emergency management system.
5. Establish and conduct one real and many virtual RSPs to relieve mass fear of exposure to radiation and treat/register those exposed.
6. Establish and conduct one real and many virtual MCPs to expand regional emergency and urgent care capacity.
7. Employ and operate an appropriate Incident Command System (ICS) structure as part of local health response to an incident of national significance.
8. Apply public health plans and procedures to an incident of national significance.

Medical Care Point (MCP)

MCP Purpose and Design. Hospital emergency rooms in metro Portland routinely operate at or near capacity. The T4 explosion and radiological dispersal scenario (a radioactive dispersal device, or RDD) resulted in a surge of additional patients to regional emergency rooms and reduced emergency medical treatment capacity. The RDD scenario itself greatly increased numbers of patients suffering behavioral or mental health symptoms, and placed an additional strain on emergency room operations.

An Incident/Unified Command with public health responsibility must also monitor impacts on hospital emergency operations, in consultation with hospital leaders. Together, they must forecast and respond to severe shortages of hospital emergency capacity. MCPs can increase emergency medical treatment capacity, and ‘protect’ overwhelmed hospital emergency rooms (ER). Each MCP linked to and ‘protected’ a nearby emergency room. Access to that emergency room may be restricted, with all but the most severe medical conditions being diverted to the MCP.

Depending on MCP staffing, equipment, supply thresholds, and patient condition, the MCP may discharge patients or refer them to further medical care. MCP staffing levels range from emergency medical technicians administering first aid and basic treatments, to emergency room physicians performing complex procedures. The exercise MCP was a large, sophisticated operation staffed by ~150 responders, including nurses and physicians. It ‘treated’ over 200 ‘patients’ during two hours of operation.

The overall MCP objective was: Establish and conduct an MCP to ‘protect’ overwhelmed hospital emergency rooms. Sub-objectives were:

1. **Apply Plans.** Apply/adapt Public Health MCP plan, Portland Fire Bureau MCP training, and the health/medical IC/UC’s Incident Action Plan.
2. **Apply ICS.** Apply ICS criteria to assemble resources from a number of different organizations and disciplines into a cohesive, well led, and coordinated MCP. Focus on ICS components such as unity of command, span of control, communications, and execution of MCP’s related response objectives.
3. **Production.** Adjust the organization and MCP processes to gain the highest throughput consistent with triage priorities and relationship with supported hospital(s).
4. **Relationships with Superior, Host, and Supported Organizations.** Establish information and resource management relationships with the MCP’s superior response organization, supported hospital, and ordering point(s)

Rapid Screening Point (RSP)

RSP Purpose and Design. In some emergencies people may be exposed, or concerned that they may have been exposed, to a harmful substance (e.g. a chemical, biological, or radiation hazard) in an amount less than that required to produce symptoms or effects that require immediate medical care. Small numbers of exposed people can be accommodated by the primary medical care system. However, thousands of such

individuals requiring timely screening may indicate a need for RSPs. RSP staffing, layout, and flow is a variation of the Mass Prophylaxis model detailed in Tab B of the Multnomah County Health Department Emergency Response Plan.³ RSPs can be designed to:

- Relieve pressure from a primary medical care system under severe strain from patients requiring treatment;
- Reveal who should be referred for medical treatment based on subtle symptoms and better information about actual or potential exposure to the agent;
- Relieve concerns by allowing individuals prompt access to evaluation; and
- Gather population-based information to better define the problem, and better inform important response and recovery decisions, including whether to continue RSP operations.

The IC/UC that considers public health issues determines the need for large scale health screening operations. The IC/UC consults with Agency Executive(s) and political leaders to ensure commitment for operations that may greatly exceed the resources of the department or jurisdiction. The exercise RSP processed almost 600 ‘clients’ during two hours of operations.

The overall RSP objective was: Establish and conduct a RSP as appropriate in order to respond to people fearing contamination from exposure to the air plume from the explosion/fire. RSP sub-objectives were to:

1. **Apply Plans.** Apply/adapt the Public Health RSP plan and the governing IC/UC’s Incident Action Plan.
2. **Apply ICS.** Apply ICS criteria to assembling resources from various organizations and disciplines into a cohesive, well led, and coordinated RSP. Especially consider unity of command, span of control, communications, and execution of RSP assignments.
3. **Production.** Adjust the organization and RSP processes to gain the highest throughput consistent with the imposed protocols.
4. **Relationships with Superior and Host Organizations.** Establish the information sharing and support processes with the IC/UC response organization and host facility.

³ The Plan is available at <http://www.co.multnomah.or.us/health/emergprep/plans.shtml>; Tab D is for RSPs.

SECTION 3: ANALYSIS OF CAPABILITIES BY VENUE

This section of the report reviews the performance of the exercised capabilities by exercise venue and recommends improvements.

Health/Environmental Unified Command (UC)

Capability Summary: Incident Command System (ICS) is properly applied to the Health/Environmental Incident Command. The incident or operational activity is well led and managed through the integration of facilities, resources (personnel, equipment, supplies, and communications), and procedures that use ICS as the common organizational framework.

UC.1 Title: **Unified Command, Joint Objectives/Planning/Support**

Related Activity: **Merge organizations into UC**

Observation and analysis: Late on the first day, the U.S. Environmental Protection Agency and U. S. Department of Energy joined Multnomah County Health Department to form the UC for ‘off-scene’ health/environmental response operations. The UC produced good, progressive objectives. The strength of merged expertise from various agencies and disciplines gave weight to UC health/environmental decisions. At first some USDOE and USEPA staff operated separately, but coaches helped to integrate them with public health counterparts. Oregon’s Department of Human Services Public Health Division joined the UC on the second day. Portland’s Fire and Police Bureaus joined the Unified Command on the third day, too late into the exercise to integrate their staff into the organization and become part of the planning process. This may have been due Police and Fire Bureau resources being focused on initial response operations at the blast site. Two results of Portland’s late inclusion in the UC was insufficient security planning for MCP and RSP operations, and this UC’s limited relationship with the exercised MCP.

Recommendations:

- a. **The UC should ensure that their meetings to form or expand the UC follow scripted agendas** to ensure: staffs are integrated; best qualified individuals are appointed to key ICS positions; common understanding of the situation; and understanding of other important issues.
- b. **The IC/UC should invite organizations that are or will be most critical to the success of field operations (own major resources or have major authorities) to join the UC early.** Also, integrate them into operations, planning, and logistic functions. This would have applied to law enforcement/security and fire services required to support RSP and MCP operations.

UC.2 Title: **Professionalism and Technical Competence**

Related Activity: **Individual behavior under stress of the emergency**

Observation and analysis: Participants responded very seriously to this large, complex scenario. Great professionalism was demonstrated in the urgency of deadlines and

delegations of responsibilities, serious thought and dialogs, and integration of new people and organizations. ICS processes focused technical expertise into creating objectives, interpreting data, and making assignments in ways that could not be done as quickly as well if ICS had not been a common denominator. Underlying stress was often palpable, and was not always addressed.

Recommendation:

- c. **The Medical Unit/Logistics Section will identify explicit health impacts to responders and provide support services within the ICP and at field operations.** Leverage this responsibility through each leader.

UC.3 Title: ICS Position Performance

Related Activity: **Credentialing of ICS Positions**

Observation and analysis: There were highly variable ICS processes, products, performance outcomes, and integration of new people and agencies into the organization; and a steady state of tension and low-level chaos in the changing organization as it managed its response to this changing, difficult to comprehend incident. The UC response organization was comprised of individuals from many organizations. They had widely varying levels of general and position-specific ICS training and experience. Most were trained to the Intermediate ICS (ICS-300) curriculum level. Some had major exercise experience in their ICS positions. Few had position-specific training for their assigned roles. None were formally credentialed as performing their ICS position at a given level of performance. Therefore, individuals with general ICS training and position experience at an intermediate (Type 3) level joined many others with less training and experience in response to a nationally significance, Type 1 incident. A Type 1 or 2 Incident Management Team integrated into this UC organization would have resulted in greatly improved ICS processes. Such a team might be obtained in 24-48 hours.

Recommendations:

- d. **Establish desired levels of ICS leadership and performance for various tiers of IMT members for more consistent ICS position and process performance.** For the Multnomah County Health Department, the lowest common denominator should be Type 3 IMT/positions able to competently manage the planning cycle while conducting current operations. Select ICs, Command, and General Staff should aspire to Type 2 credentials in light of the potential for Type 1/2 level incidents in a major metropolitan area.
- e. **Apply a credentialing program that will achieve and maintain the desired level of ICS performance of ICS positions, processes, and working relationships.**
- f. **Order Type 1 or 2 IMT, or key ICS positions qualified at those levels, as soon as it is apparent that the incident is Type 1 or 2.**

UC.4 Title: Logistics Support**Related Activity: Resource supply and management**

Observation and analysis: Tactics planning, ordering, warehousing/check-in/assignment, and resource display should be done in a consistent, disciplined, and transparent manner during each shift. The status of resource orders sent to ordering points was not pursued as if the next period's objectives depended on the filled orders. In one example, 1000 beds were requested for patients who overwhelmed hospital capacity. The Unified Command was unable to fill the request, and sent it to the County EOC. The EOC returned the order unfilled and the UC waited for several hours, not knowing what to do with the unfilled order.

Other resource management processes were flawed. For example, the blank for a resource's home agency in the check-in form was often left blank. Therefore, that critical information was not available for resource status displays, incident status reports, emergency notification, demobilization, and time/cost accounting processes. The Unified Command treated the MCPs as Divisions, yet the MCP exercise leadership treated itself as an independent UC, a serious break in the chain of command. Many responders did not have position-specific training and related experience. As noted above under UC 1, informal Type 3 or 4 individuals/teams were doing work that would challenge Type 1 individuals/teams.

Recommendations: Same as recommendations d., e., and f. under UC.3 above.

UC.5 Title: Incident Commander**Related Activity: Interaction with and leadership of staff**

Observation and analysis: Evaluators and response personnel (including the Incident Commanders themselves) noted that the Incident Commanders spent too much time behind closed doors deliberating among themselves and with other organizations, and less confirming that the processes managed by Command and General Staff were working well. The Unified Command was greatly burdened by the complexity and level of decisions and the regular addition of new Unified Command members. On the other hand, their dialog on issues such as movement of plume boundaries and status of Prussian Blue may have been too detailed and should have been delegated to their staffs.

Inadequate attention to leading their organization, combined with the modest level of training of many intermediate leaders, perpetuated shortfalls in:

- resource management processes;
- Joint Information System and risk communication processes;
- Medical Care Points not being properly related to other response organizations; and
- insufficient oversight of and communications with Command and General Staff.

Recommendations: Same as recommendations d., e., and f. under UC.3 above.

UC.6 Title: Multi-Agency Coordination System (MACS)**Related Activity: Delineation & coordination of response organizations**

Observation and analysis: MACS elements were established as many response organizations formed and related to one another to a far greater degree than in past major health/medical exercises. The UC's Liaison Officer, Communication Unit, and Supply Unit did this particularly well. The blast site UC included a public Health IC (County Emergency Medical Services Medical Director) during the initial response operations and several public health staff were integrated into that organization. That integration facilitated information flow and differentiation of responsibilities with the Health/Environmental UC responsible for many off-site operations. However, there was insufficient information exchange between Planning Sections/Situation Units and PIOs/JICs of other response organizations, including the Portland and Multnomah County EOCs. This prevented the establishment of a well run MACS. Responsibility belongs at each end of the prospective communication/coordination link for making the communication; however, the recipient of information has the responsibility to properly assess, analyze, and act on the information. From the perspective of this UC organization, it did not appear that superior EOCs, JICs, and ordering points accepted this responsibility.

Recommendations:

- g. **Require that positions critical to establishing and maintaining effective, efficient MACS with their counterparts in other response organizations take Advanced ICS (ICS-400) and MACS on-line short courses and/or formal training.** MACS leadership must understand processes that must operate well between different response organizations. This is most applicable to leaders of Type 1 or 2 size/complexity incidents, specifically lead elected officials, EOC Directors, Agency Executives of lead agencies, Incident Commander, Liaison Officer, Public Information Officer, Planning Section Chief, Situation Unit Leader, Logistics Section Chief, Supply Unit Leader, Communications Unit Leader, and Finance/Administration Section Chief.

UC.7 Title: Unity of Command between Response Organizations**Related Activity: Chain of Command**

Observation and analysis: Numerous organizations contributed resources to the MCPs (both real and simulated). The idea and order for an MCP of the size established at the University of Portland must come from an IC/UC or EOC. Indeed, that MCP was an objective of the Health/Environmental UC, reflected in their Incident Action Plan. Yet the Health/Environment UC did not assert its stated relationship, and the MCP leadership did not recognize external leadership or a relationship with the hospital that it supported.

Recommendation:

- h. **Response organization leaders (at Health/Environmental UC, supported hospital, or relevant EOC) must clearly define operations, their relationship and communications with supported and supporting organizations such as the MCP at the University of Portland.**

UC.8 Title: Joint Information System (JIS)

Related Activity: **Timely, accurate information releases**

Observation and analysis: Many regional PIO professionals and responders see a single Joint Information Center (JIC) as the solution to public information demands. An Oregon incident-wide JIC located away from all ICPs and EOCs evolved slowly, and did not operate well. The concept of a Joint Information System (JIS) that coordinates the many PIOs and JICs was not well understood and properly developed. The JIS collectively sets information sharing standards among the PIOs or JICs located at each response organization. The JIS imposes discipline on which organization releases what information, and what information needs to be consistent or may be tailored to the source organization.

One example of an inadequate JIS occurred when the Venue Control Center called for a new MCP press release for immediate distribution because the City of Portland's press release did not include opening times. The health Unified Command PIO issued a corrected release, but it omitted information about the University of Portland MCP (opened by the Portland Fire Bureau). The public would be confused by mixed messages, and should not be expected to discern differences in the leadership of various response operations.

The UC's PIO regularly released many public health and environmental messages to various response organizations about the UC's operations, but the contents of those messages were often not reflected in the messages and actions of superior organizations.

Recommendation:

- i. **Create a Joint Information System that adheres to established protocols** such as NIMS/ICS principles regarding the PIO position, JIS, and MACS and Table 1 of Risk Communications Tab G of the Public Health Emergency Response Plan.⁴

MEDICAL CARE POINT (MCP)

Capability Summary: The MCP is a temporary facility to relieve overwhelmed hospital emergency rooms and emergency clinics. It provides the level of care commensurate with its staffing resources, facility, and level of logistics support. ICS is the common organizational framework. In order to encourage active leadership and determine capacity levels, the exercise was designed to provide 400 patients in two hours, more than the MCP had capacity to serve.

MCP.1 Title: Interoperable communications

Related Activity: **Mutual aid interoperability**

Observation and analysis: During and subsequent to the initial briefing, the Fire Incident Commander (a Battalion Chief) ensured that all resources assigned to the fire

⁴ Tab G may be found at <http://www.co.multnomah.or.us/health/emergprep/plans.shtml>

department portion of the operations were able to use their equipment to communicate on the assigned frequency. This prevented the lack of communication that has often led to injury and death.

Recommendation:

- j. **Make the communications check and understanding of the communications plan a best practice of any operational briefing.** Confirm understanding of emergency and routine communications equipment, protocols, frequencies, and chain of command.

MCP.2 Title: **Operational Awareness**
Related Activity: **Briefing of fire department resources**

Observation and analysis: A Portland Fire & Rescue Battalion Chief/IC and Lieutenant gave a 13-minute briefing to fire department resources prior to commencing their screening, triage, and decontamination operations. This briefing covered critical factors such as the ICS structure, patient flow procedures, PPE requirements, and the site operating plan. This outstanding briefing was a major contributing factor in the success of fire department operations.

Recommendation:

- k. **Adopt the operational briefing as a best practice.** This observation affirmed the importance of this standard ICS practice.

MCP.3 Title: **MCP Location**
Related Activity: **Use of large arena as MCP site**

Observation and analysis: The Chiles Center at the University of Portland was a superb location for the MCP. With a main floor of three basketball courts and generous parking and lobby areas unimpeded by steps, the site could accommodate large numbers of patients. It had full utilities and was built to high seismic standards. Physical barriers simplified security. It would be very costly to duplicate such features at an outdoor venue.

Recommendation:

- l. **Identify and develop partnerships with the owners of the best local facilities.** Maintain facility surveys to assure rapid familiarity and arrangements with these sites during emergencies. Use outdoor venues as a last resort.

MCP.4 Title: **MCP Operations**
Related Activity: **Combined fire/DMAT operations**

Observation and analysis: This MCP departed from the MCP plan (Tab C of Multnomah County Health Emergency Response Plan⁵) and Portland Fire Bureau MCP training curriculums. Neither is scalable or flexible enough to explicitly guide an operation of this size. The federal Disaster Medical Assistance Team (DMAT) leader and Senior Fire Chief managed their respective operations and connected them rather than integrated them. The strength of fire service personnel is short-term first aid,

⁵ <http://www.co.multnomah.or.us/health/emergprep/plans.shtml>

transport, decontamination, and scene control/organization. The strength of DMAT teams is more complex treatment typically provided in a hospital emergency room. Fire services focused operations on screening, triage, and decontamination of patients in a parking lot outside of the facility. DMAT teams worked inside, separating patients into three treatment areas (red, yellow, green), each with its own discharge/disposition area. The MCPs combination of DMAT and fire department resources allowed each group to focus on areas of strength and, from what was observed, could be considered a best practice. Patient flow through the MCP was efficient and nearly flawless.

Recommendation:

- m. **Update the MCP plans and training protocols to be more scalable and flexible to the range of prospective resources (DMAT, fire, mental health, medical reserve, lay volunteers) and locations (indoor, outdoor, or both).** Exercise these more flexible plans/protocols.

MCP.5

Title: **Integration of Treatment Resources**

Related Activity: **Increasing DMAT treatment capacity**

Observation and analysis: Non-DMAT medical/health resources who reported to the scene sought leadership, purpose, and roles in the treatment organization for about an hour while Oregon DMAT waited for the Washington DMAT and its equipment. A controller questioned an overall lack of leadership during this period. Oregon DMAT's leader (IC for DMAT operations) then worked hard to assert leadership. Furthermore, some arriving personnel informed DMAT of their expertise and prospective roles and requested suitable roles. As noted in MCP.11 (below), the integration of DMAT with other treatment resources might be against federal HHS policy on DMAT operations. Fire services from several jurisdictions (see MCP.1 and MCP.2) organized very rapidly and efficiently at their parking lot area of operations. The initial DMAT IC and the Fire IC meeting occurred well after each organization was committed to their respective preparations. There appeared to be no consideration of a true Unified Command with integrated staff elements.

Recommendation:

- n. **Leaders of organizations converging at a scene of operations should report to the IC/UC to know and understand: who is IC/UC; objectives, organization; and assignments. The IC/UC must assert leadership over the entire organization.** Urgent situations or unclear instructions may delay formal meetings with every arriving organization; however, this was a planned event that allowed two hours for set-up. Leaders of response teams or organizations need to know and apply protocols for:
 - ICS common responsibilities (for each person reporting to incident);
 - formation of ICS organization (to combine and/or split resources that shape the desired organization to achieve objectives).
 - Set agendas for common ICS meetings such as transition of command, creation of UC, and Command and General Staff meetings.

MCP.6 Title: **Triage of Patients**Related Activity: **Surveyor's tape to identify patients**

Observation and analysis: Fire Department units performing triage wrapped patient wrists with colored surveyor tape that match the color of their triage category.

Recommendation:

- o. **Consider using colored tape over commercial triage tags for mass casualty operations.** With such large numbers of patients, more complicated commercial tags may have slowed patient flow and caused confusion among responders from various agencies.

MCP.7 Title: **Security Planning and Operations**Related Activity: **Develop a site-specific security plan**

Observation and analysis: Security issues included orderly flow of people through the facility, response to disruptive behavior, and prevention and response to secondary threats to this assembly. In the case of this MCP exercise, Portland Police and University of Portland security were requested radio at 0911 (operation due to start at 1030). Portland Police were simulated to be on scene at 0920 9Police were present as part of the investigation and victim identification, but none could be spared for exercise security). No federal law enforcement officer was assigned for DMAT security as would be the case for a real deployment.

Police were not part of the Health/Environmental UC when it was planning MCP and RSP operations the day before, likely due to cost and availability for the exercise.

Recommendations:

- p. **Assign a law enforcement leader to the leader of each field operation with significant security risks.** This officer would lead the security staff.
- q. **Integrate the DMAT's federal law enforcement agent into the MCP's security team.**

MCP.8 Title: **Special Needs Patients**Related Activity: **Communication with Special Needs Patients**

Observation and analysis: A hearing-impaired patient proceeded through the screening and triage process (triaged as a "red"). At the transition point between fire and DMAT operations, a fire officer who spoke American Sign Language was able to understand the patient's complaints. After transferring the patient to the DMAT team, the fire officer returned to his post. Personnel in the DMAT's "red" treatment area were unable to communicate with the patient and did not appear to have a plan in place to assist this special needs patient.

Recommendation:

- r. **Anticipate the need to communicate with special needs patients and arrange for services to be available when a mass treatment facility opens.** This observation validates a need for nationwide credentialing and tracking of emergency response resources having special skills. MCP leaders should have a

roster of qualified people, such as ASL signers, who are on call to assist with patient care.

MCP.9 Title: **Incident Management Team**

Related Activity: **Incident support**

Observation and analysis: The MCP did not have sufficient overhead to independently conduct ICS support functions such as planning and resource management processes. If the MCP were the principle field operation in this response, it might warrant the status of being an independent IC/UC, or it might have independent status for initial startup, and then become part of Operations of another IC/UC. But T4 was a much larger incident requiring the Health/Environmental UC to establish three MCPs (two simulated) and four RSPs (three simulated). However, the Health/Environment UC did not assert its leadership and support relationship responsibility over the real MCP; and the MCP UC did not establish a relationship with any superior organizations, or the supported hospital (via exercise controllers since hospitals were no longer participating in the exercise).

Recommendations: ICS structures that are more sustainable for long term operations and more responsive to needs, regional priorities, and resource allocation concerns are:

- s. **Create a single Health/Environmental IC/UC and its ICS support functions to lead multiple MCP/RSP operations in a limited geographic area.** Each MCP might be a Division of the MCP Branch of the Operations Section. Coordination, leadership, and support of the MCPs would be simplified.
- t. **Alternatively, make each MCP a Group in the Operations Section of the hospital IC/UC that it supports.** That IC/UC would lead and support its MCP. This would improve coordination between the hospital IC, its emergency room, the MCP, and the allocation of hospital resources.

MCP.10 Title: **DMAT Operational Policy on Integration with Others**

Related Activity: **Flexibility in sizing a response organization**

Observation and analysis: During MCP set-up and before operations, there was insufficient leadership of personnel from various arriving organizations. When the Oregon DMAT leader was prompted to intervene, she noted that Health and Human Services policy does not allow the integration of non-DMAT medical personnel into a DMAT, or vice versa. In the case of the senior nursing students, some strongly advocated what they could do. Ultimately the DMAT did bring nursing students, other nurses, and mental health personnel into the two DMATs (the author saw support rather than treatment roles). It is questionable that this would have been done in a real operation against stated policy.

Recommendation:

- u. **Change U. S. Department of Health and Human Services policy to allow DMATs to be reinforced by non-DMAT personnel, or split apart to join other resources.** Certain elite teams in other disciplines have this flexibility to adapt to incident needs. This could be facilitated with personnel overhead staff who would validate credentialing and competency issues.

MCP.11 Title: **Patient Tracking**
Related Activity: **Patient information**

Observation and analysis: Fire services did not start or make recorded entries on individual patients other than apply the triage wrist bands. No information regarding patients was transferred from the fire service managed initial screening and triage point to the DMAT led treatment area.

Recommendations:

- v. **Establish a pre-warning on inbound “red” and “yellow” patients and mark a D on the wrist of those who were decontaminated.**
- w. **Register exposed/decontaminated patients in the DMAT treatment records for long term health monitoring and disease registry as well as reconstructing the initial incident events and management.**

MCP.12 Title: **Numbers and Locations for Mental Health Staff**
Related Activity: **N/A**

Observation and analysis: Mental health responders felt their services adequately staffed the venue but would have welcomed more responders to be able to “float” among crowd and have adequate time to speak at length with victims.

Recommendation:

- x. **Strategically locate adequate mental health services at the entrance and exit of MCP (and RSP); i.e., for the MCP at the outside radiation survey area, the transition area from Fire decontamination tents into the MCP waiting/triage area, and again at the patient discharge table.**

MCP.13 Title: **Use of Respiratory Protection**
Related Activity: **N/A**

Observation and analysis: Well into the exercise, when masks were donned inside MCP, behavioral health responders noted an immediately increased sense of fear in room. They further noted that the verbally announcement resulted in some victims/responders wearing masks while others did not. Victims with no masks began to express concern over their safety. Hearing-challenged victims had difficulty communicating with people who had put on medical masks.

Recommendation:

- y. **Have the capacity to simultaneously and quickly convey important messages to all areas of the MCP (or RSP) operation to relieve fear or confusion.** Use a public address system, fast acting messenger service connected to leadership via radios, a “crier”, or large reader boards. Consider special needs of hearing and sight-challenged individuals.

RAPID SCREENING POINT (RSP)

Capability Summary: The RSP conducts high capacity screening of individuals who are potentially ill or exposed to a harmful substance, but do not have acute symptoms requiring prompt medical care. ICS is the common organizational framework.

RSP.1 Title: **Flexibility and Adaptability**

Related Activity: **Order out of chaos**

Observation and analysis: A number of exercise artificialities served as good surrogates for events that might severely disrupt a field operation: 1) Training designed to train RSP leaders during the previous afternoon was attended by dozens of mental health staff. 2) Lead mental health workers, who were to originally lead an 8 person crisis counseling team, imposed a psychological survey step into the RSP process that was not formally designed into the RSP. 3) A clock in the gym displayed the wrong time, and led the RSP supervisor to think she had an extra hour to prepare her Division, until she realized that there were only ~30 minutes until the doors opened and just-in-time training had not been done. 4) Key detailed maps intended to help determine the exposure of clients were not delivered in time from the ICP. 5) As the first wave of clients wound through the process, one of ~40 police officers conducting real security for the Secretary of U. S. Homeland Security's VIP visit blocked a client exit door, creating confusion as the line quickly backed up. 6) Secretary Chertoff and his ~50 person entourage walked into the middle of the operation during his briefing.

This operation was expected to process 1,000 clients in two hours. The Division Supervisor and leaders made adjustments, persistently worked around challenges, and achieved respectable flow rates that would have approached 500 clients per hour if the operation had continued beyond the scheduled two hours of operations.

Recommendation:

- z. **Identify and develop leaders who are tough, resilient, and able to project leadership in a chaotic emergency situation.** Such attributes might not be cultivated in the normal work environments.

RSP.2. Title: **Incident Facilities**

Related Activity: **N/A**

Observation and analysis: The facility had an open area larger than two basketball courts. If school operations were suspended it was an excellent venue. High schools and university field houses are superb, well supported venues for a wide array of emergency operations. They host large community events and are often under public control or have public service missions. High schools are distributed roughly according to population density. Many organizations/disciplines (e.g. Red Cross, public health departments) separately make arrangements to use these facilities during an emergency. A non-comprehensive approach creates much wasted planning effort.

Recommendation:

- aa. **Enter into broad agreements/relationships with facilities (not specific to a given risk) suitable to support general emergency services.** Seek at least partial emergency staffing by normal facility staff.

RSP.3. Title: Use of Volunteers

Related Activity: **Surge personnel resources for emergency staffing**

Observation and analysis: Thirty high school and about forty college students joined the RSP leaders and professional staff. These volunteers served as surrogates for community volunteer. They were trained just before operations began. They served as crowd control, greeters, and interpreters. They assisted clients with intake forms, interpreted completed forms, conducted mental health surveys, and provided counseling. They filled all positions except supervisor/leader positions, and use of radiation survey instruments and interpretation of results.

Recommendation:

- bb. **Have the capacity to rapidly recruit emergent volunteers and lay staff (able to perform general duties) that can be productive after just-in-time training.**

RSP.4 Title: Security Planning and Operations

Related Activity: **Develop a site-specific security plan**

Observation and analysis: Security issues include orderly flow of people through the facility, response to disruptive behavior, and prevention and response to secondary threats to this gathering of people. RSP security was planned at the Health/Environmental UC, but no professional security resources were assigned to the exercise staff due to cost/availability. News of a visit to the RSP by the U. S. Secretary of Homeland Security was revealed at the last moment. A Police Commander and the lead exercise Controller planned this security the night before without representatives of the UC or the RSP supervisor. Some 40 Portland police and other security officials provided excellent real security. Exercise staff and school officials had to ensure that all participants and visitors were known and belonged in the facility. However, there was not a direct link between VIP security and the exercise participants.

Recommendations:

- cc. **Include law enforcement and security forces (possibly even National Guard assets) to plan and execute RSP (and MCP) plans as part of the UC overseeing a number of field operations where security is a key factor.**
- dd. **Assign a law enforcement or security leader to the leader of each field operation requiring security.** Law enforcement officers are sometimes reluctant to be assigned outside of the chain of command of their normal organizations or to work for a non-law enforcement official.

RSP.5 Title: **Design Maximum Productivity Relative to Resources**

Related Activity: **Efficient Layout, Flow, and Process**

Observation and analysis: The RSP layout is supposed to be adapted from the mass prophylaxis layout (Tab B of Multnomah County Public Health Emergency Response Plan⁶). This plan designs a fast track through the process for those not requiring each step. This RSP strayed from that precept.

RSP clients went through all processes except: decontamination only for those exceeding a radiation reading threshold; and medical specialist evaluation for those exceeding exposure criteria. The design and flow of the RSP was arguably too labor intensive. This cannot be stated with certainty because we can only speculate on the real emotions and needs of clients. On one hand, radiation induces the fear of the unseen and unknown. On the other hand, the risk of short term exposures to those away from the blast site, but down-wind was stated as negligible. Would messages that explained risk and advised self-help measures (shower, change into clean clothes) in the two days since the blast have been effective? Might those who were not in the area of concern be identified early in the RSP process and be released or be referred to a counselor if needed? Did everyone really have to first go through portal monitors and then undergo full screening by a hand-held instrument? What was the risk of this facility being contaminated two days after the event? Did it really require 40 staff to administer the psychological survey tool and provided counseling or referral based on the results? Could the layout have been more linear and logical than the tight square formed by greeting, form filling, education, and medical counseling with a big loop to checkout?

Recommendation:

- ee. **Design RSP operations in the command post with great care to maximize flow and efficiency relative to staffing levels.** Adapt the mass prophylaxis plan. Create a simple and logical flow that will minimize confusion, calm clients, and ease the workload of staff.

RSP.6 Title: **Leadership, Organization, and Just-in-Time Training**

Related Activity: **Priority to organize people**

Observation and analysis: The Division Supervisor arrived about 2.5 hours prior to the 9 a.m. start of operations. Public health leaders, school support staff, administrators, and others arrived at about 7 a.m.. David Douglas students, firefighters, and others arrived closer to 8 a.m. There were constant arrivals in the midst of a fairly confused environment of determining layout and flow, setting up the facility, identifying new arrivals, and making assignments.

Most design details should be determined as the RSP is designed during the previous planning cycle. Not all leaders were trained on the situation, design, and their assignment the previous day and were clear about what resources would be assigned to them. Upon arrival at the facility, assessing it, and quickly adjusting the design, the Supervisor's next priority should be to brief leaders first, then brief all staff, call out staff assignments to

⁶ See <http://www.co.multnomah.or.us/health/emergprep/plans.shtml>

leaders, and delegate just-in-time training and facility set up responsibilities to leaders of various teams and crews.

Instead leaders were introduced to individual staff as a continuing process of trying to match leaders and staff during the chaos of staggered arrivals and setup. Many did not understand that the leader of an agency team was often not the leader of that agency's personnel in the RSP organization, or that an RSP leader may be leading personnel from other organizations. Furthermore, leaders were not readily identifiable; distinctive orange vests were available in delivered supplies, but were not used.

Recommendations:

- ff. RSP (and MCP) operations supervisors and leaders should be trained on the operation, layout, resources, and other details prior to reporting to the field.**
- gg. RSP (and MCP) Supervisors must quickly brief and dispatch prominently identified leaders (e.g. orange vests) and assigned personnel to their areas, and assign leaders the authority to organize their areas and provide just-in-time training to their staff.**
- hh. Provide leadership training and experience in addition to ICS position specific training.**

SECTION 4: CONCLUSION

Health/Environmental Unified Command, Medical Care Point, and Rapid Screening Point operations in the Oregon venue of the 2007 Top Official Exercise were conducted with great heart, seriousness, and intelligence. The UC developed and matured over the course of four days. The MCP and RSP field operations each operated for only two hours (plus about 2 hours of set-up). With more time, each would have improved efficiency and effectiveness. Most MCP and RSP resources were scheduled well in advance, independent of UC decisions and support; what if they had totally depended on UC support in real time? Consider UC performance using an arrow analogy:

- **The fin/feather representing the Unified Command aims response organization operations and services at targeted objectives.** The UC spent most of its time giving direction, developing as a UC team with the addition of new Incident Commanders, and collaborating with key partner response organizations and policy leaders. However, this did not leave enough time to ensure that Command and General Staff translated UC objectives and policy decisions into the risk communication, planning, logistics, and finance functions required to support tactical field operations – the arrowhead. The solution is a combination of better allocation of UC time between its goal-setting and leadership responsibilities, and using Deputy IC and Command and General Staff with higher ICS qualifications to ensure that direction is connected to delivered services.
- **The shaft of the arrow represents the ICS functions that connected the UC's direction to executed operations that hit the proper targets.** The quality of this connection is reflected by the quality of Incident Action Plans and resource management, public affairs, planning, finance, and other ICS processes. Many of the UC's plans did not have sufficient detail, nor were they backed by released messages, filled resource orders (complete with names for every position to be filled), operational designs, and other documents of sufficient quality to give confidence that operations would be properly supported. However, the Command Post organization was a very diverse blend of local, state, and federal officials who gelled as a team over the four days of the exercise. Together they worked tirelessly, were highly motivated, intelligent, and created many fine products. The atmosphere was supportive and encouraging.
- **The arrowhead represents the delivery of services, perhaps to clients of a RSP or patients at a MCP.** Leadership at the exercise MCP and RSP overcame initial periods of chaos and adapted well to field conditions and obstacles. Leaders filled gaps in operational design, support, and direction that may have been better filled at the remote UC. The exercised MCP and RSP did not conduct critical processes such as logistics ordering/re-supply and situation updates with their supporting organizations. However, field leaders and staff performed impressively and likely would have quickly developed the RSP and MCP into mature, well-run organizations.

In fairness to all, this and most exercises impose artificialities:

- **Unavailable emergency management personnel.** T4 design and administration prevented many full-time emergency managers and staff from participating with their organizations;
- **Unavailable incident management team members.** Some of our most experienced IMT members continued doing public health operations that would have been suspended if the emergency were real;
- **Lower experience base.** Inexperienced people were integrated into the T4 response organizations to help build their experience;
- **Artificially high turnover.** Shift changes brought more staff and leadership turnover than acceptable in a real operation;
- **Artificial suspension of operations.** Suspension of the exercise from 1500 Thursday till 0700 on Friday prevented critical preparations required to create what should have been the final and best Incident Action Plan.
- **Exercise ambiguity.** Planning both real and simulated operations can be confusing; and
- **Insufficient consequences.** Not having real consequences to planning and logistic process ‘shortcuts’, especially in support of virtual operations, is too forgiving.

Nevertheless, the above observations should not mask opportunities to improve. Most notably:

- **Obtain position-specific training** and deepen practical experience of key IMT members;
- **Adopt credentialing system** to impose standards of performance on those assigned to key ICS positions;
- **Improve large, complex incident management knowledge** of select political leaders, agency executives, and Incident Commanders and Command and General staff; and
- **Quickly request a suitably experienced Type 1 or 2 IMT** to integrate with the local team as soon as it is apparent that the incident is a Type 1 or 2. This will blend disciplined, large incident management capacity with local knowledge and discipline-specific expertise.

Almost a year before T4, Seattle-based federal agency representatives met in Portland to begin planning their T4 operations. T2 (four years ago in Seattle) was seared into their memories. They said, “We cannot respond to T4 as we did to T2... there were too many uncoordinated agency stove-pipes.” All were confident that we would do much better this time.

We have now walked in the shoes of those from three previous Top Official exercises. Agency “stovepipes” appear to have been much less of a problem than in T2. The overall level of ICS knowledge is greatly improved since the 2004 adoption of the National Incident Management System. We have reason to be proud. Yet the scenario and many aspects that might have been done better were humbling, as are this report’s recommendations summarized in Appendix B. The improvement plan is a separate document.

Large, complex incident management is a career skill that takes long to learn well.

APPENDIX A: ACRONYMS, DEFINITIONS

Acronym	Meaning
AAR	After Action Report
DMAT	Disaster Medical Assistance Team. A federal Department of Health and Human Services resource comprised of about 35 physicians, nurses, and support staff and equipment.
EOC	Emergency Operations Center. A center for support and/or coordination of information, resources, and services between a number of response organizations and agencies.
IC	Incident Commander. Official responsible for setting response objectives and leading tactical operations to achieve those objectives.
ICP	Incident Command Post. Facility for IC/UC and other ICS leadership to support tactical operations.
ICS	Incident Command System. The nationally adopted system of organization and processes for responding to emergencies.
IMT	Incident Management Team. A team identified and trained to lead and staff a response organization, typically at an IC/UC or EOC.
JIC	Joint Information Center. The PIO function of a response organization that serves to coordinate messages of more than one organization that has public affairs responsibilities for the incident.
JIS	Joint Information System. PIO functions, JICs, shared understanding of roles and situation, and use of NIMS/ICS processes, all operating as a collective system to support response objectives.
MACS	Multi-Agency Coordination System. Response organizations apply NIMS/ICS processes to efficiently and effectively differentiate responsibilities and objectives, share situational awareness, and coordinate resources.
MCP	Medical Care Point. A facility and operation in the Multnomah County Health Department and local fire/EMS plans for treatment of persons requiring emergency room type urgent care.
OSC	Operation Section Chief. ICS position responsible for operations.
PSC	Planning Section Chief. ICS position responsible for planning.
RSP	Rapid Screening Point. An operation in the Multnomah County Health Department plan for mass screening of persons exposed (perception or reality) to a significant health threat.
T4 or TOPOFF 4	Top Officials Exercise, the 4th federally mandated exercise.
UC	Unified Command. Two or more ICs jointly setting objectives and leading the same operations.
USEPA	United States Environmental Protection Agency
USDOE	United States Department of Energy

APPENDIX B: RECOMMENDATIONS

Sec. 3 Capability #	Recommendations (Highlighted bold face sentence from Section 3)
Unified Command	
UC.1	a. The UC should ensure that their meetings to form or expand the UC follow scripted agendas.
UC.1	b. The IC/UC should invite organizations that are or will be most critical to the success of field operations (own major resources or have major authorities) to join the UC early.
UC.2	c. The Medical Unit/Logistics Section will identify explicit health impacts to responders and provide support services within the ICP and at field operations.
UC.3/5	d. Establish desired levels of ICS leadership and performance for various tiers of IMT members for more consistent ICS position and process performance.
UC.3/5	e. Apply a credentialing program that will achieve and maintain the desired level of ICS performance of ICS positions, processes, and working relationships.
UC.3/5	f. Order Type 1 or 2 IMT, or key ICS positions qualified at those levels, as soon as it is apparent that the incident is Type 1 or 2.
UC.6	g. Require that positions critical to establishing and maintaining effective, efficient MACS with their counterparts in other response organizations take Advanced ICS (ICS-400) and MACS on-line short courses and/or formal training.
UC.7	h. Response organization leaders (at Health/Environmental UC, supported hospital, or relevant EOC) must clearly define operations, their relationship and communications with supported and supporting organizations such as the MCP at the University of Portland.
UC.8	i. Create a Joint Information System that adheres to established protocols
Medical Care Point	
MCP.1	j. Make the communications check and understanding of the communications plan a best practice of any operational briefing.
MCP.2	k. Adopt the operational briefing as a best practice.
MCP.3	l. Identify and develop partnerships with the owners of the best local facilities.
MCP.4	m. Update the MCP plans and training protocols to be more scalable and flexible to the range of prospective resources (DMAT, fire, mental health, medical reserve, lay volunteers) and locations (indoor, outdoor, or both).
MCP.5	n. Leaders of a organizations converging at a scene of operations should report to the IC/UC to know and understand: who is IC/UC; objectives, organization; and assignments. The IC/UC must assert leadership over the entire organization.

Sec. 3 Capability #	Recommendations (Highlighted bold face sentence from Section 3)
MCP.6	o. Consider using colored tape over commercial triage tags for mass casualty operations.
MCP.7	p. Assign a law enforcement leader to the leader of each field operation with significant security risks.
MCP.7	q. Integrate the DMAT's federal law enforcement agent into the MCP's security team.
MCP.8	r. Anticipate the need to communicate with special needs patients and arrange for services to be available when a mass treatment facility opens.
MCP.9	s. Create a single Health/Environmental IC/UC and its ICS support functions to lead multiple MCP/RSP operations in a limited geographic area.
MCP.9	t. Alternatively, make each MCP a Group in the Operations Section of the hospital IC/UC that it supports.
MCP.10	u. Change U. S. Department of Health and Human Services policy to allow DMATs to be reinforced by non-DMAT personnel, or split apart to join other resources.
MCP.11	v. Establish a pre-warning on inbound "red" and "yellow" patients and mark a D on the wrist of those who were decontaminated.
MCP.11	w. Register exposed/decontaminated patients in the DMAT treatment records for long term health monitoring and disease registry as well as reconstructing the initial incident events and management.
MCP.12	x. Strategically locate adequate mental health services at the entrance and exit of MCP (and RSP).
MCP.13	y. Have the capacity to simultaneously and quickly convey important messages to all areas of the MCP (or RSP) operation to relieve fear or confusion.
Rapid Screening Point	
RSP.1	z. Identify and develop leaders who are tough, resilient, and able to project leadership in a chaotic emergency situation.
RSP.2	aa. Enter into broad agreements/relationships with facilities (not specific to a given risk) suitable to support general emergency services.
RSP.3	bb. Have the capacity to rapidly recruit emergent volunteers and lay staff (able to perform general duties) that can be productive after just-in-time training.
RSP.4	cc. Include law enforcement and security forces (possibly even National Guard assets) to plan and execute RSP (and MCP) plans as part of the UC overseeing a number of field operations where security is a key factor.
RSP.4	dd. Assign a law enforcement or security leader to the leader of each field operation requiring security.
RSP.5	ee. Design RSP operations in the command post with great care to maximize flow and efficiency relative to staffing levels.

Sec. 3 Capability #	Recommendations (Highlighted bold face sentence from Section 3)
RSP.6	ff. RSP (and MCP) operations supervisors and leaders should be trained on the operation, layout, resources, and other details prior to reporting to the field.
RSP.6	gg. RSP (and MCP) Supervisors must quickly brief and dispatch prominently identified leaders (e.g. orange vests) and assigned personnel to their areas, and assign leaders the authority to organize their areas and provide just-in-time training to their staff.
RSP.6	hh. Provide leadership training and experience in addition to ICS position specific training.