2025

RITN Tabletop Exercise (TTX) After-Action Report/Improvement Plan

Exercise Date: July 24, 2025
Report Date: August 6, 2025

EXERCISE OVERVIEW

Exercise Name	2025 RITN Tabletop Exercise (TTX)
Exercise Date	July 24, 2025
Scope	The exercise was a distance-based tabletop exercise scheduled for 2 hours. Exercise play was limited to RITN facilities to examine the response by RITN hospitals to accommodate patient surge and care to include activating family reunification centers, identifying mental health resources, and coordinating with local, state, and federal public health agencies to track and report patient conditions.
Mission Area(s)	Response
Capabilities	Medical Surge Healthcare and Medical Response Coordination Community Resilience Information Sharing
Objective	**Objective 1:** Participants will describe the procedures for activating a family reunification center, including identifying staff, location, required resources, and the timing for activation. They will also identify potential challenges to activation and propose solutions. **Objective 2:** Participants will explain the integration of hospital-level family reunification processes with county and regional efforts, including coordination with healthcare coalitions and local public health agencies, and outline any necessary support from these partners. **Objective 3:** Participants will describe the mental health resources and educational support services to be activated in response to a radiological emergency, including how to address the psychological impact on healthcare workers, patients, families, and vulnerable populations, while ensuring accurate public messaging and coordination with external agencies. **Objective 4:** Participants will outline how the hospital coordinates with local, state, and federal public health agencies to track and report patient conditions, manage long-term health effects of radiation exposure, and share data for population health monitoring during a radiological event.
Hazard	Radiological
Scenario	Medical surge from a distant radiological incident
Sponsor	Radiation Injury Treatment Network® (RITN) Office of Naval Research (ONR)
Participating Organization	Children's Hospital of Wisconsin (WI) Duke University Medical Center (NC)

	Emory University Hospital (GA) Froedtert Memorial Lutheran Hospital (WI) Greenville Health System (SC) H. Lee Moffitt Cancer Center (FL) Medstar Georgetown University Hospital (DC) Oklahoma University Medical Center and Children's Hospital (OK) Roger Williams Medical Center (RI) Roswell Park Cancer Institute (NY) Rush University Medical Center (IL) Stanford – Palo Alto (CA) Texas Children's Hospital (TX) University of North Carolina Hospitals (NC) University Hospitals of Case Medical Center (OH) University of Kentucky Medical Center (KY)
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EXERCISE SUMMARY

On July 24, 2025, 16 Radiation Injury Treatment Network (RITN) centers participated in an online tabletop exercise (TTX) to determine their hospitals' capacities for activation of family reunification and mental health support to healthcare workers, patients, families, and vulnerable populations following a mass casualty radiological event. A facilitated series of exercise tasks were provided to participants for their consideration, response, and group discussion organized by the exercise scenario summary below.

Scenario Summary: The following points illustrate the scenario events considered for participant discussion:

Exercise Scenario:

- A 10 kiloton Improvised Nuclear Device (IND) was detonated in a major metropolitan area.
- Infrastructure and hospitals are severely damaged in the area surrounding the blast (at least 25-mile radius).
- The blast occurred at least 500 miles from your hospital and there is no concern of fallout affecting your location.
- RITN Control Cell staff begin to monitor the situation and start sending out daily Situation Reports (SitReps).
- The nuclear explosion and fallout is expected to result in thousands of casualties with marrow toxic injuries who will need to be transported to other healthcare facilities across the country.
    - Those with mild to moderate trauma and those seeking evaluation for radiation exposure will self-evacuate to other metro areas.
    - Other patients experiencing radiation exposure will be evacuated in the coming days through the National Disaster Medical System (NDMS).

ANALYSIS OF CAPABILITIES

Module 1: Family Reunification

Thirteen (13) out of 16 participants indicated their facility had a family reunification plan, though only seven had exercised the plan within the past year. Nine (9) participants reported having designated staff roles and identified space for a family reunification center, but only five felt adequately resourced to sustain activation for more than 72 hours. Several respondents noted challenges related to staffing availability, competing incident priorities, and physical space constraints during a high-volume influx of families.

Responses regarding coordination with external partners varied. Eleven (11) participants noted formal relationships with local emergency management or public health entities that could support family reunification operations. However, six reported unclear lines of authority regarding oversight responsibilities while only five had documented protocols for integrating their reunification efforts with county or regional systems. Several participants highlighted a need to revisit or expand existing memoranda of understanding (MOU) to better support collaboration in complex, multi-jurisdictional incidents such as a radiological mass-casualty event.

Participants also expressed concerns about communications and mental health surge capacity. Twelve (12) out of 16 reported challenges in maintaining psychosocial support for staff, patients, and families, especially under sustained pressure. Eight (8) respondents cited difficulty aligning their hospital's messaging with federal NDMS communications, and six requested templates or guidance for Joint Information Center (JIC) coordination and trauma-informed public outreach. Responses to Module 1 highlighted the importance of strengthening linkages between hospital reunification operations and jurisdictional emergency support functions (ESFs), as well as ensuring access to behavioral health, legal, and ethical support frameworks during large-scale emergencies.

Strengths

The following strengths were demonstrated:

Strength 1: Thirteen (13) out of 16 participating facilities indicated they have a family reunification plan in place, demonstrating a strong foundation of patient and family tracking during emergencies.

Strength 2: Nine (9) out of 16 respondents reported that their facility has identified specific staff roles and designated physical spaces for operating a family reunification center, supporting the rapid activation of reunification operations.

Strength 3: Eleven (11) out of 16 facilities reported having formal relationships with local emergency management or public health agencies, which enhances interagency coordination during large-scale incidents.

Areas for Improvement

The following areas require improvement:

Area for Improvement 1: Less than half (seven out of 16) hospitals reported exercising their family reunification plan within the past year, limiting staff familiarity and operational readiness. Facilities should incorporate drills or TTXs focused on family reunification operations into training and exercise plans to improve staff competency and identify procedural gaps. These should occur on a regular basis (e.g., annual) and may be integrated into other (e.g., MCI) exercises.

Area for Improvement 2: Only five out of 16 facilities felt they were adequately resourced to maintain a reunification center for more than 72 hours. Hospitals should conduct resource gap analyses and develop sustainment strategies (e.g., staffing rotations, logistics resupply, mutual aid agreements) to support prolonged family support operations.

Area for Improvement 3: Five (5) out of 16 facilities reported having documented protocols for integrating hospital-level efforts with county or regional family reunification systems. Facilities should work with local healthcare coalitions and emergency management agencies (EMA) to formalize coordination procedures and ensure their reunification plans are aligned with broader jurisdictional frameworks.

Area for Improvement 4: Hospitals should consult templates or guidance for JIC coordination and trauma-informed public outreach. Several references are below but also leveraging hospital and public health networks for best practices and existing templates.

- Improvised Nuclear Device Response and Recovery: Communicating in the Immediate Aftermath (FEMA, June 2013)
- Joint Information Center for Public Health Emergencies (West Virgina Department of Health and Human Resources)

Module 2: Mental Health Support Considerations

Fourteen (14) out of 16 participants indicated their hospitals had existing mechanisms to coordinate with local public health agencies for patient tracking and condition reporting. However, seven respondents noted that these systems were primarily designed for infectious disease surveillance and would require adaptation for radiation-related exposures. Only five participating facilities described streamlined, automated tools or registries that could be leveraged for radiation-specific tracking, highlighting a need for improved electronic data sharing across agencies.

Long-term public health surveillance for radiation exposure was identified as a gap. While 12 out of 16 facilities reported that such surveillance would fall under the purview of local or state public health departments, only four indicated their hospitals had protocols in place for contributing to ongoing data collection or research. Similarly, only six participants reported having experience or infrastructure to support longitudinal health monitoring in coordination with agencies such as the CDC, the Administration for Strategic Preparedness and Response (ASPR), or regional cancer registries. Many respondents expressed interest in clearer federal guidance and long-term coordination frameworks to ensure continuity of care and data integrity over months or years.

Mental and behavioral health surge capacity was a widespread concern. All 16 participants indicated that existing Employee Assistance Programs (EAP) and in-house behavioral health teams would be insufficient during a prolonged radiological event. Thirteen (13) participants reported the need to rely on county, state, or non-governmental organization (NGO) partners (e.g., mobile crisis teams, volunteer counseling services) to supplement care. However, only five facilities described a formal request or integration process for these resources. Participants emphasized the need for consistent, trauma-informed public messaging in collaboration with public health authorities and the JIC, particularly to manage anxiety among the “worried well.” Pediatric-specific behavioral health expertise and culturally competent care for vulnerable populations were also recurring priorities.

Strengths

The following strengths were demonstrated:

Strength 1: Multiple participants emphasized the importance of tailoring behavioral health services to vulnerable populations, including unaccompanied minors and pediatric patients. This demonstrates proactive consideration of developmental, cultural, and logistical needs in mental health planning.

Strength 2: All 16 participants acknowledged that in-house behavioral health teams and EAPs would be insufficient in a large-scale radiological event, indicating widespread awareness of mental health surge limitations and the need to plan for supplemental resources.

Strength 3: Thirteen (13) out of 16 facilities indicated plans to request assistance from county, state, or NGO mental health partners, reflecting a proactive stance toward engaging external support systems during sustained response operations.

Areas for Improvement

The following areas require improvement:

Area for Improvement 1: Only five out of 16 facilities reported having access to streamlined, automated systems for tracking radiation exposure, while seven noted existing tools were designed for infectious diseases and not suited to radiological data. Hospitals should assess existing surveillance platforms and coordinate with public health IT partners to develop or adopt radiation-specific tracking systems that support interoperable, real-time data sharing.

Area for Improvement 2: Although 12 out of 16 facilities deferred long-term surveillance responsibilities to public health departments, only four reported having protocols to contribute hospital data to those efforts. Facilities should collaborate with local and state public health agencies to develop formal procedures for long-term radiation health monitoring, including data submission timelines, patient tracking continuity, and research partnerships.

Area for Improvement 3: RITN should facilitate discussion with federal agency partners (e.g., CDC, ASPR) to determine if long term population monitoring following a radiological incident would be implemented and establish in advance federal guidance and long-term coordination frameworks. This will enable clear communication of data requirements/expectations from hospitals in the months to years following a large-scale radiological incident.

Area for Improvement 4: While 13 out of 16 participants anticipated the need for outside behavioral health support, only five had formal request or integration processes in place. Hospitals should establish and exercise clear protocols for requesting, receiving, and incorporating external mental health resources through existing emergency operations structures, including Emergency Management Assistance Compact (EMAC), healthcare coalitions, and local public health channels.

APPENDIX A: IMPROVEMENT PLAN

This improvement plan template has been developed specifically for the RITN centers participating in the 2025 RITN Tabletop Exercise conducted on July 24, 2025. RITN centers can utilize this table to organize the opportunities for improvement to augment and develop their own corrective actions. The improvement plan is intended to strengthen the response of RITN hospital core capabilities identified in this report.

Core Capability	Issue/Area for Improvement	Corrective Action	Capability Element[1]	Primary Responsible Organization	Organization POC	Start Date	Completion Date
Core Capability 1: [Capability Name]	1. [Area for Improvement]	[Corrective Action 1]					
		[Corrective Action 2]					
		[Corrective Action 3]					
	2. [Area for Improvement]	[Corrective Action 1]					
		[Corrective Action 2]					

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

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APPENDIX C: PARTICIPANT FEEDBACK

RITN Centers were asked to provide feedback via an online questionnaire following the exercise. The comments below are organized by observed strengths, challenges, and recommendations for future exercises.

Participating hospitals in the July 24, 2025, exercise were asked to rank the usefulness of the tabletop exercise; **50% rated it as "Very Useful", 44% rated it as "Somewhat Useful", and 6% rated it as "Netural."**

Strengths

- *Having Froedtert and Children's on the same campus is a huge strength as we are able to leverage each other's resources.*
- *Strong Social and Mental support, as well as strong support for radiation exposures and supportive care.*
- *Robust and Tested Family Reception Center (FRC) Policy and Procedure: One of Texas Children's Hospital's greatest strengths is the existence of a comprehensive and operational Family Reception Center (FRC) Plan, which is formally approved and tested annually.*
- *Participation in the Gulf 7 Pediatric Disaster Network and Use of Mutual Aid Agreements: Texas Children's Hospital is an active member of the Gulf 7 Pediatric Disaster Network, a coalition of pediatric healthcare institutions across the Gulf Coast region.*
- *Several of our internal plans are already in place for reunification, including documentation/pairing system.*
- *The infrastructure for reunification and mental health needs are established and tested.*
- *The Family Assistance Plan explains in clear details how the plan should be executed, who the leaders are, and can be easily found within University of Kentucky network.*
- *Emory's predominate strength is our partnership with our local and state partners as well as an established process for resource requests.*
- *Multiple means of setting up FRC at locations not immediately within the hospital footprint, allowing us to redirect families and focus on providing care.*

- *Coordination with our community partners for support.*
- *Rhode Island has a very strong Hospital Coalition which also includes all outpatient clinics including Behavioral health clinics.*
- *The BMT team has been drilling this for years so the team is well trained in RITN exercises.*
- *Participation from agencies - EMS and Public Health. Input from Social Work and Health Physics. Real time problem solving!*
- *Large internal resources for mental health.*
- *Excellent community relationships and partnerships within the Healthcare Coalition. Additionally, excellent partnerships with other NGOs. Oklahoma is used to community response to events, so there are many processes that already exist within the All Hazards approach.*

Challenges

- *One challenge is space- since our hospitals are located so closely together, we run the risk of being overwhelmed by families trying to reunite. We would need to move reunification off campus to keep hospital operations running smoothly.*
- *Likely spacing and parking. General capacity of the hospital may vary and being located within the city, space for operations may become difficult during a surge.*
- *While Texas Children's has a well-established Family Reception Center (FRC) Plan, the sheer scale and unpredictability of self-evacuated arrivals could overwhelm the system, especially in the early hours of the response.*
- *Texas Children's is a pediatric facility, and while adult caregivers may be triaged and treated initially, long-term inpatient care for adults is not standard practice.*
- *Out of town requests for reunification, patient information has some concerns over releasing/sharing information.*
- *Healthcare coalition and other regional assets not as mature as some other states.*
- *UK needs to design a plan to conduct public health surveillance on long-term health effects.*

- *One challenge we identified is our need to have a documented family reunification center plan that is exercised as well as an in-depth identification of our internal mental health resources as part of the larger Emory activation and response plan.*
- *Translating the county's role in infectious disease monitoring and guidance to radiological scenario. The system is there but not with the right expertise and information. This would make an extremely good best practice recommendation if we could decide criteria and information sharing together! We would be willing to pilot a program in Santa Clara County!*
- *We identified that we need to work out the process for walk ins to our facility who do not know we do not have an ER. What kind of intake we would need to do and tracking of those patients before we get them to an appropriate treatment center.*

Future Exercises

- *We would like to have our physicians more involved in exercise and focus on treatment of patients with ARS. As well as radiation screenings and initial triage post radiation event.*
- *Simulate scenarios with unaccompanied minors to test legal guardian identification, custody documentation, and coordinated release workflows.*
- *Include staff wellness injects that simulate burnout, incorporating EAP, chaplaincy, and a proposed peer support structure to assess psychological resiliency strategies.*
- *Exercise the co-admission of adult caregivers and pediatric patients, testing cross-coordination between pediatric and adult facilities.*
- *Evaluate the hospital's ability to coordinate public messaging, data sharing, and role clarity when federal activation occurs.*
- *Like this format, and scenario very plausible and great talking points. Perhaps some instances of trying to pair, share information in the future.*
- *Involving other departments within the hospital and what roles they would play (i.e.: poison control, pharmacy, apps, ed).*
- *No specific suggestions. The current rotation of topics has been very helpful.*
- *Outpatient management and tracking.*

- *More victim-centered drills with radiation sickness. This will involve our physicians and RSO and other medical professionals.*
- *They are always great! We love the rotating focus of topics.*
- *Shorten the introduction to exercise sections. This will allow more time for discussion within the room to address the questions of the exercise. Two modules is the perfect length. I think that having each module with sections that include: Internal Operations, Community Operations, etc. will allow for better engagement and discussions at the facilities.*
- *Would like to know more about federal tracking of patients. If RITN was activated what is the tracking for patients and patient information sharing look like.*
- *Support for the outpatient operations (who pays for lodging, transport, and how do we coordinate that). Not for T&E, but updated training slides and materials, maybe lessons learned from TTXs over the years, and sharing of best practices.*

APPENDIX D: ACRONYMS

Acronym	Term
AAR	After Action Report
ASPR	Administration for Strategic Preparedness and Response
EAP	Employee Assistance Program
EMA	Emergency Management Agency
EMAC	Emergency Management Assistance Compact
ESF	Emergency Support Functions
IND	Improvised Nuclear Device
JIC	Joint Information Center
MOU	Memorandum of Understanding
NGO	Non-governmental Organization
NMDS	National Disaster Medical System
ONR	Office of Naval Research
RITN	Radiation Injury Treatment Network
SitReps	Situation Reports
TTX	Tabletop Exercise