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Military Operations
MEDICAL EMERGENCY MANAGEMENT PLANNING

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CHAPTER 1

INTRODUCTION

1-1. HISTORY. This is the first printing of this publication.

1-2. PURPOSE.

a. General. This publication is a supporting document to MEDCOM Reg 525-4, U.S. Army Medical Command (MEDCOM) Emergency Management. This publication compiles emergency management and response information into a single source document, and focuses on providing MEDCOM guidance on Homeland Security (HLS), and its response to emergencies, disasters and/or the consequences of the use of Weapons of Mass Destruction (WMD) and/or a Chemical, Biological, Radiological, Nuclear or High Explosive (CBRNE) incident. It provides a strategic overview of emergency management planning, and a detailed set of concepts and procedures at the operational and tactical level for emergency plans development and execution.

b. Applicability. This publication is applicable to all MEDCOM activities with emergency management responsibilities. It supplements the information in MEDCOM Reg 525-4, and will assist activities in developing comprehensive emergency management plans to respond to both natural and manmade domestic emergencies and/or disasters.

1-3. REFERENCES. References are listed in appendix A.

1-4. EXPLANATION OF ABBREVIATIONS AND TERMS. Abbreviations and special terms used in this publication are explained in the glossary.

1-5. POLICIES.

a. All MEDCOM activities will develop plans for responding to both natural and manmade domestic emergencies, disasters, and the medical response to a CBRNE on an installation within their Health Service Region (HSR).

b. The plans will include an all hazards response for medical emergencies. Planners will consider all potential threats and vulnerabilities when doing medical contingency planning. Potential threats and vulnerabilities refer to the inventory of potential dangers that may disrupt a Military Treatment Facility's (MTF) ability to provide care.

1-6. RESPONSIBILITIES.

a. Assistant Chief of Staff for Operations, Headquarters (HQ) MEDCOM.

(1) Is the primary MEDCOM staff element responsible for domestic emergency management planning.

(2) The Plans Division, Operations Directorate, is the staff proponent for preparing, publishing, and maintaining the MEDCOM guidance on emergency management planning.

b. The MEDCOM Staff Agencies.

(1) Review the MEDCOM emergency management planning policy and guidance documents in their functional areas.

(2) Coordinate with the Plans Division, Operations Directorate, on policies, guidance, and procedures in their functional areas that affect emergency management planning prior to release to the Major Subordinate Commands (MSC).

c. Regional Medical Command (RMC)/MSC.

(1) Review MEDCOM emergency management planning policy and guidance documents. Prepare and publish emergency management guidance for their respective area of responsibility (AOR) and subordinate activities that includes, as appropriate, their HSR and Health Service Areas (HSA).

(2) Coordinate with the Plans Division, Operations Directorate, on policies, guidance, and procedures in their respective functional areas that effect emergency management planning.

(3) Operate an Emergency Operations Center (EOC) and coordinate tasking within their AOR.

(4) Organize, train, and equip Special Medical Augmentation Response Teams (SMART) as outlined in Chapter 4.

(5) Direct and coordinate professional cross leveling, backfill, and special medical mission requirements within their HSR.

(6) Support and evaluate MTF readiness to include their ability to respond in the event of a CBRNE incident.

(7) Support and evaluate MTF readiness to include their ability to respond in the event of a CBRNE incident. Update and consolidate semiannual Emergency Management Plan exercises on a monthly basis and submit to MEDCOM Plans not later than the last working day of each month.

d. MTF.

(1) Identify, categorize, and prioritize potential threats within their AOR. Potential threats are areas of vulnerability to natural and manmade domestic emergencies and/or disasters or CBRNE incidents on an installation.

(2) Plan, develop, and exercise (twice annually) emergency management plans for response to both natural and manmade domestic emergencies and/or disasters to include the medical response to a CBRNE on an installation within their HSA. MTFs will submit a monthly update of the last exercise conducted with a brief synopsis and of the next exercise planned, through the appropriate RMC for receipt by the MEDCOM Plans Section not later than the last day of each month.

(3) Provide a copy of the plans to HQ, MEDCOM through the appropriate MSC.

(4) Ensure that Memorandum(s) of Understanding (MOU)/Memorandum(s) of Agreement (MOA) are in place with local/State health service providers and surrounding community hospitals to support and augment unavailable or incomplete installation medical capabilities.

(5) Support your respective installation commanders' Anti-Terrorism - Force Protection (AT-FP) Plan, through active participation in the planning cycle, joint exercises with installation assets, and clearly articulating medical issues to the commander.

(6) Identify all civil and military facilities within your HSA, their capabilities, and conduct contingency planning and coordination to facilitate their cooperation during a CBRNE event.

(7) Ensure proper MTF security in accordance with (IAW) the Force Protection Condition (FPCON) and during an installation crisis management phase.

(8) The majority of MTFs have been supplied Powered Air Purifying Respirators (PAPR) and Personal Protective Equipment (PPE). Patient Decontamination Team and other personnel designated to respond in this equipment to CBRNE/hazard material (HAZMAT) events must be medically screened utilizing OSHA Respirator Medical Evaluation Questionnaire:

http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9783&p_search_type=STANDTEXTPOLICY&p_search_str=Respirator+Medical+Evaluation+Questionnaire&p_text_version=FALSE#ctx1

(9) All MTFs with Emergency Departments and other selected MTFs have been equipped with patient decontamination equipment. (This equipment is adequate for decontamination of small numbers of self-presenting patients. It is not high capacity for mass casualty decontamination. On-scene/mass casualty decon is the responsibility of the installation HAZMAT response organization.) At minimum, training with this equipment will be conducted quarterly and reported through RMCs to MEDCOM Plans. Patient decontamination teams will participate in semiannual Emergency Management Exercises. (Exercise participation will count as training.) These MTFs will coordinate through their RMCs to conduct Annual HAZMAT Operator Level refresher training for Decon Team Members and other personnel selected to wear PAPRs and PPE in response to CBRNE/HAZMAT events.

1-7. REPRODUCTION. This publication may be reproduced in whole or in part for official use.

1-8. REVIEW AND REVISION.

a. The Chief, Plans Division, Office of the Assistant Chief of Staff for Operations, HQ MEDCOM is responsible for the overall maintenance of this publication.

b. Users of this publication are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, US Army Medical Command, ATTN: MCOP-P, Fort Sam Houston, TX 78234-6007.

1-9. OVERVIEW. The MEDCOM subordinate activities should use this publication to assist in exercising their emergency management responsibilities.

a. Chapters 2 and 3 of this publication provide general information on the Federal Response Plan (FRP) and the National Disaster Medical System (NDMS).

b. Chapter 4 provides information and guidance on the use and deployment of MEDCOM Special Medical Augmentation Response Teams (SMART) assets.

c. Chapter 5 provides information and specific guidance on the development and execution of the activity's emergency management plan. The information should serve as a checklist for the staff elements and commanders for reviewing their plans for completeness.

d. Chapter 6 provides an Emergency Management Planning (EMP) Template that may be used as an example to develop an EMP for MEDCOM's subordinate commands and activities.

e. Chapter 7 provides examples of a Medical Emergency Management Plan Matrix and a Hospital Emergency Incident Command System (HEICS) matrix for use by MEDCOM's subordinate commands and activities. These matrixes are universally applicable. The matrixes will need to be tailored to meet the requirements of a specific activity.

CHAPTER 2

FEDERAL RESPONSE PLAN

SECTION I - OVERVIEW

2-1. GENERAL.

a. Purpose. This section provides an overview of the Federal Response Plan (FRP). It describes the mechanism and structure by which the Federal Government mobilizes resources and conducts activities to address the consequences of a disaster or emergency that overwhelms the capabilities of local and State governments. The FRP outlines how the Federal Government implements the Robert T. Stafford Disaster relief and Emergency Assistance Act. The Stafford Act outlines how the Federal Government will assist the local and State governments when a disaster or emergency overwhelms their ability to respond effectively to save lives; protect public health, safety, and property; and restore their communities. The FRP describes the policies, planning assumptions, concept of operations, response and recovery actions, and responsibilities of Federal agencies, including the American Red Cross, that guide Federal operations following a Presidential declaration of a disaster or emergency. The FRP establishes a basic mechanism and structure for how the Federal resources will be mobilized to augment local and State agencies during a disaster or emergency declared under the Stafford Act. Each area Emergency Support Function (ESF) is headed by a primary agency. An agency is selected based upon its authorities, resources, and capabilities within a functional area. Other agencies, such as the Department of Defense (DOD), have been identified as supporting agencies. Supporting agencies were selected based upon their ability to support a functional area. To facilitate the provision of Federal assistance that a State is most likely to need under the twelve ESFs, each ESF is headed by a primary agency, which has been selected based on its authorities, resources, and capabilities to support the functional area. The twelve ESFs serve as the primary mechanism through which Federal response assistance will be provided to the affected State under the overall coordination of the Federal Coordinating Officer (FCO) appointed by the Director of the Federal Emergency Management Agency (FEMA) on behalf of the President. The Plan establishes an architecture for a systematic, coordinated, and effective Federal response. The purpose of the Plan is to:

- (1) Establish fundamental assumptions and policies.
- (2) Establish a concept of operations that provides an interagency coordinated mechanism to facilitate the immediate delivery of Federal assistance.
- (3) Incorporate the coordination mechanisms and structures of other appropriate Federal plans and responsibilities into the overall response.
- (4) Assign specific functional responsibilities to appropriate Federal departments and agencies.

(5) Identify actions that participating Federal department and agencies will take in the overall Federal response, in coordination with the affected State.

b. Scope. The Plan applies to all Federal Government departments and agencies that are tasked to provide response assistance in a disaster or emergency situation. It describes Federal actions to be taken in providing immediate response assistance to one or more affected States. Under the Plan, a State means any State of the United States, the District of Columbia, Puerto Rico, the US Virgin Islands, Guam, American Samoa, the Trust Territory of the Pacific Islands, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, or the Republic of the Marshall Islands. Response assistance includes those actions and activities that support local and State government efforts to save lives, protect public health and safety, and protect property. The identified actions and activities in the Plan, carried out under the ESFs, are based on the existing Federal agency statutory authorities or on specific functional mission assignments made under the provisions of P.L.93-288, as amended, and identified in the ESF Annexes to the Plan. The Plan does not specifically address recovery assistance, including the provision of temporary housing, loans, and grants to individuals; business loans; and grants to local and State government entities provided under the disaster assistance program of FEMA and other agencies. However, in most instances, recovery activities will be conducted concurrently with response activities. In some instances, a disaster or emergency may result in a situation that affects the national security of the United States. For those instances, appropriate national security authorities and procedures will be utilized to address the national security requirements of the situation. The FRP concepts apply to a disaster or emergency as defined under the Stafford Act which includes natural catastrophe, fire, flood, or explosion regardless of cause, or any other occasion or instance for which the President determines that Federal assistance is needed to supplement local and State efforts and capabilities. The FRP may also be implemented in response to the consequence of terrorism, IAW Presidential Directives (PD) 39 and 62 that set forth United States counter-terrorism policy. Federal assistance to local and State governments covers the full range of complex and constantly changing requirements following a disaster: saving lives, protecting property, and meeting basic human needs (response); restoring the disaster-affected area (recovery); and reducing vulnerability to future disasters (mitigation). The FRP identifies Federal agency responsibilities; assigns specific functions to the appropriate agency or department; and identifies specific actions that the agency or department will take in support of the FRP.

2-2. RESOURCES.

a. All DOD forces, Department of Health and Human Services (DHHS), NDMS, Department of Veterans Affairs (DVA), and any other Federal health care resources may be employed in support of domestic emergency response operations. These resources are delineated as follows:

(1) The Federal Emergency Management Agency (FEMA). Under the Stafford Act and Executive Orders 12148 (Federal Emergency Management) and 12656 (Assignment of Emergency Management responsibilities), FEMA has been delegated primary responsibility for coordinating federal emergency planning,

management, and disaster assistance functions. FEMA also has been delegated responsibility for establishing Federal disaster assistance policy. In this role, FEMA has the lead in developing and maintaining the FRP.

(a) Provides US Army Forces Command (FORSCOM) and MEDCOM an interface with Federal agencies through Regional Interagency Steering Committees (RISC) for planning, coordinating, and supporting the emergency medical response efforts.

(b) Evaluates a Governor's request for a Presidential disaster declaration and Federal assistance, recommends a course of action to the President, and activates the appropriate ESF.

(c) Designates, on behalf of the President, an FCO for each declared disaster. The FCO is the on-scene individual responsible for the overall Federal response and recovery efforts.

(d) Manages the National Emergency Support Team (EST), an interagency group comprised of representatives from each of the primary Federal agencies, select support agencies and FEMA HQs staff to resolve issues.

(e) Activates Emergency Response Team-A (ERT-A) as required, and in coordination with the State. This team consists of selected federal agency representatives to assess the damage, establish the Disaster Field Office (DFO), and work at the State Emergency Operations Center until the DFO is established.

(2) The Department of Health and Human Services (DHHS).

(a) Provides FORSCOM, through the Public Health Service (PHS), with headquarters level health/medical interface. The DHHS/PHS Regional Offices normally coordinate health and medical interface at the regional level.

(b) Is the primary lead agency for ESF 8 (Health and Medical Services) of the FRP, which includes overall health response, triage, and treatment. The Assistant Secretary for Health, DHHS, may also regionally activate NDMS to initiate the evacuation of patients out of the disaster area to NDMS participating hospitals.

(3) The DVA established the Emergency Medical Preparedness Office (EMPO) that provides FORSCOM and MEDCOM with HQs DVA level health and medical interface.

(4) Local and State governments have primary responsibility for disaster response. An organized medical incident command response under the Domestic Preparedness/Counter Terrorism Programs consists of a Metropolitan Medical Response System (MMRS) providing immediate response utilizing, but not limited to first responders (police/fire/Emergency Medical Service (EMS)), HAZMAT team, medical transportation, and hospital care. The DOD/MEDCOM medical treatment/disease prevention/research facilities are expected to participate as local resources and members of the community's immediate response when resident in the disaster area. The Federal Government (outside the MMRS) may provide assistance only when local

resources are overwhelmed and an appropriate request has been processed through the State Governor to FEMA for assistance. The combined emergency management authorities, policies, procedures, and resources of local, State, and Federal Governments as well as voluntary disaster relief organizations, the private sector, and international sources constitute the national disaster response framework for providing assistance following a disaster or emergency. Within this framework, the Federal Government can provide personnel, equipment, supplies, facilities, and managerial, technical, and advisory services in support of local and State disaster relief efforts.

(5) ESF #8 – Health and Medical Services provides coordinated Federal assistance to supplement local and State resources in response to public health and medical care needs following a major disaster or emergency, or during a developing potential medical situation.

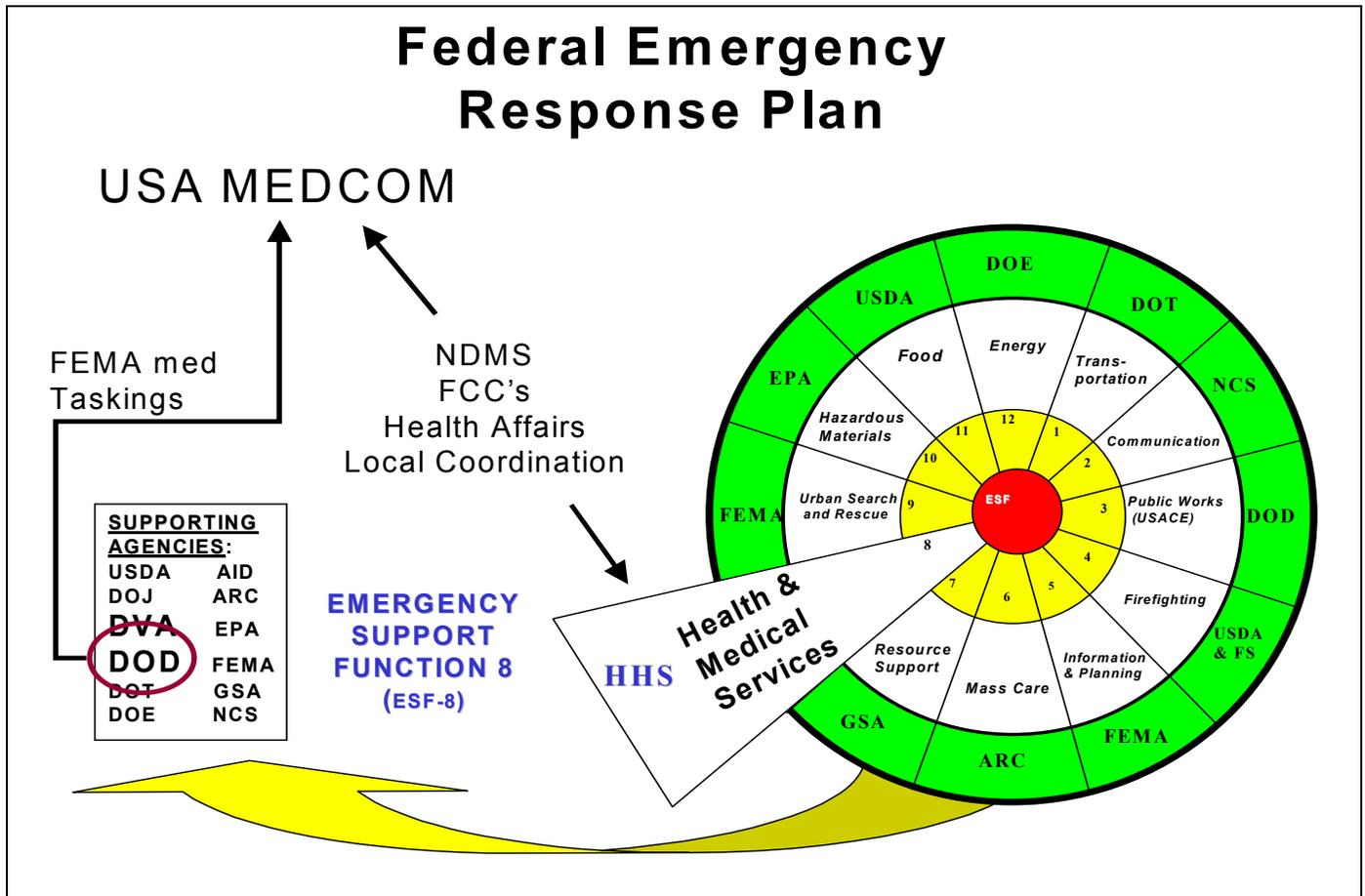


Figure 2-1, Federal Emergency Response Plan.

(a) The DHHS is the primary agency in charge of ESF #8.

(b) ESF #8 involves supplemental assistance to local and State governments in identifying and meeting the health and medical needs of victims of a disaster, emergency, or terrorist attack. This support is categorized in the following functional areas:

- 1 Assessment of health/medical needs.
- 2 Health surveillance.
- 3 Medical care personnel.
- 4 Health/medical equipment and supplies.
- 5 Patient evacuation.
- 6 In-hospital care.
- 7 Food/drug/medical device safety.
- 8 Worker health/safety.
- 9 Radiological/chemical/biological hazards consultation.
- 10 Mental health care.
- 11 Public health information.
- 12 Vector control.
- 13 Potable water/wastewater and solid waste disposal.
- 14 Victim identification/mortuary services and,
- 15 Veterinary services.

Included are overall public health response; triage, treatment, and transportation of victims of the disaster; and evacuation of patients out of the disaster area, as needed, into a network of Military Services, Veterans Affairs, and pre-enrolled non-Federal hospitals located in the major metropolitan areas of the United States. ESF #8 utilizes resources primarily available from within DHHS, other ESF #8 support agencies, NDMS, FEMA; and specific non-Federal sources such as major pharmaceutical suppliers, hospital supply vendors, the National Foundation for Mortuary Care, certain international disaster response organizations and international health organizations.

(6) Notification. Upon notification by FEMA of a major disaster or emergency, DHHS (as primary agency) alerts the DHHS EOC staff to assemble. All ESF #8 support agencies are notified and tasked to provide 24-hour representation as necessary and are responsible for ensuring that sufficient staff is available to carry out the activities tasked to its agency on a continuous basis. Individuals representing agencies who are staffing the DHHS EOC must have extensive knowledge of the resources and capabilities of their respective agencies and have access to the appropriate authority for committing such resources during the activation.

(7) Initial Actions Following a Disaster or Emergency. The DHHS EOC will become operational within 2 hours of notification. Until the regional ESF #8 becomes operational, the collection, analysis, and dissemination of requests for medical and public health assistance will be the responsibility of national ESF #8, with the assistance from the DHHS region. Upon declaration that the regional ESF #8 Command Center (CC) is operational, the major responsibilities for requests for medical and public health assistance will be transferred to regional ESF #8.

(8) Department of Defense (DOD).

(a) The FRP applies to all signatory Federal departments and independent agencies that may be tasked to provide assistance in a disaster or emergency. This includes the DOD. Additionally, the American Red Cross functions as a Federal agency in coordinating the use of Federal mass care resources in a Presidential declared disaster or emergency. For purposes of the FRP, any reference to Federal agencies with respect to their responsibilities and activities in responding to a disaster generally means Federal departments and agencies, as well as the American Red Cross.

(b) Principal Planning Agents (PPAs) coordinate with FORSCOM/MEDCOM and the Regional Planning Agents (RPAs) coordinate with regional medical points of contact (POCs) at each respective level (within MEDCOM this is the RMC level) in support of emergency medical response planning and execution within their HSA.

(c) Designate and provide resources as tasked by the Northern Command (NORTHCOM) to their respective Services for employment in medical relief operations.

(d) The Joint Forces Command (JFCOM) assigns Joint Regional Medical Planning Officers (JRMPO) as the DOD HSS liaison with the PHS on activation of ESF 8 to link up to the Defense Coordinating Element (DCE) or Response Task Force (RTF). Regional ESF #8 will be supported by the JRMP offices or other entities designated by the Defense Coordinating Officer (DCO) to coordinate military resource support to civil authorities within the disaster area. JRMPOs are part of the tiered response concept; they are part of Tier One response with DCO, DCE, and Emergency Preparedness Liaison Officers (EPLOs).

(e) Provide assistance in managing human remains, including victim identification and disposition.

(f) Provide technical assistance, equipment, and supplies through the US Army Corps of Engineers, as required, in support of DHHS to accomplish temporary restoration of damaged public utilities affecting public health.

(g) Immediately notify The Surgeons General (TSG) of the Army, Air Force, and Navy if there is likelihood that their support may be required.

(h) Provide technical facility and clerical expertise to assess the physical condition of the MTFs.

(9) The Defense Logistical Agency (DLA) provides resource support and information as required by FORSCOM. Develops appropriate supporting documents.

(10) The Commander-in-Chief Transportation Command (CINCTRANSCOM) provides multi-mode common-user transportation capabilities for conducting domestic emergency medical response operations within the United States and evacuating patients within the Continental United States (CONUS) when directed by NORTHCOM. In coordination with the Armed Services Blood Program Office (ASBPO) and the military services, Transportation Command (TRANSCOM) prepares a plan for transportation of blood products. TRANSCOM operates the

Global Patient Movement Requirements Center (GPMRC) as the regulating agent for NDMS.

(11) Other supporting Services and DOD agencies that include MEDCOM activities will provide facilities, personnel, equipment, and supplies to support disaster response as tasked by NORTHCOM and/or Joint Task Force - Civil Support (JTF-CS).

(12) The ASBPO will provide blood resources as directed by NORTHCOM.

b. Military Support.

(1) The US military is capable of rapidly responding to a broad spectrum of emergencies on short notice. Personnel and associated equipment, although organized to conduct combat operations, can apply many of their skills to support disaster or emergency assistance operations of short duration. The Command and Control (C2) system inherent in military units provides a significant advantage when deployed in an austere environment created by a catastrophic disaster. However, unless directed by the Secretary of Defense (SECDEF), continuity of military operations has priority over Disaster Relief Operations.

(2) The SECDEF has designated the Secretary of the Army (SECARMY) as the DOD Executive Agent (EA) for Military Support to Civil Authorities (MSCA). The SECDEF designates either the Commander in Chief, Joint Forces Command (CINCJFCOM), the Commander in Chief, Pacific Command (CINCPAC), or the Commander in Chief, Southern Command (CINCSOUTHCOM), as the supported CINC/PPA and Operating Agent for MSCA for all DOD components for their respective geographical AOR.

(3) DOD responds to disasters in support of the Lead Federal Agency (LFA) and IAW Department of Defense Directive (DODD) 3025.1, MSCA, DODD 3025.15, Military Assistance to Civil Authorities (MACA) which states the policy by which DOD provides military resources and forces to assist civil authorities during disasters. The CINCJFCOM Instruction 3440.2, United States Joint Forces Command (JFCOM) Policy Directive for Lead Operational Authority (LOA), empowers the Commander, US Army Forces Command (FORSCOM) to act on CINCJFCOM's behalf when directed by CINCJFCOM in all matters concerning MSCA within the CONUS.

(4) The single DOD point of contact for MSCA operations is the DCO. Should the scope of the disaster exceed the DCO's command and control capabilities, the supported CINC will establish a Joint Task Force (JTF) or a Response Task Force (RTF) to consolidate and manage supporting operational military activities. Both task forces are temporary, multi-service organizations created to provide a consequence management response to a major natural or man-made disaster or emergency. A JTF or RTF commander exercises operational control of all allocated DOD assets (except US Army Corp of Engineer personnel executing ESF #3 missions and the Joint Special Operations Task Force); provides personnel, equipment, and supplies to the affected area; and provides disaster response support based on mission assignments received through the DCO. Although both commanders may supplant the DCO as the senior DOD representative, the DCO will continue to exercise the ERT

staff function of mission assignment coordination and validation, and will act as a liaison between the ERT staff and the JTF or RTF staff.

(5) Once established the JTF or RTF Commander will have Operational Control (OPCON) of all DOD resources provided to the disaster area and will coordinate their use with the civilian authorities needing assistance.

(6) In the event DOD is unable to provide the requested support, the DCO will immediately notify the Federal Coordination Officer (FCO) or the requesting primary agency that support is not available.

2-3. EXECUTION AUTHORITY.

a. Emergency authority will be through NORTHCOM/JTF-CS and the military chain of command. During a temporary absence of communication with MEDCOM, NORTHCOM, JTF-CS, FORSCOM, or JFCOM, medical commanders may take appropriate action to sustain the mission, provide for survival, protect human lives and prevent the destruction of private property in the civilian community.

b. Medical Support to Disaster Victims and Relief Workers. The Stafford Act authorizes Federal agencies (including DOD), upon the direction of the President, to provide medical services to civilian victims of a major disaster (see 42 US Code (USC) 5107b). The Act does not specifically authorize medical assistance to civilian relief workers, but if their injuries or illnesses are attributable to their work in support of the relief effort, they are to be considered victims as well and thus eligible for medical assistance. Military medical personnel will provide only the degree of medical assistance available within the scope of the mission and the resources reasonably available.

c. Local military commanders or responsible officials may act prior to a Presidential disaster declaration to save lives, prevent human suffering, or mitigate property damage without approval from higher headquarters. Commanders must expeditiously report "immediate response" actions through their chain of command to the DOD MSCA Executive Agent.

d. Commanders use their assessment of mission requirements and the capabilities of their commands to judge the extent of immediate military assistance provided.

e. Duration of Military Medical Support. Military medical support missions should continue only until civil authorities have sufficiently restored the local civilian health care infrastructure to allow civilian medical activities to resume services. Commanders of military units/teams/elements or individuals executing medical support missions will terminate such missions only upon the order of appropriate superior military authority. MEDCOM facilities will be guided by their respective RMCs. Deployed teams will be released IAW established agreements with the lead military element on the scene (i.e., Defense Coordinating Officer (DCO)/Task Force (TF) commander).

f. JTF Civil Support or one of the two RTFs responds to events involving the use, or possible use of a CBRNE device. A JTF or RTF commander exercises operational control of all allocated DOD assets (except US Army Corps of

Engineers (USACE) personnel executing ESF #3 missions and the Joint Special Operations Task Force); provides personnel, equipment, and supplies to the affected area; and provides disaster response support based on mission assignments received through the DCO.

g. Upon receiving and validating a Request For Assistance (RFA) for medical assistance, the DCO forwards the request to NORTHCOM who passes the request directly to MEDCOM and/or to COMFORSCOM.

h. The use of Reserve Components for domestic disaster assistance is generally governed by 10 USC 12301(b). The Service Secretaries concerned may order reserve units, and personnel not assigned to units, to involuntary active duty for a period of 15 days per year. Reserve Component personnel who volunteer may be ordered to active duty for longer periods of time. National Guard units and personnel may be ordered to active duty only with the respective State Governor's consent.

i. The Economy Act, 31 USC 1535, permits Federal agencies to provide goods and services to other Federal agencies on a reimbursable basis. The Stafford Disaster Relief Act requires reimbursement to the DOD for the incremental costs of providing support.

j. The basic rule for domestic emergency response operations is that the military plays a supporting role to civilian authority. Commanders must be aware of this support, and ensure that competent legal counsel appropriately advises them.

2-4. POLICY.

a. Hospitalization. Military personnel shall be treated on-site and evacuated to the nearest military hospital. If injury or disease is too severe for movement to the nearest military hospital, the service member will be treated at the nearest appropriate medical facility. Coordination will be made with the supporting Regional TRICARE Lead Agent.

b. Patient Evacuation.

(1) Nonmilitary patients shall be evacuated under the direction of the Regional Health Administrator.

(2) Military personnel will be evacuated within military channels or by the most expeditious means available if the medical condition dictates. The senior military team member on the scene will report military casualties/evacuees through the chain of command to the parent command.

(3) Medical regulating shall be under the control of the GPMRC located at Scott Air Base, Illinois.

SECTION II - US ARMY MEDICAL COMMAND'S ROLE

2-5. GENERAL.

a. Purpose.

(1) This section is to describe MEDCOM's role in DOD's support to local, State and Federal authorities. This pamphlet describes the planned implementation of the FRP. The SECARMY, as the DOD executive agent on behalf of the SECDEF, has overall responsibility for providing policy on military assistance to civil authorities during emergencies and disasters. The SECARMY carries out these duties through the NORTHCOM who directs FORSCOM through JFCOM to conduct domestic emergency medical response operations. FORSCOM, as the LOA for JFCOM will provide DOD support through the Continental United States Army (CONUSA) to assist Federal and State efforts. The MEDCOM provides Army Medical Department (AMEDD) officer and enlisted personnel identified in the professional filler system (PROFIS) to the deployed and deploying forces as directed by NORTHCOM. Medical treatment facilities and other MEDCOM MSCs may also provide critical medical assistance to local civilian authorities at the discretion of the MTF or MSC Commander should a disaster occur in the community where the facility is located. This will be conducted under the "immediate response" authority for any local commander IAW DOD Directive 3025.1, paragraph 4.5.1. Headquarters, MEDCOM will be notified of actions taken as soon as communications can be established. The MSCs will deploy SMARTs or other deployable assets as directed by HQ MEDCOM. When directed by the DOD Executive Agent, MEDCOM supports the lead federal agency by providing health service support commensurate with the magnitude of the situation and focuses on meeting the recovery requirements beyond the capabilities of civil authorities.

(2) All DOD medical forces, Active and Reserve Component are potentially available to provide support. The actual availability of resources for domestic emergency response operations will be dependent upon the nature of the emergency/operation and previous deployment of forces to support operations in other areas of the world.

b. Assumptions.

(1) The military Services and all other health care agencies will draw from the same limited medical resource base.

(2) All CONUS medical resources will potentially be available.

(3) Plans generated within MEDCOM will be designed to respond to any medical emergency. Planners will consider all potential threats and vulnerabilities when doing medical contingency planning. Potential threats and vulnerabilities refer to the inventory of potential dangers that may disrupt a MTF's ability to provide care.

(4) Military medical resources may be limited during mobilization to support a domestic emergency.

(5) Medical support under domestic emergency medical response is provided no differently than any other military support.

(6) Logistical support will be planned for a minimum of 30 days, with a possible commitment to support subsequent operations for a period extending up to 90 days. Sufficient experience will be gained during the first 90 days of operations to assure that an adequate level of logistics support can be rendered should the operation extend past 90 days.

(7) Medical support can be rendered without direction from NORTHCOM or Presidential declaration if approved by HQ MEDCOM, and funded by another Federal agency.

(8) Medical facilities may be degraded as a result of the incident.

c. Interface Organizations.

(1) Continental United States Army (CONUSA) Commanders.

(a) Act as regional planning and execution agents.

(b) Appoint and train DCOs. Provide coordination at the regional level with Federal, and non-Federal agencies, such as FEMA, DHHS/PHS, the DVA, State Offices of Emergency Services (OES) and The Adjutant General (TAG).

(2) Commanders of DOD Installations that function as a Base Support Installation (BSI).

(3) Commanders, MEDCOM MTFs will act in their role as installation Director of Health Services (DHS) providing medical care to installation and Disaster Response Task Force (DRTF) personnel. The MTF medical logistics will become the source of medical supplies (Class VIII) for DOD elements supported by the installation, unless furnished by another Federal agency.

2-6. PURPOSE. The information in this section describes the MEDCOM's role in support of domestic emergency medical response operations.

2-7. POLICIES.

a. The MEDCOM/designated RMC/MSC will be responsible to provide teams, individuals, and/or equipment to support the FRP. The MEDCOM MTF will support the designated supporting installation within its HSA by providing medical supplies, resupply, and medical administrative support to each unit deployed for domestic emergency response operations.

b. Deployed MEDCOM medical response teams/SMARTs and individuals will be under the OPCON of the DCO if the JTF-CS is not in place. Teams and individuals will be OPCON to the JTF-CS when and if it is established. Uniform Code of Military Justice (UCMJ) Authority shall remain with the parent unit commander, unless directed in the attachment orders.

c. Except for actions initiated under the immediate response authority of DOD Directive 3025.1, military medical units or personnel should deploy only when civil sector medical resources are inadequate to meet the need for medical assistance during a civil emergency. Response will be provided based

on requirements identified by DHHS, as validated by the DCO and submitted to NORTHCOM. NORTHCOM will coordinate military participation in such responses.

d. Once mission execution is directed, only the appropriate authority may authorize mission termination.

e. TECHNOLOGY. The Homeland Security (HLS) Branch must rely heavily on functional experts who can represent the business processes that technology and information systems support. The functional proponent is the organization or staff element assigned primary responsibility for the business processes supported by a given HLS technology or HLS Information Management (IM)/Information Technology (IT) initiative. In the face of ever-decreasing resources, it is imperative that every HLS technology and HLS IM/IT investment made by the AMEDD be consistent with AMEDD and MHS strategic goals and priorities and support the functional business processes of the enterprise. No HLS technology, information system, program, or project will be funded, developed, acquired, or deployed without first being coordinated with MEDCOM HLS Branch. An identifiable functional proponent will be designated in coordination with MEDCOM HLS Branch.

2-8. PROCEDURES.

a. Upon notification by NORTHCOM and/or JFCOM, FORSCOM tasks the appropriate CONUSA to direct its designated DCO to contact the FCO or FEMA Regional Director to determine if assistance is required. If military units are required, FORSCOM alerts selected units to begin preparations for possible deployment. FORSCOM will notify MEDCOM that PROFIS personnel may be required to round out selected units. Selected PROFIS personnel may be recalled to their assigned Table of Organization and Equipment (TOE) medical units upon notification from HQ, MEDCOM. The appropriate Major Army Command (MACOM) will alert designated installations to prepare to operate as the BSI providing equipment, personnel, and facilities.

b. Sequence of Events.

(1) Upon notification of a CBRNE incident, the JTF-CS initiates alert procedures directing the DCO to contact the FCO or FEMA Regional Director. The JTF-CS contacts FORSCOM for DOD requirements. If a determination has not been made on DOD requirements, JTF-CS continues preparations IAW their planning guidance.

(2) The JTF-CS planners will coordinate with appropriate federal and non-Federal agencies in the preparation of domestic emergency plans and exercises. These authorities include but are not limited to: the Services' PPA/RPA, MACOMs, headquarters and regional DHHS, DVA, and FEMA officials.

(3) The DCO will coordinate with other Services or other federal and non-Federal agencies for required support through the established liaison structure. If the requested support is not available through DCO assets, the DCO will pass a request for the support to JTF-CS.

(4) Based upon the assessment of mission requirements, the DCO will recommend, through JTF-CS, the medical resource requirements for execution of domestic emergency response. Medical resource taskings will come from the

DCO with a mission number from either FEMA or DHHS. The DCO will capture costs for the respective AOR, and forward cost data to FORSCOM G8.

(5) Only the minimum essential military medical resources required will be deployed within CONUS.

(6) The MEDCOM Operations Directorate will issue a Warning Order for domestic emergency medical response operations missions as directed by NORTHCOM and/or JFCOM.

(7) The MEDCOM/RMC SMARTs will deploy on MEDCOM validated orders. The SMART teams will deploy within 12 hours of notification by MEDCOM. The designated RMC/MSO will be responsible for documentation of costs entailed to bring the tasked teams to readiness status, and will forward this documentation to MEDCOM.

(8) Notification of an emergency situation dictating execution of domestic emergency response operations may come from a local Federal or non-Federal official, to the nearest military commander. Approved "immediate response" activities include, but are not limited to rescue, evacuation, emergency medical services, and safeguarding the public health. The MTF or MSC Commander will forward a report through MEDCOM to NORTHCOM on initiation of this support. NORTHCOM will then notify FORSCOM to prevent multiple tasking of medical assets.

(9) The Army Medical Fusion Center (AMFC) may be established by the Office of The Surgeon General (OTSG) and the Headquarters, U.S. Army Medical Command (HQ, MEDCOM) as the Army Medical Department (AMEDD) focal point for the medical response to HLS CBRNE requirements. In support of the AMFC:

(a) Each MEDCOM RMC will establish a Regional Medical Fusion Cell (RMFC). The RMFC will be the focal point for the flow of HLS CBRNE information with the MEDCOM AMFC, within the RMC headquarters, and within the RMCs AOR. The RMFCs will coordinate medical HLS CBRNE support requirements with the military commands, State Agencies, and Federal Agencies that have a HLS CBRNE mission within their AOR.

(b) The U.S. Army Medical Research and Materiel Command (MRMC) will establish a Technical Medical Fusion Cell (TMFC). The TMFC will provide technical support to the AMFC and RMFCs during the planning and or execution of the AMEDD HLS CBRNE mission.

(c) The U.S. Army Center for Health Promotion and Preventive Medicine (CHPPM) will establish a TMFC. The TMFC will provide technical support to the AMFC and RMFCs during the planning and or execution of the AMEDD HLS CBRNE mission.

c. Administration and Logistics. Each Service will furnish, as directed, administrative and logistical support elements to assist the operations of the designated BSI(s), and to administratively support the units and individuals in the field.

(1) Medical expendable items and resupply should come from civil resources. Military resources will be used only when civil supplies are not available or when the emergency is on a military installation.

(2) Existing service medical reporting systems provide information on the medical operations readiness status, and patient care activities of the MTF that come under the influence of an unusual occurrence (e.g., natural disaster or other emergency). The MEDCOM uses this data to make operational decisions on medical support to forces during emergency operations.

(a) Existing service reports will be used to document Domestic Emergency Response Operations (i.e., MEDCOM Medical Situation Report (MEDSITREP)).

(b) Reporting activities will use joint formats for medical regulating and blood activity reporting.

(c) The MEDCOM medical facilities within the CONUSA AOR where the local/regional emergency has occurred will report their capability status using MEDCOM reporting procedures, as appropriate. If NDMS is activated, the designated Federal Coordinating Center (FCC) will include participating NDMS facility bed availability as part of their reporting requirement. The MEDCOM MTFs will provide information copies to the applicable CONUSA, which will prepare summary reports for submission to FORSCOM.

CHAPTER 3

NATIONAL DISASTER MEDICAL SYSTEM

3-1. PURPOSE. This chapter provides an overview of the National Disaster Medical System (NDMS). The purpose of the NDMS is to establish a single integrated national medical response capability for assisting local and State authorities in dealing with the health effects of major domestic natural disasters and terrorist incidents, and providing support to the DOD and VA medical systems in caring for casualties evacuated back to the United States from overseas armed conflicts.

3-2. GENERAL. The NDMS is a cooperative asset-sharing program among Federal Government agencies, local and State governments, and private businesses and civilian volunteers. The intent of NDMS is to ensure resources are available to provide medical services following a disaster that overwhelms local health care resources. The NDMS is a partnership among the DHHS, DOD, DHS, and the VA. The NDMS is a federally coordinated system that augments the nation's emergency medical response capability. NDMS is designed to care for victims of an incident that exceed the medical care capability of an affected State, region, or federal medical system. It may be used in a variety of emergency events, such as an earthquake, an industrial disaster, a refugee influx, a terrorist incident, or a military contingency.

3-3. CONCEPT OF OPERATIONS. The NDMS is a comprehensive medical system designed to provide acute care for mass casualties from the civil and military sectors. In the event of a major disaster, the governor of the affected State may request assistance and a presidential declaration of emergency from the Federal Government. The declaration of an emergency authorizes ACTIVATION OF the Federal Response Plan (FRP). The activation of the FRP will trigger a series of actions coordinated by FEMA, which may include the activation of NDMS. The NDMS may also be activated in the event of a military contingency when it is expected that military casualty levels will exceed the capability of DOD, TRICARE, and VA medical systems.

a. Medical Response. Medical response is federalized upon NDMS activation. The DHHS has the lead responsibility for medical response that includes the following:

(1) Assessment of health/medical needs.

(2) Medical care personnel to include:

(a) Disaster Medical Assistance Teams (DMATs). The DMATs are community-based volunteer groups affiliated with NDMS. Each DMAT consists of approximately 100 persons possessing a variety of health/medical skills to include medical professionals and support staff. The DMATs perform triage and provide austere medical care and casualty clearing/staging at the disaster site.

(b) Disaster Mortuary Teams (DMORTs). The DMORTs are composed of private citizens, each with a particular field of expertise, who are activated in the event of disaster. The DMORTs work under the guidance of local authorities by providing technical assistance and personnel to recover,

identify, and process fatalities. The DMORTs consist of funeral directors, medical examiners, coroners, pathologists, forensic anthropologists, medical records technicians, transcribers, finger print specialists, forensic odontologists, dental assistants, x-ray personnel, mental health specialists, computer, administrative support staff, security, and investigative personnel. The DMORTs' responsibilities include: establishing temporary morgue facilities, victim identification, forensic dental pathology, forensic anthropology services, processing, preparation, and disposition of remains.

(c) Veterinary Medical Assistance Teams (VMATs). The VMATs are composed of private citizens who are activated in the event of a disaster. The VMATs work under the guidance of local authorities by providing technical assistance and veterinary services. The VMATs are composed of clinical veterinarians, veterinary pathologists, animal health technicians (veterinary technicians), microbiologist/virologists, epidemiologists, toxicologists, and various scientific and support personnel. The VMATs' responsibilities include: assessment of clinical needs of animals, animal care and handling, animal shelter and evacuation, animal inspection and disease surveillance, technical assistance, hazard mitigation, and care and shelter of companion pets.

(d) National Medical Response Teams (NMRTs) - Weapons of Mass Destruction (WMD). The NMRT-WMDs are four level-1 DMATs that have been configured into highly specialized nationally deployable sub-units. The four NMRT-WMDs are Eastern US NMRT (North Carolina), Central US NMRT (Colorado), National Capitol Area NMRT (Washington, DC), and the Western US NMRT (California). The NMRT-WMDs' operational objective is to deploy to a hazardous material environment to provide medical services, decontamination services, and/or assist Federal agencies. The NMRTs consist of 50 members, providing 26 personnel as a standard deployment force. The NMRTs are designed to travel by ground or air, and be fully self-contained except for the water required for decontamination purposes.

(3) Health/medical equipment and supplies.

b. Patient Evacuation. The DOD has the lead responsibility for patient evacuation during an emergency or disaster involving NDMS. This responsibility includes:

(1) Providing patient movement from the disaster area.

(2) Utilizing all types of transportation, although patient evacuation will primarily rely on aeromedical evacuation.

c. Definitive Medical Care. DOD/DVA have joint lead on providing definitive medical care. The criteria for selection of NDMS medical treatment facilities is based on facilities:

(1) Located in a major metropolitan area.

(2) Having air accessibility.

(3) Having hospital support.

- (4) Having patient reception and distribution capabilities.

3-4. RESPONSIBILITIES.

a. Federal Coordinating Centers (FCCs). The NDMS FCCs are geographic areas, usually 50 miles in radius, with a minimum of 200 hospital beds, a major airport, a Federal medical facility to provide support, and adequate transportation assets to provide for patient reception and distribution. All NDMS FCCs are either associated with a DOD MTF or a Veterans Administration Medical Center (VAMC), but the role of the NDMS FCC transcends those affiliations. The NDMS FCC Guide describes the responsibilities of FCCs in the planning, exercise, and operations of a local plan to receive and provide definitive care to casualties evacuated to the area as part of NDMS. Annexes to the FCC guide provide the FCC with specific guidance on all functional areas of NDMS. FCC roles and responsibilities include:

- (1) Represent the NDMS. NDMS FCCs represent the Federal Government, in general, in dealing with the civilian medical community and local and State authorities. The Commander or Executive Officer of the FCC MTF is considered the FCC Director and has overall control and responsibility for the program. The NDMS Area Coordinator, who works for the FCC Director, is responsible for the day-to-day operation and readiness of this program. NDMS Area Coordinators are the essential link in obtaining and maintaining community participation in the system.

- (2) Solicit/Organize Community Participation. NDMS Area Coordinators should seek the support of local, regional, State disaster emergency services agencies, hospitals, EMS agencies, police and fire services, public safety officials, emergency medical transport services, voluntary agencies, and disaster medical and health services officers in their geographic areas. Additional resource support may be sought from local businesses that may be directly involved in supplying disaster response agencies. The NDMS FCC should prepare and maintain an updated list of resources available from NDMS participants. The NDMS Area Coordinator should also involve the community, as appropriate, in the concept, planning, and coordination of the local NDMS plan, including the use of a steering committee composed of members representing the various disaster, emergency, and public safety agencies, hospitals, voluntary organizations, businesses, and elected officials.

- (3) Facilitate/Maintain Non-Federal Hospital Enrollment. NDMS FCCs are required to recruit the voluntary commitment of beds from hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Hospital Association (AOHA). General acute care hospitals should have 100 operating beds or more although exceptions can be made. There is no minimum bed size for psychiatric hospitals. In general, NDMS participating hospitals should be within a 50-mile radius of the airport or Air Force Base that would be the likely arrival location of NDMS patients to the FCC. Participating hospitals are required to sign a Memorandum of Understanding (MOU) with the NDMS and participate in periodic tests of the system. While federally coordinated, to be successful, the program needs to be built on how the local community normally responds to a local medical emergency. NDMS FCCs must provide ongoing education and information to their participating civilian hospitals.

(4) Collect/Report Hospital Bed Availability Data. Non-Federal hospitals enrolling in NDMS will indicate in the MOU a general total "Minimum" and "Maximum" number of beds to be committed. The "Minimum" represents the number of beds the facility could make available within 24 hours of notification of NDMS activation. The "Maximum" represents the number of beds that could be made available within 72 hours. Hospitals must make judgments about staffed and equipped bed capacity that is available as a "Minimum" and additional beds that could be made available as a "Maximum" if certain conditions were met. FCCs should continually review changes in participating hospital infrastructures that could affect the number or type of beds available. Hospital bed reporting is generally updated on a quarterly basis.

(5) Coordinate Area Reception Plan. The NDMS FCC is responsible for coordinating the development, exercise, and evaluation of a local NDMS reception plan. This plan should address, at a minimum, the following areas:

- (a) Concept of Operations.
- (b) System Activation.
- (c) Alerting of Participating Hospitals.
- (d) Patient Reception.
- (e) Patient Administration.
- (f) Communications.
- (g) Transportation.
- (h) Personnel Administration.
- (i) Test (Exercise) and Evaluation.
- (j) Public Relations and Media Information.

(6) Coordinate Annual Plan Reviews. Planning is a dynamic process and the NDMS local plan must be exercised in order to provide feedback to planners to correct deficiencies or adjust the plan in light of changing circumstances.

(7) Conduct NDMS Exercises. Among the incentives for civilian hospitals to participate in NDMS is the opportunity for involvement in exercises that will meet the requirements of JCAHO or AOHA for an annual external disaster drill. FCCs should conduct NDMS patient movement exercises a minimum of once every 3 years.

(8) Coordinate Local Operations During Activation. FCCs will receive notification of NDMS activation through the normal chain of command (DOD or DVA). The notification should indicate if patient evacuation is imminent. FCCs will activate their area operations plan according to the appropriate level of readiness as indicated by the activation notification. FCCs may begin local bed reporting to a central collection point in anticipation of

bed reporting instructions from GPMRC. Depending on the information received from GPMRC, the FCC may begin the process of regulating patients to specific local hospitals. This is solely the responsibility of the FCC.

b. Military MTFs other than FCCs.

(1) All Army MTFs have the mission to support Army service members receiving medical care in NDMS hospitals. MTFs should be prepared to provide patient care services for those individuals during either a military contingency or national disaster use of the NDMS hospital bed system.

(2) All Army MTFs could receive incoming military patients by aircraft during a military contingency and must have a plan for patient reception and transportation at the appropriate airport. Other patients may arrive at MTFs by ground ambulance.

CHAPTER 4

SPECIAL MEDICAL AUGMENTATION RESPONSE TEAM

4-1. INTRODUCTION

a. Purpose. To provide policy, guidance, and Military Support to Civil Authorities (MSCA) during disaster, civil-military cooperative action, humanitarian, and emergency response to CBRNE incidents in the Continental United States (CONUS), United States territories or possessions, and Outside Continental United States (OCONUS) unified command areas of responsibility.

b. Mission. Upon receipt of a validated tasking from MEDCOM, the designated subordinate commands will deploy requested SMARTs in CONUS/OCONUS to provide short duration, medical liaison to local, State, Federal, and defense agencies or medical teams responding to disasters, civil-military cooperative actions, humanitarian assistance, weapons of mass destruction incidents, CBRNE incidents and emergencies. For incidents and emergencies occurring on a military installation, the MTF commander may request SMART support directly from the RMC. The RMC commander can immediately deploy a SMART in support of the MTF and notify MEDCOM. Subordinate commands will anticipate the use of SMART personnel and equipment to support OCONUS missions. Reaction time to and length of OCONUS missions will vary based on the situation.

c. References. See appendix A.

d. Assumptions.

(1) The DOD will not compete with other local, State, and Federal assets or civilian/commercial contracted support assets as indicated in DOD Directives 2000.18, 3025.15, and 3025.51.

(2) All work is reimbursable through the tasking agency.

(3) The Task Force Commander will provide logistics (log)/administrative (admin) support for a deployed SMART beyond 3 days (72 hours).

(4) MEDCOM receives validated taskings through the appropriate chain of authority.

(5) The resources will be available to perform the mission.

e. Authority. The US Army Surgeon General (TSG)/Commanding General MEDCOM, in consultation with the Chief of Staff of the US Army (CSA), NORTHCOM, JFCOM, and applicable Federal and DOD regulations, requires designated MEDCOM assigned, attached, or associated individuals and organizations to develop and maintain special organized, trained, and equipped SMARTs.

f. Commander's Intent. The designated SMARTs within each of the RMCs and other MSCs will be capable of deploying year-round, within 12-hours, in support of legitimate emergency incidents and specifically at the request of proper civil or Federal authorities. For incidences and emergencies

occurring on military installations, the RMC commander may directly respond to the request of the MTF commander. The SMARTs will not compete against, nor supplant Department of Defense or other Federal emergency operations agencies. The SMART members will be subject matter experts, sufficiently trained and prepared for their missions. The teams will deploy using standard and nonstandard transportation assets to rapidly arrive at the mission location. The SMARTs will employ in-house, off-the-shelf, resources in backpack, man-portable kits capable of sustaining themselves for up to 3 days (72 hours). The MEDCOM and its MSCs are prepared to provide command and control and other support as required to quickly get the right mix of teams into operation. No team will deploy without MEDCOM instructions (unless the MTF commander requests SMART support for an incident on a military installation), orders, mission statement, risk assessment, concept of operations, linkup and reporting instructions. Teams should travel light and will initially be self supporting; they must not become logistic, administrative, or communication burdens. Upon arrival at the mission location, the SMART will establish coordination Operational Control (OPCON) with the senior military or civilian command and control element to offer technical assistance and receive instructions for the team's employment. The senior leader of the SMARTs will be responsible for the health, welfare, and safety of team members and expect them to represent the MEDCOM in a disciplined, uniformed, and technically competent manner. The SMART members need to remember their principal role is to support, provide technical advice, assess, and provide liaison. The teams will not be over-committed or entrenched in long-term commitments of personnel, services, or materiel. The teams will clearly work for the supported lead agent. The teams will get in, link-up, coordinate, integrate, synchronize, support, pass-off, and depart promptly after an appropriate release/hand-off by the senior military commander on site. The SMARTs will provide a full debriefing upon redeployment and an after action report (AAR) within 10 days. The chain-of-command will be kept informed of all planned training missions and/or any "immediate response" missions.

4-2. REQUIRED TEAMS. There are a total of 37 SMARTs.

a. Five Trauma/Critical Care (SMART-TCC). Note: The designation SMART - Trauma/Critical Care (SMART-TCC) will be changed to SMART - Emergency Medical Response (SMART-EMR).

b. Five Nuclear/Biological/Chemical (SMART-NBC).

c. Five Stress Management (SMART-SM).

d. Six Medical Command, Control, Communications, Tele-Medicine (SMART-MC3T).

e. Five Pastoral Care (Clinical) (SMART-PC).

f. Three Preventive Medicine (SMART-PM).

g. Two Burn (SMART-B).

h. Two Veterinary (SMART-V).

- i. Two Health Systems Assessment and Assistance (SMART-HS).
- j. Two Aero-Medical Isolation (SMART-AIT).

4-3. SMART COMPOSITION. The teams are composed of military officers, warrant officers, enlisted Soldiers, Department of the Army civilians, and appropriate DOD contractors assigned to MEDCOM by name. The SMARTs are capable of deploying to provide liaison to local, state and federal response assets in domestic support, military installation support, civil-military cooperative assistance, and disaster relief and humanitarian assistance operations in CONUS. There are approximately 263 MEDCOM personnel designated to respond as SMART members. Although it is not encouraged, military personnel assigned to PROFIS positions may be used if the needed specialties in a non-PROFIS status are unavailable. Substitution rules can be used IAW AR 601-142. See Appendix C, Tab 1 for team structure by Area of Concentration (AOC)/Military Occupational Specialty (MOS).

4-4. RESPONSIBILITIES.

a. The Assistant Surgeon General, Force Projection. Overall responsibility:

(1) Policy, supervision, and oversight to organize, train, equip, deploy, employ, and redeploy the SMART team.

(2) Validate and resource special equipment requirements, periodically test and evaluate the SMARTs, develop, monitor, and report SMART readiness reporting requirements.

(3) Establish and maintain a liaison with appropriate Federal agencies such as FEMA, NORTHCOM, JFCOM, PHS, DHHS, Environmental Protection Agency (EPA), and US Army Corps of Engineers as required.

(4) On order, deploy SMARTs to designated incident sites.

(5) Organize, train and equip SMARTs using existing resources. See Appendix C, Tab 2 for team training requirements.

(6) Coordinate with appropriate civilian and/or federal agencies the credentialling of SMART healthcare providers.

b. Regional Medical Commands:

(1) Organize, train, exercise, and equip each of the following SMART teams within existing resources: Note: The European Regional Medical Command (ERMC) maintains only the MC3T, and may adjust team requirement based on mission, enemy, troops, terrain, plus time (METT-T).

(a) SMART-TCC.

(b) SMART-NBC.

(c) SMART-SM.

- (d) SMART-MC3T.
- (e) SMART-PC.
- (f) *SMART-Burn (GPRMC only).

(2) On order, deploy SMARTs within 12 hours of notification. They are prepared to deploy as required in CONUS but primarily within the assigned Health Service Region (HSR). Commanders at all levels should anticipate requests to use SMART personnel and equipment sets for OCONUS missions. OCONUS mission taskings must allow for additional movement time, personnel preparation, and equipment augmentation.

c. The US Army Center for Health Promotion and Preventive Medicine (CHPPM) will organize, train, exercise, and equip three SMART-PM teams using existing resources. On order, deploy assigned SMART-PM teams to designated domestic incident sites within 12 hours notification from RMC/MSC. The Commander, CHPPM should anticipate requests to use SMART personnel and equipment sets for OCONUS missions. All OCONUS mission taskings must allow for additional movement time, personnel preparation and equipment augmentation.

d. US Army Medical Research and Materiel Command (MRMC).

(1) The MRMC will organize, train, and equip two SMART-HS teams using existing resources. On order, deploy assigned SMART-HS teams to designated domestic incident sites within 12 hours notification from RMC/MSC. Anticipate requests to use SMART personnel and equipment sets for OCONUS missions. OCONUS mission taskings must allow for additional movement time, personnel preparation, and equipment augmentation.

(2) The MRMC will organize, train, and equip two SMART-AIT teams using existing resources. On order, deploy assigned SMART-AIT teams to designated domestic incident sites within 12 hours notification from RMC/MSC. Anticipate requests to use SMART personnel and equipment sets for OCONUS missions. OCONUS mission taskings must allow for additional movement time, personnel preparation, and equipment augmentation. Be prepared to deploy out of sector.

(3) SMART-Burn is OPCON to GPRMC.

e. The US Army Veterinary Command (VETCOM) will organize, train, and equip two SMART-V teams using existing resources. On order, deploy assigned SMART-V teams to designated domestic incident sites within 12 hours notification from RMC/MSC. The Commander, VETCOM should anticipate requests to use SMART personnel and equipment sets for OCONUS missions. OCONUS mission taskings must allow for additional movement time, personnel preparation, and equipment augmentation.

4-5. STRUCTURE. SMARTs are task organized based on METT-T and the medical mission/risk analysis in order to provide the appropriate level of response and technical liaison to civil and military authorities.

a. SMART - Trauma Critical Care (SMART-TCC). On order, the teams assemble and deploys within 12-hours within their HSR or possibly anywhere in CONUS to

provide medical liaison to local medical authorities in disaster/mass casualty incidents. Their primary missions include:

(1) Augmenting existing fixed medical treatment facilities.

(2) Providing technical expertise and consultation in triage, advanced resuscitation, trauma management, emergency operative support and evacuation.

b. SMART - Nuclear/Biological/Chemical (SMART-NBC). On order, the team assembles and deploys within 12-hours within their HSR or possibly anywhere in CONUS to provide expert technical advice to local medical authorities on the detection, neutralization, containment, personal protective equipment needs, and address unique issues regarding medical management for casualties of nuclear biological or chemical agents in accidental or intentional WMD incidents. Their capabilities include:

(1) Serving as a resource for assessment and advice to supported medical treatment facilities for the receipt and handling of contaminated patients.

(2) Providing on-scene consultation during crisis/consequence management operations.

(3) Providing consultation to civil authorities in determining/acquiring follow-on medical resources, supplies and equipment.

(4) Providing assistance to authorities in developing a hand-off strategy for SMART-NBC responsibilities in preparation for redeployment to home station.

(5) Providing a reach back capability to MRMC and CHPPM in support of the Medical Fusion Center.

(6) Capabilities include Toxic Industrial Chemical (TIC)/Toxic Industrial Material (TIM) detection, medical management of contaminated patients, workplace hazards and need for PPE (selected based on NBC, TIC/TIM threat), training requirements, consequence management activities, including health risk assessment, decontamination and building/site re-entry criteria.

(7) Commanders may augment the SMART-NBC with laboratory personnel.

c. SMART - Stress Management (SMART-SM). On order, the team assembles and deploys within 12-hours within their HSR or possibly anywhere in CONUS to provide professional mental health and stress management liaison (technical advice and support) to local authorities in the management of stress related effects associated with disaster/mass casualty incidents or post CBRNE incident. Their capabilities include:

(1) Providing consultative expertise in stress casualty prevention and management.

(2) Providing assistance to civil and military authorities in determining follow-on specialty skills and medical resources required to mitigate the incident.

(3) Providing assistance to authorities in developing a stress management transition plan, which facilitates an orderly return to preincident operations.

(4) Providing assessment of the extent and degree of psychosocial disruption and future risks, and available community resources.

d. SMART - Medical Command, Control, Communications Tele-Medicine (SMART-MC3T). On order, the team assembles and deploys within 12-hours within their HSR or possibly anywhere in CONUS. Provides medical command, control and communications to deployed SMARTs. The SMART-MC3T is capable of deploying anytime another SMART deploys. Offers professional tele-medicine capability (technical advice and support) to local medical authorities in disaster/mass casualty incidents. Its capabilities include:

(1) Providing initial on-scene liaison and incident assessment.

(2) Task organizing and calling forward additional teams, supplies, and equipment.

(3) Providing interoperable communications capability.

(4) Providing technical expertise and portable tele-medicine equipment sufficient to install, operate and maintain an emergency tele-consultation capability from a remote site.

(5) Providing interface and liaison capability to civil authorities in communicating emergency patient and provider needs. Assists local authorities with medical situational awareness.

e. SMART - Pastoral Care (Clinical) (SMART-PC). On order, the team assembles and deploys within 12-hours within their HSR or possibly anywhere in CONUS. Provides professional religious liaison (technical advice and support) to local medical authorities in the management of events, incidents, and consequences associated with critical events, trauma ministry, mass casualty ministry, and spiritual assessment.

f. SMART - Preventive Medicine (SMART-PM).

(1) Upon being alerted, the team assembles and deploys within 12-hours. Provides short duration preventive medicine liaison to regional domestic, federal, and defense agencies responding to disasters, civil-military, cooperative action, and humanitarian and emergency incidents.

(2) Provides pre-event planning and consequence management assistance for occupational and environmental health and endemic disease (OEH/ED) hazard identification, risk assessment, risk control, and risk communication following natural and accidental disasters and CBRNE incidents.

g. SMART - Burn (SMART-B). On order, the team assembles and deploys within 12-hours. It provides professional medical liaison (technical advice and support) to local medical authorities in the triage, treatment,

stabilization, care and evacuation of burn patients associated with disaster/mass casualty incidents. Its capabilities include:

(1) Providing technical expertise/augmentation in burn triage, advanced burn resuscitation, management of inhalation injury/respiratory failure, trauma management, and evacuation.

(2) Providing emergency medical care using on-scene facilities/resources and backpack/hand-carried trauma kits.

(3) Providing assistance to civil authorities in determining follow-on specialty skills and medical resources required to mitigate the incident.

(4) Providing additional mechanical ventilation expertise regardless of etiology of lung failure (mustard, nerve, etc.).

(5) Providing assistance to authorities in developing a trauma/critical care transition plan that facilitates an orderly return to preincident operations.

(6) Transportation of vesicant (mustard) injured patients (post-decon) to the Institute for Surgical Research, Fort Sam Houston, TX.

h. SMART - Veterinary (SMART-V). On order, the team assembles and deploys within 12-hours. It provides professional veterinary liaison (veterinary assessment and support) to local medical authorities in the management of veterinary events, incidents and consequences associated with disaster, mass casualty, and animal disease incidents. Its capabilities include:

(1) Providing assistance to civil authorities (e.g., EOC, American Veterinary Medical Association (AVMA), Public Health Service (PHS), and the US Department of Agriculture (USDA)) in responding to and determining follow-on specialty skills and veterinary medical resources required to resolve animal health and food safety associated with the incident.

(2) Providing veterinary preventative medicine issues assessments and response to include food-borne illness and zoonotic disease epidemiology, prevention, and control.

(3) Providing assessment of and limited response to animal triage, trauma management, evacuation, confinement, identification, humane euthanasia, and carcass disposal needs.

(4) Providing coordination of veterinary care for military working animals. When authorized, it also coordinates care for other governmental and nongovernmental agencies' animals, such as search and rescue dogs, participating in the operation.

(5) Providing limited emergency medical care using on-scene facilities/resources and backpack/hand-carried trauma kits.

(6) Providing assistance to authorities in developing a veterinary transition plan that facilitates an orderly return to preincident operations.

i. SMART - Health Systems (SMART-HS). On order, the team assembles and deploys within 12 hours. It provides professional medical liaison (technical advice and support) to local medical authorities in health system-wide and facility infrastructure assessment and reconstitution. Its capabilities include:

(1) Providing full spectrum health facility medical architecture/engineering advocacy, coordination, assessment, planning, assistance, and actions.

(2) Providing technical expertise in health facility assessment and planning from facility physical plant damage assessment to health facility and systems reconstitution, repair, and maintenance.

(3) Providing assistance to civil authorities in restoring the health care delivery system using hand-carried equipment and resources.

(4) Assistance to authorities in developing a health facilities repair/reconstitution transition plan that facilitates an orderly return to preincident operations.

j. SMART - Aero-Medical Isolation Team (SMART-AIT).

(1) On order, the team assembles and deploys within 12 hours. It provides professional aero-medical isolation capability (technical advice and support) to local medical authorities in the management of events, incidents, and consequences associated with infected patients.

(2) Provides a rapid response evacuation unit to any area of the world to transport a maximum of two patients simultaneously.

(3) Provides patient care under conditions of biological containment to service members or civilians exposed to or infected with certain contagious diseases.

4-6. CONCEPT OF OPERATIONS.

a. The SMARTs are designed to support regional domestic events or a CBRNE incident on an installation within their HSR. Weapons, ammunition, and/or explosives are not authorized for employment.

b. Headquarters MEDCOM may utilize medical readiness reports (MRRs), actual deployments, announced and unannounced deployment exercises in evaluating SMART readiness.

c. Operational reports will be submitted through appropriate Regional or Technical Medical Fusion Cells to the MEDCOM Medical Fusion Center.

d. SMARTs will typically support disaster relief, civil-military cooperative action, military installation support, humanitarian and emergency services in five phases:

(1) Phase I: Predeployment, Alert, and Assembly.

(a) This phase begins when a team is placed in 12-hour recall status and receives a valid tasking. Major actions occurring during phase I:

- 1 Team alert and call-up.
- 2 Team brief-up and rehearse.
- 3 Medical force protection actions.
- 4 Risk/mission/weather analysis.
- 5 Event monitoring and mission briefing.
- 6 Transportation request.
- 7 Higher HQ/interagency coordination.
- 8 Equipment Maintenance and checks. Check requirement for area/weather dependent items.
- 9 Individual Travel Orders.

(b) The phase ends when the team begins to deploy.

(2) Phase II: Deployment.

(a) This phase begins when the team deploys. Major actions that occur during Phase II:

- 1 Sending a departure report.
- 2 Arrival at the incident site and sending a Commander's Critical Information Requirements (CCIR) report.
- 3 Establishment of liaison with senior civil or military authorities.
- 4 Determination of OPCON status and receipt of mission brief.

(b) The phase ends when entire team arrives.

(3) Phase III: Employment.

(a) The phase begins when team is mission capable. Major actions occurring during Phase II:

- 1 Provide assigned SMART mission support and advice.
- 2 Develop a transition plan for team withdrawal.
- 3 Prepare for redeployment.
- 4 Send a situation report (SITREP) each 24 hours through channels to HQ, MEDCOM.

(b) The phase ends when the team advisory mission is complete.

(4) Phase IV: Transition to local/State/Federal agencies.

(5) Phase V: Redeployment.

(a) The phase begins when redeployment activities begin. Major actions occurring during Phase V:

1 The team redeploys and sends a departure report.

2 The team arrives at home station and sends a closure report.

3 The team is debriefed and an initial after action report produced.

4 The team repacks and refits equipment sets.

5 The team is released from the mission.

(b) The phase ends when all team members return to home station.

4-7. ADMINISTRATION AND LOGISTICS.

a. Deployment Platforms:

(1) The SMARTs will use DOD ground vehicles (General Services Administration (GSA) contracted cars, trucks, and vans) or air conveyances (military fixed and rotary wing) when possible. The installation transportation office will provide a government transportation request (GTR).

(2) When DOD conveyances are not available, standard and nonstandard commercial air and ground transportation (rental cars, trucks, and vans) will be used. Authorization will be annotated on the DD Form 1610, Request and Authorization for Temporary Travel of DOD Personnel. Payment will be made using Government Credit Card. RMCs will ensure an IMPAC credit card is available to each deploying team chief for mission-related purchases.

(3) There will be no formal backfill for deployed SMART members. Under most circumstances, backfill for deployed SMART members will be cross-leveled from organic regional resources. When SMART assets are deployed on SMART missions for extended periods, MEDCOM may selectively redistribute personnel or equivalent resources from all regions.

(4) Duration of Deployment: Teams will deploy with sufficient food, water, clothing, personal hygiene, and equipment to sustain themselves in an austere environment for 72 hours. All team members will be healthy and fit to support the mission.

(5) Deployment Orders: SMART members will deploy on DD Form 1610. These orders need to be prepared and prepositioned, or an appropriate mechanism will be in place to rapidly create emergency travel orders. Special remarks should indicate the following:

(a) Personnel are authorized to travel in civilian clothes.

(b) Authorized medical personnel performing medical duties are authorized to carry controlled medical substances.

(c) Personnel are authorized excess baggage.

(d) Variations authorized.

(6) Meals/Lodging: Team members will sustain themselves within the US Government designated per diem rates for the operational area. Members will attempt to use locally available civil or military contracted quarters, rations and subsistence. Field rations (Meals Ready to Eat (MRE)) should be the basis of sustenance for the first 72 hours.

(7) Contraband: Team members will not deploy/employ/redeploy with alcohol, privately owned weapon(s), ammunition, explosives, or pornographic materials.

(8) Personal Conduct: Deployed SMART members will not consume alcoholic beverages on- or off-duty.

(9) Medical Force Protection: Immunizations will be IAW AR 40-562. Additional immunizations appropriate to the incident site, and other force medical protection actions that may be required will be completed prior to executing any SMART mission.

(10) Risk Assessments: The team chief will conduct an Army risk assessment prior to executing any SMART mission.

b. Uniform and Equipment:

(1) Deployment/Redeployment Uniform Common to All: Civilian clothing is authorized when using commercial conveyance.

(2) Employment Uniform Common to All: Seasonal battle dress uniform (BDU) or other appropriate dress for the situation as determined by the SMART Leader. Each team member will wear a Red Cross armband and/or SMART identification (such as vests) to identify them as medical personnel.

c. Hazardous Cargo: Team deployment sets will meet all US Army, US Air Force (USAF), National Transportation and Safety Board (NTSB), and Department of Transportation (DOT) hazardous cargo labeling and briefing requirement IAW CFR 49.

d. SMART Equipment: Due to the limited SMART mission, scope and endurance, SMARTs will deploy with supplies and equipment kits using commercial backpacks, suitcases and ruggedized containers. Each equipment piece should meet commercial airframe size, weight and cube requirements. See Appendix C, Tab 3 for required equipment lists by team.

4-8. COMMAND AND SIGNAL.

a. Command. The senior officer accompanying the SMART will assume overall responsibility for deployed SMART(s) and will report to, and be OPCON to, the senior military officer or civilian authority in charge.

b. Deployment Orders. The RMC and/or subordinate command will be responsible for issuing and repositioning orders.

c. Credentials: The parent HQ of the deploying unit will contact the MTF where the SMART members are privileged to ascertain that the professional credentials of the deployed SMART members are current and complete. This includes confirmation of their service status, unit of assignment, credential/privilege status, to include licensure. Team members must have the following documents in their possession at all times during SMART operations:

(1) A copy of the individual's current license to practice in their specific discipline and a current Basic Life Support (BLS) card.

(2) A completed DD Form 1610, Request and Authorization for temporary duty (TDY) Travel of DOD Personnel, with the exception of the fund cite and authorization signature.

d. Signal.

(1) Classified Material: The SMARTs will not deploy with classified or sensitive materials.

(2) Teams deploying with local intra-team radios will use local assigned radio frequencies and call signs. Team leader will coordinate frequencies and call signs with the senior communications technician prior to departure to ensure compatibility and signal noninterference. This coordination should be accomplished with the departure Regional AFMO (Army Frequency Management Office) CONUS FAO (Foreign Area Officer) prior to departure.

(3) SMART Operational reporting will be routed through the applicable Regional Medical Fusion Cell or Technical Fusion Cell to the MEDCOM Medical Fusion Center.

CHAPTER 5

EMERGENCY MANAGEMENT PLANNING

5-1. GENERAL. Activities subordinate to the MEDCOM, and specifically the MTF, are required to prepare and maintain an Emergency Management Plan (EMP). This plan will provide the criteria to manage the consequences of natural and manmade disasters, CBRNE on an installation or other emergencies that disrupt the activity's ability to continue or maintain routine actions. The EMP is a compact set of standardized contingency execution documents compiled into one easily executable plan. The basic plan reflects command policy for response to an emergency that threatens to disrupt the normal routine and operation. Also, each MTF is assigned geographic Health Service Area (HSA), and may have subordinate outlying clinics supporting other installations. Responsibility for planning and coordinating emergency medical support to these installations belongs to the MTF in charge of the HSA. Further, the MTF must synchronize medical requirements and activities of the installation AT-FP Plan with its Emergency Management Plan.

5-2. SCOPE. This chapter establishes minimum criteria for emergency management in the plan development for effective disaster management, mitigation, response, and recovery. The information in this chapter is intended to provide criteria for the preparation and implementation of an EMP. The principles involved in the EMP development and implementations are universally applicable, but because the development of a single model that fits all activities is not possible. The template at Chapter 6 targets the level V Army Medical Center (AMC) or Army Community Hospital (ACH), and will need to be tailored to meet the emergency management requirements and capabilities of other MEDCOM subordinate commands and activities.

5-3. PURPOSE. To provide the activity commander and staff a planning process that is realistic, and can be implemented in response to any emergency situation. The planning process will provide a framework to assess, mitigate, prepare for, respond to, and recover from disasters.

5-4. APPLICABILITY. This chapter is applicable to all MEDCOM activities.

5-5. POLICY.

a. Plan contents. Subordinate HQs and activities will develop and maintain an Emergency Management Plan to ensure an effective response to disasters, medical response to a CBRNE on an installation and/or emergencies affecting the normal activity operation. The plan will include a list of HSA installations supported and specifically tailored support requirements to each installation within its HSA. The emergency management plan will address, at a minimum, the JCAHO Standards/Intents as Listed in table 1.

Table 1. JCAHO Standards/Intents

Standard/Intent	Situation Addressed
(1) Implementing specific procedures in response to a variety of disasters	Mass casualties Fire/internal disasters Bomb threats Severe weather conditions CBRNE
(2) Defining and, when appropriate, integrating the organization's role with community-wide emergency management efforts	Support services the activity can provide to the community, should emergency conditions warrant the activity's assistance Ongoing interaction with community government agencies and medical facilities involved with emergency management planning
(3) Notifying external authorities of emergencies	External authorities that may need to be notified are: <ul style="list-style-type: none"> • The Installation Emergency Operations Center • The installation Directorate of Public Works (alternate care site, supplemental logistical and patient transportation assets) • Installation Provost Marshal (security) • Installation Public Affairs Office • Installation Fire Department (fire service, hazardous material incident) • Higher Headquarters • Community Hospitals (beds and other services) • American Red Cross (blood and other services) • State Emergency Preparedness Office

Standard/Intent	Situation Addressed
(4) Notifying personnel when emergency response measures are initiated	Notification and recall of staff to support disasters and emergencies; when a recall is initiated and by whom; internal notification procedures; maintenance of the emergency notification personnel roster and by whom; internal section personnel notification roster maintenance; notification to external facilities; notification to ambulance service and the operations officer during duty hours, or the command during nonduty hours
(5) Assigning available personnel in emergencies to cover all necessary staff positions	How the manpower pool is set up, who is responsible for the manpower pool and assignments, who reports to the manpower pool, and how staff utilization and manpower pool assignments are made
(6) Managing space, supplies, and security	<p>Alternate use of space within the facility, such as clinics serving as treatment areas for casualties received during an external disaster</p> <p>Ordering and delivery of supplies during a disaster or emergency</p> <p>Security issues during disasters or emergencies</p> <p>Establish logistics support Servers and internal LAN to order and process supplies and equipment</p>
(7) Evacuating the facility when the environment cannot support adequate patient care and treatment	When and how to evacuate the facility
(8) Establishing an alternate care site when the environment cannot support adequate patient care	Location of alternate care site. Having a primary and alternate site, and contingency plan in place in case of widespread environmental contamination
(9) Managing patients during emergencies, including scheduling, modification or discontinuance of services, control of patient information, and patient transportation	Modification or discontinuance of services during emergencies, patient transportation, and patient information
(10) An alternate source of essential utilities	Alternate water, electricity conservation, resources available

Standard/Intent	Situation Addressed
(11) A backup communication system in the event of failure during disasters and emergencies	Alternate means of communication, such as hand held radios, amateur radio operators, messenger service (runners), etc
(12) Facilities for radiological, biological or chemical isolation and decontamination	Setup and location of the patient contamination survey and decontamination stations, responsibility and procedures
(13) CBRNE	<p>A continuation of the personnel pool discussion in Standard/Intent # 5</p> <p>Staff may have to work outside their normal duties</p> <p>The Chief, Personnel and the Deputy Commanders - Clinical Services and Nursing - use the staff utilization and manpower pool assignment appendix as a guide to assign department chiefs and other staff to treatment areas</p>
<p>(14) An orientation and education program for personnel who participate in implementing the Emergency Management Plan. Education addresses:</p> <p>(a) Specific roles and responsibilities during emergencies</p> <p>(b) The information and skills required to perform duties during emergencies</p> <p>(c) The backup communication system used during disasters and emergencies</p>	<p>How the orientation and education program is provided, by whom, and the frequency</p> <p>Taskings direct the orientation and education program to include the items mentioned in the Standards/intents</p> <p>Discuss the orientation and education program with each employee during their in-processing, in-service training, and annually at the birth month refresher-training program</p> <p>Conducting drills to test the Emergency Management Plan and to assess the staff's knowledge and skills to perform duties during emergencies</p>
Standard/Intent	Situation Addressed
<p>(15) Ongoing monitoring of performance regarding actual or potential risks related to one or more of the following:</p> <p>a. Staff knowledge and skills</p> <p>b. Level of participation</p> <p>c. Monitoring and inspection activities</p>	<p>Evaluation of actual or potential risks related to one or more of the items listed in the Stand/Intent</p> <p>Development and monitoring a performance improvement activity</p>

<p>d. Emergency and incident Command reporting</p> <p>e. Inspection, preventive maintenance, and testing of equipment</p>	
<p>(16) How an annual evaluation of the emergency management plan's objectives, scope, performance, and effectiveness will occur</p>	<p>Assessment of the emergency management plan's objectives, scope, performance, and effectiveness, how often, who assesses</p>

b. Monitoring the emergency management plan.

(1) Activities will conduct an organization wide process to collect information about deficiencies and improvement opportunities in the emergency management program. Each department, division, service chief will evaluate the objectives, scope, performance, and effectiveness of the EMP. The EMP will be revised if necessary based on the evaluation. The Emergency Management Planning Committee will address any problems identified, and direct changes as needed.

(2) The Emergency Management Planning Committee will review and consolidate the information, prepare an assessment, and present the report to the Commander or his/her designated representative.

c. An emergency management plan template for a medical treatment facility is provided at Chapter 6, page 55.

5-6. RESPONSIBILITIES.

a. Headquarters, US Army Medical Command.

(1) The Assistant Chief of Staff, Operations. Provides command policy and staff coordination.

(a) Chief, Plans Division, Operations Directorate. Provides EMP guidance/assistance and maintains copies of RMC/MSC EMPs on file.

(b) Chief, Current Operations Division. Validates all Federal response taskings, evaluates "Immediate Response" actions and requests, and provides taskings for backfill or augmentation.

(2) The Assistant Chief of Staff, Health Policy and Services. Provides technical medical guidance and assistance on use of the PROFIS and medical resources.

(3) The Assistant Chief of Staff, Logistics. Provides technical logistical guidance and assistance to RMCs/MSCs in all aspects of logistics support and sustainment.

(4) Safety Management Office. Provides technical guidance and assistance in the areas of safety, environment of care, and accident prevention.

(5) Provost Marshal. Provides technical guidance and assistance in the areas of law enforcement, traffic control, physical security, and antiterrorism.

(6) Patient Administration Division (PAD). Provides advice and assistance to MEDCOM MTFs on issues of eligibility for medical care, bed status reporting, and management of nonmilitary casualties/patients.

(7) Other MEDCOM staff offices. All HQ MEDCOM staff members are responsible for providing guidance and assistance in their staff specialty areas, as required.

b. MEDCOM Installation Commanders must:

(1) Review Installation Deployment and Mobilization Plans to determine all specified or implied logistical support requirements in order to properly apply available resources. Make necessary adjustments to ensure present conditions and/or situations and installation unique requirements are adequately addressed.

(2) Review and evaluate all other contingency plans, e.g., Special Threat Operations, Anti-Terrorism/Force Protection, Mass Casualty, Food Service Contingency Service Plan from a logistical perspective. Consider all specified or implied logistical support requirements. Make necessary adjustments to ensure present conditions and/or situation is addressed.

(3) Assess installation support capabilities identifying strengths and weaknesses, and plans to overcome weaknesses. Report shortfalls that cannot be resolved without the assistance of this headquarters within 10 days of receipt of this order.

(4) Evaluate Class I (Food Service), Class II and Class IV (Supply), Class III (Petroleum, Oil and Lubricants (POL)), Class V (Ammunition), Class VII (Major End Items), Class IX (Repair Parts), Laundry Service, Transportation and Maintenance Support levels. Report maximum support levels considering present inventory and service levels and contingency deployment/mobilization surge capabilities.

(5) Ensure all contractual services provide deployment and mobilization clauses addressing increased troop strength and surge requirements.

(6) Coordinate with known customer support base to further clarify and obtain specific food service, supply, transportation, and maintenance requirements. Be prepared to provide support to other DA, DOD, Federal or State agencies.

(7) Be prepared to issue organizational clothing and individual equipment (OCIE) to all mobilizing and deploying individuals and units, as necessary. Report any OCIE shortages to this headquarters within 10 days of receipt of this order.

(8) Continuously review and validate all specified and implied tasks and requirements to support increased troop support and surge requirements.

(9) Establish means of accounting for support provided, specific to a major deployment/mobilization. Utilize unique account processing code when provided and support is in excess of normally provided support and operations. Reported costs for supplies and services must be detailed and auditable.

(10) Ensure compliance with all supply and logistical regulations.

(11) Consider the possibility of having to accommodate some civilians in the event of mass casualty. Establish an internal support mechanism to cover this requirement utilizing existing installation support capabilities. Identify and report shortfalls that cannot be resolved without the assistance of this headquarters within 10 days of receipt of this order.

(12) Provide to this headquarters (MCL0-0), a Contingency Plan for accommodating increased feeding troop support.

(13) Review Installation Deployment Plans and Mobilization Plans to determine all specified or implied logistical support requirements in order to properly apply available resources.

(14) Integrate installation support capabilities into the deliberated planning training, and testing of deployable SMART Teams.

c. The RMC Commanders must:

(1) Prepare and maintain an RMC EMP Standard Operating Procedure.

(2) Review and evaluate the Emergency Management Plans of subordinate activities to ensure functional validity and completeness.

(3) Develop an Emergency Management Validation Program ensuring each subordinate activity exercises and tests its EMP at least semi-annually. The Commander will ensure the exercise and test includes mass casualty, WMD, and facility relocation.

d. The MTF Commanders/Director of Health Services must:

(1) Establish an Emergency Management Planning Committee.

(2) Prepare, maintain and test the EMP.

(3) Exercise the EMP, including a CBRNE exercise, at least semi-annually. Exercises must be at least four months apart. One exercise must include a mass casualty scenario with sufficient casualties processed to adequately stress the facility and staff capability to continue routine medical care, recall off duty staff, and activation of the EMP. Regional SMART Teams may be incorporated into each exercise scenario (semi-annually) to deploy the teams with equipment and supplies and validate Command Control and Communication. It is highly recommended that the State National Guard WMD-Civil Support Teams be incorporated into the exercise along with other agencies.

(4) Ensure all Army installations in their region lacking a level V MTF have a plan coordinated for emergency medical support included in their respective installation AT-FP Plans. This support may consist primarily of local (911 system), State or adjacent DOD installation assets, but must be feasible and planned with the RMC's guidance and approval.

(5) Monitor the training of employees in implementation of the EMP, and the employees' understanding of their roles as described in the EMP and standard operating procedures (SOP).

(6) Prepare and forward after action reports to the RMC within 30 days of the exercise or actual emergency.

(7) Participate in the installation AT-FP planning committee and/or garrison staff to ensure that an appropriate medical response (generally applicable portions of the facility EMP) is incorporated into the installation AT-FP Plan.

(8) Coordinate with the local Emergency Management Planning Committees (or equivalent) to ensure the facility is appropriately integrated into the community disaster response system, and is prepared to treat multiple casualties resulting from an incident (HAZMAT/WMD) involving hazardous substances.

5-7. PROCEDURES.

a. The Emergency Management Planning Committee will:

(1) Develop, publish, and exercise an EMP.

(2) Develop and recommend for Commanders' approval the Command Critical Supplies and Equipment Lists specifying those materials essential to treat CBRNE patients and also sustain emergency essential patient care within the MTFs or other contingency locations on an installation such as schools, theaters, buildings, etc. These lists will be reviewed and published under the commander's signature as part of the EMP on an annual basis. These lists may also include the supplies and equipment necessary for triage and operating areas within the MTFs under mass casualty (MASCAL) situations.

(3) Develop and recommend for Commanders' approval the required amount of Personal Protection Equipment (PPE) necessary to execute the plans developed to support the CBRNE events, HAZMATs and spills, and threats addressed in the EMP and Installation threat analysis. Requirements will be submitted to HQ MEDCOM, Operations Directorate, Plans Division for validation. PPE has been centrally purchased based upon availability of funding and current priorities. Level B suits with full face Powered Air-Purifying Respirator (PAPR) masks have been obtained for each lead medical facility located on an installation as listed below. These suits will be used to protect the Patient Decontamination Team and provide protection for triage or other response teams as necessary. A ratio of 2.5 (fractions rounded to the next higher) for each bed or bed space in the emergency department or receiving area of the Acute Care Clinic was utilized for the lead facility as listed below. The quantity of masks may be adjusted based

upon the facility commander's estimation of the most likelihood of receiving large numbers of self-presenting or other emergency patients.

- (a) MEDCEN or MEDDAC Emergency Department.
 - (b) MTF with Emergency Department.
 - (c) Acute Care Clinic (receiving area beds only).
 - (d) Sole Health Clinic or Occupational Health Clinic.
- (4) Evaluate exercises.
 - (5) Prepare and review after action reports.
 - (6) Use lessons learned to revise and improve the plan.
 - (7) Ensure the plan is widely understood and accepted.
 - (8) Ensure appropriate personnel are trained in the use, maintenance, and storage of PAPRs and PPE.

b. The following subjects will be addressed in the EMP, at a minimum. The subjects do not have to be in the following order:

- (1) Letter of Transmittal to the next higher headquarters.
- (2) Table of Contents.
- (3) Record of Changes.
- (4) Basic Plan.
- (5) Notification and Recall Plan.
- (6) External Disaster Plan/Mass Casualty Management Plan.
- (7) Internal Disaster Plan/Fire Protection.
- (8) Physical Security Plan.
- (9) Medical Assistance to Civil Authorities.
- (10) Hospital Evacuation/Transportation Plan.
- (11) National Disaster Medical System Implementation Plan.
- (12) Severe Weather Plan.
- (13) Communication Plan.
- (14) Logistics Plan.
- (15) Safety Plan.

- (16) HAZMAT Incident Control Plan.
- (17) CBRNE Operations Plan.
- (18) CBRNE Incident Response Plan.
- (19) CBRNE Incident Emergency Room (ER) Response Plan.
- (20) Deployment Standard Operating Procedure for Special Medical Augmentation Response Teams (SMART) (See Chapter 4).
- (21) Emergency Power Plan.
- (22) Emergency Operations Center Plan.
- (23) Family Assistance Center Plan.
- (24) Physical and Behavioral Health Follow-up Plan.
- (25) Execution Matrix checklist.
- (26) Glossary.
- (27) References.
- (28) Distribution.

c. Hazard identification and risk assessment, both internal and external, are the responsibility of every MTF. Each activity should anticipate the types of emergencies and/or disasters likely to occur, and what their role might be in such emergencies. Emergencies and/or disasters may be natural or manmade (e.g., snow storms, tornadoes, earthquakes, HAZMAT spills, facility utility systems failures, aircraft crash, nuclear accidents, fires, demonstrations, bomb threats, terrorist actions, employment of weapons of mass destruction etc.). The EMP should describe how the facility will operate under any one or a combination of these disasters. Plans should use worse case assumptions (e.g., an emergency and/or disaster will happen at night during lightest staffing). The following guidance is provided when addressing HAZMAT and WMD:

(1) This area is covered in detail in Occupational Safety and Health Administration (OSHA) Directive 29, US Code, Section 654 and in the JCAHO Standards EC.1.2, EC.1.3, EC.1.6, EC.1.9, EC.2.2, EC.2.4, and EC.2.5. Each activity is required to have a plan for handling both hazardous materials and waste in its EMP. These plans should include step-by-step procedures for decontamination and treatment of HAZMAT victims. All personnel using personal protection equipment (PPE) will require medical screening and OSHA-approved training and/or certification.

(2) The OSHA has also established HAZMAT threat levels for determining PPE protection needs. Activities must be able to determine when an individual(s) has been contaminated and when the EMP HAZMAT plan should be activated. Activities must have the capability/plan for rapidly determining the type of threat they encounter, and how to safely decontaminate casualties

without exposure to others. Activities must be able to react to all chemical (chem) and/or biological (bio) threats, whether real or false alarms. Activities must have plans for isolating suspicious materials, packages, or letters that may be received, and may be part of an anonymous chem/bio threat.

(3) The facility Commander must ensure their security plans address risk issue, and that all plant operations and the engineering staff are aware of possible threats to the facility's air handling and water supply systems.

d. The EMP should establish a line of authority within the facility. Command and control must be clear. The plan must designate who will declare the emergency, who will be in charge of each area, who are the alternates, and the location of these individuals. Alert rosters must be current and personnel recalls exercised periodically.

e. During an emergency within or outside the facility, several essential building services must be continued or patients will have to be evacuated. These services include electricity, water, ventilation, fire protection systems, fuel sources, communication systems, medical gases, and vacuum systems. These services must be covered in the EMP.

f. Internal and external communication systems should be established to facilitate communication. Communication must be maintained with security forces, emergency medical first responders within the installation, local community and other authorities having jurisdiction, as well as internal patient care and service units in the event normal communications are rendered inoperative. Coordination must be accomplished prior to departure.

g. Planning will include alerting and managing all staff in an emergency and/or disaster. Staff management includes the following:

- (1) Assignment of roles and responsibilities.
- (2) Method for identifying human resource needs.
- (3) Method for recalling personnel and augmenting staff.
- (4) Management of space (Housing, day care, etc.).
- (5) Management of staff transportation.

h. The earlier triage is initiated, the higher the chance of saving lives. Patient management may require that patients be discharged or transferred to other facilities to make room for more critical incoming casualties.

i. Contingency planning for emergencies and/or disasters resulting from CBRNE attacks must consider the temporary interruption or stoppage of transportation assets from Prime Vendor suppliers. Regional Assistant Chiefs of Staff for Logistics (ACSLGs) and MTF Chiefs of Logistics will establish minimum levels of supplies as contingencies in this event. MTF logistics and clinical staff will consider raising the on-hand inventory for essential critical Trauma, Surgical, and Critical Care cases. It is not advised to raise the level to a point that it risks waste due to expiration or cause

storage problems. These newly adjusted reorder points for any one medical item should not exceed an upward adjustment of 15% in Installation Medical Supply Activity (IMSAs) supported by the DLA. Increasing reorder points on any one medical item within Defense Health Program (DHP) direct funded IMSA accounts should not exceed an upward adjustment of 5%. Additional primary factors to consider in making these adjustments are the Prime Vendor monthly fill rates and the IMSA's ground travel distance from the Prime Vendor's supporting distribution center. Contact MCLO-0, for additional guidance on levels of supply.

j. The staff will develop security plans that address facility access, crowd control, security staff needs and traffic control. Allowing general access to an operational area during a disaster makes it very difficult for health care providers to administer patient care. Access control plays an important part in management of any emergency situation. Security personnel need to be trained, organized and available to handle traffic management issues internal and external to the facility, such as vehicular access to the emergency room and safety of the triage site. Security and traffic control are especially critical if the disaster involves management of contaminated casualties and the establishment of a decontamination site. Activities must formally coordinate their security needs with the installation Provost Marshal. This action is necessary as a means to supplement the facility security capabilities. The needs of the MTF must be integrated/incorporated into the overall installation response/EMP plan. The information provided should include availability of parking for staff, patients, and visitors; normal vehicular, emergency vehicular, and pedestrian traffic flow patterns in and around the facility. The extent of the security and traffic control problems for any given MTF will depend upon its physical arrangement, availability of visitor parking areas, number of entrances and the installation traffic flow patterns. Areas of primary interest are:

(1) Visitors can be expected to increase in number with the severity of the disaster. Visitors should not be allowed to disrupt the disaster response functions of the facility. Ideally a visitors' reception center should be established away from the main facility itself. Normal visiting hours on nursing units should be suspended.

(2) Arrangements for vehicular traffic control into and around the facility should be integrated into both the MTF and installation EMPs. It will be necessary to direct vehicles carrying casualties, support personnel, supplies, and equipment to appropriate areas. Charts showing traffic flow and entrances to be used should be included in the EMP.

(3) Internal security and traffic control are best conducted by assigned military or civilian employees who have been locally trained and are well informed about the layout of the facility, and knowledgeable of the EMP. Following activation of the EMP, security personnel should be stationed at unlocked entrances and exits as the situation dictates. Entrance to the facility should be restricted to personnel bearing staff identification cards and to casualties. Traffic flow charts for internal traffic should be prepared in the planning phase and regulated by security personnel during the plan activation to manage patient flow within the facility.

k. Because of the intense public interest in disaster casualties, news media representatives should be given as much consideration as the situation will permit. The Public Affairs Officer (PAO) should be tasked to provide and monitor a reception area, with access to telephone/computer-assisted communication and an expediter who could provide other assistance to these individuals. News media personnel should not be allowed into the facility without proper identification for security purposes. All staff personnel should be advised on handling media requests. Preplanning with the local media can ease the strain of dealing with requests under trying circumstances.

l. Each facility will implement an educational program. This program will include an overview of the components of the EMP. Education concerning the staff's specific duties and responsibilities shall be conducted upon reporting to their assigned departments or position. A general orientation to the provisions of the EMP should be given to each new employee upon hire.

m. Each facility will implement one or more specific responses of the EMP at least semi-annually. At least one semi-annual exercise will rehearse a mass casualty response of sufficient size to require the activation of EMP recall system and stress the ability of the facility to continue its routine health care mission. In addition to the semi-annual exercises that stress the MTF, the MTF commander/Director of Health Services must ensure the installation conducts at least one semi-annual exercise involving a training accident in a remote and austere location on the installation for those installations that conduct training in those environments. This will stress the installations MEDEVAC system, installation medical support for training personnel, the ability to extract casualties from remote and austere locations, and the MTF communications link-up with the installation MEDEVAC system. It is advisable that the EMP be developed in coordination with local fire and emergency medical and disaster management agencies, and exercised in coordination of these groups. MTFs with assigned Bed Expansion and casualty reception missions will at a minimum exercise semi-annually the dispatch operations and patient evacuation kits for all assigned installation medical evacuation buses and any supplemental patient transport vehicles. Procurement and turn-in approval for any patient evacuation vehicles manage on behalf of the MTFs by the installation will be coordinated directly with MEDCOM ACSLOG.

n. Domestic Response System (Disaster/CBRNE) procedures and mutual aide agreements for cooperative support between military and surrounding civilian medical facilities and emergency medical response and transportation services should be in place and continually updated. These agreements tie into the local Metropolitan Medical Response System thus resulting in a unified community approach to consequence management.

o. Participation in MMRS involves consideration of the following community goals when preparing the EMP:

- (1) Integrate biological management into the overall planning process.
- (2) Develop plans for mass patient care.
- (3) Develop plans for mass fatality management.

5-8. REPORTS.

a. After Action Reports.

(1) After action reports (AAR) provide the tool by which the Commander and the Emergency Management Planning Committee can make adjustments to the procedures outlined in the EMP. The goal of the reporting process is to ensure that the plans are effective and remain current.

(2) After action reports will be submitted to the next higher quarters within 30 days of the test, exercise, or emergency incident. Electronic mail (E-mail) is acceptable for the initial/preliminary report, but the record copy will contain a transmittal cover letter on the organization's letterhead.

(3) The AAR will include a description of the incident, or the planned exercise objectives; problems encountered; lessons learned; corrective actions; operational recovery issues; and other noteworthy areas.

b. Daily Status Reports.

(1) Daily status reports will be submitted to the next higher headquarters in the event of an actual emergency.

(2) The reports will cover the previous 24-hour period.

(3) The reports may be submitted by telephonic or electronic means.

c. Serious incident reporting will be accomplished IAW AR 190-140, and MEDCOM Supplement 1 to AR 190-40.

EMERGENCY MANAGEMENT PLAN TEMPLATE

CHAPTER 6

EMERGENCY MANAGEMENT PLAN TEMPLATE

6-1. GENERAL.

The Emergency Management Plan (EMP) Template in Figure 6-1 is provided for use by MEDCOM subordinate commands and activities. The plan template is in the five-paragraph operations order format. The principles involved in the development and implementation of the EMP are universally applicable. A development of a single model that fits all activities is not possible; the template targets the Army Community Hospital and Medical Center, and will need to be tailored to meet the requirements of a specific activity. Activities subordinate to the MEDCOM, and specifically the MTF, are required to prepare and maintain an EMP. This plan will provide the criteria to manage the consequences of natural and manmade disasters, CBRNE on an installation or other emergencies that disrupt the activity's ability to continue or maintain routine actions. The EMP is a compact set of standardized contingency execution documents compiled into one easily executable plan.

Figure 6-1, Emergency Management Plan Template.

REFERENCES

1. SITUATION.

a. General. The EMP provides guidance for operational continuity, assigns responsibility, and sets procedures to ensure maximum effectiveness during emergencies or disasters.

b. Enemy/Friendly Forces. Omitted.

c. Assumptions.

(1) A natural or manmade disaster could interrupt routine operations.

(2) Casualty information may not be reliable or readily available. Casualties may arrive on short or no advance notice.

(3) The facility ambulance service may need support in transporting patients to local hospitals.

(4) Civilian resources will be used to fulfill civilian requirements.

(5) Military assistance to civil authorities will be temporary.

(6) Damage to the facility or disruption of utilities may reduce the operational capability of the hospital.

(7) The installation commander will authorize the use of installation resources.

(8) Staff members not residing near the installation may be delayed or prevented from reporting to duty.

(9) Inter-service support agreements will continue in effect.

2. MISSION.

a. Provide emergency health service support to beneficiaries and, as directed, to civilians affected by an emergency or disaster.

b. Prepare to react to internal disaster situations or contingencies.

c. Maintain health care consistent with the situation.

3. EXECUTION.

a. Concept.

(1) The installation and facility plans provide procedures for military medical assistance to the civilian community.

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(2) If additional patient beds are needed during emergencies, the Patient Administration Division contacts other military, DVA, or civilian hospitals for support.

(3) The facility commander may curtail health care or direct hospital evacuation. (Alternate patient care site should be identified here.)

b. Tasks.

(1) Department, Division, and Service Chiefs complete all tasks assigned by annexes and appendixes to this plan.

(2) Department, Division, and Service Chiefs are responsible to maintain their portion of the EMP current.

Annex	Title	Proponent
A	Notification and Recall Plan	Chief, PTMS
B	External Disaster Plan/Mass Casualty Management Plan	Chief, PTMS
C	Internal Disaster/Fire Protection/Traffic Control Plan	Safety Officer
D	Physical Security Plan	Chief, PTMS
E	Medical Assistance to Civil Authorities	Chief, PTMS
F	Hospital Evacuation/Transportation Plan	Chief, Logistics
G	National Disaster Medical System Implementation Plan	Chief, PTMS
H	Severe Weather Plan	Chief, PTMS
I	Communication Plan	Chief, IMD
J	Logistics	Chief, Logistics
K	Safety Plan	Safety Officer
L	HAZMAT Incident Control Plan	Safety Officer
M	CBRNE Operations Plan	Chief, PM
N	CBRNE Incident Plan	Chief, PM
O	Deployment SOP for SMART Teams	Chief, PTMS
P	Emergency Power Plan	Chief, Logistics
Q	Emergency Operations Center Plan	Chief, PTMS
R	Family Assistance Center Plan	Chief, Personnel
S	Physical and Behavioral Health follow-up	
T	Public Affairs	Public Affairs
U - W	Local Use	
X	Glossary	Chief, PTMS
Y	References	Chief, PTMS
Z	Distribution	Chief, PTMS

c. Coordinating Instructions. The Commander, or representative, directs the execution of the EMP.

4. SERVICE SUPPORT.

a. Funding and Accounting. The Resource Management Division manages funding to support emergency operations.

b. Logistics. Existing policies and procedures apply. The Chief, Logistics Division, coordinates logistical support that is not readily available.

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c. Pharmacy. Existing policies and procedures apply. The Chief, Pharmacy Service, coordinates pharmacy support that is not readily available.

d. Administration. The Deputy Commander for Administration (DCA) directs administrative actions to support emergency management.

e. Personnel.

(1) Personnel and resources are coordinated through normal channels or the EOC.

(2) Department, division, service chiefs, and professional staff may perform duties outside their routine workplace.

(3) Emergencies may require that available administrative personnel work outside their normal duties. For example, the Chief of the Manpower Pool could assign a clerk typist to work as a clinic receptionist.

f. Public Affairs. The Public Affairs Officer arranges public information activities during emergency or disaster operations.

5. COMMAND AND SIGNAL.

a. Command.

(1) The Commander executes command and control through the Facility EOC.

(2) If the Commander is not available, command responsibility passes to the senior AMEDD officer present.

b. Signal. See Annex I.

Commanders Signature Block

OFFICIAL:

Deputy Commanders Signature Block

ANNEXES:

- A - Notification and recall plan
- B - External Disaster Plan/Mass Casualty Management Plan
- C - Internal Disaster/Fire Protection/Traffic Control Plan
- D - Physical Security Plan
- E - Military Assistance to Civil Authorities
- F - Hospital Evacuation/Transportation Plan
- G - National Disaster Medical System Implementation Plan
- H - Severe Weather Plan
- I - Communication Plan
- J - Logistics
- K - Safety Plan

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- L - HAZMAT Incident Control Plan
- M - CBRNE Operations Plan
- N - CBRNE Incident Plan
- O - Deployment SOP for SMART Teams
- P - Emergency Power Plan
- Q - Emergency Operations Center Plan
- R - Family Assistance Center Plan
- S - Physical and Behavioral Health Follow-up
- T - Public Affairs
- U - Local Use
- V - Local Use
- W - Local Use
- X - Glossary
- Y - References
- Z - Distribution

Annex A, Notification and Recall Plan

1. PURPOSE. To notify and recall staff members during emergencies.

2. CONCEPT.

a. The Commander uses the recall roster if a manpower pool is needed after duty hours.

b. All areas of the hospital should be operational in the shortest possible time, with 85% of the military personnel present within 2 hours.

c. If a manpower pool is needed during duty hours, the Information Management Division announces this statement:

"Attention in the hospital. All military staff that can be released from their work areas please report to the Manpower pool in the " Location". This is not an exercise." If the EMP is being exercised, include, "This is an Exercise".

d. During nonduty hours, only mission essential civilian personnel may be recalled for exercises or emergencies. Supervisors release them from duty when possible.

e. The master recall roster and section recall roster follow a pyramid chain. The Administrative Officer of the Day (AOD) starts the recall when instructed by the Commander; a Deputy Commander; Troop Commander; or a Plans, Training, Mobilization, and Security (PTMS) Division staff member. If notified by anyone else, the AOD contacts the Commander for guidance.

f. The Medical Company Commander begins the recall for barracks personnel.

3. RESPONSIBILITIES.

a. Department, division, and service chiefs prepare rosters using this guidance.

(1) Include each clinic and section, instructions on using the roster, and how to verify the recall is complete.

(2) Provide a copy of the recall roster to every assigned individual.

(3) Brief staff on their responsibility to follow instructions given during a recall.

(4) Update the roster every month, more often if needed.

(5) Give a copy of the roster to the PTMS Division by the 10th of each month.

b. Chief, PTMS Division.

(1) Maintains the master recall roster.

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- (2) Begins the recall during duty hours for emergencies.
- (3) Tests the recall plan at least twice a year.

c. Administrative Officer of the Day.

- (1) For emergencies or when contacted by anyone other than the Commander, a Deputy Commander, Troop Commander, or a PTMS Division staff member, contacts the Commander and explains the situation.
- (2) Initiates the recall roster when directed.
- (3) Makes necessary announcements.

d. Soldiers not residing in the medical company barracks must have a telephone or another way to be contacted.

4. PROCEDURES.

a. Nonduty hours.

- (1) The AOD initiates the recall roster when directed.
- (2) After the AOD begins the recall, the primary or alternate contact person continues the chain, following the master recall roster and their section roster.
- (3) When a primary or alternate person on the master recall roster cannot be contacted notify the AOD. The AOD checks the section recall roster and calls down the chain until he reaches someone. That individual continues the section recall.
- (4) The primary/alternate contact of the final section listed on the master recall roster calls the AOD to verify that the chain is complete.
- (5) The AOD records when he receives calls from the final primary or alternate contacts.

b. Duty hours.

- (1) The Chief, PTMS initiates the recall, using procedures in the preceding paragraph.
- (2) Personnel who cannot reach a contact person will notify the Chief, PTMS.
- (3) The primary/alternate contact of the final section listed on the master recall roster calls the Chief, PTMS to verify the chain is complete.

c. The Chief, Personnel Division, makes manpower pool assignments based on the contingency with the assistance of the Deputy Commander for Clinical Services (DCCS), Deputy Commander for Nursing (DCN), and the Chief, PTMS.

Appendix 1, Alert Recall Roster Checklist and Log (Add if appropriate)

Annex B, External Disaster Plan/Mass Casualty Management Plan

1. PURPOSE. To outline procedures for a mass casualty (MASCAL) situation. A MASCAL exists when the facility receives any number of casualties requiring treatment that exceeds the capability of the on-duty staff or the availability of resources.

2. CONCEPT. The (name of facility) accepts (patient categories).

a. During duty hours.

(1) The ambulance service responds to the emergency/disaster scene. The ambulance service notifies the facility of the number of casualties, type of injuries, etc., for transport to the facility. The treatment area notifies the PTMS Division of the emergency/disaster. A PTMS Division staff member notifies the Commander, a Deputy Commander, or the senior AMEDD Officer available.

(2) The PTMS Division notifies other staff members, and establishes the EOC, if directed.

b. After duty hours.

(1) After notification by the Ambulance, the emergency room contacts the AOD. The AOD then contacts the Commander, DCCS, DCN, or DCA for guidance.

(2) The AOD notifies other staff members, using the recall roster, or as the Commander, DCCS, DCN, or DCA directs.

c. If the facility ambulance service needs supplemental ambulance support, they notify the installation fire department that notifies the appropriate local agency. The EOC coordinates helicopter support, if necessary.

d. The commander uses the EOC to receive updates and brief the staff on the situation, if the EOC is set up. Deputy Commanders and selected staff may carry a hand-held radio for direct communication with the EOC and other key staff. The PTMS Division issues the radios.

e. The following sections provide a representative to staff the EOC. These representatives are the points of contact for capabilities, limitations, and problems regarding their specialty. They provide current information about their area to the Commander.

- (1) Clinical Services.
- (2) Nursing Service.
- (3) Logistics.
- (4) Information Management.
- (5) Personnel.

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(6) Patient Administration Division.

(7) Public Affairs Office.

f. The EOC staff makes recommendations to the Commander that may include:

(1) Recall of military/civilian staff.

(2) Discharge/transfer of patients.

(3) Continuation of outpatient care, revised patient scheduling, or duty shifts.

g. The triage team sorts and categorizes the casualties. Color codes depict the direction in which the patients in different categories move.

h. Follow the instructions in Annex N for contaminated patients (nuclear, biological, and chemical).

3. RESPONSIBILITIES.

a. The DCCS.

(1) Advises the manpower pool officer-in-charge (OIC) on physician and physician's assistant assignments, and supervises these staff members.

(2) Monitors inpatient and casualty management.

(3) Identifies and sends out the Medical Section of the Installation Support Team.

b. The DCA.

(1) Supervises the EOC and all administrative support.

(2) Ensures proper MTF security IAW the FPCON and during an installation crisis management phase.

c. The DCN. Advises the manpower pool OIC about assignments of nursing staff, and supervises the staff members.

d. The Assistant Chief Nurse or appropriate department head.

(1) Helps the DCN supervise nursing personnel.

(2) Guides and directs the treatment area OICs in developing supply and equipment lists.

(3) Provides the bed status report to the Patient Administration Division representative in the EOC.

e. Chief, Department of Emergency Medicine or appropriate department head.

(1) Manages the ambulance service.

(2) Assists in staffing treatment areas.

(3) Supervises the triage area.

f. Chief, Department of Surgery.

(1) Assists in staffing and equipping the treatment areas.

(2) Prepares for an increase in workload.

g. Chief, Department of Pathology.

(1) Prepares for an increase in laboratory procedures.

(2) Initiates contact with the American Red Cross, local hospitals, and the Armed Services Whole Blood Processing Laboratory (ASWBPL) to determine availability of blood products.

(3) Submits a blood status report to the EOC.

(4) Maintains MOUs/MOAs with local/State medical laboratories for specialized emergency specimen testing.

h. Chief, Social Work Service.

(1) Advises the Commander on disaster mental health interventions and stress control support to staff and patients, including stress casualties.

(2) Establishes and staffs an Assistance and Support Center where relatives, friends, and commanders can wait for further information on the situation.

(3) Coordinates with the American Red Cross and the Army Community Service for support services.

i. Chief, Behavioral Health (Psychiatry, Psychology Services).

(1) Advises the Commander on disaster mental health interventions and stress control support to staff and patients

(2) Provides technical assistance to triage, support to patients and staff, and differential diagnosis and management of stress casualties and dual diagnosis cases with mental disorders and physical injury.

j. Chief, Department of Radiology.

(1) Assists in staffing the treatment areas.

(2) Prepares for an increase in workload.

k. Chief, PTMS Division.

(1) Operates the EOC and updates the staff on the MASCAL situation. Coordinates actions with the Installation Operations Center (IOC).

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(2) Coordinates and/or requests assistance from the installation or civilian activities, as required.

(3) Issues hand-held radios.

(4) Places color-coded signs that direct patient flow.

l. Chief, Pharmacy Service.

(1) Delivers pharmaceuticals to the area that requests them.

(2) Ensures necessary on-hand Class VIII for a CBRNE incident per MEDCOM guidance.

(3) Identifies follow-on pharmaceutical requirements and a streamlined acquisition process for a CBRNE incident per MEDCOM guidance.

m. Chief Preventive Medicine.

(1) Advises the Commander on waste and refuse disposal, vector and infectious disease control, and food and water sanitation.

(2) Releases the Community Health Staff Nurse to the DCN if the Preventive Medicine Service does not need community health services during the MASCAL.

(3) Performs physician duties in the hospital at the direction of the DCCS.

(4) Coordinates for follow-on veterinary support should it be needed as part of post-consequence management.

n. Chief Information Management Division.

(1) Sets up telephone service in the manpower pool.

(2) Arranges automation support, telephone lines, copier, and FAX capability.

(3) Coordinates with the Directorate of Information management (DOIM) for addition communications assets, when required.

(4) Ensures effective communication with the IOC, Installation Support Team, EMS, and surrounding community hospitals.

(5) Ensures strip maps to surrounding hospitals are readily available.

o. Chief, Patient Administration Division.

(1) Assists in staffing the treatment areas.

(2) Maintains a bed status chart in the EOC, keeping track of patients from admission to final disposition.

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(3) Issues admission records to the triage area.

(4) Contacts civilian hospitals for additional bed support, if required.

p. Chief, Personnel Division.

(1) Establishes the manpower pool, if directed. Supervises and screens staff members for special skills, and makes assignments.

(2) Assists in staffing the triage and other areas needing litter bearers, messengers, etc.

q. Chief, Department of Ministry and Pastoral Care.

(1) Coordinates with triage to ensure proper level of Pastoral Care for patients in the triage area.

(2) Works with the Social Work Service to establish an Assistance and Support Center for relatives and friends of casualties.

(3) Coordinates with the Installation Chaplain for additional support, if required.

r. Chief, Nutrition Care Division.

(1) Keeps the dining facility and kitchen open to feed new patients and staff members who work longer hours.

(2) Submits emergency requests as needed to the subsistence prime vendor.

(3) Coordinates with the Logistics Division for vehicles, potable water, and storage facilities, as required.

s. Chief, Logistics Division.

(1) Delivers equipment to the triage area, as required.

(2) Exchanges blankets in the triage and other areas as required.

(3) Coordinates with the Installation for additional patient transportation vehicles, evacuation buses, and other support vehicles and equipment as required.

(4) Dispatches logistics support teams to specified high patient volume areas within the MTFs.

(5) Establishes liaison with IOC(s).

t. Chief, Oral and Maxillofacial Surgery Service.

(1) Assists in staffing the operating rooms areas.

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(2) Prepares for an increase in workload.

u. Public Affairs Officer.

(1) Establishes a Public Affairs Center.

(2) Briefs the media on the MASCAL, escorts the media into authorized areas, and ensures they do not interfere with patient care.

(3) Coordinates with the Installation Public Affairs Office for assistance, if required.

v. Commander, Medical Company.

(1) Informs the barracks personnel of the MASCAL. Instructs them to report to the manpower pool.

(2) Ensures the availability of personnel.

4. PROCEDURES.

a. When notified of a MASCAL, the Chief, PTMS briefs the Commander and Deputy Commanders about the situation.

b. Following the initial briefing by the Chief, PTMS, the Deputy Commanders report to the treatment areas to ensure proper staffing and preparations.

c. If the Commander activates the manpower pool, the Chief, PTMS notifies the Chief, Information Management Division (IMD) to make the announcement.

d. Staff members will report to their predesignated area.

e. Staff members that can be released from their work area will report to the manpower pool.

f. The EOC staff contacts their senior headquarters to report the situation.

g. Area OICs send supply and equipment lists to Logistics and Pharmacy as soon as they can. Area OICs needing additional staff will contact the EOC.

Appendixes (As required) (Suggested appendixes as a minimum)

1 - Reception, Triage, and Patient Flow within the facility

2 - Staff Utilization/Manpower Pool

Annex C, Internal Disaster/Fire Protection/Traffic Control Plan

1. PURPOSE. To outline procedures for an internal disaster situation.

2. CONCEPT.

a. Assumptions.

(1) A fire, explosion, or CBRNE event can cause extensive physical damage or loss to facilities, supplies, equipment, and cause personal injuries or loss of life.

(2) Utilities may be lost or interrupted depending on the location and severity of a fire or explosion.

(3) Most fires are confined to one floor. It is unlikely that the facility will need to evacuate more than one floor. Normally, closing doors within the area and timely fire fighting by trained personnel isolates fires.

(4) Most explosions cause only local damage and do not extend beyond the walls of the affected area. Severe explosions can cause damage over an extended area or an entire floor. Explosions involving more than one floor are unlikely.

3. RESPONSIBILITIES.

a. Department, division, and service chiefs ensure their staff is aware of their duties during an internal disaster situation.

b. The Facility Safety Officer.

(1) Coordinates and provides training in fire prevention for all assigned personnel.

(2) Provides consultant services to activities, including recommendations to improve fire safety and requesting assistance from the installation fire department.

(3) Advises the DCA of hazardous conditions and/or areas that are not complying with directives.

(4) Inspects clinical sections semiannually and administrative areas annually.

c. The Assistant Chief Nurse or appropriate department head.

(1) Ensures safe use of medical gases on patient care wards.

(2) Notifies the EOC if additional personnel to evacuate patients are required.

d. The Public Affairs Officer.

(1) Coordinates media support.

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- (2) Briefs the news media.
- (3) Provides photographic coverage.
- e. The Chief, PTMS.
 - (1) Establishes and operates the EOC.
 - (2) Coordinates with the Installation Provost Marshal for restricted access to dangerous and damaged areas, crowd control, and criminal investigative support as required.
 - (3) Coordinates traffic control requirement with the Installation Provost Marshal and provides input to the Installation Traffic Management Plan.
- f. The Administrative Officer of the Day.
 - (1) Notifies the safety officer of fires or explosions.
 - (2) Follows the internal disaster guidelines in the AOD instruction book until the Safety Officer arrives.
- g. The Chief, Information Management Division. Reserves the overhead paging system for official use only during the emergency.
- h. The Chief, Logistics Division/Chief, Facilities Management Division--prior to the event and as part of normal operations--
 - (1) Assesses damage and takes action to repair or replace damaged or destroyed property, facilities, equipment, etc.
 - (2) Coordinates with appropriate Installation organizations such as the DPW and Fire Department.
- i. All supervisors.
 - (1) Provide available personnel to help the nursing staff evacuate patients.
 - (2) Become familiar with Annex F, the hospital evacuation/transportation plan.

4. PROCEDURES.

- a. Use the RACE system when there is fire or smoke in your area. The RACE system is described below.
 - (1) R = RESCUE. Rescue anyone in immediate danger.
 - (2) A = ALARM.
 - (a) Use the facility code for fire. Do not shout or yell fire.

(b) Pull the fire alarm pull station.

(c) Dial 911.

(3) C = CONFINE. Confine the fire and smoke by closing doors to the affected area.

(4) E = EXTINGUISH/EVACUATE.

(a) Use the fire extinguisher only if the fire is in the early stage (small flames).

(b) Evacuate the area if necessary.

b. Close the doors in the affected areas when involved in fire fighting or removal of patients. Begin with the doors nearest the fire. Close other doors until the fire is contained behind the smoke barrier doors.

c. If the Hospital Commander or Installation Fire Chief decides to evacuate the facility, personnel not involved in direct patient care leave the facility via the exits stated in their fire SOP. Nursing personnel and other staff members systematically evacuate patients per direction of the Commander, Safety Officer, Nursing Supervisor, and/or the Installation Fire Chief.

d. Patient evacuation and service curtailment will be initiated only if directed by the Commander. The Installation Fire Chief makes the decision that the facility should be evacuated. The only exception to evacuating or moving patients without the Commander's direction is if a delay would result in additional risk, injury, or loss of life.

e. Evacuated inpatients will be transported using the procedures in Annex F.

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Annex D, Physical Security Plan

1. PURPOSE. To provide requirements and guidance to maximum protection of life and property during emergencies, while reducing interruption of patient care.

2. CONCEPT.

a. The safety of patients, visitors, and employees will be ensured by maintaining control of the healthcare setting through adherence to the procedures outlined in MEDCOM Suppl 1 to AR 190-13, The Army Physical Security Program.

b. The hospital is open to the public and to the installation military and family members in particular. MEDCOM Suppl 1 to AR 190-13 describes physical security controls.

c. The AOD monitors access to the facility after normal operating hours.

d. Access to other facility buildings after normal duty hours is limited to staff and law enforcement personnel only.

e. The Commander requires all staff members to wear security identification badges while in the facility.

3. RESPONSIBILITIES.

a. All personnel are responsible for physical security and crime prevention.

b. The Chief, PTMS Division.

(1) Is the Physical Security and Crime Prevention Officer for the facility.

(2) Provides consultant services to the Commander and staff about activities that require special physical security because of their mission essential or vulnerable status.

(3) Informs the Installation Provost Marshal of special concerns.

4. PROCEDURES.

a. MEDCOM Suppl 1 to AR 190-13 provides detailed procedures for all areas of concern.

b. The manpower pool may be used in some instance to provide physical security.

Annex E, Medical Assistance to Civil Authorities

1. PURPOSE. To provide guidance on assistance to civil authorities during a natural disaster or a peacetime emergency.

2. CONCEPT.

a. Assumptions.

(1) Support is normally temporary and assumed by civil government agencies as soon as possible.

(2) The RMCs provide assets to assist in carrying out the approved mission.

b. The nearest military installation to the federally declared disaster area is designated to provide assistance.

c. The facility will assist the Civil authorities in overcoming disasters or domestic emergencies by providing medical assistance when directed, or when immediate response is necessary to save life or lessen human suffering, and when local resources are clearly inadequate to cope with the emergency.

3. RESPONSIBILITIES.

a. Chief, PTMS Division.

(1) Represents the Medical Center (MEDCEN)/Medical Department Activity (MEDDAC)/Dental Activity (DENTAC) at the IOC.

(2) Provides an estimate of medical and dental requirement to the MEDCEN/MEDDAC and DENTAC commanders.

(3) Provides an after action report on utilization of resources to the RMC.

(4) Coordinates medical support for participation in military or civil defense exercises.

b. The MEDCEN/MEDDAC Commander or designated representative provides medical advice to the IOC.

c. The DENTAC Commander provides an on-call maxillofacial surgeon for emergency dental treatment.

d. Department, division, service chiefs provide resources and services.

4. PROCEDURES. The RMC and IOC procedures will be followed.

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Annex F, Hospital Evacuation/Transportation Plan

1. PURPOSE. To provide guidance and procedures for transporting evacuated patients, supplies, and equipment from the hospital to a temporary treatment and holding area.

2. CONCEPT.

a. An internal disaster could occur in the hospital, requiring evacuation of patients and movement of supplies and equipment to a temporary treatment and holding area. A primary and alternate location will be identified for temporary treatment and holding.

b. Evacuation and transportation operations include.

- (1) Evacuating patients and staff from danger to life and limb.
- (2) Transporting inpatients to a temporary treatment and holding area.
- (3) Discharging or transferring inpatients to other hospitals.

c. The commander or his designated representative decides if the facility will transport all or some of the patients.

3. RESPONSIBILITIES.

a. The Hospital Commander/Director of Health Services will ensure that coordination with other available hospitals has been accomplished and MOU/MOAs are in place in the event that the hospital must be completely evacuated. A primary concern is the safety and appropriate care for hospitalized patients.

b. The Ambulance Service.

- (1) Provides evacuation service for inpatients.
- (2) Notifies the MEDCEN/MEDDAC EOC or the Installation Fire Department when additional transportation is required.

c. Chief, Logistics Division.

- (1) Provides blankets and other equipment for patient comfort.
- (2) Provides stands and gurneys to the evacuation assembly point as requested.
- (3) Delivers supplies and equipment to the temporary treatment and holding area.

d. Chief, PTMS Division.

(1) Coordinates with the Installation Directorate of Plans, Training, Mobilization, and Security (DPTMSEC) for temporary facilities.

(2) Establishes and operates a command and control point, if required.

e. Safety Officer. Assists the Chief, PTMS at the command and control point.

f. The Assistant Chief Nurse or appropriate department head.

(1) Submits an initial equipment and supply list for patient care to Logistics.

(2) Estimates the number of patients requiring evacuation to other military or civilian hospitals, and notifies PAD.

g. Chief, PAD.

(1) Coordinates evacuation activities.

(2) Coordinates with local civilian hospital for support, if required.

h. Chief, Nutrition Care Division.

(1) Requests the Logistics Division to negotiate a food service contract for feeding patients and staff, or for a dining facility where meals can be prepared if the hospital is completely evacuated.

(2) Coordinates feeding requirements for the duration of the emergency.

i. All other supervisors provide available personnel to assist the nursing staff with patient evacuation.

4. PROCEDURES.

a. Evacuate patients from threatened areas or the entire hospital, as required.

b. Clinic chiefs determine which patients are evacuated, and in what priority.

c. Assembly patients for evacuation to the temporary treatment and holding area.

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Annex G, National Disaster Medical System Implementation Plan

1. PURPOSE. To provide guidance and requirements for implementing the NDMS plan.

2. CONCEPT.

a. The NDMS is a system designed to care for victims of an incident that exceeds the medical care capability of any affected State, region, or Federal medical care system. NDMS is a partnership between major Federal agencies, local and State governments, and the private sector.

b. The NDMS serves dual goals: to assist the local and State authorities in coping with medical and health effects of major peacetime disasters, and providing support to the military and the DVA medical systems in caring for returning military casualties from a theater of operations. The NDMS is a part of the continuum of care that is initiated at the disaster site, or on the battlefield, and terminates with the patient's return home to return to military duty.

c. Several assumptions can be made in conjunction with NDMS planning. These assumptions may include, but not be limited to the following:

(1) Patients entering the NDMS have been decontaminated, treated, and stabilized.

(2) It is possible that some patients will enter hospitals having missed one or more levels of care, or could be transported shortly after surgery.

(3) Stress, including the stress of travel, may aggravate some conditions. Treatment provided during air evacuation may be limited.

(4) Patients may be separated over long distances from their communities and families; family members, especially parents of children may insist on accompanying and remaining with the patients.

(5) Patients will be decontaminated prior to leaving the incident site.

(6) Some personnel may leave the incident site prior to it being secured or by-passed personnel decontamination stations and may arrive at the MTF requiring decontamination

3. RESPONSIBILITIES. Specific responsibilities will be included here.

4. PROCEDURES. Specific procedures will be included here.

Annex H, Severe Weather Plan

1. PURPOSE. To provide guidance for continuing medical services and protecting patients, staff, and visitors during periods of severe or unusual weather conditions.

2. CONCEPT.

a. Severe or unusual weather conditions, such as hurricanes, tornadoes, snow, freezing rain, etc., may interrupt normal activities and increase the need for medical services. The hospital's response to these conditions may be quite different from that planned for the installation.

b. The hospital will expand services to maximum capability for unusual circumstances while continuing to support the normal workload. Safety and mission requirements are the critical factors in deciding when to cut back on care that can be provided.

c. Because medical care needs are unpredictable, all staff may be considered essential personnel. When the Commander has a clear understanding of the situation, he determines specific essential personnel.

d. The Installation DPTMSEC gathers and disseminates weather data to installation activities. Weather warnings are received over the "hot line" in PTMS, and by the AOD after normal duty hours.

e. Personnel must know what to do before severe weather conditions threaten, and be prepared to move quickly.

3. RESPONSIBILITIES.

a. Chief, PTMS Division.

(1) Notifies the Commander and staff that an adverse weather warning was received, and what should be expected.

(2) Begin the recall of personnel IAW Annex A, as directed by the Commander.

(3) Establishes the EOC, when directed, and continuously communicates with the IOC once the Installation Severe Weather Emergency Action Plan is activated.

(4) Notifies key staff members to report to the hospital EOC. Key staff members may be some of all of the following: Commander, DCA, DCCS, DCN; Chiefs of Logistics, PAD, IMD, Personnel, and the Public Affairs Officer (PAO).

(5) Coordinates with the IOC to arrange for the following:

(a) Transportation of essential/emergency personnel.

(b) Billeting for essential/emergency personnel.

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- (c) Other emergency support as may be required.
 - (d) Coordinates participation in severe weather exercises.
- b. Chief, Department of Emergency Medicine or appropriate department head.
- (1) Provides emergency ambulance service.
 - (2) Prepares for increased medical service requirements.
 - (3) Provides communication needs to PTMS.
- c. Chief, Information Management Division. Provides weather announcements and updates over the overhead paging system once PTMS receives the weather updates from the IOC.
- d. Department, Division, Services Chiefs.
- (1) Identify essential personnel and report their status to the EOC.
 - (2) Establish safety precautions for staff in their area of responsibility.

4. PROCEDURES.

- a. Supervisors will inform essential personnel that they are considered essential staff, and are expected to report to work during severe or unusual weather conditions.
- (1) If an essential staff member is delayed from reporting to work because of severe or unusual weather conditions, the individual must contact someone in their chain of command.
 - (2) Essential personnel on leave in the local area may be recalled to duty.
- b. Nonessential personnel are staff members who may be excused from work during severe or unusual weather conditions without adversely affecting the mission. These personnel must also contact someone in their chain of command for instructions.
- c. Available nonessential personnel may be required to work outside their normal duties. For example, a clerk-typist may be assigned to work as a clinic receptionist.
- d. The following actions should be taken as necessary and as appropriate.
- (1) Close draperies and blinds during high winds to protect against shattered glass. Move patients, staff, and visitors into the hallway.
 - (2) Ensure emergency equipment operates and is close by, especially during a tornado watch. Check emergency power lines and availability of flashlights.

(3) Move your patients and staff away from windows and close all doors during a tornado warning.

(4) Patients on monitors should not be moved. Mattresses and cabinets will be placed in front of windows to block flying glass.

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Annex I, Communications Plan

1. PURPOSE. To provide information on communications during emergencies.

2. CONCEPT.

a. The voice-operated telephones are the primary communications within the hospital, and to activities outside the hospital. The following communication methods will be used when the telephone system is not available.

(1) Hand-held radios distributed to key staff members and sections.

(2) Cellular telephones.

(3) Messenger service (runners).

(4) Amateur radio operators.

(5) Military and commercial electronic mail and Internet communications.

b. Radio is the primary means of communication with ranges and training areas.

c. Primary and back-up communications will be established with the IOC(s).

3. RESPONSIBILITIES.

a. Chief Information Management Division.

(1) Has responsibility for communications services, but does not have maintenance capability for the equipment. Operator maintenance is to be performed by operators.

(2) Expedites critical requirements and repair services to the installation DOIM.

(3) Stores and distributes cellular telephones when directed by the EOC.

(4) Acquires additional portable communication from DOIM when directed by the EOC.

b. Chief, PTMS. Stores and distributes hand-held radios at the EOC.

4. PROCEDURES. Specific procedures will be included here.

Annex J, Logistics

1. **PURPOSE.** To provide a support template for an MTF's Logistics Division/ Directors of Logistics to execute in the event of an emergency situation either to its treatment facility or parent installation.

2. **CONCEPT.** It is the intent of an MTF's Logistics Division to logistically support all emergency events arising from a Chemical, Biological, Radiological, Nuclear and high Explosive attacks, emergencies, and mass casualties either internal to the facility or to its parent installation. In support of this mission it is highly recommended that the Logistics Division, establish a Logistics Operations Center (LOC) or internal operating cell to centralize all logistical requirements and direct logistical operations. The Chief, Logistics Division may develop Logistical Teams (such as A, B, and C) with designated logistical personnel on teams with predetermined support locations and missions (such as emergency area site prep with equipment and supplies, manpower pool, and logistics warehouse with vehicles and drivers). All requests and questions concerning logistics support should be directed to the LOC prior to submitting supply requisitions, medical equipment relocations, supply and services contracting support commitment or obligations, and any other logistical requirement.

3. **RESPONSIBILITIES.** MTF Logistics Division:

a. Prepare to execute internal and installation Emergency Management Plans.

b. Prepare to provide medical logistics support assigned installation.

c. Prepare to receive, store, and issue Class VIII A & B in support of Deployments, Installation Force Protection, Homeland Security, and Installation Support.

d. The installation source of supply for Medical Nuclear, Biological, and Chemical Defense Materiel.

e. Prepare to receive and distribute, regional class VIII support packages from US Army and DOD stockpiles.

f. Contact and coordinate medical logistical support directly with local and State planning authorities, as required.

4. **PROCEDURES.**

a. The existing logistics system will be used to the maximum extent possible in concert with the four-tiered system as mentioned below during an emergency situation. Develop with the appropriate clinical staff to determine critical medical supply lists with the priority of issue and support for example, the Operating Room, followed by the Immediate Care Area, the Intensive Care Unit, the Delayed Care Area, the Expectant Care Area, and the Minimal Care Area.

b. The Logistics Division should determine where critical supply packages would be stored. This could include specifics such as: Drugs maintained in

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the Pharmacy, supplies for each of the six patient care areas maintained in the Medical Supply Warehouse. Supplies will be moved from the warehouse to the main hospital during an emergency using the best means available, and keys to the warehouse will be kept with the AOD after duty hours.

c. All materiel and services ordered in support of emergency operations will be processed through established logistics automated information systems (Defense Medical Logistics Standard Support (DMLSS) or TAMMIS), to include all government credit card transactions. The mandatory source for medical materiel is Defense Supply Center Philadelphia (DSCP). Established DOD Regional Prime Vendor Distributors will be utilized to the greatest extent possible, which includes the use of standardized products. Medical materiel not available through the DOD Regional Prime Vendor Distributors may be locally procured.

d. The supply of medical materiel and MNBCDM will be obtained based on a four-tiered concept of medical logistics support as outlined below.

(1) Installation Support Packages.

(a) 15 days of Medical Nuclear Biological Chemical Defense Materiel for 25% of the installation population (Appendix D, this pamphlet).

(b) Maintained by the IMSA.

(2) Regional Medical Support Packages. 15 days of Medical Nuclear Biological Chemical Defense Materiel for 25% of the regional population.

(3) Army and Department of Defense Medical Assets. Utilizing existing assist, i.e., depot, vendor-managed inventories, and stock rotation contracts to store a 30-day supply for contingencies.

(4) National Pharmaceutical Stockpile Program (NPSP).

(a) Managed and maintained by the Center of Disease Control.

(b) If directed, IMSAs may be required to store and maintain specific quantities of National Stockpiled Materials.

(c) Available within 12 hours.

e. Logistics Support and Medical Maintenance Procedures for Short-Term emergency operations:

(1) Routine maintenance or other directed support to a CBRNE incident. Functions will cease during a short-term emergency such as a MASCAL. During these situations, Logistics Support Teams may (at the discretion of the Maintenance Chief and with concurrence of the Logistics Division Chief) be pre-positioned in critical areas such as radiology, pathology laboratories, emergency treatment areas, and other critical care locations. Logistical Support Teams should consist of the most experienced individual or individuals on the type of equipment and supplies predominantly used in the specified critical area.

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(2) All personnel (except as noted above) will be readily available within the Logistics Division. Requests for support may be routed through the Logistics Divisions/Logistics Operations Center or the MTF's Emergency Operations Center. Only under the most extreme circumstances will logistical support personnel join general labor pools, act as litter bearers, etc.

f. Logistics Support and Medical Maintenance for Long-Term Emergency Operations:

(1) Medical Maintenance support will continue IAW existing SOPs and regulations. Minor equipment undergoing routine repair or maintenance may be returned without repair to the using activity at the discretion of the Branch Chief or NCOIC.

(2) During longer contingency operations, consideration should be given to acquiring additional supply, services maintenance contracts, adding a second shift, staggering work hours to optimize access to areas such as the Operating Room, Intensive Care Room, and Central Materiel Supply. Additional repair parts and contracts may be required to handle the additional workload.

(3) Additional vigilance will be maintained for "no trouble found" and "user error" work order findings. This is usually indicative that new and backfill personnel need additional training on equipment use and or request for logistical support.

g. Housekeeping.

(1) Environmental and Housekeeping services are performed under the existing contractor or in-house government employees.

(2) Emergency response by the Contractor or government employees may be required (over and above routinely scheduled work) to provide for patient welfare and safety of the building as a result of a mass casualty situation or natural disaster. The hospital shall be maintained, as much as possible, in a hygienically clean condition during emergency situations and returned to a totally cleaned condition within a reasonable time frame after termination of the emergency situation.

(3) The contractor shall be familiar with the MTF Emergency Management Plan and shall participate in exercises.

(4) The contractor shall establish an emergency recall system for contractor employees who may be required to work in the event of a disaster or contingency operation. The Contractor's emergency recall system shall require that the Government notify only the Contractor's Representative of a disaster situation or contingency operation to initiate the Contractor's recall system.

h. Equipment and Property Management Procedures.

(1) The PBO will use existing policies and procedures for the acquisition/accountability and disposal of all equipment. At a minimum, the PBO will need to coordinate with the Chief of Logistics, IMSA, Regional Medical Commands, Patient Regulating Officers, and the Emergency Operation

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Center (EOC). In the event of an emergency, medical and nonmedical equipment should be identified and pre-positioned in designated locations for immediate delivery when required.

(2) Local and Regional SOPs should be established as necessary for internal accountability policy and procedures. Property accountability used and identified in support of patient evacuation will be accounted for using the procedures outline in AR 40-61 and AR 40-538. These procedures will specify "user friendly methods" for temporary hand receipt and lateral transfers to support contingency, humanitarian, and peacekeeping missions. Supervisory responsibility as outlined in AR 735-5 applies to every person in managing evacuation equipment. Property Book Officers will use the procedures outlined in AR 710-2-1 and AR 710-2-2 for Operations Other than War as well as Wartime Accountability procedures.

Annex K, Safety Plan

1. PURPOSE. To provide guidance to ensure a safe operational and working environment for medical activity employees, patients, and visitors during emergencies, while enhancing patient care.

2. CONCEPT.

a. A safe and healthful workplace and environment for employees, patients, and visitors will be ensured by elimination or control of hazards through integration of risk management, per AR 385-10 and FM 100-14, into all emergency management plans, processes, and operations.

b. All standards established by Department of Labor pursuant to sections 6 and 19 Of Public Law 91-596 are adopted as Army standards and will be complied with in applicable army workplaces.

c. Commanders will apply and integrate all DOD and Army safety policies and standards, Occupational Safety and Health Act (OSHA), and other non-DA regulatory or consensus safety and health standards into all emergency management plan scenarios, in whole or part, insofar as practicable.

d. Commanders will ensure application and integration of all Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards and requirements into emergency management plans.

3. RESPONSIBILITIES.

a. All DA personnel, military and civilian, will:

(1) Comply with safety and occupational health rules, regulations, and standards.

(2) Use and maintain Protective Clothing and Equipment provided for their protection.

(3) Report any unsafe and unhealthful working conditions and accidents to their supervisor.

b. Commanders at all levels will be responsible for protecting personnel, equipment, and facilities under their command, effective implementation of safety and occupational health policies; and the integration of the risk management process into their safety and health program, including emergency management plans.

c. Chiefs of activity staff sections, supervisors, and operating personnel who direct or affect the actions of others will:

(1) Use the risk management process during the planning, preparation for, and execution of all operations, including emergency management plans.

(2) Maintain a safe and healthful environment for employees, patients, and visitors.

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(3) Promptly evaluate and take action as required to correct hazards or deficiencies affecting safety and health identified during review of emergency management plans and/or related training operations.

d. Emergency Medical Planning Committee will:

(1) Ensure the risk management process is integrated during the planning, preparation for, and execution of all emergency management plans and related operations and/or training.

(2) Ensure risk assessments are completed for all changes to emergency management plans to identify, eliminate, and/or control hazards to personnel, facilities, or operations.

(3) Ensure the minutes of all EMMC are reported to the activity Safety and Occupational Health Council.

e. Safety Manager/Officer:

(1) Acts as principal advisor and provides consultant services, including recommendations, to activity leadership, supervisors, and employees to eliminate or control hazards related to emergency management plans.

(2) Develops, coordinates, and disseminates safety program and risk management operational direction and guidance to activity leaders, supervisors, and employees.

(3) Monitors emergency management program effectiveness to identify any hazards or safety deficiencies to activity leaders.

(4) Serves as risk management integration proponent for the activity Commander.

Annex L, HAZMAT Incident Control Plan

1. PURPOSE. To provide guidance for medical support to the local and surrounding community if there is a HAZMAT incident.

2. CONCEPT.

a. Assumptions.

(1) Medical assistance to the civilian community passes to civil authorities when possible.

(2) Sufficient assets are available for approved missions.

(3) The HAZMAT or a designated nonmedical team will conduct personnel decontamination that will include personnel requiring medical treatment.

b. The installation may ask the MEDCEN/MEDDAC to provide medical assistance to the installation HAZMAT Team.

c. A HAZMAT incident may occur within the MTF or its area of responsibility.

d. Local Health Departments, State Health Departments, FBI Offices, and the Centers for Disease Control and Prevention (CDC) will have a responsibility in responding to a terrorist related HAZMAT incident on the installation.

3. RESPONSIBILITIES.

a. Chief, Department of Emergency Medicine.

(1) Coordinates MTF-level and installation-level HAZMAT planning and training with the Installation HAZMAT Team.

(2) Directs and coordinates ambulance support to the site of an installation HAZMAT event.

(3) Coordinates medical personnel to support the paramedics with on site triage (when numbers and types of casualties exceed the ambulance service capability); establishes a notification system, designates assembly points, and maintains equipment.

(4) Arranges for emergency medical personnel to receive training on emergency response to HAZMAT incidents.

(5) Ensures limited patient decontamination just outside the Emergency Department for those patients who bypass the Installation Support Team decontamination site.

b. The Assistant Chief Nurse. Provides nursing personnel to augment emergency medical personnel (when numbers and types of casualties exceed the ambulance service capability).

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c. Chief, Logistics Division.

(1) Coordinates HAZMAT issues with the Chief, Preventive Medicine and the Installation HAZMAT team.

(2) Acquires medical supplies requested to respond to a HAZMAT incident.

(3) Maintains and updates quarterly a master listing of all chemical, biological (to include hazardous medical wastes), and radiological materials that are stored and/or used by the MTF within its area of responsibility.

(4) Ensures proper CBRNE and HAZMAT contaminated waste disposal.

d. Chief, Preventive Medicine Services.

(1) Task organizes preventive medicine assets to provide direct support to the MTF, the installation, and the installation HAZMAT Team in the areas of:

(a) Stress control, assisted by Behavioral Health assets.

(b) Additional Toxic Industrial Material (TIM) monitoring, surveillance, and laboratory capabilities.

(c) Subject Matter Experts on TIMs.

(d) Health risk assessment and risk communication.

(2) In coordination with the Chief, Logistics Division and the Installation HAZMAT Team, develops listings of all HAZMAT materials or sites within the MTF, on the installation, and within the surrounding community that could require a response from the MTF and/or the installation in the event of an accident.

(3) Evaluates the ability of the Preventive Medicine Services to execute preventive medicine programs in support of HAZMAT as described in AR 40-5. Ensures HAZMAT support resources are sufficient for a CBRNE terrorist incident requiring mass decontamination. Identifies shortfalls and makes recommendations required to execute the MTF preventive medicine HAZMAT mission.

(4) Trains assigned personnel to provide HAZMAT support as directed by the MTF commander.

(5) Ensures that staff are trained and qualified to fulfill local responsibilities under local, State, and Federal declarations.

(6) Conducts installation level medical training for medical personnel on treatment and countermeasures for patients on high threat HAZMAT materials on or near the installation to include response to the "worried well."

EMERGENCY MANAGEMENT PLAN TEMPLATE

(7) Establishes and maintains liaison with local Health Departments, State Health Departments, the local FBI Office, and the Centers for Disease Control EOC and enters into MOAs and MOUs as appropriate.

(8) Conducts periodic water and food checks in coordination with surrounding public health officials.

EMERGENCY MANAGEMENT PLAN TEMPLATE

Annex M, Chemical, Biological, Radiological, Nuclear and High Explosive (CBRNE) Operations Plan

1. PURPOSE. To provide guidance for medical support to the local and surrounding community if there is an incident involving Nuclear, Biological, and Chemical (NBC) agents.

2. CONCEPT.

a. Assumptions.

(1) Medical assistance to the civilian community passes to civilian authorities when possible.

(2) Sufficient assets are available for approved missions.

(3) A CBRNE event will result in a local, State and Federal response.

(4) Decontamination will be accomplished as near to the incident site as practical IAW the Installation Plan. A number of individuals may bypass the installation decontamination site and require decontamination by the MTF.

b. The NBC Operations Team includes the MEDCEN/MEDDAC NBC Section and the Ambulance Service, augmented by emergency medical personnel when numbers and types of casualties exceed the capabilities of the ambulance service. The team is specifically trained in NBC operations.

c. The installation may ask the MEDCEN/MEDDAC to provide medical section to the Installation Support Team.

3. RESPONSIBILITIES.

a. Chief, Department of Emergency Medicine or appropriate department head.

(1) Directs and coordinates the appropriate medical response based upon the CBRNE threat which is encountered. This may not always be readily apparent and may be based upon the presentation of unusual numbers of patients and/or their symptoms.

(2) Coordinates medical personnel to support the paramedics with on-site triage (when numbers and types of casualties exceed the ambulance service capability); establishes a notification system, designates assembly points, and maintains equipment. The safety of medical personnel takes priority over initial treatment of patients when a CBRNE incident is suspected.

(3) Arranges for emergency medical personnel to receive training on emergency response to nuclear and chemical accidents and incidents.

(4) Initiates the Building Security Plan (restrict entry or contaminated individuals).

(5) Initiates patient monitoring for contamination.

EMERGENCY MANAGEMENT PLAN TEMPLATE

b. The Assistant Chief Nurse or appropriate department head. Provides nursing personnel to augment emergency medical personnel (when numbers and types of casualties exceed the ambulance service capability).

c. Chief, Logistics Division. Acquires medical supplies requested by the NBC Operations Team.

d. Chief Personnel Division.

(1) Designates personnel to fill positions within the NBC Section.

(2) Notifies the NBC Officer when personnel in-process with specialty training in NBC operations.

(3) Establishes a manpower pool of individuals trained in decontamination procedures.

e. Nuclear, Biological, and Chemical Officer.

(1) Provides training to the NBC Operations Team, and conducts operations in a contaminated environment.

(2) Establishes a MEDCEN/MEDDAC NBC Section notification system, and designates assembly points.

(3) Coordinates with Logistics Division for required equipment.

(4) Provides radiological, chemical, and biological monitoring data on the hospital and facilities.

(5) Advises the Command on NBC issues, and the radiological, chemical and biological contamination threat posed to the hospital and facilities.

f. Chief, Preventive Medicine Services.

(1) Task organizes preventive medicine assets to provide direct support to the MTF, the installation, and the NBC Defense Officer in the areas of:

(a) Disease prevention and control, i.e., recommendations on immunizations, evaluation of acute respiratory disease, population health management, and hospital infection control.

(b) Stress control, i.e., facilitate natural group support (unit, family, work, church), psychological first aid, BH/COSC triage assisted by Behavioral Health Assets.

(c) Environmental health, i.e., safety of drinking water, pest and disease vector prevention and control, all waste storage and disposal, air quality, and sanitation and hygiene in housing, troop billets, and installation facilities.

(d) Occupational health, i.e., occupational medicine, radiation safety for ionizing radiation, industrial hygiene, health hazard assessments, medical facility systems safety, and medical exams.

EMERGENCY MANAGEMENT PLAN TEMPLATE

(e) Health surveillance and epidemiology, i.e., deployment occupational and environmental health surveillance, application of the Defense Occupational and Environmental Health Readiness System (DOEHRS) and Occupational Health Management Information System (OHMIS) databases to individual readiness, medical surveillance, and epidemiology.

(f) Conducts medical surveillance for unusual trends in patient complaints with surrounding community hospitals and clinics as an early warning that a CBRNE attack may have occurred.

(g) Soldier, family, community health, and health protection, i.e., communicable disease prevention and control, and community health needs assessments, child development centers.

(h) Conducts periodic water and food checks in coordination with surrounding public health officials.

(i) Preventive medicine toxicology services, i.e., toxicology assessments of potential CBRNE, HAZMATs, Toxic Industrial Chemicals (TICs), and Toxic Industrial Materials (TIMs) and toxicology clearances for Army chemicals/materials, and other toxicology based health risk assessments.

(j) Preventive medicine laboratory services.

(k) Health risk assessment and risk communication.

(2) Evaluates the ability of the Preventive Medicine services to execute preventive medicine programs in support of CBRNE as described in Para 3f(1) above and AR 40-5. Identifies shortfalls and makes recommendation for any additional resources required to execute the MTF preventive medicine CBRNE mission.

(3) Trains assigned personnel to provide CBRNE support as directed by the MTF commander.

g. Chief, Behavioral Health Department/Services.

(1) Provides training in stress control and differential diagnosis of stress casualties to the NBC operations team.

(2) Deploys a trained technical assistant with the team when requested.

h. Chief, Department of Pathology. Coordinates with mortuary affairs for autopsies and storage/transport of chemically or biologically contaminated remains.

i. Chief, Facility Management Division.

(1) Coordinates with and assists the MEDCEN/MEDDAC NBC Officer in planning and programming decontamination facilities both portable and fixed.

(2) Coordinates with Installation NBC and HAZMAT elements and establishes protocols for contaminated effluent disposal.

(3) In conjunction with the Provost Marshal Office (PMO) and Safety Officer, conducts facility threat and vulnerability assessment and develops a Protective Action Plan (see USACE TI 853-01 for additional guidance). The assessment will include but not be limited to the baseline threat, asset value, asset recognition, maintenance of continued operations, criticality to mission, time of replacement, number of personnel present, security of water source, security of mechanical, electrical and communication systems. The Protective Action Plan could include programming AT/FP construction projects commensurate with the identified baseline threat and required protective measures. At a minimum, the Protective Action Plan will consider requirements in the following areas:

- (a) Security of fresh air intakes.
- (b) Security of mechanical rooms.
- (c) Isolation of entry and storage zones.
- (d) Building hardening.
- (e) Standoff distances (see tables listed in chapter 2, DOD Antiterrorism Construction Standards).
- (f) Effective building layout (coordinate with MTF space utilization committee).
- (g) Equipment enclosures.
- (h) Overhead mounted architectural features.
- (i) Redundant utilities.
- (j) Equipment bracing.
- (k) Facility and equipment decontamination (see Acquisition Process Improvement Campaign (APIC) Guideline for Selection and Use of Disinfectants for additional guidance).
- (l) HAZMAT pumping and draining systems.
- (m) Incorporation into the Facilities Emergency Management Plan (EMP) immediate action plans for facility infrastructure systems. These immediate action plans will address the prevention and mitigation of NBC contamination.
- (n) Contingency operations.
- (o) Emergency notification procedures.
- (p) Damage assessment procedures.
- (q) Reporting procedures.

EMERGENCY MANAGEMENT PLAN TEMPLATE

(4) Trains Facility Management Division personnel on contingency operations and Immediate Action Plans.

4. PROCEDURES.

a. MEDCEN/MEDDAC NBC Section.

(1) Assesses the initial contamination and provides recommendations on NBC hazards.

(2) Provides assessment and determines the amount of contamination.

(3) Decontaminates uninjured personnel.

(4) Assists medical personnel decontaminate and monitor injured personnel.

(5) Monitors hospital contaminated areas, and recommends protective measures.

(6) Ensures limited patient decontamination just outside the Emergency Department for those patients that bypass the Installation Support Team decontamination site.

b. Ambulance service personnel and augmenting emergency medical personnel, if required.

(1) Provide on-site emergency medical treatment and evacuation of casualties at the hotline of an NBC accident or incident.

(2) Ambulance service and augmentation personnel will not provide technical assistance on radiation or chemical hazards.

c. See Appendix 1 to this Annex for procedures on treating contaminated patients.

Appendixes

- 1- Handling Contaminated Patients Plan
- 2- Biological Event Protocol (Noncontagious)
- 3- Biological Event Protocol (Contagious)
- 4- Chemical, Radiological, or HAZMAT Event Protocol
- 5- CB Threat Characteristics Table

Appendix 1, Handling Contaminated Patients Plan, to Annex M, Nuclear, Biological, and Chemical (NBC) Operations Plan

1. PURPOSE. To outline procedures for receiving patients contaminated by NBC agents.

2. CONCEPT.

a. The actions taken will depend on the situation and the number of casualties. This plan is a guide for initial preparation.

b. The hospital could receive contaminated patients from accidents or incidents that involve NBC agents. The casualties may be military or civilian, and may require decontamination. In addition, self-presenting patients may arrive with other family members or pets. These additional individuals may require decontamination. If there is known NBC contamination, patients will be decontaminated prior to transportation in emergency evacuation vehicles.

c. The NBC Operations Team surveys, decontaminates, and advises medical personnel on treatment of casualties.

d. Notification and staff response is the same as Annex A and B when this plan is used with the MASCAL plan.

e. This plan is a stand-alone plan when the situation is not a MASCAL situation.

f. Patient Evacuation/CBRNE/NBC.

(1) Only clean, decontaminated patients will be evacuated. PAD Office will, thru TRANSCOM Regulating and Command and Control Evacuation System (TRACES), coordinate patient evacuation requirements for military personnel. Medical regulating shall be under the control of the Global Patient Movement Requirements Center (GPMRC) located at Scott Air Base, Illinois. Nonmilitary patients shall be evacuated under the direction of the Regional Health Administrator, PHS.

(2) Local medical evacuation (MEDEVAC) Assts, Medical Company (AA) should be used when possible to transport patients to local hospitals in area.

(3) Attempt to Decon medical documents (i.e., medical records) that become decontaminated, although highly unfeasible, if possible, re-transcribe vital medical information on separate document.

(4) PAD office will use current systems for all administrative procedures, to include Uniform Business Office, patient accountability, MASCAL readiness, and absent sick tracking for Health Service Region, while ensuring available back up plans exist to use manual procedures if there is a systems failure.

(5) Collect/Report Hospital Bed Availability Data; be prepared to submit contingency bed reporting capabilities. Hospitals must make judgments

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about staffed and equipped bed capacity that is available as a "Minimum" and additional beds that could be made available as a "Maximum." Also, bed capacity can be affected by staff known to have Armed Forces Reserve or National Guard commitments that could impact staffing of available beds, particularly during NDMS activation for a military contingency. FCCs should continually review changes in participating hospital infrastructures that could affect the number or type of beds available. Hospital bed reporting is generally updated on a quarterly basis.

(6) MTFs will report special interest patients to HQ MEDCOM IAW MEDCOM Reg 40-7.

(7) Of special interest are civilian burn patients generated from a CBRNE event, if necessary, coordinate eligibility under Secretary of Army Designees program.

3. RESPONSIBILITIES.

a. Chief, PTMS.

(1) Establishes and operates the EOC when directed by the Commander, DCCS, DCA, DCN, or senior AMEDD officer, and updates the Commander and staff on the situation.

(2) Ensures the IOC is aware of the accident/incident.

(3) Ensures the Installation Provost Marshal is aware of the accident/incident. Requests assistance on traffic control at the patient decontamination survey and decontamination areas.

(4) Ensures the Installation HAZMAT is aware of the accident/incident.

b. The MEDCEN/MEDDAC NBC Officer.

(1) Notifies the NBC Section to assemble at the designated area.

(2) Recommends minimum levels of protection for emergency medical personnel, based on initial information provided from the scene of the accident/incident.

(3) Remains in communication with the accident/incident site for additional information about contaminants.

(4) Reports status of NBC operations to the EOC/Commander.

c. Chief, Preventive Medicine Services.

(1) Recommends levels of control to ensure compliance with disease prevention and control protocols and initiates epidemiological studies as appropriate.

(2) Conducts a health hazard and risk assessment and prepares risk communication guidelines to ensure compliance with occupational health and radiological safety protocols.

(3) Initiates medical surveillance of CBRNE, HAZMAT and/or TICs and TIMs, and prepares appropriate recommendations to the MTF commander.

(4) Provides preventive medicine toxicology services and preventive medicine laboratory services as appropriate.

d. Chief, Facility Management Division.

(1) Coordinates with NBC Officer and programs for decontamination facilities if required.

(2) Coordinates with Installation HAZMAT organizations.

(3) Implements appropriate elements of the Facilities EMP.

4. PROCEDURES. The NBC Section takes the following actions.

a. Assembles, acquires the necessary equipment and supplies, and establishes the patient contamination survey and decontamination stations at the Emergency Services entrance.

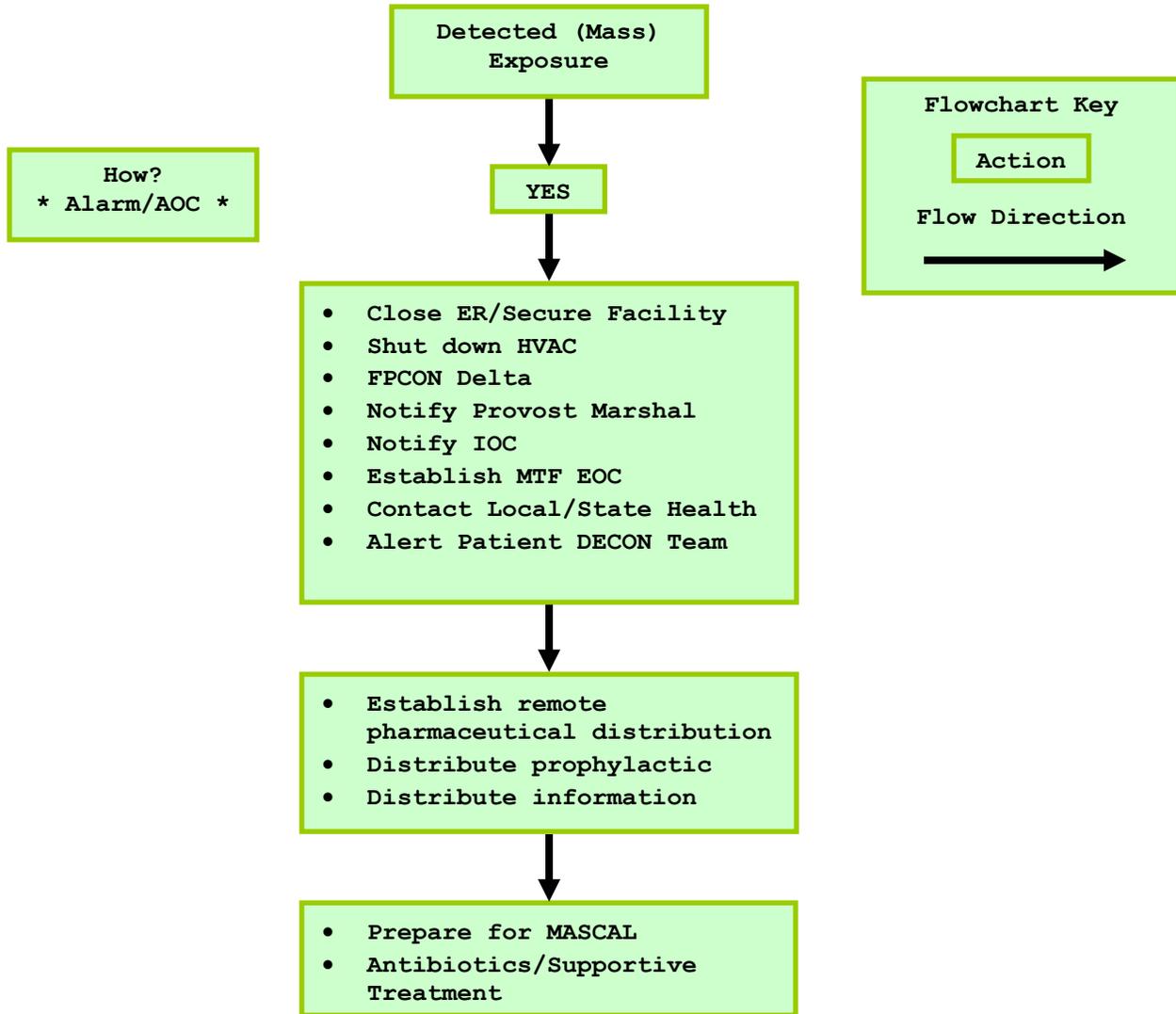
b. Issues dosimeters or other appropriate detection device to the appropriate medical staff if radioactive contamination is expected.

c. Begins continuous monitoring of the hospital area, if necessary.

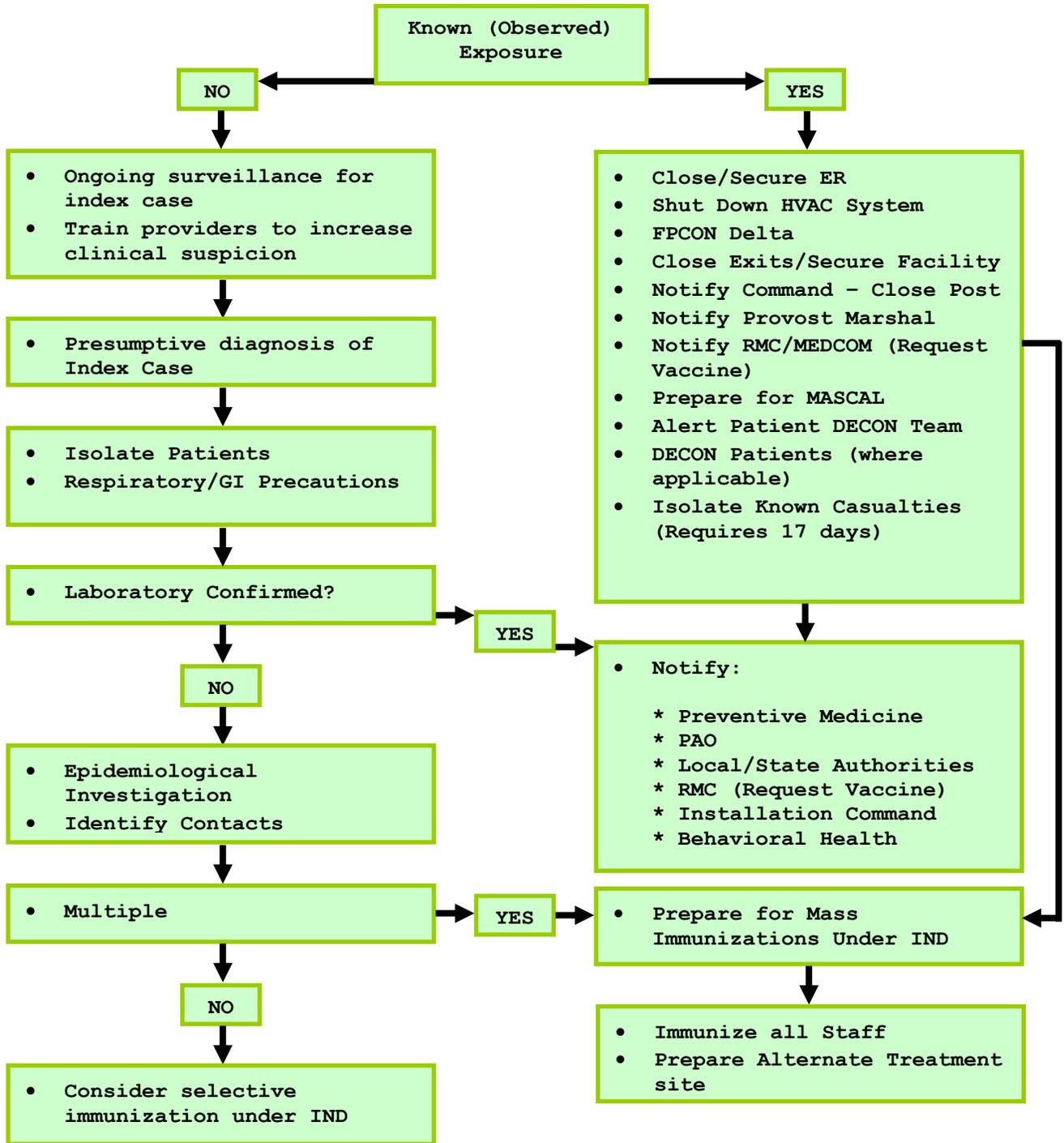
d. Surveys all casualties for contamination. Clean casualties are directed to triage, and contaminated casualties are directed to the decontamination station before triage.

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Appendix 2, Biological Event Protocol Noncontagious Agent (Anthrax), to Annex M, Chemical, Biological, Radiological, Nuclear and High Explosive (CBRNE) Operations Plan

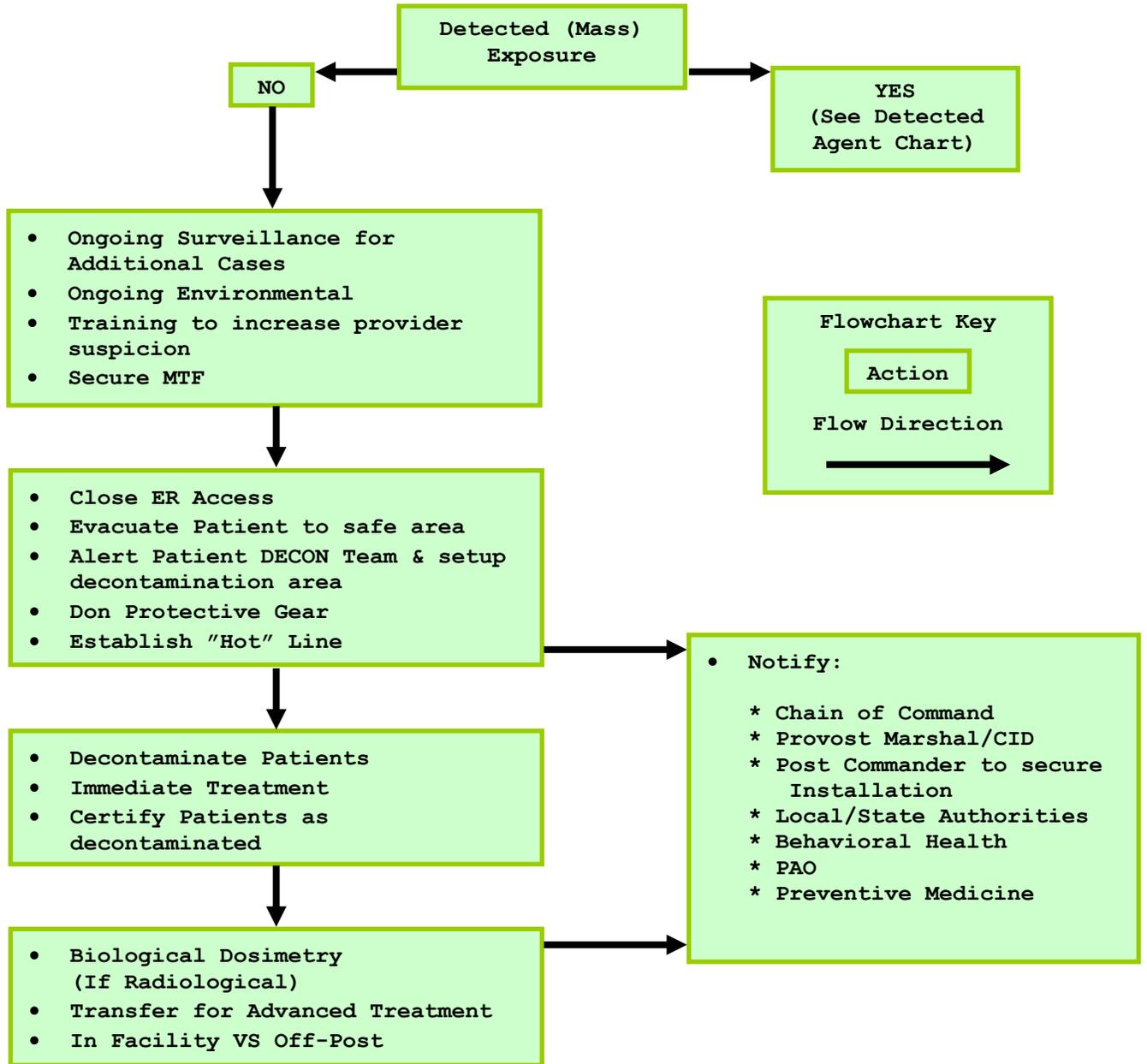


Appendix 3, Biological Event Protocol Contagious Agent (Smallpox), to Annex M, Chemical, Biological, Radiological, Nuclear and High Explosive (CBRNE) Operations Plan



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Appendix 4, Chemical, Radiological or Toxic Industrial Chemical Event Protocol, to Annex M, Chemical, Biological, Radiological, Nuclear and High Explosive (CBRNE) Operations Plan



Appendix 5, Chemical Biological Threat Characteristics Table, to Annex M, Chemical, Biological, Radiological, Nuclear and High Explosive (CBRNE) Operations Plan

CHEMICAL BIOLOGICAL WARFARE AGENTS CHARACTERISTICS			
Types	Agents*	Untreated Effect	Potential for Epidemic Spread
Bacteria	Anthrax	Lethal	Negligible
	Tularemia	Incapacitant-lethal	Negligible
	Plague	Lethal	High
	Cholera	Incapacitant-lethal	High
	Glanders	Lethal	Negligible
	Clostridium Perfringens	Incapacitant	Negligible
	Brucellosis	Incapacitant	Negligible
	Shigellosis	Incapacitant	Possible
	Q Fever	Incapacitant	Possible
Toxins	Botulinum Toxin	Lethal	None
	Ricin toxin	Lethal	None
	Staphylococcal Enterotoxins	Incapacitant	None
	Mycotoxins	Incapacitant-lethal	None
	Marine Neurotoxins	Incapacitant-lethal	None
	Aflatoxin	Incapacitant-lethal	None
	Bioregulatory Peptides	Incapacitant-lethal	None
Viruses	Venezuelan Equine Encephalitis	Lethal	Possible
	Smallpox	Lethal	Very High
	Marburg/Ebola	Lethal	Possible
*In many cases the more commonly known disease is listed rather than actual causative agent			

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COMMON CHEMICAL WARFARE AGENTS		
Types	Agents	Effects
Blister	Mustard Nitrogen Mustard Lewisite	Causes large skin blisters; respiratory; long-term debilitating injuries, including blindness
Choking	Phosgene	Death from lack of oxygen
Blood	Hydrogen Cyanide Cyanogen Chloride	Interferes with body oxygen supply, causing death
Nerve	Tabun Sarin Soman Cyclosarin VX Fourth generation	Loss of muscular control, respiratory failure, and death
Other	TFNM* BZ*	Penetrates air filters; incapacitation
* Trifluoronitrosomethane ** 3-Quinuclidinyl Benzilate		

Annex N, Chemical, Biological, Radiological, Nuclear, and High Explosive (CBRNE) Incident Response Plan for Weapons of Mass Destruction (WMD)

1. REFERENCES. See Annex Y.

2. SITUATION. Basic plan.

3. MISSION. Provide a medical response in support of an installation response to a CBRNE, HAZMAT, or TICs/TIMs accident. Medical support, emergency medical treatment and evacuation of casualties will be accomplished IAW the Force Protection (FP) Installation Planning Template. The MTF PTMS should refer to the installation CBRNE Appendix published by the Joint Chiefs of Staff (JCS), J-34 Plans and Policy, for implementation at all DOD installations for a CBRNE, HAZMAT, or TICs/TIMs accident.

4. EXECUTION.

a. Concept of Operations.

(1) In the event of a CBRNE, HAZMAT, or TICs/TIMs accident at an installation, the supporting MTF Commander will provide medical assistance within its capabilities, IAW the provisions of the FP Installation CBRNE, HAZMAT, or TICs/TIMs Appendix and appendixes to this Annex.

(2) The SMART-NBC and SMART-SM (local RMC assets) and Weapons of Mass Destruction-Civil Support (WMDCS) (National Guard/State controlled) teams are available from RMC and FEMA regional assets within 12 hours.

(3) For incidents involving radiation hazards, the Walter Reed Army Medical Center (WRAMC) is tasked to deploy a Radiological Advisory Medical Team (RAMT) within 8 hours.

(4) The SMART-PM is available from the USACHPPM within 12 hours.

(5) Upon arrival of assistance teams the MTF Commander will furnish additional medical personnel and resources as required (within its capability) and in coordination with the On-Site Incident Commander.

b. Tasks.

(1) Chief, PTMS Division (or the equivalent) will:

(a) Notify the Chief, Department of Emergency Medicine, and the Radiation Protection Officer of the situation.

(b) Provide a coordination link between the IOC, Fire Department's HAZMAT team or the incident commander and the MTF for determining medical support requirements.

(c) On order from the MTF Commander initiate action to obtain medical assistance from the RMC for the regional SMART-NBC, (and other SMART specialties as required) or the WMDCS team provided by the National Guard.

(2) Chief, Department of Emergency Medicine will:

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(a) Prepare to receive and decontaminate casualties before reaching the entrance to the emergency room (ER) within capabilities.

(b) Respond to the emergency site hot line, treat, and evacuate decontaminated casualties.

(3) Chief, Preventive Medicine will:

(a) Provide technical advice and guidance to the Chief, Department of Emergency Medicine on CBRNE occupational and environmental health issues.

(b) Provide personnel and equipment to Chief, Department of Emergency Medicine to assist in the monitoring and control of CBRNE contaminants and provide assistance to the deployed external specialty teams.

(4) Chief, Facility Management Division will:

(a) Implement appropriate elements of the Facilities EMP.

(b) In the event of an attack that results in facility damage, the Facility Manager (FM) will assess extent of damage and determine if the facility is structurally sound. If the nature of the damage is outside the realm of the FM's expertise the FM will contact the ACS, Industrial Engineering and Facilities Management (IE&FM) and arrange for assistance from subject matter experts.

(c) Coordinate with MTF and external NBC, HAZMAT and DPW organizations.

(d) Initiate reporting procedures.

(e) Program repair projects.

(5) Chief, Behavioral Health will:

(a) Provide technical advice and guidance to Chief, Dept of Emergency Medicine on disaster mental health interventions and control support to staff, patients, and other affected populations.

(b) Provide personnel to assist in differential diagnosis and management of patients and offer affected persons guidance.

5. SERVICE SUPPORT. See Base Plan.

6. COMMAND AND SIGNAL.

a. Command. Normally, an incident commander will be designated to control the accident/incident site. Medical personnel assigned to or assisting the Emergency Medical Team will come under the operational control of the incident commander.

b. Signal. See Base Plan.

Appendix 1, Handling of Contaminated Patients, to Annex N, Chemical, Biological, Radiological, Nuclear, and High Explosive (CBRNE) Incident Response Plan for Weapons of Mass Destruction (WMD)

1. REFERENCES. See Annex Y.

2. SITUATION. A significant amount of hazardous material is stored in and/or transported through the MTF's MEDCOM Reg 40-21/AR 5-9 areas. Because of these factors, and the possibility of a CBRNE event the potential exists for receipt of contaminated patients at the MTF.

3. MISSION. Provide a capability to receive, decontaminate, and treat chemical, biological, or radiological contaminated patients to prevent and control the spread of contamination within the MTF.

4. EXECUTION.

a. Concept of Operations.

(1) The handling of contaminated patients will not fundamentally change the techniques of patient care, except that procedures will be instituted to restrict the spread of contamination.

(2) Only clean, decontaminated patients will be evacuated. PAD Office will, thru TRACES², coordinate patient evacuation requirements for military personnel. Medical regulating shall be under the control of the Global Patient Movement Requirements Center (GPMRC) located at Scott Air Base, Illinois. Nonmilitary patients shall be evacuated under the direction of the Regional Health Administrator, PHS.

(3) Local MEDEVAC Assts, Medical Company Air Ambulance (AA) should be used when possible to transport patients to local hospitals in area.

(4) Attempts to decontaminate medical documents (i.e., medical records) that become contaminated, contact local Installation Chemical Office or Office of Preventive Medicine for recommendations on corrective procedures.

(5) PAD office will use current systems for all administrative procedures, to include Uniform Business Office, patient accountability, MASCAL readiness, and absent sick tracking for Health Service Region, while ensuring available back up plans exist to use manual procedures if there is a systems failure.

(6) Collect/Report Hospital Bed Availability Data, be prepared to submit contingency bed reporting capabilities. Hospitals must make judgments about staffed and equipped bed capacity that is available as a "Minimum" and additional beds that could be made available as a "Maximum." Also, bed capacity can be affected by staff known to have Armed Forces Reserve or National Guard commitments that could impact staffing of available beds, particularly during NDMS activation for a military contingency. FCCs should continually review changes in participating hospital infrastructures that could affect the number or type of beds available. Hospital bed reporting is generally updated on a quarterly basis.

EMERGENCY MANAGEMENT PLAN TEMPLATE

(7) MTFs will report special interest patients to HQ MEDCOM IAW MEDCOM Reg 40-7.

(8) Of special interest are civilian burn patients generated from a CBRNE event, if necessary, coordinate eligibility under Secretary of Army Designees program.

(9) Procedures outlined in Tabs A, B, and C will be put in effect as appropriate.

(10) If possible, contaminated patients will be thoroughly decontaminated at the site of the incident or outside the hospital facility by the Installation Fire Department/HAZMAT team. A decontamination facility needs to be located en route to the Emergency Room where any additional decontamination can be performed before being admitted to the hospital. There is a strong probability that a number of victims will self refer to the MTF and decontamination will need to be initiated prior to admission to the ER.

(a) All outer clothing and shoes will be carefully removed and placed in a tagged plastic bag for later disposal.

(b) Valuables will be put in a separate tagged plastic bag and held in a specifically designated place for monitoring and decontamination. Valuables will not be disposed of as contaminated waste without the individual's written permission.

(c) If needed for diagnostic evaluation, urine, feces, vomitus and blood will be collected, labeled with patient identification, time of collection, and type of suspected contamination. These specimens will be refrigerated and held for appropriate analysis and/or proper disposal as the situation warrants. Tabs A, B, and C of this Appendix provide further specific guidance.

(11) When a contaminated patient is admitted to the MTF prior to complete decontamination, his records will be clearly marked with code words as follows, to indicate type of contamination:

Radiation = RADCON, Chemical = CHEMCON, Biological = BIOCON

Once decontamination has been completed and verified, the code word will be lined out and the code word "CLEAR" entered on the medical record with the date and initials of the person verifying that decontamination is complete.

(12) Patients who have not been thoroughly decontaminated prior to admission will be admitted to designated rooms and kept in semi-isolation.

(13) Decontamination and treatment of contaminated patients will be conducted IAW the procedures outlined in Tabs A, B, or C as appropriate.

(14) Consideration should be given to the behavioral health needs of contaminated, infected, injured, or traumatized patients. Support and early intervention including Psychological First Aid, provided by trained disaster mental health personnel, should be readily available where needed inside MTF,

EMERGENCY MANAGEMENT PLAN TEMPLATE

on the installation and in the adjacent civilian community. Significant numbers of concerned individuals not necessarily contaminated, infected, or injured can be expected to converge on MTF's. A carefully planned system for support to these individuals as well as provision of accurate information will be critically important.

b. Tasks.

(1) The Chief, Preventive Medicine in coordination with the Radiological Protection Officer has the overall responsibility to provide guidance and direction to staff physicians concerning diagnosis and treatment of radiation contaminated patients. He will provide personnel and equipment to assist the Radiation Protection Officer (RPO) in containing the spread of radioactive contamination.

(2) The RPO, in a radioactive contamination situation, will:

(a) Establish monitoring sites at the entrance to the Emergency Room.

(b) Direct and/or conduct decontamination of the patient at the earliest possible time consistent with the medical needs of the patient.

(c) Record a detailed history of the incident if possible.

(3) The Chief, PTMS Division, will, in the event of a major situation, coordinate with the installation for additional decontamination support from the installation Fire Department as required.

(4) The Chief, Department of Emergency Medicine will:

(a) Provide emergency life-saving procedures, participate in the conduct of decontamination, and consult with appropriate clinical staff members on the handling of contaminated patients.

(b) Organize a treatment team in the ER to handle contaminated patients. Members of the team will wear appropriate protective clothing and equipment, based upon the recommendation of the RPO or other expert staff member.

(c) Assist the RPO in preparing the Decontamination Site and ER to receive contaminated patients IAW Tabs A, B, or C as appropriate.

(5) The Chief, Behavioral Health will provide technical advice on disaster mental health and stress control, and other personnel as needed.

(6) Chief, Facility Management Division will:

(a) Implement appropriate elements of the Facilities EMP.

(b) Coordinate with MTF and external NBC, HAZMAT and DPW organizations.

(c) If required, initiate facility decontamination procedures.

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(d) IF the MTF itself is in danger of becoming contaminated, the FM will initiate immediate actions to limit and mitigate contaminate dispersal within the MTF.

1 If the contaminate is outside the building FM personnel will immediately shut off the air handling system.

2 If the contamination is inside the building the FM will immediately place the air handling system on full (or 100%) outside air.

c. Coordinating Instructions.

(1) Admission of contaminated patients will be coordinated between the DCCS, DCN, and other appropriate department chiefs.

(2) The EOC will be opened to coordinate for outside assistance/support as required.

(3) Provision of dental treatment for contaminated patients will be coordinated between the DENTAC commander, the DCCS, and other appropriate medical department chiefs.

(4) Provision of veterinary services for contaminated military or civilian animals will be coordinated between the local Commander or Chief of Veterinary Services, the DCCS, and other appropriate medical department chiefs.

5. SERVICE SUPPORT. See Base Plan.

6. COMMAND AND SIGNAL. See Base Plan.

Tab A - Radiation Casualties

Tab B - Chemical Casualties

Tab C - Biological Casualties

Tab A, Radiation Casualties, to Appendix 1, Handling of Contaminated Patients, to Annex N, Chemical, Biological, Radiological, Nuclear, and High Explosive (CBRNE) Incident Response Plan for Weapons of Mass Destruction (WMD)

1. REFERENCES. See Annex Y.

2. SITUATION. Significant amounts of hazardous radioactive materials are transported daily throughout and around the MTF. The potential exists for radioactively contaminated patients to be evacuated for emergency treatment to the MTF. Additionally, potential enemies of the United States possess the capability to initiate nuclear warfare; thereby creating contaminated patients in the process.

3. PURPOSE. Prescribe procedures regarding the receipt and handling of patients contaminated with radioactive material in order to provide all necessary emergency medical care to such patients with the least radiation exposure to attending emergency room personnel.

4. DEFINITIONS. Casualties from a radiological incident are categorized as:

a. Wounded, but not exposed to ionizing radiation or radioactive material. The patient has sustained simple mechanical trauma in an environment that uses radiation or radioactive material but no patient radiation exposure occurred during the course of the accident. No radiation hazard is present to emergency room medical personnel.

b. Irradiated either localized or whole-body from an external radiation source with or without accompanying trauma. Such patients are analogous to cancer radiation therapy patients and present no radiation hazard to emergency room personnel.

c. Internally contaminated patients with or without accompanying trauma. Such patients present a minimal radiation hazard to emergency room personnel and are analogous to chemically poisoned patients. Excreta are usually collected for later laboratory analysis, but no further precautions are required.

d. Externally contaminated patients with or without accompanying trauma involving radioactive material embedded in tissue/wounds or present on the intact skin or clothing. Such patients are analogous to vermin-infested patients, and substantial radioactive contamination control precautions must be employed. As much as 70-90 per cent of the gross external radioactive contamination can be removed by removing the patient's clothing prior to entry into the emergency room treatment area.

5. RESPONSIBILITIES.

a. The Chief, Department of Emergency Medicine will ensure that appropriate medical care is rendered to any radiation casualties transported to the MTF ER and in consultation with the RPO, will designate rooms for radiation casualty triage, decontamination, and treatment.

EMERGENCY MANAGEMENT PLAN TEMPLATE

b. The Chief, Nuclear Medicine Clinic in coordination with the Chief Preventive Medicine will provide professional consultation to the Chief, Department of Emergency Medicine in the treatment of radiation casualties. The Chief, Nuclear Medicine Clinic will augment, upon request, the Radiation Protection staff with Nuclear Medicine personnel to assist in radioactive contamination control efforts.

c. The Radiation Protection Officer will supervise contamination control and radiation monitoring efforts and provide Health Physics consultation to the Chief, Department of Emergency Medicine.

d. The Chief, Radiation Therapy Clinic will provide professional consultation/dose calculation support regarding radiation effects to the Chief, department of Emergency Medicine.

e. The Chief, Behavioral Health will provide technical advice on disaster mental health and stress control, and other personnel as needed.

f. DENTAC Commander will ensure:

(1) Appropriate facility and personnel security measures for dental clinics and administrative locations.

(2) Procedures to verify that patients/staff who enter dental clinics are not contaminated.

(3) Coordination for patient transportation from decontamination check points to dental clinics.

6. PROCEDURES.

a. Notification. The Department of Emergency Medicine will ensure notification of the MTF Commander of impending receipt of radiation casualties via established notification procedures. Additionally, the RPO, PAD, and the PAO will be notified. After-hour notifications will be through the AOD.

b. Preparation. Prompt treatment of the acute trauma associated with life-threatening injuries has the highest priority over any other type of medical care or radioactive contamination control.

(1) Only in the case of patients externally contaminated with radioactive material must substantial contamination control efforts be implemented. In light of the resource intensive nature of contamination control, every effort will be made to ascertain the category of casualty (paragraph 4 above) about to be received at the emergency room.

(2) Upon notification of an accident with radiological involvement the Chief, Department of Emergency Medicine or designated representative will decide which radiological contamination control procedures to implement and whether to implement the Department of Emergency Medicine recall list. Consideration will include type of accident, condition, and number of contaminated and uncontaminated casualties. Personnel responding to the

accident site will be asked to ascertain the type of isotope involved and obtain a sample if possible.

7. EXECUTION.

a. External Contamination.

(1) Receiving Area.

(a) Clear the receiving area of unnecessary personnel and equipment and cover it and the route to the decontamination suite with sheets or paper taped to the ground.

(b) Place in the receiving area, at least one large trash can lined with as many red, disposable plastic liners as there are casualties and ambulance drivers/attendants.

(2) Decontamination Suite/Treatment Areas.

(a) Prepare the decontamination suite and the treatment areas by covering patient tables with multiple layers of hospital sheets. The floor will be covered with plastic, paper, or sheets secured with tape, and all nonessential equipment will be removed or covered with plastic or sheets.

(b) Strips of tape will be placed on the floors so as to delineate the contaminated side from the uncontaminated side.

(c) All light switches, door and cabinet handles will be covered with tape.

(d) Several large containers with red plastic liners will be placed in the area to receive discarded contaminated items such as clothing and used medical supplies.

(e) The RPO will test radiation monitoring instrumentation and cover it with plastic to prevent its contamination. Background readings of the area will be taken and recorded, and film badges will be issued to appropriate personnel.

(3) All Emergency Medical Technician (EMT) attendants, drivers, treatment and decontamination team members, and other persons responding will don protective clothing, including two pairs of surgical gloves, and film badges prior to response.

b. Administration.

(1) The Chief, PAD will assign one person, or more if necessary to provide administrative support during the initial triage operation. Using paper forms or automation if available, this person will record each patient's name, social security number (SSN), injury description, triage category, and other available identifying personal information. They will assign each patient an ID or admissions number to be used when tagging contaminated articles and samples/specimens.

EMERGENCY MANAGEMENT PLAN TEMPLATE

(2) As patients, drivers and attendants are monitored, any contaminated clothing/valuables for each individual will be placed within one bag and tagged/labeled with the persons ID number for further monitoring or later decontamination.

c. Medical Response.

(1) The EMT personnel will perform normal trauma procedures and duties. A patient evacuation tag will be completed with as much information as is available and placed around the patient's neck or ankle.

(2) Emergency Physician is in charge of patient medical needs and will direct decontamination procedures.

(3) The Emergency Nurse will designate persons to remain outside the contamination zone to obtain supplies for the decontamination and treatment personnel. At least 50 sets of disposable surgical gloves are brought to the decontamination suite. The nurse will medically assist as needed and make nursing personnel assignments to include persons collecting specimens of saliva, nasal, and urine samples, and swabs of contaminated areas.

(4) If staffing permits, a person will be designated to assist the RPO by recording contamination readings.

(5) The RPO will monitor all patients, decontamination team and other involved persons during treatment and care of the patient. A record of all data will be made and radio-assays conducted as soon as possible. The RPO will designate a person to monitor all personnel, samples, and equipment leaving the area and to ensure that they are properly decontaminated or labeled.

d. Casualty Treatment.

(1) A covered patient table or gurney will be taken to the ambulance to receive the contaminated patient.

(2) A preliminary examination by the Emergency Physician and the RPO will be conducted while still near the ambulance to determine the airway, breathing, and cardiovascular status of the patient and the extent of injuries and contamination.

(3) Emergency treatment takes precedence over possible radiation hazard. Immediate threats to life must be addressed first.

(a) Critical and noncritical contaminated patient, will be removed from the ambulance and placed on the prepared patient table; clothing will be removed and placed in a red bag. The patient will be covered and taken to the decontamination suite.

(b) Take Swab samples of ear canals, nails, and mouth/nose before washing or showering of the patient.

EMERGENCY MANAGEMENT PLAN TEMPLATE

(c) Diagnostic test specimens will be taken and held in the decontamination suite until cleared by the RPO. Patient excreta will also be screened and, if contaminated, disposed of as directed by the RPO.

(d) The RPO monitors entire patient, including back and records on an anatomic chart the areas and amounts of contamination.

(e) The RPO will take swab samples of all contaminated areas, label and store for later analysis.

(4) Ambulance attendants and driver will remain with the vehicle until they and the ambulance have been monitored for contamination. If not contaminated, they will be returned to duty, and if contaminated, the RPO will give instructions for decontamination.

e. Decontamination/Treatment.

(1) Open wounds receive first attention. They will be washed with normal saline for 3 minutes and monitored for radioactivity. The wash will be repeated until monitored radiation level approaches background values or a steady state is reached. Persistent contamination will be gently scrubbed with surgical soap/cleansing solution and resurveyed. Repeat as needed and cover after decontaminated to prevent recontamination.

(2) Eyes will be rinsed with a stream of water in nose-to-temple direction, away from medial canthus. Monitor and repeat as needed.

(3) Ears will be swabbed then rinsed gently with small amounts of water and suctioned frequently. Monitor and repeat as needed.

(4) Nose and mouth will be rinsed with small amounts of water and suctioned frequently. If possible, turn patient's head to the side or down and urge them to avoid swallowing.

(5) If contaminant is known or suspected to have been ingested, insert nasogastric tube into stomach, suction and monitor contents. Note: If gastric contents indicate radioactivity, lavage stomach with small amounts of normal saline until washings are clear of contamination. Then begin chelation procedure.

(6) Intact skin should be gently scrubbed with a soft brush, soap, and tepid water without irritating or reddening. Monitor and repeat as necessary. Note: Ambulatory patients may be showered, if runoff can be contained for proper disposal. Monitor and repeat as necessary. If contamination persists, use Clorox, full strength, for small areas diluted for large areas and around the face or wounds.

(7) Hair should be washed with mild shampoo for 3 minutes and rinsed. Monitor and repeat as necessary, but if contamination persists, clip off hair; do not shave.

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f. Patient Exit.

(1) The patient will be dried, and the RPO will survey the entire body for radioactivity.

(2) When RPO is satisfied with decontamination, a clean floor covering will be laid to the clean, uncontaminated area. Attendants from outside the contaminated area will bring in an appropriate conveyance, and staying on the clean covering will transfer the patient and remove them for further treatment. The RPO will monitor the wheels of the conveyance and feet of the attendants at the edge of the contamination zone (clean line).

g. Decontamination Team Exit.

(1) Red bag lined containers; marked "Contaminated Clothing" will be placed at the clean line where team members will remove their protective clothing.

(2) Team members will stand at the clean line and remove their protective clothing, starting with the outer pair of surgical gloves, followed by apron, and tape around cuffs and sleeves. Outer clothing will then be removed and turned inside out without shaking.

(3) After having been resurveyed for contamination and cleared by the RPO, the surgical mask and inner surgical gloves will be removed and placed in red bag container. The team member may then step across the line.

Tab B, Chemical Casualties, to Appendix 1, Handling of Contaminated Patients, to Annex N, Chemical, Biological, Radiological, Nuclear, and High Explosive (CBRNE) Incident Response Plan for Weapons of Mass Destruction (WMD)

1. REFERENCES. See Annex Y.

2. SITUATION. Significant amounts of hazardous materials may be stored in and/or transported through the MEDCOM Reg 40-21/AR 5-9 areas. The potential for accidents may result in the evacuation of contaminated patients for emergency treatment to the MTF. Additionally, potential enemies of the United States possess the capability to initiate a CBRNE attack, thereby creating a requirement to evacuate contaminated patients to the MTF.

3. PURPOSE. Prescribe procedures regarding the receipt and handling of patients contaminated with chemical material in order to provide all necessary emergency medical care to such patients with the least exposure to attending emergency room personnel.

4. DEFINITIONS.

a. A chemically injured patient is such by virtue of inhalation, ingestion, or physical contact with solid, liquid, or gaseous chemicals that cause clinically manifest illness.

b. A chemically contaminated patient is one whose skin or clothing has been contaminated. This chemical contamination may be injurious to the patient as well as to attending medical personnel.

5. RESPONSIBILITIES.

a. The Chief, Department of Emergency Medicine will ensure that appropriate medical care is rendered to any chemically injured or chemically contaminated patient received at the ER.

b. The Chief, Preventive Medicine Service will provide professional consultation through a chemically trained physician and industrial hygienists regarding the medical management of chemically contaminated patients and the identification, hazards, control, and clean up of the hazardous chemicals involved.

c. The Director, Respiratory Care will provide closed system respirators to Department of Emergency Medicine personnel upon request by that department.

d. The Chief, Behavioral Health will provide technical advice on disaster mental health and stress control, and other personnel as needed.

e. The DENTAC Commander will ensure:

(1) Appropriate facility and personnel security measures for dental clinics and administrative locations.

(2) Procedures to verify that patients/staff who enter dental clinics are not contaminated.

EMERGENCY MANAGEMENT PLAN TEMPLATE

(3) Patient transportation from decontamination check points to dental clinics.

f. The Chief, Veterinary Services will:

(1) Provide technical guidance and information to local commanders regarding the storage, protection, decontamination, and use of subsistence affected by CBRNE incidents.

(2) Provide veterinary medical care to military, other government, and privately owned animals presented following a CBRNE incident. This includes guidance and support to decontamination of animals if necessary. In addition, Veterinary preventive medicine support will be provided to detect, prevent, and/or control the spread of animal diseases transmissible to human. Finally, provide support to civil authorities in surveillance and control of foreign animal disease outbreaks if required.

6. PROCEDURES.

a. The handling of chemically contaminated patients will not fundamentally change the techniques of patient care except that procedures will be instituted to restrict the spread of chemical contamination. Protective measures similar to those described in Annex I, Appendix 1, Tab A, for radiation contamination will be utilized.

b. Tasks.

(1) Prehospital Management - Radio Orders. Radio instructions to paramedical personnel treating a patient with hazardous chemical exposure should include:

(a) A reminder to use proper chemical protective gear and self-contained breathing apparatus (SCBA).

(b) Decontamination and removal of the patient's clothing should be accomplished at the scene by the local civilian Fire Department or on post by the installation Fire Department HAZMAT team whenever possible.

(c) Transport by BLS ambulance, if possible, to avoid contamination of Advanced Life Support (ALS) ambulances.

(2) Emergency Department Management. If sufficient chemical decontamination is not accomplished at the scene, it must be accomplished in the Decontamination Suite, before the patient enters the ER. Personnel must wear adequate chemical protective gear when attending such patients. Such protective gear could consist of additional layers of surgical scrubs with sleeves rolled down, surgical gloves, and appropriate respirators.

(a) Clothing removal and copious water irrigation of skin/hair areas should be accomplished in most cases. Wash water should be collected by having it fall on to absorbent materials such as a blanket or suitable absorbers which will be placed in plastic bags, sealed, and tagged as chemically contaminated (CHEMCON).

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(b) If the identity of the chemical contaminant is unknown, a portion of the contaminated skin area should be rinsed with water. If no adverse skin reaction occurs, then proceed as in paragraph (2) (a) above. The water used in skin decontamination should not be "ice" cold, but rather should be room temperature. If available, a 0.5% bleach solution should be used to decontaminate the skin, and a 5% bleach solution such as double-strength Clorox used to decontaminate equipment.

(c) In cases where the application of water to the contaminated areas is contraindicated, the patient should be decontaminated by gently wiping the skin with sterile towels. These used towels should be placed in plastic bags, sealed, and tagged as CHEMCON.

(d) Emergency Department equipment and gurneys should be protected from contamination by plastic covering or layered sheets/blankets.

(e) Patient valuables suspected of being chemically contaminated should be placed in plastic bags, sealed, and tagged as CHEMCON until cleared by MTF industrial hygienists.

(f) Efforts should be made to identify and separate contaminated patients from uncontaminated patients.

(g) Emergency Department nursing personnel will maintain a log of all MTF individuals who come into contact with the contaminated patient until such time as the patient has been declared "clean."

(h) After decontamination, and prior to entry into the ER, the patient should be clothed in hospital pajamas or other suitable garment as clear indication to ER personnel that the patient is "clean."

(3) After decontamination, the patient is brought to the ER for definitive resuscitation and diagnostic tests.

(4) Ambulances used to transport chemically exposed patients will be detained until cleared by Emergency Department and Preventive Medicine Service personnel.

(5) Preventive Medicine Service personnel in coordination with Emergency Department personnel will record a detailed history of the chemical accident as soon as possible.

(6) After the patient leaves the Emergency Department, the entire Emergency Department area, equipment and personnel, will be evaluated by Preventive Medicine personnel to verify no residual chemical contamination exist.

(7) In the event that chemically contaminated patients are so severely injured as to require immediate surgery prior to decontamination, the Chief, Preventive Medicine Service and Chief, Respiratory Care, in conjunction with the Chief, Emergency Medicine, will recommend appropriate protective measures for OR personnel. If necessary, baseline and follow-up studies should be drawn, i.e., Acetylcholinesterase (ALCE) Test.

EMERGENCY MANAGEMENT PLAN TEMPLATE

(a) The operating rooms (ORs) used will be limited as necessary to contain chemical contamination.

(b) OR surgery will be managed according to SOPs for handling cases contaminated with infectious hazards with the following additions/exceptions:

1 All waste material will be saved, placed in large plastic bags, sealed, and tagged as CHEMCON.

2 All effluents will be captured for proper disposal.

3 Operating room personnel will shower completely after working on chemically contaminated patients.

4 Preventive Medicine personnel will survey OR and remove and/or neutralize any residual chemical contamination.

5 One elevator will be designated for use for contaminated patients and will be neutralized by Preventive Medicine personnel.

c. Coordination.

(1) The US Army Medical Research Institute of Chemical Defense, Aberdeen Proving Ground, Maryland, should be notified at DSN 584-3393/2230 whenever a clinically significant, presumed hazardous chemical exposed patient is admitted to the ER.

(2) Local public health authorities should be notified of chemical casualties.

(3) All BLS and ALS ambulances should have current stocks of atropine, 2-PAM-Chloride and bleach decontamination solution.

(4) Stocks of MARK I and Convulsant Antidote Nerve Agent (CANA) shall be enough to issue to every member of the Installation Quick Reaction Forces (QRF) should the installation commander and MTF commander determine that the FPCON requires it.

(5) The Installation Commander should be contacted for decontamination assistance from the post Fire Department in the event of a chemical mass casualty situation.

(6) Rapid emergency chemical information can be obtained from the 1980 Department of Transportation Emergency Response Guide Book, poison index.

Tab C, Biological Casualties, to Appendix 1, Handling of Contaminated Patients, to Annex N, Chemical, Biological, Radiological, Nuclear, and High Explosive (CBRNE) Incident Response Plan for Weapons of Mass Destruction (WMD)

1. REFERENCES. See Annex Y.

2. SITUATION. Biological casualties may be generated by the use of biological agents, usually as aerosol clouds, and by inadequate hygiene and/or field sanitation. Other potential sources include poor mess operations, poor pest and rodent control, and/or the lack of adequate amounts of specific active and passive immunoprophylactic agents in the area of operations.

3. PURPOSE. Outline procedures to receive, isolate, investigate, and treat biological agent casualties.

4. RESPONSIBILITIES. The Chief, Department of Clinical Investigation; the Chief, Department of Medicine; the Chief, Department of Pathology; and the Chief, Preventive Medicine will initiate procedures to investigate and identify the biological agent involved and to determine the probable source of the agent.

5. PROCEDURES.

a. Biological casualties received at the MTF will be processed using normal admission procedures except when a mass casualty situation occurs. During a mass casualty situation, applicable annexes of this EMP apply. Persons suspected of biological agent infection will be isolated for clinical investigation and treatment.

b. If the disease is determined to be communicable, personnel listed in paragraph 4 above will establish an isolation ward in collaboration with the Chief, Department of Nursing for biological casualties.

c. Close coordination will be maintained with local health authorities, installation Command Group, RMC, and MEDCOM to ensure that all elements concerned are kept apprised of the situation. Chief, Preventive Medicine Service will recommend which higher Army elements should be notified in the event MTF receives mass biological casualties.

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Annex O, Deployment Standard Operating Procedures (SOP) for Special Medical Augmentation Response Teams (SMARTs)

1. PURPOSE. To provide guidance and standard procedure to be followed when deploying SMARTs.

2. CONCEPT.

a. This guidance applies to all officers, warrant officers, enlisted Soldiers, and Department of the Army civilians assigned to RMC/MSC SMARTs.

b. Upon receipt of a validated tasking from MEDCOM, the RMC/MSC will deploy requested SMARTs to CONUS/OCONUS areas to provide short duration, medical liaison to local, State, Federal, and Defense Agencies or Medical Teams responding to disasters, civil-military cooperative actions, humanitarian assistance, Weapons of Mass Destruction, and emergencies. Designated SMARTs within Brooke Army Medical Center (BAMC) will be capable of deploying year-round, within 12 hours, in support of legitimate emergency incidents and specifically at the request of proper civil or Federal authorities.

c. The teams are composed of military officers, warrant officers, enlisted Soldiers, and civilian employees assigned to the RMC/MSC by name. Military personnel assigned to PROFIS positions may be used if the needed specialties in a non-PROFIS status are not available. First priority for selection should be non-PROFIS personnel with a minimum of 18 months stability as a SMART member. Substitution rules are addressed in Appendix C, Tab 1 for team structure by Area of Concentration (AOC)/Military Occupational Specialty (MOS). Personnel assignments to SMARTs will be forwarded to Chief of Staff, RMC/MSC for approval. SMART members will only be assigned to one team position; members will not be double slotted as a Primary or Alternate team member.

3. RESPONSIBILITIES.

a. Commander, RMC/MSC.

(1) Overall responsibility for SMARTs.

(2) Provide supervision and oversight to organize, train, equip, deploy, employ, and redeploy SMARTs.

(3) Validate and resource special equipment requirements, periodically test and evaluate the SMARTs; develop, monitor, and report SMART readiness reporting requirements.

(4) Organize, train, and equip each of the following SMARTs with resources to accomplish their assigned mission.

(a) SMART - Trauma Critical Care (TCC).

(b) SMART - Nuclear/Biological/Chemical (NBC).

(c) SMART - Stress Management (SM).

(d) SMART - Medical Command, Control, Communications Telemedicine (MC3T).

(e) SMART - Pastoral Care (PC).

(5) On order, deploy SMARTs within 12 hours of notification. Be prepared to deploy as required in CONUS but primarily within the assigned Health Service Region (HSR). Anticipate requests to use SMART personnel and equipment sets for OCONUS missions. OCONUS mission taskings must allow for additional movement time, personnel preparation, and equipment augmentation.

(6) Command and control of SMARTs will remain with the Commander, RMC/MSC unless otherwise specified on orders.

b. Deputy Commander/Chief of Staff.

(1) Monitor status of SMARTs.

(2) Quarterly - receive briefings on status of SMARTs.

(3) Approval authority for all proposed SMART training off post.

(4) Determine dates/times and initiate "No Notice" alerts (telephonic, assembly, roll out and establishment of operations).

(5) Receive AARs from SMART Chiefs after all "No Notice" alerts and actual deployments within 15 days of completion of activity.

(6) Approval authority for additions, substitutions, or deletions of SMART members.

c. Assistant Chief of Staff, Personnel.

(1) Review SMART personnel rosters, verify deployable status of team members, and cross-reference PROFIS rosters to identify potential conflicts with PROFIS readiness requirements.

(2) Assist the Troop Command/Brigade Commander and other MTF Commanders and Troop Commanders, as needed in coordination of Soldier Readiness Processing (SRP) and other personnel matters.

(3) Notify the RMC/MSC Chief of Staff when SRP is completed. In the event that a team member is identified as not deployable, initiate the process to identify all eligible replacements. In those cases where an alternate is available the alternate will replace the primary team member and deploy. The Assistant Chief of Staff for Personnel (ACSPER) will identify a new alternate in the event that they are required.

d. Assistant Chief of Staff, Operations and Readiness.

(1) Act as agent for Commander/Deputy Commander, RMC/MSC in monitoring overall status and readiness of SMARTs.

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(2) Monitor/evaluate/assist teams in actions pertaining to training of SMARTs.

(3) Coordinate with MEDCOM OPS for alert orders, deployment dates and times, teams to deploy, and locations in case of actual deployment.

(4) Conduct "No Notice" alerts and evaluations for Commander and Deputy Commander, RMC/MSC.

e. Assistant Chief of Staff, Logistics.

(1) Monitor/evaluate/assist teams in actions pertaining to the readiness of equipment and provide technical guidance as necessary.

(2) Conduct periodic checks and inventories to ensure teams are equipped and that the equipment is properly maintained.

(3) Recommend procedures and/or policies for improving and maintaining the teams' logistics readiness posture.

f. Medical Logistics Readiness NCO.

(1) Responsible for the direct coordination, requisitioning, and receipt of Class I and Class VIII items with SMART Chiefs. Provide guidance and assistance to the Team Chiefs on logistical matters for all deployments.

(2) Ensure that Hand Receipt Holders are briefed on responsibilities of accountable nonexpendable, durable, and expendable medical supplies. Conduct joint inventory with team chief semi-annually, report shortages, and identify items that have expired.

(3) Provide the team's chief with a predeployment checklist prior to deployment to ensure SMART members are briefed on safety precautions and required deployment equipment (Appendix C, Tab 3) is accounted for and prepared properly for deployment.

g. Commander, Troop Command/Brigade.

(1) Ensure all teams remain at 100% personnel fill at all times.

(2) Provide alternate Liaison Officer (LNO) to the RMC/MSC who is familiar with operations and functions of SMARTs and who can fill in for primary LNO should he/she be gone (leave, TDY, hospitalized, deployed, etc.).

(3) Monitor and report the deployable status of SMART members and report to the ACSPER, RMC/MSC any changes, additions, or deletions of SMART members because of a change in their deployable status or availability.

(4) Maintain current DA Form 7425 on all Smart members with information that will not change completed by the team member. Update the DA form annually.

(5) Upon alert of the SMART coordinate the following:

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(a) SRP of all team members (primary and alternate and those not assigned to the RMC/MSC). Request assistance from the ACSPER as required to accomplish this requirement. Coordinate with the MTF Commander and MTF Troop Commander for SRP of SMART members assigned to other MTFs.

(b) Establish Family Assistance program for all deploying SMART members.

(c) Notify the ACSPER immediately of any changes/problems with team members that will preclude them from deployment. Upon completion of the SRP report the status to the ACSPER, RMC/MSC.

(6) Provide trained movement control officers/NCOs to prepare load plans, etc., in order for a team to deploy by air, rail, or ship.

h. Plans Officer, Troop Command/Brigade.

(1) Acts as LNO between RMC/MSC and SMART Chiefs. Provides data as required by RMC/MSC for reporting status on MRR and provides other reports as required.

(2) Requests and coordinates all proposed SMART training off post for approval through HQ's RMC/MSC.

(3) Maintains current status/list of SMART members.

(4) Maintains current status/list of SMART equipment.

(5) Informs RMC/MSC Assistant Chief of Staff, Operations of any issues, concerns, or shortages identified by SMART Chiefs.

(6) Ensures SMART AARs are completed and forwarded within established time frames.

(7) Responsible for submitting written request for approval of personnel to be added or deleted as SMART members to the Deputy Commander/Chief of Staff, RMC/MSC.

(8) Responsible for maintaining current access and alert rosters for each SMART in the RMC/MSC AOD Instruction Book and the RMC/MSC Flow Diagram. Rosters are to be reviewed on a monthly basis and changes posted NLT 3d working day of each month.

i. SMART Chiefs.

(1) Responsible for supervision and oversight to organize, train, equip, deploy, employ, and redeploy their team.

(2) Identify the documents to be maintained by the team chief on the team and its members.

(3) Maintain and ensure all team members' administrative data and training records are current, accurate, and meet all prerequisites for team's deployment. Develop Appendixes to this Annex including: Appendix 1 Team

EMERGENCY MANAGEMENT PLAN TEMPLATE

Composition, Appendix 2 Team Readiness and Deployment Checklist, Appendix 3 SMART 12-Hour Deployment Sequence, Appendix 4 Team Quarterly Team Training Report and Appendix 5 Clothing/Equipment Checklist.

(4) Ensure changes to alert and access rosters are reported immediately to the BAMC LNO.

(5) Ensure team members are trained and qualified to use the equipment they will deploy with.

(6) Ensure equipment authorized is on hand or on order and is properly serviced and maintained.

(7) Ensure all SMART equipment is stored ONLY in a designated team storage area. Team equipment will not be used or stored in any clinic area. Proper and redundant access systems to team equipment will be published and maintained by each Team Chief. Access will not be limited to one individual.

(8) Perform inventory of team equipment every 6 months, and immediately following deployment conduct inventory of team equipment and supplies. Report any equipment or supply shortages to the RMC/MSC Logistics Readiness NCO.

(9) Report any potency and dated items, which are approaching their expiration date (i.e., within 9 months) to the RMC/MSC Logistics Readiness NCO.

j. SMART Members.

(1) Maintain and ensure all training requirements and administrative data is current, accurate, and meet all prerequisites for deploying as a team member.

(2) Ensure team chief is notified immediately of any duty or personal changes that would or could change status as a SMART member.

4. PROCEDURES.

a. General Training: All SMART members are required to maintain compliance with training standards outlined in this memorandum. Personnel who are designated as members of SMARTs are additionally responsible for team specific requirements outlined in Para 4b, Specific SMART Training. Listed below are additional general training requirements for all SMART members and augmentees.

(1) Annual training and familiarization in tactics, techniques, and procedures outlined in FM 100-23-1, Multiservice Procedures for Humanitarian Assistance Operations.

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(2) Annual training and certification on use, care, and maintenance of specific SMART equipment items.

(3) Semi-annual SMART alert and activation exercise.

(4) Annual medical specialty training appropriate to the SMART mission.

(5) Annual Soldier Readiness Process (SRP) IAW the Readiness & Deployment Checklist, DA Form 7425, July 2001.

b. Specific SMART Training.

(1) Appendix C, Tab 2 - Specific training requirements and frequency for both primary/alternate team members and all augmentees.

(2) Appendix C, Tab 3 - Listing of SMART equipment with which members should train.

c. Assessments and Reporting.

(1) SMARTs are subject to NO-NOTICE assessment by the direction of the RMC/MSC Commander or the RMC/MSC Deputy Commander/Chief of Staff during duty hours, after duty hours and on weekends and holidays.

(2) The training status of each SMART will be reported each quarter utilizing the MEDCOM Medical Readiness Report (MRR). This status will go through the SMART Team LNO to the Chief of Current Operations, RMC/MSC.

(3) A quarterly review and assessment of each team member's personnel will be conducted by each team chief and forwarded through LNO to the RMC/MSC Current Operations.

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Appendix 1, 12-Hour (N-Hour) Deployment Sequence, to Annex O, Deployment Standard Operating Procedures (SOP) for Special Medical Augmentation Response Teams (SMARTs)

12-HOUR (N-HOUR) DEPLOYMENT SEQUENCE
SPECIALTY MEDICAL AUGMENTATION RESPONSE TEAMS

<u>HOUR</u>	<u>EVENT</u>	<u>RESPONSIBILITY</u>
N+0	Receive and verify alert notification	Chief, SPO
	Commence recall	AOD/Deploying Teams
	Initiate Staff Duty Journal	Chief, SPO
N+1	STU III commo check	EOC
	Activate and secure EOC	EOC
	Verify Access Roster	Security Manager
	EOC initiates staff duty journal	EOC
	Check STU III with RMC/MS/MEDCOM EOC	OC
N+2	Coordinate with RMC/MS/MEDCOM/designated Teams	Chief, SPO
	MEDCOM situation brief	SMART Chiefs/ Chief, SPO
	Personnel assemble with individual equipment	Deploying Teams
	Request maps	Chief, SPO
	Report 80% accountability of personnel to	Chief, SPO Deploying Teams
N+3	Review/reconcile impact credit card accounts	Deploying Teams
	Submit unit mission essential equipment shortage list to Logistics	Deploying Teams
	EOC brief: Issue special instructions/ Coordination for CMD brief at N+6	Chief, SPO
	2d Percentage Strength Report (PERSAT)	Chief, SPO
	Roster of deploying personnel to supporting TMC and Chief, SPO for SRP	Deploying Teams
	Review plans & orders: prepare for CMD brief at N+6	SMART Chiefs

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	Review area med intel for inclusion in CMD brief at N+6	SMART Chiefs
	ID special training requirements for inclusion in CMD brief at N+6	SMART Chiefs
	Classified files prep: prepare files for storage	Chief, SPO
	Pack Regs/etc. for loading	Deploying Teams
	Submit consolidated unit mission essential Equipment shortage list to Logistics	Deploying Teams
N+3.5	Coordinate for SRP	Chief, SPO
	Submit verified deployment rosters to Post AG	Chief, SPO
	Submit report of levels supply: 5-day supply to Chief, SPO for command brief	Chief, LOG
	100% Accountability due to EOC	All Teams OICs
	Request basic load (MREs)	Deploying Teams
N+4	Obtain contingency items and special clothing/ Equipment as identified by TEAM Chiefs.	Chief, LOG
	CTA 50-900	Chief, LOG
	Obtain special support requirements submitted (plastic covers, portable lights, etc.) as identified by TEAM Chiefs	Chief, LOG
N+4.5	SRP processing begins	Post AG
N+5	Final deployment roster submitted to Military Personnel (RMC/MSC/Post AG)	Chief, SPO
N+6	Command Brief	Chief, SPO/ SMART Team Chiefs
N+7	SRP complete	Post AG
N+7.5	Manifest	RMC/MSC Military Personnel
N+12	Submit departure report	Chief, SPO

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Appendix 2, Clothing/Equipment Checklist, to Annex O, Deployment Standard Operating Procedures (SOP) for Special Medical Augmentation Response Teams (SMARTs)

EXAMPLE ONLY

**CLOTHING/EQUIPMENT CHECKLIST FOR SPECIALTY MEDICAL AUGMENTATION RESPONSE TEAM
INDIVIDUAL PREPARATION**

1. Clothing and Equipment. Individual Readiness will be prepacked IAW unit SOP and will accompany individuals on exercises or alerts. Below is a standardized minimum clothing and equipment list. Team Chiefs may add to this list as the mission dictates.

<u>ITEM</u>	<u>LBE/LVE WORN</u>	<u>ALICE PACK</u>	<u>A-BAG</u>
Bag, Duffel OD			1
Belt, Trousers, Cotton Webbing	1		
Boots, Combat, Leather	1		1
Buckle, Belt	1		
Cap, Field, BDU	1		1
Drawers, Cotton	1	1	2
Gloves, Insert, Wool, OG-108			1
Gloves, Shell, Leather, Black			1
Handkerchief	1	1	2
Socks, Cushion Sole, OG-408		1	2
Towel, Bath		1	2
Undershirt, Cotton, 1/2 sleeve	1	1	2
Necklace, Personnel, ID Tag	1		
Tag, Identification, Personnel	2		
Insignia, Grade (worn on uniform)	1		
Bag, Waterproof, GLO, OG-107		1	1
Belt, Pistol	1		
Liner, Poncho			1
Canteen, Water	1		
Cover, Canteen, 1 Quart	1		
Cup, Canteen	1		
Carrier, Sleeping Bag			1
Carrier, Entrenching Tool		1	
Entrenching Tool, Combination		1	
Case, Field First Aid	1		
Case, SA Ammo	2		
Sleeping Bag		1	
Pack, Alice w/Frame		1	
Overshoes, Rubber			1
Pad, Sleeping			1
Suspenders, Field Pack	1		
Liner, Coat			1
Helmet, Ballistic Protective	1		
Cover, Helmet, Camouflage	1		
Shirt, Sleeping			1

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<u>ITEM</u>	<u>LBE/LVE WORN</u>	<u>ALICE PACK</u>	<u>A-BAG</u>
Canteen, 2-Quart w/Cover		1	
Band, Helmet, Camouflage	1		
Poncho, Nylon		1	
Scarf, Wool, OG-108			1
Trouser, Wet Weather		1	
Trousers, BDU	1	1	2
Coat, BDU	1	1	2
Parka, Wet Weather		1	
Personal Protective Equipment, consisting of:			
Powered air purifying respirator (PAPR) W/NICAD battery-3M FR57N10			1
Battery, NICAD -3M 520-01-15 R01			1
Battery, LITHIUM -3M 520-04057 R01			1
Overgarment, Protective, TYCHEM-BR			1
Boots, HAZMAX			1 pr
Gloves, Butyl Rubber			1 pr
Gloves, Nitrile			1 pr

NOTE:

- Seasonal and wet weather items that are not listed as worn may be worn during appropriate season or weather conditions or at commander's discretion.

- Personal Protective Equipment will be packed on top of the A-Bag; placed in the Alice Pack on order.

2. Load Bearing Equipment (LBE). The following individual equipment will normally be assembled and stored in the individual's wall locker or quarters whichever is appropriate. Unless directed otherwise by the SMART commanders and EDRE Team Evaluators, team members will be in the prescribed uniforms.

<u>ITEM</u>	<u>QUANTITY</u>
Suspenders, Field Pack	1 each
Belt, Pistol	1 each
Case, SA Ammo	2 each
Case, Field First Aid w/Dressing and Burn Packs	1 each
Cover, Canteen w/ Cup, Canteen and Canteen Water	1 each
Alice Pack	1 each
Poncho, Nylon	1 each

3. Standard Markings.

a. Alice Pack: Name Tape sewn on the closing flap.

b. A-Bag/B-Bag: Last name character and last four (4) of SSN on the bottom.

Annex P, Emergency Power Plan

1. PURPOSE. To provide guidance on conserving or restoring electrical power during emergency conditions.

2. CONCEPT.

a. Generators provide a backup electrical system when the power fails or is inoperable.

b. Use as little electricity as possible should be used during electrical power emergencies.

c. The Commander may discharge or place some patients in a convalescent status if the emergency is expected to last more than 12 hours.

d. Only emergency surgical procedures will be performed.

3. RESPONSIBILITIES.

a. Chief, Logistics Division/Chief, Facility Management Division.

(1) Tests the power generating equipment and ensures the emergency system provides electrical power within 10 seconds after interruption of normal power. Conducts the test at least once a month for one-half hour under load conditions.

(2) Coordinates with the installation Directorate of Public Works (DPW) for electrical repairs as necessary.

b. Department, Divisions, and service Chiefs.

(1) Ensures electrical equipment for life support and safety is connected to the emergency system.

(2) Ensures the staff is aware of procedures during interruption of electrical power.

(3) Coordinates with MEDCOM Assistant Chief of Staff for Installations, Environment, and Facilities Management (ACSIE&FM) for Emergency Utility Support Services assessment.

(4) Incorporates the potential for complete disruption of all utilities into the Facility EMP.

(5) Ensures the staff is aware of the location of emergency power receptacles and equipment connected to the emergency system.

(6) Ensures the staff conserves auxiliary power without jeopardizing patient care and sanitation.

(7) Notifies the facility management branch when a loss of power or malfunction of medical equipment during normal hours, or the AOD after normal duty hours.

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Appendixes (As necessary, recommended appendixes are as follows)

- 1 - Energy Conservation Plan
- 2 - Electrical Blackout/Brownout Plan

Annex Q, Emergency Operations Center (EOC)

1. PURPOSE. To provide policy and guidance for establishing and operating the EOC.

2. CONCEPT.

a. The EOC is the command center where the necessary communications and personnel are located to coordinate medical activities during emergency or contingency operations. The EOC can operate 24 hours per day. It is the focal point for staff actions leading to decisions and command and control operations. The EOC also provides a means of informing higher headquarters, the Installation, and other activities of the capabilities, limitations, and problems within the hospital.

b. Deputy Commanders and designated Division Chiefs provide a representative to the EOC. This individual has the authority to make decisions and initiate actions for the Deputy Commanders or Division Chiefs.

c. The PTMS Division staff provides the normal staffing for the EOC. However, the EOC is staffed based on the magnitude and nature of the exercise or emergency. Duty rosters are prepared, and personnel notified as soon as possible.

3. RESPONSIBILITIES.

a. The DCA is the EOC coordinator, and directs staff of the EOC to meet contingency or situation requirements.

b. Chief, PTMS Division.

(1) Performs the duties of the EOC Operations Officer.

(2) Notifies the EOC primary point of contact.

(3) Briefs the staff about the situation.

(4) Maintains situation boards.

(5) Records EOC operations and significant information on DA Form 1594 (Daily Staff Journal or Duty Officer's Log).

(6) Coordinates and allocates space in the EOC to staff elements, when required.

(7) Maintains a log of all incoming and outgoing correspondence.

c. Chief, IMO. Works with the PTMS Division to establish communications for the EOC staff to accomplish tasks.

d. Administrative Officer. Prepares a duty roster for the EOC, and notifies the personnel.

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e. The Commander, Medical Company prepares a duty roster for enlisted drivers and administrative staff.

f. Chief Personnel Division. Provides typing support for the EOC.

4. PROCEDURES.

a. An initial medical situation report will be submitted to the next higher headquarters on order, and daily thereafter. The report will cover a 24-hour period, as of 2400Z, and will be submitted to arrive not later than the time directed by the next higher headquarters.

b. The MEDSITREP will specify direct medical requirements, expedite supply actions, provide for requisitioning of personnel, and facilitates decision making about the management of patients.

c. The Secure Telephone Unit (STU) or Secure Telephone Equipment (STE) and the classified FAX or SECRET Internet Protocol Router Network (SIPRNET) will be used for transmittal of classified information.

Annex R, Family Assistance Center Plan

1. PURPOSE. To provide guidance for establishing and operating the MTF's Family Assistance Center (FAC) that provides emotional support and information to the visiting families and other authorized friends of patients who are hospitalized or die of injuries from a disaster or terrorist CBRNE event, and a telephone hotline for those families who cannot reach the MTF.

2. CONCEPT.

a. In addition to the grief, concern, fear, and anxiety surrounding any traumatic injury, CBRNE events produce particularly high levels of concern among the family and friends of those with actual physical injuries. Concern for the victim and concern for the safety of self and others contribute to the anxiety and tension the family members and others experience. They are at risk for post-traumatic stress disorders. This risk can be substantially mitigated by a conspicuously caring and supportive health care system, by early identification of warning signs for developing Post Traumatic Stress Disorder (PTSD), and by assisted referral to other support agencies or treatment.

b. The Army Casualty and Mortuary Affairs Office (ACMAO) has primary responsibility for notifying next of kin of service members who become casualties, and for death notification and assistance to families of those who die. The MTF FAC and its staff will support that process. However, additional support will be required for family members and significant others who already know of the patient's injury and come to the hospital, or who call in requesting information on the patient's status and other support services.

c. Some of the patients brought to the MTF may not be service members who are entitled the ACMAO's services. Those patients' next of kin will need to be notified by other means IAW standing procedure, and receive referral to other sources of support.

d. The installation's Army Community Service (ACS) has primary responsibility for providing or coordinating material support for service members and their families who are in need. For disasters or CBRNE incidents involving many service members and families, the ACS will establish a post FAC, but will need medical advice regarding the medical risks and implications of the event. The MTF must coordinate effectively with ACS, refer families to them, and assist them by providing behavioral health/social work service personnel as needed. Minimum services established at the ACS FAC will include emergency financial assistance, emergency food and shelter, crisis intervention, legal information, Defense Enrollment Eligibility Reporting System (DEERS), military medical benefits briefing, information and referrals to appropriate sources for other assistance.

e. The American Red Cross (ARC) has statutory responsibility for support to civilians in disasters, but may need preventive medical and behavioral health information and advice from the MTF, especially regarding risks of exposure, and protective measures and treatments. The MTF must coordinate with ARC, and refer families and other civilians to them. The SMART from the RMC has the mission of liaison support to ARC and other civilian relief and

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charitable organizations, but the MTF must be prepared to do this liaison until it can be turned over to a SMART or to ARC personnel stationed at the MTF and ACS on post.

f. In large disasters, Joint Forces Command may be tasked to provide FORSCOM and the other Military Service's combat, combat support and combat service support units. These will include medical units, some with organic behavioral health personnel, and Army combat stress control units. In some situations, the military units may be given responsibility for the feeding, billeting and emergency medical care of civilians. Those units will need to interface with the MTF for patient care, and may rely on the MTF to assist with family assistance to DOD beneficiaries.

g. In most scenarios, a FAC within the MTF is needed to support visiting family members and friends within the hospital and to respond to appropriate telephone inquiries. The MTF FAC will become less needed as the patients achieve a safe status and inpatient census declines over time. It will downsize and eventually terminate as its functions are duplicated by a fully capable FAC nearby, run by another agency such as ACS or a joint command. Some staff of the MTF FAC may then be detailed to that other facility as needed.

3. RESPONSIBILITIES.

a. The Commander, Medical Treatment Facility will:

(1) As DHS for the installation, keep the post commander informed of family assistance issues and assure integration of the MTF FAC with other installation support operations.

(2) Designate the Chief, Social Work Service as director of the MTF FAC Plan, and approve opening a FAC when assessment of family assistance workload in the MTF justifies it.

(3) Assure that the Chiefs of Planning, Training and Operations and of the Legal Office work with the Chief, Social Work Service and with higher headquarters' staffs to assure that resource availability, funding, and legal issues are addressed in the plans and during implementation.

(4) Make visits and briefings to the visitors in the MTF FAC at appropriately scheduled times, and encourage the installation commander to do the same if that would be helpful for demonstrating compassionate consideration for families in the context of comprehensive patient care.

b. Chief, Plans, Training and Operations will work with the Chief, Social Work Service and other sources of data to:

(1) Assess the resource allocations and legal issues for the likely family support needs in the MTF support plans for different CBRNE scenarios.

(2) Incorporate Family Assistance requirements in the Emergency response plan, including the materiel requirements, and assure inclusion of the FAC in semi-annual training exercises.

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(3) Reassess the resource availability, funding and related legal issues, and advise the MTF Commander and Chief, Social Work Services throughout implementation.

c. Chief, Legal Office will work with the Chief, Social Work Service and other sources to:

(1) Assess the legal issues for the likely family support needs in the MTF support plans for different CBRNE scenarios.

(2) Reassess the legal issues related to entitlement, funding, responsibility for continuing care, and other legal issues, and advise the MTF Commander and Chief, Social Work Services throughout implementation.

d. The Chief, Social Work Service will:

(1) Staff and create a local SOP for an MTF Family Support Center and/or for coordinating an MOA with the local installation and civilian agencies delineating the responsibilities and procedures for operating a coordinated family support effort.

(2) Coordinate with Plans, Training & Operations and with the MTF facility managers for contingency provision of a room of suitable location, size and equipment, as described under Procedures.

(3) Plan for and assure provision of sufficient internal communications equipment (cell phones or voice/text capable pagers).

(4) Coordinate and train sufficient social work and behavioral service staff, chaplain, occupational therapy personnel and administrative support personnel on rotation to provide 24-hour coverage.

(5) On notification of a local disaster or CBRNE event, and in collaboration with other MTF services, make an assessment and devise an appropriately scaled response plan IAW existing regulatory guidance, SOPs, and MOAs. This plan should "fill in the blanks" by communicating how the guidance will be applied in the specific event, and by designating what resources and staff are needed in the FAC.

(6) Provide adequate staffing to manage workload on the FAC call-in telephone hotline and distraught referrals from the hospital telephone operator.

(7) Station or regularly send additional staff to the wards and other areas of high patient activity in order to communicate current patient status back to the FAC. Communication is critical between forward deployed staff and those supporting the family members.

(8) Coordinate the MTF FAC's operations with the installation ACS, ARC, and other agencies engaged in family support to assure maximum and proper use of all available resources.

(9) If the MTF FAC function is relocated to a consolidated installation FAC, cooperate with the ACS officer in charge to provide staff for the

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medically specific family assistance functions and provide liaison with the hospital staff.

(10) Assure tracking of contact, services and workload information, and complete documentation and data basing IAW MEDCOM and CHPPM policies.

(11) Complete an after action report following the completions of the support mission and the closure of the FAC.

e. Chief, MTF Facility Management shall plan for and provide the room and equipment for the FAC, which meets the criteria described under Chief of Social Work Service's responsibilities.

f. Chief, Behavioral Health Services shall provide psychiatry and psychology officers and mental health enlisted personnel to assist Social Work Service in making the assessment, and in staffing the FAC 24 hours a day or providing backup consultation.

g. Deputy Chief, Nursing Department will provide psychiatric nursing officers and mental health specialist (MOS 91X) in support of the MTF FAC as needed.

h. The Hospital Chaplain shall coordinate chaplains to visit the FAC at scheduled times and be available on call 24 hours a day.

i. Chief, Occupational Therapy Service shall provide officer and enlisted occupational therapy personnel to assist Social Work Service with daytime staffing or consultation.

j. Chief, Patient Administration Division (PAD) will provide current lists of patient dispositions in support of the FAC.

4. PROCEDURES.

a. Chief, Social Work Services assesses the need for a FAC based on the following considerations, and gains permission from the MTF Commander to activate the FAC Plan.

(1) The number of immediate and projected beneficiary casualties and nonbeneficiary casualties to be admitted to the MTF over what duration.

(2) The estimated magnitude of the psychological stress threat, which is strongly related to:

(a) The number of casualties.

(b) The shock and horror induced by the disaster and/or CBRNE event.

(c) The ambiguity about the exposure to CBRNE agents and of their immediate and long-term medical consequences.

(d) The economic, occupational and social disruption caused by the event, and its possible extension in space and time by contamination or contagion.

(3) An estimate of the number of family and other visitors who will therefore need MTF FAC assistance, including visitors and call-ins on the hotline.

b. The MTF is set up in a room or rooms which were preplanned with the MTF Facility Manager to meet the projected peak number of visitors at any one time, for example: one room for up to 15 visitors plus 3-4 staff; a larger room and/or 1-3 adjacent rooms for up to 45 visitors plus 5 staff; a very large room and up to 4-5 adjacent rooms for up to 100 visitors plus 6 staff.

c. The rooms should meet the following criteria and contain the following equipment.

(1) Be in a relatively quiet part of the MTF or very close outside the MTF, with easy access to:

(a) Toilet facilities, ideally including showers.

(b) Public telephones where the visitors can make outside calls.

(c) The MTF dining facility or a nearby inexpensive restaurant, or at least to adequate food and beverage machines that will be restocked in spite of the emergency.

(2) Equipment and material should include:

(a) Desk(s), table(s), and computer(s) and comfortable chair(s) for the FAC Intake Reception Area.

(b) Desk or table, computer, comfortable chair(s), and telephone(s) for the MTF FAC call-in hotline (which should be toll-free if possible).

(c) Sufficient comfortable chairs for the expected number of visitors, which may be augmented with folding chairs at peak times such as scheduled briefings.

(d) Audiovisual projection equipment for presentation of official briefings and updates, and for educational classes (e.g., stress management skills).

(e) A table kept supplied with comfort foods and beverages.

(f) Reading material including entertaining books and magazines and informative brochures.

(g) Television, radio, and music CD players, with earphones.

(h) Potential for cots or beds, preferably in an adjacent room, for those visitors whose loved one (especially if a child) is in critical/expectant condition, or the visitor is unable to find billeting nearby (with the help of ACS) that allows rapid reentry into the MTF.

d. The FAC Intake reception area is staffed 24 hours/day and:

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e. The MFT Telephone Hotline is staffed 24 hours/day and:

(1) Is ideally in a screened-off, quiet area or adjacent room, but may be at the Reception desk in small MTFs or during times of low activity.

(2) Maintains a record-log or short form of all calls, including identifying information about the caller that establishes their entitlement to receive information, identifying information about patient, presenting issues, action taken, and any follow-up required.

(3) Directs calls to appropriate helping agencies (e.g., ACS, ARC, other community resources).

(4) Enters data into a family contact database according to SOP based on guidelines from MEDCOM (MCHO-CL-H) and CHPPM.

f. Notification of next of kin (and of any others with a right to know) regarding patient status, personal information, disposition, or death will follow standard procedures set by regulation and policy to assure information does not go to unauthorized persons. This applies to both in-person and telephone communications.

g. Visitors to the FAC who show signs or symptoms of emotional distress, psychiatric disorder, or physical illness:

(1) Receive psychological first aid and crisis intervention, and/or medical first aid (e.g., BCLS), from the FAC staff.

(2) Are referred immediately to the appropriate MTF clinical service when the condition requires and the visitor is an entitled beneficiary or the condition is an emergency.

(3) Are assisted in finding follow-up care outside the MTF if the visitor is not an entitled beneficiary and the condition persists and is not an emergency.

Annex S, Physical and Behavioral Health Follow-up Plan

(To Be Published)

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Annex T, Public Affairs

REFERENCES.

Annex A of Basic Plan.

United States Army. Army Crisis Communications Preparation Guide. Washington, DC: January 1999.
<http://www.dtic.mil/armylink/apac/Documents/crisiscommguide.pdf>.

1. **General.** The U.S. Army Medical Command's Public Affairs Office will coordinate and facilitate the media's coverage of the Army's medical support of the Federal Response Plan (FRP). The Secretary of the Army, as the DOD executive agent on behalf of the Secretary of Defense, has overall responsibility for providing policy on military assistance to civil authorities during emergencies and disasters. FORSCOM, as the lead operational authority for JFCOM, will provide DOD support through the Continental U.S. Army to assist Federal and State efforts.

a. **Mission:** Public Affairs Officers (PAOs) throughout DOD will inform and educate relevant audiences about plague infection, its symptoms, and consequences. PAOs will also educate relevant audiences about important health strategies to prevent and control the plague (e.g., vaccination, contact tracing, isolation). Further, PAOs will support and augment the government lead agency's Joint Information Center (JIC), to respond to media queries relating to military support to civilian agencies/authorities.

b. **Assumption:** The first suspected or confirmed case of plague will generate intensive local, regional, state, national, and international media interest. Dealing with a plague outbreak will require extensive communications activities among numerous government agencies.

c. **Background:** Reference "a" outlines the government's plans and activities before and after a plague outbreak. This plan reflects the government's goal of synchronizing messages from government's lead agency ("speaking with one voice"). Reference "b" provides suggestions for developing installation communications plans for dealing with emergency situations.

2. **Communications Objectives.**

a. To instill and maintain public confidence in the DOD's leadership credibility, its healthcare system, and its ability to work in coordination with civilian authorities to respond to, and manage, a plague outbreak. Public messages from DOD will provide accurate, rapid, and complete information to educate, calm fears, and maintain public order.

b. To minimize, as much as possible, public panic and fear related to the plague.

c. To rapidly provide the public, healthcare providers, policymakers, and the media access to accurate, consistent, and comprehensive information about the plague, plague treatment, and the management of the situation.

d. To address and correct, as quickly as possible, rumors, inaccuracies, and misperceptions.

e. To provide accurate, consistent, and highly accessible information and materials through the coordination of communication efforts with other Federal, State, and local partners.

3. **Strategies.**

a. Support timely and aggressive education of service members, DOD civilians, contract employees and retirees, and their families about the plague.

b. Ensure the public and media perceive that the military and public health systems are prepared for such contingencies and are working to treat those affected and to contain the disease.

c. Ensure all supporting medical activities have credible and trained spokespersons to answer media, Congressional, and public queries related to the military's support of the government lead agency's efforts.

d. Encourage media and other interested parties with questions to use DOD and government websites (e.g., www.cdc.org; www.fema.org).

e. Leverage all DOD communications tools and products to support the government lead agency's efforts and to educate the various publics.

f. Decentralize information to the lowest level, empowering local commands to provide answers to media and other public inquiries about the military's support of lead agency's efforts as well as the military's handling of any cases that occur on military installations.

4. **Communication Challenges and Threats.** To address these challenges, specific message maps and communication tools will be developed.

a. Identifying source of outbreak.

b. The subtle differences between quarantine, isolation, and restriction of movement.

c. The purpose of contact tracing and surveillance.

d. Prioritization for immunization.

e. Counteracting misinformation, controlling rumors, and minimizing alarm.

5. **Primary Audiences and Stakeholders.**

a. U.S. military personnel, including active duty, Reserve Components, civilians, and contractors.

b. Family members and other healthcare beneficiaries.

c. DOD leadership.

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- d. Congress and the Executive Branch.
- e. Government civilian agencies that respond to terrorist events.
- f. American public via public media.
- g. Government contract personnel.

6. Responsibilities.

- a. U.S. Army Medical Command (MEDCOM) Public Affairs Office.

(1) Prepares and distributes press releases, in coordination with DOD, if an outbreak develops and as it progresses. Additional involvement is needed for outbreaks directly affecting military installations.

(2) Creates and maintains an on-going crisis communications plan.

(3) Creates and distributes PAO and other informational products as needed to subordinate units.

(4) Prepares advisories and responds to media queries.

(5) Conducts media training for senior leadership.

(6) Posts appropriate messages/articles about the plague on the MEDCOM websites.

(7) Supports plague education efforts in MEDCOM command information products and ensures all products include the CDC and FEMA websites: www.cdc.org; www.fema.org .

b. Army Medical Center/Hospital/Military Treatment Facility Public Affairs Offices.

(1) Use DOD PAO and all other products in responding to media queries.

(2) Encourage each MTF commander to act as a spokesperson and/or to identify subject matter experts to respond to media queries.

(3) Coordinate with DOD agencies and government's lead agency subject matter experts to respond to requests for interviews.

(4) Design or modify websites with plague information, updates, fact sheets, frequently asked questions and answers, and healthcare provider resources, including patient and public education materials.

(5) Monitor public media for articles and inform leadership of stories that have high impact on the medical department.

(6) Provide public-affairs advice to all agencies that request assistance.

(7) Identify PAO representatives to augment the government's lead agency Joint Information Center once established.

(8) Respond quickly and accurately to requests for information about the military's support of CDC.

c. Healthcare providers. Augment their own knowledge of the plague and its treatment to ensure their ability to answer Soldiers' questions and help relieve anxiety.

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Annexes U, V, and W

(RESERVED FOR LOCAL USE)

Annex X, Glossary

(List All Acronyms and Terms here)

EMERGENCY MANAGEMENT PLAN TEMPLATE

Annex Y, References

(List all References here)

Annex Z, Distribution

ACTIVITY/HEADQUARTERS/AGENCY

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CHAPTER 7

MEDICAL EMERGENCY MANAGEMENT PLAN EXECUTION MATRIX
HOSPITAL EMERGENCY INCIDENT COMMAND SYSTEM (HEICS) MATRIX**7-1. GENERAL.**

The Medical Emergency Management Plan Matrix at figure 7-1 and the Hospital Emergency Incident Command System (HEICS) matrix at figure 7-2 are provided for use by MEDCOM subordinate commands and activities. These matrixes are universally applicable. These matrixes will need to be tailored to meet the requirements of a specific activity.

Figure 7-1, Medical Emergency Management Plan Execution Matrix.

MEDICAL EMERGENCY MANAGEMENT PLAN				
Incident Execution Matrix				
CONDITIONS & RESPONSES				
EMERGENCY	DESCRIPTION	INITIAL RESPONSE	SECONDARY RESPONSE	FOLLOW-UP
CBRNE Incident	A chemical, biological, radiological, nuclear, or high explosive event occurs	Obtain as much information as possible (use the CBRNE threat form posted by each telephone) i.e., - Where is/was the incident? Were there any casualties? If so, how many and what is their condition, etc. Notify supervisor/call the Staff Duty Officer (after normal duty hours/weekends) (XXX-XXXX) or the Commander's Office during normal duty hours (XXX-XXXX)	Notify Security (XXX-XXXX). Report all information to the Security Office	Follow-up missions vary depending on type of incident encountered. See Medical Emergency Management Plan (MEMP). Go to Page XXX
Unknown Substance Discovered/ Bio-terrorism Act	An unknown substance is discovered or a bio-terrorist act occurs	Secure/Isolate the area. Notify supervisor/call the Staff Duty Officer (after normal duty hours/weekends) (XXX-XXXX) or the Commander's Office during normal duty hours (XXX-XXXX)	Notify Threat Response Team (Preventive Medicine, Environmental Safety, Lab Office, Safety Office, etc.) (XXX-XXXX)	Follow established bio-hazard/ bio-terrorism protocols. Go to Page XXX
Contaminated Casualty	Patient self presents	Secure Area. Isolate patient. Notify Patient Decontamination Team XXX-XXXX. Call the Staff Duty Officer (after normal duty hours/weekends) (XXX-XXXX) or the Commander's Office during normal duty hours (XXX-XXXX)	Patient Decontamination Team begins decontamination process. Notify Threat Response Team (XXX-XXXX)	Assess personnel/ facility for possible contamination. Isolate contaminated personnel. Decontaminate facility. Go to Page XXX
Radioactive Material Release	Possible radiation exposure or spill	Isolate the spill area (evacuate if necessary). Deny entry to others.	Initiate emergency procedures IAW Radiation Protection Officer	Complete report of the incident and forward to the

		Notify the Radiation Protection Officer (XXX-XXXX). Call the Staff Duty Officer (after normal duty hours/weekends) (XXX-XXXX) or the Commander's Office during normal duty hours (XXX-XXXX)	instructions	Radiation Protection Officer. Go to Page XXX.
Bomb Threat	Notification of a bomb in the facility, usually by an outside caller	Obtain as much information as possible (use the bomb threat form posted by each telephone.) Where is/was the incident? Were there any casualties? If so, how many and what is their condition, etc.	Notify Security (XXX-XXXX). Report all information to your supervisor and the Security Office	Follow the instructions of the Security Officer. Go to Page XXX
Fire	Fire	Remember R.I.D.E.S. <u>Rescue</u> those in immediate danger. <u>Isolate</u> the fire by closing all doors. <u>Dial</u> XXX-XXXX the Fire Department & pull the fire alarm. <u>Extinguish</u> the fire (if safe to do so). Call <u>Security</u>	Use a fire extinguisher to put out the fire. Remember P.A.S.S. <u>Pull</u> the pin. <u>Aim</u> the nozzle at the base of the fire. <u>Squeeze</u> the handle. <u>Sweep</u> from side to side	Evacuate outpatient areas. Prepare inpatient areas for possible horizontal movement to primary or secondary evacuation routes. Vertical evacuations are by hospital commander's directive only. Go to Page XXX
Hazardous Materials Spill	Chemical spill	1. Cordon off area 2. Call Fire Department (XXX-XXXX) 3. Provide Fire Department Material Safety Data Sheets	Dispose of contaminated materials by calling the Safety Office (XXX-XXXX), or Materiel Branch, Logistics Division (XXX-XXXX)	Complete report of incident and forward to the Safety Office so the Hospital Safety Council may review the incident.

		(MSDS) on spilled product		Go to Page XXX
Regulated Waste Spill	Blood or bodily fluids spill	1. Contain spill to prevent tracking 2. Notify Housekeeping (XXX-XXXX)	Housekeeping personnel will clean spill using appropriate barrier protection and a 1:10 solution of bleach	Complete report of incident and forward to the Safety Office so the Hospital Safety Council may review the incident. Go to Page XXX
Armed/ Unarmed Assailant, Combative Patient	An individual is being held against their will by an armed perpetrator	Notify Security (XXX-XXXX). Clear and isolate the area to prevent others from becoming a hostage	Report all pertinent information to your supervisor and others in charge of response	Complete report of the incident and forward to the Security Office. Go to Page XXX
Infant Abduction	An infant is missing or is known to be abducted	Notify security (XXX-XXXX). Go to the closest exit and watch for a person with an infant or with a package that could hold an infant	Ask for verification of identity (wrist name tag) or see contents of packages. Get clear description of adult and note direction of travel	Complete report of the incident and forward to the Security Office. Go to Page XXX
Cardiac arrest	An individual in cardiac or pulmonary arrest	Initiate CPR. Call for help	Dial XXX-XXXX (pager system) then enter: For Adult Code XXXX. For Pediatric Code XXXX	Complete Code Blue Form and forward to QI and Cardiac Arrest Committee. Go to Page XXX
MASS Casualty	An incident occurs that generates casualties that exceed the capability of the ER	See MASS Casualty Plan	See MASS Casualty Plan	See MASS Casualty Plan

**CBRNE
Incident Execution Matrix**

Purpose:

To describe actions and responsibilities in the event of an imminent warning of or mass attack by weapons causing mass destruction and mass casualty situations.

Execution Matrix

1.	Upon notification from the Installation Operations Center (IOC) that a mass attack is imminent or has occurred, key personnel will be alerted and provided guidance IAW the situation.	
2.	The MTF will not relocate, medical support will continue unless a post-wide evacuation is ordered.	
3.	The MTF EOC will be activated during the initial notification and remain operational until "All Clear" is ordered.	
4.	Health care will be limited to emergencies.	
5.	Surgery will be limited to emergency procedures.	
6.	Additional portions of the EMP will be activated.	
7.	Teams will be established and dispatched as needed. Medical personnel will be assigned to predetermined locations based on military operations and supported population.	
8.	Chemical incidents will be handled IAW the Medical Emergency Management Plan (MEMP) or as otherwise directed. Go to page	
9.	Unknown Substance/Bio-terrorism incidents will be handled IAW the MEMP or as otherwise directed. Go to page	
10.	Radiological incidents will be handled IAW the MEMP or as otherwise directed. Go to page	
11.	Nuclear incidents will be handled IAW the MEMP or as otherwise directed. Go to page	
12.	High Explosive incidents will be handled IAW the MEMP or as otherwise directed. Go to page	
13.	Contaminated Patients will be handled IAW the Contaminated Casualty Response Plan or as otherwise directed. Go to page	
14.	Response teams will provide monitoring and survey reports to the Commander and/or EOC IAW established procedures.	

CBRNE SUPPORT RESPONSIBILITIES:

MEDDAC Commander

1.	Determines medical support requirements.	
2.	Provides medical support (equipment, supplies, and personnel) and emergency treatment for personnel assigned to shelters.	
3.	Provides medical support to designated decontamination sites.	
4.	Evacuates hospital patients as necessary.	
5.	Maintains operational control of all medical personnel and equipment for the duration of the emergency.	
6.	Provides critical health services to the communities to include the dispersal area.	
7.	Coordinates with the installation commander to determine when MARK I and CANA will be issued to the Installation QRF.	

Deputy Commander for Clinical Services

1.	Assigns medical personnel to designated decontamination sites.	
2.	Coordinates the entire medical staff.	
3.	Identifies medical supplies to be used in designated decontamination sites and coordinates these needs with the Chief, Logistics.	
4.	Tracks all medical officers that attend the Management of Biological and Chemical Casualties Course in Aberdeen Proving Ground, Maryland.	

Deputy Commander for Nursing

1.	Ensures the effective utilization and management of all nursing personnel.	
2.	Manages the utilization of all nursing personnel.	

Deputy Commander for Administration

1.	Supervises the EOC.	
2.	Manages the utilization of all administrative personnel.	

Chief, Logistics

1.	Monitors the usage of available medical supplies to ensure efficient utilization of limited resources.	
2.	Coordinates and plans with the DCCS, DCN, and installation Director of Logistics for the basic medical supplies needed at decontamination sites.	
3.	Prepares to execute internal Emergency Management Plans.	

4.	Establishes a Logistics Operations Center (LOC) or internal operating cell to centralize all logistical requirements and direct logistical operations.	
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Chief, PTMS

1.	Establishes and operates the MEDDAC EOC and maintains contact with the IOC.	
2.	Implements internal security procedures as required.	
	Acts as point of contact for coordination with higher headquarters and other external agencies.	

Public Affairs Office

1.	Handles all PAO inquiries and refers them to the Installation PAO.	
2.	Coordinates information concerning survival and recovery measures with Installation PAO before release.	

**UNKNOWN SUBSTANCE/BIO-TERRORISM
Incident Execution Matrix**

Purpose: To describe those actions to be taken in the event an unknown substance is discovered that is suspected to be a chemical or biological agent or a possible bio-terrorism incident occurs.

Initial Execution Matrix:

1.	Any individuals in contact with the substance will cover the substance (if possible), remove any clothing that has visible contamination, leave the area and close the door(s), and will wash hands immediately. The individuals will not come into physical contact (e.g., touch, brush-up against) with any other individuals until they are authorized by the threat response team.	
2.	Individuals will notify command group/SDO of unknown substance and give details of the circumstances.	
3.	SDO will temporarily segregate the affected individuals in a designated area.	
4.	The immediate area around the substance (e.g., hallway, room) is blocked off.	
5.	Determination of credible threat. Characteristics of a credible threat may include any of the following: <ul style="list-style-type: none"> a. Direct verbal or written threat of chemical or biological terrorism. b. Package or letter containing an unexplainable powdery substance. c. Other reasonable physical evidence of a credible threat. 	
6.	If a credible threat is present, then the Bio-terrorism response and Contaminated Casualty response procedures are followed. If no credible threat is present, then the following steps will be accomplished: <ul style="list-style-type: none"> a. SDO notifies threat response team, consisting of C, Preventive Medicine, Environmental Safety Officer (ESO), Lab Officer, and Safety Officer. The command group is also notified. b. The threat response team evaluates the circumstances involving substance. Universal precautions are followed, including gloves, gown, and N95 mask (fit testing required). The threat team determines whether there is a credible threat. c. If there is a determination of a credible threat, then the Bio-terrorism response and Contaminated Casualty response procedures are followed. 	
7.	If there is a determination that there is no credible threat, a sample is taken for lab culture and gram stain, and the remainder of the substance is cleaned with 0.5% hypochlorite solution (one part bleach added to 9 parts	

	water). An incident report is filed with risk management.	
8.	Report incident to higher headquarters.	

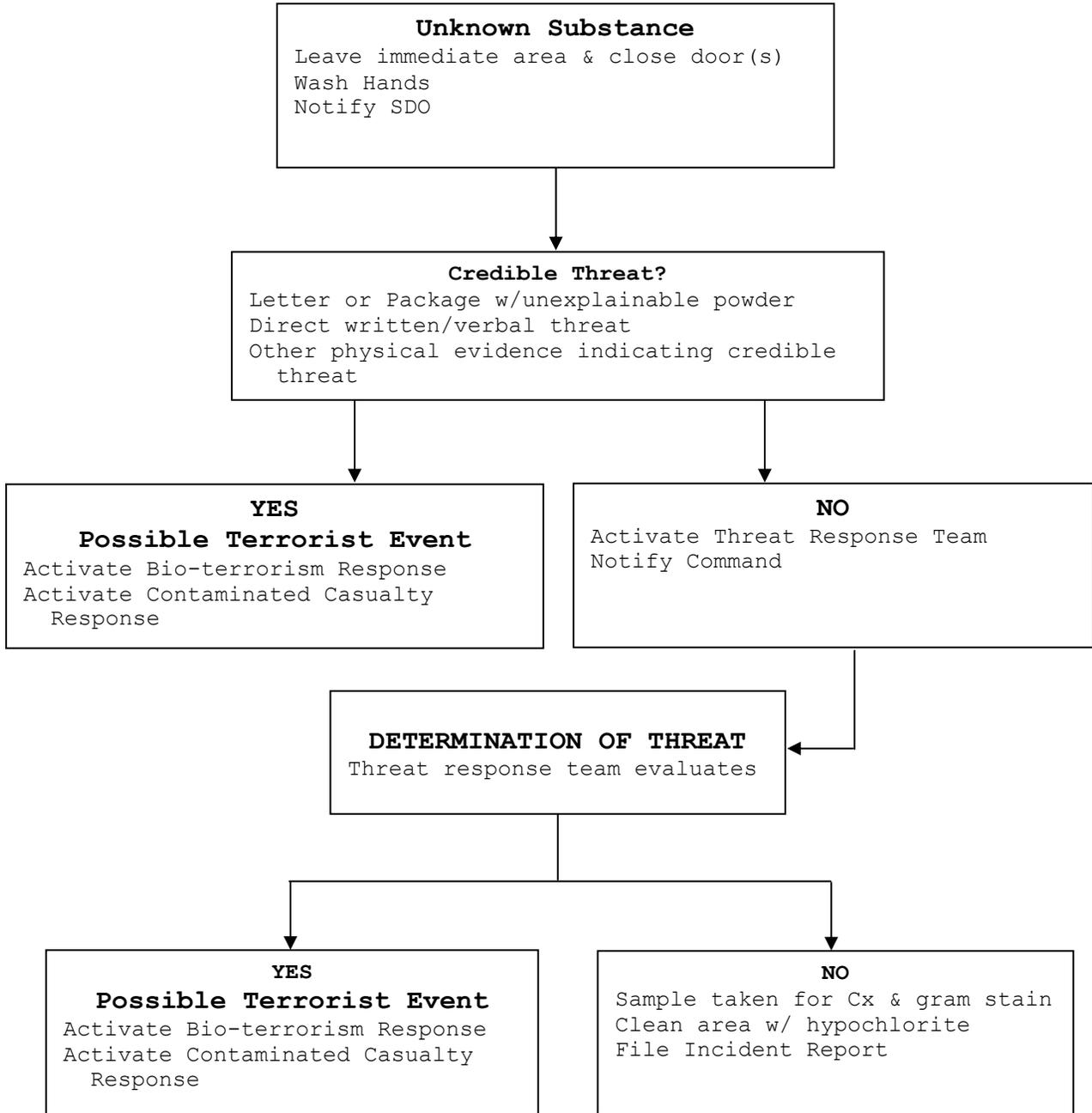
Secondary Response Matrix:

1.	SDO will isolate and block off area, and will ensure that all air-handling systems are turned off by maintenance. Negative pressure rooms will remain operational, unless this poses a threat to the patient, as assessed by the threat response team.	
2.	SDO will notify the following key personnel (if not previously notified): fire and law enforcement, Threat Response Team (Preventive Medicine Officer, Environmental Safety Officer, Lab Manager, and Safety Officer), Command Group, EMS, FBI office, and WMD-CSTs.	
3.	The Incident Commander retains authority over operations during the incident, with input from the threat response team, chemical officer, law enforcement, and FBI. All information and decisions will go through the Incident Commander.	
4.	The Threat Response Team will evaluate possible degree of exposure from interviews with first responders and SDO.	
5.	Those with direct contact with the substance via skin will be decontaminated with soap and water, having clothes sealed in plastic bags. This can be accomplished with the Emergency Department decontamination station or with a simple shower, depending on the risk assessed by the threat response team. Those with only possible inhalation exposure will wash hands, and be evaluated by medical personnel.	
6.	The Threat Response Team will assess the need for further evacuation of the hospital, based on the facility's layout of air-handling systems.	
7.	The HAZMAT will secure the sample for law enforcement officials. The HAZMAT will decontaminate the affected area with 0.5% hypochlorite solution, as per their protocols.	
8.	The hospital infection control policy will be followed with regard to care of patients who have been exposed to biological agents within the hospital.	
9.	Provide chemo-prophylaxis measures as clinically directed.	
10.	Information may only be released to the public by way of the Public Affairs Officer. Information will be disseminated to those affected by the incident via law enforcement or their designee.	

Unknown Substance/Bio-terrorism	Contacts	
Preventive Medicine		
Environmental Officer		
Senior Nurse On-Call		
Safety Office		

Command Group		
IOC		
Federal Bureau of Investigation		
WMD-CSTs		
Higher Headquarters (RMC)		

UNKNOWN SUBSTANCE RESPONSE FLOWSHEET



<p>CONTAMINATED CASUALTY Incident Execution Matrix</p>

Purpose: To describe actions and responsibilities in the event of a patient contaminated with nuclear, biological, or chemical contaminants arrives for treatment at the MTF.

Initial Response Matrix:

1.	ISOLATE the contaminated patient(s). Preferably, move them or keep them outside of the facility. NO CONTAMINATED PATIENTS will be knowingly brought INSIDE THE HOSPITAL.	
2.	Cover contaminated patients with sheets and isolate all staff and personnel who have touched or may have come in contact with the patient(s).	
3.	Preventive Medicine and the Environmental Science Officer (ESO) and Radiation Protection Officer (RPO) will be contacted to assist in handling contaminated casualties.	
4.	Contact Security to coordinate heightened security and restrict access to the contaminated areas to prevent further contamination.	
5.	Provide life-saving measures, as needed, to the contaminated patients ensuring proper personal protective measures are taken by medical providers.	
6.	Restrict access to contaminated areas and entrances used by contaminated personnel until deemed safe.	
7.	If patients arrive in areas other than the Emergency Department (ED) direct them out of the facility from the entrance they came and contact the below listed contacts.	

Secondary Response Matrix:

1.	The ED upon notification or receipt of contaminated patient(s) will handle patients similar to isolation techniques employed with a highly contagious patient. Isolated patients will be set up outside in a designated decontamination area that is down wind of the hospital and the decontamination equipment located in the ED will be deployed by trained personnel.	
2.	Additional personnel trained in using the equipment will be notified and will report to the decontamination site outside the ED.	
3.	Medical personnel will immediately don personal protective equipment (PPE).	
4.	Patients will be handled outside of the ED.	
5.	All clothing, belongings, body fluids removed from the patient will be placed in buckets or containers clearly labeled "Contaminated - Do Not Discard."	
6.	Contaminated valuables will be taken, inventoried, and recorded. They will be given to the RPO who will safeguard and decontaminate the items.	

	Decontaminated items will be stored in the Treasurer's Office or returned to the patient.	
7.	Decontamination of the patient(s) will begin with the highest contaminated area or areas and repeated as necessary until the patient is fully decontaminated.	
8.	Following complete decontamination, the remaining medical care will be provided through normal channels.	
9.	Decontamination of the Emergency Treatment Area will be done as quickly as possible and under the direction of the Preventive Medicine, Industrial Hygiene, Safety, and the RPO.	
10.	All personnel treating or having contact with the contaminated patient will be properly decontaminated and monitored as appropriate.	
11.	All contaminated equipment and vehicles will be identified, tagged, decontaminated, or disposed of properly.	
12.	The decontamination process will be monitored by Safety, Industrial Hygiene, and Environmental Safety to ensure OSHA, EPA, and JCAHO policies are enforced.	
13.	Facilities engineers will monitor the hospital ventilation and drainage systems to ensure the contamination does not spread.	
14.	Security of the contaminated area "hot zone" will be maintained and traffic control to and from these areas will be restricted. Security personnel will be requested from the Medical Company.	
15.	PAO will ensure publicity and reporting of the situation is accomplished according to prescribed guidelines.	
16.	Contaminated equipment and materials must be properly decontaminated or disposed of following treatment of contaminated patients.	

Follow Up Matrix:

1.	All personnel involved will be decontaminated at the direction of Preventive Medicine.	
2.	All disposable PPE will be discarded properly.	
3.	Contaminated wash water will be disposed of properly.	
4.	Facility engineers will ensure hospital systems are clear of contamination.	
5.	Safety, Industrial Hygiene, and Environmental Safety will ensure the proper authorities are contacted and will monitor the proper cleaning of the facility to eliminate all contaminants and contaminated waste.	
6.	AARs from those involved will be submitted within 72 hours of the incident to the Chief, PTMS.	
7.	The Chief, PTMS will submit final AAR to appropriate authorities.	

1.	Personnel exposed to the contaminated patient should be decontaminated and monitored.	
2.	Areas affected by contamination should be decontaminated IAW directives given by HAZMAT personnel, Preventive Medicine, Safety, Industrial Hygiene, ESO/RPO.	

Contacts		
Preventive Medicine/Industrial Hygiene		
RPO/Environmental Safety Officer		
Safety		
Command Group		
Staff Duty Officer/Front Desk		
Emergency Department		
PTMS (Plans, Training, Mobilization, Security)		
Fire/HAZMAT		
IOC		

CONTAMINATED CASUALTY INCIDENT PERSONNEL RESPONSIBILITIES**Deputy Commander for Clinical Services**

1.	Notifies the Chief, Preventive Medicine.	
2.	Ensures maximum number of Medical Officers have received Medical Management of Biological and Chemical Casualty training.	

Chief, Emergency Medicine

	Supervises the treatment of contaminated patients following decontamination.	
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Chief, PTMS

1.	Establishes the EOC as directed by the Command Group.	
2.	Coordinates with the IOC for additional evacuation and decontamination support.	
3.	Coordinates security procedures to restrict access to the contaminated area.	
4.	Coordinates with Military Police for additional support.	
5.	Submits appropriate incident reports.	

Preventive Medicine

1.	Provides advice on the care and handling of radioactive or contaminated casualties.	
2.	Provides exposure control and monitoring of staff and personnel attending to casualties.	
3.	Advises decontamination procedures IAW medical treatment requirements.	
4.	Directs contamination control measures to restrict the spread of contamination in the MTF.	
5.	Surveys the hospital for radioactive contamination.	
6.	Advises decontamination procedures of affected areas after treatment is complete.	
7.	Notifies the PAO and provides updated information concerning the incident.	
8.	Submits appropriate reports to all internal and external agencies to include the Regional Medical Command, MEDCOM, Surgeon General, and the Nuclear Regulatory Commission.	
9.	Investigates internal incidents.	
10.	Issues specific guidance for the handling of radioactive casualties.	

Industrial Hygiene/Safety/Environmental Safety

	Monitors decontamination procedures to ensure OSHA, EPA, and JCAHO standards are met.	
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Chief, Logistics

	Ensures Facilities Engineers monitor ventilation and drainage systems for contamination and coordinates for the proper decontamination of these systems as needed.	
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Ambulance Section

1.	Upon arrival at the scene of a nuclear, biological, or chemical accident, the Senior EMT/Paramedic will report to the site Nuclear Accident/Incident Control Officer (NAICO) for the presence of casualties, accident type, and the threat of radioactive contamination.	
2.	The Ambulance Crew will take directed personal protective measures as directed.	
3.	Casualties will be assessed and simple decontamination measures taken (i.e., removal of shoes, external clothing, etc.) to minimize spread of contamination.	
4.	Every effort will be made to minimize exposure during medical treatment.	
5.	The RPO will provide, as needed, advice on exposure and contamination control at the site of patient treatment.	
6.	If it is absolutely necessary to evacuate injured personnel before contamination is complete, the receiving treatment facility will be notified that a radioactive/chemically-contaminated patient is en route.	
7.	A radioactive/chemical hazard exit will be coordinated through the NAICO and the post should be notified to set up additional decontamination points as necessary.	
8.	Decontamination of all personnel, equipment, and vehicles will be accomplished following the conclusion of the incident.	

<p>RADIOACTIVE MATERIALS RELEASE Incident Execution Matrix</p>

Purpose: To describe actions and responsibilities to be taken in the event radioactive material is spilled or released in an area or on a person.

Initial Response Matrix:

1.	Notify key staff members. Call the RPO to report the incident.	
2.	If the incident occurs after normal business hours call the Staff Duty Officer who will contact the Chief, Preventive Medicine and the RPO.	
3.	Notify others in the area, not involved in the event, of the potential danger.	
4.	Evacuate the immediate area of all noncontaminated, nonessential personnel. Remain in adjacent areas for monitoring.	
5.	Prevent the spread of contamination by covering spills with disposable absorbent material or covering areas in which contaminated patients may contact with nonabsorbent material such as plastic.	

If the spill is on a person:

1.	Remove any contaminated clothing and place in a properly marked plastic bag.	
2.	Immediately wash the contaminated areas with soap and copious amounts of warm water for 2-3 minutes.	
3.	Provide all emergency medical care required prior to extensive decontamination efforts. It is highly unlikely that a single patient could be contaminated to such an extent that they present a significant hazard to medical personnel.	
4.	Decontamination, monitoring, and evaluation of the radiation hazard will be conducted by Preventive Medicine and the RPO.	

If the spill is on the floor or on equipment:

1.	Identify outer limits of the spill and dam the area to prevent further spreading of the material.	
2.	Decontaminate identified areas as soon as possible.	
3.	Blot up excess liquid with paper towels. Dampen the towel if the spill is a powder.	
4.	Anyone who may have touched or walked through the contaminated area will require monitoring by the RPO to evaluate if decontamination is necessary.	

Secondary Response Matrix:

1.	Further decontaminate with soap and minimal water, working from the outer perimeter to the middle of the spill area. Blot dry.	
2.	All materials used to decontaminate the spill will be placed in properly marked plastic bags and are to be disposed of IAW facility policy through Environmental Health.	
3.	Thoroughly wash your hands with soap and copious amounts of warm water for 2-3 minutes.	
4.	Be prepared to respond to changing work hours and duty assignments as directed.	
5.	Provide assistance as needed.	

Follow Up: All areas will be monitored for further exposure and once cleared will return to normal duty operations.

Contacts		
Radiation Protection Officer		
Preventive Medicine		
SDO		
Command Group		
IOC		

RADIOACTIVE MATERIALS SPILL/RELEASE SUPPORT PLAN:

Purpose: To safely mitigate a radioactive materials incident, within the facility or on its grounds.

Supporting Information:

The Radiation Protection Officer and Preventive Medicine are the lead responders for all radioactive materials incidents. Others are to clear the area and report problems to Preventive Medicine, unless they are otherwise directed. Preventive Medicine will take action and direct supporting staff as appropriate. This is a special type of hazardous materials incident. Large spills requiring large group response are very unlikely. A radioactive materials incident may be classified (in order of likelihood) as:

1.	An operational event involving the loss of control of radioactive material within the facility.	
2.	An external event with either contaminated or radiologically exposed patients transferred to the facility.	

RADIOACTIVE MATERIALS SPILL/RELEASE RESPONSIBILITIES:

1.	As indicated in above response plan.	
2.	Refer to Contaminated Casualty Execution Matrix. Go To Page	

<p>BOMB THREAT Incident Execution Matrix</p>

Purpose: To specify those actions to be taken when notification, usually by an outside caller, of a potential bomb is received. All bomb threats are considered serious.

DO NOT USE PORTABLE RADIOS DURING BOMB THREATS.

Initial Response Matrix:

1.	Obtain as much information as possible using the FBI bomb threat card (beside your telephone): <ul style="list-style-type: none"> • When is bomb going to explode? • Where is it right now? • What does it look like? • What kind of bomb is it? • What will cause it to explode? • Did you place the bomb? • Why? • What is your address and phone number? • What is your name? • Listen for accents and background noises. • If threat is made in person, try to detain the individual through conversation and make mental notes of their physical description 	
2.	Keep the caller on the phone as long as possible. Do not upset the caller if possible	
3.	If a bomb threat note is found, DO NOT HANDLE THE NOTE. Notify the Security Manager; Chief, PTMS; or Military Police and secure the area until authorities arrive.	
4.	In any instance, immediately call the Military Police at 911.	
5.	Report obtained information to Department Chief or NCOIC.	
6.	Forward report to Command Group and Provost Marshal.	
7.	Call Front Desk to announce Code Clean Sweep.	

Secondary Response Matrix:

1.	Make a quiet, orderly search of your area for suspicious or out-of-place items, packages, boxes, etc.	
2.	Report the results of your search to your supervisor who will contact the Security Manager and EOC. Negative reports are required.	
3.	If a suspected package or object is found, DO NOT TOUCH! The senior person available will make the decision to evacuate the immediate area.	
4.	Fire evacuation routes will be used.	

5.	If no suspicious items are found, DO NOT EVACUATE. unless directed by the Hospital/Incident Commander.	
6.	If the order to evacuate is issued, follow procedures defined in the Evacuation Plan.	
7.	Seal off evacuated areas to prevent personnel from inadvertently entering potentially hazardous areas.	
8.	Military Police will search suspect areas with bomb dogs. If needed, a staff member from the respective activity may be called upon to assist the search.	
9.	Search will be continued until complete in case of multiple devices.	
10.	Clear area hallways to emergency responder traffic.	
11.	Prepare to receive traffic from staff and patients evacuating their work area.	
12.	Be prepared to respond to changing work hours and duty assignments when directed, as needed.	
13.	In the event a device detonates do the following: a. Follow procedures in the MASS Casualty SOP. b. If contamination is suspected as a result of the detonation, Go To Page	

Follow-up: Complete the FBI bomb threat phone report and submit to the MTF Security Manager or SDO.

NOTE: Department/Division Chiefs are expected to call the EOC or Security Manager to report the results of their entire Department's/Division's search as soon as possible.

Bomb Threat Contacts (use runner)		
Emergency Response		
Military Police		
EOC		
Safety		
Security Manager		
Command Group		

BOMB THREAT SUPPORT PLAN

When a bomb threat has been reported at the MTF, the Bomb Threat Search plan will need to be activated.

A bomb threat alert requires an immediate search for any packages, boxes, or items that could be a bomb. When a bomb search is initiated each department/division/ service/activity is assigned a search area that is their immediate area of responsibility. Facilities Management Branch may be required to search several service areas. The Chief, Nutrition Care Division and the Chief, Pharmacy will be required to allow access to restricted areas so that a search may be conducted.

In accordance with the situation and direction from the Hospital Commander, departments/divisions/services/activities will evacuate nonessential

personnel (staff, patients, visitors). This determination will be made at the onset of the situation.

A systematic search system will be implemented to assist the Hospital Commander and Emergency Operations Center to search the hospital as needed. Department/division/service/activity search reports are given to the EOC to record. All areas of the hospital are to report the results of their search findings as soon possible after a search is ordered. Reports will be made telephonically or by runner. **RADIOS WILL NOT BE USED.**

Searched and "All Clear" areas will be marked with an inverted empty trash can placed in front of the entrance door indicating that the area has been searched. If a trash can is not available, mark the searched area with a unique identifying marker that will be relayed to the EOC for coordination with Military Police/Explosive Ordnance Detachment (EOD).

Actions to be taken prior to conducting any Search activity:

- _____ Coordinate with your supervisor and review your search area.
- _____ Determine the details of potential hazards likely to be encountered in the search area, based on known and suspected hazards.
- _____ Appoint a Search Team Safety Officer and Search Team Members.
- _____ Identify and locate the tools and materials likely to be needed to perform the Search.
- _____ Conduct Team Search procedures, safeguards, and communication skills **before** beginning **any** Search and Rescue activity.

Search Procedures:

- _____ When in doubt about the safety of the Team, **DO NOT PROCEED!** Leave the area and await a professionally trained Bomb Search Team.
- _____ Watch for signs of stress and fatigue in yourself and others. Report concerns to Team Safety Officer.
- _____ Search each room/common area from the floor up.
- _____ Once the area is searched, place inverted trash can in front of the door. This assists the EOD search team in identifying areas that have been searched.
- _____ Be prepared to respond to changing work hours and duty assignments when directed, as needed.
- _____ Provide assistance as requested.
- _____ Terminate the search when all areas have been searched and no suspicious items/noises/etc. have been found in the search area or it is unsafe to continue the mission.
- _____ If suspicious items, noises, etc. are found in the search area, notify the EOC immediately and the EOD search team will be sent to the area immediately.

All Clear: Maintain your normal work duties, unless otherwise directed.

BOMB THREAT SUPPORT PLAN RESPONSIBILITIES:

MTF Commander

1.	Directs establishment of EOC.	
2.	Directs the resources of the hospital to support the Bomb Search Plan.	
3.	Directs the evacuation of the hospital if deemed necessary.	

C, PTMS

1.	Establishes the EOC under the direction of the Hospital Commander/designee.	
2.	Serves as liaison between Post EOC, Military Police, and the Explosive Ordnance Detachment (EOD).	
3.	Coordinates with C, Facilities; C, Pharmacy; C, NCD for search of their restricted areas.	
4.	Serves as Bomb Threat Officer implementing the Bomb Search Plan until the Military Police and EOD arrive.	
5.	Completes the Serious Incident Report and submits within 24 hours of incident.	
6.	Coordinates with the PAO to handle any inquiries regarding the incident.	
7.	Receives and tracks areas searched and coordinates results with the EOD team and Military Police.	
8.	Compiles AARs and submits to Command Group.	

Safety Officer

Assists the C, PTMS in implementing the Bomb Search Plan.

Security Manager

1. Collects completed FBI Bomb Threat Card and coordinates with Military Police for heightened security measures around the hospital.
2. Ensures access to the hospital is restricted.

Chief, Logistics

Ensures all necessary equipment, supplies, and floor plans are available to support the Bomb Threat Support Plan/Military Police/EOD.

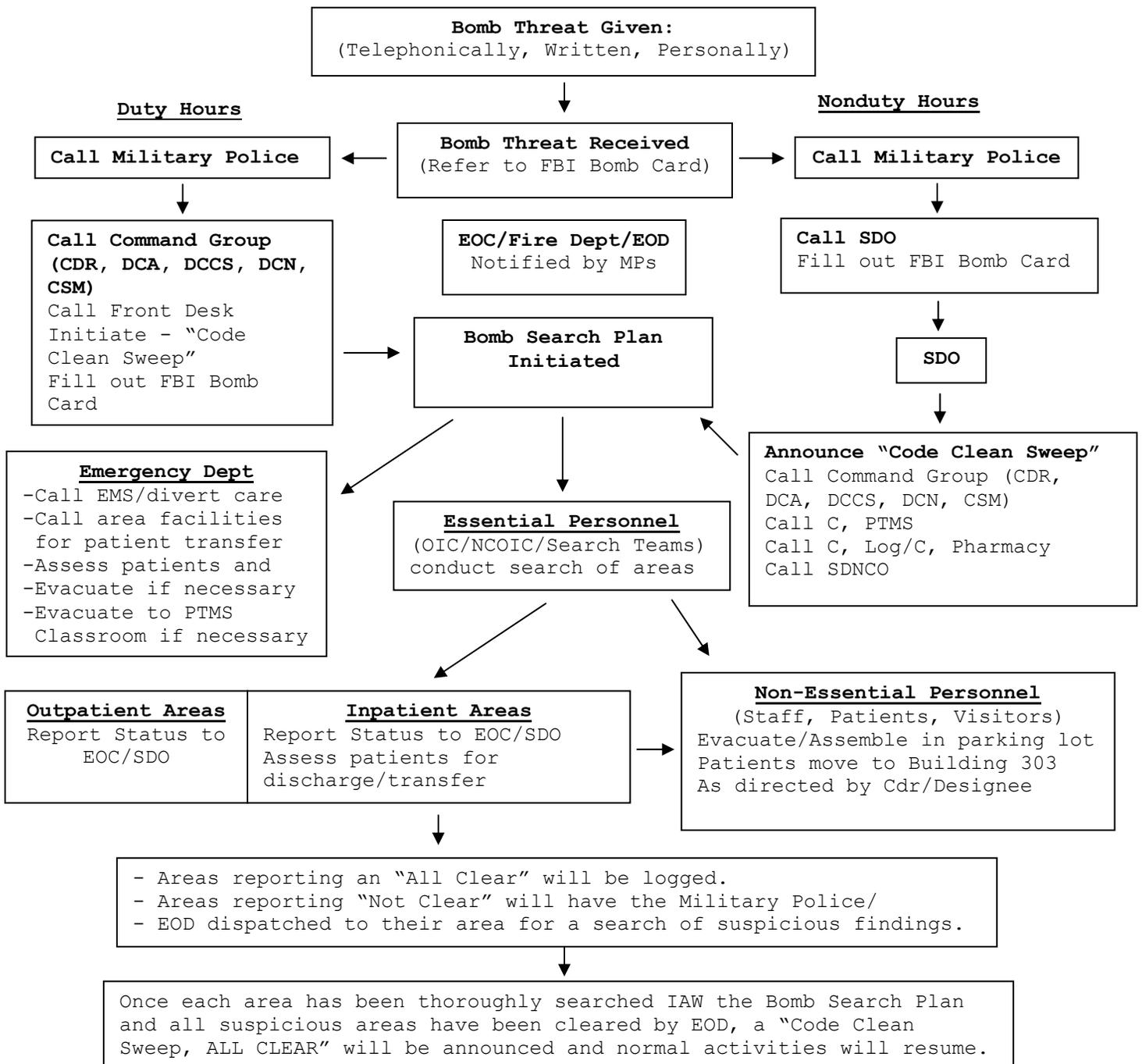
Chief, Nutrition Care Division/Chief, Pharmacy

Assist search teams with gaining access to secured areas within your department so they can be searched.

Chief, Facilities

Assists search teams with gaining access to secured areas so they can be searched.

BOMB THREAT RESPONSE SEQUENCE



Bomb Threat Format

(This information should be placed next to your telephone)

QUESTIONS TO ASK:

1. When is the bomb going to explode? _____
2. Where is it right now? _____
3. What does it look like? _____
4. What kind of bomb is it? _____
5. What will cause it to explode? _____
6. Did you place the bomb? _____
7. Why? _____
8. What is your address? _____
9. What is your name? _____

Exact wording of the threat: _____

Sex of caller: M/F _____ Race: _____ Age: _____

Number at which the call was received: _____

Time: _____ Date: _____

CALLER's VOICE: (circle)

- | | | |
|-----------------|----------------|----------|
| Calm | Angry | Excited |
| Slow | Rapid | Soft |
| Loud | Laughter | Crying |
| Normal | Distinct | Slurred |
| Nasal | Stutter | Lisp |
| Raspy | Deep | Ragged |
| Clearing Throat | Deep Breathing | Cracking |
| Disguised | Accent | Familiar |
| Whispered | Other _____ | |

If the voice was familiar, whom did it sound like? _____

BACKGROUND SOUNDS: (circle)

- | | | |
|-------------------|------------------|---------------|
| Street Noises | Crockery | Voices |
| PA System | Music | House Noises |
| Motor | Office Machinery | Animal Noises |
| Factory Machinery | Clear | Static |
| Local | Long Distance | Phone Booth |
| Other _____ | | |

THREAT LANGUAGE: (circle)

- | | | |
|------------------------|-------|--------------|
| Well spoken (educated) | Foul | Irrational |
| Incoherent | Taped | Message Read |

REMARKS: _____

Report Call Immediately: Military Police - 911/Security Manager XXXXX/
PTMS XXXXX

BOMB THREAT DEPARTMENT SEARCH REPORT

To: Emergency Operations Center, ATTN: Chief, PTMS/Security Manager

From Department: _____ Date: _____ Time: _____

Areas Searched: _____

Suspicious Items Found: _____

Location: _____

Actions Taken:

- Sealed off area
- Evacuated Patients # Patients _____ Staff _____
- Posted Guard
- Continued to provide care # Patients _____ Staff _____

Comments: _____

Signed: _____ Title: _____ Date: _____

<p>FIRE Incident Execution Matrix</p>
--

Purpose: To describe actions to be taken in the event of a fire, smoke, or the odor of something burning is detected.

Initial Response (R.A.C.E.) Matrix:

	<p><u>Immediate Area</u> Rescue those in immediate danger, if safe to do so. Activate the alarm (pull manual alarm & call 911 or 6965). State name, department, room # and floor of the fire. Describe extent of fire (open flames, smoke, smoke odor, etc.). Contain the fire (close doors and windows). Extinguish the fire, if safe to do so. Evacuate self and patients laterally to an area of refuge. (See "Evacuation Plan.")</p>	
--	---	--

Secondary Response (P.A.S.S.) Matrix:

	<p>Use an extinguisher to put out the fire, if safe to do so Pull the pin on the extinguisher Aim the hose Squeeze the handle Sweep from side to side</p>	
--	---	--

Follow-up Matrix:

1.	Evacuate vertically only if directed by your supervisor, Area Fire Warden or Senior Fire Department Official. DO NOT use elevators unless advised to use the Emergency Elevator. Take records if safety permits.	
2.	Move to your Department Assembly Area, as directed.	
3.	Complete an Incident Report and submit to your supervisor.	

NOTE: If you hear from another unit or area:

1.	Remain away from the area in alarm.	
2.	Be alert, and await further instructions from Area Fire Warden or via the overhead pager system.	
3.	Be prepared to receive and assist evacuees from the evacuation zone (validate 1 st).	
4.	When you hear "ALL CLEAR," the fire hazard has subsided; resume normal duty.	

Fire Contacts		
Emergency Response		
Safety		
EOC		
Command Group		

<p>HAZARDOUS MATERIALS SPILL Incident Execution Matrix</p>

Purpose: To describe those actions that must be taken in the event a Chemical/Radioactive Spill or Hazardous Fumes release.

Initial Response Matrix:

1.	Alert your co-workers and clear the immediate area.	
2.	Remove ignition sources and shut down equipment.	
3.	Locate the spill kit, MSDS and appropriate Personal Protective Equipment (PPE).	
4.	Confine or contain the spill.	
5.	Attend to victims.	
6.	Clean up spill completely.	
7.	Decontaminate equipment and PPE.	
8.	Dispose of waste properly.	
9.	Submit a spill report to the Safety Office.	
10.	Notify department supervisor (of if after hours, the Senior Nurse On Call) and call the Safety Manager to report the spill. After duty hours contact the Staff Duty Officer. Include the following information: Your name, phone number, department, location, room number and floor of spill Name of the chemical spilled Estimated quantity of the spill (gallons, pounds, millicurie, etc.)	
11.	Isolate the spill area by closing windows and doors. Move to a safe area.	

NOTE: The Safety Officer or the Staff Duty Officer will contact the Environmental Safety Officer and Chief, Preventive Medicine Service, who will evaluate the spill and supervise the cleanup.

Follow-up/Cleanup Responsibilities Matrix:

1.	Major spills (those determined to be considered a significant safety threat, as determined by the Environmental Safety Officer, Preventive Medicine, and the Safety Officer) will be cleaned by specially trained staff under supervision or by designated spill response personnel.	
2.	Spill wastes will be managed as potential hazardous wastes and will be turned in to the Environmental Protection Specialist for proper disposal.	
3.	Mercury spills: Cleanup of mercury spills will be completed by mercury spill cleanup and notification procedures. Department staff using mercury spill cleanup kits will clean spills equivalent to the amount of mercury in one thermometer or less. Spills equivalent to 2 thermometers or larger will be cleaned up by staff after Environmental Health/Industrial Hygiene has evaluated the	

	spill and can monitor exposure during cleanup	
--	---	--

HAZMAT Spill/Release Contacts		
Preventive Medicine		
Environmental Health		
Senior Nurse On Call		
Safety		
Command Group		

HAZARDOUS MATERIALS SPILL/RELEASE SUPPORT PLAN

Purpose: To identify unsafe exposure conditions, safely evacuate an area, and protect others from exposure, within the facility or on its grounds, due to a hazardous materials spill/release.

Supporting Information: A hazardous material spill/release is one which is likely to cause injury/illness, may result in exposure which exceeds State or Federal exposure limits, or may harm the environment.

1.	Each department is to develop a disaster specific plan that supports this plan.	
2.	Department plans should identify all hazardous materials used in the area, the location of Material Safety Data Sheets (MSDS), and Personal Protective Equipment (PPE).	
3.	An incident allowed to escalate may develop into a multiple casualty or require Evacuation.	

Initial Response upon discovering a hazardous spill/release Matrix:

1.	Safety First! When in doubt treat it as an emergency condition.	
2.	Isolate the Area. Evacuate the area and deny access to others.	
3.	Notify the Supervisor.	
4.	Confine the spill to minimize its spread, if it can be done safely.	

Secondary Response Matrix:

1.	If you are in the area of the hazardous spill: <ol style="list-style-type: none"> 1. Assist those who may have been contaminated, ONLY if your exposure is unlikely. Refer to Material Safety Data Sheets (MSDS). 2. Secure the area and expand the safety zone, as necessary, to prevent unauthorized exposure to hazardous conditions. 3. Assist emergency responders, as directed. Prepare to evacuate the area, notify all others at risk, taking records, as safety permits. Prepare to move to your designated area of refuge, as directed. 	

2.	If you are outside the hazardous spill area: 1. Clear hallways to permit safe passage of any emergency responders. Be prepared to support area in alarm, if required to do so. Be prepared to respond to changing work hours and duty assignments as directed	
----	---	--

NOTE: Incidental spills/releases are minor spills that will clearly not constitute exposure or cause environmental problems. These spills may be contained at the unit level by staff with the appropriate decontamination materials and personal protective equipment (PPE). If there is any doubt contact Preventive Medicine at 5066 or Safety Officer at 6012.

<p>REGULATED MEDICAL WASTE Incident Execution Matrix</p>

Purpose: To describe those actions that must be taken in the event of exposure to regulated medical waste (body fluids, blood or contaminated waste).

Response Matrix:

1.	Wash exposed area immediately. Use mild, nonirritating soap for skin. Rinse mucous membrane with water or saline solution.	
2.	Change soiled clothing.	
3.	Notify supervisor immediately. Supervisor will assist with reporting the accident to Occupational Health or Infection Control and getting the employee seen for evaluation and treatment.	
4.	Employee will then report to Occupational Health Clinic during normal duty hours and the ED after normal duty hours for evaluation and treatment. This evaluation should take place as soon as possible after the exposure incident, preferably within the first one to two hours after the injury.	
5.	Contact Infection Control or the Environmental Safety Officer (ESO) for questions regarding waste segregation and disposal. NOTE: Notify Preventive Medicine or Infection Control for all reportable infections (communicable diseases of public health importance).	

Follow-up:

	Report to Occupational Health Clinic during normal duty hours for completion of follow-up.	
--	--	--

Infection Control Contacts		
Occupational Health/Industrial Health		
Infection Control		
Preventive Medicine		
Environmental Health Officer (EHO)		

INFECTION CONTROL SUPPORT PLAN:

Supporting Information:

The hospital environment lends itself for exposure to a myriad of airborne pathogens, blood and body fluid contact, communicable diseases as well as other infection risks.

Some areas within the hospital pose a higher risk for exposure to such agents. It is the responsibility of everyone in the hospital to protect themselves properly.

Infection Control, Preventive Medicine, Occupational Health, and Industrial Hygiene are specialized services within the hospital that exist to assist the staff in ensuring the proper protective measures are followed in preventing and treating exposure to these infectious agents. During Newcomers and Birth month training, staff members are briefed on the basics of potential hazards and the importance of personal protective measures. These offices are open during normal duty hours for more information.

INFECTION CONTROL SUPPORT PLAN RESPONSIBILITIES:

Infection Control/Occupational Health.

1. Record and monitor all personnel that have been exposed to blood, body fluid, airborne pathogens, and communicable diseases.
2. Coordinate fit testing of the N95 particulate respirators for staff members as needed.
3. Provide new staff members and remind current staff members of potential hazards and personal protective measures during Newcomers and Annual training.

ARMED/UNARMED ASSAILANT, COMBATIVE PATIENT, OTHER HOSTILE Incident Execution Matrix
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Purpose: To describe those actions that must be taken in the event a hostage incident occurs.

UNARMED ASSAILANT

Description: An unarmed assailant assaults staff member(s) verbally or physically.

Initial Response Matrix:

1.	Keep your distance from the assailant.	
2.	Protect/defend self.	
3.	Dial 911 first then if time permits Security or the Staff Duty Officer, ask for assistance and give your location and important details.	

Secondary Response Matrix:

1.	Attempt to verbally deescalate the assailant.	
2.	Put distance/barrier between self and assailant, or return force, as necessary, for personal safety.	
3.	Only get involved when your own life or others are at risk and involvement is a logical, relatively safe option considering other options/choices being made.	

Follow-up Matrix:

	Provide aide to injured persons, if possible. Remain observant. Complete Incident Report.	
--	--	--

ARMED ASSAILANT

Description: An armed assailant displaying a weapon in a threatening manner confronts staff member(s).

Initial Response Matrix:

1.	STAY CALM! Warn others to stay clear.	
2.	Seek cover and protection.	
3.	Dial 911, ask for assistance and give your location and important details.	

Secondary Response Matrix:

1.	Dial Military Police at 911.	
2.	Only get involved when your own life or others are at risk and involvement is a logical, relatively safe option considering other options/choices being made.	

Follow-up Matrix:

	Provide aide to injured persons, if possible. Remain observant. Complete Incident Report.	
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COMBATIVE PATIENTS

Patients that are physically out of control and may cause harm to themselves, other patients, and staff. Action must be taken to medically restraining patients. Medical personnel specially trained in restraining combative patients will need to be called. Call the staff duty desk, report the location and request the initiation of Code Strong to that area.

OTHER SECURITY INCIDENTS OR ACTIVITIES:

Description: Gang activity, suspicious behavior, breaking and entering, stealing/theft, vandalism, weapons found in the facility, drug use, public intoxication, irrational behavior, lost items, unlocked doors, etc.

Response Matrix:

1.	STAY CALM! Warn others to stay clear of areas at risk.	
2.	Protect self, bystanders, and property if needed.	
3.	Call Security/Military Police and report all suspected illegal activity.	

Follow-up:

	Provide aide to injured persons, if possible. Remain observant. Complete Incident Report.	
--	---	--

Combative Behavior/Hostage Contacts		
Emergency Response		
Safety		
Security		
Staff Duty Officer/Front Desk		
Military Police/Provost Marshal		
Dept of Behavioral Medicine		

INFANT ABDUCTION Incident Execution Matrix

Purpose: To describe those actions to be taken in the event an infant is missing or known to be abducted.

Initiating Code Baby Matrix

1.	Announce over PA System "Code Baby" and "Type."	
2.	Contact Military Police (911).	
3.	Contact Command Staff (CDR, DCN, DCA, DCCS) and Security at XXXX.	
4.	Monitor Closed Circuit Television System (as applicable) and Immediate Area.	

Code Baby Types:

INFANT = newborn to 1 year
 TODDLER = 1-3 years
 CHILD = 3 + years

Initial Staff Response Matrix:

1.	Notify the Security Manager and Nursing Supervisor immediately. Go to assigned areas including stairwells, elevators, and exterior doors/exits within your work area and watch for a person with an infant/a package that could hold an infant	
2.	STOP persons acting suspiciously or carrying infants and/or small children. Explain what's occurred and ask to verify their identity (wrist name tag) or see contents of packages/baggage.	
3.	Call Military Police if the person flees.	
4.	Do NOT chase the person, follow the person, get a detailed description of the individual and their escape vehicle and route (if possible).	
5.	Account for all infants and search the unit.	

The typical abductor profile:

- Female age 14-45; often overweight.
- Visits maternity units frequently prior to the abduction; asks detailed questions about hospital procedures.
- May be disguised as a nurse, physician, or healthcare provider.

KIDNAPPER PROFILE: The typical abductor is a female between 14 and 45 years old. She would be:

- Carrying an infant.
- Carrying a bag large enough to hold an infant.
- Covering the infant with her coat, baby blanket or,

- May be in a nurse uniform carrying an infant.

NOTE: Staff members **NEVER** hand-carry an infant except from Labor & Delivery to the Nursery. Staff members **ALWAYS** use a bassinet to transport infants.

Typical MTF Policy:

- Nursing staff members **NEVER** carry infants; they always use a bassinet to transport inpatients.
- Parents of a newborn wear an identical patient bracelet as the newborn.
- Children are **NOT** to be left alone while in the MTF. They should always be under direct supervision of a parent or guardian.
- Staff members will wear their hospital identification at all times.
- Staff members will be familiar with infant security policy.

Secondary Response Matrix:

1.	If an infant/child is abandoned, keep the infant/child in your custody, call Security, and inform your supervisor.	
2.	If you suspect someone of the infant/child abduction but are unable to become directly involved, call security and report details (description of suspicious person, vehicle, location, child, etc.).	

Follow-up Matrix:

1.	Direct all questions asked by strangers or media to the Public Affairs Officer.	
2.	Only approach persons you believe are acting suspiciously, persons with infants or person(s) specifically described by the Military Police/Security Manager.	
3.	DO NOT alarm the general public. Quiet observation may facilitate the abductor's confidence and allow detection without jeopardizing the infant/child's safety.	

Infant Abduction Contacts		
Military Police		
Safety		
Security		
Command Group		

CARDIAC ARREST (CODE BLUE) Incident Execution Matrix

Purpose: To describe actions and responsibilities in the event an individual is in cardiac or pulmonary arrest.

Initial Response Matrix:

1.	Initiate BCLS (CPR).	
2.	Announce on the overhead "(Adult/Pediatric) Code Blue, location" or notify the front desk of Code Blue.	
3.	Give location and type of patient.	
4.	Call 911 for all other outside locations and the paramedics will respond.	
5.	Perform BCLS until help arrives.	

Secondary Response Matrix:

	Provide necessary patient information to Medical Response Personnel, when requested.	
--	--	--

Follow-up Matrix:

	Assist visitors or family members of patient, if present.	
--	---	--

Code Blue Contacts		
Emergency Response (All other areas)		
Emergency Room		
Front Desk/SDO		

MESSAGE RECEIPT PROCEDURE TEMPLATE

1. **PURPOSE:** To provide standard procedure(s) for receiving and disseminating Notification and Recall information in the event of an actual emergency/disaster or exercise of the Emergency Management Plan (EMP).

2. **MESSAGE RECEIPT PROCEDURE:**

a. **DATE TIME GROUP (DTG)** of receipt of initial emergency or exercise message: _____ . (e.g., 240330Jan97 - 24 January 1997 at 0330 hours)

b. **NAME AND ORGANIZATION OF INDIVIDUAL INITIATING THE MESSAGE OR EMERGENCY NOTIFICATION:**

(e.g., LTC Kurtz, USMA DOPS, John Doe, family member)

c. **TYPE OF EMERGENCY:**

(e.g., explosion, fire, downed aircraft, vehicular accident etc.) (If the alert is an exercise, then state "exercise" on this form.)

d. **LOCATION OF EMERGENCY:**

(e.g., Central area, Bldg 624, the commissary, ACH 3d floor, etc.)

e. **NUMBER AND TYPES OF CASUALTIES (IF KNOWN):**

f. **STATUS OF SITUATION (IF KNOWN):**

(e.g., Fire department is on scene, no one else notified, bus is sinking in the river, etc.)

Figure 7-2, MEDCOM Hospital Emergency Incident Command System (HEICS) Matrix.

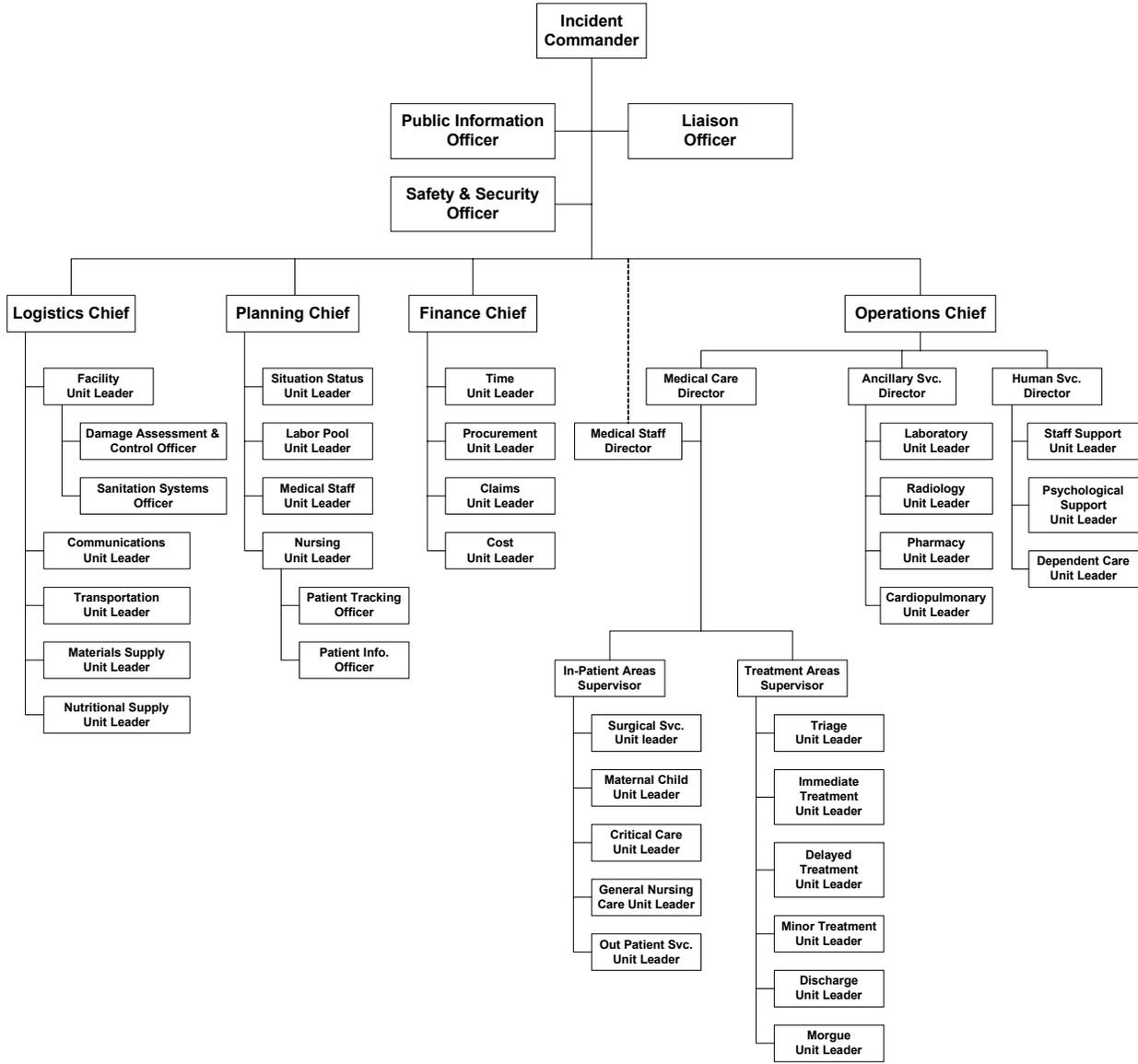
**MEDCOM
HOSPITAL EMERGENCY INCIDENT COMMAND SYSTEM (HEICS) MATRIX**

PURPOSE. The HEICS management system matrix has been included to assist the Hospital Commander in CBRNE emergencies that may be internal or external to the Medical Treatment Facility and complement the Installations Emergency Plan. The following are included:

ORGANIZATIONAL CHART. The recommended organizational chart shows the variety of positions that may be needed to address an emergency situation. There may be some positions that possibly are not needed for hours or days after the onset of the emergency. Commander's can adapt this chart to their MTF and add other positions if required.

JOB ACTION SHEETS. The Job Action Sheets, or job descriptions, found in this chapter are the essence of the HEICS program. This is the component that tells responding personnel "what they are going to do; when they are going to do it; and who they will report it to after they do it." These job descriptions are inclusive and the commander and staff will make decisions based on METT-T.

Hospital Emergency Incident Command (HEICS)
Organizational Chart



LIN	POSITION	WHEN	WHAT
1	<p>Hospital Commander/DHS</p> <p>Mission: Organize and direct Emergency Operations Center (EOC). Give overall direction for hospital operations and if needed, authorize evacuation.</p>	<p>Immediate</p>	<p>Initiate the Hospital Emergency Incident Command System IAW this pamphlet by assuming role of Incident Commander.</p> <p>Assemble Division/Key Staff Directors.</p> <p>Announce a status/action plan meeting of all section representatives to be held within 5 to 10 minutes.</p> <p>Receive initial hospital status report.</p> <ul style="list-style-type: none"> -Facility/Installation damage -Patient Census -Staff Accountability/Recall Status <p>Discuss an initial action plan with Section Chiefs. Determine appropriate level of service during immediate aftermath.</p> <p>Determine the appropriate level of service during "immediate response" if applicable.</p> <p>Receive initial facility damage survey report from Logistics Chief, if applicable, evaluate the need for evacuation.</p> <p>Emphasize proactive actions within the Planning Section. Call for a hospital-wide projection report for 4, 8, 24 & 48 hours from time of incident onset. Adjust projections as necessary.</p> <p>Authorize a patient prioritization assessment for the purposes of designating appropriate early discharge, if additional beds needed.</p> <p>Establish Liaison with Installation EOC (XXX) (XXX-XXXX).</p> <p>Establish Liaison with RMC EOC (XXX) (XXX-XXXX).</p>
		<p>Intermediate</p>	<p>Authorize resources as needed or requested by Section Chiefs.</p> <p>Designate routine briefings with Section Chiefs to receive status reports and update the action plan regarding the continuance and termination of the action plan.</p> <p>Communicate status to higher headquarters Consult with Section Chiefs on needs for</p>

			<p>staff, physician, volunteer responders, food and shelter. Consider needs for dependents.</p> <p>Authorize plan of action.</p> <p>Establish AT/FP protective posture commensurate with FPCON IAW AR 525-13.</p>
		Extended	<p>Obtain progress reports from Section Chiefs as appropriate.</p> <p>Direct calls from those who wish to volunteer to Labor/Manpower Pool.</p> <p>Contact Labor/Manpower Pool to determine requests to be made to the public via the media.</p>

LIN	POSITION	WHEN	WHAT
2	<p>Public Affairs Officer</p> <p>Mission: Provide information to the news media.</p>	Immediate	<p>Identify restrictions in contents of news.</p> <p>Release information from Incident Commander.</p> <p>Coordinate a Public Information area away from EOC and patient care.</p>
		Intermediate	<p>Coordinate with Installation PAO.</p> <p>Ensure that all news releases have the approval of the Incident Commander.</p> <p>Issue an initial incident information report to the news media with the cooperation of the Situation-Status Unit Leader. Relay any pertinent data back to Situation-Status Unit Leader.</p> <p>Inform on-site media of what they are restricted from in the hospital and they should report to the Public Information area. Coordinate with Safety Officer and Security Officer.</p> <p>Contact other at-scene agencies to coordinate released information, with respective PAO/PIOs. Inform Liaison Officer of action.</p>
		Extended	

LIN	POSITION	WHEN	WHAT
3	<p>Liaison Officer</p> <p>Mission: Function as</p>	Immediate	<p>Obtain briefing from Incident Commander.</p> <p>Obtain information to provide the</p>

	<p>incident contact person for representatives from other agencies.</p>		<p>inter-hospital emergency communication network, municipal EOC and/or IOC as appropriate, upon request.</p> <p>The following information should be gathered for relay:</p> <ul style="list-style-type: none"> • The number of "Immediate" and "Delayed" patients that can be received and treated immediately (Patient Care Capacity). • Any current or anticipated shortage of personnel, supplies, etc. • Current condition of hospital structure and utilities (hospital's overall status). • Number of patients to be transferred by wheelchair or stretcher to another hospital. • Any resources that are requested by other facilities (i.e., staff, equipment, supplies). <p>Establish communication with the assistance of the Communication Unit Leader with the inter-hospital emergency communication network, IOC, municipal EOC or with county EOC/County Health Officer, and/or NDMS coordinator. Relay current hospital status.</p> <p>Establish contact with liaison counterparts of each assisting and cooperating agency (i.e., RMC, HQ MEDCOM, Red Cross, Local Fire and Police, etc.). Keeping Liaison Officers updated on changes and development of hospital's response to incident.</p>
		<p>Intermediate</p>	<p>Request assistance and information as needed through the inter-hospital emergency communication network or municipal/county EOC.</p> <p>Respond to requests and complaints from incident personnel regarding inter-organization problems.</p> <p>Prepare to assist MTF/Installation Labor Pool Unit Leader (Manpower Pool OIC) with problems encountered in the volunteer</p>

			<p>credentialing process.</p> <p>Relay any special information obtained to appropriate personnel in the receiving facility (i.e., information regarding toxic decontamination or any special emergency conditions).</p>
		Extended	<p>Assist the Medical Staff Director and Labor Pool Unit Leader (Manpower Pool OIC) in soliciting physicians and other hospital personnel willing to volunteer as Disaster Service Workers outside of the hospital, when appropriate.</p> <p>Inventory any material resources that may be sent upon official request and method of transportation, if appropriate.</p> <p>Supply casualty data to authorities.</p>

LIN	POSITION	WHEN	WHAT
4	Safety Officer	Immediate	Obtain a briefing from Emergency Incident Commander.
	Mission: Monitor and have authority over the safety of rescue operations and hazardous conditions.	Intermediate	<p>Communicate with Damage Assessment and Control Officer to secure and post non-entry signs around unsafe areas. Keep staff alert to identify and report all hazards and unsafe conditions to the Damage Assessment and Control Officer.</p> <p>Secure areas evacuated to and from, to limit unauthorized personnel access.</p> <p>Initiate contact with fire, police agencies through the Liaison Officer, when necessary.</p> <p>Advise the Incident Commander and Section Chiefs immediately of any unsafe, hazards Establish routine briefings with Incident Commander.</p> <p>Inform staff to document all actions and observations.</p> <p>Establish routine briefings with staff.</p> <p>Observe all staff, volunteers and patients for signs of stress and inappropriate behavior. Report concerns to Psychological Support Unit Leader. Provide for staff rest periods and relief.</p>
		Extended	

LIN	POSITION	WHEN	WHAT
5	<p>Security Officer</p> <p>Mission: Monitor and have authority over the security of rescue operations and the hospital area.</p> <p>Organize and enforce scene/facility protection and traffic security.</p>	Immediate	<p>Obtain a briefing from Liaison Officer</p> <p>Implement the facility's disaster plan emergency lockdown policy and personnel identification policy.</p> <p>Have unauthorized persons removed from restricted areas.</p> <p>Establish ambulance entry and exit routes in cooperation with Transportation Unit Leader.</p> <p>Secure the EOC, triage, patient care, morgue, and other sensitive or strategic areas from unauthorized access.</p> <p>Arrange for and coordinate MP support from Military Police.</p> <p>Notify EOC if Bomb dogs and EOD are needed.</p> <p>Ensure that MPs assigned to traffic control points are briefed and understand the procedures to assist the press.</p> <p>Provide for safe removal, storage, and accountability of any weapons/ammunition, which may be received with patients.</p> <p>Be prepared to secure the MTF in a CBRNE incident.</p>
		Intermediate	<p>Communicate with Damage Assessment and Control Officer to secure and post non-entry signs around unsafe areas. Keep staff alert to identify and report all hazards and unsafe conditions to the Damage Assessment and Control Officer.</p> <p>Secure areas evacuated to and from, to limit unauthorized personnel access.</p> <p>Effect liaison with the CDR and Military Police.</p> <p>Initiate contact with fire, police agencies through the Liaison Officer, when necessary.</p> <p>Advise the Incident Commander and Section Chiefs immediately of any unsafe, hazardous, or security related conditions.</p>

			<p>Prepare to manage large numbers of potential volunteers.</p> <p>Confer with Public Information Officer to keep out and direct media personnel.</p> <p>Ensure all pedestrian traffic is cleared from the helicopter landing area.</p> <p>Establish routine briefings with Incident Commander.</p> <p>Provide traffic control plan.</p> <p>Provide vehicular and pedestrian traffic control.</p> <p>Inform staff to document all actions and observations.</p> <p>Establish routine briefings with PTMS staff.</p> <p>Observe all staff, volunteers, and patients for signs of stress and inappropriate behavior.</p> <p>Report concerns to Psychological Support Unit Leader.</p> <p>Provide for staff rest periods and relief.</p>
		Extended	

LIN	POSITION	WHEN	WHAT
6	<p>Logistics Officer</p> <p>Mission: Organize and direct those operations associated with maintenance of the physical environment, and adequate levels of food, shelter, and supplies to support the medical objectives.</p>	Immediate	<p>Obtain briefing from Emergency Incident Commander.</p> <p>Brief unit leader on current situation; outline action plan and designate time for next briefing.</p> <p>Establish Logistics Division Center for collecting and reporting information to the EOC.</p> <p>Attend damage assessment meeting with IC, Facility Unit Leader, and Damage Assessment and Control Officer.</p>
		Intermediate	<p>Obtain information and updates regularly from unit leaders and officers; maintain current status of all areas; pass status info to Situation-Status Unit Leader.</p>

			<p>Communicate frequently with Emergency Incident Commander.</p> <p>Obtain needed supplies with assistance of the Finance Section Chief and Liaison Officer.</p> <p>Prepare for the possibility of evacuation and/or the relocation of medical services outside of existing structure, if appropriate.</p> <p>Receive continually updated reports from the Facilities Unit Leader.</p>
		Extended	<p>Document actions and decisions on a continual basis. Obtain assistance of a documentation aide, if necessary.</p>

LIN	POSITION	WHEN	WHAT
7	<p>Facilities Leader</p> <p>Mission: Maintain the integrity of the physical facility to the best level. Provide adequate environmental controls to perform the medical mission.</p>	Immediate	<p>Activate Facility Emergency Management Preparedness Plan.</p> <p>Meet with Logistics Section Chief to receive briefing and develop action plan; deliver preliminary report on the physical status of the facility if available.</p> <p>Receive a comprehensive facility status report as soon as possible from Damage Assessment and Control Officer.</p> <p>Facilitate and participate in damage assessment meeting between Incident Commander, Logistics Chief, and Damage Assessment and Control Officer.</p>
		Intermediate	<p>Prepare for the possibility of evacuation and/or the relocation of medical services outside of existing structure, if appropriate.</p> <p>Receive continually updated reports from the Damage Assessment and Control Officer, and Sanitation Systems Officer.</p>
		Extended	<p>Forward requests of outside service providers/resources to the Materials Supply Unit Leader (Chief, Acquisition & Distribution) after clearing through the Logistics Section Chief.</p> <p>Document actions and decisions on a continual basis. Obtain the assistance of a documentation aide, if necessary.</p>

			Observe all staff, volunteers, and patients for signs of stress and inappropriate behavior. Report concerns to Psychological Support Unit Leader. Provide for staff rest periods and relief.
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LIN	POSITION	WHEN	WHAT
8	<p>Damage Assessment and Control Leader</p> <p>Mission: Provide sufficient information regarding the operational status of the facility for the purpose of decision/policy making, including those regarding full or partial evacuation. Identify safe areas where patients and staff can be moved if needed. Manage fire suppression, search and rescue and damage mitigation activities.</p>	Immediate	<p>Obtain briefing from Facility Unit Leader.</p> <p>Assign teams to check system components of entire facility, and report back within 15 minutes.</p> <p>Identify hazards (e.g., fire) and assign staff to control and eliminate.</p> <p>Receive initial assessment/damage reports and immediately relay information in a briefing to Incident Commander, Logistics Chief, and Facility Unit Leader; follow-up with written documentation.</p> <p>Notify Safety Officer of unsafe areas and other security problems.</p> <p>Notify Labor Pool (Manpower Pool) of staffing needs.</p> <p>Identify areas where immediate repair efforts should be directed to restore critical services.</p>
		Intermediate	<p>Arrange to have structural engineer under contract report and obtain more definitive assessment if indicated.</p> <p>Inspect those areas of reported damage and record photographically.</p> <p>Identify areas where immediate salvage efforts should be directed in order to save critical services and equipment.</p>
		Extended	<p>Assign staff to repair operations.</p> <p>Brief Facility Unit Leader routinely to provide current damage/recovery status.</p> <p>Provide for staff rest periods and relief.</p> <p>Assign staff to salvage operations as necessary.</p>

LIN	POSITION	WHEN	WHAT
9	<p>Sanitation Systems Leader</p> <p>Mission: Evaluate and monitor sewage and sanitation systems. Enact preestablished alternate methods of waste disposal if necessary.</p>	Immediate	<p>Obtain briefing from Facility Unit Leader.</p> <p>Inspect the hazardous waste collection areas(s) to ensure tolerance of containment measures. Cordon off unsafe areas with assistance of the Safety Officer.</p> <p>Control observed hazards, leaks, or contamination with the assistance of the Safety Officer and the Damage Assessment and Control Officer.</p> <p>Report all findings and actions to the Facility Unit Leader. Document all observations and actions.</p>
		Intermediate	<p>Implement preestablished alternative waste disposal/collection plan, if necessary.</p> <p>Assure that all sections and areas of the hospital are informed of the implementation of the alternative waste disposal/collection plan.</p> <p>If necessary, position portable toilets in accessible areas away from patient care and food preparation.</p> <p>Ensure an adequate number of hand-washing areas are operational near patient care/food preparation areas, and adjacent to portable toilet facilities.</p> <p>Inform Infection Control personnel of actions and enlist assistance where necessary.</p>
		Extended	<p>Monitor levels of all supplies, equipment, and needs relevant to all sanitation operations</p> <p>Brief Facility Unit Leader routinely on current condition of all sanitation operations; communicate needs in advance.</p> <p>Obtain support staff as necessary from Labor Pool (Manpower Pool).</p> <p>Provide for staff rest periods and relief.</p>

LIN	POSITION	WHEN	WHAT
10	Procurement Unit Leader Mission: Responsible for administering accounts receivable and payable to contract and non-contract vendors.	Immediate	Obtain briefing from Finance Section Chief; assist in the development of the section action plan. Ensure the separate accounting of all contracts specifically related to the emergency incident; and all purchases within the enactment of the emergency management plan. Establish a line of communication with the Material Supply Unit Leader (Chief, Acquisition & Distribution). Obtain authorization to initiate purchases from the Finance Chief or authorized representative.
		Intermediate	Forward a summary accounting of purchases to the Cost Unit Leader on a routine basis.
		Extended	Prepare a Procurement Summary Report identifying all contracts initiated during the declared emergency incident. Provide for staff rest periods and relief.

LIN	POSITION	WHEN	WHAT
11	Transportation Unit Leader Mission: Organize and coordinate the transportation of all casualties, ambulatory, and nonambulatory. Arrange for the transportation of human and material resources to and from the facility.	Immediate	Receive briefing from Logistics Section Chief. Assess transportation requirements and needs for patients, personnel, and materials; request patient transporters from Labor Pool to assist in the gathering of patient transport equipment. Establish ambulance off-loading area in cooperation with the Triage Unit Leader. Assemble gurneys, litters, wheelchairs, and stretchers in proximity to ambulance off-loading area and Triage Area.
		Intermediate	Contact Security Officer on security needs of loading areas. Provide for the transportation/shipment of resources into and out of the facility. Secure ambulance or other transport for discharged patients. Identify transportation needs for ambulatory casualties.

		Extended	<p>Maintain transportation assignment record in Triage Area, Discharge Area, and Material Supply Pool (Chief, Acquisition & Distribution).</p> <p>Keep Logistics Section Chief apprised of status.</p> <p>Direct unassigned personnel to Labor Pool.</p> <p>Provide for staff rest periods and relief.</p>
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LIN	POSITION	WHEN	WHAT
12	<p>Materials Supply Leader</p> <p>Mission: Organize and supply medical and nonmedical care equipment and supplies.</p>	Immediate	<p>Establish and communicate the operational status of the Materials Supply Pool to the Logistics Section Chief, EOC, and Procurement Unit Leader.</p> <p>Dispatch predesignated supplies to Triage Area, Immediate Treatment Area, Delayed Treatment Area, Expectant Treatment Area, and the Minor Treatment Area, once these areas have been established. Enlist the assistance of the Transportation Unit Leader.</p> <p>Release Search and Rescue Team equipment packs to those teams designated by the Damage Assessment and Control Officer.</p> <p>Collect and coordinate essential medical equipment and supplies. (Prepare to assist with equipment salvage & recovery efforts.)</p> <p>Develop medical equipment inventory to include, but not limited to the following:</p> <ul style="list-style-type: none"> • Bandages, dressings, compresses. and suture material • Sterile scrub brushes, normal saline, anti-microbial skin cleanser • Waterless hand-cleaner and gloves • Fracture immobilization, splinting and casting materials • Backboard, rigid stretchers • Nonrigid transporting devices (litters)

			<ul style="list-style-type: none"> • Oxygen-ventilation-suction devices • Advance life support equipment (chest tube, airway, major suture trays)
		Intermediate	
		Extended	<p>Identify additional equipment and supply needs. Make requests/needs known through Logistics Section Chief. Gain the assistance of the Procurement Unit Leader when indicated.</p> <p>Determine the anticipated pharmaceuticals needed with the assistance of the Medical Care Director and Pharmacy Unit Leader to obtain/request items.</p> <p>Coordinate with Security Officer to protect resources.</p>

LIN	POSITION	WHEN	WHAT
13	<p>Nutritional Supply Unit Leader</p> <p>Mission: Organize food and water stores for preparation and rationing during periods of anticipated or actual shortage.</p>	Immediate	<p>Receive briefing from Logistics Section Chief.</p> <p>Meet with and brief Nutritional Services personnel.</p> <p>Estimate the number of meals that can be served utilizing existing food stores; implement rationing if situation dictates.</p> <p>Inventory the current emergency drinking water supply and estimate time when re-supply will be necessary. Implement rationing if situation dictates.</p> <p>Procure rations for immediate support.</p> <p>Coordinate with EOC for field mess equipment if necessary.</p> <p>Determine if rations can be obtained from vendor.</p> <p>Determine what utilities can be utilized in food preparation.</p> <p>Estimate disposable tableware available for use.</p> <p>Determine water allocations if main facility source becomes unusable.</p>

			Report inventory levels of emergency drinking water and food stores to Logistics Section Chief.
		Intermediate	<p>Meet with Labor Pool Unit Leader (Manpower Pool OIC) and Staff Support Unit Leader (Department of Behavioral Medicine) to discuss location of personnel refreshment and nutritional break areas.</p> <p>Prepare and deliver hot and cold beverages to areas of the hospital as requested. Triage and treatment areas.</p> <p>Secure nutritional and water inventories with the assistance of the Safety & Security Officer.</p> <p>Submit an anticipated needs list of water and food to the Logistics Section Chief.</p> <p>Request should be based on current information concerning emergency events as well as projected needs for patients, staff, and dependents.</p>
		Extended	<p>Meet with Logistics Section Chief regularly to keep informed of current status.</p> <p>Provide for staff rest period and relief.</p>

LIN	POSITION	WHEN	WHAT
14	<p>Planning/Operations Leader</p> <p>Mission: Organize and direct all aspects of the Emergency Operations Center. Ensure the Distribution of critical information and data. Compile scenario/resource projections from all section chiefs and effect long range planning. Document and distribute facility Action Plan.</p>	Immediate	<p>Determine location and level of activation necessary for Emergency Operations Center.</p> <p>Brief Planning section personnel on situation and expectations.</p> <p>Utilize all available means of communications, including public address system or runners if necessary, to inform the hospital staff of the level of response.</p> <p>Direct all administrative activities in support of the disaster/emergency to include authorization for overtime pay or the call up of civilian employees not on duty at the time of the disaster.</p> <p>Supervise situation briefings and direct Emergency Operations Center operations.</p>
		Intermediate	

		Extended	
LIN	POSITION	WHEN	WHAT
15	<p>Situation Status Leader</p> <p>Mission: Assist in establishing EOC as directed. Maintain current information regarding the incident status for all hospital staff. Ensure a written record of the hospital's emergency planning and response. Assist in developing the hospital's internal information network</p>	Immediate	<p>Obtain briefing from Planning Section Chief</p> <p>Obtain status reports on:</p> <ul style="list-style-type: none"> • Communications Systems • Facility Status • Patient bed status • Personnel status • Surgical capabilities • Logistical capabilities <p>Establish status/condition boards in the Emergency Operations Center. Keep boards current.</p> <p>Assign recorder to document decisions, actions, and attendance in EOC.</p> <p>Provide a current copy of the Medical Facilities personnel security clearance roster to control access to the Operations Center.</p>
	<p>Monitor the maintenance and preservation of the computer system.</p>	Intermediate	<p>Coordinate with Labor Pool (Manpower Pool).</p> <p>Conduct situational briefings.</p> <p>Consolidate input for Hospital elements and prepare and submit reports as required.</p>
		Extended	

LIN	POSITION	WHEN	WHAT
16	<p>Communications Unit Leader</p> <p>Mission: Organize and coordinate internal and external communications; act as custodian of all logged/documented communications.</p>	Immediate	<p>Obtain briefing from Emergency Incident Commander or Logistics Section Chief.</p> <p>Coordinate with Situation Status Unit Leader for establishment of EOC Communications.</p> <p>Coordinate with Logistics Section Chief to ensure the issue of pagers to additional personnel as directed.</p> <p>Establish a Communications Center in close proximity to EOC.</p>

			<p>Request the response of assigned amateur radio personnel assigned to facility.</p> <p>Assess current status of internal and external telephone system and report to Logistics Section Chiefs and Damage Assessment and Control Officer.</p> <p>Establish a pool of runners and assure distribution of 2-way radios to predesignated areas.</p> <p>Use preestablished message forms to document all communication. Instruct all assistants to do the same.</p> <p>Establish contact with Liaison Officer.</p> <p>Receive and hold all documentation related to internal facility communications.</p> <p>Monitor and document all communications sent and received via the inter-hospital emergency communication network or other external communication.</p>
		Intermediate	<p>Ensure pager alert system, Composite Health Care System (CHCS) messaging system and all other means of communication are employed to distribute information as widely as possible.</p>
		Extended	<p>Provide for staff rest periods and relief.</p>

LIN	POSITION	WHEN	WHAT
17	<p>Labor Pool Unit Leader</p> <p>Mission: Collect and inventory available staff and volunteers at a central point. Receive requests and assign available staff as needed. Maintain adequate numbers of both medical and nonmedical personnel. Assist in the maintenance of staff morale.</p>	Immediate	<p>Obtain briefing from the Planning Section Chief.</p> <p>Receive accountability reports from all departments, utilizing personnel non-essential to patient care to establish a manpower pool.</p> <p>Establish and control the Labor Pool (Manpower Pool) in the Radiology Waiting Room.</p> <p>Assign Field managers to assist with proper utilization of personnel.</p> <p>Coordinate with the Red Cross station manager on personnel requirements that may be filled by volunteers.</p> <p>Provide Personnel status report numbers to</p>

			<p>EOC and update every 4 hours. Provide instruction for litter bearers.</p> <p>Meet with Medical Care Director and Clinical Operations Chief/Ancillary Services Director to coordinate long-term staffing needs.</p> <p>Brief Planning Section Chief as frequently as necessary on the status of labor pool (manpower pool) numbers and composition.</p> <p>Assist the Situation-Status Unit Leader in publishing an informational sheet to be distributed at frequent intervals to update the hospital population.</p> <p>Maintain a message center in Labor Pool area with the cooperation of Staff Support Unit Leader and Situation-Status Information Systems Unit Leader.</p> <p>Develop staff rest and nutritional area in coordination with Staff Support Unit Leader and Nutritional Supply Unit Leader.</p> <p>Document actions and decisions on a continual basis.</p>
		Intermediate	
		Extended	

LIN	POSITION	WHEN	WHAT
18	Chief, PAD	Immediate	<p>Report personnel status to EOC.</p> <p>Provide patient census to EOC as required.</p> <p>Update patient status board in EOC.</p> <p>Ensure 100% patient accountability throughout the disaster period.</p>
	<p>Mission: To record and collect all patient accounting information and maintain status boards in the EOC. Control and provide guidance to the Patient Affairs Officer, Patient Information</p>	Intermediate	

	Officer, and Patient Tracking Officer. Provide PAD related guidance to the Hospital Commander and EOC staff.		
		Extended	

LIN	POSITION	WHEN	WHAT
19	<p>Patient Tracking Leader</p> <p>Mission: Maintain the location of patients at all times within the hospital's patient care system.</p>	Immediate	<p>Account for personnel that have signed in and report to EOC.</p> <p>Position PAD personnel in patient receiving and treatment area, i.e., triage, immediate, delayed, expected, and minimal areas and evacuation points.</p> <p>Keep C, PAD or designated representatives informed in EOC and send patient status reports as required.</p> <p>Manage the staff of the admission control center in the ER who account for and admit patients in CHCS.</p> <p>Maintain patient status board in admission control center.</p> <p>Coordinate release of patient information with PAO.</p> <p>Collect and maintain patient log sheets from admission clerks.</p> <p>Secure patient valuables at patient control office.</p> <p>During transfer of inpatients to other hospitals coordinate process and timing of discharges with Department of Nursing (DON).</p> <p>Schedule air evacuation of patients.</p> <p>Provide for staff rest periods and relief.</p>
		Intermediate	
		Extended	

LIN	POSITION	WHEN	WHAT
20	Patient	Immediate	Meet with NCOIC, Patient Accountability

	<p>Information Leader</p> <p>Mission: Provide information to visitors and families regarding status and location of patients. Collect information necessary to complete the Disaster Welfare Inquiry process in cooperation with the American Red Cross.</p>		<p>Branch to exchange patient related information and establish regularly scheduled meetings.</p> <p>Direct patient related news releases through the PAO.</p> <p>Receive and screen requests (by phone and in person) about the status of individual patients. Obtain appropriate information and relay to the PAO. Work with American Red Cross, Social Work Service, Chaplain's Office, and other representatives in disseminating information.</p> <p>Provide for staff rest periods and relief.</p>
		Intermediate	
		Extended	

LIN	POSITION	WHEN	WHAT
21	<p>Finance Section Chief</p> <p>Mission: Monitor the utilization of financial assets. Oversee the acquisition of supplies and services necessary to carry out the hospital's medical mission. Supervise the documentation of expenditures relevant to the emergency incident.</p>	Immediate	<p>Obtain briefing from Incident Commander.</p> <p>Appoint Time Unit Leader, Procurement Unit Leader, Claims Unit Leader and Cost Unit Leader; distribute the corresponding Job Action Sheets and vests. (May be preestablished.)</p> <p>Confer with Unit Leaders after meeting with Emergency Incident Commander; develop a section action plan.</p> <p>Establish a Financial Operations Center. Ensure adequate documentation/recording personnel.</p>
		Intermediate	<p>Approve a "cost-to-date" incident financial status report submitted by the Cost Unit Leader every 8 hours summarizing financial data relative to personnel, supplies, and miscellaneous expenses.</p> <p>Obtain briefings and updates from EOC as appropriate. Relate pertinent financial status reports to appropriate chiefs and unit leaders.</p> <p>Schedule planning meetings to include Finance Section and unit leaders to discuss</p>

			updating the section's incident action plan and termination procedures.
		Extended	Ensure that all requests for personnel or supplies are copied to the Communications Unit Leader in a timely manner. Provide for staff rest periods and relief.

LIN	POSITION	WHEN	WHAT
22	Time Unit Leader Mission: Responsible for the documentation of personnel time records. The monitoring and reporting of regular and overtime hours worked/ volunteered.	Immediate	Obtain briefing from Finance Section Chief; assist in the development of the section action plan. Ensure the documentation of personnel hours worked and volunteer hours worked in all areas relevant to the hospital's emergency incident response. Confirm the utilization of the Emergency Incident Time Sheet by all section chiefs and/or unit leaders. Coordinate with Labor Pool Unit Leader (Manpower Pool OIC).
		Intermediate	Collect all Emergency Incident Time Sheets from each work area for recording and tabulation every eight hours or as specified by the Finance Section Chief. Forward tabulated Emergency Incident Time Sheets to Cost Unit Leader every eight hours.
		Extended	Prepare a total of personnel hours worked during the declared emergency incident. Provide for staff rest periods and relief.

LIN	POSITION	WHEN	WHAT
23	Claims Unit Leader Mission: Responsible for receiving, investigating, and documenting all claims reported to the hospital during the emergency incident which are alleged to be the result of an accident or action on hospital property.	Immediate	Obtain briefing from Finance Section Chief; assist in the development of section action plan. Receive and document alleged claims issued by employees and nonemployees. Use photographs or video documentation when appropriate. Obtain statements as quickly as possible from all claimants and witnesses. Enlist the assistance of security where necessary.
		Intermediate	Inform Finance Section Chief of all alleged

			claims as they are reported. Document claims on hospital risk/loss forms.
		Extended	Report any cost incurred as a result of a claim to the Cost Unit Leader as soon as possible. Prepare a summary of all claims reported during the declared emergency incident. Provide for staff rest periods and relief.

LIN	POSITION	WHEN	WHAT
24	Cost Unit Leader	Immediate	Obtain briefing from Finance Chief; assist in development of section action plan. Meet with Time Unit Leader, Procurement Unit Leader, and Claims Unit Leader to establish schedule for routine reporting periods.
	Mission: Responsible for providing cost analysis data for declared emergency incident. Maintenance of accurate records of incident cost.	Intermediate	Prepare a "cost-to-date" report form for submission to Finance Chief once every 8 hours. Inform all section chiefs of pertinent cost data at the direction of the Finance Section Chief or Incident Commander.
		Extended	Prepare a summary of all costs incurred during the declared emergency incident.

LIN	POSITION	WHEN	WHAT
25	Clinical Operations/ Ancillary Services Mission: Organize and direct aspects relating to Clinical Operations. Carry out directives of the Incident Commander. Coordinate and supervise the Medical Services Subsection, Ancillary Services	Immediate	Obtain briefing from Emergency Incident Commander. Appoint Medical Staff Director, Medical Care Director, Ancillary Services Director, and Human Services Director and transfer the corresponding Job Action Sheets. (May be preestablished.) Brief all Clinical Operations Section directors on current situation and develop the section's initial action plan. Designate time for next briefing. Meet with the Medical Care Director, to plan and project patient care needs.

	Subsection, and Human Services Subsection of the Clinical Operations Section.		Appoint Unit Leaders for Laboratory Services; Radiology; Pharmacy, and Morgue.
		Intermediate	<p>Designate times for briefings and updates with all Operations Section directors to develop/update section's action plan.</p> <p>Ensure that the Medical Services Subsection, Ancillary Services Subsection, and Human Services Subsection are adequately staffed and supplied.</p> <p>Brief the Incident Commander routinely on the status of the Operations Section. Ensure the proper supplies are being ordered and received for the Ancillary Services.</p> <p>Receive status reports from Ancillary Services leaders routinely.</p>
		Extended	Provide for staff rest periods and relief.

LIN	POSITION	WHEN	WHAT
26	<p>Medical Care Director</p> <p>Mission: Organize and direct the overall delivery of medical nursing care in all areas of the hospital. Collect available nurses and other medical staff at a central point. Carry out directives of the Incident Commander and coordinate efforts with Clinical Operations Chief. Assist in the assignment of available medical staff, as needed.</p>	Immediate	<p>Meet with Clinical Operations Chief and Planning Chief for briefing and development of an initial action plan. Establish time for follow-up meetings.</p> <p>Appoint the Inpatient Area Supervisor and the Medical Staff Director and transfer the corresponding Job Action Sheets.</p> <p>Provide current inpatient census and a prioritization assessment (triage) of all in-house patients to the Incident Commander and EOC.</p> <p>Meet with Clinical Operations Chief, Medical Staff Director, and Incident Commander to assess and project medical staff and patient care supply needs.</p> <p>Implement Emergency Patient Discharge Plan at the direction of the Incident Commander with support of the Clinical Operations Chief.</p> <p>Request Medical Staff Unit Leader to provide medical staff support to assist with patient priority assessment to</p>

			<p>designate those eligible for early discharge.</p> <p>Meet with Inpatient Areas Physician Supervisor and Treatment Areas Supervisor to discuss medical care needs and physician staffing in all patient care areas.</p> <p>Confer with the Clinical Operations Chief and Medical Staff Director to make medical staff and nursing staffing/material needs known.</p> <p>Establish 2-way communication (radio or runner) with Inpatient Areas Supervisor and Treatment Areas Supervisor.</p>
		Intermediate	<p>Meet regularly with Medical Staff Director, Inpatient Areas Supervisor, and Nursing Areas supervisors to assess current and project future patient care conditions.</p> <p>Brief Incident Commander and coordinate with Clinical Operations Chief routinely on the status/quality of medical care.</p>
		Extended	<p>Provide for staff rest periods and relief.</p>

LIN	POSITION	WHEN	WHAT
27	<p>Inpatient Leader</p> <p>Mission: To assure appropriate medical treatment of inpatients. Provide for a controlled patient discharge, as needed, to support the emergency situation. Carry out directives of the Medical Care Director.</p>	Immediate	<p>Request a Documentation Recorder/Aide, for each subsection.</p> <p>Direct subsection personnel to report to their assigned areas to begin patient priority assessment and triage.</p> <p>Assist in the establishment of inpatient care areas in new locations, if necessary.</p> <p>Assess problems and treatment needs in each area; request staffing needs through Medical Care Director. Coordinate supply needs through Inpatient Areas Officer.</p> <p>Obtain adequate number of patient transportation resources from Transportation Officer, through Medical Care Director.</p> <p>Contact Security Officer for any security needs. (Advise Medical Care Director of any actions/requests.)</p> <p>Meet with Medical Care Director to discuss medical care plan of action and staffing in all inpatient areas.</p>

		Intermediate	<p>Report frequently and routinely to Medical Care Director on situation status. Enlist the assistance of the Medical Staff Director, in documenting all medical staff assignments and facilitating rotation of medical staff.</p> <p>Enlist the assistance of the Inpatient Areas Nursing Supervisor to assess environmental services (housekeeping) needs in all inpatient areas.</p>
		Extended	<p>Direct nonmission essential medical personnel to Labor Pool (Manpower Pool). Document all action/decisions. Send copy of status reports to Medical Care Director.</p> <p>Provide for staff rest periods and relief.</p>

LIN	POSITION	WHEN	WHAT
28	<p>Outpatient Service Leader</p> <p>Mission: Prepare any outpatient service areas to meet the needs of in-house and new patients.</p>	Immediate	<p>Receive briefing from Inpatient Areas Supervisor with other Inpatient Area unit leaders.</p> <p>Assess current capabilities. Project immediate and prolonged capacities to provide medical services based on current data.</p> <p>Begin outpatient priority assessment; designate those eligible for immediate discharge; admit those patients unable to be discharged. Remind all staff that all patient discharges are routed through the Discharge Unit.</p> <p>Develop action plan in cooperation with other Inpatient Area unit leaders and the Inpatient Areas Supervisor.</p> <p>Request needed resources from the Inpatient Areas Supervisor.</p> <p>Assign patient care teams in configurations to meet the specific mission of the Out-Patient areas; obtain additional personnel as necessary from Labor Pool (Manpower Pool).</p>
		Intermediate	<p>Contact Security Officer of security and traffic flow needs. Inform Inpatient Areas Supervisor of action.</p> <p>Report equipment/material needs to Materials Supply Unit Leader (Chief,</p>

			Acquisition & Distribution). Inform Inpatient Areas Supervisor of action.
		Extended	<p>Ensure that all area and individual documentation is current and accurate. Request documentation/clerical personnel from Labor Pool (Manpower Pool) if necessary.</p> <p>Keep Inpatient Areas Supervisor apprised of status, capabilities, and projected services.</p> <p>Observe and assist any medical staff member who exhibits signs of stress and fatigue. Report concerns to Inpatient Areas Supervisor. Provide for staff rest periods and relief.</p> <p>Review and approve the areas documented recordings of actions/decisions in the Surgical Services Area. Send copy to the Inpatient Areas Supervisor.</p> <p>Direct nonutilized personnel to Labor Pool (Manpower Pool).</p>

LIN	POSITION	WHEN	WHAT
29	<p>Treatment Area Leader</p> <p>Mission: Assess and coordinate initial patient care as emergency physician on duty. Assure adequate physician staffing in all patient care areas. Facilitate treatment of patients and disposition. Carry out directives of the Clinical Operations Chief/Ancillary Services Director.</p>	Immediate	<p>Liaison as soon as possible with Clinical Operations Chief (DCCS). Designate time for next meeting.</p> <p>(If you are the only available physician, you will be filling several positions until sufficient help arrives.)</p> <p>If a disaster has been declared, request private branch exchange (PBX) to activate the Physician Disaster.</p> <p>Designate teams for the Delayed, Immediate, and Expectant Treatment Areas.</p> <p>Determine number of Treatment/Resuscitation Teams needed.</p> <p>Request Physician Augmentation from the Labor Pool (Manpower Pool) to establish teams.</p> <p>Identify all patients currently in the ED who can be discharged or moved to the minor treatment area.</p>

			<p>Stabilize as many patients as possible in terms of Airway, Breathing, Circulation (ABCs).</p> <p>Establish trauma teams IAW Mass Casualty Plan.</p> <p>Designate qualified physicians to supervise and/or staff the Treatment Areas - Delayed, Immediate, Minimal, Expectant (DIME).</p> <p>Contact Security Officer for any security needs.</p> <p>Obtain adequate number of patient transportation resources from Transportation Officer.</p> <p>Request additional help from the Labor Pool.</p>
		Intermediate	<p>Report frequently and routinely to Medical Care Director on situation status.</p> <p>Enlist the assistance of the Medical Staff Unit Leader in documenting all medical staff assignments and facilitating rotation of medical staff.</p> <p>Enlist the assistance of the Inpatient Areas Nursing Supervisor to assess environmental services (housekeeping) needs in all treatment and triage areas.</p>
		Extended	<p>Direct nonutilized medical personnel to Labor Pool (Manpower Pool).</p> <p>Document all actions/decisions. Send copy of status reports to Medical Care Director.</p> <p>Provide for staff rest periods and relief.</p>

LIN	POSITION	WHEN	WHAT
30	<p>Triage Unit Leader</p> <p>Mission: Sort casualties according to priority of injuries, and assure their disposition to the proper treatment area.</p>	Immediate	<p>Receive briefing from Treatment Areas Supervisor with other Treatment Area unit leaders.</p> <p>Establish patient Triage Area.</p> <p>Ensure sufficient transport equipment and personnel for Triage Area.</p> <p>Assess problem, triage-treatment needs relative to specific incident.</p>

			<p>Assist the Inpatient Areas Supervisor with triage of internal hospital patients, if requested by Treatment Areas Supervisor.</p> <p>Develop action plan; request needed resources from Treatment Areas Supervisor.</p> <p>Assign triage teams.</p>
		Intermediate	<p>Identify location of Immediate, Delayed, Minor Treatment, Discharge and Morgue areas; coordinate with Treatment Areas Supervisor.</p> <p>Contact Security Officer of security and traffic flow needs in the Triage Area. Inform Treatment Areas Supervisor of action.</p>
		Extended	<p>Report emergency care equipment needs to Logistics. Inform Treatment Areas Supervisor of action.</p> <p>Ensure that the disaster chart and admission forms are utilized. Request documentation/clerical personnel from Labor Pool (Manpower Pool) if necessary.</p> <p>Keep Treatment Areas Supervisor apprised of status, number of injured in the Triage Area or expected to arrive there.</p> <p>Observe and assist any staff member who exhibits signs of stress and fatigue. Report concerns to Treatment Areas Supervisor. Provide for staff rest periods and relief.</p> <p>Review and approve the areas documented recordings of actions/decisions in the Triage Area. Send copy to the Treatment Areas Supervisor.</p> <p>Direct nonutilized personnel to Labor Pool (Manpower Pool).</p>

LIN	POSITION	WHEN	WHAT
31	<p>Immediate Treatment Leader</p> <p>Mission: Coordinate the care given to patients received</p>	Immediate	<p>Assign treatment teams to each patient in the immediate treatment area. A team, whenever possible, will consist of a physician, nurse, and a runner.</p> <p>Advise treatment teams of the following management guidelines and distribute their</p>

	<p>in the immediate treatment area. Assure adequate medical staffing. Facilitate the treatment and disposition of patients in the immediate treatment area. Carry out directives of the Treatment Area Unit Leader.</p>		<p>Job Action Sheets.</p> <p>Stabilize as many patients as possible in terms of ABCs. Apply the following guidelines until sufficient help arrives.</p> <p>Enlist the assistance of treatment teams; assign priority list for patients needing lab, X-ray, surgery, and specialty consultation.</p> <p>Receive all lab and X-ray reports, and distribute them to the appropriate treatment teams.</p> <p>Maintain patient status.</p> <p>Assess situation/area for supply and staffing needs; request staff and supplies from Immediate Treatment Manager, through the Treatment Area Unit Leader.</p> <p>Obtain adequate number of patient transportation resources from Transportation Officer, through Treatment Area Unit Leader.</p>
		Intermediate	<p>Report frequently and routinely to Treatment Area Unit Leader on situation status.</p> <p>Ensure rapid, appropriate disposition and flow of patients treated within the immediate treatment area.</p> <p>Contact Security Officer for any security needs. (Advise Treatment Area Unit Leader of any actions/requests.)</p>
		Extended	<p>Direct nonutilized personnel to Labor Pool.</p> <p>Document all actions/decisions. Send copy of status reports to Treatment Areas Unit Leader.</p> <p>Provide for staff rest periods and relief.</p>

LIN	POSITION	WHEN	WHAT
32	<p>Surgical Services unit Leader</p> <p>Mission: Supervise and maintain the surgical</p>	Immediate	<p>Receive briefing from Inpatient Areas Supervisor with other Inpatient Area unit leaders.</p> <p>Assess current pre-op, operating suite, and post-op capabilities. Project immediate</p>

	<p>capabilities to the best possible level in respect to current conditions in order to meet the needs of in-house and newly admitted patients.</p>		<p>and prolonged capacities to provide surgical services based on current data. Begin patient priority assessment; designate those eligible for early discharge. Remind staff that all inpatient discharges are routed through the Discharge Unit.</p> <p>Develop action plan in cooperation with other Inpatient Area unit leaders and the Inpatient Areas Supervisor.</p> <p>Request needed resources from the Inpatient Areas Supervisor.</p> <p>Assign and schedule O.R. teams as necessary; obtain additional personnel from Labor Pool.</p>
		<p>Intermediate</p>	<p>Identify location of Immediate and Delayed Treatment areas; inform patient transportation personnel.</p> <p>Contact Safety & Security Officer of security and traffic flow needs in the Surgical Services area. Inform Inpatient Areas Supervisor of action.</p> <p>Report equipment/material needs to Logistics. Inform Inpatient Areas Supervisor of action.</p>
		<p>Extended</p>	<p>Ensure that all area and individual documentation is current and accurate. Request documentation/clerical personnel from Labor Pool if necessary.</p> <p>Keep Inpatient Areas Supervisor, Immediate Treatment and Delayed Treatment Unit Leader apprised of status, capabilities, and projected services.</p> <p>Observe and assist any staff member who exhibits signs of stress and fatigue. Report concerns to Inpatient Areas Supervisor. Provide for staff rest periods and relief.</p> <p>Review and approve the areas' documented recordings of actions/decisions in the Surgical Services Area. Send copy to the Inpatient Areas Supervisor.</p> <p>Direct nonutilized personnel to Labor Pool (Manpower Pool).</p>

LIN	POSITION	WHEN	WHAT
33	<p>Maternal Child Unit Leader</p> <p>Mission. Supervise and maintain the obstetrical, labor & delivery, nursery, and pediatric services to the best possible level in respect to current conditions in order to meet the needs of in-house and newly admitted patients.</p>	Immediate	<p>Receive briefing from Chief, Clinical Nursing; Chief, Nursing Administrative; and/or Chief Nurse.</p> <p>Assess current capabilities. Project immediate and prolonged capacities to provide all obstetrical and pediatric services based on current capabilities. (Give special consideration to the possibility of an increase in normal and premature deliveries due to environmental/emotional stress.)</p> <p>Begin patient priority assessment; with the Chief, OB (or representative) and Head Nurse/Charge Nurse; designate those eligible for early discharge. Establish time for all nursing service chiefs to meet to evaluate patient status and staffing needs.</p> <p>Request needed resources from the Inpatient Areas Supervisor.</p> <p>Assign delivery and patient teams as necessary; obtain additional personnel from Labor Pool.</p>
		Intermediate	<p>Identify location of Immediate and Delayed Treatment areas; inform patient transportation personnel.</p> <p>Contact Security Officer for security and traffic flow needs.</p> <p>Report equipment/material needs to Materials Supply Unit Leader.</p> <p>Inform Inpatient Areas Supervisor of action.</p>
		Extended	<p>Ensure that all area and individual documentation is current and accurate. Request documentation/clerical personnel from Labor Pool if necessary.</p> <p>Keep Inpatient Areas Supervisor, Immediate Treatment and Delayed Treatment Unit Leader apprised of status, capabilities, and projected services.</p> <p>Observe and assist any staff member who exhibits signs of stress and fatigue. Report concerns to Inpatient Areas</p>

			<p>Supervisor. Provide for staff rest periods and relief.</p> <p>Review and approve the areas' documented recordings of actions/decisions in the Surgical Services Area. Send copy to the Inpatient Areas Supervisor.</p> <p>Direct nonutilized personnel to Labor Pool.</p>
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LIN	POSITION	WHEN	WHAT
34	<p>Critical Care Nursing Unit Leader</p> <p>Mission: Supervise and maintain the critical care capabilities to the best possible level to meet the needs of in-house and newly admitted patients.</p>	Immediate	<p>Receive briefing from Inpatient Areas Supervisor with other Inpatient Area unit leaders.</p> <p>Assess current critical care patient capabilities. Project immediate and prolonged capabilities to provide services based on known resources. Obtain medical staff support to make patient triage decisions if warranted.</p> <p>Develop action plan in cooperation with other Inpatient Area unit leaders and the Inpatient Areas Supervisor.</p> <p>Request the assistance of the Inpatient Areas Supervisor to obtain resources if necessary.</p> <p>Assign patient care teams as necessary; obtain additional personnel from Labor Pool (Manpower Pool).</p>
		Intermediate	<p>Identify location of Discharge Area; inform patient transportation personnel.</p> <p>Contact Security Officer of security and traffic flow needs in the critical care services area(s). Inform Inpatient Areas Supervisor of action.</p> <p>Report equipment/material needs to Logistics. Inform Inpatient Areas Supervisor of action.</p>
		Extended	<p>Ensure that all area and individual documentation is current and accurate. Request documentation/clerical personnel from Labor Pool if necessary.</p> <p>Keep Inpatient Areas Supervisor, Immediate Treatment Unit and Delayed Treatment Unit Leaders apprised of status, capabilities, and projected services.</p>

			<p>Observe and assist any staff member who exhibits signs of stress and fatigue. Report concerns to Inpatient Areas Supervisor. Provide for staff rest periods and relief.</p> <p>Review and approve the areas' documented recordings of actions/decisions in the Critical Care Area(s). Send copy to the Inpatient Areas Supervisor.</p> <p>Direct nonutilized personnel to Labor Pool (Manpower Pool).</p>
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LIN	POSITION	WHEN	WHAT
35	<p>General Nursing care Unit Leader</p> <p>Mission: Supervise and maintain general nursing services to the best possible level to meet the needs of in-house and newly admitted patients.</p>	Immediate	<p>Receive briefing from Inpatient Areas Supervisor with other Inpatient Area unit leaders.</p> <p>Assess current capabilities. Project immediate and prolonged capacities to provide general medical nursing services based on current data.</p> <p>Begin patient priority assessment; designate those eligible for early discharge. Remind all staff that all inpatient discharges are routed through the Discharge Unit.</p> <p>Develop action plan in cooperation with other Inpatient Area unit leaders and the Inpatient Areas Supervisor.</p> <p>Request needed resources from the Inpatient Areas Supervisor.</p> <p>Assign patient care teams as necessary; obtain additional personnel from Labor Pool (Manpower Pool).</p>
		Intermediate	<p>Identify location of Immediate and Delayed Treatment areas; inform patient transportation personnel.</p> <p>Contact Security Officer of security and traffic flow needs. Inform Inpatient Areas Supervisor of action.</p> <p>Report equipment/material needs to Logistics. Inform Inpatient Areas Supervisor of action.</p>
		Extended	<p>Ensure that all area and individual documentation is current and adhered.</p>

			<p>Request documentation/clerical personnel from Labor Pool (Manpower Pool) if necessary.</p> <p>Keep Inpatient Areas Supervisor, Immediate Treatment and Delayed Treatment Unit Leader apprised of status, capabilities, and projected services.</p> <p>Observe and assist any staff member who exhibits signs of stress and fatigue. Report concerns to Inpatient Areas Supervisor. Provide for staff rest periods and relief.</p> <p>Review and approve the areas' documented recordings of actions/decisions in the Surgical Services Area. Send copy to the Inpatient Areas Supervisor.</p> <p>Direct nonutilized personnel to Labor Pool (Manpower Pool).</p>
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LIN	POSITION	WHEN	WHAT
36	<p>Discharge Unit Leader</p> <p>Mission: Coordinate the controlled discharge, (possible observation and discharge) of patients received from all areas of the hospital. Facilitate the process of final patient disposition by assuring adequate staff and supplies in the Discharge Area(s).</p>	Immediate	<p>Receive briefing from Inpatient Areas Supervisor with other Treatment Areas unit leaders.</p> <p>Assist Inpatient Areas Supervisor in the establishment of Discharge Area(s). Coordinate with Human Services Director, Transportation Unit Leader, Safety Manager, and Security Officer.</p> <p>Assess situation/area for supply and staffing need; request staff and supplies from the Labor Pool and Materials Supply Unit Leaders. Request medical staff support through Inpatient Areas Supervisor. Prepare area for minor medical treatment and extended observation.</p>
		Intermediate	<p>Request involvement of Human Services Director in appropriate patient disposition. Communicate regularly with Patient Tracking Officer.</p> <p>Ensure that all patients discharged from area are tracked and documented in regards to disposition.</p>

			<p>Ensure a copy of the patient chart is sent with patient transfers. If copy service is not available, record chart number and destination for future retrieval. (If other hospital areas are discharging patients, provide for accurate controls and documentation.)</p> <p>Coordinate with Pharmacy Unit Leader to provide medications for patients requiring extended stay.</p> <p>Coordinate with the Nutrition Services Unit Leader to provide meals for extended stay.</p> <p>Report frequently and routinely to Inpatient Areas Nursing Supervisor on situational status.</p>
		Extended	<p>Observe and assist any staff or patient who exhibits signs of stress. Report concerns to the Inpatient Areas Nursing Supervisor. Provide for staff rest periods and relief.</p> <p>Review and approve the areas' documented recordings of action/decisions in the Discharge Area(s). Send copy to the Treatment Areas Supervisor.</p> <p>Direct nonutilized personnel to Labor Pool (Manpower Pool).</p>

IN	POSITION	WHEN	WHAT
37	<p>Treatment Areas Unit Leader</p> <p>Mission: Initiate and supervise the patient triage process. Assure treatment of casualties according to triage categories and manage the treatment area(s). Provide for a controlled patient discharge. Supervise morgue service.</p>	Immediate	<p>Receive briefing from Medical Care Director and develop initial action plan with Medical Care Director, Inpatient Areas Supervisor, and Medical Staff Director.</p> <p>Appoint unit leaders for the following treatment areas:</p> <ul style="list-style-type: none"> Triage (Outside ER) Immediate Treatment (Emergency Room) Expectant (Morgue Hallway) Delayed Treatment (3BC) Minimal Treatment (Ortho Clinic) <p>Distribute corresponding Job Action Sheets; request a recorder/assistant for each unit leader from Labor Pool (Manpower Pool).</p> <p>Brief Treatment Area unit leaders. Designate time for follow-up meeting.</p>

			<p>Assist establishment of Triage, Immediate, Delayed, Minimal Treatment, Discharge, and Transportation Areas in preestablished locations.</p> <p>Assess problem, treatment needs, and customize the staffing and supplies in each area.</p> <p>Meet with Medical Care Director to discuss medical care plan of action and staffing in all Triage/treatment/discharge/morgue areas. Maintain awareness of all inpatient capabilities, especially surgical services via the Inpatient Areas Supervisor.</p> <p>Receive, coordinate, and forward requests for personnel and supplies to the Labor Pool Unit Leader, Medical Care Director, and Material Supply Unit Leader. Copy all communication to the Communications Unit Leader.</p>
		Intermediate	<p>Contact the Security Officer for any security needs especially those in the Triage, Discharge, and Morgue areas. Advise the Clinical Operations Chief of any actions/requests.</p> <p>Report equipment needs to Logistics.</p> <p>Assess environmental services (housekeeping) needs for all Treatment Areas; contact Sanitation Systems Officer for assistance.</p> <p>Observe and assist any staff member who exhibits signs of stress and fatigue. Report any concerns to Psychological Support Unit Leader. Provide for staff rest periods and relief.</p> <p>Assist Patient Tracking Officer and Patient Information Officer in obtaining information.</p>
		Extended	<p>Report frequently and routinely to Medical Care Director to keep apprised of situation.</p> <p>Document all action/decisions with a copy sent to the Medical Care Director.</p>

LIN	POSITION	WHEN	WHAT
38	Minimal Treatment Area unit Leader Mission: Coordinate the minor care of patients received from the Triage Area, and other areas of the hospital. Assure adequate staffing and supplies in the Minor Treatment Area. Facilitate the minor treatment of patients and disposition.	Immediate	Receive briefing from Treatment Areas Supervisor with other Treatment Area unit leaders. Assist Treatment Areas Supervisor in the establishment of Minor Treatment Area. Assess situation/area for supply and staffing need; request staff and supplies from the Labor Pool and Materials Supply Unit Leaders. Request medical staff support through Treatment Areas Supervisor.
		Intermediate	Obtain an adequate number of patient transportation resources from the Transportation Unit Leader to ensure the movement of patients in and out of the area. Ensure a rapid, appropriate disposition of patients treated within Minor Treatment Area. Report frequently and routinely to the Treatment Areas Supervisor on situational status.
		Extended	Observe and assist any staff member who exhibits signs of stress or fatigue. Report any concerns to the Treatment Areas Supervisor. Provide for staff rest periods and relief. Review and approve the areas' documented recordings of actions/decisions in the Minor Treatment Area. Send copy to the Treatment Areas Supervisor. Direct nonutilized personnel to Labor Pool.

LIN	POSITION	WHEN	WHAT
39	Delayed Treatment Unit Leader Mission: Coordinate the care given to	Immediate	Receive briefing from Treatment Areas Supervisor with other Treatment Area unit leaders. Assist Treatment Areas Supervisor in the establishment of Delayed Treatment Area.

	patients received from the Triage Area. Assure adequate staffing and supplies in the Delayed Treatment Area. Facilitate the treatment and disposition of patients in the Delayed Treatment Area.		<p>Assess situation/area for supply and staffing needs; request staff and supplies from the Labor Pool and Materials Supply Unit Leaders.</p> <p>Request medical staff support through Treatment Areas Supervisor.</p> <p>Obtain an adequate number of patient transport resources from the Transport Unit Leader to ensure the movement of patients in and out of the area.</p>
		Intermediate	<p>Ensure a rapid disposition and flow of treated patients from the Delayed Treatment Area.</p> <p>Report frequently and routinely to the Treatment Areas Supervisor on situational status.</p>
		Extended	<p>Observe and assist any member/staff member who exhibits signs of stress or fatigue. Report any concerns to the Treatment Areas Supervisor. Provide for staff rest periods and relief.</p> <p>Review and approve the areas' documented recordings of actions/decisions in the Delayed Treatment Area. Send copy to the Treatment Areas Supervisor.</p> <p>Direct nonutilized personnel to Labor Pool.</p>

LIN	POSITION	WHEN	WHAT
40	<p>Radiology Unit Leader</p> <p>Mission: Maintain radiology and other diagnostic imaging services at appropriate levels. Ensure the highest quality of service under current conditions.</p>	Immediate	<p>Receive briefing from Ancillary Services Director with other subsection unit leaders; develop a subsection action plan.</p> <p>Evaluate Radiology Service's capacity to perform x-ray and other appropriate procedures:</p> <ul style="list-style-type: none"> • Number of Operational X-ray suites_____ • Number of operational portable X-ray units_____ • Availability of CT scan or MRI_____ • Availability of fluoroscopy_____

			<ul style="list-style-type: none"> • Staffing Assessment_____ • Report status to Clinical Operations Chief/Ancillary Services Director <p>Provide radiology technician and portable X-ray unit to Emergency Department and Delayed Treatment Areas as needed.</p>
		Intermediate	<p>Contact Logistics in anticipation of needed supplies.</p> <p>Send any unassigned personnel to Labor Pool.</p> <p>Inform patient care areas of currently available radiology services.</p> <p>Communicate with Patient Tracking Officer to ensure accurate routing of test results.</p>
		Extended	<p>Provide for routine meetings with Clinical Operations Chief/Ancillary Services Director.</p> <p>Review and approve the documented recordings of actions/decisions in the Radiology Services Area. Send copy to Ancillary Services Director.</p> <p>Observe and assist any staff member who exhibits signs of stress and fatigue. Report concerns to Ancillary Services Director. Provide for staff rest periods and relief.</p>

LIN	POSITION	WHEN	WHAT
41	<p>Pharmacy Unit Leader</p> <p>Mission: Ensure the availability of emergency, incident specific, pharmaceutical, and pharmacy services.</p>	Immediate	<p>Receive briefing from Ancillary Services Director with other subsection unit leaders; develop a subsection action plan.</p> <p>Assign pharmacy technicians to Immediate and Delayed Treatment Areas, when appropriate.</p> <p>Inventory most commonly utilized pharmaceutical items and provide for the continual update of this inventory.</p> <p>Identify any inventories which might be transferred upon request to another facility and communicate list to the Ancillary Services Director.</p>
		Intermediate	Coordinate with Prime Vendor to ensure

			adequate pharmaceutical supplies.
		Extended	<p>Provide for routine meetings with Ancillary Services Director.</p> <p>Review and approve the documented recordings of actions/decisions in the Pharmacy Service Area. Send copy to Ancillary Services Director.</p> <p>Observe and assist staff members who show signs of stress and fatigue. Report any concerns to Ancillary Services Director. Provide for staff rest periods and relief.</p>

LIN	POSITION	WHEN	WHAT
42	<p>Laboratory Unit leader</p> <p>Mission: Maintain Laboratory services, blood and blood products at appropriate levels. Prioritize and manage the activity of the Laboratory Staff.</p>	Immediate	<p>Receive briefing from Ancillary Services Director with other subsection unit leaders; develop a subsection action plan.</p> <p>Assess available blood supply and designate those units of blood, if any, which may be released for use outside the facility.</p> <p>Report information to Ancillary Services Director and Communications Unit Leader.</p> <p>Evaluate Laboratory Service's capacity to perform:</p> <ul style="list-style-type: none"> • Hematology studies, Chemistry studies, Transfusion Services <p>Ascertain the approximate "turn around" time for study results. Report capabilities and operational readiness to Clinical Operations Chief/Ancillary Services Director.</p>
		Intermediate	<p>Contact Logistics in anticipation of needed supplies.</p> <p>Prepare for the possibility of initiating blood donor services.</p> <p>Send any unassigned personnel to Labor Pool (Manpower Pool).</p> <p>Inform patient care areas of currently available service.</p> <p>Communicate with Patient Tracking Officer to ensure accurate routing of test results.</p>
		Extended	<p>Provide for routine meetings with Clinical Operations Chief/Ancillary Services</p>

			<p>Director.</p> <p>Review and approve the documented recordings of actions/decisions in the Laboratory Services Area. Send copy of to the Ancillary Services Director.</p> <p>Observe and assist any staff member who exhibits signs of stress and fatigue.</p> <p>Report concerns to Clinical Operations Chief/Ancillary Services Director. Provide for staff rest periods and relief.</p>
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LIN	POSITION	WHEN	WHAT
43	<p>Morgue Unit Leader</p> <p>Mission: Collect, protect, and identify deceased patients. Assist Discharge Area Unit Leader in appropriate patient discharge.</p>	Immediate	<p>Receive briefing from Clinical Operations Chief and assist Treatment Areas Supervisor. Establish Morgue Area.</p> <p>Obtain assistance from the Transportation Unit Leader for transporting deceased patients.</p> <p>Assure all transporting devices are removed from under deceased patients and returned to the Triage Area.</p> <p>Request decedent affairs support from Patient Information Officer.</p>
		Intermediate	
		Extended	<p>Maintain master list of deceased patients with time of arrival for Patient Tracking Officer and Patient Information Officer.</p> <p>Keep Laboratory Unit Leader apprised of number of deceased.</p> <p>Contact the Security Officer for any morgue security needs.</p> <p>Arrange for frequent rest and recovery periods, as well as relief for staff.</p> <p>Schedule meetings with the Psychological Support Unit Leader to allow for staff debriefing.</p> <p>Observe and assist any staff member who exhibits signs of stress or fatigue. Report any concerns to the Laboratory Unit Leader.</p> <p>Review and approve the areas' documented recordings of actions/decisions in the Morgue Area. Send copy to the Laboratory Unit Leader.</p>

LIN	POSITION	WHEN	WHAT
44	<p>Human Services Director</p> <p>Mission: Organize, direct, and supervise those services associated with the social and psychological needs of the patients, staff, and their respective families. Assist with discharge planning.</p>	Immediate	<p>Obtain briefing from Clinical Operations Chief with other section directors and assist with development of the Clinical Operations action plan. Designate time for follow up meeting.</p> <p>Appoint Staff Support Unit Leader and Psychological Support Unit Leader. Distribute corresponding Job Action Sheets and identification vests.</p> <p>Brief unit leaders on current situation; outline action plan for subsection and designate time for next briefing.</p> <p>Establish Human Services Center near Discharge Area or near staff rest/rehabilitation area.</p> <p>Assist with establishment of Discharge Area. Lend support personnel to assist with patient discharge process.</p> <p>Assist in the implementation of patient early discharge protocol on the direction of Clinical Operations Chief.</p>
		Intermediate	<p>Assist Psychological Support Unit Leader in securing a debriefing area.</p> <p>Meet regularly with unit leaders to receive updates and requests.</p> <p>Communicate frequently with Clinical Operations Chief.</p>
		Extended	<p>Document action and decisions on a continual basis.</p> <p>Observe and assist anyone who exhibits signs of stress and fatigue. Provide for staff rest and relief.</p>

LIN	POSITION	WHEN	WHAT
45	<p>Staff Support Unit Leader</p> <p>Mission: Assure the provision of logistical and psychological support of the hospital staff.</p>	Immediate	<p>Obtain briefing from Human Services Director with other subsection unit leaders; assist in development of subsection action plan.</p> <p>Designate time for follow-up meeting. Anticipate staff needs as they might relate to the specific disaster.</p>

		Intermediate	<p>Establish a staff rest and nutritional area in a low traffic area. Provide for a calm relaxing environment as well as provide overall disaster information updates (bulletins) for rumor control. Provide for nutritional support and sleeping arrangements; contact Nutritional Supply Unit Leader and Labor Pool Unit Leader for assistance.</p> <p>Establish a staff Information Center. Provide overall disaster info updates (bulletins) for rumor control.</p> <p>Arrange for routine visits/evaluations by the Psychological Support Unit Leader. Assist in establishment of separate debriefing area.</p>
		Extended	<p>Observe all staff closely for signs of stress and fatigue; intervene appropriately. Provide for personal staff rest periods and relief.</p> <p>Assist staff with logistical and personal concerns; act as facilitator when appropriate. Report routinely to the Human Services Director.</p> <p>Document all actions, decisions, and interventions.</p>

LIN	POSITION	WHEN	WHAT
46	Psychological Support Unit Leader	Immediate	<p>Receive briefing from Human Services Director; assist in development of subsection action plan.</p> <p>Designate time for follow up meeting.</p> <p>Establish teams composed of staff, clergy, and other mental health professionals to support the psychosocial needs of the staff, patients, and guests.</p>
	Mission: Assure the provision of psychological, spiritual, and emotional support to the hospital staff, patients, dependents, and guests. Initiate and organize the Critical Stress	Intermediate	<p>Designate a secluded debriefing area where individual and group intervention may take place. Coordinate with Staff Support Unit Leader.</p> <p>Appoint psychological support staff to visit patient care and nonpatient care areas on a routine schedule.</p> <p>Meet regularly with all members of the Human Services Subsection.</p>

	Debriefing process.		Assist the Staff Support Unit Leader in establishment of staff information/status board (situation, disaster update, and hospital activities).
		Extended	<p>Advise psychological support staff to document all contacts.</p> <p>Observe psychological support staff for signs of stress and fatigue. Arrange for frequent, mandatory rest periods and debriefing sessions.</p> <p>Schedule and post the dates and times for critical stress debriefing sessions during and after the immediate disaster period.</p>

Appendix A, References, to this pamphlet (Medical Emergency Management Planning)

CHAPTER 1 - INTRODUCTION

The Federal Response Plan (for Public Law 93-288 as Amended), The Federal Emergency Management Agency.

MEDCOM Reg 525-4, U.S. Army Medical Command (MEDCOM) Emergency Management.

CHAPTER 2 - FEDERAL RESPONSE PLAN

The Federal Response Plan (for Public Law 93-288 as Amended), The Federal Emergency Management Agency.

AR 5-9, Area Support Responsibilities.

Accreditation Manual for Hospitals, Joint Commission on Accreditation of Healthcare Organizations (Environment of Care Standards EC.2.9 & EC.1.6).

Medical Response to Chemical Warfare and Terrorism, Chemical Casualty Care Division, MCMR-UV-ZM, USAMRICD.

CHAPTER 3 - NATIONAL DISASTER MEDICAL SYSTEM (NDMS)

The Federal Response Plan (for Public Law 93-288 as Amended), The Federal Emergency Management Agency.

CHAPTER 4 - SPECIAL MEDICAL AUGMENTATION RESPONSE TEAM (SMART)

AR 40-562, IMMUNIZATIONS AND CHEMOPROPHYLAXIS

The Federal Response Plan (for Public Law 93-288 as Amended), The Federal Emergency Management Agency.

CHAPTERS 5, 6, & 7 - EMERGENCY MANAGEMENT PLANNING

The Federal Response Plan (for Public Law 93-288 as Amended), The Federal Emergency Management Agency.

AR 5-9, Area Support Responsibilities.

AR 40-5, Preventive Medicine.

AR 40-538, Property Management During Patient Evacuation.

AR 385-10, The Army Safety Program.

AR 525-13, Antiterrorism.

AR 710-2-1, Using Unit Supply System (Manual Procedures).

AR 710-2-2, Supply Support Activity Supply System: Manual Procedures.

MEDCOM Pam 525-1

MEDCOM Reg 40-21, Regional Medical Commands and Regional Dental Commands.

FM 100-14, Risk Management

FM 100-23-1, Multiservice Procedures for Humanitarian Assistance Operations.

Accreditation Manual for Hospitals, Joint Commission on Accreditation of Healthcare Organizations. (Environment of Care Standards EC.2.9 & EC.1.6).

APPENDIX C

Hazardous Waste Operations and Emergency Response (HAZWOPER) Standard, Title 29, Code of Federal Regulations (CFR) 1910.120, effective 1990.\

FM 8-42, Combat Health support in Stability Operations and Support Operations, Appendix I, Specialty Response Teams.

FM 100-23-1, Multiservice Procedures for Humanitarian Assistance Operations.

APPENDIX D

AR 40-61, Medical Logistics Policies and Procedures.

Appendix B, Installation DHS CBRNE Medical Response Guideline to MEDCOM
Pam 525-1 (Medical Emergency Management Planning)

PRE-EVENT PREPARATION	REMARKS
Conduct surveillance and provide the installation with regular threat assessment updates.	
Ensure that MOUs/MOAs are in place with local/State health service providers and surrounding community hospitals to support and augment unavailable or incomplete installation medical capabilities.	
Be part of the military decision-making process as the installation considers courses of action as it transitions between (Force Protection Conditions (FPCON)).	
Obtain estimates of MTFs and surrounding community hospitals' resuscitative surgical and critical care capabilities.	
Ensure proper MTF security IAW the FPCON and during an installation crisis management phase.	
Conduct medical surveillance for unusual trends in patient complaints with surrounding community hospitals and clinics as an early warning that a CBRN attack may have occurred.	
Conduct periodic water and food checks in coordination with surrounding public health officials.	
Maintain MOUs/MOAs with local/State medical laboratories' specialized emergency specimen testing.	
Ensure MTF staff have specific emergency/disaster assignments as part of their written job descriptions.	
Ensure staff are trained and qualified to fulfill local responsibilities under local, State, and Federal declarations.	
Obtain trained personnel from other tenant commands for augmentation.	
Put mutual aid agreements/MOUs in place.	
Identify legal liabilities associated with the use of solicited and convergent volunteers during disasters.	
Develop policies and procedures to lessen the liability associated with the use of solicited and convergent volunteers.	
Assign responsibility for coordinating resource management issues in the Comprehensive Emergency Management Plan (CEMP).	
Establish procedures to allocate resources based on prospectively established priorities.	
Identify the resource requirements to maintain operations at critical infrastructure facilities during disasters (e.g., backup generators).	
Maintain resource inventories.	
Update resource inventories and maintain a list of main resource supply points.	
Request and coordinate with local government and the private sector for personnel and equipment.	
Maintain liaison with installation organizations that have primary responsibility for resources in short supply.	
Establish mutual aid agreements/compacts with neighboring jurisdictions, domestic or international.	
Identify State resources that can be expected as a result of a request for assistance.	

Identify locations throughout the installation and make arrangements for use as staging areas for receipt and distribution of critical medical resources.	
Assign staff to medical staging areas.	
Develop Standard Operating Procedures (SOPs) to manage the receipt and distribution of resources at medical staging areas.	
Acquire appropriate and sufficient equipment for response to weapons of mass destruction (WMD), terrorism, and/or chemical, biological, radiological, nuclear, or high yield explosive (CBRNE) events.	
Ensure HAZMAT/EMS support resources are sufficient for a WMD terrorism incident requiring mass decontamination.	
Ensure medical responders have personnel monitoring equipment, and procedures are in place, to minimize cumulative exposure to radiological and chemical hazards.	
Ensure WMD equipment is consistent with the Inter Agency Board (IAB) standard equipment list.	
Ensure WMD response equipment is compatible with installation WMD equipment.	
Ensure EMS teams supporting HAZMAT WMD operations have sufficient quantities of antidotes to support operations, are trained in their use, and are authorized usage.	
Ensure response resources are adequately equipped and able to detect and make preliminary identification of chemical, nuclear, and biological agents, including but not limited to anthrax, smallpox, tularemia, Q fever, and Venezuelan Equine Encephalitis (VEE).	
Identify other WMD capable response teams and WMD related equipment sources, such as private/corporate, intra-state, WMD-CSTs, and neighboring military.	
Ensure the capability to obtain adequate pharmaceuticals in the event of a WMD incident.	

EVENT RESPONSE	REMARKS
Implement the Comprehensive Emergency Management Plan (CEMP)	
<p>Immediate health implications of identified threats are relayed to installation officials.</p> <p>Initiate contact with:</p> <p><u>Internal Contacts:</u></p> <p>EOC # MTF Staff # Infection Control # Public Affairs #</p> <p><u>External Contacts:</u></p> <p>Army EOC # MEDCOM # Liaison with Local Health Department, State Health Department, FBI Office, CDC EOC</p>	
Ensure communication links between the MTF EOCs and the IOC are established and maintained. Assign liaison.	

Protection/Security	
Initiate surveillance activities to assess the extent of the incident and to monitor changes (e.g., radiological and chemical surveys, epidemiological surveillance).	
Recommend limits on installation access.	
Control ER access.	
Don appropriate protective gear.	
Turn off ventilation system.	
Consider Evacuation	
Consider evacuation options and primary and alternate routes to preestablished evacuation sites.	
Implement procedures for evacuating special needs populations (e.g., hospitalized patients, nonambulatory).	
Identify assembly areas for people without immediate transportation.	
Plan reentry.	
Assess environmental health concerns before reentry.	
Addresses site remediation (e.g., "How clean is clean?") for the different types of WMD agents.	
No Evacuation	
Consider options for increasing the capacity of the supporting MTF, including canceling elective surgery, expedient discharge or evacuation of existing patients, and bed expansion options within the MTF.	
Initiate in-place sheltering, if appropriate, based on number of casualties and agent.	
Implement infection control procedures.	
Establish isolation wards.	
Arrange disposal of infectious materials (e.g., linen).	
Arrange handling of bulk regulated medical waste.	
Consider host community status of the installation for evacuees from other jurisdictions.	
Identify local resources that may be used to support mass care operations (e.g., mass care facilities, communications, food, water, health/medical, registration, a system to reunite families, and disaster housing).	
Manage solicited and convergent volunteers.	
Set up necessary laboratory services (e.g., biological dosimetry).	
Address specimen collection handling and preservation.	
Address local laboratory presumptive testing IAW CDC recommendations.	
Addresses specimen chain of custody requirements.	
Addresses packaging and shipping additional specimens to (1) BSL 3 laboratory, (2) CDC (3) USAMRIID (4) AFRRRI.	
Identify key pathological specimen markers indicative of possible bioterrorism attack.	
Address procedures for pathological specimen collection, handling, and preservation.	
Manage Contaminated Patients	
Establish Hot Line.	
Dispatch personnel to site of contamination.	
Triage.	
Emergency treatment.	

Initiate isolation, cohorting for contagious biological infections.	
Decontaminate/Disinfect.	
Identify alternate decontamination sites.	
Support Decon and other MTF personnel (e.g., stress monitoring, toilet facilities).	
Certify Decon/Disinfection before entry into MTF.	
Definitive/Advanced Treatment.	
Plan for inter-facility transfer and patient evacuation services.	
Initiate mass prophylaxis, if appropriate.	
Consider off-site location for prophylaxis and immunization.	
Implement Infection Control activities (i.e., negative pressure isolation rooms).	
Provide crisis counseling to the beneficiary population.	
Revise clinical protocols for treatment, triage, decon/disinfection, and stress/crisis management.	
Implement fatality management plan.	
Ensure morgue security.	
Address visitation by next of kin.	
Establish procedures for the safe handling and disposition of NBC fatalities.	
Decontaminate deceased if necessary.	
Consider temporary interment and cremation, release to next of kin.	
Maintain inventory of mortuary resources.	
Maintain radiological and epidemiological surveillance.	
Long-term monitoring/surveillance of patients after release from the MTF (active duty military and civilians).	
Information Operations and Public Affairs	
Distribute fact sheets and "canned" messages regarding chemical and biological (C/B) agents and radiation dispersal.	
Miscellaneous	
Implement animal control program as addressed in the CEMP.	
Address food, water, and commodities distribution.	
Logistics	
Conduct resupply and prepare for delivery from National Pharmacy Stockpile and other sources.	
Special interest items: Potassium Iodide Atropine Pralidoxime Chloride Valium Cipro Doxycycline Vaccines: Smallpox, Anthrax	

Appendix C, Special Medical Augmentation Response Teams (SMARTs) to this pamphlet (Medical Emergency Management Planning)

Tab 1, Personnel for Special Medical Augmentation Response Team (SMART), to Appendix C, SMART, to this pamphlet (Medical Emergency Management Planning)

TEAM COMPOSITIONS.

All position AOC/MOS or nonspecific specialties may be substituted by a civilian equivalent, at the commander's discretion.

1. SMART - Trauma/Critical Care (SMART-TCC) - 8.

- a. 1 Emergency Medicine Physician (AOC 62A).
- b. 2 Physicians Assistant (AOC 65D M2 or M1).
- c. 1 Critical Care Nurse (AOC 66H 8A).
- d. 2 Emergency Room Nurse (AOC 66H M5).
- e. 2 Health Care Specialist (MOS 91W).

2. SMART - Nuclear/Biological/Chemical (SMART-NBC)- 8.

a. 1 Preventive Medicine Officer (AOC 60C or 60D), or a physician with a Masters in Public Health (MPH), Epidemiology or public health training and experience, such as infectious disease or aerospace medicine physician.

b. 1 Acute Care Physician (AOC 60A, 60P, 61G, or 61H) or a physician with critical care; emergency medicine triage and mass casualty training; training on the acute medical management of patients with TIC/TIM exposure; and risk assessment methodologies.

- c. 1 Nurse (AOC 66B or 66H).
- d. 1 Health Physicist (AOC 72A).
- e. 1 Environmental Scientist (AOC 72D or 72E).
- f. 1 Practical Nurse (MOS 91WM6).

g. 1 Preventive Medicine Noncommissioned Officer (NCO) (MOS 91S40 or 91S50).

- h. 1 Medical Administration NCO (MOS 91W).
- i. Commander may augment laboratory personnel to team.

3. SMART - Stress Management (SMART-SM)- 8. (NOTE: Of the members listed below, at least one social work officer, psychiatrist, or psychologist must hold active clinical privileges in child and adolescent behavioral health.)

- a. 1 Psychiatrist (AOC 60W or 60U).
- b. 1 Clinical Psychologist (AOC 73B67).

- c. 1 Social Work Officer (AOC 73A67).
 - d. 1 Psychiatric Nurse (AOC 66C7T, may substitute with 66C).
 - e. 2 Mental Health NCOs (MOS 91X) can substitute with one Occupational Therapy NCO (91WN3).
 - f. 1 Hospital Chaplain (AOC 56A).
 - g. 1 Occupational Therapy Officer (AOC 65A).
4. SMART - Medical Command, Control, Communications, Tele-Medicine (SMART-MC3T)- 6.
- a. 1 Chief Medical Officer (AOC 60-62).
 - b. 1 Operation Officer (AOC 70D or 70H/GS 301).
 - c. 1 Medical NCO (MOS 91W).
 - d. 1 Practical Nurse (MOS 91WM6).
 - e. 1 Computer Specialist (AOC/GS nonspecific).
 - f. 1 Communications Specialist (AOC/GS nonspecific).
5. SMART - Pastoral Care (SMART-PC)- 2.
- a. 1 Chaplain (AOC 56A7R).
 - b. 1 Chaplain Assistant (MOS 56M).
6. SMART - Preventive Medicine (SMART-PM)- 9.
- a. 1 Preventive Medicine Officer (AOC 60C or civilian equivalent).
 - b. 1 Industrial Hygienist (AOC 72D, or civilian equivalent).
 - c. 1 Health Physicist (AOC 72A, NCO [N-4 qualified] or civilian equivalent).
 - d. 1 Medical Entomologist (AOC 72B or civilian equivalent).
 - e. 1 Community Health Nurse (AOC 66H).
 - f. 1 Preventive Medicine NCO (MOS 91S20 or higher).
 - g. 1 Environmental Science Officer (AOC 72D or civilian equivalent).
 - h. 2 Rapid Response Officers (72B, 72D, or 72E).
7. SMART - Burn (SMART-B)- 6.
- a. 1 Board Certified, or board eligible, General Surgeon (AOC 61J).

- b. 1 Critical Care Registered Nurse (AOC 66H8A or civilian equivalent).
 - c. 1 Respiratory Therapist (MOS 91V).
 - d. 1 Health Care Specialist (MOS 91W or civilian equivalent).
 - e. 1 Training/Operations Officer/NCO (MOS nonspecific).
 - f. 1 Training/Operations NCO (MOS immaterial).
8. SMART - Veterinary (SMART-V)- 8.
- a. 1 Team Leader (AOC 64X, Grade 05/06).
 - b. 1 Veterinary Preventive Medicine (AOC 64B, Grade 04/05).
 - c. 1 Veterinary Service Technician (AOC 640A, Grade CW2/CW3).
 - d. 1 Veterinary Corps Officer (AOC 64A, Grade 03/04/).
 - e. 1 Animal Care Specialist (MOS 91T, Grade E7).
 - f. 2 Animal Care Specialists (MOS 91T, Grade E5/E6).
 - g. 1 Food Inspection Specialist (MOS 91R, Grade E5/E6).
9. SMART - Health Systems (SMART-HS)- 6.
- a. 1 Team Leader (planner/clinician).
 - b. 1 Health Facility Planner (AOC 70K9I) (Mission dependent).
 - c. 1 Health Services Maintenance Technician (AOC 670A) (Mission dependent).
 - d. 1 Clinician (physician or nurse-66H) (Mission dependent).
 - e. 1 Nurse Methods Analyst (Mission dependent).
 - f. 1 Subject Matter Expert (Mission dependent).
10. SMART - Aero-Medical Isolation Team (SMART-AIT)- 12.
- a. 1 Medical Director, Medical Corps (MC) (AOC nonspecific).
 - b. 1 Assistant Medical Director, MC (AOC nonspecific) (Mission dependent).
 - c. 1 Officer-in-Charge, Army Nurse Corps (AN) (AOC nonspecific).
 - d. 1 Assistant OIC, AN (AOC nonspecific) (Mission dependent).
 - e. 1 Noncommissioned Officers-in-Charge (NCOIC) (MOS 91W30).
 - f. 5 Health Care Specialists (MOS 91W).

g. 1 Laboratory Technicians (MOS 91K).

h. 1 Veterinary Medicine Technician (MOS 91T) (Mission Dependent).

Tab 2, Training for Special Medical Augmentation Response Team (SMART), to Appendix C, SMART, to this pamphlet (Medical Emergency Management Planning)

1. REFERENCES.

- a. DODI 1322.24; Military Medical Readiness Training.
- b. FM 8-42, Combat Health Support in Stability Operations and Support Operations; Appendix I, Specialty Response Teams.
- c. US Army Medical Command Regulation 350-4; Readiness Training Requirements.
- d. Annual Command Training Guidance.

2. GENERAL TRAINING. All MEDCOM personnel are required to maintain compliance with training standards outlined in references 1a through 1c. Personnel who are designated as members of SMARTs are additionally responsible for team specific requirements outlined in reference 1d. The following are additional general training requirements of SMART members and augmentees.

- a. Annual training and familiarization in tactics, techniques, and procedures outlined in FM 100-23-1, Multiservice Procedures for Humanitarian Assistance Operations (chapter 5).
- b. Annual training and certification on use, care, and maintenance of specific SMART equipment items to include radios.
- c. Semi-annual SMART alert and activation exercise.
- d. Annual medical specialty training appropriate to the SMART mission.
- e. Annual medical screening and PPE & PAPR training. (OSHA Respirator Medical Evaluation Questionnaire).
- f. Familiarization training with the current Information Management (IM) Emergency Management Planning Software.

3. SPECIFIC SMART TRAINING.

- a. SMART - Trauma/Critical Care (SMART-TCC).

Note: The designation SMART - Trauma/Critical Care (SMART-TCC) will be changed to SMART - Emergency Medical Response (SMART-EMR).

(1) Each physician member must be a current Advanced Trauma Life Support (ATLS) provider, Board Certified/Board Eligible (BC/BE), State licensed and hospital privileged and credentialed.

(2) Each Physicians Assistant must be a current ATLS trained, National Commission Certification of Physicians Assistant and currently practicing.

(3) The critical care nurse and emergency room (ER) nurses will be trauma nursing combat care (TNCC) certified.

(4) Each Health Care Specialist must be current with certifications and practicing in MOS.

(5) All team members must meet current standards for deployment and Soldier Readiness Processing (SRP) and must maintain a minimum of 15 hours of trauma related continuing medical education (CME) yearly.

(6) Emergency room physicians should be involved in active practice involving acutely injured patients.

(7) The critical care nurse will be will be currently practicing in AOC 66H8A.

(8) Team should participate in two local collective training events per year.

(9) Team members should be cross-trained in NDMS and CBRNE.

(10) Team members should be trained in use and maintenance of hand-held radios.

b. SMART - Nuclear/Biological/Chemical (SMART-NBC).

(1) Team leader will attend the FEMA Incident Command Systems Course and/or Combined Humanitarian Assistance Response Training (CHART).

(2) Physicians and nurses: Initial: Medical Management of Chemical Biological Casualties (MCBC) and Medical Effects of Ionizing Radiation (MEIR). Annual sustainment training on satellite broadcast of Chem/Bio course or equivalent.

(3) Science Officers: Initial: Field Medical Management of Chemical Biological Casualties Course (FCBC) and MEIR. Annual Sustainment: Satellite broadcast of chem/bio course or equivalent. Optional: Nuclear Emergency Team Operations (NETOPS) and/or Nuclear Hazards Training Course (NHTC).

(4) Noncommissioned Officers. FCBC, NHTC, or NETOPS. Annual Sustainment: Satellite broadcast Chem/bio course or equivalent.

(5) Each member attends quarterly meetings and/or semi-annual Exercises.

(6) Team members should be trained in use and maintenance of hand-held radios and ChemPro 100 chemical agent profiler.

c. SMART - Stress Management (SMART-SM).

(1) All SM team members are trained in introductory concepts of disaster mental health. Training may be provided by organizations such as the National Organization of Victims Assistance (NOVA), the Department of Veteran's Affairs National Center for Post Traumatic Stress Disorder, the

(ICISF), Department of Veterans Administration, American Red Cross, or training approved by MEDCOM.

(2) Continuing annual education in traumatology.

(3) Minimum of two SMART-SM team members to receive advanced courses in disaster management and disaster mental health.

(4) Team members should be trained in use and maintenance of hand-held radios.

(5) Each team should conduct at least one collective training exercise per year.

d. SMART - Medical Command, Control, Communications, and Tele-medicine (SMART-MC3T).

(1) Each member trained in Basic Life Support (BLS).

(2) The team leader and assistant team leader will be Combined Humanitarian Assistance Response Training (CHART) trained.

(3) Recommended training: MEIR, MMCBC, Combat Casualty Care Course (C4), CBRNE, WMD, FEMA-EPC and conduct internal cross training on MC3T equipment.

(4) All team members will be Image Communication Services (ICS) trained.

e. SMART - Pastoral Care (SMART-PC).

(1) Chaplain.

(a) Disaster Mental Health/CISM (ICSF, NOVA, or Red Cross).

(b) NDMS Training.

(c) Recommend FEMA Training.

(d) Trained in use and maintenance of hand-held radios.

(2) Chaplain Assistant.

(a) Emergency Medical Ministry Course (EMMC).

(b) Recommend: Disaster mental Health/CISM (ICISF, NOVA, or Red Cross).

(c) Trained in use and maintenance of hand-held radios.

f. SMART - Preventive Medicine (SMART-PM).

(1) All team members will be trained in media relations and anti-terrorism/force protection/CBRNE annually.

(2) All designated rapid response Officers will attend the DOD Emergency Management Course (CONUS Only) and basic risk communications.

(3) Recommended AOC-specific training. Entomologists, Environmental Science Officers, Industrial Hygienist, Nuclear Medical Science Officer, and the Preventive Medicine NCO attend Hazardous Waste Operations and Emergency Response (HAZWOPER), Respiratory Protection, Combined Humanitarian Assistance Response Training (CHART), and basic risk communications.

(4) Recommend Community Health Nurses and Preventive Medicine Physicians attend the CHART course and basic risk communications.

g. SMART - Burn (SMART-B).

(1) All team members will have US Air Force Critical Care Aeromedical Transport Team (USAF CCATT) training. (Permissive TDY at Brooks AFB, San Antonio, TX).

(2) All team members will have Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), and Advanced Burn Life Support (ABLS) Certification. All team members must have 1 year of ICU experience and at least 6 months of general burn care experience.

(3) All team members must have BLS training.

(4) Physicians will have ATLS training.

(5) Team members should be trained in use and maintenance of hand-held radios and in satellite phone use.

(6) Recommended courses:

(a) Advanced Trauma Life Support (ATLS), Pediatric Advanced Life Support (PALS), Trauma Nurse Core Course (TNCC), Medical or Field Management of Chemical and Biological Casualties Course (VTC or Resident course), Combined Humanitarian Assistance Response Training (CHART), Joint Medical Regulation Officer Course, Combat Casualty Care Course.

(b) Quarterly deployments.

(c) One Aero-medical evacuation mission (training or real world) per quarter.

h. SMART - Veterinary (SMART-V).

(1) At least one trained Foreign Animal Disease Diagnostician per team.

(2) Incident Command System (ICS) training.

(3) National Disaster Medical System training.

(4) Foreign Animal Disease Diagnosticians Course.

- (5) Combined Humanitarian Assistance Response Training (CHART).
- (6) Veterinary Disaster Operations Course (formerly Veterinary Emergencies of Large Populations (VELP)).
- (7) Recommended applicable FEMA and USDA courses.
- (8) Alerts, equipment check familiarization, CTT, and team training.
- (9) Training in the use and maintenance of hand-held radios.
- i. SMART - Health Systems Assessment and Assistance (SMART-HS).
 - (1) Subject matter expertise (SME) credentials (architecture, engineering, clinician, veterinary, environmental science, etc.).
 - (2) Security Engineering Training Course.
 - (3) Deployable Medical System (DEPMEDS) Doctrine and Tactics training.
 - (4) Space and Equipment Planning System training.
 - (5) Combined Humanitarian Assistance Response Training (CHART).
 - (6) Recurring training: SMART-HS Basic Course (bi-annual), Personal Protective Equipment familiarization.
 - (7) Team members should be trained in use and maintenance of hand-held radios.
- j. SMART-Aero-Medical Isolation Team (SMART-AIT).
 - (1) Air Evacuation Course.
 - (2) BCLS or ACLS Courses as appropriate.
 - (3) Management of Chemical Biological Casualties (MCBC) or Field Medical Management of Chemical Biological Casualties Course (FCBC), as appropriate.
 - (4) Joint training exercises as appropriate.
 - (5) Team members should be trained in Joint training exercises and the Use and Maintenance of hand-held radio.

4. FUNDING OF TRAINING. Each RMC/MSC will submit request for SMART training funds to MEDCOM no later than 30 September of each fiscal year. Requested amounts will be broken down by team and by what training and/or exercises are to be accomplished.

5. THE POINT OF CONTACT. The POC at this headquarters for questions concerning SMART training is the Readiness and Training Branch, Operations Division at DSN 471-7294/commercial 210-221-7294.

Tab 3, Logistics for Special Medical Augmentation Response Team (SMART), to Appendix C, SMART, to this pamphlet (Medical Emergency Management Planning)

1. MEDCOM READINESS REPORTS STATUS OF SMART EQUIPMENT.

a. Equipment authorization tables list the mission critical items for each SMART. These mission critical items are the only equipment items considered when completing the SMART portion of the table of distribution and allowances (TDA) medical readiness report (MRR). All pacing items must be on hand for the SMART to report a C-1 rating.

b. Additional SMART equipment.

(1) Local commanders may authorize additional SMART equipment to be maintained and employed by the SMART. This equipment may only be purchased after all mandatory equipment items identified in Appendix C, Tab 3, paragraphs 3a through 3j have been requisitioned. Additional SMART equipment purchases must be funded locally and will not be funded by MEDCOM. Additional SMART equipment items will not be considered when completing the SMART portion of the TDA Unit Status Report (USR).

(2) Substitution of SMART equipment. Local commanders will not authorize any substitution for SMART mandatory equipment items. The Assistant Chief of Staff for Operations (ACSOPS), MCOP-P, is the approval authority to authorize substitution of SMART equipment items.

(3) Procedures for requesting substitution or changes of SMART authorized equipment. Requests for authorized substitution or changes of mandatory SMART equipment, to include addition of new SMART equipment items or deletion of existing mandatory SMART equipment items, must be approved by the ACSOPS, MCOP-P. Requests must be forwarded in writing and must include documentation of the requested substitution or change on DA Form 4610-R. Requests must be mailed to: Commander, MEDCOM, ATTN: MCOP-P, 2050 Worth Road, Fort Sam Houston, TX 78234-6007.

2. SMART PERSONAL PROTECTION EQUIPMENT. In addition to the equipment listed on the authorization tables, Personal Protection Equipment has been procured and will be maintained for each SMART member. These are listed on the authorization tables. Each member requires a Powered Air-Purifying Respirator (PAPR) Mask, a Level B Suit, Butyl Boots and Gloves, and Nitrile Gloves. One set is allocated for each team member. Sizing or alternate team member additions should be sent to HQ MEDCOM, Plans Division, DSN 471-6425/commercial 210-221-6425.

3. TEAM EQUIPMENT. (SMART Chiefs may coordinate with Installation Commanders for CTA 50-900 items for additionally equipping their teams.)

a. SMART - Trauma/Critical Care (SMART-TCC).

ITEM	QUANTITY	MISSION CRITICAL
Emergency Med Physician Pack. (Note: Pending Contents, or Super Aide Bag.)	1 each	X
MREs, Chem Lights, Flashlights	6 each	
Hand-held Radios	6 each	X
Powered Air Purifying Respirator (PAPR)	6 each	
Battery, NiCad (rechargeable)	6 each	
Battery, Lithium (long life)	6 each	
Coverall, Tychem-BR	6 each	
Gloves, Butyl	6 pair	
Gloves, Nitrile	6 pair	
Boots, HAZMAX	6 pair	

b. SMART - Nuclear/Biological/Chemical (SMART-NBC).

ITEM	QUANTITY	MISSION CRITICAL
Disposable Surgical Mask N95/99	1 box	
Surgical Gloves	1 pkg	
M9 Paper	1 roll	
M8 Paper	1 book	
M256 A1 Chemical Agent Detection Kit	1 each	X
M272 Chem Agent Water Detection Kit	1 each	
AN/PDR-77 RADIAC Set with extension kits	1 each	
Containers	2 each	
Antidotes/Antibiotics/Pretreat	9 each	X
Laptop Computer with Modem and NBC Software	2 each	
Bag-valve-mask Device with Chemical Filter	4 each	
Medical Aid Bag	9 each	
Personal Protection Equipment (PPE) Level C or higher	9 each	
HAZMAT Draeger Kit	1 each	X
M291 Decontamination Kit	9 each	X
Pagers	9 Each	
Hand-held Radios	6 each	X
MREs, Chem Lights, Flashlights	9 each	
Powered Air Purifying Respirator (PAPR)	9 each	
Battery, NiCad (rechargeable)	9 each	
Battery, Lithium (long life)	9 each	
Coverall, Tychem-BR	9 each	
Gloves, Butyl	9 pair	
Gloves, Nitrile	9 pair	
Boots, HAZMAX	6 pair	
Battery Charger, 5-unit	1 each	
Chemical Agent Profiler, ChemPro 100	1 each	

c. SMART - Stress Management (SMART-SM).

ITEM	QUANTITY	MISSION CRITICAL
Neuropsychiatric Treatment Set w/Selected Medications: Hypnotic, Antipsychotic, Antidepressant	1 each	
Laptop Computer w/Modem & CD Drive	4 each	X
Printer, Color	2 each	X
Global Positioning System	4 each	
Pagers, Nationwide, 2-way	8 each	X
Cell Phone	4 each	X
Hand-held Radios	8 each	X
Portable Public Address System	1 each	
MREs, Chem Lights, Flashlights	8 each	
Medical Aid Bag	1 each	
PDA / hand-held PC	8 each	X
Digital camera w/laptop interface	1 each	x
Powered Air Purifying Respirator (PAPR)	8 each	
Battery, NiCad (rechargeable)	8 each	
Battery, Lithium (long life)	8 each	
Coverall, Tychem-BR	8 each	
Gloves, Butyl	8 pair	
Gloves, Nitrile	8 pair	
Boots, HAZMAX	8 pair	
Portable equipment transport containers for equipment above		x

d. SMART - Medical Command, Control, Communications, Tele-medicine (SMART-MC3T).

ITEM	QUANTITY	MISSION CRITICAL	SENSITIVE	
Laptop Computer, Rugged w/PCMCIA3 Card, Floppy Drive, Internal Modem, Software	2 each	X	X	
Portable Video Conferencing Computer (w/active matrix color, with video/audio capture capability)	1 each		X	
Portable Printer/Scanner	1 each			
Tiny Bridge	1 each	X		
A/B Switch Box	1 each			
MS Operating System Compatible with Application Software (95/98/NT/2000) with Peripherals	1 each			
MS Office Professional Suite	1 each			
Basic Aid Bag (M5)	1 each			
MREs, Chem Lights, Flashlights	8 each			
Digital Photograph Manipulation Software	1 each			
Digital Camera (with minimum resolution of 640X480 450 Kilopixels)	1 each			

or greater)			
Hand-held Radios	10 each		X
Generator (capable of providing 800 watts at 120 volts AC for a total of 1000 volt/amps)	1 each	X	
Uninterruptible Power Supply (UPS) (with world-wide adapters capable of providing 5 minute backup, and converting 110v AC-240V AC - 110V AC 60hz)	1 each		
Power Strip/Surge Protector	1 each		
Transit Cases for Equipment Set	5 Each		
INMARSAT ("B" Satellite Service DHSD 56/64Kbps Capable)	1 each	X	X
Cell Phones (Modernized)	2 each		
Table, Folding (5'x2'app) (folds to store 2½'x2')			
Chair, camping, folding type			
Tarp Cover			
Iridium GPS (DOD Type)			
Powered Air Purifying Respirator (PAPR)	8 each		
Battery, NiCad (rechargeable)	8 each		
Battery, Lithium (long life)	8 each		
Coverall, Tychem-BR	8 each		
Gloves, Butyl	8 pair		
Gloves, Nitrile	8 pair		
Boots, HAZMAX	8 pair		

e. SMART - Pastoral Care (SMART-PC).

ITEM	QUANTITY	MISSION CRITICAL
Hand-held Radios	2 each	X
Laptop Computer w/modem	1 each	
Printer	1 each	
Chaplain Kit (Christian, Jewish, Islamic, Orthodox)	1 each	
First Aid Kit	1 each	
Portable mike	2 each	
MREs, Chem Lights, Flashlights	8 each	X
Expendable Ecclesiastical Supplies	2 each	
Powered Air Purifying Respirator (PAPR)	2 each	
Battery, NiCad (rechargeable)	2 each	
Battery, Lithium (long life)	2 each	
Coverall, Tychem-BR	2 each	
Gloves, Butyl	2 pair	
Gloves, Nitrile	2 pair	
Boots, HAZMAX	2 pair	

f. SMART - Preventive Medicine (SMART-PM).

ITEM	QUANTITY	MISSION CRITICAL
MIRAN SapphIRE*	1 each	X
AN/PDR-77 RADIAC Set with extension kits	1 each	
Hach Drel 2010 Water Quality*	1 each	X
Digital Camera	1 each	
Global Positioning System (Commercial)	1 each	
MREs, Chem Lights, Flashlights.	6 each	
Laptop Computer	1 each	X
Vector Surveillance Kit	1 each	
Hand-held Radios	6 each	X
Powered Air Purifying Respirator (PAPR)	6 each	
Battery, NiCad (rechargeable)	6 each	
Battery, Lithium (long life)	6 each	
Coverall, Tychem-BR	6 each	
Gloves, Butyl	6 pair	
Gloves, Nitrile	6 pair	
Boots, HAZMAX	6 pair	
* Substitution Authorized		

g. SMART - Burn (SMART-B).

ITEM	QUANTITY	MISSION CRITICAL
(The following are per each of the two teams)		
Routine mission (per team-single patient): (3 SKEDCO Back-Packs, 1 for Respiratory Therapist and 2 for General Medical Care. Two Black Pelican cases containing SMEED, Ventilator, IV Pumps, Impact Portable suction unit I-STAT Blood Analyzer and Propaq Physiologic Monitor. 1 NATO litter with Orange Bedroll, 1 life-Pak 10 defibrillator//monitor, Standard 72-hour medication stock.	1 each	
Deployable Burn Supply Set (MES Chests): 8 double-sided MESS chests, each stocked for a 50% total body surface burn injury (70 kg patient) to care for a patient for 72 hours. Total 16 "bed" scaleable, modular set. Note: No narcotics stored. No "routine" medications stored. No blood products stored. Four hours of medical grade oxygen carried x 16 beds. No tentage/cover. Limited internal power generation. (Each set includes 12 prepacked backpacks and chests; size of set can be tailored to mission requirements)		
Cell Phones	2 each	
INMARSAT M SATCOM nonsecure	1 each	
Iridium SATCOM	1 each	
Lap Top Computer	1 each	
Ventilators, TXP/Duotron high-frequency type	10 each	X
IVAC 3 channel IV pump	8 each	

Portable Bronchoscope LPT10	2 each	
Monitors	8 each	
Life-Pack-10 Monitor-defibrillators	2 each	
M-Cylinders with cases Medical Oxygen	10 each	X
ISTAT Analyzers And Test Cartridges And Electronic Calibration Unit	2 each	X
Laerdal or IMPACT Brand Flight Certified Suction Unit	3 each	
Generator	1 each	
Hand-held Radios	2 each	X
Baxter AS50 Auto-Syringe Infusion Pump	2 each	
MREs, Chem Lights, Flashlights	4 each	
Ferno Aviation Equipment Platform	5 each	
NATO Litters and Stands	10 each	
SMEED Equipment Platform	5 each	
(The following are per both of the two teams)		
Electrocautery Device Portable Bovie	1 each	
Ortho Set	1 each	
Minor Surgery/Trache Set	2 each	
Hudson Drill Set	1 each	
General Surgery Set	1 each	
Thoracic Surgery Set	1 each	
Long Instrument Set	1 each	
Balfour Retractor	1 each	
Vascular Set	1 each	
Suture Pack List	2 each	
Powered Air Purifying Respirator (PAPR)	12 each	
Battery, NiCad (rechargeable)	12 each	
Battery, Lithium (long life)	12 each	
Coverall, Tychem-BR	12 each	
Gloves, Butyl	12 pair	
Gloves, Nitrile	12 pair	
Boots, HAZMAX	12 pair	

h. SMART - Veterinary (SMART-V).

ITEM	QUANTITY	MISSION CRITICAL
Emergency Veterinary Set	1 each	X
Food Safety Kit	1 each	X
Administrative Equipment Set	1 each	
Hand-held Radios	8 each	X
Laptop Computer	2 each	X
MREs/Flashlights/Chem Lights	6 each	
Powered Air Purifying Respirator (PAPR)	8 each	
Battery, NiCad (rechargeable)	8 each	
Battery, Lithium (long life)	8 each	
Coverall, Tychem-BR	8 each	
Gloves, Butyl	8 pair	
Gloves, Nitrile	8 pair	
Boots, HAZMAX	8 pair	
Portable printer	1 each	

Global positioning system (commercial)	3 each	
Hand-held computers (iPAQ or like item) w/ memory cards	6 each	
Digital camera	1 each	

i. SMART - Health Systems Assessment and Assistance (SMART-HS).

ITEM	QUANTITY	MISSION CRITICAL
INMARSAT (voice/data) (rent INMARSAT or Satellite/World Phone) MC3T System (Mission Dependent)	1 each	
Digital Camera	1 each	
Laptop Computer	2 each	
Hand-held Radios	6 each	X
MREs, Chem Lights, Flashlights, etc	6 each	
Powered Air Purifying Respirator (PAPR)	6 each	
Battery, NiCad (rechargeable)	6 each	
Battery, Lithium (long life)	6 each	
Coverall, Tychem-BR	6 each	
Gloves, Butyl	6 pair	
Gloves, Nitrile	6 pair	
Boots, HAZMAX	6 pair	

j. SMART - Aero-Medical Isolation Team (SMART-AIT).

ITEM	QUANTITY	MISSION CRITICAL
Aircraft Transit Isolator	2 each	X
Stretcher Transit Isolator	4 each	X
Isolator Laboratory Bench top	2 each	X
Shower, Portable Decontamination	2 each	X
Protective Over garments w/HEPA Filtration	17 each	X
Defibrillator, Portable w/Monitor	2 each	X
Analyzer, Portable Clinical w/Printer (ISAT)	2 each	
Analyzer, Portable Lactate (Accusport)	2 each	
Pump, Infusion	4 each	X
Patient Monitor, Mobile	2 each	X
Apparatus, Suction Portable	4 each	X
Medical Aid Bag	4 each	X
Drug Box	2 each	X
MREs, Chem Lights, Flashlights	8 each	X
Hand-held Radios	6 each	X
Laptop Computer W/Docking Station	2 each	
Printer	2 each	
Fax Machine, Portable	2 each	
Camera, Digital 2.1 Mega Pixel	2 each	
Portable Gas-powered Generator	2 each	X
Lights, Flood Staging	8 each	
Power Strip	4 each	
Professional Book Set	2 each	
Tools, Medical Maintenance	1 each	
Equipment Case Set, Padded	2 each	

Powered Air Purifying Respirator (PAPR)	8 each	
Battery, NiCad (rechargeable)	8 each	
Battery, Lithium (long life)	8 each	
Coverall, Tychem-BR	8 each	
Gloves, Butyl	8 pair	
Gloves, Nitrile	8 pair	
Boots, HAZMAX	8 pair	

Tab 4, Outside Continental United States (OCONUS) for Special Medical Augmentation Response Team (SMART), to Appendix C, SMART, to MEDCOM Pam 525-1 (Medical Emergency Management Planning)

1. INTRODUCTION.

a. Reference The Surgeon General's Guidance.

b. Authority. The US Army Surgeon General may deploy SMART teams OCONUS only with the authority from Department of the Army and MEDCOM.

c. Commanders Intent. For OCONUS contingency planning SMART will be capable of rapidly deploying year round in support of legitimate emergency incidents and specifically at the request of the proper Federal authorities and cleared through the chain of command. Teams will utilize their organic personnel and material. Teams will respond to the senior US military commander having OPCON on the ground. Due to possible extended distances to mission location site, OCONUS SMART missions will require preparation time and coordination to sustain personnel for periods of up to 7 days.

d. Teams. The provisions of this appendix are applicable to all SMARTS.

e. Team Composition. Teams may be tailored for the mission and task force organized based on the request and mission analysis. The MEDCOM will approve the composition.

f. Responsibilities. Parent organizations are responsible for determining special immunizations and vaccinations required by personnel prior to deployment on a SMART mission based upon the area of operation(s) (AO) into which the team is deploying.

2. PURPOSE. To provide guidance, support, and liaison to military/civil authorities OCONUS during disaster, civil-military cooperative actions, humanitarian assistance, weapons of mass destruction and emergency incidents, supporting the OCONUS Unified Command in whose area of responsibility the SMART is operating.

3. MISSION. Upon receipt of a validated SMART tasking from MEDCOM, the designated subordinate command(s) will deploy the requested SMARTs OCONUS to provide short duration medical liaison to defense agencies or medical teams responding to disaster, civil-military cooperative action, humanitarian, and emergency response to OCONUS incidents.

4. STRUCTURE. The SMARTs are task organized based on the factors of METT-T and the medical mission/risk analysis in order to provide the appropriate level of response and technical liaison required to OCONUS civil and military authorities.

5. CONCEPT OF OPERATION.

a. The SMARTs are designed to support regional domestic events. Arms, ammunition, or explosives may be authorized by MEDCOM only for employment, if the situation OCONUS to which they are deploying indicates such for self-protection and/or mission accomplishment.

b. SMARTs will typically support disasters, civil-military cooperative action, humanitarian and emergency services in five phases as identified in paragraph 4-6 of the concept of operations (CONOPS) in chapter 4 with the following exceptions.

(1) Phase I, Predeployment, Alert, and Assembly. Under major actions, add "Vaccinate and immunize as necessary for the AO to which deploying." Add "Ensure all members have valid passports for the AO to which deploying."

(2) Phase II, Deployment. Change paragraph 4-6b(2)(a)(3) to "Establish liaison with senior US military authority."

(3) Phase III, Employment. No change. Because of distances involved, this phase will almost certainly exceed 72 hours, and may extend beyond the maximum 7 days anticipated within CONUS.

(4) Phase IV, Transition. Delete "change" and add "transition to supported OCONUS command."

(5) Phase V, Redeployment. No change.

6. ADMINISTRATION AND LOGISTICS.

a. Deployment Platforms. No Change.

b. When SMART assets are deployed on OCONUS missions for extended periods, MEDCOM may selectively redistribute personnel, equipment, and/or resources from all regions to units tasked with OCONUS missions.

c. Duration of Deployment. Teams should deploy with sufficient food, clothing (weather dependent), personal hygiene items and equipment to sustain themselves in an austere environment for 72 hours. Equipment and supplies for this initial period are managed and maintained as basic loads. Logistical sustainment support will be planned and provided for a minimum of 30 days.

d. Sustainment. If extenuating or mitigating circumstances requiring extension of deployment beyond the minimum period forecasted in the mission, team members will obtain logistical support from a combination of local procurement through team member's government card and formal requisitions utilizing the TAMMIS Customers Assistant Module (TCAM) to local supporting IMSAs or through directed means through local, Civil, or lead Federal Agency.

e. Deployment Orders. Same as paragraph 4-7a(6), in basic CONOPS with the following exceptions: 4-7a(6)(b) - Uniform for travel is dependent on the situation and will be prescribed on the order. Temporary duty orders will have authorizations for rental car, variances, excess baggage, hotel, supplies, and official phone calls and faxes.

f. Meals/Lodging, Contraband, Personal Conduct, Medical Force Protection, and Risk Assessments. No change.

g. Uniform and Equipment (Paragraph 4-7b. Deployment/Redeployment Uniform Common to All: "As specified on temporary duty orders when using commercial conveyance." (Uniform and equipment are situation dependent.)

h. Hazardous Cargo: No Change.

i. SMART Equipment. SMART Equipment (paragraph 4-7d): Due to the nature of OCONUS, equipment list may be expanded. However, if commercial air is to be utilized, all equipment must be packed/boxed/containerized so that it meets commercial airframe size, weight, and cube requirements.

j. Official Passports. Each SMART member is required to have an official passport.

k. Country Clearance. The MEDCOM will coordinate country clearances for each member on the team. It is imperative that personnel listed to deploy have been cleared through MEDCOM and approved.

l. Credit Cards. Each SMART member will have a government credit card and will verify credit card status prior to deployment. Each team chief will deploy with an IMPAC card for mission-related expenses.

m. Military Identification. Military identification items will be verified to include the military identification (ID) card (DD Form 2) and the personnel identification tags. The individual's Serviceman's Group Life Insurance (SGLI) and emergency data card will be updated prior to deployment.

n. Antiterrorism. Once alerted, each member is required to receive an antiterrorism update prior to deployment.

7. COMMAND AND CONTROL.

a. Command. See Base Plan.

b. Signal. See Base Plan.

Tab 5, Commander's Critical Information Requirements (CCIR) for Special Medical Augmentation Response Team (SMART,) to Appendix C, SMART, to this pamphlet (Medical Emergency Management Planning)

1. INTRODUCTION. This appendix is to provide the structure and process of providing the Commander's Critical Information Requirements (CCIR) to HQ MEDCOM once a team(s) is alerted and deployed.

2. RESPONSIBILITIES. The senior team member of each SMART will be responsible for reporting the CCIR once on the ground and every 12 hours thereafter.

3. PURPOSE. To ensure immediate feedback of accurate information and assessment back to the Commander, MEDCOM via the Emergency Operations Center.

4. CONCEPT OF OPERATIONS. The following format will be used to report the CCIR.

- a. Date/Time Group.
- b. Location.
- c. Current situation.
- d. Lead Federal Agent in Charge.
- e. Assessment (by team) of the situation.
- f. Additional military medical support required.
- g. Duration/length projected.
- h. Senior military officer and unit.
- i. Senior AMEDD Officer.
- j. Logistical requirements.

Appendix D, Medical Nuclear Biological Chemical Defense Materiel (MNBCDM) to this pamphlet (Medical Emergency Management Planning)

1. **PURPOSE.** To provide policy and procedural guidance on the storage, issue, and usage of MNBCDM.

2. **CONCEPT.**

a. Due to the increased threat level to CONUS installations, MNBCDM must be on hand in greater quantities, have decentralized storage, have rapid distribution systems, and be readily available to installation and MTF commanders.

b. The target population receiving MNBCDM has increased and will be at the discretion of the local installation commander based on the scope of a CBRNE event occurring on or near a CONUS installation.

3. **PROCEDURES.**

a. Medical items that have been designated as MNBCDM are:

(1) Nerve Agent Antidote Treatment Kit (NAAK)/multi-chamber Auto Injector Kit (Mark I), which consist of (1) atropine and (1) 2-pam chloride Auto injector, NSN 6505-01-174-9919.

(2) Atropine Injection, NSN 6505-00-926-9083.

(3) Pralidoxime Chloride injection (2-pam chloride), NSN 6505-01-125-3248.

(4) Pyridostigmine Bromide, 30 mg tablets, US Pharmacoeological 210 tabs/package, Nerve Agent Pretreatment Pyridostigmine (NAPP)/PB, NSN 6505-01-178-7903.

(5) Diazepam US Pharmacological 5 mg/ml, 2 ml Auto injector, (Convulsant Antidote Nerve Agent) (CANA), NSN 6505-01-274-0951.

(6) Cyanide Kit, consisting of Sodium Nitrite and Sodium Thiosulfate, NSN 6505-01-143-4641 or 6505-01-457-8901.

(7) Ciprofloxacin, 500 mg, tablets, NSN 6505-01-333-4154, 6505-01-273-8650 or 6505-01-272-2385 or 6505-01-149-2834.

(8) Patient Chemical Wrap and Litter, NSN 6530-01-383-6260.

(9) Medical Aerosolized Nerve Agent Antidote (MANAA), NSN 6505-01-332-1281.

(10) Doxycycline 100, capsules, NSN 6505-01-009-5060.

(11) Skin Exposure Reduction Paste Against Chemical Warfare Agents (SERPACWA), NSN 6505-01-483-7162.

(12) Potassium Iodide, Tablets, NSN 6505-01-116-8198.

(13) Potassium Iodide USP, 1 pound bottle, NSN 6505-00-136-7000.

b. MNBCDM is managed under two different programs.

c. The Centralized Managed (DA-funded) Program funds, procures, consolidates, and stores strategic MNBCDM stockpiles for Army Forces in support of DOD or Joint Chiefs of Staff Operations. The Army Deputy Chief of Staff for Operations (DCSOPS), with OTSG and US Army Medical Materiel Agency (USAMMA), manages this program. This program has two parts, one for Individual Service Members and a second for Installation Support Package.

d. Materiel for Individual Service Members is configured into Deployable Force Packages (DFP). This materiel supports deploying forces in support of Joint Chiefs of Staff Operations. This program consists of MNBCDM that supports individual service member requirements during the initial stages of a contingency, and allows the industrial base time to move into full production of these items. (NOTE: DFP is the new term for the Division Ready Brigade (DRB) packages that were configured to 5,000 individuals.) The current packages are configured to different size forces, based on the missions. The components of the DFP sets are:

(1) NAAK/MARK I (Basis of issue is 3 per individual).

(2) NAPP/PB (Basis of issue is one package per five individuals).

(3) CANA (Basis of issue is one per individual).

(4) Ciprofloxacin 500mg tablets (Basis of issue is 30 tablets per individual).

(5) Doxycycline 100, capsules, NSN 6505-00-009-5060 (Basis of issue is 30 capsules per individual).

e. The Antibiotics in the DFP will consist of Ciprofloxacin and Doxycycline.

4. Materiel for Installation Support Package is managed similar to the DFP but does not include NAPP/PB.

a. The locally managed (MACOM/Unit Funded) program funds, procures, and stores MNBCDM that:

(1) A 15-day of the supply of MNBCDM is on hand for 25% of the installation population.

(2) Is a component of Medical Equipment Sets.

(3) Supports the installation in the event of a CBRNE incident.

(4) Is for the support of nonmilitary personnel in overseas areas.

(5) Supports Chemical Accidents/Incident Response Assistance (CAIRA).

(6) Supports explosive ordnance disposal missions.

(7) Supports toxic storage/research/ammunition facility support missions.

(8) Supports ARNG Incident Teams involving Weapons of Mass Destruction (WMD)/Domestic Preparedness.

(9) Supports other emergency response teams such as DA response teams (DART), Special Medical Augmentation Response Teams (SMART) and QRF/Ready Reaction Forces (RRF) that are not part of the Installation Force Protection Program.

b. Functions for Centralized Managed Program.

(1) OTSG will approve MNBCDM requirements, identify storage locations, and provide policy guidance as well as programming, budgeting, funding, and coordinating the release of MNBCDM.

(2) USAMMA will procure and coordinate with storage locations, distribute, maintain accountable records, manage the MNBCDM in the Shelf Life Extension Program (SLEP) and provide disposition instructions.

(3) MTF/Installations will exercise prudent care, accountability, custody, and reporting of MNBCDM. All materiel will be stored and maintained per security and environmental requirements as required per manufacturer's specifications, governmental regulations, or as noted in the Army Master Data File (AMDF), Federal Logistics Record (FEDLOG), or Universal Data Repository (UDR). Inventory and surveillance reports will be submitted monthly to USAMMA. All materiel will be recorded on accountable records and assigned applicable project and ownership/purpose codes. Applicable codes will be given to each activity when materiel is being shipped to them for storage.

c. Requesting release for materiel.

(1) Elements requesting materiel from the Centralized Managed Program, for deployment in a JCS Operation, DOD Force Protection Operation will request the materiel as follows:

(a) The DFP materiel is only for use for forces deploying to an operation, not for exercises or security missions. The element requesting the materiel must be on deployment orders or if Individual Augmentees, must be in the World Wide Individual Augmentation System (WWIAS).

(b) Units/Individuals identified for Installation Force Protection missions must be listed in a formal tasking from the MACOM/CINC. The tasking must be in writing as a letter, message, or other formal means.

(c) Mandatory Request for release authority to OTSG-OPS Health Care Operations, OPS Center XXI 703-681-8052. Information required for release is as follows:

1 Deployment Order Number, WWIAS Task Number, message or letter giving the element of the mission, and what MNBCDM is required.

2 Number of personnel who will need the materiel.

3 Date the materiel will be required.

4 Location of the personnel and where are they deploying out of.

5 For Individual Augmentees, are they joining up with the unit before it deploys to its mission or will they join it already deployed?

6 For Individual Augmentees, that are joining up with a Special Operations Element.

(d) Release instructions to the storage activity for centrally managed materiel, will include instructions on how and what materiel the activity is to issue to the unit:

(1) In-bulk to the unit.

(2) Issue only the NAAK/MARK I to the unit.

(3) Bulk shipment of CANA and antibiotics (Cipro/Doxy/Tetracycline) to the theater.

(4) Individual Issue of CANA and Antibiotics are not authorized until directed by the Theater CINC.

(5) NAPP/PB may only be issued from the storage activity with written permission from The Surgeon General.

d. Materiel being requested for a MACOM/Unit Directed Mission:

(1) The element/units requesting the materiel will submit a letter through channels to Headquarters DASG, ATTN: DASG-HCO, 5111 Leesburg Pike, Suite 401, Falls Church, VA 22041-3258. The letter should state the following:

(a) Who gave the unit the mission that required it to have on-hand MNBCDM. Attach a copy of the mission, if available.

(b) Quantity, description, and NSN of the MNBCDM being requested.

(c) Certification that there is appropriate storage and security for the materiel at the location.

(d) Name of storage activity that the materiel will be obtained from (i.e., Medical Supply Activity, MED LOG BN, EST).

(2) Approvals will include the validation of materiel with an Acquisition Advice Code (AAC) for army units. The approval/validation will be sent to deploying units, requesting RMC/IMSA, or other storage activities, USAMMA as a templated standardized message from the MEDCOM through EOC channels. The approval/validation will be for a maximum of 5 years. Storage activities will process the requisition offline IAW directions of the approval/validation letter and AR 40-61. No further authorization is needed for materiel that is not part of the Centrally Managed Program.

e. Storage procedures.

(1) Storage procedures for MNBCDM not listed below can be found in the UDR. If materiel has been exposed to conditions other than those stated below, report immediately to USAMMA. Store MNBCDM items as follows:

(a) Mark I/NAAK/atropine/2-pam chloride: store at room temperature between 50 and 86 degrees Fahrenheit. Keep from freezing. Mark I/NAAK is a prescription use only item and contains two needles. It must be stored in a locked container, (i.e., wall locker in limited access area) with limited access, IAW AR 190-51, para 4-20 until issued to an individual.

(b) CANA: this item is a schedule IV, CIIC code Q, controlled substance and requires storage in a GSA approved safe or vault, IAW Para 4-8, AR 190-51 and at room temperature between 50 and 86 degrees Fahrenheit. It is a prescription use only item. This item must be inventoried monthly IAW AR 40-3, appendix B and AR 40-61, chapter 3.

(c) Antibiotics (Cipro/Doxy)/Cyanide kits: store at room temperature between 50 and 86 degrees Fahrenheit. Antibiotics/cyanide kits are a prescription use only item.

(d) NAPP/PB:

(2) This item requires refrigeration. It should be in a refrigerator that has an automatic temperature monitor with recorder that will ensure that the temperature in the refrigerator is maintained between 35-46 degrees Fahrenheit. No other items, e.g., food, batteries, photo film, etc., may be stored in this refrigerator except for class viii materiel. Anytime the NAPP/PB is exposed to temperatures above 46 degrees; a record must be made of the time exposed. When the cumulative time in storage above 46 degrees has exceeded 6 months, segregate those packages and report this materiel to USAMMA, ATTN: Ms. Teresa Bess, DSN 343-4306 or commercial (301) 619-4306 for disposition instructions. Funding for replacement materiel exposed to temperatures above 46 degrees will normally be the responsibility of the custodial unit/activity, not OTSG.

(3) NAPP/PB is not FDA approved for the pretreatment of nerve agent exposure. It is considered an Investigational New Drug (IND). Storage, inventory, and accountability of an IND are the same as for a controlled substance with a CIIC code of Q. The refrigerator needs to be locked or maintained in a limited access, locked room.

(4) NAPP/PB may only be issued from the storage activity with written permission of The Surgeon General.

f. Do not store MNBCDM or any other Class VIII items with-in the same container/refrigerator with Non-Class VIII materiel, i.e., Cs2 pellets, mal alarms, chemical DECON kits, Chemical-Testing Kits, cleaning and lube products for weapons or ammunition, batteries, photo film, food or beverages.

g. Custody of materiel:

(1) A chain of custody must be maintained from the storage activity to the unit to the individual service member.

(2) The storage activity will give a copy of the directions for release to individuals in paragraph 3.d and 4 above, or to the requestor, when the materiel is released to the unit.

h. Release of materiel to individuals:

(1) A roster, manual or automated, will be maintained for all MNBCDM issued to individuals. The roster will contain the individual's name, SSN, rank, name of drug, quantity issued, and the time and date of the issue.

(2) When the materiel is turned-in, the roster will be annotated with the quantity returned along with the time and date of the action. Comments will explain reasons for any nonreturn assets (consumed, lost, damaged, etc.). Assets issued to individual service members will be segregated and turned in the storage activity for destruction. This materiel will not be placed in the SLEP. A copy of the destruction document will be sent to USAMMA.

(3) Assets not issued to individual service members will be turned-in separately to the storage activity. The unit, turning in the materiel, will provide information on how the materiel was stored (temperature), a unit POC and commercial phone number. The storage activity will segregate this materiel, place it in condition code j, and report it to USAMMA. USAMMA will issue disposition instruction on this materiel.

(4) Copies of the roster will be sent to Headquarters DASG, ATTN: DASG-HCO, 5111 Leesburg Pike, Suite 401 Falls Church, VA 22041-3258.

i. Accounting/Documentation for all elements with MNBCDM:

(1) Centralized-managed assets will be accounted for on TAMMIS/DMLSS as Contingency Stocks. All receipts and issues will be recorded. Centralized managed assets will be issued to storage accounts free of charge and issued to approved customers, free of charge. Use of specific project code, fund code and ownership purpose codes will be identified to the storage activity when applicable materiel is issued to the activity. Activities will not use or invent project codes without specific guidance from USAMMA.

(2) Units without medical automation capability (TAMMIS or DMLSS) will account for MNBCDM on DA Form 1296 or other DA/DD or local forms. One form will be used for each item.

(3) Documentation: All storage areas must have a thermometer and the temperature recorded automatically or manually, twice a day. A log/file will be maintained for minimum of 5 years or until the current items are turned-in and new materiel is issued. Any deviations in the required storage temperatures will be reported when the materiel is turned-in.

(4) Any changes in on-hand balances of MNBCDM will be reported immediately to USAMMA. Copies of release documents for materiel in centralized managed program will be sent to USAMMA when assets are received

or released. Information required for the report is: Reason for change in quantity, i.e., receipt of new materiel, issue, turn-in, lot number, NSN, nomenclature, expiration date and reason for having on hand (i.e., exercise, mission, deployment) and thereafter by the 5th of every month. You may fax the report to USAMMA.

j. When materiel is within 6 months of expiring, or is no longer needed, coordinate with USAMMA Quality Assurance DSN 343-4306 or commercial (301) 619-4306 for disposition instructions. Medical supply activities/units are not authorized to retain extended assets of Atropine, 2-PAM Chloride, CANA, Ciprofloxacin, or MARK I kits. Army Prepositioned Stocks/Unit Deployment Package (APS/UDP) assets are excluded from the policy of not retaining extended assets, but must continue to segregate and report extended assets to USAMMA Quality Assurance. APS/UDP assets may only be issued after they are relabeled IAW FDA's guidance for SLEP items.

k. Use of MNBCDM for training. Units will not use, issue, or be issued expired or extended MNBCDM for training purposes. Trainers will use training kit, Nerve Agent Antidote, NAAK/MARK I, NSN 6910-01-194-7251.

Glossary

-A-

AA.....Air Ambulance
AAC.....Acquisition Advice Code
AAR.....After Action Report
ABC.....Airway, Breathing, Circulation
ABLS.....Advance Burn Life Support
ACH.....Army Community Hospital
ACLS.....Advance Cardiac Life Support
ACMAO.....Army Casualty and Mortuary Affairs Office
ACSArmy Community Service
ACSIE&FM.....Assistant Chief of Staff for
Installations, Environment, and
Facilities Management
ACSLOG.....Assistant Chief of Staff for Logistics
ACSOPS.....Assistant Chief of Staff for Operations
ACSPER.....Assistant Chief of Staff for Personnel
AFMOArmy Frequency Management Office
AFRRI.....Armed Forces Radiobiology Research
Institute
ALS.....Advanced Life Support
AMC.....Army Medical Center
AMDF.....Army Master Data File
AMEDD.....Army Medical Department
AMFC.....Army Medical Fusion Center
AN.....Army Nurse
AO.....Area of Operations
AOC.....Area of Concentration

AOD.....Administrative Officer of the Day
 AOHA.....American Osteopathic Hospital Association
 AOR.....Area of Responsibility
 APIC.....Acquisition Process Improvement Campaign
 APS.....Army Prepositioned Stocks
 AR.....Army regulation
 ARC.....American Red Cross
 ASBPO.....Armed Services Blood Program Office
 ASD-HA.....Assistant Secretary of Defense for Health
 Affairs
 ASWBPL.....Armed Services Whole Blood Processing
 Laboratory
 AT.....Anti-Terrorism
 ATLS.....Advance Trauma Life Support
 AVMA.....American Veterinary Medical Association

-B-

BAMC.....Brooke Army Medical Center
 BC/BE.....Board Certified/Board Eligible
 BDU.....Battle Dress Uniform
 Bio.....Biological
 BH.....Behavioral Health
 BLS.....Basic Life Support
 BSI.....Base Support Installation

-C-

C2.....Command and Control
 C4.....Combat Casualty Care Course
 CAIRA.....Chemical Accidents/Incident Response
 Assistance
 CANA.....Convulsant Antidote Nerve Agent

CBRNE.....Chemical, Biological, Radiological,
Nuclear and Explosives

CC.....Command Center

CCIR.....Commander's Critical Information
Requirements

CDCCenters for Disease Control and
Prevention

CEMP.....Comprehensive Emergency Management Plan

CHART.....Combined Humanitarian Assistance Response
Training

CHCS.....Composite Health Care System

CHEM.....Chemical

CHEM/BIO.....Chemical/Biological

CHEMCON.....Chemically Contaminated

CHPPM.....US Army Center for Health Promotion
and Preventive Medicine

CINC.....Commander In Chief

CINCJFCOM.....Commander In Chief, Joint Forces Command

CINCPAC.....Commander In Chief, Pacific Command

CINCSOUTHCOM.....Commander In Chief, Southern Command

CINCTRANSCOM.....Commander In Chief Transportation Command

CME.....Continuing Medical Education

COMFORSCOM.....Commander, Forces Command

CONOPS.....Concept of Operations

CONUS.....Continental United States

CONUSA.....Continental United States Army

COSC.....Combat Stress Control

CPR.....Cardio-Pulmonary Resuscitation

CSA.....Chief of Staff of the Army

CTA.....Common Tables of Allowances

CTT.....Common Task Test

-D-

DART.....DA Response Teams

DCA.....Deputy Commander for Administration

DCCS.....Deputy Commander for Clinical Services

DCE.....Defense Coordinating Element

DCN.....Deputy Commander for Nursing

DCO.....Defense Coordinating Officer

DCSOPS.....Deputy Chief of Staff for Operations

DEERS.....Defense Enrollment Eligibility Reporting
System

DENTAC.....Dental Activity

DEPMEDS.....Deployable Medical System

DFO.....Disaster Field Office

DFP.....Deployable Force Packages

DHHS.....Department of Health and Human Services

DHP.....Defense Health Program

DHS.....Director of Health Services

DIME.....Delayed, Immediate, Minimal, Expectant

DLA.....Defense Logistics Agency

DMAT.....Disaster Medical Assistance Team

DMLSS.....Defense Medical Logistics Standard
Support

DMORT.....Disaster Mortuary Team

DOD.....Department of Defense

DODD.....Department of Defense Directive

DODI.....Department of Defense Instruction

DOEHRS.....Defense Occupational and Environmental
Health Readiness System

DOERS.....Department of Energy Record Schedules

DOIM.....Directorate of Information Management

DOMS.....Directorate of Military Support

DON.....Department of Nursing

DOT.....Department of Transportation

DPTMSEC.....Directorate of Plans, Training,
Mobilization, and Security

DPW.....Directorate of Public Works

DRB.....Division Ready Brigade

DRTF.....Disaster Response Task Force

DSCP.....Defense Supply Center Philadelphia

DTG.....Date Time Group

DVA.....Department of Veterans Affairs

-E-

EA.....Executive Agent

ED.....Emergency Department

EHO.....Environmental Health Officer

EMMC.....Emergency Medical Ministry Course

EMP.....Emergency Management Plan

EMPC.....Emergency Management Planning Committee

EMPO.....Emergency Medical Preparedness Office

EMS.....Emergency Medical Service

EMT.....Emergency Medical Technician

EOC.....Emergency Operations Center

EOD.....Explosive Ordnance Detachment

EPA.....Environmental Protection Agency

HAZMAT.....Hazardous Material
HAZWOPR.....Hazardous Waste Operations and Emergency
Response
HEICS.....Hospital Emergency Incident Control
System
HLS.....Homeland Security
HQ.....Headquarters
HSA.....Health Service Areas
HSR.....Health Service Regions

-I-

IAW.....In Accordance With
ICISF.....International Critical Incident Stress
Foundation
ICS.....Image Capture System/Image Communication
Services
ICU.....Intensive Care Unit
ICS.....Incident Command System
ID.....Identification
IEM.....Incident Execution Matrix
IM.....Information Management
IMD.....Information Management Division
IMSA.....Installation Medical Supply Activity
IND.....Investigational New Drug
IOC.....Installation Operations Center
ISR.....US Army Institute of Surgical Research
IT.....Information Technology

-J-

JCAHO.....Joint Commission on Accreditation of
Healthcare Organizations

JCS.....Joint Chiefs of Staff
 JFCOM.....Joint Forces Command
 JIC.....Joint Information Center
 JRMPO.....Joint Regional Medical Planning Officer
 JSOC.....Joint Special Operations Command
 JTF.....Joint Task Force
 JTF-CS.....Joint Task Force - Civil Support

-K-

-L-

LAN.....Local Area Network
 LBE.....Load Bearing Equipment
 LFA.....Lead Federal Agency
 LNO.....Liaison Officer
 LOA.....Lead Operational Authority
 LOC.....Logistics Operations Center
 LOG.....Logistics

-M-

MACA.....Military Assistance to Civil Authorities
 MACOM.....Major Army Command
 MANAA.....Medical Aerosolized Nerve Agent Antidote
 MASCAL.....Mass Casualty
 MC.....Medical Corps
 MD.....Medical Doctor
 MEDCEN.....Medical center
 MEDCOM.....US Army Medical Command
 MEDDAC.....Medical Department Activity
 MEDEVAC.....Medical Evacuation

MEDSITREP.....Medical Situation Report

MEIR.....Medical Effects of Ionizing Radiation

MEMP.....Medical Emergency Management Plan

METT-T.....Mission, Enemy, Troops, Terrain, + Time

MMCBC.....Medical Management of Chemical Biological
Casualties

MMR.....Medical Readiness Report

MMRS.....Metropolitan Medical Response System

MNBCDM.....Medical Nuclear Biological Chemical
Defense Materiel

MOA.....Memorandum of Agreement

MOS.....Military Occupational Specialty

MOU.....Memorandum of Understanding

MPH.....Masters of Public Health

MRE.....Meal Ready to Eat

MRMC.....US Army Medical Research and Materiel
Command

MRR.....Medical Readiness Report

MSC.....Major Subordinate Command

MSCA.....Military Support to Civil Authorities

MSDS.....Material Safety Data Sheets

MTF.....Military Treatment Facility

-N-

NAAK.....Nerve Agent Antidote Treatment Kit

NAICO.....Nuclear Accident/Incident Control Officer

NAPP.....Nerve Agent Pretreatment Pyridostigmine

NBC.....Nuclear, Biological, and Chemical

NCO.....Noncommissioned Officer

NCOIC.....Noncommissioned Officer-in-Charge

NDMS.....National Disaster Medical System

NETOPS.....Nuclear Emergency Team Operations

NHTC.....Nuclear Hazards Training Course

NMRT.....National Medical Response Team

NORTHCOM.....Northern Command

NOVA.....National Organization for Victims
Assistance

NPSP.....National Pharmaceutical Stockpile Program

NTSB.....National Transportation Safety Board

-O-

OACSOPS.....Office of the Assistant Chief of Staff
for Operations

OCIE.....Organizational Clothing and Individual
Equipment

OCONUS.....Outside Continental United States

OEH/ED.....Occupational and Environmental Health and
Endemic Disease

OES.....Office of Energy Services

OHMIS.....Occupational Health Management
Information System

OIC.....Officer-in-Charge

OPCON.....Operational Control

OR.....Operating Room

OSHA.....Occupational Safety and Health
Administration

OTSG.....Office of The Surgeon General

-P-

PAD.....Patient Administration Division

PALS.....Pediatric Advanced Life Support

PAM.....Pamphlet

PAO.....Public Affairs Officer

PAPR.....Powered Air-Purifying Respirator

PASS.....Pull, Aim, Squeeze, Sweep

PBX.....Private Branch Exchange (private
telephone switchboard)

PD.....Presidential Directive

PHS.....Public Health Service

PM.....Preventive Medicine

PMO.....Provost Marshal Office

POC.....Point of Contact

POL.....Petroleum, Oil, and Lubricants

PPA.....Principal Planning Agent

PPE.....Personal Protection Equipment

PROFIS.....Professional Filler System

PTMS.....Plans, Training, Mobilization, and
Security

PTSD.....Post Traumatic Stress Disorder

-Q-

QRF.....Quick Reaction Forces

-R-

RACE.....Rescue, Alarm, Confine, Extinguish/
Evacuate

RAMT.....Radiological Advisory Medical Team

REG.....Regulation

RFA.....Request for Assistance

RFI.....Request For Assistance

RIDES.....Rescue, Isolate, Dial, Extinguish,
Security

SMART-MC3T.....Special Medical Augmentation Response
Team - Medical Command, Control,
Communications, Telemedicine

SMART-NBC.....Special Medical Augmentation Response
Team - Nuclear/Biological/Chemical

SMART-PC.....Special Medical Augmentation Response
Team - Pastoral Care

SMART-PM.....Special Medical Augmentation Response
Team - Preventive Medicine

SMART-SM.....Special Medical Augmentation Response
Team - Stress Management

SMART-TCC.....Special Medical Augmentation Response
Team - Trauma/Critical Care

SMART-V.....Special Medical Augmentation Response
Team - Veterinary

SME.....Subject Matter Expert

SOP.....Standard Operating Procedures

SRP.....Solider Readiness Processing

SSAN.....Social Security Account Number

STU.....Secure Telephone Unit

-T-

TAG.....The Adjutant General

TAMMIS.....Theater Army Medical Materiel Information
System

TATRC.....Tele-Medicine and Advanced Technology
Research Center

TBP.....To Be Published

TCAM.....TAMMIS Customer Assistance Module

TCC.....Trauma/Critical Care

TDA.....Table of Distribution and Allowances

TDY.....Temporary Duty

TF.....Task Force

TIC.....Toxic Industrial Chemical

TIM.....Toxic Industrial Material

TMFC.....Technical Medical Fusion Cell

TNCC.....Trauma Nursing Combat Care

TOE.....Table of Organization and Equipment

TRACES.....TRANSCOM Regulating and Command and
Control Evacuation System

TRANSCOM.....Transportation Command

TSG.....The Surgeon General

-U-

UCMJ.....Uniform Code of Military Justice

UDP.....Unit Deployment Package

UDR.....Universal Data Repository

USACE.....US Army Corps of Engineers

USAF.....US Air Force

USAFSAM.....US Air Force School of Aerospace
Medicine

USAMMA.....US Army Medical Materiel Agency

USAMRICD.....US Army Medical Research Institute of
Chemical Defense

USAMRIID.....US Army Medical Research Institute of
Infectious Disease

USC.....US Code

USCINCCENT.....US Commander-in-Chief, Central Command

USCINCEUCOM.....US Commander-in-Chief, European Command

USCINCJFCOM.....US Commander-in-Chief, Joint Forces
Command

USCINCPAC.....US Commander-in-Chief, Pacific Command

USCINCSOUTH.....US Commander-in-Chief, Southern Command

USCINCTRANS.....US Commander-in-Chief, Transportation
Command

USDA.....US Department of Agriculture

USJFCOM.....US Joint Forces Command

USPHS.....US Public Health Service

USR.....Unit Status Report

-V-

VAMC.....Veterans Administration Medical Center

VCO.....Veterinary Control Officer

VELP.....Veterinary Emergencies of Large
Populations

VETCOM.....US Army Veterinary Command

VMAT.....Veterinary Medical Assistance Team

-W-

WMD.....Weapons of Mass Destruction

WMDCS.....Weapons of Mass Destruction Civil Support

WRAMC.....Walter Reed Army Medical Center

WWIAS.....World Wide Individual Augmentation System

-X-

-Y-

-Z-

The proponent of this publication is the Office of the Assistant Chief of Staff for Operations. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, US Army Medical Command, ATTN: MCOP-P, 2050 Worth Road, Fort Sam Houston, TX 78234-6007.

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