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III. GENERAL CONCEPT OF OPERATIONS

A. MANAGEMENT SUPPORT TEAM CAPABILITIES

Federal, State, and local emergency management officials may not be fully aware of the HHS health and medical response capability and its uses. It is incumbent upon the responding management element to provide ongoing briefings for officials to ensure the best use of these resources.

Depending on the nature of the disaster, the MST may respond fully staffed for 24-hour operation. The MST-A initially deploys without health and medical specialty teams. Its purpose is to perform an assessment of the need for and the potential uses of additional HHS health and medical response resources. The MST-A may also brief Federal, State, and local officials on the capabilities of available HHS health and medical response resources.

The lead agency with overall management of the disaster may concur with the State's request to have the MST and specialty teams work within the local incident command structure, and not be a part of the Federal response organization. Depending upon the need of State and local officials, the MST may manage all health and medical response resources.

ICs from assisting agencies, involved either by law, jurisdiction or functional responsibility including the designee from the HHS health and medical response may be formed into a Unified Command. This Unified Command structure joins ICs together in a unified command with one set of objectives and a single Action Plan and organization. These management options depend on the procedures in place in the local jurisdiction, the kind and extent of the disaster, and the approval of agencies providing Unified Commanders.

Unified Commanders would work together to identify and establish priorities for strategic and tactical objectives in action planning. The Operations Section Chief would be from the agency having the greatest functional and/or geographic involvement. Deputies would be used as needed from all agencies participating, down to and including the Branch Director level. Deputies would be assigned in conjunction with their functional or geographic responsibilities. Deputies are fully qualified in their assigned position and are not trainees.

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A. MANAGEMENT SUPPORT TEAM CAPABILITIES

There may be occasions, when the State and local officials require one or more of the health and medical teams to work with a local Incident Management Team. This situation might require a modified MST for coordination purposes that would be part of the local Incident Management Team. The RHA and CFO need to evaluate these options and provide local officials with recommended procedures. Depending on the need of State and local officials, the following assistance can be provided by the MST.

- Brief officials on the availability and capabilities of available and responding resources;

- Provide additional assessment capability;

- Provide a HHS health and medical official to be part of a Unified Command;

- Provide Technical Specialists to assist State and local teams;

- Prepare for the arrival, briefing, and assignment of DMATs and other specialty teams to disaster activities;

- Recommend appropriate health and medical measures to support disaster objectives;

- Recommend to officials the deployment of additional health and medical response resources as appropriate;

- Establish a system of resupply for the MST and specialty teams that does not diminish local resources;

- Manage specialty teams to reduce workload on the local Incident Management Teams; and

- Manage teams to meet stated objectives and to provide for health and welfare of all health and medical response resources assigned.

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B. ACTIVATION

The request for HHS health and medical response resources comes from the headquarters of other agencies that have response agreements with HHS or from the HHS region in a situation where the State requests assistance. These requests are received at the OEP/EOC in Rockville, Maryland and are generally specific in nature and initiate pre-established procedures in place at the OEP/EOC. Depending on the severity of the incident, HHS places HHS health and medical response resources on alert or activates them to respond to a previously designated point of departure for deployment to the disaster. The RHA will contact requesting officials and begin the process of assessing the potential for disaster assistance and be in place to receive and brief incoming resources. If the region is unable to provide appropriate health and medical liaison where it is required, it will be provided by assignment by OEP through the OEP/EOC.

Upon request by another Federal agency or under their own authority, HHS responds rapidly to an impending event or one that has just occurred. Upon activation the OEP/EOC will assign a Chief of Party (CFO, MST Leader or other designated senior official traveling in the group) for responding resources. The Chief of Party represents the HHS in all contacts en-route with the OEP/EOC and in dealings with other response coordination organizations like FEMA's Emergency Support Team (EST). When en-route personnel reach their point of arrival and/or their reporting location, the responsibilities of the Chief of Party will end and the MST is integrated into the existing response organization.

Qualified MST members are rostered from established rosters of personnel. These rosters are maintained by the OEP. The individuals identified have completed all training and experience requirements for the position assigned in accordance with Units VI - Position Requirements and VII - Position Descriptions.

The OEP/EOC maintains team balance and standards by assuring that at least half of deployed team members have had actual field experience in the position and all team members are fully qualified for their assigned position. Maximizing the use of Technical Specialists and Administrative Specialists reduces workloads and help meet stated objectives.

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B. ACTIVATION

During disasters where a large geographic area is affected and/or multiple States or regions are involved, there may be a need to increase the number of personnel on a MST or increase the number of MSTs assigned to the disaster. The decision to deploy additional resources of this kind will be made by the CFO in consultation with the MST Leader, RHA, and OEP/EOC.

C. MST INTERACTIONS

1. Health and Human Services (HHS) Health and Medical Response Resources

Depending on the nature of the disaster, some MST members will deploy directly to the disaster and the others will go to the BoO, DFO, or other location to establish a work area for the support of activities in the field. Usually the Operations Section and specialty teams will establish a BoO at an assigned location in close proximity to their work area. Those reporting to the BoO will usually be the Command and Command and General Staff. Some team members reporting to the BoO will spend part of each operational period at various field locations in support of the MST, DMATs and other specialty teams.

The MST Leader must ensure Team meetings, planning meetings and shift briefings are scheduled well in advance and known to those required to attend. MST meetings and briefing times should be coordinated with the schedule set by the lead agency managing the disaster to take advantage of the latest disaster planning information.

2. Lead Agency Emergency Operations Center (EOC)

The RHA, CFO and the health and medical liaison assigned to the lead agency EOC share information and provide clarification on disaster related issues. Information is transmitted to the MST by the CFO and provides strategic objectives and other information for providing health and medical assistance.

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3. Office of Emergency Preparedness/Emergency Operations Center (OEP/EOC)

The OEP/EOC is operational from the initial request for assistance through the demobilization of field resources and;

- Provides senior HHS management with situation reports, recommendations and other information from the CFO and MST to help them make informed decisions;

- Resolves issues requiring a higher level of interagency coordination not available in the field; and

- Provides senior HHS management with information and or recommendations for the resolution of issues requiring a higher-level policy review by the national-level policy makers from the lead agency.

4. Regional Health Administrator (RHA)

The RHA, or their designee at the disaster site, will maintain contact with the OEP/EOC. The RHA is the Senior HHS official of the affected region and will be deployed in the region when any HHS health and medical response resources are assigned. The RHA coordinates the HHS health and medical response with the CFO and MST Leader.

5. Regional Coordinating Group (RCG)

At the regional level the RHA determines the need to activate the Regional Coordinating Group (RCG) and determines the level of staffing required to carry out the functions of the RCG. The primary responsibility of the RCG is to advise the RHA on HHS regional response needs and policy issues. The RCG also maintains status on initial HHS health and medical response resources until the MST is operational. The RCG operates from a Regional Coordination Center (RCC), which is normally located within the HHS regional office. The RCC differs from the OEP/EOC in that the RCC's major activity occurs during the early stages of the HHS response before the MST is operational.

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C. MST INTERACTIONS

5. Regional Coordinating Group (RCG) (Continued)

On non-Stafford Act responses, the RCG may continue to be active as long as HHS health and medical response resources are deployed. The OEP/EOC should remain operational throughout the duration of emergency responses until all deployed resources are returned to their home units

During Stafford Act responses, the RCC is the primary site from which the RHA directs and coordinates regional ESF#8 operations. The RCG provides liaison with EST ESF#8, OEP/EOC, FEMA, MST, supporting regional agencies, Advanced Element Emergency Response Team (ERT-A), Regional Operations Center (ROC) and State EOCs involved in the ESF#8 response.

6. Federal Response Organization

Once the Federal response organization is operational and HHS health and medical response resources are in the field, the RHA has the continuing responsibility to provide direction and management of the region's overall health and medical response. Direction and coordination is accomplished by communicating and coordinating with the Federal liaison or ERT ESF#8 Leader, and the CFO, OEP/EOC, and civilian counterparts. Periodic field visits by the RHA to HHS facilities, the MST and organizational elements, are used to assess progress on any problems that may be impeding the delivery of HHS health and medical response resources to the affected population.

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C. MST INTERACTIONS

7. State/Local Emergency Operations Center (EOC)

The RHA, in consultation with the CFO and MST Leader, may decide to assign a person to the State or local EOC once the MST has moved to the BoO or other assigned field location. The assignment of this individual could prove useful to State and local officials in clarifying the role of the MST and specialty teams as well as serving as a liaison between the State or local EOC and the MST.

8. Point of Arrival/Mobilizations (POA/MOB) Centers

The Point of Arrival/Mobilizations (POA/MOB) Centers Center Specialist in the MST Logistics Section will work at the designated arrival point and/or Mobilization Center for incoming HHS health and medical response resources. This position provides information to incoming resources about their final destination, arranges transportation with Logistics and records information to be forwarded to the Planning Section for resource tracking purposes. Specialty teams will be met upon arrival at the POA/MOB Center and be briefed by the assigned specialist or an Operations Section member. The briefing will include reporting structure, hours of work, location of facilities and other related issues. When resources are demobilized, the POA/MOB Center Specialist coordinates return travel needs and provides other exit services as directed in the Demobilization Plan.

9. Rapid Needs Assessment Process

The rapid needs assessment process is activated as needed to gather early assessment information. The rapid needs assessment process has a Health and Medical Specialist representing HHS health and medical response resources who reports health and medical issues as part of the team's field assessment process. This assessment information is disseminated to other involved agencies' Information and Planning Sections for processing and sharing with other involved management units including the MST. The Health and Medical Specialist, when released from this assignment, may be reassigned to the MST if qualified to fill unmet MST needs.

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C. MST INTERACTIONS

10. Health and Human Services (HHS) Health and Medical Specialty Teams

The MST will manage assigned HHS health and medical specialty teams unless they are assigned to work directly for State or local Incident Management Teams after consultation with the RHA and CFO. In this case a modified MST will still be used to assist the State or local agency with technical health and medical issues and related logistical support. Team Leaders will participate in the on-going identification and accomplishment of objectives for their teams for the current and next operational period. This process will be reported by the MST Operations Section and will be part of the planning process using the Functional Action Plan Form.

Team Leaders will participate in planning meeting, briefing sessions, demobilization planning, and the after action reporting process. The Planning Cycle Guide, Planning Process Guide, and the Shift Briefing Guide are necessary for this process. These HHS guides are located in Appendix D - Forms, Reports and Guides.

D. DEPLOYMENT STRATEGIES

Deployment can be for an on-going disaster or the anticipation of such an event. Specialty teams are not deployed unless a MST is in place to receive these teams. However, simultaneous deployment of the MST and specialty teams may be required in situations requiring immediate medical assistance. OEP/EOC will assign a point of arrival and the name of a contact person for all deployed resources. This information will be provided to the Chief of Party, or Team Leader. This is especially important when individuals or small groups of personnel come from different parts of the country to meet at a single location. Chiefs of Party and other designated individuals are required to maintain periodic contact with the OEP/EOC.

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D. DEPLOYMENT STRATEGIES

The MST should arrange for and conduct an initial Team meeting when all members are present to discuss the latest situation report, Team assignment, and the Team Leader's expectations. If a team meeting is not possible with all members, then the Team Leader should make as many individual contacts as necessary for this critical initial briefing.

The OEP/EOC provides coordination and control of all deployed resources until the MST is in the field and operational. At this time the MST assumes responsibility and control of these resources.

OEP/EOC may elect to use various methods of ground and air travel for team members. Air travel options may include DoD aircraft or commercial air carriers. Ground travel options may include rental vehicles, personal vehicles, or transportation provided by local response agencies. HHS maintains a contract with a 24-hour 7-day-a-week travel service to assure commercial travel access is available. The service is expected to provide for car rental and lodging. HHS will provide reimbursement consistent with Federal travel regulations for authorized travel and subsistence paid by the responder while under orders.

In addition to meeting physical fitness requirements for their positions, MST and specialty team members provide their own prescriptions, extra eyeglasses, and other personal care needs. Team members should be able to begin travel to a designated location within 2-hours of a request. HHS will provide standard work uniforms for the MST that includes khaki pants, official shirts and caps. HHS will also provide outerwear for assignments where weather extremes are likely to be encountered. It is the employee's responsibility to provide under clothing, suitable footwear and attire for off-duty hours. Clothing provided by HHS will be issued to qualified MST members in advance of assignment and it is the employee's responsibility to maintain the clothing in ready-to-wear condition. Sufficient personal gear should be carried to be able to complete a 21-day assignment as shown in Unit V-D - Personal Equipment List.

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E. LOCATION WITHIN THE LOCAL COMMAND ORGANIZATION

The MST and specialty teams can operate as a cell within the Operations Section of the local incident command structure when requested by the State or local agency and agreed to by the RHA and CFO. The RHA may be part of the Unified Command and the CFO is assigned as the Health and Medical Branch Director or Division Supervisor managing these resources. The following organization chart depicts a typical local command organization.

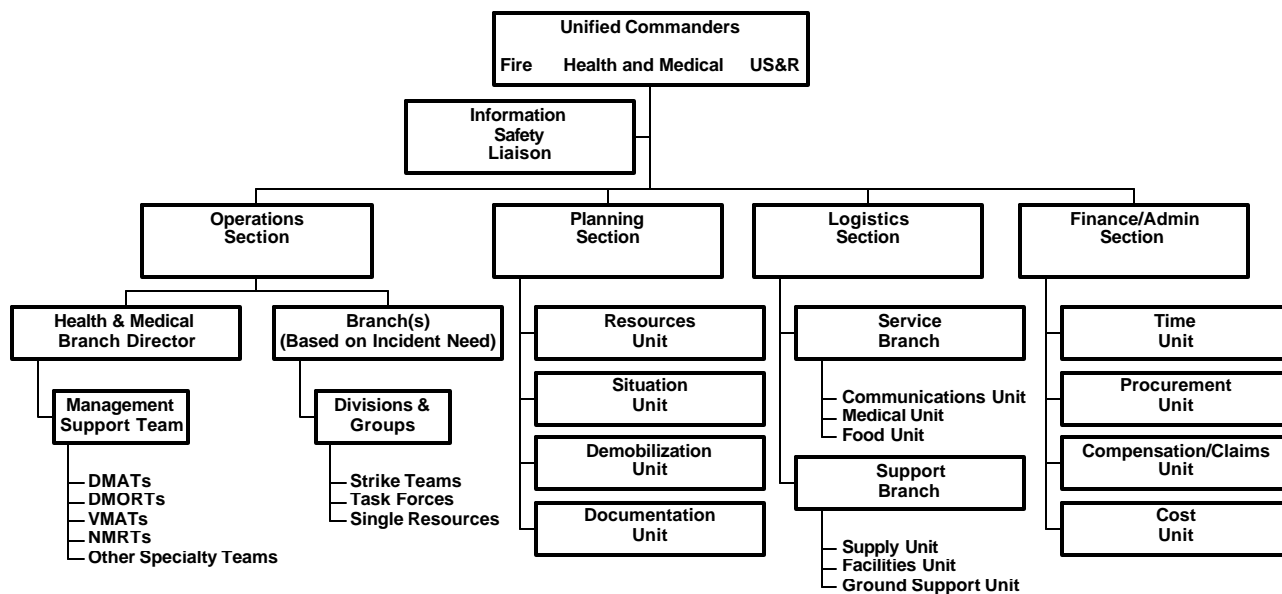


Figure 3-1 Local Incident Command System Organization

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F. MST EXPANDED OPERATIONS SECTION

Large scale, catastrophic disasters may require that additional positions be added to the MST to accommodate the complexities of the disaster. The MST organization structure is designed to be augmented with additional personnel if the disaster escalates. Each specialty team has a Division Supervisor assigned for coordination, control and support. When a recommended number (5-7) of Division Supervisors are in place a Branch Director may be assigned to reduce the span of control. The following is an example of how the MST's organization may be expanded:

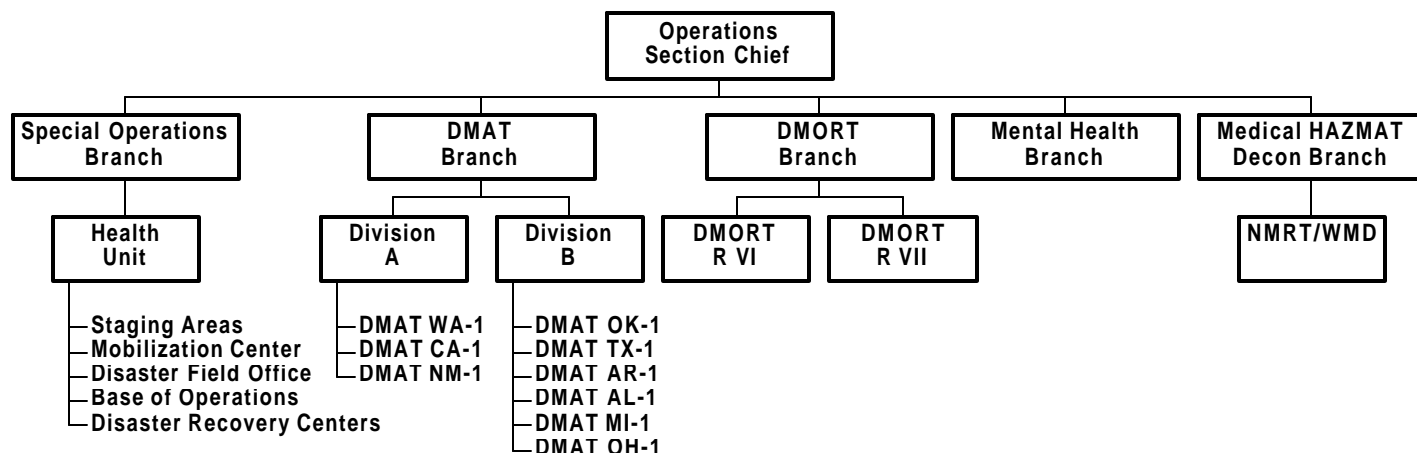


Figure 3-2 MST Expanded Operations Section

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F. MST EXPANDED OPERATIONS SECTION

1. Rapid Needs Assessment Process Information Flow

The lead agency for any incident will follow a rapid needs assessment process which allows a large amount of data about an incident to be collected in a very short time frame. The process may include an ad-hoc team of assessors with varied technical expertise that is deployed to perform a general survey of the incident to determine what kind of response resources may be appropriate for the mitigation of the incident. The numbers and types of technical expertise included on this team will be situation dependent. Information gathered by this team is sent back to the lead agency's Information and Planning Section which then disseminates it to all other agencies who may be called upon for response resources.

2. Rapid Needs Assessment Process Information Flow within the Emergency Response Team (ERT)

When the MST is located within the ERT, the MST works within the Emergency Services Branch in the ERT Operations Section. The ERT ESF#8 Leader works with the Emergency Services Branch Chief and provides liaison and coordination necessary to the CFO and MST Leader for MST operations.

Other agencies with primary responsibility like ESF#8 may have similar structure and may coordinate with the MST.

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F. MST EXPANDED OPERATIONS SECTION

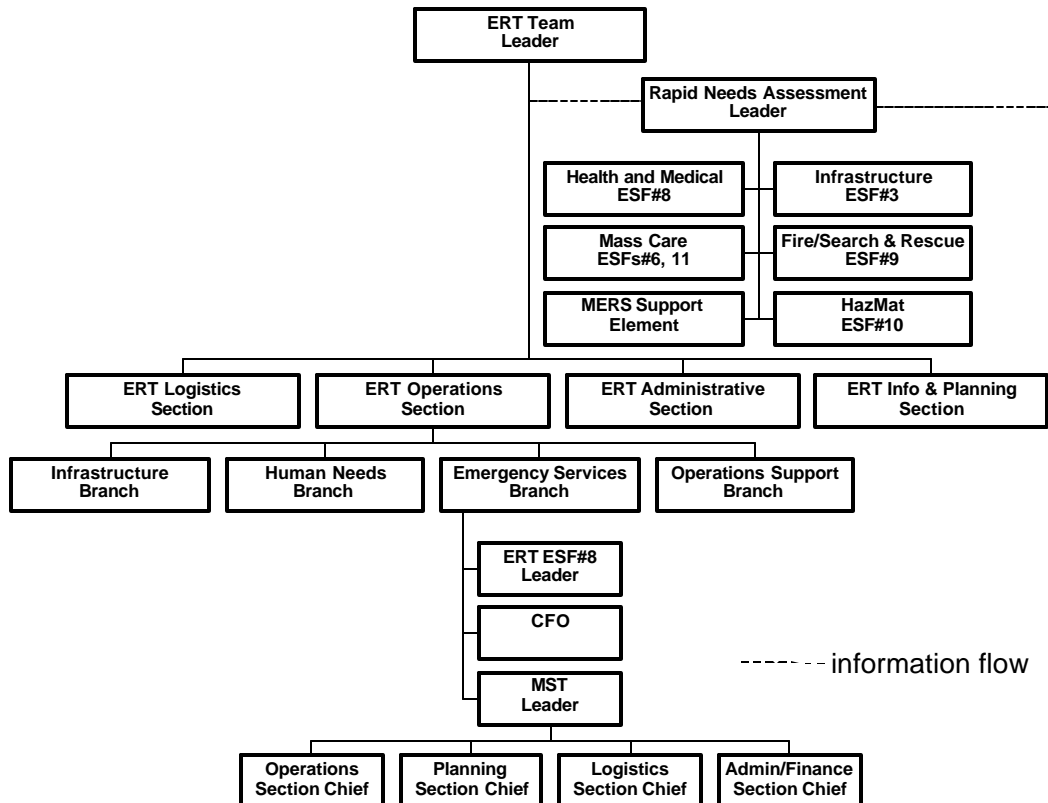


Figure 3-3 Rapid Needs Assessment Process Information Flow through ERT ESF#8

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G. MST OPERATIONS

Depending at what stage of the disaster the MST becomes operational, the MST is provided with situation estimates from the rapid needs assessment process, MST Operations Section, other Federal agencies and/or the local incident management organization. These reports along with strategic direction provided to the health and medical leadership becomes the material needed for the development of the Action Plan for the initial and next operational period. The following is an outline of the functional activities that occur during the initial phases of deployment.

1. Command and Control

During the initial phases of operation, the MST arrives in the affected State and is integrated into Federal response organization or the local Incident Management Team. Management of all HHS health and medical response resources is coordinated through the RHA and CFO.

2. Coordination of MST Resources

Coordination of all health and medical response resources changes during the initial operation. During the alert and activation phase the OEP/EOC maintains coordination and control of HHS health and medical response resources. When the MST becomes operational at the disaster the OEP/EOC relinquishes any authority over these resources to the RHA, CFO, or MST Leader depending on the situation.

HHS health and medical response resources may ultimately be reporting to the primary Lead agency of the disaster or to the local Incident Management Team as agreed by the RHA and other involved officials. No matter which lead agency originated the request for HHS health and medical response resources, the demobilization of HHS health and medical response resources is the responsibility of the MST. Once resources are en-route to and from their home location they are under the coordination and tracking of the OEP/EOC.

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G. MST OPERATIONS

3. Subdivision of Personnel

Upon arrival and integration into the Federal emergency response organization or local Incident Management Team, the MST Leader and CFO will participate in the assignment of and preparation for personnel deployment to the field or other assigned locations. This includes the following functional groups:

- POA/MOB Center Specialists to designated arrival locations;
- Health and Medical Technical Specialists to field assignments after processing through the MST Planning Section; and
- MST members assigned either to the Disaster Field Office (DFO), local command post, BoO or other facility.

Once assignments are made, the MST will move necessary cache items to these locations to support the deployment. Prior to deployment, all personnel will receive a briefing covering names of contacts at the various locations, mission orders, relevant procedures and schedules for meetings, briefings, and information exchange. Personnel should take their personal gear and work materials with them in case there is a delay in the departure and arrival of required cache items.

4. MST Management Element

The RHA, CFO, and MST Leader make up the management element for field operations and coordinate all specialty team activities through the MST General Staff.

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G. MST OPERATIONS

4. MST Management Element (Continued)

The MST Leader is responsible for the following:

- Managing planning meetings, briefings, team meetings, and AARs. Headquarters and regional personnel may assist in the planning and directing any of these activities;
- Ensuring coordinated logistical support for the DMATs and specialty teams including resupply and the coordination of transportation through the Logistics Section;
- Approving, in consultation with the health and medical leadership, requests for the activation of additional resources to meet strategic objectives;
- Providing approval of SITREPs, Action Plans, briefings, resource status reports, and selected historical documentation;
- Ensuring the well being of all MST and specialty team personnel;
- Requesting and review of cost estimates for MST operations;
- Approving, in consultation with health and medical leadership, Demobilization Plans for HHS health and medical response resources;
- Approving measures to minimize disaster site health risks for all personnel; and
- Provide OEP/EOC with information on current situation and significant anticipated changes in conditions.

5. Multi-State/Multi Region Command and Control

In the event that multiple MSTs are used to manage operations in multiple States or are separated by great distances, a RHA, or other designated official, may be assigned to coordinate health and medical issues between MSTs, through the CFOs, RHAs, other Federal agencies, or Incident Management Teams. This ensures that the critical HHS health and medical response resources are assigned in a manner that meets the overall disaster objectives provided by the lead agency. This senior RHA Coordinator will take the lead in all contacts with the OEP/EOC pertaining to the assignment of priorities for resources and the briefing of senior HHS officials.

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H. DEMOBILIZATION

Demobilization planning begins well before the need to start demobilization. The Demobilization Plan is prepared in the Planning Section by the Demobilization Unit Leader. The draft plan is a living document which changes, as needed, to reflect the changes in the disaster. The MST Demobilization Plan is coordinated with the overall Disaster Demobilization Plan with requirements provided by the CFO.

The plan not only deals with how to get personnel home, but how to deal with replacement and repair of cache items, documentation of lost or damaged property, performance evaluations, AARs, and the assurance of the physical and mental well being of all personnel.

Once the plan is reviewed and approved by the MST Leader, health and medical leadership, and the lead agency, copies will be distributed to disaster Planning Sections, OEP/EOC, MST Command and General Staff and Team Leaders for functional planning and briefings. Refer to Unit IX - Demobilization Process for detailed information on the demobilization process.

I. INDIVIDUAL PERFORMANCE RATINGS

A written performance evaluation of all individuals will be completed by the employee's immediate supervisor and signed by both parties prior to leaving the disaster. Performance Appraisal Form will be used for this process. A copy of the rating will be signed by both parties and will be given to each employee at the time of review.

Overall ratings reflecting either poor or outstanding performance will be given to the Section Chief, MST Leader, or CFO for review and counter signature. Overall poor or outstanding ratings will be transmitted by the RHA to the OEP senior official for review and processing. Ratings for overall average performance require only the signature of the employee and supervisor and will be forwarded to the Section Chief for transmittal to the MST Leader for processing.