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## **I. INTRODUCTION**

### **A. PURPOSE**

The purpose of this manual is to describe the emergency preparedness, response structure, and operating procedures for health and medical response to disasters or emergencies. This manual provides policies and standardizes the methods of operations and organization used to facilitate prompt and efficient delivery of health and medical disaster assistance. The Department of Health and Human Services (HHS) with mutual consent of the supporting agencies that participate in nationally declared disasters will implement these standards. These standards will also apply when providing health and medical support to other Federal agencies during non-declared incidents when requested to do so under the guidelines established in formal agreements with these agencies.

The role and responsibilities for carrying out these policies and standards, specifically the HHS, Office of the Secretary (OS), Office of Public Health and Science (OPHS), Office of Emergency Preparedness (OEP), and the HHS regions, are included in this manual. HHS/OPHS/OEP will be referred to throughout this manual as OEP.

### **B. MISSION STATEMENT**

The mission of HHS is to coordinate and facilitate the HHS health and medical response to disasters and emergencies as rapidly as possible and to assist other Federal agencies and State and local governments when a major disaster or emergency overwhelms their ability to respond effectively to save lives, protect property, and restore their communities. This responsibility is vested to HHS in three legislative acts. First, the Robert T. Stafford Disaster Relief and Emergency Assistance Act, created under the provisions of Public Law 93-288, referred to in this manual as the Stafford Act. Second, the Aviation Disaster Family Assistance Act which authorizes HHS to provide support to the National Transportation Safety Board (NTSB) following major aviation accidents. Third, the Public Health Service Act, 42 U.S.C. 319, which authorizes HHS to provide health and medical services in situations that are not covered by either the Stafford Act or Aviation Disaster Family Assistance Act.

## **I. INTRODUCTION**

### **C. BACKGROUND**

The need for a nationally coordinated health and medical response to disasters was recognized because of the amount of damage caused by earthquakes, hurricanes, tidal waves, volcanic eruptions, floods, fires, industrial accidents, and many other disasters that have affected the United States. While these have not caused the massive casualties of similar incidents in other parts of the world, our Nation is still at risk. The threat of terrorism involving weapons of mass destruction raises additional challenges for medical care systems.

The United States has never experienced a great disaster comparable in magnitude to the 1996 Kobe Japan, 1988 Armenian, or the 1985 Mexico City earthquakes or the 1984 Bhopal India toxic gas release, but the United States is still susceptible to the kinds of catastrophic accidents that occur elsewhere. For example, the 1857 earthquake (Richter magnitude of 8+) that destroyed Fort Tejon, California, approximately 100 miles northwest of the center of Los Angeles, caused negligible casualties. Because the area is now densely populated, a modern recurrence could cause a devastating number of fatalities and casualties requiring hospital treatment. There is also substantial risk of an earthquake in the Central United States, which could devastate an area from Memphis, Tennessee to St. Louis, Missouri; no portion of the U.S. is free of risk from a major earthquake.

No single city or State can be fully prepared for naturally occurring or man-made catastrophic events. Although many cities in the Nation are well provided with health resources, those resources would be overwhelmed by a sudden surge of disaster related injuries proportional to the population. The health resources of most States would be similarly overwhelmed. A system for dealing with disaster casualties and the health needs of the affected population must, therefore, provide for "mutual aid" among all parts of the Nation and must be able to handle large numbers of patients that might result from a catastrophic incident.

In addition to disaster response, in the event of an overseas war involving American forces, health and medical services from both Federal and private hospitals would be needed to treat military casualties.

## **I. INTRODUCTION**

### **D. POLICIES**

The lead policy official for HHS health and medical response is the Assistant Secretary of Health (ASH). The Director of OEP is the action agent and is responsible for coordinating implementation of the delivery of health and medical services with partner HHS agencies, and for ensuring that HHS policy officials have current and up-to-date information to make sound management decisions during disasters. The HHS Regional Health Administrator (RHA) is the operating agent assisting OEP and is responsible for coordinating regional health and medical service activities.

The HHS Emergency Operations Center, hereafter referred to as OEP/EOC, located at OEP Headquarters, will provide liaison between HHS Headquarters, the involved HHS regional officials in the response structure at the disaster scene, and the EOCs of other Federal departments and agencies. The purpose of this liaison is to assure the coordination of HHS health and medical assistance takes place to meet requirements of the situation. The OEP/EOC will coordinate and facilitate the overall health and medical response.

OEP/EOC is the primary source of public health and medical response information for all disasters or emergencies where HHS is engaged. This is necessary to ensure:

Patient confidentiality protection. OEP/EOC will not release medical information on individual patients to the general public;

Appropriate information on casualties and patients are provided to the American Red Cross (ARC) for inclusion in the Disaster Welfare Information (DWI) System for access by the public; and

The types of information and format for input to recurring Situation Reports (SITREPs) will be pre-identified in coordination with the agency having overall responsibility for managing the disaster or emergency.

## **I. INTRODUCTION**

### **E. CONCEPT OF OPERATIONS**

As lead agent for the National Disaster Medical System (NDMS), included in the HHS overall public health and medical response to disasters and emergencies is providing for, arranging for, or coordinating the triage, treatment, and transportation of victims from the immediate disaster area. HHS also ensures through the United States Transportation Command (USTRANSCOM), evacuation of patients out of the disaster area, as needed, into a network of pre-enrolled non-Federal hospitals located in the major metropolitan areas of the United States. This is accomplished by utilizing resources available through NDMS as well as within HHS to include the Administration on Children and Families, Health Resources Services Administration (HRSA), Health Care Financing Administration, and the Administration on Aging.

NDMS is a joint Federal/private sector partnership. At the Federal level it includes, in addition to HHS as the lead agent, the Department of Veterans Affairs (VA), the Department of Defense (DoD), and the Federal Emergency Management Agency (FEMA). NDMS includes a deployable medical response capability to the disaster site or receiving location, a medical evacuation system, and more than 110,000 pre-committed non-Federal acute care hospital beds in more than 2,000 hospitals throughout the Nation. See Unit II-D-1 - Health and Medical Response Teams, for description of the response teams and other components of the NDMS.

NDMS does not replace State and local disaster planning efforts, rather it is prepared to supplement and assist where State and local medical resources are overwhelmed. NDMS response teams and other elements of the NDMS could be available to respond to local mass casualty incidents or on an intra-State basis. Thus, the NDMS not only enhances Nationwide medical response capability, it also improves the ability of participating States and localities to respond to disasters within their own jurisdictions and under their own authorities.

Other health and medical assets available include: technical specialists for worker health and safety, food/drug/medical device safety, radiological safety, chemical and biological hazards, mental health, public health information, vector control, potable water/wastewater, and solid waste disposal.

## **I. INTRODUCTION**

### **E. CONCEPT OF OPERATIONS**

Upon notification of a significant disaster or emergency, the Director of OEP, or designee, will initiate the following actions as needed:

Determine under which authority HHS health and medical services and assets are being requested;

Activate the OEP/EOC. This will be accomplished by assigning available OEP personnel to operate the initial OEP/EOC under the direction of the OEP/EOC Director. Depending on the magnitude of the disaster, other HHS agencies may be requested to provide a representative at the OEP/EOC to carry out the activities tasked to their respective agency;

Alert and deploy a Management Support Team (MST) to the disaster area to provide liaison and support to the RHA. A MST is a management team that provides field command and control on a disaster for deployed HHS health and medical response resources;

Request OEP/EOC to alert HHS health and medical response resources;

Through its VA and DoD representatives, alert NDMS Federal Coordinating Centers (FCC) of the activation or other readiness status of the NDMS definitive care component;

Through the VA and DoD representative, alert the USTRANSCOM/Global Patient Movement Requirements Center (GPMRC) to initiate bed status reporting and the requirement for evacuation of casualties to NDMS areas;

Determine the geographic area affected by the disaster and also obtain weather information for the disaster area including present conditions and the immediate and long-range forecast; and

Request that HHS Substance Abuse/Mental Health Administration (SAMHSA) initiate mental health support activities in the event this service is needed.

## I. INTRODUCTION

### F. RESPONSIBILITIES

The success of the delivery of HHS health and medical response resources to disasters is dependent on the degree to which the organizational elements identified below meet the outlined responsibilities and direction and standards outlined in this Operations System Description Manual.

#### 1. Health and Human Services (HHS), Office of Emergency Preparedness (OEP)

OEP is responsible for overall policy development, guidance, information storage and retrieval, management, and oversight of health and medical response, which includes the following:

##### *a. Policy*

The OEP is responsible for managing the development and implementation of health and medical response policy. This policy will be developed through the coordinated efforts of OEP Program Offices and HHS regional offices. Policies will be articulated in and disseminated through official Agency documentation and publications.

##### *b. Documentation*

OEP is responsible for the development, coordination, approval and publication of National-level documentation. This would include corrective action resulting from lessons learned on disaster responses. Wherever possible, policies and standards are uniformly implemented and follow standardized documentation procedures.

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### F. RESPONSIBILITIES

#### b. Documentation (Continued)

Documentation will include:

- Operations System Description Manual;
- Field Operations Guides (FOG);
- Disaster Response Teams Description Manual;
- Emergency Operations Center Procedural Manual;
- Management Support Team Operations System Description Manual;
- Forms Manual;
- Personnel Manual;
- Readiness Evaluation Procedures;
- Documentation Control Process;
- Corrective Action Process;
- Mobilization Guide;
- Response Standard Operations Procedures; and
- Training and Qualifications Manual.

#### c. *Regional Coordination*

OEP is responsible for coordinating the development of health and medical response policy and documentation, training, readiness evaluations, staffing and implementation activities with the regions. OEP will establish a network of working groups or committees with national and regional representation to assist in the development, coordination, and implementation of HHS health and medical response procedures. Both formal and informal communication mechanisms such as working groups and committee meetings, conference calls, e-mail messages, memorandums, etc., will be utilized to ensure that the policies and procedures established are consistently followed throughout the regions.

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### F. RESPONSIBILITIES

#### *d. Training*

OEP will provide training development and support using the guidelines in the HHS Health and Medical Training and Qualifications Manual. This will be accomplished by working with the regions to develop, conduct, and support both formal and informal training programs. As a minimum, formal training courses will be developed for RHAs, Regional Emergency Coordinators, and the Command and General Staff positions in the various organizational structures described in Unit III-C-I - Interagency Integration. OEP will also assist in the development and implementation of a certification program that ensures a work force of qualified personnel are established and maintained.

#### *e. Corrective Action*

OEP will conduct After Action Reviews (AAR) of disasters in which HHS health and medical response resources were deployed. Corrective actions resulting from these reviews will be implemented by OEP in consultation with HHS regions.

### 2. Health and Human Services (HHS) Regions

HHS regions, in consultation with OEP, have the responsibility for pre-disaster planning, assisting OEP in rostering and training personnel, and managing the day-to-day response activities in their respective regions.

#### *a. Pre-disaster Planning*

HHS Regions have the responsibility of developing contacts among Federal, State, and local officials, professional, voluntary, and private sector organizations within their respective regions, and to acquire extensive knowledge about facilities, personnel, and other regional assets that might be activated in responding to a major disaster or emergency. This is accomplished through participation in scheduled meetings, conferences, development of Memorandums of Understanding (MOU), attendance at FEMA Regional Interagency Steering Committee (RISC) meetings, participation in State emergency response exercises, annual updates of State Nuclear Preparedness Plans and exercises, and the development of State Emergency Health Profiles.

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### F. RESPONSIBILITIES

#### a. Pre-disaster Planning (Continued)

A State Emergency Health Profile, as a minimum, provides an overview of State demographics, the health infrastructure, State emergency management infrastructure, State Emergency Health Plan and a variety of health and medical resources available to assist in the public and primary health care response to an emergency situation.

#### b. *Regional-Level Response Structure*

When an event occurs or is imminent, The RHA convenes a Regional Coordinating Group (RCG) consisting of a core of regional staff that may be supplemented by other HHS regional support agencies as the situation dictates. The RCG's primary purpose is to provide staff support to the RHA during the activation and mobilization of personnel and other regional assets during the response phase of a disaster or emergency. The RCG accomplishes this by:

- Facilitating the RHA decision making process by obtaining, developing and displaying situation information;
- Maintaining the proper equipment and systems to ensure agency resource and situation status is current;
- Determining resource availability;
- Advising RHA on current policies, procedures and agreements;
- Maintaining the proper equipment to be able to provide current information on the numbers of personnel and major items of equipment committed and/or available for response;
- Identifying both essential and excess resources;
- Assembling information for briefings and situation reports for RHA review and transmittal;
- Maintaining information on meteorological conditions and forecast conditions that may have an effect on operations;
- Confirming response and estimated time of arrival of responding HHS resources and supplies; and
- Maintaining activity log of major actions/decisions.

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### F. RESPONSIBILITIES

#### b. Regional-Level Response Structure (Continued)

The RCG normally operates in the HHS Regional Coordination Center (RCC) where communications systems are established. The RCC is the primary site from which the RHA directs and coordinates the initial regional response operations.

The RHA will appoint, as necessary, a HHS representative who is normally the Regions Emergency Coordinator to deploy to the disaster or emergency to assist in coordinating the overall health and medical response. The specific duties and responsibilities of the HHS representative are dependent upon which legal authority HHS is responding under. Each legal authority, i.e., legislative act, is accompanied by a response plan that identifies HHS responsibilities when activated. See Unit III-B - Authorities for more information.

The Chief of Field Operations (CFO) leads on-the-ground health and medical field operations in the disaster area with support provided by the MST Leader. The CFO establishes an organizational system where field command and control can be effectively implemented. The CFO reports directly to the RHA. The CFO is assisted by a MST that provides planning, communications, and logistics support to the HHS health and medical response resources. See Unit II-B-2 - Management Support Team for a more detailed description of the MST.

#### c. *Training*

HHS regions will be represented on the HHS Health and Medical Training and Qualifications Committee to identify training needs within the region and coordinate with HHS headquarters in developing and presenting formal and informal training programs to meet these needs. The Training and Qualifications Committee is composed of a chair person from OEP/EOC; a representative from each HHS region; a member from each agency having a significant number of employees participating in the HHS health and medical response programs; and a member representing each to the HHS health and medical response group. Regional Directors have the responsibility of assuring they have a cadre of trained personnel to respond to and staff a disaster or emergency event occurring within the region.

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### F. RESPONSIBILITIES

#### *d. Corrective Action*

HHS regions have the responsibility for implementing corrective action measures resulting from AARs conducted either within the region or under the responsibility of OEP.

### 3. Health and Medical Response Personnel

Health and medical response personnel have the responsibility to maintain a state of readiness to deploy to a disaster location within several hours of activation. This readiness includes being prepared to work long hours in austere, difficult and stressful conditions, and arriving at the designated work site with proper supplies, equipment and clothing, as well as personal supplies (including medications).

HHS health and medical response personnel have the responsibility to keep their supervisors informed of their individual status when this status could affect their availability for assignment. Factors that could affect their status include extended sick leave, reassignment to other job responsibilities, or retirement. Once activated or placed on alert, health and medical response personnel must have the capability to be reached via pager and/or telephone and should have a portable computer to receive information relative to their assignment.