DEPARTMENT OF HOMELAND SECURITY

Medical Readiness Responsibilities and Capabilities:

A Strategy for Realigning and Strengthening the Federal Medical Response

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January 3, 2005

Executive Summary

The Department of Homeland Security (DHS) has the responsibility to prevent, protect, respond to, and recover from major terrorist attacks or natural disasters, but currently lacks a clearly-defined and unified medical capability to support this mission. Additionally, it lacks the capability to properly support DHS personnel operating in field units and hazardous conditions by providing little or no medical support. Therefore, it is imperative that an Office of Medical Readiness becomes established within DHS, so these medical readiness responsibilities are addressed in a coordinated, effective, and efficient manner. A review of existing DHS medical readiness responsibilities and capabilities indicates a realignment of assets, personnel, and fiscal resources, is required.

Prior to the establishment of DHS, the Department of Health and Human Services (HHS) was responsible for national medical and public health programs. HHS responsibilities included preventive medicine, health promotion, and disaster medical response. With the passage of the Homeland Security Act 2002 and the establishment of DHS, the DHS Secretary was tasked to prevent, protect, respond to, and recover from incidents of national significance which includes a medical response. The Homeland Security Act also mandated the transfer of the HHS Office of Emergency Preparedness, the National Disaster Medical System (NDMS), Metropolitan Medical Response System (MMRS), the Strategic National Stockpile (SNS), as well as the functions of the HHS Secretary and Assistant Secretary for Public Health Emergency Preparedness to DHS. Homeland Security Presidential Directives (HSPDs) 5, 8, 9, and 10 specified additional DHS medical readiness requirements. However, portions of HSPD-10 and Emergency Support Function # 8 (ESF-8), Health and Medical Services of the National Response Plan (NRP) are currently in conflict with the requirements of the Homeland Security Act 2002.

In September 2004, Secretary Tom Ridge directed a review of the medical response requirements and capabilities within DHS. This report summarizes the findings of that review and provides a strategy for strengthening and realigning medical readiness assets within DHS and improving coordination and collaboration with other Federal partners. To ensure the Secretary of DHS has the ability to meet the demanding medical response requirements, the following actions are recommended:

- Appoint a DHS Assistant Secretary for Medical Readiness.
- Establish a DHS Office of Medical Readiness and provide the requisite staff, resources, and clearly-defined authorities and responsibilities.
- Realign key DHS medical intelligence, preparedness and response assets under this new office.
- Revise HSPD-10 and ESF-8 to bring them into compliance with the Homeland Security Act of 2002.
- Transform NDMS to provide the initial Federal medical response and sustain medical operations until transition to the recovery phase.
- Create an NDMS Advisory Board, chaired by the Assistant Secretary for Medical Readiness and consisting of senior representatives from each of the NDMS partner organizations, to provide strategic guidance to the Assistant Secretary's staff to facilitate NDMS operations.

- Establish a national EMS coordination program in cooperation with relevant professional organizations.
- Establish and provide oversight for the DHS occupational health and safety program to protect DHS employees while on deployments and in the workplace.
- Provide force health protection for DHS field operating units/divisions (tactical deployments -e.g., Border and Transportation Security, Immigration and Customs Enforcement).

Table of Contents

Department of Homeland Security
Medical Readiness Responsibilities and Capabilities:
A Strategy for Realigning and Strengthening
the Federal Medical Response System

Introduction

Prior to the events of September 11, 2001 this nation's medical preparedness and response efforts primarily focused on the medical and public health concerns and events of the day—preventing and eliminating childhood diseases; improving the nutrition and health of minorities, women and children; fighting HIV/AIDS and drug-resistant tuberculosis; and building a national medical response system capable of providing emergency assistance in times of large-scale natural disasters. For the most part, disease reporting was accomplished retrospectively to determine the focus and funding of future medical and public health efforts rather than to identify potential new threats.

The Department of Health and Human Services (HHS) is the Federal agency primarily responsible for the nation's health and wellness. Its services and expertise cover the spectrum from health and social science research, disease prevention, health promotion, and assuring food and drug safety, to providing targeted services for the aging, Native Americans, and other special populations. A number of healthcare focused agencies reside under the HHS umbrella. These include the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration, the Indian Health Service, the Health Research and Services Agency, the Substance Abuse and Mental Health Services Administration, the Agency for Healthcare Research and Quality, and the U.S. Public Health Service (USPHS). With the exception of a few medical response functions within NIH and CDC, HHS' principal role remains that of health promotion and disease prevention, not the response to incidents of national significance.

In the current environment, the potential for a terrorist attack on the United States involving weapons of mass destruction (WMD) has dramatically increased. Consequently, the need for the U.S. private sector healthcare system and its 6000+ hospitals to prepare for an influx of casualties as the result of such an attack has also increased. For most of the 20th century, healthcare costs rose but did not have a significant impact on the surge capacity and capability of city, county, and regional hospitals. However, with the closure of more than 500 hospitals and 1100 emergency departments in the past decade, the national ability to respond to mass casualties resulting from large-scale disasters has been substantially reduced. During testimony before the Subcommittee on Oversight and Investigations of the House Committee on Energy and Commerce in October 2001, Dr. Dennis O'Leary, MD, President of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), underscored the need for medical worker training, community or state-wide analyses of preparedness, national funding policies, and a medical/public health surveillance system.

Since 2002, the Department of Homeland Security has had the responsibility to prevent, protect, respond to, and recover from major terrorist attacks or natural disasters, but it currently lacks a clear and unified medical capability to support this mission. In September 2004,

Secretary Tom Ridge directed a review of the medical response requirements and capabilities within the department. This report summarizes the findings of that review and provides a strategy for strengthening and realigning medical readiness assets within DHS and improving coordination and collaboration with other Federal partners.

Methodology

A qualitative medical needs assessment was conducted within DHS between September 23 and November 9, 2004 to identify current DHS medical response capabilities and assets, document the perceived effectiveness of those capabilities, identify gaps and concerns, and develop medical readiness improvement strategies. Preliminary interviews were conducted, the resulting data were analyzed, and an assessment instrument was created. The assessment instrument consisted of eight open-ended topical discussion points intended to stimulate free-flowing discussion. Thirty-two management and non-management employees across all five DHS directorates (Management, Science and Technology, Information Analysis and Infrastructure Protection, Border and Transportation Security, and Emergency Preparedness and Response) and included representatives from the U.S. Secret Service, the Federal Law Enforcement Training Center, Citizenship and Immigration Services, and the U.S. Coast Guard were interviewed. Interviewees were provided the assessment objective and reassurance that their identity would remain confidential. Response data were recorded, categorized by subject area, and analyzed to extract significant findings.

Findings and Recommendations

The DHS medical needs assessment confirmed what has been perceived by many internal and external observers—that the nation's medical leadership works in isolation, its medical response capability is fragmented and ill-prepared to deal with a mass casualty event, and that DHS lacks an adequate medical support capability for its field operating units. Major findings of the assessment are discussed in this section (see Appendices 4-6 for detailed results of the medical needs assessment). A major paradigm shift in DHS planning and operations is required to mount a successful response to any incident of national significance, especially those involving chemical, biological, radiological, nuclear, and high-energy explosives (CBRNE). The medical response must be staffed, trained, and equipped to manage overwhelming numbers of casualties, prevent subsequent morbidity, and decrease mortality. Thorough preparation and efficient performance are necessary to maintain public order, engender confidence in the government, and foster a rapid return to national normalcy. This will also require carefully designed, coordinated and delivered medical risk communications. Additionally, DHS must meet its requirements for force health protection to ensure the health and safety of its personnel. Therefore, to ensure the Secretary of DHS has the capability to meet the Department's medical response requirements, the following findings and recommendations are provided:

DHS Medical Infrastructure

1. Finding: Unclear and overlapping legislation delegating medical responsibility to one department and response assets to another has left significant gaps in the nation's medical

response capability (see Appendices 2 and 3 for DHS medical readiness responsibilities delineated by the Homeland Security Act of 2002 and HSPDs 5, 8, 9, and 10 respectively).

Recommendation: Revise HSPD-10 and ESF-8 to bring them into compliance with the Homeland Security Act of 2002.

2. Finding: DHS lacks a centralized, coordinated medical organizational structure to:
   - Coordinate disparate efforts within DHS.
   - Serve as the central medical point of contact to coordinate with other Federal, State, and local agencies.
   - Provide single-contact medical advice to the Secretary of DHS.
   - Design, coordinate and deliver comprehensive medical risk communications.
   - Develop medical policy, doctrine, and oversight mechanisms within DHS.
   - Ensure DHS employees are protected while on deployments and in the workplace.
   - Ensure that medical issues are addressed in critical planning, policy development, and decision-making processes.

Recommendation: Appoint a DHS Assistant Secretary for Medical Readiness and establish a DHS Office of Medical Readiness and provide the requisite staff, resources, and clearly-defined authorities and responsibilities. Realign key DHS medical response assets under this new office as described below:

Assistant Secretary for Medical Readiness

The Office of Medical Readiness should be headed by an Assistant Secretary for Medical Readiness who reports directly to the Secretary for Homeland Security. The Assistant Secretary should be the Department's senior medical official who serves as principal advisor to the Secretary on all matters pertaining to Federal emergency medical support operations and DHS Force Health Protection. The Assistant Secretary should establish priorities for, fund, and ensure the mission readiness of the NDMS.

Office of Medical Readiness

The proposed mission of the Office of Medical Readiness should be to coordinate and deliver rapid Federal emergency medical support to Federal, state, and local authorities in support of homeland security operations, and mitigate operational hazards to the DHS work force through comprehensive force health protection programs. The Office of Medical Readiness should be structured to provide the core architecture for managing and coordinating the delivery of Federal emergency medical support. The Office should be organized into four functionally oriented divisions to execute its responsibilities. The NDMS contains the Office's operational staff, resources, and capabilities to deliver Federal emergency medical support services. The Office's other divisions contain the necessary support staff and resources that enable the NDMS to maintain readiness and execute the Federal emergency medical support mission. A functional representation of the proposed DHS Office of Medical Readiness is shown in Figure 1. The draft Concept of Operations (CONOPS) for the proposed DHS Office of Medical Readiness is provided in Appendix 6 and notional costs are provided in Appendix 7.

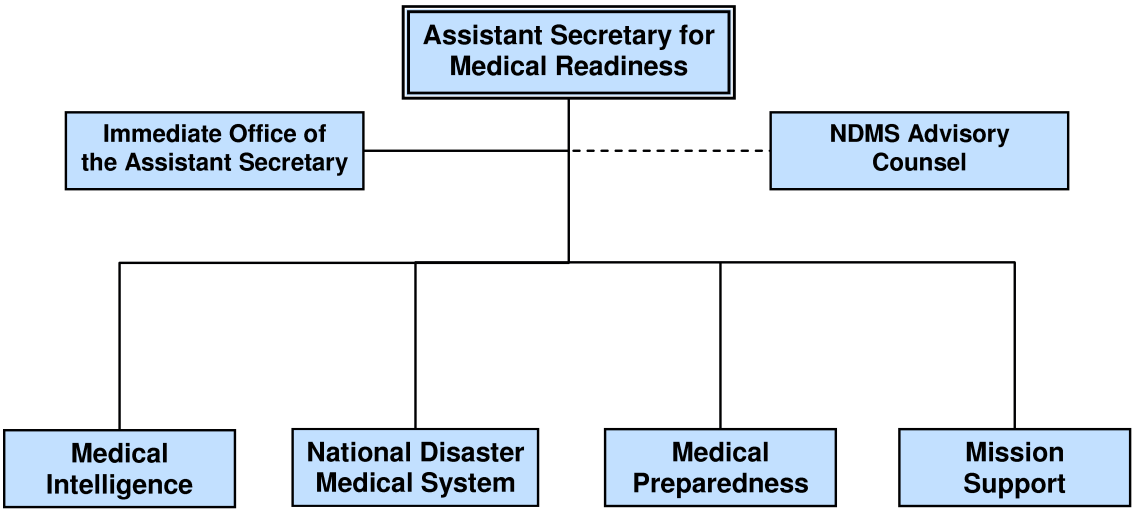

Figure 1. Organization of the Proposed DHS Office of Medical Readiness.

Immediate Office of the Assistant Secretary

The Deputy Assistant Secretary for Medical Readiness and the Chief of Staff should oversee the functions of Immediate Office of the Assistant Secretary for Medical Readiness. This headquarters element should be responsible for executing the daily administrative management and support functions of the Office. Specific functions should include organizational strategic planning, budget management, policy development, legal affairs, legislative affairs, public affairs/risk communications, human capital management, credentialing, and security. The Immediate Office of the Assistant Secretary for Medical Readiness should also be responsible for providing administrative oversight and ensuring coordination, integration, and interoperability of Office activities across its other Divisions and its Regional and Field Offices.

NDMS Advisory Council

The NDMS Advisory Council should be chaired by the DHS Assistant Secretary for Medical Readiness and consist of senior representatives from each of the NDMS partner organizations. The Council should be responsible for providing strategic guidance to the Assistant Secretary's staff to facilitate NDMS operations. During an incident, the Assistant Secretary could convene the Council to consider NDMS response to emergency situations. The Council would establish connectivity and dialog with key stakeholders; review courses of action; and provide counsel, advice, and recommendations to the Assistant Secretary on administrative, financial, policy, and programmatic matters.

Medical Intelligence Division

The Medical Intelligence Division should be responsible for collecting, evaluating, and analyzing all-source information concerning the immediate readiness, capabilities, capacity, and needs of the Nation's emergency medical systems to improve Federal emergency medical support policy, planning, and operations. The Division should be responsible for collaboration and liaison with State and local governments, federal departments and agencies, and National biomedical surveillance/detection programs including the National Biodefense Analysis and Countermeasures Center (NBACC). The Division should be responsible for generating timely and accurate medical intelligence products both at the strategic level (to support the Office's policy, preparedness, and readiness activities) and at the operational level (to support decision-making for Federal emergency medical support to incident management operations).

National Disaster Medical System

The National Disaster Medical System should be responsible for delivering Federal emergency medical support services in the field. The NDMS should be an asset-sharing partnership designed to provide emergency medical assistance to State and local jurisdictions following a terrorist attack, major disaster, or other emergencies within the United States. The system should be designed to care for victims of any incident that exceeds the medical care capability and resources of the effected State and local jurisdictions. DHS should administer the program in partnership with other Federal agencies such as HHS, the Department of Defense, and the Department of Veterans Affairs. The NDMS should maintain capabilities to deploy on short-notice and deliver support under eight mission areas: 1) Medical Command and Control; 2) Pre-Hospital Patient Care; 3) Inpatient Care; 4) Community Outreach Services; 5) Casualty Transportation; 6) Medical Logistics; 7) Veterinary Services; and 8) Mass Fatality. The NDMS should consist of both full-time and part-time Federal teams, as well as volunteer teams located throughout the United States, with staffing levels determined by mission requirements.

Medical Preparedness Division

The Medical Preparedness Division should be responsible for coordinating medical preparedness efforts at the Federal level, and working with all State, local, tribal, parish, and private sector emergency response providers to improve all-hazards emergency medical response to incidents of national significance. Specific functions should include: providing training to NDMS emergency response providers, providing grants to states and local jurisdictions, providing hands-on training through a number of residential training facilities and in-service training at the local level, working with State and local jurisdictions to plan and execute exercises, and providing on-site technical assistance to State and local jurisdictions. Part of the Division's responsibilities should include oversight and administration of the MMRS and NDMS transformation activities, as well as directing the Office of Protective Medicine's Casualty Care Research Center and Counter Narcotics and Terrorism Programs (CONTOMS), which are currently in Immigrations and Customs Enforcement (ICE), within the Border and Transportation Security (BTS) Directorate.

Mission Support Division

The Mission Support Division should be responsible for providing the necessary support services for transporting, coordinating, sustaining, and maintaining an effective NDMS. Specific functions should include medical logistics, communications and information technology, facilities and resource management, and force health protection. Part of the Division's responsibilities for the provision of force health protection should involve oversight of the Department's occupational health and safety program and other mutual support of health and safety risk management programs (e.g., risk communication, personnel medical screening and medical surveillance, respiratory protection, personal protective equipment).

Deployed Medical Response

3. Finding: There is widespread concern within DHS that the nation lacks the ability to adequately respond to mass casualty events, develop and sustain healthcare surge capacity, and effectively manage a quarantine situation. The National Disaster Medical System (NDMS) lacks the medical oversight required to effectively develop, prepare for, employ, and sustain deployable medical assets (see Appendix 6 for detailed information regarding NDMS concerns).
   - NDMS teams are pre-deploying to National Security Special Events (NSSEs) and responding to incidents of national significance for which they are not fully prepared.
   - NDMS teams have not been adapted to meet current requirements with new doctrine, policies, or basic organization. These teams are inflexible in structure, training is outdated, and equipment is designed to support natural disasters rather than a broader range of response scenarios (including terrorist incidents).
   - NDMS is currently assigned to the Emergency Preparedness and Response (EP&R) Directorate where there are few qualified medical personnel assigned to develop the requisite medical doctrine, policies, and procedures.
   - During the transition from HHS to DHS, the number of NDMS management personnel was reportedly reduced from 144 to 57 and that staffing does not include a physician, medical planner, or logistician.
   - NDMS is considered by many insiders to be woefully under-funded, under-manned, and too remote from DHS leadership to gain the visibility it needs.
   - Recent deployments to Florida following the 2004 hurricanes confirmed critical shortfalls in doctrine, training, logistics support, and coordination with ESF-8 as well as other Federal agencies.

Recommendation: Transform NDMS to provide the initial Federal medical response and sustain medical operations until transition to the recovery phase. Develop a tiered approach to the Federal medical response that includes full-time medical teams, a uniformed reserve corps, as well as volunteer teams, to satisfy casualty requirements. Conduct a thorough analysis and revision of DMAT staffing levels and team composition to satisfy medical care needs dictated by current mission requirements. This will require a substantial resource investment, for both personnel and materiel. A full-time and uniformed reserve medical corps will need to be recruited and supported. This medical corps could be developed as part of the

medical element of the National Guard, as a new clinical readiness component of the U.S. Public Health Service, or as an independent DHS medical corps. Expand the NDMS program staff to include diverse medical specialists to develop concepts of operations and standardized procedures, and to provide coordination with other Federal, State, and local agencies. Create an NDMS Advisory Board, chaired by the Assistant Secretary for Medical Readiness and consisting of senior representatives from each of the NDMS partner organizations, to provide strategic guidance to the Assistant Secretary's staff to facilitate NDMS operations.

4. Finding: The Metropolitan Medical Response System (MMRS) program assists highly-populated jurisdictions (numbering 124 in FY03) to develop plans, conduct training and exercises, acquire pharmaceuticals and personal protective equipment, and achieve the enhanced capability necessary to respond to a mass casualty event until significant external assistance can arrive. This approach requires linkages among first responders, medical treatment facilities and resources, public health, emergency management, volunteer organizations, and other local elements. It also requires planning and integration with neighboring jurisdictions, State, and Federal agencies. In FY04, 110 grants totaling $46 million reached 114 MMRS jurisdictions. Yet, in FY05, program support was nearly eliminated and was only reinstated as a result of Congressional pressure. The MMRS is one of the most effective programs for integrating State and local emergency management and medical readiness planning and preparedness activities. Yet, it lacks central medical oversight and integration into an overall national medical response strategy and is currently only being funded on a year-to-year basis with no sustained budget or planning.

   Recommendation: Provide support and direction to this highly-valued and relatively low-cost program from a focused medical readiness proponent within DHS. Develop regional integrations of MMRS jurisdictions to provide an interim capability before the activation/arrival of a Federal medical response.

Surge Capacity

5. Finding: A national healthcare system-wide strategy for providing surge capacity does not exist. Thus, the ability to provide care to large numbers of casualties following a major incident remains one of the greatest challenges and vulnerabilities. Aggressive planning at local levels may have identified appropriate overflow facilities, but few communities have successfully met requirements for managing several hundred or thousands of patients. Numerous Federal programs (e.g., NDMS, Commissioned Corps Readiness Force, and the Medical Reserve Corps program) exist to enhance surge capacity, but they are fragmented and not incorporated into the national response effort.

   Recommendation: Develop a surge capability to address not only facilities but healthcare personnel, equipment, supplies, and transportation assets to care for, track, house, feed, and if necessary the movement of injured personnel to locations where definitive care is available. Such a capability must: (1) be available within 12-24 hours to save the seriously injured, (2) not decimate the communities of the medical expertise required for normal operations, and

(3) must be sustainable for as long as required. Develop mechanisms to address personnel tracking, provider credentialing and privileging, interoperable data and communications, electronic patient tracking, and training and exercises.

Emergency Medical Services (EMS)

6. Finding: The nation's EMS programs and assets are numerous, varied, and lack a central coordination point. EMS programs are currently situated within several different U.S. Government (USG) Departments: DHS Emergency Preparedness and Response Directorate, Department of Transportation, HHS, State, and local/private service providers. The lack of a single USG program coordinator to provide consistent direction and oversight of State and local programs, standards, and funding is of significant concern. Within the DHS EP&R Directorate, there is a "first responder" focus which provides very strong technician level expertise but lacks depth from the emergency medicine perspective. For example, the Noble Training Center at Ft. McClellan, Alabama is a DHS asset that could be better utilized for this purpose. It is the only hospital facility in the U.S. devoted entirely to multidisciplinary medical training, applied research and beta testing, injury treatment, protection of healthcare personnel and facility protection for weapons of mass destruction (WMD) incidents. Yet since its transfer to DHS, it has been severely under-utilized and lacks coordination and support from knowledgeable DHS medical readiness personnel.

   Recommendation: Establish a national EMS coordination program in cooperation with relevant professional organizations. Monitor state and national EMS activities and make recommendations on EMS policy, standards, legislation, liability and educational issues. Ensure that adequate funding is provided to EMS agencies for CBRNE response. Assist in developing educational programs and products for the EMS community.

Occupational Health and Safety

7. Finding: The DHS internal occupational health and safety program is fragmented and inconsistently implemented across organizational units. It currently lacks the visibility, authority, and manpower to effectively implement the policies and programs necessary to provide the minimal workplace occupational health and safety elements required by the Federal Government or to medically protect or treat DHS employees and contractors within their assigned mission operations. Program deficiencies include:
   - Lack of personal protective equipment (PPE) or training on its use.
   - A lack of people in positions to administer occupational health policies and programs.
   - A lack of information on whom to call, where to go, for medical assistance.
   - Personnel not trained in Self-Aid/Buddy Care.
   - Lack of medical support to field operating units.
   - No occupational health and safety policy communication.
   - Program evaluations for physical fitness to deploy not accomplished.
   - Insufficient and, in some cases, complete lack of orientation or periodic training on occupational health and safety policies and programs for either management or employees.

Recommendation: Identify and resource an organizational entity to establish and provide oversight for the DHS occupational health and safety program, including workforce health protection. This includes an effective occupational health and safety program for all DHS employees, a PPE program including an appropriate medical monitoring program, and a program for medical support to field operating units including tactical field medics.

Conclusion

The creation of DHS required the Secretary to prevent, protect, respond to, and recover from natural and man made disasters. Throughout history disasters really only occur when an event negatively impacts people. Clearly, meeting the health and medical needs of nation at times of disaster is a core requirement of DHS and the Secretary. To efficiently and effectively complete this mission, it is imperative that DHS re-evaluate and refine the medical component of its mission; design, develop, and realign medical response capabilities within DHS; and collaborate with HHS and other Federal partners to ensure the seamless integration of medical preparedness and response capabilities at the Federal, Regional, State, and local levels. Through the creation of the Office of Medical Readiness, DHS will be able to design medical response operations and capabilities to leverage existing federal, state, and local medical capability to successfully respond to any incident of national significance, especially those involving CBRNE. The Office of Medical Readiness will provide a medical response that is staffed, trained, and equipped to manage overwhelming numbers of casualties, prevent subsequent morbidity, and decrease mortality, while enabling DHS to meet its requirements for workforce health protection ensuring the health and safety of its personnel. Such a major paradigm shift in philosophy and approach is critical for DHS to carry out its mission of securing the homeland.

List of Acronyms and Abbreviations

ASPHEP	Assistant Secretary for Public Health Emergency Preparedness (HHS)
BTS	Border and Transportation Security
CBRNE	Chemical, Biological, Radiological, Nuclear, and High-Yield Explosives
CDC	Centers for Disease Control and Prevention
CONOPS	Concept of Operations
CONTOMS	Counter Narcotics and Terrorism Programs
DoD	Department of Defense
DHS	Department of Homeland Security
EMS	Emergency Medical Services
EP&R	Emergency Preparedness and Response (DHS)
ESF	Emergency Support Function
FEMA	Federal Emergency Management Agency
GSA	General Services Administration
HHS	(Department of) Health and Human Services
HSOC	Homeland Security Operations Center
HSPD	Homeland Security Presidential Directive
IAIP	Information Analysis and Infrastructure Protection (DHS)
ICE	Immigrations and Customs Enforcement
IIMG	Interagency Incident Management Group
MMRS	Metropolitan Medical Response System
MST	Medical Strike Team (NDMS)
NBACC	National Biodefense Analysis and Countermeasures Center
NDMS	National Disaster Medical System
NIH	National Institutes of Health
NRP	National Response Plan
NSSE	National Security Special Event
OMR	Office of Medical Readiness (DHS)
PPE	Personal Protective Equipment
S&T	Science and Technology Directorate (DHS)
SNS	Strategic National Stockpile (CDC)
USG	United States Government
USPHS	United States Public Health Service
VA	(Department of) Veterans Affairs
WMD	Weapons of Mass Destruction

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Appendix 1

Stated/Implied DHS Medical Readiness Responsibilities: Homeland Security Act of 2002

- Establish Homeland Security Advanced Research Projects Agency
- Transfer the U.S. Coast Guard, Office of Domestic Preparedness (ODP), Federal Law Enforcement Training and Education Center, and the Animal and Plant Health Inspection Service.
- Transfer to the Secretary the authority (in connection with an actual or threatened terrorist attack, major disaster, or other emergency in the United States) to direct the Nuclear Incident Response Team of the Department of Energy (DOE) to operate as an organizational unit.
- Transfer to the Science and Technology (S&T) Directorate:
  - The chemical and biological national security and supporting programs and activities of the nonproliferation and verification research and development program of the DOE.
  - The life sciences activities related to microbial pathogens of the Biological and Environmental Research Program of the Department of Energy.
  - The National Bio-Weapons Defense Analysis Center of the Department of Defense.
  - The Integrated Hazard Information System of the National Oceanic and Atmospheric Administration, which shall be renamed FIRESTAT.
  - The Plum Island Animal Disease Center of U.S. Department of Agriculture.
- Transfer to the Emergency Preparedness and Response (EP&R) Directorate:
  - The Federal Emergency Management Agency (FEMA).
  - The National Domestic Preparedness Office of the Federal Bureau of Investigation, including the functions of the Attorney General relating thereto.
  - The Domestic Emergency Support Team of the Department of Justice, including the functions of the Attorney General relating thereto.
  - The Metropolitan Medical Response System of the Department of Health and Human Services (HHS), including the functions of the Secretary of Health and Human Services and Assistant Secretary for Public Health Emergency Preparedness relating thereto.
  - The National Disaster Medical System of the HHS, including the functions of the Secretary of Health and Human Services and Assistant Secretary for Public Health Emergency Preparedness relating thereto.
  - The Office of Emergency Preparedness including the functions of the Secretary of Health and Human Services and Assistant Secretary for Public Health Emergency Preparedness relating thereto.
  - The Strategic National Stockpile (SNS) of the HHS, including the functions of the Secretary of Health and Human Services relating thereto. (SNS has since reverted to HHS responsibility.)
- Within Information Analysis (IAIP Directorate):
  - Identify and assess the nature and scope of terrorist threats to the homeland, detect and identify threats of terrorism against the United States, and understand such threats in light of actual and potential vulnerabilities of the homeland.

- In coordination with the Assistant Secretary for Infrastructure Protection, integrate relevant information, analyses, and vulnerability assessments (whether such information, analyses, or assessments are provided or produced by the Department or others) in order to identify priorities for protective and support measures by the Department, other agencies of the Federal Government, State, and local government agencies and authorities, the private sector, and other entities.

- Within Infrastructure Protection (IAIP Directorate):
  - Carry out comprehensive assessments of the vulnerabilities of the key resources and critical infrastructure of the United States, including the performance of risk assessments to determine the risks posed by particular types of terrorist attacks within the United States (including an assessment of the probability of success of such attacks and the feasibility and potential efficacy of various countermeasures to such attacks).
  - Integrate relevant information, analyses, and vulnerability assessments (whether such information, analyses, or assessments are provided or produced by the Department or others) in order to identify priorities for protective and support measures by the Department, other agencies of the Federal Government, State and local government agencies and authorities, the private sector, and other entities.

- Within the S&T Directorate:
  - Advise the Secretary regarding research and development efforts and priorities in support of the Department's missions.
  - Develop, in consultation with other appropriate executive agencies, a national policy and strategic plan for identifying priorities, goals, objectives, and policies for, and coordinating the Federal Government's civilian efforts with respect to, identifying and developing countermeasures to chemical, biological, radiological, nuclear, and other emerging terrorist threats, including the development of comprehensive, research based definable goals for such efforts and of annual measurable objectives and specific targets to accomplish and evaluate the goals for such efforts.
  - Support the Under Secretary for IAIP by assessing and testing homeland security vulnerabilities and possible threats.
  - Establish priorities for directing, funding, and conducting national research, development, test and evaluation, and procurement of technology and systems for:
  - Preventing the importation of chemical, biological, radiological, nuclear, and related weapons and material; and
  - Detecting, preventing, protecting against, and responding to terrorist attacks.
  - Collaborate with the Secretary of Agriculture and the Attorney General as provided in Section 212 of the Agricultural Bioterrorism Protection Act of 2002 (7 U.S.C. § 8401), as amended by Section 1709(b) of the Act.
  - Collaborate with the Secretary of Health and Human Services and the Attorney General in determining any new biological agents and toxins that shall be listed as 'select agents' in Appendix A of part 72 of title 42, Code of Federal Regulations, pursuant to Section 351A of the Public Health Service Act (42 U.S.C. § 262a).

- Within the Border and Transportation Security (BTS) Directorate:
  - Director of the Office for Domestic Preparedness (ODP) - Will report directly to the Under Secretary for Border and Transportation Security and will have the primary responsibility within the Executive Branch of the Federal Government for the

preparedness of the United States for acts of terrorism, including the following responsibilities:

- Coordinate preparedness efforts at the Federal level and work with all State, local, tribal, parish, and private sector emergency response providers on all matters pertaining to combating terrorism, including training, exercises, and equipment support.
- Direct and supervise terrorism preparedness grant programs of the Federal Government (other than those programs administered by HHS) for all emergency response providers.
- Incorporate homeland security priorities into planning guidance on an agency level for the preparedness efforts of the ODP.
- Provide agency-specific training for agents and analysts within the Department, other agencies, State and local agencies, and international entities.
- As the lead executive branch agency for preparedness of the United States for acts of terrorism, cooperate closely with the FEMA, which shall have the primary responsibility within the 14 executive branches to prepare for and mitigate the effects of non-terrorist related disasters in the United States.
- Assist and support the Secretary, in coordination with other Directorates and entities outside the Department, in conducting appropriate risk analysis and risk management activities of State, local, and tribal governments consistent with the mission and functions of the Directorate.
- Supervise those elements of the Office of National Preparedness of FEMA that relate to terrorism, which shall be consolidated within the Department in the ODP established pursuant to Section 430 of the Act.

- Within the EP&R Directorate:
  - Ensure the effectiveness of emergency response providers to terrorist attacks, major disasters, and other emergencies.
  - Provide the Federal Government's response to terrorist attacks and major disasters, including: managing such response; directing the Domestic Emergency Support Team, the Strategic National Stockpile (since changed), the National Disaster Medical System, and (when operating as an organizational unit of the Department pursuant to the Act) the Nuclear Incident Response Team; overseeing the Metropolitan Medical Response System; and coordinating other Federal response resources in the event of a terrorist attack or major disaster.
  - Aid the recovery from terrorist attacks and major disasters.
  - Build a comprehensive national incident management system with Federal, State, and local government personnel, agencies, and authorities to respond to such attacks and disasters.
  - Consolidate existing Federal Government emergency response plans into a single, coordinated national response plan.

Source**:** DEPARTMENT OF HOMELAND SECURITY REORGANIZATION PLAN, November 25, 2002, "This Reorganization Plan is submitted pursuant to Section 1502 of the Department of Homeland Security Act of 2002 ("the Act"), which requires submission, not later than 60 days after enactment, of a reorganization plan regarding two categories of information concerning plans for the Department of Homeland Security ("the Department" or "DHS")."

Appendix 2

Stated/Implied DHS Medical Readiness Responsibilities: HSPDs 5, 8, 9, and 10

HSPD-5: Incident Management

Pursuant to HSPD-5, the Secretary of the Department Homeland Security (DHS) is responsible for coordinating Federal operations within the United States to prepare for, respond to, and recover from terrorist attacks, major disasters, and other emergencies. HSPD-5 further designates the Secretary of Homeland Security as the Principal Federal Official (PFO) for domestic incident management. In this role, the Secretary is also responsible for coordinating Federal resources utilized in response to or recovery from terrorist attacks, major disasters, or other emergencies if and when any of the following four conditions applies:

(1) A Federal department or agency acting under its own authority has requested DHS assistance;
(2) The resources of State and local authorities are overwhelmed and Federal assistance has been requested;
(3) More than one Federal department or agency has become substantially involved in responding to the incident; or
(4) The Secretary has been directed to assume incident management responsibilities by the President.

HSPD-5 is primarily focused on the management of domestic incidents. In this directive, guidance is provided for the establishment of DHS to manage domestic incidents and develop the National Incident Management System (NIMS) and National Response Plan (NRP).

HSPD-8: Preparedness

The Secretary of Homeland Security is the PFO for coordinating the implementation of all-hazards preparedness in the United States. In cooperation with other Federal departments and agencies, the Secretary coordinates the preparedness of Federal response assets as well as the support for, and assessment of, and the preparedness of State and local first responders.

To help ensure the preparedness of the nation to prevent, respond to, and recover from threatened and actual domestic terrorist attacks, major disasters, and other emergencies, the Secretary, in coordination with the heads of other appropriate Federal departments and agencies and in consultation with State and local governments, shall develop a national domestic all-hazards preparedness goal. Federal departments and agencies will work to achieve this goal by:

(a) Providing for effective, efficient, and timely delivery of Federal preparedness assistance to State and local governments; and

(b) Supporting efforts to ensure first responders are prepared to respond to major events, especially prevention of and response to threatened terrorist attacks.

The national preparedness goal will establish measurable readiness priorities and targets that appropriately balance the potential threat and magnitude of terrorist attacks, major disasters, and other emergencies with the resources required to prevent, respond to, and recover from them. It will also include readiness metrics and elements that support the national preparedness goal including standards for preparedness assessments and strategies, and a system for assessing the nation's overall preparedness to respond to major events, especially those involving acts of terrorism.

HSPD-9: Food and Agriculture Terrorism

This directive establishes a national policy to defend the agriculture and food system against terrorist attacks, major disasters, and other emergencies.

The U.S. agriculture and food systems are vulnerable to disease, pest, or poisonous agents that occur naturally, are unintentionally introduced, or are intentionally delivered by acts of terrorism. The U.S. agriculture and food system is an extensive, open, interconnected, diverse, and complex structure providing potential targets for terrorist attacks. The best protection possible should be provided against a successful attack on the agriculture and food system which could have catastrophic health and economic effects.

As established in HSPD-7, the Secretary of Homeland Security is responsible for coordinating the overall national effort to enhance the protection of the critical infrastructure and key resources of the United States. The Secretary of Homeland Security shall serve as the PFO to lead, integrate, and coordinate implementation of efforts among Federal departments and agencies, State, and local governments, and the private sector to protect critical infrastructure and key resources. This directive shall be implemented in a manner consistent with HSPD-7.

The Attorney General, the Secretary of Homeland Security, and the Director of Central Intelligence, in coordination with the Secretaries of Agriculture, Health and Human Services, and the Administrator of the Environmental Protection Agency shall develop and enhance intelligence operations and analysis capabilities focusing on the agriculture, food, and water sectors. These intelligence capabilities will include collection and analysis of information concerning threats, delivery systems, and methods that could be directed against these sectors.

The Secretary of Homeland Security shall coordinate with the Secretaries of Agriculture, Health and Human Services, and the Administrator of the Environmental Protection Agency, and the heads of other appropriate Federal departments and agencies to create a

new biological threat awareness capacity that will enhance detection and characterization of an attack. This new capacity will build upon the improved and upgraded surveillance systems described in paragraph 8 and integrate and analyze domestic and international surveillance and monitoring data collected from human health, animal health, plant health, food, and water quality systems.

The Secretaries of Agriculture, Health and Human Services, and Homeland Security shall expand and continue vulnerability assessments of the agriculture and food sectors. These vulnerability assessments should identify requirements of the National Infrastructure Protection Plan developed by the Secretary of Homeland Security, as appropriate, and shall be updated every two years.

The Secretary of Homeland Security and the Attorney General, working with the Secretaries of Agriculture, Health and Human Services, the Administrator of the Environmental Protection Agency, the Director of Central Intelligence, and the heads of other appropriate Federal departments and agencies shall prioritize, develop, and implement, as appropriate, mitigation strategies to protect vulnerable critical nodes of production or processing from the introduction of diseases, pests, or poisonous agents.

The Secretaries of Agriculture, Health and Human Services, and Homeland Security shall build on existing efforts to expand development of common screening and inspection procedures for agriculture and food items entering the United States and to maximize effective domestic inspection activities for food items within the United States.

The Secretary of Homeland Security, in coordination with the Secretaries of Agriculture, Health and Human Services, the Attorney General, and the Administrator of the Environmental Protection Agency will ensure that the combined Federal, State, and local response capabilities are adequate to respond quickly and effectively to a terrorist attack, major disease outbreak, or other disaster affecting the national agriculture or food infrastructure. These activities will be integrated with other national homeland security preparedness activities developed under HSPD-8 on national preparedness.

The Secretary of Homeland Security, in coordination with the Secretaries of Agriculture, Health and Human Services, the Attorney General, and the Administrator of the Environmental Protection Agency shall develop a coordinated agriculture and food-specific standardized response plan that will be integrated into the National Response Plan. This plan will ensure a coordinated response to an agriculture or food incident and will delineate the appropriate roles of Federal, State, local, and private sector partners, and will address risk communication for the general public.

The Secretaries of Agriculture and Health and Human Services, in coordination with the Secretary of Homeland Security and the Administrator of the Environmental Protection Agency, shall enhance recovery systems that are able to stabilize agriculture production, the food supply, and the economy; rapidly remove and effectively dispose of contaminated agriculture and food products or infected plants and animals; and decontaminate premises.

HSPD-10: Biodefense

The essential pillars of the national biodefense program are: Threat Awareness, Prevention and Protection, Surveillance and Detection, and Response and Recovery.

Successful implementation of the program requires optimizing critical cross-cutting functions such as: information management and communications; research development and acquisition; creation and maintenance of needed biodefense infrastructure, including the human capital to support it; public preparedness; and strengthened bilateral, multilateral, and international cooperation.

National biodefense preparedness and response requires the involvement of a wide range of Federal departments and agencies. The Secretary of Homeland Security is the PFO for domestic incident management and is responsible for coordinating domestic Federal operations to prepare for, respond to, and recover from biological weapons attacks. The Secretary of Homeland Security coordinates, as appropriate, with the heads of other Federal departments and agencies to effectively accomplish this mission.

Assessments

One critical element of the biodefense policy is the development of periodic assessments of the evolving biological weapons threat. First, the United States requires a continuous, formal process for conducting routine capabilities assessments to guide prioritization of ongoing investments in biodefense-related research, development, planning, and preparedness. These assessments will be tailored to meet the requirements in each of these areas. Second, the United States requires a periodic senior-level policy net assessment that evaluates progress in implementing this policy, identifies continuing gaps or vulnerabilities in the biodefense posture, and makes recommendations for rebalancing and refining investments among the pillars of the overall biodefense policy. The Department of Homeland Security, in coordination with other appropriate Federal departments and agencies, will be responsible for conducting these assessments.

Critical Infrastructure Protection

Protecting the critical infrastructure from the effects of biological weapons attacks is a priority. A biological weapons attack could deny access to essential facilities and response capabilities. Therefore, efforts are underway to improve the survivability and ensure the continuity and restoration of operations of critical infrastructure sectors following biological weapons attacks. Assessing the vulnerability of this infrastructure, particularly the medical, public health, food, water, energy, agricultural, and transportation sectors, is the focus of current efforts. The Department of Homeland Security, in coordination with other appropriate Federal departments and agencies, leads these efforts which include developing and deploying biodetection technologies and decontamination methodologies.

Attack Warning

Early warning, detection, or recognition of biological weapons attacks to permit a timely response to mitigate their consequences is an essential component of biodefense. Through the President's recently proposed biosurveillance initiative, the United States is working to develop an integrated and comprehensive attack warning system to rapidly recognize and characterize the dispersal of biological agents in human and animal populations, food, water, agriculture, and the environment. Creating a national bioawareness system will permit the recognition of a biological attack at the earliest possible moment and permit initiation of a robust response to prevent unnecessary loss of life, economic losses, and social disruption. Such a system will be built upon and reinforce existing Federal, State, local, and international surveillance systems. The Department of Homeland Security, in coordination with other appropriate Federal departments and agencies, integrates these efforts.

Attribution

Deterrence is the historical cornerstone of defense, and attribution (the identification of the perpetrator as well as method of attack) forms the foundation upon which deterrence rests. Biological weapons, however, lend themselves to covert or clandestine attacks that could permit the perpetrator to remain anonymous. Attribution capabilities are being improved to enhance the deterrence posture. The capability to perform technical forensic analysis and to assimilate all-source information to enable attribution assessments is being improved. The National Bioforensic Analysis Center of the National Biodefense Analysis and Countermeasure Center, under the Department of Homeland Security, has been created and designated as the lead Federal facility to conduct and facilitate the technical forensic analysis and interpretation of materials recovered following a biological attack in support of the appropriate lead Federal agency.

Response Planning

Once a biological weapons attack is detected, the speed and coordination of the Federal, State, local, private sector, and international response will be critical in mitigating the lethal, medical, psychological, and economic consequences of such attacks. Responses to biological weapons attacks depend on pre-attack planning and preparedness, capabilities to treat casualties, risk communications, physical control measures, medical countermeasures, and decontamination capabilities.

A biological response annex is being drafted as part of the National Response Plan (NRP). State and local plans, consistent with the NRP, are being developed to ensure a seamless coordinated effort. Capabilities required for response and mitigation against biological attacks will be based on interagency-agreed scenarios derived from plausible threat assessments. These plans will be regularly tested as part of Federal, State, local, and international exercises. The Department of Homeland Security, in coordination with other appropriate Federal departments and agencies, is developing comprehensive plans

that provide for seamless, coordinated Federal, State, local, and international responses to a biological attack.

Risk Communication

A critical adjunct capability to mass casualty care is effective risk communication. Timely communications with the general public and the medical and public health communities can significantly influence the success of response efforts, including health- and life-sustaining interventions. Efforts will be made to develop communication strategies, plans, products, and channels to reach all segments of society, including those with physical or language limitations. These efforts will ensure timely domestic and international dissemination of information that educates and reassures the general public and relevant professional sectors before, during, and after an attack or other public health emergency.

The Department of Homeland Security, in coordination with other appropriate Federal departments and agencies, is developing comprehensive coordinated risk communication strategies to facilitate emergency preparedness for biological weapons attacks. This includes travel and citizen advisories, international coordination and communication, and response and recovery communications in the event of a large-scale biological attack.

Appendix 3

Survey Methodology

General

The assessment instrument was formulated after conducting a series of preliminary interviews with DHS medical and non-medical staff that included discussions with Jeffrey Lowell, MD, FACS, Senior Advisor to the Secretary for Medical Affairs; and CAPT Veronica Stephens, MSN, ANP-C, WMD Operations and Incident Management, Science and Technology Directorate, DHS, as well as others. The actual interviews were conducted and analysis performed by an expert team from the international consulting firm, Battelle. Data from the preliminary interviews was analyzed and compiled with input and direction from DHS personnel to create the assessment instrument.

Methodology

The assessment instrument consisted of eight open-ended topical discussion points intended to stimulate free-flowing discussion from the individuals interviewed. Interviews were conducted with thirty-two management and non-management employees across all five DHS directorates, (Management, Science and Technology, Information Analysis and Infrastructure Protection, Border and Transportation Security, and Emergency Preparedness and Response), and the U.S. Secret Service, Federal Law Enforcement Training Center, Citizenship and Immigration Services, and U.S. Coast Guard.

Responses were categorized by the following eight subject areas:

- Medical Capabilities
- Medical Requirements
- Occupational Health
- Buddy Aid
- Organizational Vision/Issues
- Political Issues
- Communications/Messaging - Language
- Career Care and Feeding of PHS Officers Detailed to DHS

Data collected from 32 interviews was analyzed comprehensively.

	S&T	CIS	IA/IP	BTS	EP&R	Mgt	ODP	Secret Service	Coast Guard	FLETC
Non-Med Mgt	8	1	1		4	2	1			
Non-Med Non-Mgt	1	1	1	1				1		1
Medical Mgt.	4	1			1				1	
Medical Non-Mgt	1				1					
Total (n=32)	**14**	**3**	**2**	**1**	**6**	**2**	**1**	**1**	**1**	**1**

Appendix 4

Assessment Interview Instrument
Preamble and Topics/Questions for Discussion

Preamble:

- We are in the process of determining what medical and public health requirements and capabilities are needed within DHS. We have been tasked to conduct confidential and non-attribution interviews with selected staff. Your insights and thoughts will help us get a clear picture of the medical/PHS requirements and capabilities. When we prepare our notes from this interview, a number will be substituted for your identity to prevent any attribution to you personally. We'd appreciate it if you would be candid and share your personal perspective with us.

Discussion Points:

1. Personal Data for perspective of depth & breadth of their knowledge (brief bio-sketch of interviewee -background, time in role, which role, how individual got there).

2. What is your understanding of any Medical/PH Requirements and capabilities for your specific area of responsibility?
    - Can you think of any circumstances where you would want to be able to have medical expertise? Use list of medical/PH functional disciplines as stimulant.
    - Are there any Med/PH areas where you need reach-back capability?
    - Do you know who these folks in DHS are? Do you know how to reach them? Do you have an understanding of the system to reach out to these folks?
    - What do you know about the internal mechanisms or protocols within DHS for reaching medical/PH assets/resources?
    - What is your understanding of contacting the HSOC within DHS?
    - How do you currently use the Medical/PH assets within DHS? At all?
    - How do you see them supporting your area of responsibilities?
    - Are there any impediments, (blocks, gaps, or disconnects to obtain the Med/PH information and/or assistance you need?
    - Do the current capabilities meet your needs?

3. Talk to us about how your directorate or area of responsibility ensures you have the equipment, training, fitness levels you need to safely operate if you are deployed to a disaster or incident site.
    - Does anyone ensure you have the inoculations you need? Tetanus? Vaccines?

4. If you are deployed to a field situation, how does your team manage any injuries or exposure to toxic substances or bio-agents you might encounter?

5. Tell me about any medical or PH operational and organizational policies that pertain to your area.
    - Did you bring those policies with you when your division moved to DHS, or formed them from start-up?
    - Are they uniform throughout DHS?

6. We're going to lighten up a little now – here's an opportunity to have some fun, be creative. We're looking at an image, a message that can be used internally, maybe externally to communicate about the important work being done at DHS. Think of the role that DHS employees hold – the role that you hold within DHS. Now take your vision of that role and design a character that you might see in a television series or an action movie that would play that role. What would that be person be like?

7. PHS Commissioned Corps only: Let's talk about what you see as the career advantages or disadvantages of being detailed to DHS.

8. Other: Are there any other issues you want to discuss or anything else you might want to share with us?

Appendix 5

Survey Responses and Conclusions by Topical Categories

1. Medical Capabilities

General: Responses focused on the understanding and knowledge of medical capabilities within DHS, ranging from current capabilities to required capabilities.

Conclusion: DHS employees do not know the medical capabilities that exist within DHS, but they know which capabilities *are not* in DHS. Regardless of the medical capabilities that exist, those medical capabilities are not known throughout the Department, or the directorate in which the medical capability resides.

Currently, there is no medical component or system that can manage a medical event involving mass casualty injury or illness.

The use of existing medical capabilities to respond to a medical event creates a secondary medical emergency for local medical facilities.

HHS response units are not capable of responding to a medical event on their own.

Issues with the Current Medical Capabilities – Survey Quotes:

- *"I have visited all the training centers and S&T is not capable to train physicians and nurses to respond to a WMD event. Docs and nurses will be the first responders, and they need to know the DHS perspective and issues they need to deal with regarding CBRNE."*

- *"Most hospitals are understaffed and overbooked. Only a couple of extra patients overwhelms most hospital systems today.*

- *"Here is the issue, I have 60 physicians (USCG). Most are flight surgeons with bio-weapons training. Only 60 docs of 40, for 40,000 USCG personnel. We've had two docs in the Persian Gulf, along with seven Physician Assistants. We are barely doing the mission now. We are not manned to assist with all these other deployment requests that come in. Of the 60 docs, 10 are administrative, leaving 50 for the mission. We have 17 Physician Assistants, 630 Corpsmen, 59 dentists."*

- *"NDMS said we had to go to the next hurricane. HHS sent in the Commissioned Corps Readiness force with three gallons of water and no stethoscopes, nor refills or gas. CCRA said, "We need your toys." They sent the patients to the local hospitals. The goal was to keep the patients from overwhelming the local hospitals. HHS thinks it was a big success, but none of these people were injured."*

- *"We have to fix the key problem on medical surge. We cannot afford a solution to protect everyone, everywhere. We have to tell the public how we are parsing this."*

- *"Without NDMS, their [HHS] healthcare providers have no infrastructure, no supplies, no team structure, no training. They come as individuals from all over the country. Not very many of them have current clinical skills. Some have had no clinical experience in ten years. This is not good."*

- *"HHS has the responsibility for the medical response, but aren't capable of doing it, especially alone."*

- *"HHS is not really getting any lower than the state level."*

- *"There is absolutely no impact. It is extremely small in S&T. Medical has a very small footprint in DHS."*

- *"NDMS is the medical component under DHS. We are going to get a terrorist attack and our NDMS in the capital region is out of service because no one pays the bills. NDMS is decaying."*

- *"I heard they literally shut down the Indian Health Emergency Room in New Mexico to put the medical assets in Florida."*

- *"We just put together a catastrophic incident plan. It's just a plan. But do we have the capability of carrying out the plan? No. We used the army model of 100,000 casualties."*

- *"FEMA asks the PHS for assistance for officers, and PHS then calls the USCG for those people. It's a triangle."*

- *"We need to rethink patient movement. We would be in big trouble if there was a large hit."*

- *"Training in clinical forensic medicine, forensic science dealing with living patients. We do not train physicians to do forensic science. Physicians are wrong 70% of the time. In 30% of the cases, wounds that are documented on the chart are not there at all, and exit wounds are erroneously labeled."*

- *"They [HH]) advertise that they have 1200 , but they are really not able to do it. There are 1200 HHS employees – the PHS Commissioned Corps – that are detailed to Indian Health, Prisons, other agencies, that could be deployed. But many are not clinically competent, and they send them to liaison spots."*

- *"I have no one to reach out to. I see a large need for mental health consequence management and mitigation, we need to look at the psychosomatic phenomenon which is widespread."*

- *"We were ready to treat 200 patients in Orange County, Florida, in twenty-four hours. This was a HHS mission that was accomplished by NDMS. HHS was not ready to treat patients."*

- *"There are DMATS (NDMS) around the country, but they are so slow to activate and respond, then by the time they get there, they are not needed."*

- *"A lot of people sign up to volunteer (DMAT), but when the call comes, they're not available. There is a limited number of people who can go to a disaster when it occurs."*

- *"Even though DHS is not the lead for medical, to guide the Secretary, he needs an inherent medical public health capability."*

- *"If you looked at defending your country, the medical is necessary. It makes sense to have it here [DHS]."*

2. Medical Requirements

General: Responses focused on the perceptions of the medical requirements that DHS has to fulfill its overall mission. Responses ranged from discussions of extensive medical planning, readiness and response needs to comments that medical is strictly for someone else to do.

Conclusion: DHS needs a unified medical component at the headquarters level to (1) educate its internal management as to how a medical component within DHS contributes and is necessary to fulfill the DHS mission, (2) provide additional medical assets to meet the medical element of it mission, (3) lead efforts for a nationwide medical credentialing and standardization initiative that will enable licensed and credentialed medical professionals, including EMTs, to work nationwide, (4) advocate for appropriate funding of its medical components, (5) correct its organizational restrictions that impede its ability to hire and retain qualified medical professionals, and (6)correct human capital policies and practices that medically protect its federal employees, but exclude its contractors from those protections.

Medical Readiness Requirements – Survey Quotes:

- *"We have a requirement to talk medicine, preventative medicine, resulting effects, mitigating medical requirements after the incident. We need a smart element like that in DHS."*

- *"The need for a medical understanding of medical issues to manage an event is needed throughout all of DHS."*

- *"Clearly, mass casualty care, assessment, planning, doctrine, execution are a very critical part, if not the critical part, of our bio-defense capability."*

- *"The SNS (Strategic National Stockpile) needs to be expanded to regional stockpiles. They need to be closer to the incident. We need to get that out more immediately. If we have a major terrorist incident, the planes won't be flying. It needs to be decentralized. We need to expand to a parallel system. I think that we don't want to duplicate what HHS is doing, but with the threats out there, we need to build a robust medical response capability."*

- *"I could use medical oversight. I need an MD with medical operational emergency experience. I need an aviation medical specialist MD, nurses, and managers."*

- *"DHS has a responsibility to address public health areas that would reduce our vulnerability to a chem/bio attack. You have a doctor that doesn't recognize the bio-threat and wouldn't be able to detect it if he had a two-by-four upside the head."*

- *"I reached out and tried to get a Tropical Disease doctor. We needed one badly. We deploy P3s to Peru, Columbia, and other countries in South and Central America in areas with tropical diseases like Malaria. On my own I had to research the parasite and find out how to kill it without any assistance. I am not a physician."*

- *"We need clinical infectious disease expertise. Clinical consequence of disease is important, but help on responder issues is needed."*

- *"There needs to be outreach from characterization programs to the larger medical community in terms of doing risk assessments focusing largely on infectious disease issues. We need infectious disease expertise in the organization."*

- *"I see the need for a training and education awareness piece. The first responder is getting trained and equipped, but when you get to the hospital, the doctor doesn't have a clue what to do with a mustard gas patient."*

- *"We need someone who can say, I'm a doc, I care for you. Someone who knows what they're going through."*

- *"The other thing we're concerned about is developing three medi-vac teams. DoD doesn't have enough people to do it."*

- *"There are some critical specialties needed like psychology, infectious disease, pathology, anesthesiologists, radiation oncology, and surgeons."*

- *"The Secretary needs strategic level medical staff in the role of staff advisors to do strategic planning initiatives and as the connecting conduit to HHS regarding similar initiatives. If he had these people on board, he would not have to call Tommy Thompson."*

- *"People supporting the Secretary need to be a real doctor or nurse so they can advise."*

- *"The entire healthcare system is shutting doors, and it is difficult to get support from them when they are shutting down."*

- *"We have to have 24/7 availability to respond to the needs of this country whenever the locals or states are overwhelmed by a medical incident."*

- *"When Challenger blew up, they sent search teams with EMTs in them, but the EMTs weren't licensed to operate in the state of Texas, and Texas won't recognize the National Registry."*

- *"Whose license do we apply our services to? It was the Surgeon General. We do not have anyone here (in DHS) with a medical license to apply to."*

- *"Also, we need someone who can put forth a nationwide (medical) certification process that allows people to go anywhere. In Virginia, it's all local. (EMT) license is local, protocols are local. When activated you could do paramedic advanced support in that county, but once I step out of that county, I can't do it. Those issues need to be taken and dealt with."*

- *"We are not necessarily federalized when we work on these teams."*

- *"There are no nationwide protocols on what to do or how to do it."*

- *"DoD sets protocols for first responders. It should be something like that. There needs to be a scope of practice with a line of licensure, medical control docs, and protocols to use within that. We need some more complete than those from DoD for first responders for the NDMS teams that are activated. Nowhere do they set these standards."*

- *"There is a position open now, but what MD would come in here and work in an office with low pay?"*

- *"If a flask is dropped with the vapors wafting in the air and you decide if you're going to treat or not treat because of the distinction between a government employee and a contractor."*

- *"Contractors could not receive care at WRAMC because they were not government employees. We had to farm them out to occupational health physicians in the community. There is no consensus to treatment. The treatment protocol is up to ad hoc occupational health physicians. If dealing with more dangerous organisms, it is helpful to have a way for government and contractors to get care there at the government facility."*

- *"Number one is funding. Until you have funding, you can't get what you need. Number two, you can't attract anyone worth their salt upstairs, can't attract the quality types and the numbers you need without proper funding. You can't develop teams. They need to have training and equipment, but you can't without the funding."*

- *"Our (NDMS) budget last year was $34M, not nearly enough. We've got 70 teams, and we got $34M. They just haven't been paying attention."*

- *"We are grossly under funded."*

- *"I need mostly money to support the teams. We have $34M appropriated. We are starting at zero-based assessment and have a requirement for $87M and $14M just to keep the doors open. It is hard to maintain the system when we are not supported."*

3. Occupational Health, Buddy Aid, and Occupational Health Policies

General: Responses to the three topical areas of Occupational Health, Buddy Aid, and Occupational Health Policies were so closely connected and intertwined that it was deemed necessary to conduct the analysis of these areas together. In all three areas, responses reflected disparate awareness and knowledge of the need and utilization of DHS occupational health policies and programs in the extreme. Across DHS directorates and agencies, that awareness and utilization of occupational health policies and programs appears to be connected to the origin of the particular operational unit.

Conclusion: Occupational Health and Safety for DHS lacks the visibility, authority, and manpower to effectively implement the policies and programs necessary to provide the minimal workplace occupational health and safety elements required by the federal government, or to medically protect or treat DHS employees and contractors within their assigned mission operations.

A lacking key component in the Department is internal communication, messaging, and program support that reaches all organizational units within DHS. Management and employees of DHS need basic orientation and training to understand what the DHS occupational health and safety policies are and how they apply to their work as managers and employees.
Managers need particular orientation towards occupational health and safety matters in operations and continuity planning; in their decisions as to staff deployments and

utilization; in the provision of necessary support services, equipment, and training for deployed staff; and to the necessity and importance for the proper adherence to and enforcement of these policies and procedures within their organizational units.

DHS needs management accountability for communicating, implementing, staffing, and enforcing occupational health and safety policies and programs, in each and all organizational units, as is necessary to achieve DHS compliance with basic federal mandates in this area.

DHS managers need (1) access to occupational health and safety service support for program implementation and maintenance, and (2) individual analysis of their organizational unit's mission, operations, and staffing to determine their unit's occupational health and safety program needs.

Responses to Occupational Health, Buddy Aid and Occupational Health Policies:

- *"If someone becomes ill, we call 9-1-1."*
- *"Do we have occupational health policies? Nope."*
- *"Those created by law (S&T, UM, IA/IP, and the Office of the Secretary – that's where there is a big lack of occupational health people."*
- *"I have not seen medical support in DHS."*
- *"Right now there are as many approaches as there are agencies."*
- *"There is no occupational health component active in WMDO-IM in S&T. We've been stuck out at the RNC (Republican National Convention) in tunnels, on bridges, with no water, no protective clothing or equipment."*
- *"During RNC, EML lab people were working side by side with the New York Port Authorities who had PPE (Personal Protective Equipment), but EML people did not have any PPE."*
- *"At RNC we sent people up there. They were going to put a guy who had just had open heart surgery five months before on the George Washington Bridge in a protective mask for 8 hours with no water. No relief was planned..."*
- *"They sent a guy who had just had a stent put in. He was a DMORT person."*
- *"We got a frantic call from the office of Research and Development within S&T to get them. They could have been hurt or sick. They needed mask protection from internal combustion engine fumes, no plan whatsoever. It has not been corrected. It is not a part of operations planning – it's never done."*

- *"I need medical and public health support for potential CBRNE events and to protect my people and the people I am moving out of town. We have no training."*

- *"Most managers in DHS don't know about any DHS policies."*

- *"I have no knowledge of a DHS occupational health policy. We get no orientation as an employee or a manager."*

- *"We need to figure these things out (DHS internal safety and occupational health needs). "We need to be compliant to the extent that other federal agencies have to comply with federal agency requirements." (Repeated this twice.)*

- *"We need standard programs and policies and medical operational support."*

- *"There isn't any Buddy Aid. It doesn't exist out in the field. DMATS have management support teams to take care of the people. Employees of DHS sent out separate from the DMATs are on their own."*

- *"Take SOCOM for example, special operations command, they had special operations trooper hit with an IED (Improvised Explosive Device), and he literally bled to death. There was an entire troop around him. All he needed was a tourniquet."*

- *"For most bio agents, it is urgent care, not emergency care. We need a system set up for when people have accidents they can get care promptly."*

- *It's hard to go to a local hospital if working on a classified project. You can't tell them what they were exposed to."*

- *"I need imbedded medical support for these people, and this should extend to all of DHS – all DHS deployments need embedded medical support."*

- *"Perhaps we should go the PHS route so that not every directorate has their own capability. We should have the same medical support for all DHS employees and all DHS deployed employees. I will help at any time to help with this initiative."*

- *"We want consistent policies to look at the impact and mitigation. We don't want to cause adverse health effects."*

4. Organizational Vision/Issues

General: Responses to the topics for discussion revealed organizational issues concerning medical assets existing within DHS. There were numerous comments about the need for placing all DHS medical assets under a unified leadership with comparable authority to an undersecretary.

Background: A major medical asset within DHS is the National Disaster Medical System (NDMS) which currently resides under the Federal Emergency Management Administration (FEMA) within the Emergency Preparedness and Response (E P & R) Directorate. Responses focused on the issues that arise with NDMS being placed under FEMA, as well as the need for NDMS to be a part of a separate medical readiness and response organizational unit within DHS.

NDMS is currently managed by FEMA within DHS. NDMS consists of volunteers from the medical profession that perform medical response in a national disaster. They also include non-medical teams. These volunteer teams are equipped with trucks containing emergency medical equipment and supplies. The team members who respond to a request to provide medical assistance are paid for the services they provide and generally leave their regular jobs to perform these volunteer services. FEMA operates under strict management rules and directives originally designed to manage non-medical emergency response and recovery to natural national disasters. In such cases, FEMA sends staff and contractors to set up satellite offices near the disaster to provide recovery funding assistance to disaster victims. Those field administrative systems are not designed for medical response teams deployed to a disaster site. Their administrative and payment systems do not work well for the volunteer teams deployed through NDMS.

Conclusions: Medical assets within DHS are fragmented, under-utilized, and mismanaged: (1) NDMS is losing functional effectiveness under FEMA's inflexible and inappropriate management for medical response circumstances; (2) medical assets need to be organized under a unified leadership that has authority comparable to the undersecretary level within DHS; (3) DHS medical assets need to be included in response planning throughout DHS; and (4) DHS needs to establish a culture of national response to replace an organizational culture of federalized bureaucracy.

Responses to Organizational Vision/Issues:

- *"Problems are with administration, personnel actions, and excessive signature chains to get things done."*

- *"Right now, we're in a crisis. Some teams are being evicted (DMAT teams) from warehouses – where all their stuff is stored. Three semis full of stuff they store – because FEMA hasn't paid the bills."*

- *"The teams put up with a lot of stuff, but don't you dare screw with their pay and expense reimbursement."*

- *"People are leaving the teams because they don't get paid. They're angry, and they can't afford two weeks without pay. They need it right away and can't wait months to be paid."*

- *In California, one team leader put the whole team's expenses on a personal credit card so they could get their mission done. It was $11,000 – so the team would have what they needed, and he couldn't get paid back."*

- *"When NDMS was with HHS, we had management support teams for us while we were deployed. Now it is pushed to one support team to manage two different assets with two different missions and skill levels. It doesn't work very well. It is not effective. To date it has not worked. There is a lot of discontent over it."*

- *"I am a DHS employee, but I cannot say that. FEMA does not want you to say you are a DHS employee. FEMA wants it done the FEMA way, but I work for DHS."*

- *"To FEMA credentialing means getting your fingerprints and your picture…not medical credentials."*

- *"FEMA does not use people appropriately. For example, they wanted an MD to pass out brochures as a community relations person in Florida."*

- *"Traditional (medical) disaster response is through NDMS."*

- *"FEMA's attitude on everything is, if it doesn't fit the rules, we don't do it. No one will change the rules."*

- *"They don't ever fix the rule to get the job done. In FEMA, rules take priority over getting the job done. FEMA will spend $3.00 to watch a dime. They go completely out of common sense to follow the rule. It is really frustrating."*

- *"There is no flexibility in the system. Rules apply over the mission. They don't treat employees like adults. They are twenty years behind in personnel management."*

- *"My team (recent deployment to Kirksville, MO, plane crash site) was in Personal Protective Equipment (PPE), and it was hot, and we can't buy water for the team because of a FEMA rule. The teams have to use their per diem for supplies for themselves."*

- *"FEMA buys water for disaster victims, but does not provide it to the team, who have to use their per diem. Many times there is no vehicle, no way to get to a place to buy it."*

- *"On the other hand, I'm not sure from what I've seen that FEMA does not see how to take care of the medical response teams. They've got to provide what the teams need to get the job done."*

- *"The folks on the DMORT teams in Kirksville were under USERA, not the Stafford Act. They have no on-the- job protection. We need to fix that."*

- *"If you stick medical and health under one directorate, it then becomes subordinate to that director who is not medical. The medical voice gets stifled and lost and the department does not benefit."*

- *"We used to be one step under the secretary in HHS, and now we are a section under an operations chief seven layers down."*

- *"Here in DHS almost everyone is law enforcement, and as a result, the right thing to do for medical support and operations is not understood. It is lost. This is medical operations, and it needs a clean uninhibited role."*

- *"We need to look at setting up a separate medical arm in DHS, a medical undersecretary that handles all that stuff. It needs to be a stand alone area in DHS. We need to do a careful study."*

- *"It absolutely needs to be its own directorate – an acting secretary for medical affairs. Take the best methods from everywhere and make a standardized and efficient program. Medicine is an operational mission here in DHS. We need to take the best of the best medical in DHS and widen it for all of DHS."*

- *"I believe that within DHS all of our bio support needs to be coordinated. It is not coordinated among directorates, and it should be."*

- *"This place really needs a deputy SG (Surgeon General), someone with horsepower to make things happen."*

- *"I am not sure that we are organized to address operational health versus security issues."*

- *"I have no problem with DHS standing up their own unit of corporate medical care. Right now the capability does not exist. An autonomous directorate is needed."*

- *"Effecting change means stepping on feet and poking a skunk. The institutional beliefs, cronyism, and bureaucracy is still in place."*

- *"There are so many cultures here. It's like splitting up the Navy, and it is no more, and then try to blend it with other groups."*

- *"DHS is a typical government bureaucracy with all its faults and inefficiencies and the real problem is keeping the best people once they start and hit the wall with the government system."*

- *"We need to establish our culture here. We need to integrate that culture and integrate it with DMAT teams and local fire and rescue – so everyone understands what is to be done and how. We need the same standards, same protocols. We can do this if we can pull it together within the department. If we could have an office in DHS that is put in charge, will define the mission, set the regulations for all employees, put in performance appraisals of each of the undersecretaries in DHS and make them accountable so they don't blow it off."*

- *"In strict disaster response, we are not consulted."*

- *"There are people with no understanding of the health implications of a bio-event, and they set up this knowledge center. What were they thinking? The FBI and the CIA are connected to it, but not the organizations that have to do with health and medical."*

5. Political Issues

General: Responses to the topics for discussion revealed political issues existing between DHS and other agencies that could cause interference in the performance of the DHS mission in a NSSE, National Disaster, or other event requiring response or support from DHS. Political issues also affect internal DHS operations and capability.

Discussions of political issues with agencies outside DHS came primarily from the S&T Directorate and the EP&R Directorate interviews. Discussion of political issues centered on disagreements over legal responsibilities for medical readiness and response to national disasters and events between DHS and HHS. HSPD-10 and ESF #8 stipulate that HHS has the lead role in medical response, but the DHS Secretary is the Incident Commander (IC) when two or more federal agencies are involved. Further aggravating disagreements between these two agencies are bad feelings over the tearing off of NDMS from HHS and placing it with DHS. Public Health Service Commissioned Corps Officers (headquartered in HHS) face political retaliation that impacts their individual careers when they accept assignments within DHS. A number of respondents expressed the need to enact legislation that will clarify and assign the medical leadership, readiness, and response roles to DHS.

Conclusions: Politically adversarial turf wars between DHS and HHS and similar battles between organizational units within DHS threaten DHS' ability to lead effective medical response in the event of a national medical event. DHS needs (1) legislative clarification regarding medical readiness and response in Homeland Security responsibility, (2) address and reconcile inter-agency and internal turf wars, (3) establish a clear medical response mission philosophy, and (4) unify DHS medical assets under a centralized leadership.

Responses to Political Issues:

- *"My perspective right now is that agencies have an adversarial role."*
- *"I don't personally know this, but there is yelling and screaming on conferences, and they (HHS) are screaming – we have the medical lead."*
- *"What don't you get about what the President said that Ridge is the IC (Incident Commander)?"*
- *"HHS fought tooth and nail to keep NDMS in HHS. Some of those officers (PHS) who stayed at HHS called those that came to DHS, "cast-offs"."*
- *"Some of the problems will take legislation to correct."*
- *"The approach medicine takes, the medical approach versus science. From the public Health perspective, any death is too many. From the strict science perspective, there will be deaths. The HHS perspective is they take extreme measures to protect the dying."*
- *"It is an accepted fact from the DHS side – someone is going to die, but we must protect the nation."*
- *"The military approach is to let a person die to save others, the civilian approach is to save the most critical."*
- *"Public Health wants a zero loss – treat the most critical first. From the Homeland Security side, that may not be the approach."*
- *"We could use our teams to take care of those victims that would otherwise use up the resources. Let the local docs use the resources and personnel that could be saved."*
- *"How we deal with the medical versus public health side is an inter-agency issue."*
- *"A quarantine has never been done before, and there are issues of responsibility and authority between DHS and HHS and we may not get a quick decision that would mitigate the spread of disease."*
- *"I believe that within DHS all of our bio support needs to be coordinated. It is not coordinated among directorates, and it should be."*
- *"We are not playing well with each other. We need to be more successful at bridging stovepipes."*

- *"Quarantine, that's raising the number one issue. How are you going to enforce quarantine? We are sending in unprotected cops, so we need to train. If we isolate people, we need laws. We need procedure to localize and give them gear. We need cops talking to cops. We ought to be taking the lead in quarantine."*

- *"We have been propping up HHS since the transition."*

- *"It absolutely needs to be its own directorate, an acting secretary for medical affairs. Take the best methods from everywhere and make a standardized and efficient program."*

- *"We need to look at setting up a separate medical arm in DHS – a medical undersecretary that handles all that stuff. It needs to be a stand alone here in DHS."*

- *"We must get the word out that medical problems need to be addressed at the highest levels of DHS."*

- *"Cronyism may continue to be a problem with pay banding. I don't expect things to change with pay banding. Supervising staff must be trained well on how to rate performance."*

- *"Battles at WMDO-IM level and up – turf fights and people who report directly to the Undersecretary or Assistant Secretary, that's where things are wishy-washy."*

- *"Networks and friendships are more important than performance."*

- *"If you want to be an SES in this organization, your old friends will get you the SES."*

- *"We can't do anything about it. We're caught in the politics of DHS."*

6. Communications/Messaging

General: Responses focused on capturing image and language from DHS employees for potential use of medical asset communications, messaging, branding, and recruitment.

Preliminary interviews used in the instrument creation revealed the messaging/branding topic to be somewhat problematic in achieving responses. DHS employees are, by the nature and purpose of their work, not prone to imaginative flights of fancy and had difficulty switching their mindset from serious medical response needs and capabilities to promotional images and language about the medical aspects of the DHS mission.

In this topic, interviewers found the most effective approach to be one of asking the interviewees about the image of a DHS medical recruitment poster or a DHS medical recruitment poster character that most reflected the medical mission of DHS.

Conclusions: DHS currently lacks a clear, focused branding image and message that articulates a clean vision of its mission, and how it will fulfill that mission. DHS needs (1) to create a branding image and message to clearly communicate its mission and identity to the American people, (2) a strong medical readiness and response message to communicate with public health, internal DHS organizational units, and with inter-agency coordination, (3) a system of knowledge management to foster and ensure the sharing and integration of information across and throughout the organizational units of DHS, and (4) to capture and formalize its internal cultural language to use in internal communications and external messaging.

Communications/Messaging Responses:

- *"It needs a visible, nationally recognized and trusted spokesperson who communicates well and openly."*
- *"The DHS medical requirement is serving the country. They should be formulating and putting together a cavalry."*
- *"Like the old NDMS – it was people at the local level who hold the line until the cavalry gets there."*
- *"Emergency rooms are the place where the medical – nurses, EMTs, fire, all come together. One of the old NDMS brochures had pictures and stuff like that – rescue type pictures."*
- *"I like the Minute Man image – the 3-cornered hat, holding a rifle. A lot of people will probably talk about shields. Shields imply that we are about war. We need to avoid images that show separation – like moats, walls, etc."*
- *"The image? I think the Surgeon General. We need to see him more."*
- *"Our interest needs to be in the overall healthcare of our country."*
- *"I'm a big believer in making sure our hometowns are secure."*
- *"It needs to give solutions and needs to communicate to people in a language they understand, and they need to build that trust."*
- *"For DHS to be a success, it has to have an articulate, a clean vision of where it is going, a plan on how to get there and a way of assessing whether it's there or not."*
- *"Response to stay the course, even when it is not in the news."*
- *"I love the mission. I love what we do. What we do has a real and immediate impact. We have a pretty neat mission. It's the purpose that matters."*

- *"We need to ensure our focus is in the best health interest of Americans."*
- *"Protect the Protectors."*
- *"The mission of the Office of Protective Medicine is "To serve as a unique national resource, safeguarding federal employees and their workplace, through protective medicine operations, specialized consultation and education for the public health community."*
- *"It is clear we have to attract the right people. We need to be able to retain and keep them on board."*
- *"Scientists managing leading edge research and development programs to dramatically change the current paradigm."*
- *"This is the place where the action is – where you can affect things in the short term. Research and development is translated into immediate products."*
- *"Work is interesting scientifically and intellectually. This is not basic research, but cutting edge applied research."*
- *"Personnel and colleagues in contact with are top flight people."*
- *"Come to DHS and apply your talents in making the nation safe, and I suggest always couching the statement in meeting our mission to protect the nation."*
- *"Working for DHS is a noble cause."*
- *"You have the chance to be on the ground floor of an organization that can't go anywhere but up."*
- *"You'd have a significant environment to learn in, grow in, interact with other people, it's phenomenal."*
- *"Opportunity to get into building a new organization – join something new. You are serving your nation."*
- *"Public service to your country."*
- *"We need to put forth the DHS values in appealing to them. Integrity, fairness, dealing with people's live. These are important."*
- *"People come here for altruistic reasons. It's glamorous. You're protecting the country. No one knows what DHS actually does, so they are attracted to the mystery and glamour."*

- *"When recruiting, I explain the downside challenges and the upside opportunities. I sell the mission and the upside opportunities to make it."*

- *"I explain to them that this is a dysfunctional organization with an important mission. I sell it on a case-by-case basis. I make sure they're informed about the downside, and let them know about the upside opportunities."*

- *"DHS is a typical government bureaucracy with all its faults and inefficiencies and the real problem is keeping the best people once they start and hit the wall with the government system."*

- *"There is the perspective in the public health community that bio-defense preparation is a waste of resources that take them away from their core mission."*

- *"Public health has no trust except from a medical diagnosis, as opposed to an architecture or surveillance system. But they would have missed their best treatment window."*

- *"We are all over the place and trying to talk to get the directorates to talk with one another."*

- *"The biggest issue is no one is talking. We say it's a rice bowl. This is mine. Knowledge is power. We are not going to share, instead of all of us working together."*

- *"We are the glue that is supposed to facilitate communication and coordination. There is no system in place at this point in time."*

- *"We have to figure out how to share."*

Language

General: The language, or vernacular, used within an organization is a reflection of its corporate culture, member mindset, and individual employee behavior. The organizational language can be a significant means to changing or establishing an organizational culture.

Interviews revealed a unique blend of scientific, military, law enforcement, medical, "federal government speak" language, and geographical colloquialisms. Interviews revealed extensive use of analogies and metaphors throughout DHS as a primary method of translating meaning.

This special blend of language specific to the mission of DHS creates an excellent opportunity to formulate branding and communication messages unique to the DHS mission. The use of this language identifies messaging as a DHS communication. It supports and reinforces the use of logos and other DHS

identifiers, resulting in an opportunity to develop a strong branding presence for DHS amid a multitude of competing government agency images and communications.

Repeatedly used and topically significant vocabulary was isolated by terms, images, and messaging phrases. It's inclusion to this report provides a basis for communications language, branding messaging, and recruitment messaging. It could also be used as support for corporate culture change efforts, should change be implemented.

7. PHS Officers Detailed to DHS

General: This topic was brought up for discussion only with Public Health Service (PHS) Commissioned Corps Officers working at DHS who were interviewed as a part of the total assessment. Some of those officers hold permanent positions with DHS, but most of them are detailed to DHS. PHS Commissioned Corps Officers were asked to discuss what they see are career advantages or disadvantages in working at DHS.

Conclusion: DHS organizational units have not been able to incorporate special career management necessary for PHS officers. The adversarial inter-agency relationship with HHS is threatening DHS' ability to utilize the skills and services of PHS Commissioned Corps Officers. DHS needs (1) to establish an internal agency program for awards and personnel management modeled after other agencies that employ PHS Commissioned Corps detailees, and (2) resolve pay, promotion, and clearance status issues for PHS Commissioned Corps Officers that threaten PHS employee retention within DHS.

PHS Officers Detailed to DHS Responses:

- *"There are big-time battles going on at HHS. Very senior leadership dislike senior officers at DHS, and they control the promotion boards."*
- *"I feel I am stuck as an 0-5, even though I am in an 0-6 job. Part of it is being in DHS and part of this is because of the new rules they are imposing on us now, requiring a Masters in Public Health to be promoted to 0-6."*
- *"I am an 0-6, but filling an 0-7 billet. The only issue I have about being with DHS is that I will not get an 0-7 promotion. I can't get an 0-7 and stay at DHS."*
- *"Military people here don't have the same career restrictions. They get promoted."*
- *"All the agencies where PHS officers are located – PHS officers are owned by that agency, not PHS. PHS has control of about 20 of 6,000 PHS officers. PHS is trying to exert control to have a ready force. They tell us we need to buy uniforms, follow their rules, and this hurts morale."*

- *"PHS holds promotion panels, and the precept is to have a PHS deployment. My PHS officers are called directly, and they in turn are told to speak wit their commanding officer and work it out. Makes for a difficult relationship between the commanding officer and the PHS officer. The commander is in a catch-22: don't let him go, then no promotion; let him go and get no backfill to do the work at hand."*

- *"One officer in Alaska has deployed six or seven times for PHS deployments and the CO is furious. He is the only one in a 400 mile arc, from Sitka to Victoria, Canada. He is the only one doing life-saving missions weekly, and these do not count as a PHS deployment."*

- *"The PHS has asked the USCG for dentists to examine Marine recruits at Camp LeJune. To do this, the USCG had to pull dentists from Cape May, New Jersey, where they were providing oral health to USCG recruits, also getting ready for deployment."*

- *"Where this comes into play is the security clearances are an issue. DHS thinks HHS holds the security clearance. If you are not a detailee, then DHS holds the security clearance. XXX and XXX are PHS and hold a DHS clearance. There is no grandfather clause."*

- *"…This position should be in Washington, D.C."*

- *"…Ordinarily, liaisons are in headquarters where the agencies reside."*

- *"There is a total breakdown. HHS doesn't care. We have an MOU, but FEMA doesn't have a mechanism for the Commissioned Corps. They have no rule about it, so they ignore it."*

- *"Most of the people working for me make more money than I do. Most of them are at least a GS-15."*

- *"One of the advantages, we fall into loopholes in the laws because of PHS we don't count as FTEs. Since DHS sends the money out, they don't count against HHS FTEs. They don't appear as FTE to either organization."*

- *"For our level of expertise, we are cheap."*

- *"If DHS cut off PHS officers, the officer does not have an organization to go back to. I would have to go find an organization to take me, or I would have to quit (PHS)."*

- *"People are leaving. Lost two people…who have gone to other agencies for better pay and opportunities. This place is like a swinging door."*

- *"I am eligible, but I have been told that I won't get a star over here (DHS), and that sends the negative message that HHS doesn't care. The negative implication for DHS might be that I decide to go back to HHS just to get my star. That would have a big impact on DHS."*

- *"Morale is awful. We have lost about 10%, more professionals than in any other time in history (USCG)."*

- *"More have left this year than in any other."*

8. Other

General: Very little data was collected in the "Other" category. Most of the data categorized in this topic dealt with disconnects in understanding the DHS internal organizational structure or with previous issues that have been partially addressed. "*We just started out with our 5th set of space planners*," is an example of expressed frustration over the organizational issues that DHS has faced as a start up organization.

A negative corporate cultural may already be forming and becoming entrenched in DHS as an organization and is an indicator of the need to proactively and positively take actions to intentionally instill a chosen corporate culture. This was expressed in the statement, "*You often get the answer that we have never done that that way… and we never will!*"

Appendix 6

National Disaster Medical System: Recommendations for Disaster Medical Assistance Team (DMAT) Transformation

Background

A federally-coordinated system, the National Disaster Medical System (NDMS) was initially developed by the U.S. Public Health Service (USPHS) to support state and local healthcare agencies during natural disasters. Following the tragic events of September 11, 2001, the NDMS mission has expanded to include technological disasters, major transportation accidents, acts of terrorism including weapons of mass destruction events, and support for national security special events (NSSEs). Working in partnership with the Departments of Health and Human Services (HHS), Defense (DoD), and Veterans Affairs (VA), the NDMS deploys health and medical personnel, equipment, and supplies in a phased regional approach.

The NDMS has gone through major management changes in recent years. In 2001, the Office of Emergency Response (OER)—of which the NDMS Section was a component—was transferred to the newly-formed Assistant Secretary for Public Health Emergency Preparedness in HHS. On March 1, 2003, the NDMS and OER were reassigned to the Emergency Preparedness and Response (EP&R) Directorate of the Department of Homeland Security (DHS). Personnel changes during these two moves reduced the staff from a reported 144 to 57 positions. In addition, the Commissioned Corps Readiness Force (CCRF) personnel (who had previously worked closely with and augmented the OER staff) were retained by HHS.

Methodology

An initial review of the NDMS was conducted concurrently with the DHS medical needs assessment between September 23 and November 9, 2004. The NDMS review focused on documenting the perceived effectiveness of NDMS capabilities (particularly the Disaster Medical Assistance Teams (DMATs)), identifying gaps and concerns, and developing recommendations for transforming the DMATs to satisfy current mission requirements.

Previous assessments of the NDMS, recent after-action reports from the Democratic and Republican national conventions and hurricane response deployments, and other relevant reports were reviewed. Interviews with NDMS core staff members solicited ideas for improving the NDMS. DMAT commanders and team members who deployed to these disasters were interviewed telephonically or contacted via email to discuss their experiences and elaborate on recommendations to improve capabilities and responsiveness.

Findings

The National Disaster Medical System is an organization comprised of over 8000 personnel. With the exception of a very small number of committed management personnel in the NDMS Section of the EP&R Directorate, the bulk of NDMS staff members are devoted volunteers located throughout the country. Past NMDS successes can be directly attributed to these committed and dedicated personnel. During an event, these volunteer members and the few full-time staff members accomplish the NDMS mission by taking days to weeks away from their primary jobs, often living in austere and sometimes dangerous environments, while their colleagues at home cover their work shifts and practices. Major findings of the NDMS assessment are discussed in this section.

- The NDMS lacks the medical oversight required to effectively develop, prepare for, employ, and sustain deployable medical assets. The chief medical officer position is vacant and there is no plan to provide a supporting medical staff to develop operational plans or standard operating procedures.

- Even though the NDMS mission has expanded beyond response to natural disasters, there has been no substantial change in doctrine, organization, or funding to satisfy the demands of the new requirements.

- DMATs are now frequently pre-deployed to support National Security Special Events (NSSEs) as an on-scene asset to provide emergency care within minutes of an untoward event. The DMATs are not currently organized, trained, or equipped to accomplish such tasks.

- The Center for Naval Analysis (CNA) “Corporate Readiness Assessment” dated October 2002 was focused on the DMATs, National Medical Response Teams (NMRTs), and Management Support Team (MST). The in-depth evaluation identified the following key components as deficient or completely lacking:
  - DMAT guidelines did not correlate to mission requirements.
  - The HHS OER lacked data to completely assess readiness.
  - Partial readiness assessments based on OER administrative data conflicted with data derived from team members.
  - DMATs were fulfilling missions unrelated to stated capabilities.

- Absent or outdated doctrine and policy has resulted in the lack of consistency among DMATs. The policies that do exist are not enforced. As a result, DMAT commanders have developed their own policies and guidelines which vary considerably from one team to another. These variations negatively affect the ability of DMATs to work together cohesively and have an adverse impact on the frequent requirement for one team to replace or augment another.

- A letter from one prominent DMAT leader to DHS reported the loss of warehouse space resulting from DHS not paying the rent as previously negotiated. Another DMAT member reported providing $7000 in personal funds to pay for warehouse space when DHS did not

make the rent payments. Some warehouses have been locked and team members denied entry, while others have received threats of eviction. Problems like these are common and continue to degrade federal response capabilities.

- The recent report, Bioterrorism: America Still Unprepared, by the House Select Committee on Homeland Security dated October 22, 2004 concludes that our nation is not prepared to distribute federally-supplied medicines and vaccines quickly enough to successfully respond to a bioterrorism event or other public health emergency, such as pandemic flu. Even though initial response to such incidents is not the immediate mission of the NDMS, the lack of readiness at the state and local levels could be further compounded by continued degradation of the federal medical response capability which is intended to augment and support local healthcare response efforts.

- The absence of medical leadership within the Federal Emergency Management Agency (FEMA) and DHS is clearly apparent. The structure and volunteer nature of the NDMS is different from other components of DHS and FEMA. No other vital U.S. Government program in the Department of Justice, Health and Human Services, or Department of Defense is being staffed predominantly by volunteers. The responsibility for planning for and responding to incidents of such national significance cannot be relegated to a volunteer workforce which, when activated, are not legally bound to report for duty.

- Recent hurricanes in the Southeast severely taxed the NDMS—nearly three-quarters of fully-deployable NDMS teams were reportedly mobilized. In addition, a substantial number of USPHS personnel were deployed to support local medical requirements rather than providing direct care to hurricane victims. Coupled with the fact that there were few, if any, serious injuries incurred raises serious questions about the ability of NDMS to respond to mass casualty events resulting from a CBRNE incident or a pandemic illness in which hundreds of healthcare providers would be needed for extended periods.

Recommendations

To ensure the NDMS possesses the requisite capabilities to provide the primary federal medical response, the following actions are recommended:

NDMS Leadership

- Appointing a senior medical leader within the proposed DHS Office of Medical Readiness to provide oversight of the NDMS is essential. Without this, the nation's only federal emergency medical response system will continue to degrade and will not achieve the response level required by the National Response Plan (NRP) and the National Incident Management System (NIMS).

- Close and continuous collaboration with the U.S. Surgeon General, HHS Assistant Secretary for Public Health Emergency Preparedness, Director of CDC, DoD Surgeons General, and VA emergency response leadership is required to develop cohesive and integrated response plans.

NDMS Staffing

NDMS Section staffing must be expanded to include diverse medical and healthcare professionals, operational and deployment specialists, and support specialists (such as communications, logistics, and occupational health and safety) to address the full spectrum of medical response requirements and functions. An experienced, multidisciplinary cadre of skilled healthcare professionals is required to establish policy and guidance, develop plans and procedures, conduct medical operations, and provide training. A full-time and uniformed reserve medical corps will need to be recruited and supported. This medical corps could be developed as part of the medical element of the National Guard, as a new clinical readiness component of the U.S. Public Health Service, or as an independent DHS medical corps. Adequate support staff is required to provide the infrastructure for personnel, finance, information management/information technology (IM/IT), and other essential administrative functions. This will require a substantial resource investment, for both personnel and materiel.

- DMAT staffing levels and team composition need to be thoroughly analyzed and revised to satisfy medical care needs dictated by current mission requirements. The White House Homeland Security Council (HSC) has developed multiple planning scenarios with 100,000 casualties. Proven medical staffing models from agencies such as the U.S. Coast Guard, Military Reserve components, and National Guard (modified to reflect civilian population demographics such as infants, children, elderly, and disabled persons) should be evaluated and used where appropriate to determine the necessary skill sets and the proper number of personnel to carry out DMAT taskings. This will require a substantial increase in personnel, and will require a phased implementation.

- The development of a committed professional Medical Reserve Corps is necessary to ensure there will be an adequate number of and appropriate type of specialists available for a substantial federal medical response.
  - The medical corps reservists should serve one weekend a month and two weeks a year (similar to their military reserve or National Guard counterparts). Duty time should be devoted to training, exercises, or enhancement of clinical skills necessary to support the mission.
  - The reserve medical corps could be developed as part of the medical element of the National Guard, as a new clinical readiness component of the U.S. Public Health Service, or as an independent DHS medical corps.

- Full-time staff should be acquired to fill key positions on the various teams currently filled with part-time and/or volunteer personnel. Logistical, administrative and training/operations support functions need to be constantly maintained to achieve the required readiness posture. The teams presently exist through the efforts of volunteers who work without pay to keep the team data and supplies prepared for deployment. National Guard units have full-time personnel to maintain these functions for national security. NDMS teams must have a similar model of full-time support personnel. The cost to staff these positions full-time would be off-set with a much higher level of readiness and subsequent ability to meet health care needs as the federal healthcare response system.

- A full-time response component, such as Medical Strike Teams (MSTs), should be developed to support contingencies 365 days a year. Regional dispersion of these MSTs would provide an initial medical response that will be light, lean, and capable of deploying nation within hours to assist state and local healthcare entities. During periods of non-deployment, these teams should report to the DHS Emergency Coordinators to assist in coordination and collaboration functions to support the NDMS mission.
  - This full-time, medical corps could be developed as part of the medical element of the National Guard, as a new clinical readiness component of the U.S. Public Health Service, or as an independent DHS medical corps.

- Management systems to support administration, logistics, and training processes need to be evaluated and implemented. An analysis of Reserve and National Guard models as well as civilian models developed by the fire service, EMS or off-the-shelf programs designed for business purposes need to be evaluated as viable solutions.

Mission Execution and Support

Clear objectives need to be identified that correspond to plausible medical threats and casualty estimations. Planning scenarios resulting in up to 100,000 casualties resulting from a biological or nuclear event will require weeks to months of medical response and recovery support. A response and recovery strategy should be developed, based on the Homeland Security Counsel's 15 scenarios. The strategy should allow for a time phased and regionally based approach that is specifically tailored to meet the requirements of the state and local areas involved. A substantial investment in the development, recruitment and support of both a full-time and reserve medical corps will be necessary to provide care for 100,000 casualties. This will also necessitate a substantial investment in fixed and portable facilities and medical equipment, and supplies.

- The size and skill set requirements to meet NDMS missions will be based upon DOD force-projection models modified to account for civilian injuries (i.e. infants, children, elderly and disabled persons). Near and long term plans to continually develop and improve the federal medical response are essential to progress the system and meet national expectations. Determining goals and objectives will permit a realistic phased approach to realignment of team capabilities, improvement in geographical team dispersion, and a much needed increase in the medical response posture.

- The NDMS should maintain capabilities to deploy on short-notice and deliver support under these key areas: 1) Medical Command and Control; 2) Pre-Hospital Patient Care; 3) Inpatient Care; 4) Community Outreach Services; 5) Casualty Transportation; 6) Medical Logistics; 7) Veterinary Services; and 8) Mass Fatality.

- NDMS deployable assets need to be inventoried, reviewed, and restructured to meet current mission requirements, especially with regard to CBRNE events. DMAT members must be trained and equipped to protect themselves, treat casualties, and provide assistance to local healthcare workers. Adopting applicable concepts and procedures from the National Medical Response Teams (NMRTs) for operating in a contaminated environment could provide near-

term benefits. DMAT training needs to address the appropriate type and level of PPE required for specific agents and exposure levels. All NDMS teams must be properly equipped to fulfill assigned missions and meet expected capabilities.

- The U.S. House of Representatives House Select Committee on Homeland Security report - Bioterrorism: America Still Unprepared – reported that state and local officials listed poor funding, minimal drills, and no guidance and training as the major causes of their lack of preparedness. Regionally placed, full-time MSTs should assist state and local responders in training, exercises and evaluations, thus, assist in providing the needed 'guidance' identified as a shortfall. This increased ability to collaborate, coordinate, and participate in state and local training would be an adjunct to the mission of the DHS Emergency Coordinators planning and coordination mission.

- Fixed and portable facilities (which might also include hospital ships) should be considered as alternate care facilities to meet the needs of sustained operations resulting from mass casualty events. Federal assistance may be required to provide portable structures suitable for patients that allow medical providers adequate space and equipment to manage casualty care. The ability to expand the portable civilian hospital with compatible military tentage and equipment to maximize resources in these austere environments will enhance the federal medical response. A civilian model that can be incorporated into the existing military systems should be designed and evaluated. Medical surge facilities should be:
  - Constantly ready for transport.
  - Quickly erected by personnel will little training.
  - Portable and adaptable so they can be integrated into other systems to allow expansion.
  - Climate-controlled and durable (essential for long periods as patients recover).
  - Able to withstand extreme temperatures.
  - Capable of withstanding snow and wind loads.
  - Ruggedized with self-contained, well-lit areas for patient care similar to and compatible with military field hospitals.

The number of fixed and portable facilities required should be based upon mission requirements. The purchasing of facilities and equipment should coincide with the development and recruitment of staffing (full-time, reserve and volunteer), and be phased.

- Legacy systems need to be identified, inventoried, and evaluated to assess their continued utility. Currently fielded supplies, pharmaceuticals, and equipment need to be realigned within the DMATs to meet current requirements. Policies and doctrine need to be developed and supported by NDMS operational plans, standard operating procedures, and field operating guides to direct DMAT operations. Gaps in expected capabilities and teams' current equipment and training should be immediately addressed.

Regionalization

- To enable the DHS Emergency Coordinators (EC) to accomplish their regional missions a Regional Medical Strike Team (MST) will be assigned to each DHS region. This regional MSTT will consist of the same personnel and equipment as the DMAT MSTs; with the additional mission to support the ECs in daily operations. During an event they will deploy first to assist in a detailed medical assessment of the situation, to staff appropriate EOCs and to provide medical care as needed. The NDMS teams within the regions will be assigned to these Regional Coordination Teams for command and control and administrative and logistics support. The function of the Regional Coordination Teams will include:

  - Identify needs and define requirements for NDMS and Federal medical augmentation to all-hazard disaster response events.
  - Identify needs and define requirements for NDMS and Federal medical augmentation to Special/National Security Events.
  - Provide Medical Liaison to ESF #8 operations at Federal, State, and local Emergency Operations Centers in the disaster affected area as well as the OSC, SCC, and MST as required.
  - Pre-deployment to potential disaster areas as requested.
  - Provide Rapid Needs Assessments with EP&R (FEMA)
  - Coordinate and communicate logistic footprint and cost estimate information to State and Federal officials.
  - Coordinate State/local requirements for patient and or human remains movement within NDMS.
  - Coordinate State/local requirements for definitive care via NDMS Hospitals.
  - Identify needs and define requirements for NDMS and Federal medical augmentation for state and local receipt, storage, breakdown and distribution/dispensing of SNS.
  - Collaborate with the Systems Development Unit (NDMS) in enhancing NDMS readiness.
  - Provide Regional NDMS Readiness oversight for assigned teams.
  - Provide Regional NDMS Federal Coordinating Centers (FCC) Area Coordinator meetings to enhance education and development.
  - Conduct Regional NDMS Team Readiness Evaluations.
  - Conduct Regional NDMS Readiness Analysis
  - Facilitate relationship building between NDMS and Federal, state, and local partners.
  - Serving as a conduit of information to field constituents
  - Collaborate with the appropriate agencies in development of State Medical Response Teams
  - Additional duties as defined by the Director, NDMS.

Proposed Transformation Timeline and Actions

- A phased approach is recommended for the tactical, operational, and strategic transformation of the NDMS.

- FY05 (Phase 1):
  - Resolve financial issues related to rented storage space for DMAT assets.

- Develop formal communication mechanisms between DMATs.
- Define NDMS infrastructure requirements.
- Fill critical medical leadership vacancies.
- Increase funding to obtain critical equipment and personnel to support near-term goals.
- Develop a strategy and budget to address long-term development and maintenance of required capabilities.
- Develop a concept of operations and standard operating procedures to support current mission requirements.
- Develop the Phase 2 staffing plan to support critical DMAT functions.
- Develop training and exercise master plan.

- FY06-10 (Phase 2):
  - Transition the NDMS to the proposed Office of the Assistant Secretary for Medical Readiness.
  - Develop a full-time, regional response capability.
  - Develop, recruit, support a full-time professional, uniformed Medical Corps, either as a part of the proposed USPHS Reserve system, part of the existing National Guard medical units or as independent DHS Reserve component.
  - Develop, recruit, support a professional, uniformed Medical Reserve Corps, either as a part of the proposed USPHS Reserve system, part of the existing National Guard medical units or as independent DHS Reserve component. Develop a Reserve Corps component for each state and develop a linkage to the respective National Guard medical unit(s) for that state in order to improve collaboration and capitalize on shared asset, training, and exercise opportunities.
  - Hire full-time support personnel.
  - Develop requirements for, and acquire fixed and portable facilities and equipment to support mission requirements. Development and purchase of facilities and equipment should be time-phased, and in parallel with the recruitment of medical personnel (full-time, reserve, and trained/credentialed volunteers).

Conclusion

A radical transformation of the NDMS and its deployable assets (e.g., DMATs) is required to address identified organizational and operational deficiencies. DHS has insufficient health and medical resources; lacks an infrastructure to support its mission; and lacks human resource, funding, and training to address critical elements of mass casualty support. In addition, the location of the limited health and medical DHS resources are fragmented and lie at low levels within the Department. In addition, the DMATs must be staffed, trained, and equipped to satisfy current mission requirements. As a result, the Nation has a limited Federal medical response capability to a mass casualty event.

The all-volunteer NDMS organization is no longer capable of supporting the new demands being placed on the system. Providing trained and responsive Federal response assets in times of crisis requires a dedicated force of healthcare providers. Military models may be useful in developing a smaller, mobile, and scaleable DMAT structure. Employing a small number of medical strike teams will provide a ready response to crises. These teams need to be staffed with

full-time personnel to ensure the immediate federal response. Reserve component DMAT teams, DOD medical units, VA teams, and trained and credentialed volunteers should be utilized in a tiered-response approach.

The many and extensive changes required of the NDMS will require careful deliberate planning. There are immediate needs that must be resolved in FY05, short-term requirements that need to be addressed in FY06, and long-term strategic requirements that will demand continued planning to keep abreast of response needs, medical advances, and progress in the medical and technological fields. A phased approach will ensure the NDMS will meet the present and future operational and medical demands of the nation. Immediate attention is required to revitalize a degrading system. Through appropriate staffing, funding, and commitment, the U.S. Government and DHS can be prepared for a federal medical response to events of national significance.

DEPARTMENT OF HOMELAND SECURITY

CONCEPT OF OPERATIONS FOR THE OFFICE OF MEDICAL READINESS

DRAFT

DECEMBER 18, 2004

Department of Homeland Security
Washington D.C. 20528

PREFACE

This concept of operations (CONOPS) has been prepared to guide personnel assigned to the Department of Homeland Security's (DHS) Office of Medical Readiness as they develop, implement, and manage Federal emergency medical support to homeland security operations and incident management.

This concept supports the operations and incident management mission of the Assistant Secretary for Medical Readiness of the Department of Homeland Security and describes the functions, organizational components, the intended operational environment, and the primary command and control relationships and responsibilities associated with the delivery of Federal emergency medical support.

The intent of this document is to establish a framework by which authorities at all levels of government across the country have the ability to leverage the Federal government's extensive medical resources through DHS for the purpose of improving emergency preparedness and crisis and consequence management operations.

Questions, comments, and suggested improvements related to this CONOPS are encouraged. Inquires, information, and requests for additional copies should be directed in writing to the Department of Homeland Security, Office of Medical Readiness, Washington, D.C. 20528.

APPROVALS

This concept of operations has been prepared in support of the operations and incident management mission of the Assistance Secretary for Medical Readiness of the Department of Homeland Security. The following authorities have approved this concept for implementation.

Approved by: // Pending //

_____ _____

Jeffrey A. Lowell, MD, FACS Date
Senior Advisor to the Secretary for Medical Affairs

TABLE OF CONTENTS

I. INTRODUCTION.

A. Background. Prior to the enactment the Homeland Security Act of 2002 (P.L.107–296), the Department of Health and Human Services (HHS) was the Federal government's Primary Agency for managing and coordinating all Federal public health and medical assistance to Federal, state, and local authorities for emergency response. The ratification of P.L.107–296 established the Department of Homeland Security (DHS) and with it the most significant reorganization of the Federal government in the past fifty years. Title V of the Act transferred the functions, personnel, assets, and liabilities of the former Office of Emergency Preparedness (OEP), the National Disaster Medical System (NDMS), the Metropolitan Medical Response System (MMRS), and the Strategic National Stockpile (SNS), including the authorities and responsibilities of the Secretary of Health and Human Services and the Assistant Secretary for Public Health Emergency Preparedness relating thereto, from the HHS to DHS. This transfer of functions was part of the larger National Strategy to consolidate the Federal government's basic emergency response capabilities within a single organization to ensure the most efficient provision of Federal assistance during Incidents of National Significance.

The Title V transfer in effect distributed the Primary Agency responsibilities for coordinating Federal emergency health and medical support between the HHS and DHS respectively. The Secretary for Homeland Security subsequently established the Office of Medical Readiness as the executive agent for overseeing and administering the Department's emergency medical support functions, on his behalf. Part of the Office's charter includes providing the required operational concept and organizational structure for the management, coordination, and delivery of supplemental Federal medical assistance to Federal, state, and local authorities to prevent terrorist attacks within the United States; reduce the Nation's vulnerability to terrorism and other major disasters; minimize damage, illness, and loss of life; and aide in the recovery from terrorist attacks, major disasters and other emergencies that occur within the United States.

B. Purpose. The purpose of this concept of operation (CONOPS) is to:

1. Provide an overview of the Office of Medical Readiness for leadership, staff, and support organizations;

2. Describe the composition and capabilities of Federal emergency medical support;

3. Describe command and control relationships, operational responsibilities, and mission areas for Office of Medical Readiness components;

4. Describe the intended operating environment for delivering Federal emergency medical support;

5. Describe how DHS through the Office of Medical Readiness processes requests for Federal emergency medical support;

6. Describe how DHS through Office of Medical Readiness delivers Federal emergency medical support to Federal, state, and local authorities and emergency response providers in the field; and

7. Describe how DHS through Office of Medical Readiness provides comprehensive workforce health protection for DHS employees; and

8. Provide a common foundation for the development contingency plans, standard operating procedures and future operational requirements documents.

C. Concept Intent. The intent of Federal emergency medical support is to ensure authorities at all levels of government across the country have the ability to leverage the Federal government's extensive medical resources efficiently and effectively for the purpose of improving emergency preparedness and crisis and consequence management operations. DHS through the Office of Medical Readiness will work to achieve this end-state objective by developing, coordinating, and integrating key Federal medical capabilities to provide enhanced medical surge capacity —that is both responsive and tailored to the needs of the incident, shaped by timely and accurate medical intelligence, and sustained through a robust medical logistic support structure and comprehensive force health protection measures.

D. Scope. Federal emergency medical support described herein has been designed specifically for the purpose of assisting in the prevention of, protection from, response to, and management of Incidents of National Significance; with special emphasis on incidents involving large numbers of casualties, such as major natural disasters or the terrorist use of chemical, biological, radiological, nuclear, and high explosives (CBRNE) weapons of mass destruction (WMDs). However, this in no way precludes DHS or its partners from providing support to routine (non-emergency) operations, National Security Special Events, or other homeland security operations.

Federal emergency medical support includes, but is not limited to the following functions:

1. Receiving and processing requests for Federal emergency medical support;

2. Tasking NDMS component organizations to plan, prepare for, and commit resources in response to received requests for support;

3. Establishing and maintaining command and control, and operational coordination of NDMS assets;

4. Monitoring, assessing, and reporting on the operational readiness, capabilities, capacity, and needs of the Nation's emergency medical systems;

5. Providing rapid expert information, analysis, consultation to the President, the Secretary of Homeland Security, DHS response units, interagency partners, and state and local authorities on all strategic, operational, and technical matters related to Federal emergency medical support;

6. Providing medical care personnel to augment state and local emergency response providers;

7. Providing medical equipment and supplies to supplement state and local resources;

8. Providing inter-facility transport of patients within an affected area and evacuation of patients to facilities outside an affected area;

9. Providing emergency patient care, including: pre-hospital care, hospital inpatient care, outpatient care, and home-based care services;

10. Providing medical logistic support services;

11. Providing victim identification and mortuary services;

12. Providing emergency veterinary services; and

13. Providing liaison to designated National Response Plan (NRP) Entities and other Federal agency operations centers.

E. Applicability. This CONOPS is applicable to all personnel assigned to the Office of Medical Readiness and all Federal government, private

sector, and non-governmental partners ("NDMS component organizations") that collectively compose or support the NDMS.

F. Related Plans. There is a critical linkage between this CONOPS, its components, and key National, regional, and departmental strategies, contingency plans, and standard operating procedures that support homeland security operations during Incidents of National Significance. This document is derived from the National Strategy for Homeland Security and Homeland Security Act of 2002 and incorporates and/or supplements information presented in the NRP, the National Incident Management System (NIMS) and standard operating procedures for the Interagency Incident Management Group (IIMG), National Homeland Security Operations Center (HSOC), the Principal Federal Official (PFO) Support Cell, and the NIMS Integration Center.

II. POLICIES.

A. Authorities. The following documents provide the mandate and guidance for the development of this CONOPS:

- National Strategy for Homeland Security, July 2002;
- P.L.107–296: Homeland Security Act of 2002, November 2002;
- Department of Homeland Security Directive XXXX – Establishment of the Office of Medical Readiness, Dated XXXX

B. Guiding Principles. The underlying principles for the role of DHS and the Office of Medical Readiness in coordinating Federal emergency medical support are as follows:

1. DHS planning will employ the most effective means to deliver Federal emergency medical support, including the use of private sector resources, and non-governmental resources, and resources owned or operated by other Federal agencies;

2. DHS planning will recognize state policies and plans used to deliver Federal emergency medical support, as well as state established methods for determining support requirements;

3. Federal emergency medical support will be scalable and tailorable to meet the emergency medical requirements of any particular incident;

4. Federal emergency medical support will be delivered through a time-phased and echeloned response;

5. Federal emergency medical support will be centrally managed and regionally delivered to augment state and local resources. The Office of Medical Readiness will manage and coordinate requests for Federal emergency medical support at the DHS National Headquarters (HQ) through the HSOC. HQ and/or Regional DHS Offices will deliver Federal emergency medical support in an echeloned and phased approach through the employment of mission-tailored NDMS response teams, and medical equipment and supply packages.

6. NDMS component organizations will refer all requests received directly from Federal, State, or local authorities to the HSOC Medical Coordination Desk for formal processing.

7. The HSOC will provide NDMS elements with relevant situational awareness and threat information.

8. DHS and other NDMS component organizations will implement necessary risk management measures to ensure that employees are protected against occupational and workplace health hazards and are given the knowledge necessary to attain a high state of health readiness and deployability.

III. SITUATION.

A. General. Today's threat environment includes not only the traditional spectrum of manmade and natural hazards—wildland and urban fires, floods, oil spills, hazardous materials releases, transportation accidents, earthquakes, hurricanes, tornadoes, pandemics, and disruptions to the Nation's energy and information technology infrastructure, —but also the deadly and devastating terrorist arsenal of chemical, biological, radiological, nuclear, and high explosive weapons. The capability to rapidly mobilize and employ the Nation's extensive medical resources in times of emergency is critical to mitigating the consequences of these complex and emerging 21st century threats. Accordingly, DHS, through the Office of Medical Readiness, is organizing and partnering with a variety of Federal government, private sector, and non-governmental organizations in an effort to coordinate and enhance the Federal emergency medical support capability. This capability streamlines the means by which emergency planners, policymakers, and responders can leverage the Federal government's extensive medical resources for homeland security operations and incident management. In addition, the Office manages and administers a number of complementary initiatives on behalf of the Department aimed ensuring that DHS employees are protected against occupational and workplace health hazards and are

given the knowledge necessary to attain a high state of health readiness and deployability.

B. Threat Conditions. DHS continues to assess the Nation's threat situation. To communicate the nature and degree of terrorist threats to the homeland, the Department has instituted the Homeland Security Advisory System (HSAS). This system is based on general, non-specific intelligence collected from a range of sources. The HSAS characterizes appropriate levels of vigilance, preparedness, and readiness in a series of graduated threat conditions. Among other things, these threat levels are used by the Office of Medical Readiness Leadership as the basis for making adjustments to the on-duty and on-call staffing levels of DHS Federal emergency medical support capability.

C. Monitored Information Sources. The Office of Medical Readiness monitors a variety of both classified and unclassified information sources to provide maximum situational awareness to its leadership and operational elements of the Federal emergency medical support capability. Monitored information sources include but are not limited to the following:

- DHS Information Assurance/Infrastructure Protection Intelligence Briefings/Products,
- HSOC Situation Status Boards,
- Community On-Line Intelligence System for End-users and Managers (COLISEUM),
- Joint Regional Information Exchange System (JRIES),
- Joint World-wide Intelligence Communications System (JWICS),
- INTELINK intelligence network,
- Structured Evidential Argumentation System (SEAS),
- Terrorist Threat Integration Center (TTIC) Online,
- FBI Law Enforcement Online (LEO) Information Sharing Platform; and
- Open source media outlets.

D. Assumptions. The following planning assumptions were used by the Office of Medical Readiness as the basis for the development of the Federal emergency medical support capability:

1. DHS is the responsible federal department to provide the initial medical response for major natural disasters and other Incidents of National Significance;

2. The HSOC will provide Federal emergency medical support elements with relevant situational awareness and threat information reports;

3. Individuals or agencies requesting Federal emergency medical support will have a reliable means to communicate support requirements to DHS (i.e. telephone, fax, email, or internet access);

4. Individuals or agencies requesting Federal emergency medical support will submit their requests through the HSOC Medical Coordination Desk;

5. DHS components will provide the Office of Medical Readiness necessary network access and architecture to support the effective use of electronic virtual collaboration applications; and

6. Federal medical coordinators and members of NDMS will be granted necessary access to operational intelligence and incident related technical information to process requests for support.

IV. MISSION.

The mission of the Office of Medical Readiness is to coordinate and deliver rapid Federal emergency medical support to Federal, state, and local authorities in support of homeland security operations, and mitigate operational hazards to the DHS employees through comprehensive workforce health protection programs.

V. ORGANIZATION.

A. General. The Office of Medical Readiness is structured to provide the core architecture for managing and coordinating the delivery of Federal emergency medical support. The Office is organized into four functionally oriented divisions to execute its responsibilities. The NDMS contains the Office's operational staff, resources, and capabilities to deliver Federal emergency medical support services. The Office's other divisions contain the necessary support staff and resources that enable the NDMS to maintain readiness and execute the Federal emergency medical support mission. The basic organizational structure for the Office of Medical Readiness is depicted in Figure 1.

B. Assistant Secretary for Medical Readiness. The Office of Medical Readiness is headed by the Assistant Secretary for Medical Readiness, who reports directly to the Secretary for Homeland

Security. The Assistant Secretary is the Department's senior medical official and serves as principal advisor to the Secretary on all matters pertaining to Federal emergency medical support operations and DHS Force Health Protection. The Assistant Secretary establishes priorities for, funds, and ensures the mission readiness of the NDMS.

C. NDMS Advisory Board. The NDMS Advisory Board is chaired by the DHS Assistant Secretary for Medical Readiness and consists of senior representatives from each of the NDMS partner organizations. The Board is responsible for providing strategic guidance to the Assistant Secretary's staff to facilitate NDMS operations. During an incident, the Assistant Secretary may convene the Board to consider NDMS response to emergency situations. The Board establishes connectivity and dialog with key reviews courses of actions and provides counsel, advice, and recommendations to the Assistant Secretary on administrative, financial, policy, and programmatic matters.

D. Immediate Office of the Assistant Secretary for Medical Readiness. The Deputy Assistant Secretary for Medical Readiness and the Chief of Staff oversee the functions of Immediate Office of the Assistant Secretary for Medical Readiness. This headquarters element is responsible for executing the daily administrative management and support functions of the Office. Specific functions include organizational strategic planning, budget management, policy development, legal affairs, legislative affairs, public affairs/risk communications, human capital management, credentialing, and security. The Immediate Office of the Assistant Secretary for Medical Readiness is also responsible to provide administrative oversight and ensure coordination, integration, and interoperability of Office activities across its other Divisions and its Regional and Field Offices.

E. Medical Intelligence Division. The Medical Intelligence Division is responsible to collect, evaluate, and analyze all-source information concerning the immediate readiness, capabilities, capacity, and needs of the Nation's emergency medical systems to improve Federal emergency medical support policy, planning, and operations. The Division is responsible to collaborate and liaison with state and local governments, federal departments and agencies, and National biomedical surveillance/detection programs. The Division is responsible for generating timely and accurate medical intelligence products both at the strategic level –to support the Office's policy, preparedness, and readiness activities, and at the operational level –to support decision-making for Federal emergency medical support to incident management operations.

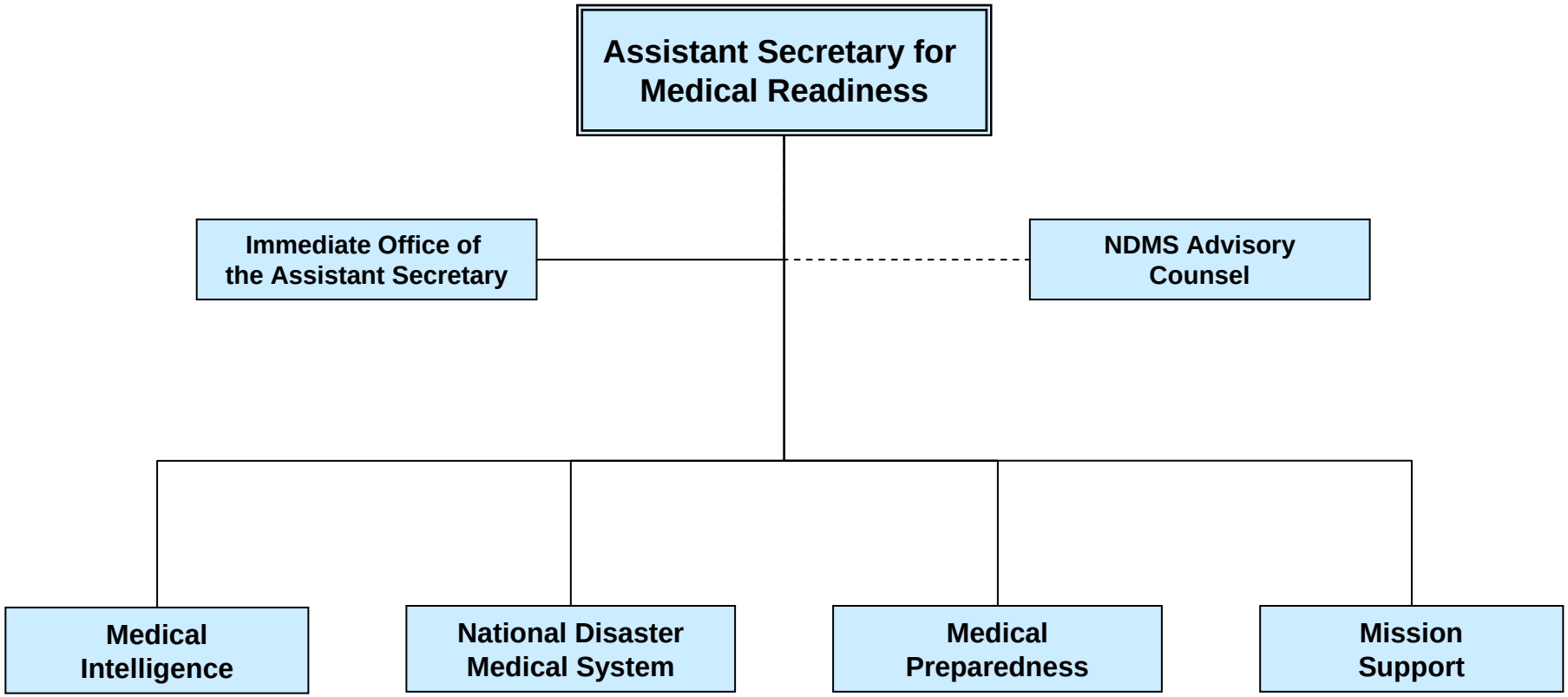
F. National Disaster Medical System (NDMS). The NDMS is responsible for delivering Federal emergency medical support services in the field. The NDMS is an asset sharing partnership designed to provide emergency medical assistance to state and local jurisdictions following a terrorist attack, major disaster and other emergencies that occur within the United States. The system is designed to care for victims of any incident that exceeds the medical care capability of the effected state and local resources. DHS administers the program in partnership with other Federal agencies such as HHS, the Department of Defense, and Department of Veterans Affairs. The NDMS maintains capabilities to deploy with short-notice and deliver support under eight mission areas: 1) Medical Command and Control; 2) Pre-Hospital Patient Care; 3) Inpatient Care; 4) Community Outreach Services; 5) Casualty Transportation; 6) Medical Logistics; 7) Veterinary Services; and 8) Mass Fatality. The NDMS consists of both full-time and part-time Federal teams and volunteer teams located throughout the United States.

G. Medical Preparedness Division. The Medical Preparedness Division is responsible for coordinating medical preparedness efforts at the Federal level, and working with all State, local, tribal, parish, and private sector emergency response providers to improve all-hazards emergency medical response to Incident of National Significance. Specific functions include: providing training to NDMS emergency response providers, providing grants to states and local jurisdictions, providing hands-on training through a number of residential training facilities and in-service training at the local level, working with state and local jurisdictions to plan and execute exercises, and providing technical assistance on-site to state and local jurisdictions. The part of the Division's responsibilities includes oversight and administration of the Metropolitan Medical Response System (MMRS) and NDMS transformation activities.

H. Mission Support Division. The Mission Support Division is responsible for providing the necessary support services for transporting, coordinating, sustaining, and maintaining an effective NDMS. Specific functions include medical logistics, communications and information technology, facilities and resource management, and force health protection. Part of the Division's responsibilities for the provision of force health protection involves overseeing the Department's occupational health and safety program and other mutually supporting health and safety risk management programs (i.e. risk communication, personnel medical screening and medical surveillance, respiratory protection, personal protective equipment). This also includes the establishment of a deployable field support capability to identify, quantify and conduct risk assessments for occupational and

environmental health hazards on deployed operations. Deployable Health Hazard Assessment Teams (DHHAT) provide DHS leaders with quantitative health risk assessments and risk mitigation advice.

Figure 1. Office of Medical Readiness Organizational Structure



VI. Operational Construct.

A. General. The Federal emergency medical support capability and its operational elements are designed to provide full spectrum emergency medical support. The modular design allows the necessary redundancy and flexibility to accommodate the wide-range of requirements that might result from an Incident of National Significance. The operational construct facilitates both vertical integration and synergies between the DHS National, regional, and field support operations, and horizontal integration between the Federal departments and agencies, and private sector and nongovernmental organizations. In general, HQ-level components provide support to the regional-level components that implement the on-scene support in the field. The process for coordinating and delivering Federal emergency medical support is depicted is Figure 2.

B. Headquarters. The Headquarters (HQ) Medical Coordination Team is a multi-discipline staff that operates under the Office of Medical Readiness – Director of NDMS. The team is organized administratively to facilitate normal daily command and control, and operational coordination of NDMS programs and response activities. Operating in support of the DHS National Homeland Security Operations Center (HSOC) in Washington, D.C., the Team is responsible for coordinating the development and implementation of all necessary plans, programs, policies, and procedures to ensure the readiness, integration, safety, and sustainment of the NDMS.

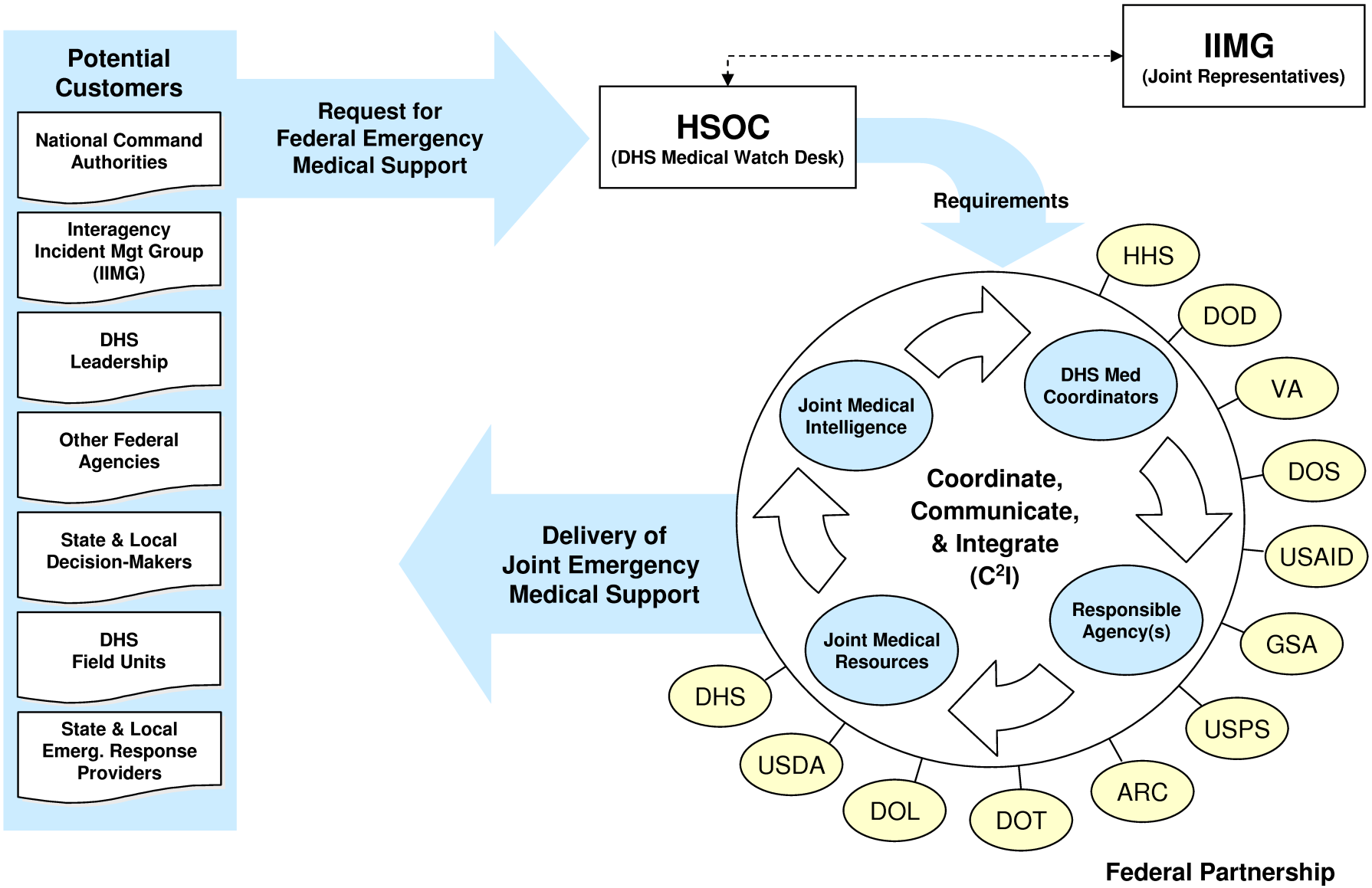
The HQ Medical Coordination Team serves as the central source of information at the HQ level regarding the status of ongoing and planned NDMS operations, providing the DHS Leadership with periodic situations reports. In the event of multi-region emergency medical support operations, the team facilitates coordination between regions. The HQ Medical Coordination Team also works with other agency representatives to help resolve conflicts involving Federal emergency medical support operations and assets.

C. Regional. Regional Medical Coordinators operate as the regional counterpart to the HQ Medical Coordination Team. Upon activation of the DHS regional office structure, Regional Medical Coordinators serve as the primary interface with state and local authorities for Federal emergency medical support. During normal daily operations, Regional Medical Coordinators work to form partnerships with their state and local counterparts, and Federal government, private sector, and non-governmental organizations that are capable of providing emergency medical support. Regional Medical Coordinators work with these organizations to identify, recruit, and coordinate training for Federal

emergency medical providers within their region to build on-call medical response teams for specific NDMS mission areas.

D. Field. The NDMS is the responsible to deliver Federal emergency medical support services in the field. NDMS field elements include: Disaster Medical Assistance Teams (DMAT) that provide emergency medical care; Disaster Mortuary Teams (DMORT) that provide mortuary services; Veterinary Medical Assistance Teams (VMATs) and that provide veterinary services, and National Medical Response Teams (NMRTs) that are equipped and trained to provide medical care for victims of weapons of mass destruction. NMRS field elements are modular in design, composed of 8-12 person strike teams. NMRS field units are equipped with sufficient supplies and equipment to sustain themselves for a period of 72 hours while providing medical care at a fixed or temporary medical care site.

Figure 2. Federal Emergency Medical Support Process



VII. Support to National Response Plan (NRP) Entities.

A. General. To effectively manage and coordinate the delivery of Federal emergency medical support under the NRP, the Department of Homeland Security's Office of Medical Readiness provides support to a number of operational command and coordination entities, including the Interagency Incident Management Group (IIMG), National and Regional Homeland Security Operation Centers (HSOC), State and local officials, and depending on the situation the Federal Coordinating Officer (FCO), Principal Federal Official (PFO) or the Lead Federal Agency Official. The basic operational structure for delivering Federal Emergency Medical Support to NRP entities is depicted in Figure 3. Principal NRP command and coordination entities supported by Office of Medical Readiness include:

B. National Homeland Security Operations Center (HSOC). The HSOC is coordinated by the DHS Information Analysis/Infrastructure Protection Directorate and is comprised of representatives from Federal departments and agencies, non-governmental organizations. The center serves as the primary National-level hub for operational communications and information pertaining to domestic incident management. The HSOC is a standing 24/7 interagency body which fuses law enforcement, national intelligence, and emergency support reporting for situational awareness, incident monitoring, and incident management coordination and facilitation. The HSOC is designed to surge in staffing as the situation requires, and absent such surge conditions, operate with nominal core staff.

The HSOC is the primary entry point for all requests for Federal emergency medical support. Office of Medical Readiness provides a Medical Coordination Desk and a team of on-call Medical Coordinators to the HSOC. The Medical Coordination Desk is responsible for receiving, documenting, evaluating, forwarding, and tracking emergency medical support requests. Medical Coordinators review all requests for support received by the HSOC Medical Coordination Desk, determine support requirements, and coordinate the delivery of Federal emergency medical support to the field. The HSOC Medical Coordination Desk has access to all-source medical intelligence, extensive technical databases and reference materials on all topics related to disaster medicine, as well as the ability to activate, task, and employ one or more on-call NDMS components on behalf of DHS.

C. Interagency Incident Management Group (IIMG). The IIMG is comprised of senior representatives from Federal departments and agencies, non-governmental organizations, as well as DHS components to facilitate National-level decision making, situation

awareness, policy coordination, and incident management coordination. When the IIMG is activated, the Assistant Secretary for Medical Readiness or his designated representative serves as the Medical Representative to the IIMG.

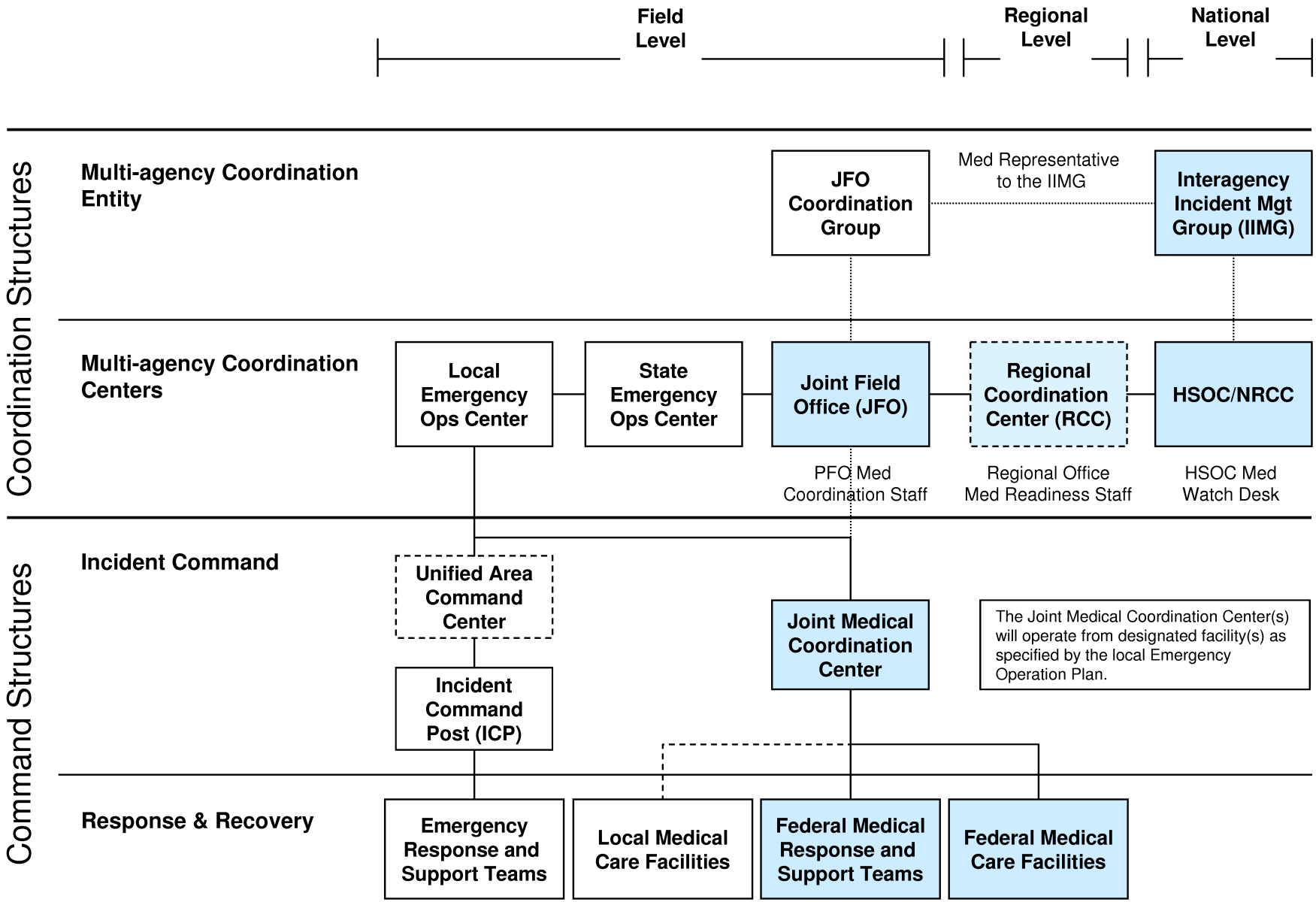
D. Principal Federal Official (PFO) Support Cell. For actual or potential Incidents of National Significance, the Secretary of Homeland Security may designate a PFO to serve as his representative locally. The PFO and his staff provide strategic guidance and operations integration for catastrophic events, terrorist incidents, and other high-visibility, multi-state, multi-jurisdiction events. The exact composition of the PFO Support Cell is dependent on the nature and magnitude of the incident; however Office of Medical Readiness provides a Medical Advisor to the PFO Support Cell for all operations. When deploying in support of the PFO, the Medical Advisor has two functions: 1) they serve as the PFO's technical consultant on Federal emergency medical support operations and all matters pertaining to disaster medicine and 2) they work with the PFO staff to perform mission assessments, develop operational plans and procedures, and identify medical requirements.

E. Joint Medical Coordination Center (JMCC). For catastrophic incidents that result in a massive medical response, the State or local emergency operations center will activate one or more JMCCs to maximize the utility and capacity of local medical system and coordinate and manage the medical response at field level. For each JMCC that is established, the Office of Medical Readiness provides a Medical Coordination Team to coordinate and manage Federal field support activities to the incident medical response. In the event the local agencies are unable to establish and operate the JMCC, the Medical Coordination Team has the capability to execute that function on behalf of the local jurisdiction, under the direction and control of the appropriate State or local authority.

F. National Disaster Medical System (NDMS). Working in partnership with the Departments of Health and Human Services (HHS), Defense (DoD), and Veterans Affairs (VA), the NDMS deploys medical personnel and equipment supplies in a phased regional approach. NDMS elements are deployed by DHS to meet the medical response needs that may result from natural or manmade crises including natural disasters, technological disasters, major transportation accidents, or acts of terrorism including weapons of mass destruction events. The NDMS is setup to work within the Incident Command System (ICS) and follows the ICS structure and concepts. A key guiding principle for development of the NDMS is that success is more likely when existing medical infrastructure is used and expanded upon. NDMS medical response teams are designed to maximize the utility

and capacity of local medical system assets. Preplanned communication and coordination links between components and the application of additional resources will help to increase the healthcare system's surge capacity of a community. NDMS does not dictate how local and state governments must develop their emergency response plans but rather is designed as a highly flexible system using communication and collaboration to assist the local and state governments to meet their identified medical needs.

Figure 3. Federal Emergency Medical Support to NRP Entities



VIII. Federal Emergency Medical Support Functions.

A. General. The Office of Medical Readiness will employ elements of the NDMS to meet operational requirements for medical response and the delivery of mass care.

B. Assess Medical Needs. In collaboration with HHS, mobilizes and deploys ESF #8 personnel to support the ERT-A to assess medical needs. This function includes the assessment of the medical system system/facility infrastructure.

C. Medical Command and Control (MCC). The purpose of the MCC is to provide command, control, administrative assistance, medical intelligence, technical supervision, and consultation services in support of medical response operations during times of emergency or disaster conditions. The MCC will ensure that the federal medical response is based on requirement specific to the incident and on existing state and local response plans. The MCC will be co-located with the local emergency operations center. The MCC command structure is based on the principles of the Incident Command System (ICS). Responsibilities are separated into four sections planning, operations, logistics, and administrative/finance.

D. Medical Care Personnel. Immediate medical response capabilities are provided by assets internal to DHS (e.g., National Disaster Medical System (NDMS) and from ESF #8 supporting organizations (e.g., U.S. Public Health Service Commissioned Corps)). The Department of Defense (DOD) may be requested to provide support in casualty clearing/staging and other missions as needed. DHS may seek individual clinical health and medical care specialists from the Department of Veterans Affairs (VA) to assist State, local, and tribal personnel.

E. Patient Care. Patient Care: DHS may task its components and the Medical Reserve Corps, and request the VA, DOD, and HHS to provide available personnel to support inpatient hospital care and outpatient services to victims who become seriously ill or injured regardless of location (which may include mass care shelters).

1. *Pre Hospital Care (PHC)*. The purpose of PHC is to: Direct casualties, especially non-critical and asymptomatic, potentially exposed patients, away from the emergency departments to allow hospitals to continue to remain open in some capacity. Render basic medical evaluation and triage. Provide limited treatment including stabilization and distribution of prophylaxis, medication, self-help information and instruction. Decontamination

2. *Inpatient Care (IC)*. The IC is designed to treat patients who need inpatient treatment but do not require mechanical ventilation and those who are likely to die as a result of the incident. Patient requiring advanced life support will receive priority hospital admission rather than admission to the IC. The IC is mobile and scalable. The IC can be located in an existing permanent structure or a temporary structure. Specialty care facilities based on requirements of incident and specialty MST capabilities.

3. *Outpatient Care Services*.

4. *Home-based Care*. The mission of community outreach is to; Disseminate information related to the incident, assess the affected community and incident area, and conduct mass prophylaxis if indicated. Provide some form of limited home-based patient care beyond mass prophylaxis.

F. Medical Equipment and Supplies. In addition to deploying assets from the Strategic National Stockpile (SNS), DHS may request HHS, DOD, or the VA to provide medical equipment and supplies, including medical, diagnostic, and radiation-emitting devices, pharmaceuticals, and biologic products in support of immediate medical response operations and for restocking health care facilities in an area affected by a major disaster or emergency.

G. Patient Movement / Evacuation. At the request of DHS, DOD coordinates with ESF #1 – Transportation to provide support for the evacuation of seriously ill or injured patients to locations where hospital care or outpatient services are available. DOD is responsible for regulating and tracking patients transported on DOD assets to appropriate treatment facilities (e.g., NDMS non-Federal hospitals).The mission of CT is to: Provide prompt coordinated transportation service of patients within the incident area by maintaining efficient movement of patients among all levels of care. Provide medical transport services for non-critical patients from local medical facilities to collection points or facilities. Provide medical transport to move patients from the collection points (normally at airports) to distant hospitals outside the affected area.

H. Medical Consultation and Technical Assistance. DHS may task its components to assist in assessing medical effects resulting from all hazards. Such tasks may include assessing exposures on the general population and on high-risk population groups; conducting field investigations, including collection and analysis of relevant samples; providing advice on protective actions related to direct human and animal exposures, and on indirect exposure through contaminated

food, drugs, water supply, and other media; and providing technical assistance and consultation on medical treatment and decontamination of injured/contaminated individuals. At the request of a State or another Federal agency, ESF #8 can deploy teams with limited capabilities for patient decontamination (e.g., NDMS). These teams typically arrive on scene within 24-48 hours.

I. Victim Identification/Mortuary Services. DHS may request DOD to assist in providing victim identification and mortuary services; establishing temporary morgue facilities; performing victim identification by fingerprint, forensic dental, and/or forensic pathology/anthropology methods; and processing, preparation, and disposition of remains. The mission areas include: establishing temporary morgue facilities; ensuring proper care of fatalities within the incident area including processing, preparation, and disposition of remains; performs victim identification by fingerprint, forensic dental, and/or forensic pathology/anthropology methods; ensuring that appropriate resources are available to assist medical examiners; and ensuring proper handling of remains. This function also includes processing contaminated remains, crime scene evaluation, recovery, initial evaluation, autopsy, embalming, and disposition.

J. Medical Logistics (ML). Ensures that adequate supplies including pharmaceuticals are available to onsite medical staff based on the requirements of the incident. This includes adequate numbers of personnel to distribute and maintain the supply. This function includes the receipt, breakdown, and distribution the Strategic National Stockpile (SNS). The MLS is particularly important in biological events to provide for mass prophylaxis.

K. Veterinary Services (VS). Provides assistance in assessing the extent of disruption and need for veterinary services following major disasters or emergencies. These responsibilities include: Assessing the medical needs of animals; Medical treatment and stabilization of animals; Animal disease surveillance; Zoonotic disease surveillance and public health assessments; Technical assistance to assure food and water quality; Hazard mitigation; Animal decontamination; and biological and chemical terrorism surveillance.

IX. Responsibilities.

A. Department of Homeland Security.

1. Provides leadership in coordinating and integrating overall Federal efforts to provide medical assistance to the affected area.

2. Coordinates the staffing of the DHS headquarters national ESF #8 group as necessary to support the response operations.

3. Requests appropriate ESF #8 organizations to activate and deploy medical personnel, equipment, and supplies in response to requests for Federal medical assistance.

4. Uses DHS personnel to address medical needs, and augment with assets from ESF #8 partner organizations.

5. In coordination with HHS, evaluates State requests for deployment or pre-deployment of the SNS based upon relevant threat information.

6. Coordinates with other primary and supporting departments, agencies, and governments throughout the incident.

7. Directs the activation of NDMS as necessary to support the incident response operations.

8. Requests ESF #8 support from HHS, VA, and DOD to coordinate NDMS operations.

9. Activates and deploys NDMS health/medical personnel, equipment, and supplies in a time-phased regional approach, and coordinates the provision of pre-hospital, hospital care, outpatient services, home-based care, veterinary services, and mortuary services through NDMS.

10. Activates the NDMS MIACG, composed of NDMS partner representatives (DHS, DOD, VA, and HHS), to support placement of victims/patients in NDMS hospitals for care.

11. Coordinates NDMS to assist in establishing priorities with HHS for application of medical support, including veterinary and mortuary services.

12. Assists in providing information/liaison with emergency management officials in NDMS FCC areas.

13. Provides logistics support to medical response operations as appropriate.

14. Through ESF #1, identifies and arranges for use of U.S. Coast Guard aircraft and other assets in providing urgent airlift and other transportation support.

15. The Interagency Modeling and Atmospheric Assessment Center (IMAAC) provide predictions of hazards associated with atmospheric releases for use in emergency response. The IMAAC provides a single point for the coordination and dissemination of Federal dispersion modeling and hazard prediction products that represent the Federal position during an Incident of National Significance.

B. Department of Agriculture.

1. Provides appropriate personnel, equipment, and supplies, coordinated through ESF #4 – Firefighting or the Branch Chief, Disaster and Emergency Operations, Fire and Aviation Management Office in Washington, DC. This support is primarily for communications aircraft and the establishment of base camps for deployed federal medical teams in the disaster area.

2. Provides support for public health matters for radiological incidents as a member of the Advisory Team for Environment, Food, and Health.

3. USDA also supports a multi-agency response to a domestic incident through: Provision of nutrition assistance; Control and eradication of an outbreak of a highly contagious or an economically devastating animal disease; Assurance of food safety, and security, in coordination with other responsible Federal agencies, or any combination of these requirements; and Provision of appropriate personnel, equipment, and supplies, coordinated through the Animal and Plant Health Inspection Service Emergency Management Operations Center. Support is primarily for coordination of animal issues arising from a disaster such as disposal of animal carcasses, protection of livestock health, and Zoonotic diseases associated with livestock.

C. Department of Defense.

1. Alerts DOD NDMS Federal Coordinating Centers (FCCs) (Army, Navy, Air Force) and provides specific reporting/regulating instructions to support incident relief efforts.

2. Alerts DOD NDMS FCCs to activate NDMS patient reception plans in a phased, regional approach, and when appropriate, in a national approach.

3. At the request of HHS, DOD coordinates with ESF #1 to provide support for the evacuation of seriously ill or injured patients to locations where hospital care or outpatient services are available.

4. Using available DOD transportation resources, in coordination with the NDMS Medical Interagency Coordination Group (MIACG), evacuates and manages victims/patients from the patient collection point in or near the incident site to NDMS patient reception areas.

5. Provides available logistical support to health/medical response operations.

6. Provides available medical personnel for casualty clearing/staging and other missions as needed including aero-medical evacuation and medical treatment.

7. Mobilizes and deploys available Reserve and National Guard medical units, when authorized and necessary to provide support.

8. Coordinates patient reception, tracking, and management to nearby NDMS non-Federal hospitals, VA hospitals, and DOD military treatment facilities that are available and can provide appropriate care.

9. Provides available military medical personnel to assist HHS in activities for the protection of public health (such as food, water, wastewater, solid waste disposal, vectors, hygiene, and other environmental conditions).

10. Provides available DOD medical supplies for distribution to mass care centers and medical care locations being operated for disaster victims with reimbursement to DOD.

11. Provides available emergency medical support to assist State, local, and tribal governments within the disaster area and the surrounding vicinity.

12. Such services may include triage, medical treatment, mental health support, and the use of surviving DOD medical facilities within or near the disaster area.

13. Provides assistance in managing human remains, including victim identification and mortuary affairs.

14. Provides evaluation and risk management support through use of Defense Coordinating Officers, Emergency Preparedness Liaison Officers, and Joint Regional Medical Planners.

15. Provides available blood products in coordination with HHS.

16. Provides DOD confirmatory laboratory testing support in coordination with HHS.

17. Provides technical assistance, equipment, and supplies as required in support of HHS to accomplish temporary restoration of damaged public utilities affecting public health.

D. Department of Energy.

1. Through the National Atmospheric Release Advisory Capability, provides near real-time transport, dispersion, and dose predictions of atmospheric releases of radioactive and hazardous materials that may be used by authorities in taking protective actions related to sheltering and evacuation of people.

2. Through the Federal Radiological Monitoring and Assessment Center (FRMAC), assists health and medical authorities in determining radiological dose information; assists in providing coordinated gathering of environmental radiological information and data; assists with consolidated data sample analyses, evaluations, assessments, and interpretations; and provides technical information.

E. Department of Health and Human Services.

1. Provides leadership in coordinating and integrating overall Federal efforts to provide public health assistance to the affected area.

2. Coordinates the staffing of the HHS headquarters national ESF #8 group as necessary to support the response operations.

3. Uses HHS personnel (U.S. Public Health Service Commissioned Corps) to address health and medical needs.

4. Assists and supports State, local, and tribal governments in performing monitoring for internal contamination and

administering pharmaceuticals for internal decontamination as deemed necessary by State health officials.

5. Assists local and State health departments in establishing a registry of potentially exposed individuals, performing dose reconstruction, and conducting long-term monitoring of this population for potential long-term health effects.

6. Monitors blood and blood product shortages and reserves with the coordination of the American Association of Blood Banks Inter-Organizational Task Force on Domestic Disasters and Acts of Terrorism.

7. Assures the safety and security of food in coordination with other responsible Federal agencies (e.g., USDA). (Note: HHS, through the FDA, has statutory authority for all domestic and imported food except meat, poultry, and egg products, which are under the authority of USDA/Food Safety and Inspection Service.)

8. In cooperation with State and local authorities, assesses whether food facilities in the affected area are able to provide safe and secure food.

9. In cooperation with State and local authorities as well as the food industry, conduct tracebacks or recalls of adulterated products.

10. In cooperation with Federal, State, and local authorities, ensures the proper disposal of contaminated products and the decontamination of affected food facilities in order to protect public health.

11. Provides support for public health matters for radiological incidents as a member of the Advisory Team for Environment, Food, and Health.

F. Department of Justice.

1. Assists in victim identification, coordinated through the Federal Bureau of Investigation (DOJ/FBI).

2. Provides State, local, and tribal governments with legal advice concerning identification of the dead.

3. Provides HHS with relevant information of any credible threat or other situation that could potentially threaten public health. This support is coordinated through DOJ/FBI headquarters.

4. Provides communication, transportation, and other logistical support to the extent possible. This support is provided through DOJ/FBI.

G. Department of Transportation.

1. In collaboration with DOD, GSA, and other transportation-providing agencies, assists in identifying and arranging for all types of transportation, such as air, rail, marine, and motor vehicle.

2. At the request of HHS, provides patient movement assistance from DOT resources subject to DOT statutory requirements.

3. Coordinates with the Federal Aviation Administration for air traffic control support for priority missions.

H. Department of Labor.

1. Coordinates the safety and health assets of cooperating agencies and the private sector to provide technical assistance and conduct worker exposure assessment and responder and worker risk management within the Incident Command System. This assistance may include 24/7 site safety monitoring; worker exposure monitoring; health monitoring; sampling and analysis; development and oversight of the site-specific safety and health plan; and personal protective equipment selection, distribution, training, and respirator fit-testing.

2. Provides personnel and management support related to Worker Health and Safety in field operations during ESF #8 deployments.

I. Department of State.

1. Coordinates international activities related to chemical, biological, radiological, and nuclear incidents and events that pose trans-border threats.

2. Assists in communicating real-time actions taken by the United States and U.S. projections of the international consequence of the event (e.g., disease spread, quarantine, isolation, travel restrictions, pharmaceutical supply and distribution, and displaced persons).

3. Assists with coordination with foreign states concerning offers of support, gifts, offerings, donations, or other aid. This includes

establishing coordination with partner nations to identify the U.S.-validated immediate support in response to an Incident of National Significance.

J. Department of Transportation.

1. In collaboration with DOD, GSA, and other transportation-providing agencies, assists in identifying and arranging for all types of transportation, such as air, rail, marine, and motor vehicle.

2. At the request of HHS, provides patient movement assistance from DOT resources subject to DOT statutory requirements.

3. Coordinates with the Federal Aviation Administration for air traffic control support for priority missions.

K. Department of Veteran Affairs.

1. Subject to the availability of resources and funding, and consistent with the VA mission to provide priority services to veterans, when requested.

2. Coordinates with participating non-Federal NDMS hospitals to provide incident-related medical care to authorized NDMS beneficiaries affected by a major disaster or emergency;
3. Furnishes available VA hospital care and medical services to individuals responding to, involved in, or otherwise affected by a major disaster or emergency, including members of the Armed Forces on active duty;

4. Designates and deploys available medical, surgical, mental health, and other health service support assets; and

5. Provides a Medical Emergency Radiological Response Team for technical consultation on the medical management of injuries and illnesses due to exposure to or contamination by ionizing radiation.

L. General Services Administration. Provides facilities, equipment, supplies, and other logistical support, including contracting for private-sector ground and air transportation.

M. U.S. Agency for International Development. Provides assistance in coordinating international offers for health/medical support.

N. U.S. Postal Service. Assists in the distribution and transportation of medicine and pharmaceuticals and medical information to the general public affected by a major disaster or emergency as needed.

O. American Red Cross.

1. Provides emergency first aid, consisting of basic first aid and referral to appropriate medical personnel and facilities, supportive counseling, and health care for minor illnesses and injuries to disaster victims in mass care shelters, the JFO, selected incident cleanup areas, and other sites deemed necessary by the primary agency.

2. Assists community health personnel subject to staff availability.

3. Provides supportive counseling for the family members of the dead, injured, and others affected by the incident.

4. Provides available personnel to assist in temporary infirmaries, immunization clinics, morgues, hospitals, and nursing homes. Assistance consists of administrative support, logistical support, or health services support within clearly defined boundaries.

5. Acquaints families with available health resources and services, and makes appropriate referrals.

6. At the request of HHS, coordinates with the American Association of Blood Banks Inter-organizational Task Force on Domestic Disasters and Acts of Terrorism to provide blood products and services as needed through regional blood centers.

7. Provides coordination for uploading appropriate casualty/patient information from ESF #8 into the Disaster Welfare Information system.

8. Refers all concerns regarding animal health care, safety, or welfare to American Veterinary Medical Association contact(s) in the disaster area, as appropriate. These contact people are veterinarians affiliated with national, State, county, or local veterinary associations.

X. Communications. TBD

XI. Logistics. TBD

XII. Administration. TBD

APPENDIX A: LEGAL AUTHORITIES.

The Homeland Security Act 2002, Section 101 requires Department of Homeland Security to: Prevent terrorist attacks within the United States; Reduce the vulnerability of the United States to terrorism; Minimize the damage, and assist in the recovery from terrorist attacks that do occur within the United States; Carry out all functions of entities transferred to the Department, including by acting as a focal point regarding natural and manmade crises and emergency planning.

The Homeland Security Act 2002, Section 503 (5) transferred “the Office of Emergency Preparedness, the National Disaster Medical System, and the Metropolitan Medical Response System of the Department of Health and Human Services, including the functions of the Secretary of Health and Human Services and the Assistant Secretary for Public Health Emergency Preparedness relating thereto.” The Homeland Security Act 2002, Section 503 (6) transferred “the Strategic National Stockpile of the Department of Health and Human Services, including the functions of the Secretary of Health and Human Services relating thereto.” The Homeland Security Act 2002, Section 2 Definitions defined the term functions as “includes authorities, powers, rights, privileges, immunities, programs, projects, activities, duties, and responsibilities.” Title XV TRANSITION Subtitle A—Reorganization Plan of the Homeland Security Act 2002 defined the “term ‘‘transition period’’ means the 12 month period beginning on the effective date of this Act.”

The Office of Emergency Preparedness (OEP) within the Department of Health and Human Services (HHS) was part of a reorganization defined in the Federal Register (July 26, 2002 Volume 67, Number 144). This reorganization established the Office of the Assistant Secretary for Public Health Emergency Preparedness (OASPHEP), the Assistant Secretary for Public Health and Emergency Preparedness (ASPHEP) and renamed OEP as the Office of Emergency Response (OER). The functions of OER are delineated as the following: “provides staff support to the ASPHEP in the accomplishment of emergency preparedness responsibilities. In support of the ASPHEP, OER maintains the operational readiness required for timely and effective responses to Federal, State, and local government requests for social services, health and medical assistance following major disasters or terrorist incidents.” Three divisions within OER were established the Division of Program Development (DPD), the Division of Emergency Readiness and Operations (DERO) and the Division of Administration and Support (DAS).

The functions of DPD are delineated as the following: “is responsible for developing planning and implementation of processes to improve local response capabilities and the integration of national and local response resources. A key function of DPD is the development of Metropolitan Medical Response Systems (MMRS). DPD also supports the Director of OER and the ASPHEP in coordinating activities with the Centers for Disease Control and Prevention,

Agency for Toxic Substances and Disease Registry, and the Food and Drug Administration and other OPDIVs to develop technical support systems to deal with the consequences of Weapons of Mass Destruction (WMD) terrorist events."

The functions of DERO are delineated as the following: "is responsible for improving the range of emergency response capabilities and for assuring emergency response readiness. To Accomplish these tasks, DERO supports the interdepartmental National Disaster Medical System (NDMS) Senior Policy Group, Directorate, and Directorate Staff; coordinates the NDMS Disaster Medical Assistance Teams (DMATs) and provides administrative support to DMAT personnel; manages the Rockville Emergency Operations Center during emergencies; develops national WMD response capable DMATs; improves the communications infrastructure to support DMAT deployments; works with the Department of Veterans Affairs to assure appropriate pharmaceutical availability, especially for WMD incidents; and establishes Medical Support Units at the site of emergencies."

The functions of DAS are delineated as the following: "is responsible for OER budget execution and formulation, personnel and procurement actions, as well as other administrative activities. To accomplish these tasks, DAS works with the OASPHEP Operations Officers, the Office of the Secretary Executive Office (OSEO) and OER Division Directors to develop solutions to administrative related problems and to develop more effective and efficient administrative related support for accomplishing OER activities. DAS also provides staff support for the OASPHEP Operations Officer in coordinating cross-cutting activities, such as, the management of Regional Emergency Coordinator work plans and Regional Advice of Allowance."

The OASPHEP underwent a reorganization defined in the Federal Register (December 2, 2002 Volume 67, Number 231). This reorganization changed the Office of Emergency Response moving the functions of the DPD into the newly created the Office of Planning and Emergency Response Coordination (OPERC). DERO was changed from the Division of Emergency Readiness and Operations to the Division of Emergency Response Operations. In this reorganization OER retained training and administrative support for NDMS and MMRS. However, the functions for emergency response and planning were placed within OPERC.

OPERC has three components the Readiness Enhancement and Assessment Program, The Secretary's Emergency Response Team Office, and the Secretary's Command Center. The functions of OPERC are as follows: "is responsible for ensuring that the ASPHEP has in place the systems and processes necessary to coordinate the HHS response to bioterrorism and other public health emergencies." "Key functions of OPERC include: (1) Development and direction of the Secretary's Command Center; (2) implementation and management of the Secretary's Emergency Response Teams; (3) development of the HHS Continuity of Operations Plan (COOP) and coordination of its

execution whenever required; (4) direction and coordination under the Federal Response Plan (especially Emergency Support Function *); (5) liaison with the OASPHEP Office of Emergency Response (OER); (6) primary HHS liaison with emergency response entities elsewhere with HHS (especially CDC and FDA), within other Departments and Agencies (especially the Office of Homeland Security, the Department of Justice, the Department of State, and the Federal Emergency Management Agency), and within other nations and multi-national organizations such as the World Health Organization; (7) planning, development, and implementation of exercises and other tools for assessing the readiness of HHS emergency response entities; and (8) professional education and training of OPERC personnel and response staff."

The Secretary's leadership role is defined in HSPD-5 and HSPD-8 which state: The Secretary of Homeland Security is: The principal Federal official for domestic incident management; Pursuant to the Homeland Security Act of 2002, the Secretary is responsible for coordinating Federal operations within the United States to prepare for, respond to, and recover from terrorist attacks, major disasters, and other emergencies; The principal Federal official for coordinating the implementation of all-hazards preparedness in the United States; In cooperation with other Federal departments and agencies, the Secretary coordinates the preparedness of Federal response assets, and the support for, and assessment of, the preparedness of State and local first responders.

In summary the Homeland Security Act 2002, HSPD-5 and HSPD-8 require DHS to provide the medical response to natural or man-made disasters or incidents of national significance. The functions of the former Office of Emergency Preparedness within the Department of Health and Human Services will be maintained, improved, and implemented to meet the DHS medical response mission set forth in the Homeland Security Act 2002.

These functions are:

- Maintains the operational readiness required for timely and effective responses medical care personnel.
- Developing planning and implementation of processes to improve local response capabilities.
- Integration of national and local response resources.
- Development of Metropolitan Medical Response Systems.
- Develop technical support systems to deal with the consequences of Weapons of Mass Destruction (WMD) terrorist events.
- Improving the range of emergency response capabilities.
- Assuring emergency response readiness.
- Interdepartmental National Disaster Medical System (NDMS) Senior Policy Group
- Coordinates and provides administrative support the NDMS Disaster Medical Assistance Teams (DMATs).

- Improves the communications infrastructure to support DMAT deployments.
- Establishes Medical Support Units at the site of emergencies.
- Meet Emergency Support Function 8 of the National Response Plan
    - Medical Needs Assessment
    - Medical Care Personnel
    - Medical Equipment and Supplies
    - Patient Movement and Evacuation
    - Patient Care
    - Medical Consultation and Technical Assistance
    - Medical Information
    - Victim Identification / Mortuary Services
    - Protection of Animal Health (Veterinary Services)

APPENDIX B: SUMMARY OF FEDERAL EMERGENCY MEDICAL SUPPORT CAPABILITIES.

Under Development

APPENDIX C: FEDERAL EMERGENCY MEDICAL SUPPORT PROCESS FLOW.

Under Development

APPENDIX D: OVERVIEW OF NATIONAL DISASTER MEDICAL SYSTEM TRANSFORMATION.

Under Development

APPENDIX E: FEDERAL EMERGENCY MEDICAL SUPPORT TO NATIONAL SECURITY SPECIAL EVENTS.

Under Development

APPENDIX F: REFERENCES

Under Development

APPENDIX G: TERMS AND DEFINITIONS

Under Development

Appendix 8

Preliminary Budget Estimate to Establish the Office of Medical Readiness

The preliminary budget estimate summary below provides an approximation of the personnel costs required for the establishment of the DHS Office of Medical Readiness. The preliminary budget estimate does not include other separate equipment, training, and DMAT redesign costs associated with the recommended transfer and upgrade of NDMS from EP&R to the Office of Medical Readiness, nor does it include or account for the present NDMS budget which is believed to be $33M. Also this budget assumes the existing budgets of entities relocated to OMR will be transferred with personnel and assets.

	Personnel	Estimate	
FY05 (Phase 1)	25 critical OMR staff	$ 4.11M	
	FY05 Subtotal		**$ 4.11M**
FY06 (Phase 2)	69 new OMR staff, 150 NDMS staff, and 80 MST members	$ 42.46M	
Specialized equipment (Deployable 1000-bed MTF/$7.5M/100 Beds)		$ 75.00M	
Estimated costs for NDMS supplies, equipment, and training		$100.00M	
	FY06 Subtotal		**$217.46M**
	FY05-06 Total		**$221.57M**

The following information represents a more detailed preliminary budget estimate projecting the costs to establish the proposed DHS Office of Medical Readiness including the NDMS transformation.

FY05 (Phase 1)*

Establish the Office of Medical Readiness in February 2005. Immediately fill the Assistant Secretary position and the following critical OMR staff positions. Transfer NDMS as indicated below.

25 New OMR Staff Positions:

- Assistant Secretary – Physician (Schedule C, O-10 military equivalent, $250K)
- Deputy Assistant Secretary (SES, O-8 military equivalent, $225K)
- Chief of Staff (SES, O-7 military equivalent, $200K)
- Executive Assistant (GS-12/13, $110K)
- Executive Secretary (GS-11, $100K)
- Public Affairs/Risk Communications Specialist (GS-14, $125K)
- Headquarters Division Director (SES, $210K)
    - Policy Specialist (GS-13/14, $125K)
    - Admin/Budget Specialist (GS-13/14, $125K)
    - General Counsel (GS-15, $150K)
- Medical Intelligence Division Director (SES, $210K)
- Medical Response Division Director (SES, $210K)
    - Two Med/Operations personnel (2 GS-14s, $250K)
    - Medical Logistician (GS-13/14, $125K)
    - Medical Logistician for NDMS (GS-14, $125K)
    - HSOC Support Personnel (5 GS-14/15s, $150K, $750K)
- Mission Support Director (SES, $210K)
    - Occupational Health/Safety Program Development/Management Specialist (GS-14, $125K)
    - Occupational Health Nurse (GS-14, $125K)
- Mission Preparedness Division Director (SES, $210K)

Contract Position:

- Organizational Transformation Consultant responsible for guiding the establishment of the Office of Medical Readiness for first 18 months ($200K/yr)

Transfer Positions:

- Existing NDMS full-time staff to new directorate

Cost: $4.11M annually (excluding the contract position)

*Costs are approximate annual personnel costs (including 40% benefits package). Use of GS/SES grades does not preclude use of USPHS, contract, or other equivalents. Salary tables obtained from OPM.gov were used for salary estimates (GS/SES grade at step 6). Professional pays (physician incentive pay), office space, travel, supplies, equipment, IT, and other support requirements are not included in this estimate.

FY06 (Phase 2)

Continue the Office of Medical Readiness implementation plan with 69 new staff members, 150 new NDMS core positions, and 80 new NDMS Medical Strike Team members:

- Two additional Public Affairs personnel (2 GS-13, $220K)
- Legislative Affairs Coordinator (GS-14, $125K)
- Legal Counsel (GS-14, $125K)
- NDMS –150 core staff - $22.5M (150x$150K) Note: Prior to 2001, NDMS had a similarly-sized staff but with little true medical expertise.
- NDMS – add 80 new Strike Team Members; full-time positions distributed regionally across the country - $12M (80x$150K)
- Headquarters Division
    - Liaison Staff - HHS, DOD, VA, CDC, International Health, FDA, USDA, State/Local (8 GS-13, $880K)
    - 12 HR Development Specialists (GS-12, $1.2M)
    - 6 Budget Analysts (GS-11, $600K)
- Medical Response Division
    - SMEs such as toxic industrial materials, bioterrorism and emerging diseases, health physicist, and occupational health and safety personnel (20 GS-14, $2.5M total)
    - Veterinarian (GS-15, $150K)
    - Mental Health Specialist (GS-14, $125K)
    - 4 IM/IT Operators (4 GS-13, $440K)
    - 4 additional HSOC support personnel (4 GS-13, $440K)
- Mission Preparedness Division
    - Deputy Director (GS-15, $150K)
    - Exercise/Training Specialist and staff (1 GS-14, $125K; 3 GS-13, $440K)
    - Program Evaluation/Improvement Coordinator and staff (4 GS-13, $440K)

Total Estimated Cost: $ 42.46M