CHAPTER IX

IMPLEMENTATION, MONITORING, AND ANTICIPATED IMPACT

CHAPTER IX: IMPLEMENTATION, MONITORING, AND ANTICIPATED IMPACT

In this chapter, the general approach for implementing the Strategic Vision and an outline for monitoring implementation are described.

Finally, implementation includes assessing outcomes, that is, determining whether or not the objectives have been met. This chapter concludes with a statement of the expected impact from implementing the recommended objectives in each of the four program areas.

A. IMPLEMENTATION AND CONTINUED DEVELOPMENT OF THE DOCUMENT

The Director of the Office of Emergency Preparedness is responsible for administering the implementation process. Implementation involves the selective adoption of the recommended objectives over a five-year period from the initiation of the Strategic Vision. This requires a procedure for reviewing and adjusting the objectives, prioritizing and selecting them for adoption, and integrating them into the NDMS program. This process will be carried out by the NDMS Directorate Staff and representatives of the NDMS work groups who will form an NDMS Strategic Vision Implementation Committee. This Committee will meet initially to prioritize the objectives to be implemented. The Committee will meet at least once per quarter to facilitate the implementation process and, at least once per year, to identify the objectives to be implemented in the following year, make whatever adjustments are necessary to implement the objectives selected, and assign agency responsibility for implementing each objective by carrying out the associated tasks.

The results of this process will be reported to the NDMS Directorate quarterly and to the NDMS Senior Policy Group at least once annually. At least twice during the five-year period, the NDMS Strategic Vision document will be revised to reflect changes based on reassessments of the objectives by the implementation committee, and the experience gained in the implementation process. The implementation process is intended to be dynamic, not a

rote following of a fixed prescription. The goal of the implementation process and the Strategic Vision which it reflects is to identify improvements in the four program areas identified in this document and integrate these improvements into NDMS organization and operations. This will be carried out through a participatory process of the NDMS partners and other participants under the administration of the Director of the Office of Emergency Preparedness.

Implementation also involves obtaining resource commitment for pursuing the objectives selected under the Strategic Vision.

B. MONITORING FOR RESULTS

The Director of the Office of Emergency Preparedness is responsible for monitoring progress on implementing the Strategic Vision. This activity will be carried out by the Planning Division on the NDMS headquarters staff in conjunction with the NDMS Directorate Staff and the implementation committee. Once each month, the Directorate Staff representative for each agency responsible for an implementation task will report progress on the implementation. The Planning Division will consolidate these reports for review by the Directorate at least once per quarter. The results will be summarized and reported to the Directorate and NDMS Senior Policy Group at least once per year. The format illustrated in Appendix C can be used to summarize this report.

Once an objective is implemented, the Director of OEP will receive a report from the responsible agency representative on the impact of the objective. This information will be reported to the NDMS Directorate Staff, Directorate and Senior Policy Group. In addition, the Director of OEP will sponsor special evaluation studies periodically to assess on-going usefulness of the changes implemented under the Strategic Vision.

Although attention will be paid to progress made on implementing individual objectives under the Strategic Vision, the larger purpose of this document is to stimulate a continuing process of improvement for the major areas identified as concerns in the NDMS

program The implementation and monitoring process will be oriented to this larger goal. Review of implementation results by the NDMS Senior Policy Group and the Directorate will focus on assessing the results in terms of this larger objective.

C. ANTICIPATED IMPACT FROM IMPLEMENTATION

The overall impact anticipated from implementing the Strategic Vision is to establish and perpetuate a process for assessing the NDMS program and introducing required changes for improvement. This process will involve the active participation of NDMS partner agencies and generate wide commitment to searching for and implementing improvements to the NDMS program. This process will involve the continuous reassessment of previously established plans.

Besides this overall goal of improving NDMS operations, specific expectations for impact are associated with each of the four program areas. These expected impacts are summarized below.

1. ANTICIPATED IMPACTS FOR NDMS POLICY AND OVERALL PROGRAM DIRECTION

The main impact expected from implementation of the NDMS Strategic Vision in this program area is to firmly establish the National Disaster Medical System as a regular, permanent program of the Federal government and improve its overall organization and executive-level management. This will increase its ability to provide needed services during a disaster and to assist the nation in conducting preparation activities at other times. Along with this general impact, some specific results from implementing the objectives for this program area include the following:

- The program will have a better basis to receive the regular budget and policy-level support from within its home agency, the Department of Health and Human Services, and from the partner agencies that it requires to carry out its mandate and fully meet the expectations of the nation for health and medical support in a major disaster. At present, the resources of each department are coordinated by DHHS with a budget for NDMS of contributions by three of the four partner agencies totalling $150,000 per annum.

- The basic authorization for the program will be grounded in public law which will stabilize operations and policy-level direction. Currently, NDMS has a somewhat precarious existence, based on a series of interdepartmental agreements and departmental declarations. No budget is appropriated for NDMS, and, as mentioned earlier, the entire amount of expenditures is $150,000 per year. This situation has contributed to confusion in the overall direction of the program and a lack of clarity about its appropriate functions.

- The leadership for the program will be firmly established in one department. This will clarify current questions about overall responsibility and ameliorate problems of organizational complexity associated with program operations.

- Implementation of objectives in this program area will clarify and strengthen the roles of the partner agencies in NDMS. Partnership agencies have resources and expertise that can contribute significantly to health and medical response. For instance, adequate geographic coverage for high risk areas across the United States is enhanced by focusing the resources of several agencies under one, clearly specified program.

- Objectives related to improving program communication positively address problems inherent in initiating program activity through a complex network of organizations at several jurisdictional levels. NDMS represents a consortium of four agencies which coordinate their activities with over twenty other Federal agencies in the Federal Response Plan, and many other entities at the regional, State and local levels. Communications has often been identified as a major problem, and it is expected that this problem will be significantly reduced by implementing objectives in this program area.

- NDMS, as a Federal level catastrophic disaster support program, is oriented to a role of assisting local disaster program efforts, both in terms of preparation and response. Implementing objectives in this program area reinforce the orientation on the part of top program managers and policy makers that the ultimate purpose of NDMS is to continuously support the local disaster base, not just in a disaster situation. This contributes to making the entire disaster system in the United States function more effectively.

- The implementation of objectives in this program area are expected to reinforce the professional status of NDMS, thereby contributing to program effectiveness and increased client confidence. NDMS is a professional service. The voluntary and decentralized structure of its

resources may obscure this fact. But, NDMS has always been concerned about developing, maintaining and being recognized for its professional competence. Strengthening overall direction and policy will contribute to realizing this goal.

2. ANTICIPATED IMPACTS FOR DMAT POLICY AND PROGRAM

From the inception of NDMS, the DHHS sponsored DMATs participating in training exercises and real life events have performed their duties using various formats of disaster response. These variations have led to a mixture of personnel, equipment, and operating procedures, during deployments. By standardizing DMATs, which is the major impact expected from implementing objectives under this program area, NDMS will be better prepared to identify the readiness of teams to meet the requirements of effective catastrophic disaster response.

Other benefits of standardization of DMATs include the following:

- o more effective response to medical assistance upon activation;
- o increased efficiency and economy of deployment;
- o better continuity of medical assistance during augmentation in a response;
- o participation of more qualified personnel; and
- o more efficient team interface with other organizations under the Federal Response Plan.

3. ANTICIPATED IMPACTS FOR EDUCATION AND TRAINING FOR DMAT POLICY AND PROGRAM

Standardization is also a primary goal and expected impact stemming from successful implementation of the objectives under this program area. At the present time, there is no standardized training and exercise program for participants in NDMS or DMATs. Although exercises are conducted annually, training is uneven and largely dependent upon local efforts or the adaption of other training programs to the requirements of NDMS. Furthermore, there is uneven knowledge of the workings and provisions of the Federal Response Plan and the interface between health and medical and other functional areas of Federal response.

The following represent some of the major benefits that can be expected to result from the development of a fully integrated and standardized training and exercise program for NDMS and ESF #8 of the Federal Response Plan:

- o more effective and coordinated response of health and medical activities upon activation;
- o increased readiness for NDMS participants and DMATs;
- o better ability to evaluate readiness of individual areas and programs;
- o increased efficiency and economies regarding the use of training resources among participating agencies and departments;
- o better understanding of the responsibilities of agencies, departments, and other activities;
- o more effective integration of health and medical training and exercise activities with those of the other Emergency Support Functions (ESFs) of the Federal Response Plan;
- o increased integration of efforts among all NDMS areas and DMATs;
- o increased ability to facilitate taking corrective and remedial actions by being able to highlight program deficiencies and address them on a multi-agency basis in a consistent and organized manner;
- o ability to quickly incorporate system and procedural changes in training and educational materials and make dissemination to relevant participants;
- o better understanding of the Federal Response Plan and the concepts of health and medical response by State and local governments;
- o more predictable response outcomes;
- o improved service to those affected by catastrophic events; including reduction in mortality and morbidity, faster response, and more timely care;
- o more accurate projections of response capability; and
- o better recruitment and retention of volunteers in response units through training, education and exercise.

4. ANTICIPATED IMPACTS FOR NETWORKING: FEDERAL, REGIONAL, STATE AND LOCAL PLANNING AND RESPONSE

It has been stressed several times in this document that disaster response is a State and local responsibility. This statement is not the product of arbitrary public policy. More than a policy, it is a reflection of the natural condition of a disaster. Catastrophic disasters strike specific localities, and the well being of the local population is directly related to how quickly local and nearby health and medical resources respond effectively. This "natural fact" is reinforced by American public policy which orients Federal catastrophic disaster response to backing up State and local disaster efforts.

The expected impacts of implementing objectives in this area are, as follows:

- Implementing objectives in this area will strengthen the ability of State and local jurisdictions to respond effectively to catastrophic disaster situations. Success in disaster response is closely linked to how well State and local areas are prepared to respond. Recent assessments of responses in real disasters provide evidence that State and local preparedness is not well developed in many areas. This is especially the case in the program area of health and medical disaster response planning. Many objectives under the Strategic Vision are oriented to strengthening State and local plans and programs for catastrophic disaster medical response.

- Reinforcing at the Federal level the recognition of the importance of building the State and local catastrophic disaster response planning and program base is also an expected impact under this section of the document. Federal policy is oriented to insuring that State and local areas are prepared and maintaining readiness to step in and help States and local jurisdictions for those requirements for which State and local resources prove inadequate. The system works best if State and local areas can meet the needs of a disaster. It works next best if Federal resources are used incrementally in support of a firm local base. It works least well when Federal resources are used without a local base. Insuring that Federal policy is actively in support of the philosophy that the State and local base should be as strong as possible is a goal under this section of this document.

- Fully developing the relationships and linkages among organizations at all levels of the response structure is an important expected impact of implementing the Strategic Vision. This set of inter-organizational relationships runs vertically from the Federal through the regional and State levels and on to the local jurisdictions. It also runs horizontally at each of these levels between responding and planning organizations involving the concept of mutual aid. The effectiveness of NDMS, both in planning and in actual response, is dependent on these relationships. Many of the objectives in this section involve a Federal level initiative which is administered through the regional and State offices and implemented at the local level. This process reinforces effective interaction among organizations in this network.

Improving these relationships is a task NDMS cannot perform alone. Implementation requires cooperative, joint action with other programs and organizations in the catastrophic disaster response network. One of the expected impacts of implementing the objectives of this program area is that the inter-organizational network related to catastrophic disasters in which NDMS operates and upon which it is dependent will be strengthened.

This Strategic Vision presents a set of objectives to be pursued and an implementation process to improve NDMS.

CHAPTER X

CONCLUSION

CHAPTER X: CONCLUSION

The National Disaster Medical System was established ten years ago and the concept for the program is less than fifteen years old. Each agency has contributed unique assets: DHHS has contributed the rapid response elements of DMATs, the Medical Support Unit concept, and DHHS Agency expertise. DoD has provided medical back-up personnel, patient regulation, transportation, and FCC administration. VA has contributed a full range of backup primary and secondary care assets, as well as FCC administration. Yet, in this short time, it has become the centerpiece of the Federal government's catastrophic disaster response program in the health and medical area. In the last five years, the program has been tested in a number of real-world disasters, and NDMS has passed the test. Regardless of what type of reorganization the Federal catastrophic disaster response structure will experience in the future, it will have to include a component like NDMS. NDMS has proven itself to be a valuable and necessary resource for the nation's response to disasters.

NDMS is now at a crossroads. It is a highly professional service at the center of a complex organization of services offered by the Federal government. Yet, it retains many of the characteristics of its origins as an ad hoc program created through a series of short term agreements among small scale programs in several government agencies and relegated to a relatively low level in the executive structure of the Federal government. It is now time to assign the program organizational attention and resources commensurate with its level of responsibilities.

The process of improving NDMS began with the follow-up assessment of its performance in Hurricane Andrew. It was continued through the formal evaluation and promulgation of this document. It will be the continuation of this process through the implementation of the Strategic Vision that will bring about changes that NDMS needs to operate at a full level of effectiveness now and in the future.

Improving NDMS as called for in this document will require the commitment of more resources to the program. However, as pointed out in the NDMS evaluation study, the entire program costs the Federal government approximately $10 million annually, a bargain in terms of the costs to benefits ratio. However, the size of this budget belies the program's

importance Past experience with disasters indicates that the Federal government ends up paying significantly more for not being prepared than it might have had the preparation been more thorough Disasters are expensive, and the trend is for the Federal government to pay the bill Therefore, it seems prudent to invest a relatively small amount of resources and effort to improve the response capability now so that the Federal government may save a great deal later Special attention for these improvements needs to be given to the areas identified in this document. They include full development of NDMS as the core of the Federal government's response program in heath and medical services, and ensuring that the State and local base is also well developed To conserve resources, selected high risk geographic areas should be especially targeted in this effort

APPENDICES

APPENDIX A

ORIGINAL PARTICIPANTS IN THE NDMS STRATEGIC VISION DEVELOPMENT PROCESS

APPENDIX A: ORIGINAL PARTICIPANTS IN THE NDMS STRATEGIC VISION DEVELOPMENT PROCESS

A. NDMS SENIOR POLICY GROUP

Philip R. Lee, M.D. (Chair)
Assistant Secretary for Health
Department of Health and Human Services

Jo Ivey Boufford, M.D. (Alternate Chair)
Deputy Assistant Secretary for Health
Department of Health and Human Services

Edward Martin, M.D.
Acting Assistant Secretary of Defense for Health Affairs
Department of Defense

John T. Farrar, M.D.
Acting Under Secretary for Health
Department of Veterans Affairs

James L. Witt
Director
Federal Emergency Management Agency

B. NDMS DIRECTORATE

Audrey Manley, M.D. (Chair)
Deputy Assistant Secretary for Health
Department of Health and Human Services

Joseph G. Gray
Director, Emergency Medical Preparedness
Department of Veterans Affairs

Ron Richards
Deputy Assistant secretary for Health Affairs
Department of Defense

Robert Fletcher
Program Director for State and Local Services
Federal Emergency Management Agency

C. NDMS DIRECTORATE STAFF

RADM Frank Young, M.D., Ph.D. (Chair)
Director, Office of Emergency Preparedness
Department of Health and Human Services

CAPT James Hanrahan, USN
Director. Office of Medical Readiness (Health Affairs)
Department of Defense

Thomas Cushing
Deputy Director, Planning, Policy & Support,
Emergency Medical Preparedness Office,
Department of Veterans Affairs

Peter Podell
Medical Planning Specialist
Federal Emergency Management Agency

D. WORK GROUP MEMBERS (ORIGINAL ROSTERS)

WORK GROUP 1: AMEND PUBLIC LAW

Robert Jevec (Chair)
U.S. Public Health Service

Andrew Flacks
Department of Veterans Affairs

Nancy Carr
Federal Emergency Management Agency

WORK GROUP 2: FUNCTIONS OF NDMS

RADM Frank Young, M.D., Ph.D. (Chair)
U.S. Public Health Service

John Malone
Department of Veterans Affairs

Jim Thomas
Federal Emergency Management Agency

Kim Vasconez
Federal Emergency Management Agency

Greg Jones
Federal Emergency Management Agency

Tracy Hanbury
U.S. Public Health Service

John Hoyle
U.S. Public Health Service

Donald R. Bennett
Department of Defense

Gary Sirmons
U.S. Public Health Service

Jack Whitney
U.S. Public Health Service

Bruce Baughman
Federal Emergency Management Agency

Reba Kestler
Federal Emergency Management Agency

WORK GROUP 3: ORGANIZATIONAL LINES OF NDMS

James Carmona (Chair)
Department of Veterans Affairs

Edward Lord
Department of Veterans Affairs

Chan Von Schrader
Federal Emergency Management Agency

Chuck Mills
Federal Emergency Management Agency

Rick Bath
Federal Emergency Management Agency

William Clark
U.S. Public Health Service

Hugh Sloan
U.S. Public Health Service

Charles Mahan
U.S. Public Health Service

Podge Reed, AHA
U.S. Public Health Service

Joe Lamb
U.S Public Health Service

Paul Roth, M.D.
New Mexico DMAT

Tony Fitzpatrick
U.S. Public Health Service

Linda Vogel
U.S. Public Health Service

Heidi Fitton
U.S. Public Health Service

WORK GROUP 4: DMATS POLICY AND PROGRAM

Earle Belue (Co-Chair)
U.S. Public Health Service

John Wassell (Co-Chair)
U.S. Public Health Service

Robert Harris
Department of Veterans Affairs

Steve Hood
Federal Emergency Management Agency

William Troup
Federal Emergency Management Agency

Joseph Barbera
Federal Emergency Management Agency

Mike Post
Federal Emergency Management Agency

Harold Rebuck
U.S. Public Health Service

Fred Gallaher
New Mexico DMAT

Charles Mitchell, M.D.
Hawaii DMAT

Jo Ellen Smith
U.S. Public Health Service

Al Taylor
U.S. Public Health Service

Susan Briggs, M.D.
U.S. Public Health Service

Lew Stringer, M.D.
North Carolina DMAT

WORK GROUP 5: TRAINING AND EXERCISE REQUIREMENTS

Col. Sheila Bowman (Chair)
Department of Defense

Connie Boatright
Department of Veterans Affairs

John Crawford
Federal Emergency Management Agency

Robert Jevec
U.S. Public Health Service

Conrad Salinas, M.D.
California DMAT

Commander Kevin Yeskey, M.D.
U.S. Public Health Service

LTC Scott Wells
Department of Defense

WORK GROUP 6: EDUCATION

Michael Vojtasko (Chair)
Department of Veterans Affairs

Peter Brewster
Department of Veterans Affairs

Peggy Phillips
Federal Emergency Management Agency

Kim Vasconez
Federal Emergency Management Agency

Tracy Hanbury
U.S. Public Health Service

LTC Kevin Tonat
U.S. Public Health Service

Bob Davidson
U.S. Public Health Service

Claude Cadoux
U.S. Public Health Service

Craig Llewellyn, M.D.
U.S. Public Health Service

Brian Flynn
U.S. Public Health Service

WORK GROUP 7: INTEGRATION OF LOCAL, STATE AND FEDERAL GOVERNMENTS

Joe Moreland (Chair)
Federal Emergency Management Agency

Judson Fuller
Department of Veterans Affairs

Steve Hood
Federal Emergency Management Agency

Peter Podell
Federal Emergency Management Agency

Jeffery Glick
Federal Emergency Management Agency

Roy Smith
Federal Emergency Management Agency

Alma Armstrong
Federal Emergency Management Agency

Bruce Baughman
Federal Emergency Management Agency

Gary Moore
U.S. Public Health Service

Hugh Sloan
U.S. Public Health Service

Calvin Freeman
U.S. Public Health Service

Ellery Gray
U.S. Public Health Service

CAPT. Steve Posner
U.S. Public Health Service

Carol Horne
Federal Emergency Management Agency

Dave Abbott
Federal Emergency Management Agency

Eric Tolbert
Federal Emergency Management Agency

Ed Wilson
Federal Emergency Management Agency

David Maxwell
Federal Emergency Management Agency

Lee Gershner
Federal Emergency Management Agency

Peter Jesperson
U.S. Public Health Service

Billy Conner
U.S. Public Health Service

Robert Bade
Federal Emergency Management Agency

Ace Hagebak
U.S. Public Health Service

Lauren Beauch
U.S. Public Health Service

Tony Fitzpatrick
U.S. Public Health Service

CONSULTANTS

Robert Muzzio
MAXIMUS

Dean Conley
MAXIMUS

APPENDIX B

MEETINGS IN THE NDMS STRATEGIC VISION DEVELOPMENT PROCESS 1993-1994

APPENDIX B: MEETINGS IN THE NDMS

STRATEGIC VISION DEVELOPMENT PROCESS

June 8, 1993 - January 18, 1994

A. INITIAL MEETINGS: FIRST ROUND

NDMS Directorate meeting	June 8	HHH/PHS
Work Group 1: Amend Public Law	July 13	FEMA Headquarters
Work Group 2: Functions of NDMS	June 29-30	Sheraton BWI
Work Group 3: Organizational Lines	June 23-24	Parklawn
Work Group 4: DMAT Policy and Program	June 29-30	Sheraton BWI
Work Group 5: Training and Exercises	July 12-13	Pentagon
Work Group 6: Education	June 10	DVA Medical Center
Work Group 7: Government Networks	June 16-17	FEMA Headquarters

B. NDMS PARTNER AGENCY REVIEW: FIRST ROUND

NDMS Directorate Staff	Sep 1	San Antonio
NDMS Directorate	Sep 10	Parklawn
NDMS Senior Policy Group	Sep 24	HHH/PHS

C. INITIAL MEETINGS: SECOND ROUND

NDMS Directorate/Directorate Staff	Oct 12	Parklawn
Work Group 1: Amend Public Law	Oct 19	Parklawn
Work Group 2: Functions of NDMS	Oct 26	NIH
Work Group 3: Organizational Lines	Nov 2-3	Parklawn
Work Group 4: DMAT Policy and Program	Oct 26	NIH
Work Group 5: Training and Exercises	Oct 19-22	Parklawn
Work Group 6: Education	Oct 19-22	Parklawn
Work Group 7: Governmental Networks	Oct 27-29	FEMA Berryville Fac.

D. NDMS PARTNER AGENCY REVIEW: SECOND ROUND

NDMS Directorate Staff	Nov 22 & 27	Parklawn
NDMS Directorate	Nov 29, Dec 9 & Jan 6	Parklawn
NDMS Senior Policy Group	Jan 18	HHS/PHS

APPENDIX C

SUMMARY OF OBJECTIVES, TASKS, AND MILESTONES BY PROGRAM AREA

APPENDIX C
SUMMARY OF OBJECTIVES, TASKS AND MILESTONES BY PROGRAM AREA
[Tracking, Monitoring, and Reporting]

PROGRAM AREA	OBJECTIVE	TASK	MILESTONE	ACTUAL STARTS*		ACTUAL COMPLETIONS*	
				NUMBER	PERCENT	NUMBER	PERCENT
I. NDMS Policy and Overall Direction	13	34	42				
II. DMAT Policy and Program	6	12	22				
III. Education, Training, and Exercises	4	12	26				
IV. Networking: Federal, Regional State and Local Planning and Response							
A. Objectives	10	12	15				
B. Adopted Options**	(12)	(12)	(12)				
TOTALS	33 (45)	70 (82)	105 (117)				

* Milestone counts and percents: These columns are to be completed periodically during the period of implementation of the Strategic Vision and used for monitoring and reporting progress toward attaining goals.

** Options to be reviewed as part of the implementation process. If an option is selected, it should be added into the objectives, tasks and milestones count for monitoring and reporting.