provision of patient reception, patient staging, casualty clearing, or other medical care activities in meeting the needs of the situation.

Certain military medical units, including active duty, National Guard and Reserve, may be tasked to deploy to support ESF #8 requirements. These requirements will be coordinated with the NDMSOSC DOD representative who will coordinate with DOMS to activate and deploy the necessary military units.

c. Coordination of Medical Transportation Requests

Arrangements for medical transportation should be made at the lowest levels possible. Normally local transportation requirements are to be handled by local authorities. If it is determined by Regional ESF #8 that local or regional resources are inadequate to meet the requirements, a request for Federal medical transportation assistance will be worked at the National ESF #8 level and will be referred to representatives from DOD, Department of Transportation (DOT), General Services Administration (GSA), Department of Agriculture (USDA), and United States Postal Service (USPS) to initiate assistance by their respective agencies, including arrangements for aeromedical evacuation. Patient regulation will be the responsibility of ASMRO.

d. Coordination of Requests for Medical Facilities

Arrangements for medical facilities are primarily a local function. Requests for additional assistance should first be referred to State authorities. Requests by State officials for Federal aid for NDMS hospital support should be routed through Regional ESF #8 to the NDMSOSC. The NDMSOSC will verify the request and refer it to the DOD and VA representatives. The VA and DOMS, through its Service representatives, will notify NDMS FCCs to activate area operations/patient reception plans. HQUSAF will alert ASMRO regarding NDMS activation. ASMRO will establish and disseminate appropriate bed reporting instructions to FCCs. Further, the 57th Aeromedical Evacuation Squadron/Aeromedical Evacuation Control Center, Scott Air Force Base, Illinois (hereafter referred to as the AECC [formerly the Patient Airlift Center]) will provide appropriate patient reception/patient arrival information to ASMRO and to the local FCCs. Local FCCs, through their patient reception teams, will distribute arriving patients to specific NDMS participating hospitals based upon the patients' need and facility capability.

e. Coordination of Requests for Aeromedical Evacuation of Patients from the Disaster Area

(1) State and local health/medical authorities identify the need for patient evacuation support from the disaster area. The requirement for aeromedical evacuation is

communicated through Regional ESF #8 to the NDMSOSC. The DOD representative in the NDMSOSC, in turn, will coordinate with the appropriate commands such as FORSCOM, USTRANSCOM, USLANTCOM, USPACOM, and/or HQAMC Command Centers. The agency contacted will then coordinate with the appropriate supporting command to obtain the needed support.

(2) The concept of operation is for local authorities to operate Casualty Collection Points (CCPs) that will feed into State operated Regional Evacuation Points (REPs). ESF #8 will coordinate the "hand-off" of patients from the REPs into the NDMS patient evacuation system.

(3) Patient regulating is the responsibility of the ASMRO. Because the movement of patients is based upon the availability of hospital beds, ASMRO will receive patient requirements from the disaster area and regulate patients to destination reception areas reporting available beds. Regional ESF #8 will establish a Patient Reporting Activity (PRA) to report the number of patients to ASMRO requiring movement out of the area. Patients will be reported in the specified contingency categories. FCCs will likewise report available beds in the same contingency categories. Once the regulating decision is made, ASMRO will pass it to the PRA and the receiving FCCs. After receipt by the PRA, Regional ESF #8 will coordinate with the State to have the patients moved.

(4) AE resources will be deployed based on the nature of the emergency or disaster and estimated length of support requirement. In a limited operation, support may be restricted to the providing of Aeromedical Evacuation Crew Members (AECM), airlift, and/or liaison personnel with centralized management remaining with the AECC, Scott Air Force Base. In a larger or more prolonged event which may require sustained support, elements of the Tactical Aeromedical Evacuation System (TAES), to include an Aeromedical Evacuation Casualty Element (AECE), Mobile Aeromedical Staging Facility (MASF), Aeromedical Evacuation Liaison Team (AELT), and AECMs may be deployed to the region. When deployed, the AECE will provide regional control for the AE elements with overall responsibility for continental United States (CONUS) AE operations remaining with the AECC, Scott Air Force Base. Outside the continental United States (OCONUS), overall responsibility will rest with the appropriate military command (CINCLANT or CINCPAC) having military support responsibility for the geographic area of the disaster/emergency.

(a) An AELT could deploy to the REPs to provide a direct HF radio communications link and immediate coordination between the REP originating the requirements for aeromedical evacuation and the AECC. The primary mission of the AELT is to coordinate patient movement requests and the movement schedule between the AECC and the REP.

(b) The AECC is the operations center responsible for mission planning, coordinating, and management of the disaster area AE operations. The AECC establishes and is the focal point for communications and provides the source of control and direction for disaster area AE forces.

(c) The MASF is a mobile, tented, temporary staging facility deployed to provide supportive care and administration. It does not have beds or cots. Since it has no organic patient carrying vehicles, it is normally located near runways, taxiways, or airfields.

(d) The AECMs provide inflight supportive medical care aboard AE mission directed aircraft.

(e) Control teams will be deployed to identify the closest appropriate airhead to a REP that can handle the AE aircraft, normally C-9 or C-130. Aeromedical staging capability (utilizing a joint operation between military MASFs and NDMS DMATS) will be established near the runways or taxiways of the designated airfield or forward operating base. The regulated patients are then moved from the REP to the aeromedical staging location for entrance into the AE system and movement to the regulated destination.

(f) The AELT, AECC, and MASF have equipment and personnel to establish a HF radio network in support of the system. The AECC functions as the net control for the various elements. The following message formats are used throughout the AES, using specific portions of the AMC Form 801, Tactical Aeromedical Evacuation Mission Message.

(1) AE Support Request Message (Alpha Message) - The Alpha Message starts a patient movement request and is originated by an AELT. Pertinent information concerning the patient movement is gathered by the liaison official and transmitted by radio operator to the AECC and MASF.

(2) AE Support Response Message (Bravo Message) - The Bravo Message is originated by the AECC. When all information concerning the evacuation aircraft is obtained from the ALCC, this information and other applicable data are transcribed onto the Bravo section of the AMC Form 801, and then transmitted by radio operator to the MASF and the AELT.

(3) AE Support Confirmation Message (Charlie Message) - The Charlie Message is originated by the MASF. The patients are transported from the REP to the MASF. Assigned MASF personnel administratively process and stabilize the patients for tactical aeromedical evacuation. Upon aircraft departure, the MASF radio operator transmits

the pertinent information that has been transcribed onto the Charlie section of the AMC Form 801, to the AECC and the AELT.

(g) If AE elements are not deployed to the disaster area, personnel/medical facilities reporting patient movement requirements should be prepared to provide as much medical information on patients as is known, e.g. current condition, diagnosis, vital signs, any special equipment requirements, etc. A point of contact should be provided so the AECC can obtain any additional information needed to prepare for the mission.

(h) If State/local authorities request patient evacuation but are unable to establish REPs and/or CCPs, ESF #8 will deploy the necessary additional medical force structure to facilitate the lowest echelon level of care required to successfully accomplish the mission.

f. Coordination for Obtaining, Assembling, and Delivering Medical Equipment and Supplies to the Disaster Area

Representatives of PHS, VA, DOD, DOT, and GSA will coordinate arrangements for the procurement and transportation of medical equipment and supplies to the disaster area. A "push" concept will be employed when feasible to expedite medical resupply to the disaster area from pre-identified medical supply caches. Included in this response will be the PHS requested support, as needed, of certain medical supplies from HWC.

g. Coordination of Requests for Reimbursement

Federal agencies and other organizations which are tasked by PHS to support ESF #8 are eligible for reimbursement. All Federal agencies which are tasked will be reimbursed by FEMA directly, typically through a Standard Form 1080 or 1081, the On-Line Payments and Collection System, or a cash disbursement. Reimbursement of non-Federal entities will be accomplished by other mechanisms. Those officials authorized to approve expenditures should validate the reimbursement requests and ensure that all requests cite and are relevant to ESF #8.

h. Communications

National ESF #8 will establish communications necessary to effectively coordinate assistance. At a minimum, National ESF #8 will be expected to maintain communication with the following: Regional ESF #8; the FCO; EST; State health/medical officials as necessary; PHS AECs; DOMS; ASMRO; AMC; and local NDMS FCCs. As the situation dictates, other agencies such as: FEMA Regional Offices and PHS Regional

Offices, also the appropriate centers of the United States Geological Survey (USGS): National Hurricane Center (NHC); National Earthquake Center (NEC); and the Severe Weather Center (SWC). A variety of communications networks and organizations will be utilized to effect these communications including the public switched telephone network, the Federal Telecommunications System (FTS), and various high frequency radio networks coordinated by FEMA and the National Communications System (NCS). Additionally, amateur radio frequencies and networks and the United States Army Military Affiliate Radio System (MARS) will be utilized to the extent necessary to help meet the communications requirements. DOD units employed in support of this ESF #8 will utilize their organic communications equipment and preassigned frequencies to facilitate their internal communications requirements.

i. Information Requests

Requests for information may be received at ESF #8 from various sources, such as the media and the general public, and they will be referred to the appropriate agency or JIC for response.

j. Journal of Activities

A journal of ESF #8 activities shall be maintained by the senior representative of each of the participating agencies. Entries should be made in the journal for each major action, occurrence, or event. OASH/OEP will, upon completion of the emergency, review the separate journals and prepare a summary after action report. The after action report, which summarizes the major activities of ESF #8, will identify key problems, indicate how they were solved, and make recommendations for improving response operations in subsequent activations. Support agencies/organizations will assist in the preparation of the after action report and endorse the final report.

E. Intra-State Actions

Regional ESF #8, supported by National ESF #8, will collaborate with the identified State health/medical coordinator(s), whose functions include working issues such as:

1. Assessment of health/ medical needs;
2. Health surveillance;
3. Medical care personnel;
4. Health/medical equipment and supplies;
5. Patient evacuation;
6. In-hospital care;
7. Food/drug/medical device safety;

8. Worker health/safety;
9. Radiological Hazards;
10. Chemical Hazards;
11. Biological Hazards;
12. Mental health;
13. Public health information;
14. Vector control;
15. Potable water/wastewater and solid waste disposal; and
16. Victim identification/mortuary services.

V. RESPONSIBILITIES

A. Primary Agency: Department of Health and Human Services, U.S. Public Health Service

1. Provide leadership in directing, coordinating, and integrating the overall Federal efforts to provide medical and public health assistance to the affected area.

2. Direct the activation of NDMS and the staffing of the NDMSOSC as necessary to support the emergency response operations.

3. Direct the activation and deployment of health/medical personnel, supplies, and equipment in response to requests for Federal health/medical assistance.

4. Coordinate the evacuation of patients from the disaster area when evacuation is deemed appropriate by State authorities.

5. Provide human services assistance under the direction of the HHS RD to ESF #8 and other ESFs as necessary.

B. Support Agencies

1. Department of Agriculture

Assist Federal health and medical response operations by providing support with personnel, equipment, food, and supplies. This support will be coordinated through the Forest Service Fire and Aviation Management Office (located in Washington, DC) and the National Interagency Coordination Center (NICC) located at Boise, Idaho. Support will primarily be for communications and aircraft and the establishment of base camps for deployed Federal health and medical teams in the disaster area.

2. *Department of Defense*

a. Alert ASMRO to provide DOD NDMS FCCs (Army, Navy and Air Force) and VA NDMS FCCs reporting/regulating instruction to support disaster relief efforts.

b. Alert DOD NDMS FCCs to activate NDMS area operations/patient reception plans; initiate bed reporting based on ASMRO instructions.

c. In coordination with NDMSOSC, evacuate and manage patients as required from the disaster area to NDMS patient reception areas.

d. In coordination with DOT and other transportation support agencies, transport medical personnel, supplies and equipment into the disaster area.

e. Provide logistical support to health/medical response operations.

f. Provide active duty, reserve and National Guard medical units for casualty clearing/staging and other missions as needed including aeromedical evacuation.

g. Coordinate patient reception and management in NDMS areas where military treatment facilities serve as local NDMS FCCs.

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

i. Provide available DOD medical supplies for distribution to mass care centers and medical care locations being operated for disaster victims.

j. Provide available emergency medical support to assist in the support of State/local governments within the disaster area. Such services may include triage, medical treatment, and the utilization of surviving DOD medical facilities within the disaster area.

k. Provide assistance in managing human remains including victim identification and disposition.

l. Provide technical assistance, equipment and supplies through the United States Army Corps of Engineers (USACE) as required, in support of PHS to accomplish temporary restoration of damaged public utilities affecting public health.

3. Department of Justice

a. Assist Federal health and medical response operations in victim identification. This support will be coordinated through the Federal Bureau of Investigation (FBI) Disaster Squad located at FBI Headquarters in Washington, D.C.

b. Provide State and local governments legal advice concerning the identification of the dead.

c. Provide OASH/OEP with relevant intelligence information of any credible threat or other situation that could potentially threaten public health. This support will be coordinated through FBI Headquarters in Washington, DC.

d. Provide communications, transportation, and other logistical support to the extent possible. This support is provided through the FBI.

4. Department of Transportation

a. Assist in identifying and arranging for utilization of all types of transportation, such as air, rail, marine, and motor vehicle.

b. Assist in identifying and arranging for utilization of United States Coast Guard (USCG) aircraft, in providing urgent airlift support when not otherwise required by ESF #1 or the USCG.

c. Provide supplemental casualty distribution assistance from DOT resources subject to DOT statutory requirements.

d. Coordinate with the Federal Aviation Administration (FAA) for air traffic control support for priority missions.

5. Department of Veterans Affairs

a. Alert VA NDMS FCCs to activate NDMS area operations/patient reception plans; initiate bed reporting based on ASMRO instructions; and coordinate patient reception and management in those VA NDMS FCC areas where VA medical centers serve as local NDMS FCCs.

b. Provide available medical support to assist in the support of State/local governments within the disaster area. Such services may include triage, medical treatment, and the utilization of surviving VA medical centers within the disaster area.

c. Provide available medical supplies for distribution to mass care centers and medical care locations being operated for disaster victims.

d. Provide assistance in managing human remains including victim identification and disposition.

6. Agency for International Development, Office of U.S. Foreign Disaster Assistance

a. Provide assistance in coordinating international offers for health/medical support.

b. Provide communications support to the extent possible.

7. American Red Cross

a. Provide emergency first aid, supportive counseling, health care for minor illnesses and injuries to disaster victims in Mass Care shelters, ARC DFO, selected disaster clean-up areas, and other sites deemed necessary by the primary agency.

b. Supplement the existing community's health system subject to the availability of staff.

c. Provide supportive counseling for the family members of the dead and injured.

d. Provide available personnel to assist in temporary infirmaries, immunization clinics, morgues, hospitals, and nursing homes.

e. Acquaint families with available health resources and services and make appropriate referrals.

f. Provide blood and blood products through regional Blood Centers at the request of the appropriate agency.

g. Provide coordination for uploading of appropriate casualty/patient information from ESF #8 into the DWI System.

8. Environmental Protection Agency

Assist Federal health and medical response operations by providing technical assistance and environmental information for the assessment of the health/medical aspects of situations involving hazardous materials.

9. Federal Emergency Management Agency

a. Assist NDMS in establishing priorities for application of health and medical support.

b. Assist in providing NDMS communications support.

c. Assist in providing information/liaison with emergency management officials in NDMS FCC areas.

10. General Services Administration

Assist Federal health and medical response operations by providing facilities, equipment, supplies and other logistical support including the acquiring of private sector ground and air transportation resources.

11. National Communications System

Assist Federal health and medical response operations by providing communications support for medical command and control. This support will be coordinated through the Office of the Manager.

12. U.S. Postal Service

Assist Federal health and medical response operations by providing air and ground transportation support.

VI. RESOURCE REQUIREMENTS

A. Assets Critical for Initial 12 hours

The most critical requirements during the initial 12 hours of a major disaster will be medical response personnel, necessary medical supplies and equipment, transportation, logistical and administrative support, and communications systems support. The principal requirements will be:

1. The alerting and deployment of emergency response coordinators, National ESF #8 ERT, the Regional ESF #8 emergency response structure, and other necessary ESF #8 personnel.

2. The alerting and deployment of Federalized NDMS DMATs, DMORTs, and supporting military medical units to assist State/local authorities in the delivery of patient care to victims of the disaster and the provision of mortuary services as required. Patient care will probably be rendered under austere field conditions for casualty clearing, casualty staging, and during transportation.

3. Medical supplies (including pharmaceutical and biologic products) and equipment necessary to replace those damaged or destroyed by the disaster. Additionally, resupply will be needed for deployed DMATs/DMORTS, supporting military medical units, and State/local medical units providing patient care in the affected area.

4. Transportation support to include:

   a. Aircraft for transport of incoming medical response personnel, supplies, and equipment;

   b. Ground transportation for deployment of incoming assets within the disaster area;

   c. Ground transportation and rotary wing aircraft for movement of casualties within the affected area;

   d. Fixed wing short, medium, and long-range aircraft for patient evacuation from the disaster area;

   e. Ground transportation and rotary wing aircraft for patient distribution within local NDMS patient reception areas; and

   f. Aircraft for retrograde transport of medical response personnel and equipment following deactivation.

5. Logistic and administrative support including:

   a. One or more representatives of each ESF #8 lead/support agency to be located at or to be immediately available via telecommunications (as appropriate to support) to National ESF #8, Regional ESF #8, or within disaster area;

b. One or more representatives of the lead agency to be located with the FEMA EST;

c. One or more representatives of the lead agency to be located with the FEMA CDRG;

d. One or more ERCs from OASH/OEP to deploy to the disaster area to assist Regional ESF #8 with emergency response coordination;

e. One or more representatives at the Centers for Disease Control Emergency Response Coordination Group (CDC ERCG) facility in Atlanta, GA. to deploy to the disaster area to assist Regional ESF #8 with emergency response coordination;

f. One or more representatives of National ESF #8 to deploy as required to assist Regional ESF #8 with emergency response coordination;

g. Qualified personnel to establish, maintain, and operate communications systems;

h. Clerical support personnel at the National ESF #8 and Regional ESF #8 centralized locations;

i. Reference material including plans, directories, maps, etcetera necessary for coordination of medical and public health response; and

j. Facilities adequate for the operation of the National ESF #8 and Regional ESF #8 on a 24-hour basis.

6. Communications systems including:

a. Voice and data communications systems connecting National ESF #8 and Regional ESF #8, DOMS, ASMRO, local NDMS FCCs, FEMA EST, and the CDC ERCG;

b. Voice communications with DMAT sponsors;

c. Intra-regional voice communications systems connecting national, regional, State, and local officials involved in immediate medical response operations; and

d. Communications required to support casualty clearing, aeromedical staging, and patient evacuation and reception operations.

B. Assets Required for Continuing Operations

The assets required for the initial 12 hours will also be required for the remainder of the response period. Requirements may be modified (increased or decreased) depending on verification of initial requests for assistance, confirmation of casualty and damage estimates/locations, and the time required for medical and public health (including environmental health) response. The discovery of previously undetected damage, hazardous conditions, or other requirements could also modify the Federal medical and public health response. Some significant increases in public health and mental health assistance will probably be required following the initial response period and will probably need to continue well into the recovery and restoration phases. Such assistance may include the provision of environmental health services for shelters.

VII. REFERENCES

A. Robert T. Stafford Disaster Relief and Emergency Assistance Act (P.L 93-288), as amended.

B. Public Health Service Act, 42 U.S.C. 217; 42 U.S.C 243(c)(1); 42 U.S.C. 243(c)(2); 42 U.S.C. 319.

C. Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (P.L. 96-510).

D. National Security Decision Directive 47, July 1982.

E. Executive Order 12656, November 18, 1988.

F. Executive Order 12657, November 18, 1988.

G. DOD Directive 6010.17, National Disaster Medical System, December 28, 1988.

H. DOD Directive 3025.1, Use of Military Resources During Peacetime Civil Emergencies within the United States, its Territories, and Possessions, May 23, 1980.

I. 55 FR 2885, Office of the Assistant Secretary for Health; Statement of Organization, Functions, and Delegations of Authority, January 29, 1990.

J. 55 FR 2879, Office of the Secretary; Statement of Organizations, Functions, and Delegations of Authority, January 29, 1990.

K. "Public Health Service Disaster Response Guides," May 1987.

L. "Facts on the National Disaster Medical System," January 1991.

M. "National Disaster Medical System - Concept of Operations," January 1991.

N. "National Disaster Medical System - Operations Support Center Manual," April 1991.

O. "National Disaster Medical System - Federal Coordinating Center Guide," March 1985.

P. "National Disaster Medical System - Disaster Medical Assistance Team Organization Guide," July 1986.

Q. "The Public Health Consequences of Disasters," Centers for Disease Control, U.S. Public Health Service, September 1989.