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Supplemental Resource: MMRS Target Capabilities/Capability Focus Areas and NIMS Compliance

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U.S. DEPARTMENT OF HOMELAND SECURITY

MMRS Target Capabilities/Capability Focus Areas and NIMS Compliance

This listing constitutes revised Metropolitan Medical Response System (MMRS) Target Capabilities/Capability Focus Areas (TC/CFAs) and NIMS compliance. It reflects the correlation of the Goal, National Priorities and TCL, and updates the FY 2004 and 2005 MMRS CFAs. The Target Capabilities constitute the primary guidance for the MMRS activities engaged in achieving these capabilities. Particular emphasis is placed on the preparedness and performance measures in each TC document. Reference to previous and continuing MMRS program guidance is also incorporated. MMRS jurisdictions must give priority attention to these TCs/CFAs, but also have the option of using grant funds to improve capabilities in any of the other Target Capabilities listed in the MMRS column of Appendix G, provided they are reflected in the relevant State and/or UASI strategies, enhancement plans, and investment justifications.

MMRS jurisdictions must also sustain enhanced capabilities achieved through the implementation of prior years' program guidance and funding.

A. Target Capabilites/Capability Focus Areas

TC/CFA 1 - Strengthen Medical Surge Capabilities
Elements of the MMRS baseline deliverables apply to this area, including the "Plan Component for Responding to a Chemical, Radiological/Nuclear or Explosive WMD" and MMRS "Plan Component for Local Hospital and Regional Healthcare Systems." The provisions of FY 2004 and FY 2005 CFA 2, "ensure operational viability of mass care shelters and medical treatment facilities," are incorporated into this capability:

- Revise or update current plans to include the provision of hazardous/toxic substances portal and point detection and monitoring, decontamination and public safety support to mass care shelters and medical treatment facilities by designated personnel and equipment
- Ensure that alternate medical treatment facilities have immediately available electric power, water and sewer, environmental controls, and other necessary infrastructure support to become operationally viable on short notice
- Establish and maintain regional capability to track the triage, treatment and transport of ambulatory and non-ambulatory patients under emergency or disaster conditions. Consider developing a regional electronic patient tracking capability

In its FY 2006 National Bioterrorism and Hospital Preparedness Program cooperative agreement guidance[1], HRSA adopted the '"Tiered Response Systems" described in a manual entitled *Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large- Scale Emergencies.* HRSA is requiring that its :

[1] https://grants.hrsa.gov/webexternal/DisplayAttachment.asp?ID=E6845085-1A82-4743-948F-632433485951

> Awardees will use this section to clearly articulate the tiered regional response capability that exists in the State according to the following structure and nomenclature. Given the previous four years of funding awardees are expected to describe the system that exists in their State through Tier 5 which should include the state's integration with Federal response. (p. 23)

MMRS jurisdictional leadership shall coordinate with HRSA NBHPP funds recipients in their Operational Areas to ensure that MMRS plans, capabilities, and organizational arrangements are accurately incorporated in local implementation of *Medical Surge Capacity and Capability* (MSCC) guidance, especially at MSCC Tier 3, which constitutes a systems description of the MMRS program:

> *Tier 3 – Jurisdiction Incident Management*
>
> Jurisdiction incident management (Tier 3) is the primary site of integration of healthcare facilities (HCFs) with fire/EMS, law enforcement, emergency management, public health, public works, and other traditional response agencies. It provides the structure and support necessary for medical assets to maximize MSCC, and it allows direct input by medical representatives into jurisdictional action planning and decision-making. In addition, it links local medical assets with State and Federal support.
>
> It is the most critical tier for integrating the full range of disciplines that may be needed in a mass casualty or complex medical event. The focus of Tier 3 is to describe how to effectively coordinate and manage diverse disciplines in support of medical surge demands. This requires healthcare assets to be recognized as integral members of the responder community and to participate in management, operations, and support activities. In other words, health and medical disciplines must move from a traditional support role based on an Emergency Support Function (ESF), of the NRP, to part of a unified incident management system. This is especially important during events that are primarily health and medical in nature, such as infectious disease outbreaks.
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> The basic capability of Tier 3 is the integration of health and medical assets into the functional organization of incident management in the traditional emergency response community. This is accomplished through a well-organized and tested jurisdiction EOP.

1. Discuss how healthcare facilities, within the defined sub-State regions already established for this cooperative agreement, integrate with other response disciplines (e.g., public health, public safety, emergency management) through an incident management system to maximize jurisdictional medical surge capacity and capability.

2. Describe the activities undertaken to date to train and exercise hospital and other healthcare provider staff in the NIMS and how healthcare incident

management system fits into the jurisdictional emergency management system. (p.26)

In addition the NBHPP guidance includes these provisions regarding Alternate Care Sites and Mobile Medical Facilities:

a) **Alternate Care Sites (required of all awardees) –** Awardees must have the ability to provide surge capacity outside of the hospital setting as has been demonstrated through recent public health emergencies. Many States have undertaken very thoughtful and deliberate processes for identifying off site or alternate care sites within a certain radius of healthcare facilities. An important concept for States to keep in mind is that while selecting these sites planning must consider that Federal assets exist that can be brought to bear but require an "environment of opportunity" for set up and operation and may not be available for 72 hours. Awardees should clearly articulate:
   - How many sites have been identified at the State and sub-State regional level?
   - What type of facilities are being considered?
   - What can the facilities accommodate in terms of the numbers of patients and level of care, (i.e. triage, basic care and stabilization, trauma level type care, patients transferred from hospitals, medical needs shelters etc)?
   - What staffing plans have been developed for these facilities?
   - What are the plans for supply and re-supply of the facilities?
   - What are the plans for the security of the site?
   - What are the plans for patient movement to the sites and from the sites to more definitive care sites either within or outside of the State?

b) **Mobile Medical Facilities –** Awardees must have the ability to surge outside of the hospital or healthcare system. Awardees are not required to purchase mobile medical facilities but for some jurisdictions this may be a viable option until large population centers can be evacuated to outlying less affected areas with intact healthcare delivery systems. Awardees will describe:
   - What activities have been undertaken to establish mobile medical facilities in the State?
   - What activities have been undertaken to provide for the staffing, supply and re-supply of the facilities and associated training of medical teams associated with these facilities?
   - If these facilities exist in the State how many of them are available, where are they positioned?

- What are they capable of handling in terms of numbers of patients and level of care provided (triage, primary care, tertiary care, trauma etc)?
- What capabilities do they possess? (i.e., Do they posses the capability to perform surgery? Do they have a lab? Can they provide x-ray services? Do they posses an ICU? Do they have pharmacy services?)
- How long can these assets be deployed to the field before they would need to be re-supplied?
- What plans, MOU's and other arrangements exist for the transfer and use of the facilities and any associated medical teams, equipment and supplies within the State and between adjoining States as may be needed in an emergency? (pp. 31-32)

MMRS jurisdictions must work local NBHPP fund recipients to coordinate these requirements with MMRS capability enhancement and maintenance activities.

MMRS jurisdictions are strongly encouraged to develop, in conjunction with State and Urban Area officials, altered standards of care authorities, guides, and training, based on the information provided in the Agency for Healthcare Research and Quality (AHRQ) report, "Altered Standards of Care in Mass Casualty Events" (pub. No. 05-0043, April 2005).

TC/CFA 2 - Strengthen Mass Prophylaxis Capabilities

The provisions of former CFA 8, "Pharmaceutical Cache Management and Status Reporting," are incorporated into this capability. In addition, previous MMRS guidance is revised as follows: The purpose of the MMRS pharmaceuticals cache is to provide CBRNE release prophylaxis for first responders, *and their families, as well as the general public, as determined by the MMRS Steering Committee.*

MMRS jurisdictions should ensure that all sources of medicines and medical supplies for their Operational Area (e.g., MMRS cache, CHEMPACK, Strategic National Stockpile (SNS), and HRSA-funded hospital-based caches), necessary to protect first responders and first receivers are aggregated into a NIMS-compliant master resource list and management system.[2]

In support of the CDC's Cities Readiness Initiative (CRI), all MMRS jurisdictions which are in metropolitan statistical areas participating in CRI, must update their mass prophylaxis plans to be able to provide support for the distribution of pharmaceuticals to their entire population within 48 hours of receipt from the Strategic National Stockpile.

In addition, all MMRS jurisdictions must maintain on file an inventory of the MMRS local pharmaceutical cache, in Microsoft® Excel format, to be provided electronically to DHS upon request. This inventory must include the following data elements:

[2] See the NIMS Resource Inventory Management System (NIMS-RIMS) alert at: http://www.fema.gov/pdf/emergency/nims/rims_81406.pdf

- Pharmaceutical products contained, and inventory of, jurisdiction's pharmaceutical cache in units of dosage
- Names and official titles of individuals authorized to release cache pharmaceuticals
- Each product's Lot Number, cost, and expiration date
- Pharmaceutical storage management and conditions, including percentage stored in hospitals and other fixed facilities, and percentage forward-deployed on emergency responder vehicles

TC/CFA 3 - Strengthen WMD/Hazardous Materials Response and Decontamination Capabilities

Elements of MMRS baseline capabilities in CBRNE response plans are applicable to this capability. The decontamination items in CFA 1, above, also apply to this capability.

TC/CFA 4 - Strengthen Interoperable Communications Capabilities

Katrina/Rita after-action lessons learned revealed that, in addition to the interoperable communications guidance provided in the general section of this grant guidance, a Minimum Essential Emergency Medical Communications Network (MEEMCN) must be established in each MMRS Operational Area. The MEEMCN must be capable of processing voice and data communications independent of the Public Switched Network. MMRS jurisdictions in areas with significant hazard vulnerability to large-scale or catastrophic incidents (such as hurricanes, earthquakes, tornadoes, or ice storms should avoid, whenever possible, reliance on terrestrial fixed site components which are vulnerable to disruption or destruction by a terrorist act or natural disaster. The Network shall, at a minimum, include selected medical treatment facilities, public health departments, emergency operations centers, public safety departments, emergency medical and law enforcement dispatch centers, and State National Guard nodes.

Network design and communications operations planning must be integrated with Urban Area and State communications upgrade activities, and should be conducted in consultation with DHS assistance resources, including the Interoperable Communications Technical Assistance Program.

TC/CFA 5 - Strengthen Information Sharing and Collaboration Capabilities

This capability links to the National Priority for Information Sharing and Collaboration.

TC/CFA 6 - Expand Regional Collaboration

This CFA links to the National Priority for Regional Collaboration and all Target Capabilities. Previous MMRS guidance applicable to this CFA includes Deliverable 4 of the FY 2003 MMRS Contract, and the capabilities sustainment element of the FY 2004 MMRS grant guidance.

The term "MMRS Operational Area" means all of the political jurisdictions and special jurisdictions (such as port authorities and transportation authorities) with which an MMRS jurisdiction has mutual aid agreements and other preparedness and response

coordination and cooperation arrangements. This term should not be confused with special purpose "regions" (e.g., emergency management, public health, homeland security, transportation/highway) that exist in most States. The jurisdictions in an MMRS Operational Area which receive MMRS grants funds are referred to as "principal MMRS jurisdictions;" whereas, other jurisdictions in the operational area are "affiliated MMRS jurisdictions."

Grant funding is available to support continuing, and newly established, MMRS Operational Areas. This multi-jurisdictional approach is a hallmark of the MMRS Program and achieves efficiency and economy by providing protection for a greater at-risk population, and by incorporating more highly trained response personnel (e.g., hospitals) and special-purpose resources (e.g., pharmaceuticals, equipment).

- States with two or more MMRS jurisdictions shall establish and achieve formal State-wide mass casualty preparedness and response programs.
- MMRS jurisdictions with Operational Areas in two or more States shall achieve common response protocols, common or compatible credentialing and permissions for first responder and medical treatment personnel, and interoperable communications capabilities.

(See also, the material on MSCC Tier 3 under TC/CFA-1, Strengthen Medical Surge Capabilities, above.)

TC/CFA 7 - Triage and Pre-Hospital Treatment
Elements of MMRS baseline capabilities plans are applicable to this capability.

TC/CFA 8 - Medical Supplies Management and Distribution
Activities under this CFA must implement NIMS resource management requirements, support mutual aid agreements with respect to medical treatment facilities and medical services for mass care shelter residents, and address airborne delivery of supplies to areas where ground transportation infrastructure is vulnerable to heavy damage and/or obstruction. Plans should describe the means, organization and processes by which a jurisdiction will find, obtain, and distribute resources to satisfy generated needs, and should address resource priorities, supplier of last resort, costs, notification, activation and employment of resources.

TC/CFA 9 - Mass Care (Sheltering, Feeding, and Related Services)
Elements of former CFA 2, "Ensure operational viability of mass care shelters and medical treatment facilities" are incorporated into this capability. MMRS jurisdictional programs must:
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- Consider establishing reception centers, which consolidate triage, decontamination, registration, tracking and monitoring of affected persons
- Consider the needs of individuals with disabilities and those who require continued medical maintenance when planning for, and establishing, shelters and reception centers

- Develop procedures for daily reporting of the number of people staying at facilities, status of supplies, conditions at facilities and requests for specific types of support
- Ensure plans address decision-making authority for which mass care services will be provided; methods to activate and manage facilities, including operational resources; and administrative tools such as job action sheets and other planning aids

TC/CFA 10 – Emergency Public Information and Warning
Former CFA 3 applies to this capability. Jurisdictions must be capable of alerting citizens to emergency situations in order to minimize loss of life and unnecessary property damage, and reduce the dependency on government-provided services.

Alerting mechanisms should be redundant, inclusive of special needs populations, and capable of functioning without electric power. Accordingly, jurisdictions should review and revise pre-scripted emergency public information message content/templates to ensure that radiological, biological, and chemical agents are covered in separate template messages, and that self-help contamination avoidance and decontamination actions are included. Ensure plans and arrangements for multiple modes of message dissemination include accessible communications for individuals with hearing and vision disabilities, as well as language translations. Develop a plan and formal mechanism to monitor and measure the degree to which the public is taking appropriate action as instructed in messages.

TC/CFA 11 – Fatality Management
This capability links to the Target Capability for Fatality Management.

The "Implementation Plan for the National Strategy for Pandemic Influenza" (Homeland Security Council, May 2006) provides this guidance under *Fatality Management:*

> Given the anticipated increase in the number of deaths associated with an influenza pandemic, hospitals and health care facilities working with State, local, or tribal health officials and medical examiners should assess current capacity for refrigeration of deceased persons, discuss mass fatality plans and identify temporary morgue sites, and determine the scope and volume of supplies needed to handle an increased number of deceased persons. (p.112)

Identify surge resources to support the medical examiner's/coroner's mortuary operations as part of a regional fatality management plan, relative to catastrophic/mass fatality events such as pandemic flu.

[CFA 12 promulgated in FY-06 guidance is deleted. This capability is considered to be primarily the responsibility of emergency management.]

B. NIMS Implementation

MMRS Deployment Initiative

In support of the recently established NIMS Medical/ Public Health Working Group[3], MMRS jurisdictions are invited, on a voluntary basis, to participate in an initiative to create guidelines and procedures for resource-typing and credentialing, and development of deployment (intra-state, inter-state, and nationwide) operational policies and procedures, for components of their local MMRS program. Details on this initiative will be provided separately.*

NIMS Implementation Activities

The NIMS Integration Center (NIC) has issued "NIMS Implementation Activities for Hospitals and Healthcare Systems." [4] Specific emphasis elements for local MMRS preparedness and capabilities, as stated in the referenced guidance, are:

Element 3 - Multi-agency Coordination System

This is the basic concept and functionality of the MMRS program, and is directly relevant to the "Tiered Response System" [MSCC] guidance under TC-CFA1 – Strengthen Medical Surge Capabilities, above.

Element 6 - Develop and implement a system to coordinate appropriate hospital preparedness funding to employ NIMS across the organization.

These activities should be administered/coordinated by the local MMRS Steering Committee.

Element 8 - Participate in and promote interagency mutual-aid agreements, to include agreements with public and private sector and/or nongovernmental organizations.

This is relevant to several MMRS program requirements, including, the "Component Plan for Local Hospitals and Healthcare System," expansion of MMRS Operational Area, and Pandemic Influenza preparedness, continuity of operations, guidance, below.

Element 13 - Participate in an all-hazard exercise program based on NIMS that involves responders from multiple disciplines, multiple agencies and organizations.

Such exercises will, *prima facie,* involve local MMRS partners organizations.

Element 15 - Maintain an inventory of organizational response assets.

Such an inventory should be consistent with the medicines and medical supplies resource management requirement contained in TC/CFA2 - **Mass Prophylaxis,** above.

[3] NIMS Integration Center, inter-departmental memo, October 2006.
[4] NIMS Alert http://www.fema.gov/pdf/emergency/nims/imp_act_hos_hlth.pdf