Fiscal Year 2008

HOMELAND SECURITY GRANT PROGRAM

SUPPLEMENTAL RESOURCE: MMRS TARGET CAPABILITIES/CAPABILITY FOCUS AREAS AND COMMUNITY PREPAREDNESS

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U.S. DEPARTMENT OF HOMELAND SECURITY

MMRS TARGET CAPABILITIES

This supplement to the Fiscal Year 2008 Homeland Security Grant Program defines the Metropolitan Medical Response System (MMRS) Target Capabilities in correlation with the National Preparedness Guidelines (Guidelines). The Guidelines are supported by a capabilities-based approach to planning for major all-hazards events; thus, the Target Capabilities below constitute the primary federal guidance for MMRS jurisdictions. Reference to previous and continuing MMRS program guidance is also incorporated.

The Target Capabilities List (TCL) identifies and defines 37 specific capabilities that the Nation may need to achieve and sustain, depending on relevant risks and threats, in order to be prepared for all hazards. MMRS jurisdictions are uniquely suited to plan, organize, staff, equip, train and exercise to achieve many of the desired outcomes for one distinct capability: Emergency Triage and Pre-Hospital Treatment. Therefore, jurisdictions must give priority attention to improving Emergency Triage and Pre-Hospital Treatment capability within their operational area. Jurisdictions should give tertiary consideration to the remaining 10 supporting capabilities but also have the option of using grant funds to improve on any of the other allowable program activities identified in the MMRS column of Appendix 1, in accordance with State and/or UASI strategies related to medical mass casualty preparedness and response.

The FY08 HSGP also establishes two key funding priorities for MMRS: Measure Progress and Strengthen Preparedness Planning. Detailed information about FY08 HSGP funding priorities is contained in the "Introduction" section of the FY08 HSGP Guidance and Application Kit.

Sections A and B of this document describe those MMRS activities that support the priority capability and ten supporting capabilities. Sections C and D describe activities that support the DHS-HHS alliance and Community Preparedness.

A. Priority Capability

Emergency Triage and Pre-Hospital Treatment

MMRS jurisdictions will provide an inventory of capabilities to their State Administrative Agent (SAA) for submittal to the State Preparedness Officer no later than June 30, 2008. This inventory will document current progress toward enhancing Emergency Triage and Pre-Hospital Treatment capability. The inventory will include, at a minimum, a self-assessment of the jurisdiction's progress and/or capabilities in the following activities:

- Develop and Maintain Plans, Procedures, Programs and Systems
- Develop and Maintain Training and Exercise Programs
- Direct Triage and Pre-Hospital Treatment Tactical Operations

- Triage
- Provide Treatment
- Transport
- Demobilize Triage and Pre-Hospital Treatment

The Capabilities Inventory for Emergency Triage and Pre-Hospital Treatment satisfies previous grant years' requirement to maintain a local MMRS inventory of capabilities. Specific performance measures and tasks related to the above activities are contained in the TCL for Emergency Triage and Pre-Hospital Treatment. The TCL is available on the Lessons Learned Information Sharing (LLIS) portal at *http://www.llis.gov* and in the MMRS compartment of the Office for Domestic Preparedness (ODP) Secure Portal at *https://odp.esportals.com*.

In addition, during the FY08 period of performance, MMRS jurisdictions will refine plans and validate processes for:

- Integrating public and private emergency medical services into all aspects of emergency triage and pre-hospital treatment plans, processes, procedures, training and exercises
- Ensuring that responders are adequately trained to use personal protective equipment (PPE)
- Providing critical incident stress management to responders
- Managing the security and inventory of the personal belongings of patients.

B. Supporting Capabilities

MMRS jurisdictions may continue to strengthen the following supporting capabilities as needed, based on their most current assessment of the risks and vulnerabilities for their local operational area, and in accordance with State and UASI strategies as well as U.S. Department of Health and Human Services (HHS) preparedness and response funding programs. Jurisdictions are encouraged to reference the activities, critical tasks and performance measures identified in the TCL in order to assess whether vulnerability gaps exist locally for any of these supporting capabilities.

Medical Surge

The Medical Surge capability is a national priority because of the urgent need to enable our healthcare system, particularly hospitals, to handle large numbers of patients requiring immediate hospitalization following any type of incident. Emergency-ready hospitals and other healthcare entities must be able to work collectively to handle different types of injuries, including physical and psychological trauma, burns, infections, bone marrow suppression, or other chemical- or radiation-induced injuries. In anticipation of a mass casualty incident that exceeds the aggregate surge capacity of local hospitals, the community of medical providers must also have provisions in place

to immediately accommodate an influx of supplemental healthcare assets from mutual-aid partners, States, and the Federal Government.

MMRS jurisdictions are encouraged to refine their capability to rapidly and appropriately care for victims of a mass casualty event, placing emphasis on each of the critical tasks identified in the TCL for medical surge. In addition, MMRS jurisdictions will:

- Develop and test plans and procedures for managing the “worried well,” or those individuals who are asymptomatic
- Ensure that appropriate medical countermeasures resources are locally available, including vaccinations and prophylaxis, for emergency responders and their families
- Ensure that responders possess and are adequately trained to use PPE.

Mass Prophylaxis

In addition to the critical tasks identified in the TCL, MMRS jurisdictions will work with their local/regional public health officials to identify and test local agency roles and responsibilities for receiving, managing and incorporating federal resources such as the Strategic National Stockpile (SNS) during a large-scale medical incident.

In support of the CDC’s Cities Readiness Initiative (CRI), all MMRS jurisdictions in metropolitan statistical areas that participate in CRI must update their mass prophylaxis plans to support the distribution of pharmaceuticals to their entire population within 48 hours of receipt of the Strategic National Stockpile.

WMD/Hazardous Materials Response and Decontamination

An attack utilizing WMD could potentially cause mass casualties, compromise critical infrastructure, adversely affect our economy, and inflict social and psychological damage that could negatively affect the American way of life.[1] MMRS jurisdictions will update their baseline plan for responding to a chemical, radiological, nuclear or explosive WMD event to ensure that a hazardous materials release is rapidly identified and mitigated; victims exposed to the hazard are rescued, decontaminated and treated; the impact of the release is limited; and responders and at-risk populations are effectively protected.

In addition to addressing the critical tasks identified in the TCL, MMRS jurisdictions will develop and assess their capability to accomplish the following:

- Responder decontamination resources are in place and staffed within 30 minutes
- Patient mass decontamination resources are in place, staffed and operational within 30 minutes.

[1] Homeland Security Presidential Directive 18: Medical Countermeasures Against Weapons of Mass Destruction, Jan. 31, 2007.

- Decontaminate EMS vehicles, apparatus, resources and supplies in accordance with established procedures.

Medical Supplies Management and Distribution

MMRS jurisdictions will assess their local capability to procure and manage medical supplies and equipment prior to an incident, and to transport, distribute and track those materials during an incident. Jurisdictions should identify, plan for and test alternate modes for delivery of supplies to areas where ground transportation infrastructure is vulnerable to heavy damage, disruption and/or obstruction. Plans should describe the means, organization and processes for locating, procuring and distributing medical resources.

MMRS jurisdictions will coordinate with local/regional public health officials to develop a plan for managing the collective medical resources associated with the CDC Cities Readiness Initiative, Urban Areas Security Initiative and other Federal, State and local programs. MMRS jurisdictions will ensure that all stockpiled pharmaceuticals and related supplies in their Operational Area are aggregated into a NIMS-compliant master resource list and management system.

The MMRS pharmaceutical cache provides rapidly-deployable emergency prophylaxis for first responders, their families and, as determined by the MMRS Steering Committee, the general public. All MMRS jurisdictions must maintain a logistical resource inventory of the MMRS local pharmaceutical cache to be provided electronically to DHS upon request. This inventory must include the following information:

- Name and title of pharmaceutical logistics officer or point of contact
- Product nomenclature, quantity and unit of dosage
- Product Lot/Stock Number, cost and expiration date
- Pharmaceutical cache storage and maintenance conditions, including environmental controls, security and inspection/rotation schedule.

Emergency Public Information and Warning

Jurisdictions must be capable of alerting citizens to emergency situations in order to minimize loss of life or injuriy, prevent or minimize 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 nuclear/radiological, biological, chemical and improvised explosives events are covered in separate message templates, and include self-help contamination avoidance and decontamination actions when applicable. Ensure plans and arrangements for multiple modes of message dissemination include accessible

communications for special needs populations, such as those with hearing and vision impairments, 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.

Interoperable Communications

The desired outcome of a local jurisdiction's communications program may be measured by its capability to maintain a continuous flow of critical information among multi-jurisdictional and multi-disciplinary emergency responders, command posts, health and medical providers and governmental officials. MMRS jurisdictions must maintain this capability for the duration of a mass casualty emergency response operation, in compliance with the National Incident Management System (NIMS). In addition, the jurisdiction's continuity of operations plan for public safety communications should address critical components, networks, support systems, personnel, and an appropriate level of redundant communications systems in the event of an emergency.

Information Sharing and Collaboration

The emergence of an infectious disease, whether naturally occurring or the deliberate bioterrorist release of a pathogen, could result in a serious loss of life and social disruption. Information sharing and collaboration among the medical, public health, animal health, and intelligence communities will be necessary in order to minimize the medical and social consequences of the resulting disease outbreak.[2]

MMRS jurisdictions are encouraged to support the development and enhancement of a medical intelligence infrastructure that will achieve a coordinated awareness of, prevention of, protection against, and response to a threatened or actual terrorist attack, major disaster, disease outbreak or other public health emergency. This capability will support a multi-jurisdictional, multi-disciplinary exchange and dissemination of information and intelligence among entities at all levels of government. Fatality management activities also need to be incorporated in surveillance and intelligence sharing networks, such as fusion centers, to identify sentinel cases of bioterrorism and other public health threats.

Regional Collaboration

Formal arrangements among geographic regions enable governments at all levels to coordinate preparedness activities more effectively, spread costs, pool resources, disburse risk, and thereby increase the overall return on investment. Therefore, expanding regional collaboration is a continuing national priority. MMRS Steering Committees are encouraged to discuss their existing MMRS operational area, and work with neighboring communities and their State to:

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[2] Senate testimony by Jonathan B. Tucker, Ph.D., Director, Chemical and Biological Weapons Nonproliferation Program, Center for Nonproliferation Studies, Monterey Institute of International Studies, Oct. 3, 2001.

- Develop and update mutual aid agreements based on existing capabilities, including personnel and equipment
- Develop integrated, collaborative strategies for expanding the MMRS operational area as needed.

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 and special-purpose resources.

- 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.

Fatality Management

MMRS jurisdictions should develop, maintain and continually strive to enhance their capability to independently manage an event involving mass fatalities. Plans should anticipate local fatality management without federal assistance for the first 72 hours following a mass fatality incident. The National Preparedness Guidelines and Target Capabilities List provide preparedness measures; however, MMRS jurisdictions should develop a minimum essential capability to accomplish the following:

- **Safety precautions** – All persons involved in mass fatality management understand and abide by hazardous materials regulations regarding the safe handling, transport and disposition of remains. Those with the authority and responsibility to establish and implement standards for fatality management (usually coroner/medical examiner) will impose all necessary restrictions on transportation and disposition of remains.
- **Remains processing** – Unless catastrophic circumstances dictate otherwise, human remains are examined, identified and released to the next-of-kin's funeral home with a complete, certified death certificate. Reports of missing persons and ante mortem data are collected and released to authorized agencies.
- **Notification of Next of Kin** – Provide updated information to victims' family members prior to release to the media.
- **Information sharing** – Provide law enforcement agencies the information needed to investigate and prosecute the case successfully. Provide families incident-specific support services.
- **Resource management** – Identify local/regional surge resources to support mortuary operations as part of a regional mass fatality management plan.

Isolation and Quarantine

Isolation and Quarantine strategies provide the capability to protect the health of the community at large in order to contain the spread of disease. Isolation of ill individuals may occur in homes, hospitals, designated health care facilities, or alternate facilities to prevent the spread of communicable disease to uninfected populations. Quarantine refers to the separation and restriction of movement of persons who, while not yet ill, have been exposed to an infectious agent and may become infectious.

MMRS jurisdictions will coordinate with their local/regional public health counterparts to develop, integrate and/or update plans, and organize, train and test the capability to accomplish the following:

- Segregate or restrict the movement of individuals who are ill, exposed, or likely to be exposed.
- Ensure essential support services (e.g., food) are available to individuals placed in isolation or quarantine, and their health is monitored in order to limit the spread of a contagious disease.
- Clearly define and communicate legal authorities for isolation/quarantine measures to responding agencies and the public.
- Provide logistical support to maintain isolation/quarantine measures until the danger of contagion has elapsed.

C. DHS-HHS Alliances

In FY 2007 the Hospital Preparedness Program (formerly the National Bioterrorism Hospital Preparedness Program administered through HRSA) moved to the Office of the Assistant Secretary for Preparedness and Response (ASPR) at HHS. The program still encourages the use of the Medical Surge Capacity and Capability (MSCC) Tiered response system. Due to passage of the Pandemic and All Hazards Preparedness Act in December 2006, all Hospital Preparedness Program activities must be consistent with the five preparedness goals outlined in the Act:

1. **Integration** -- Ensure the integration of public and private medical capabilities with public health and other first responder systems.
2. **Medical** – Increase the preparedness, response capabilities, and surge capacity of hospitals, other health care facilities (including mental health facilities), and trauma care and emergency medical service systems, with respect to public health emergencies. This shall include developing plans for the following:
    - Strengthening public health emergency medical management and treatment capabilities
    - Medical evacuation and fatality management

- Rapid distribution and administration of medical countermeasures, specifically to hospital based healthcare workers and their family members or partnership entities
- Effective utilization of any available public and private mobile medical assets and integration of other Federal assets
- Protecting health care workers and health care first responders from workplace exposures during a public health emergency.

3. **At-risk individuals** – Being cognizant of and prepared for the medical needs of at-risk individuals in their community in the event of a public health emergency.
4. **Coordination** -- Minimizing duplication of, and ensuring coordination between, Federal, State, local, and tribal planning, preparedness, response and recovery activities (including the State Emergency Management Assistance Compact). Planning shall be consistent with the National Response Plan, or any successor plan, the National Incident Management System and the National Preparedness Goal as well as any State and local plans.
5. **Continuity of operations** -- Maintaining vital public health and medical services to allow for optimal Federal, State, local, and tribal operations in the event of a public health emergency.

MMRS jurisdictions are expected to collaborate with their local, regional and State public health and medical counterparts to mutually support, deconflict, align and synchronize any plans, processes, strategies and investments related to the following:

- Interoperable communications systems
- Patient tracking system
- Emergency Systems for Advance Registration-Volunteer Health Professionals (ESAR-VHP) and Medical Reserve Corps programs
- Fatality management
- Hospital evacuation.

D. Community Preparedness

Homeland Security Presidential Directive 21, released in October 2007, identifies community resilience as one of the current and most critical components of public health and medical preparedness. Toward that end, MMRS jurisdictions are encouraged to be a part of the community preparedness planning process through the local Citizen Corps Council, where one exists, to build an integrated, comprehensive community preparedness effort.

Program Responsibilities

MMRS jurisdictions will coordinate their efforts related to the common target capability of Community Preparedness and Participation with their state and local Citizen Corps Council(s). In addition, all citizen involvement in emergency preparedness, mitigation, response and recovery should be coordinated with the State Citizen Corps Program

Manager. A listing of current State Citizen Corps Program Managers is available at *http://www.citizencorps.gov/councils*.

MMRS jurisdictions should consider Community Preparedness and the critical role that citizen support provides to first responders in supporting surge capacity. MMRS jurisdictions are encouraged to coordinate their Community Preparedness planning efforts with their local Citizen Corps Council, and incorporate volunteers into local and regional training and exercises where appropriate.