



DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
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IN REPLY REFER TO
BUMEDINST 3440.10A
BUMED-M3B4
26 Jun 2015

BUMED INSTRUCTION 3440.10A

From: Chief, Bureau of Medicine and Surgery

Subj: NAVY MEDICINE FORCE HEALTH PROTECTION EMERGENCY MANAGEMENT PROGRAM

Ref: (a) SECNAVINST 3400.4
(b) OPNAVINST 3440.17A
(c) OPNAVINST 3440.16D
(d) DoD Instruction 6055.17 of 13 Jan 2009
(e) DoD Instruction 6200.03 of 5 Mar 2010
(f) CNICINST 3440.17
(g) CNICINST 3440.3
(h) MCO 3440.9
(i) 29 CFR 1910
(j) DoD Instruction 6055.01 of 14 Oct 2014
(k) OPNAVINST 5100.23G
(l) National Response Framework
(m) National Incident Management System (NIMS)
(n) Hospital Incident Command System (HICS) Guidebook
(o) SECNAV M-5210.1 of January 2012
(p) BUMEDINST 3500.3A
(q) SECNAV M-5214.1 of December 2005

Encl: (1) Navy Medicine (NAVMED) Force Health Protection (FHP) Emergency Management (EM) Program Manual

1. Purpose. To execute policy as delineated in references (a) through (e), provide guidance and operational structure, and assign responsibilities for implementing a comprehensive, all-hazards NAVMED FHP EM Program at all Bureau of Medicine and Surgery (BUMED) commanded activities.

2. Cancellation. BUMEDINST 3440.10.

3. Applicability and Scope

a. Applicability. This instruction applies to all BUMED commanded activities. It does not apply to mobile, expeditionary, afloat, or other deployed personnel.

b. Scope. This instruction defines the roles and responsibilities of all BUMED commanded activity commanders, commanding officers (COs), officers in charge (OICs), medical treatment facility (MTF) emergency managers (MEMs), and non-MTF emergency management officers

(EMOs) to implement and sustain a comprehensive FHP EM program as required per references (a) through (e), consistent with references (f) through (h), and as delineated in this instruction. It also establishes capabilities for all-hazards preparedness, mitigation, prevention, first receiver response, and recovery to sustain mission readiness, save lives, reduce human suffering, and protect property. This instruction also serves as the FHP companion to references (f) through (h). References (f) and (g) are available at: <https://g2.cnic.navy.mil/cnichome/Pages/CNICHome.aspx>.

(1) All BUMED commanded activities shall follow worker safety and health requirements in executing this program as designated in references (i) through (k).

(2) BUMED-M3B4 shall collaborate with Commander, Navy Installations Command (CNIC) and Marine Corps Installation Command (MCICOM) to ensure the NAVMED FHP EM Program standards and policies are aligned with key stakeholders.

(3) This instruction establishes a NAVMED FHP EM Program and unifies the FHP component of programs that address EM, anti-terrorism (AT), critical infrastructure protection (CIP), and chemical, biological, radiological and nuclear (CBRN) preparedness programs, to promote efficiency and eliminate duplication.

4. Definitions

a. Medical Treatment Facility (MTF). A medical facility operated by the military that may provide inpatient or outpatient care to active duty military and eligible TRICARE beneficiaries. MTF capabilities vary from limited acute care clinics to teaching and tertiary care medical centers. MTFs are under the leadership of a commander, CO, or OIC and report to a NAVMED Region commander.

b. Non-Medical Treatment Facility (non-MTF). Any BUMED commanded activity not meeting the definition of an MTF is considered a non-MTF for the purpose of this instruction. Non-MTFs vary from research and training facilities to logistics activities and many do not fall under the NAVMED Region commands, but report directly to BUMED Headquarters (HQ). For those requirements established in this instruction that require reporting via, or approval of a NAVMED Region commander, it is understood that non-MTFs which do not report to a NAVMED Region commander will report via or request approval from their immediate superior in command (ISIC).

c. MTF Emergency Manager (MEM). Per reference (e), the MEM serves as the MTF lead for EM and is the primary point of contact with the host installation emergency manager (IEM), as well as the EM lead with any local civilian medical facilities and emergency response organizations. MEMs coordinate EM planning and preparedness, and assist in the execution of all-hazards EM activities on behalf of the MTF commander, CO, or OIC. Assignment as an MEM is a full-time position at Tier 1 and 2 facilities, and a primary collateral duty assignment at Tier 3 and 4 MTFs.

d. Emergency Management (EM). A risk-based, comprehensive and continual process to prepare for, respond to, and recover from an incident that threatens life, property, operations, or the environment.

e. Emergency Management Officer (EMO). The EMO duties and responsibilities mirror those of the MEM, but are assigned at non-MTF facilities, including BUMED HQ, NAVMED Regions, school commands, laboratories, detachments, and research facilities. At BUMED HQ and NAVMED Regions, the EMO position will be staffed by a full-time Federal civilian EM specialist or active duty military in the pay grade of O-4 or above. At all other locations, the EMO duties may be assigned as either a full-time position, or a primary collateral duty, as determined by the facility commander, CO, or OIC.

f. First Responders. First responders are defined as personnel who immediately deploy to the disaster scene to provide initial command and control (C2), save lives, stabilize the incident, and suppress and control hazards. Medical first responders are dispatched to the scene at the request of the incident commander and typically include ambulance services or emergency medical service (EMS).

g. Emergency Responders. Emergency responders are defined as personnel who deploy to the scene after first responders in order to expand C2 or perform support functions. Medical emergency responders are follow-on medical teams dispatched to the scene in support of the first responders, as well as non-clinical medical teams requested by the incident commander, such as a mass casualty response team provided by the MTF.

h. First Receivers. First receivers are a subset of emergency responders who receive patients for treatment at the MTF. They include clinicians and other medical staff who have a role in receiving and treating patients (triage, decontamination, clinical services, security, etc.) and those whose roles support these functions (manpower, administration, etc.). First receivers also decontaminate, triage, and treat self-reporting patients, including those who have been contaminated by hazardous substance(s) during an emergency event.

i. Hospital Command Center (HCC). An emergency operations center (EOC)-like capability at an MTF. This capability provides commanders, COs, and OICs with robust command, control, communications, computers and intelligence (C4I) tools.

j. Assessment. The aggregation of numerous evaluations, informal results, actual operations, and any other available and pertinent feedback of an exercise, plan, or policy. This data is subjected to an official and comprehensive analysis by all relevant stakeholders to determine the organization's capability to execute the exercise, plan, or policy in the future.

k. Review. An administrative effort to determine whether exercises, plans, and policies are kept current by determining whether they have been updated as required, and by identifying and correcting fundamental errors.

5. Background. The terrorist attacks on the United States in the fall of 2001 resulted in a historic restructuring of the Federal Government's strategies on homeland defense and civil support, and in rapidly evolving concepts of defense against all forms of disasters, as well as a unified approach to incident management. Subsequent Department of Defense (DoD) policy established the protection of installation resources and personnel is paramount to military

readiness and the effectiveness of EM planning will directly impact the ability of all supporting MTFs, installations, and commands to successfully execute their operational missions. Reference (f) is the principal guidance for EM onboard U.S. Navy (USN) installations and replaces the disaster preparedness construct previously employed by the USN. Reference (h) is the counterpart onboard U.S. Marine Corps (USMC) installations. References (a) through (e) direct the implementation of an “all-hazards” EM program. The intent of the NAVMED FHP EM Program is to establish and sustain the capabilities for all-hazards preparedness, mitigation, prevention, first receiver response and recovery necessary to sustain mission readiness, save lives, reduce human suffering, and protect property. Additionally, there is significant overlap across the DoD policy spectrum within the related program areas of EM, AT, CIP, and CBRN preparedness. The NAVMED FHP EM Program is intended to complement, without duplicating the requirements and capabilities addressed in these related program areas.

6. Policy. All BUMED commanded activities shall plan for and prepare to respond to all-hazard emergencies to prevent and/or mitigate the impact of any contingency on their critical missions or mission-essential functions.

a. The NAVMED FHP EM Program Manual (enclosure (1)) shall serve as the principal guidance within BUMED and across all BUMED commanded activities for implementing all-hazards EM plans as directed by references (a) through (e).

b. All BUMED commanded activities shall develop a local, all-hazards FHP EM plan that supports the installation EM plan and is aligned with USN, USMC, or Joint Base regional EM plans, as required by references (a) through (e).

c. Within the U.S., its territories, and possessions, commanders, COs, and OICs of BUMED commanded activities shall be prepared to assist civil authorities under local immediate response authority or through Defense Support of Civil Authorities (DSCA), as outlined in references (c) and (l).

d. All BUMED commanded activities shall implement the Hospital Incident Command System (HICS) as the approved Incident Command System (ICS), which meets the requirements of reference (m) and supports reference (e). Reference (n) and section 2 of enclosure (1) provide further clarification of HICS and additional information is located at <http://www.emsa.ca.gov>.

7. Responsibilities

a. The Deputy Chief, Medical Operations (BUMED-M3) shall ensure full coordination and collaboration across all BUMED commanded activities for the NAVMED FHP EM Program.

b. Director, BUMED Emergency Preparedness (BUMED-M3B4) is responsible for oversight and management of the NAVMED FHP EM Program.

c. The EM division chief reports to the Director of M3B4 (or Force Health Protection) and serves as the program manager for the NAVMED FHP EM Program, as well as the BUMED

subject matter expert in addressing FHP for EM and the specific health sector aspects of the DoD Critical Infrastructure Protection (CIP), civilian-military (CIV-MIL) operations, and other EM program issues. Specific responsibilities include to:

- (1) Develop, execute, and maintain an overarching and integrated program.
 - (2) Establish a framework for EM program support and oversight at all BUMED commanded activities. Such oversight and support shall include, but is not limited to:
 - (a) Analysis of vulnerabilities of BUMED commanded activities from all-hazards incidents.
 - (b) Definition of EM program standards and requirements.
 - (c) Analysis of readiness, preparedness, and response capabilities.
 - (d) Risk-based prioritization of program capabilities.
 - (e) EM program development.
 - (f) Resource identification and procurement.
 - (g) Exercise development and evaluation.
 - (h) Incorporation of relevant lessons learned.
 - (3) Determine expected competencies for BUMED commanded activity personnel supporting installation FHP programs.
 - (4) Identify education and training requirements for BUMED commanded activity personnel in support of the FHP EM program.
 - (5) Determine materiel requirements and standards in support of the program.
 - (6) Maintain appropriate liaison and collaborate with all relevant DoD program offices and Federal agencies to further the development of EM standards, coordination, integration, interoperability, and information sharing.
- d. The CO, Navy and Marine Corps Public Health Center (NMCPHC) shall:
- (1) Provide occupational and environmental medicine (OEM) and industrial hygiene (IH) technical and scientific subject matter expert (SME) reach-back support to the NAVMED EM program.
 - (2) Serve as the public health surveillance hub for the NAVMED EM program.

(3) Ensure occupational medicine and IH support for the EM program is consistently aligned with the governing standards and policies per reference (k).

(4) Provide EM related risk communication support and training.

e. The Naval Operational Medical Lessons Learned Center (NOMLLC) shall provide the archival Web site for retaining program after action reports (AARs) and lessons learned per references (o) and (p).

f. The Director for Administration (BUMED-M09B1) shall develop, implement, and execute the Occupant Emergency Plan (OEP) at BUMED HQ.

g. The Director, Medical Legal Affairs (BUMED-M09B9) shall provide legal consultation, as needed.

h. The Deputy Chief, Total Force (BUMED-M1) shall ensure all NAVMED FHP EM Program personnel requirements are established and documented in manpower and personnel systems. The Deputy Chief, Reserve Policy and Integration (BUMED-M10) shall leverage, wherever possible, Navy Reserve capabilities to promote and facilitate an effective NAVMED FHP EM Program.

i. The Deputy Chief, Research and Development (BUMED-M2) shall ensure full coordination and collaboration across all BUMED commanded activities for all CBRN equipment, doctrine, and technologies that support the NAVMED FHP EM Program.

j. The Director, Countering Weapons of Mass Destruction Defense Directorate (WMD) (BUMED-M22) is responsible for oversight and management of all CBRN programs supporting activities, including:

(1) Ensuring appropriate representation within the Chemical and Biological Defense Program (CBDP) financial planning construct.

(2) Conducting technology and equipment reviews on a continual basis to promote fielding and the regular updating of effective and efficient CBRN preparedness and response capabilities across the Enterprise.

(3) Providing CBRN technical and SME support, including reach back from the Naval Medical Research Command (NMRC) and its subordinate activities.

(4) Ensuring appropriate representation within the Joint Capabilities Integration Development System (JCIDS).

(5) Identify current and emerging issues that will impact the NAVMED CBDP.

(6) Collaboration with the Intelligence Community (IC) to promote an informed, trained, and robust medical information and medical intelligence capability to ensure situational awareness of worldwide threats and risk.

k. The Deputy Chief, Installations and Logistics (BUMED-M4) shall assist in the management and implementation of the logistics and facilities support aspects of the EM program. Additionally, BUMED-M4 will provide safety and Occupational Health (OH) support, including Industrial Hygiene (IH) and AT policy, for the NAVMED FHP EM Program.

l. The CO, Naval Medical Logistics Command (NMLC) shall ensure sufficient resources are allocated to establish and maintain readiness in the area of medical logistics, including:

(1) Ensuring revisions to any related assemblages are captured in the Defense Medical Logistics Standard Support (DMLSS) Automated Information System (AIS).

(2) Providing DMLSS assemblage management training.

(3) Providing training for biomedical equipment repair and maintenance.

(4) Providing support for the Food and Drug Administration Shelf-Life Extension Program (SLEP).

m. The Deputy Chief, Education and Training (BUMED-M7) will coordinate with Commander, Navy Medicine Education and Training Command (NMETC) to ensure current, comprehensive education and training program to support readiness and public health preparedness initiatives.

n. The Deputy Chief, Resource Management/Comptroller (BUMED-M8) shall assist in identifying funding necessary to facilitate the execution and sustainment of the NAVMED FHP EM Program, to include the storage and phased replacement of EM equipment.

o. The BUMED Public Affairs Officer (BUMED-M09B7) shall serve as the point of contact for guidance regarding media inquiries and public affairs related information.

p. The BUMED Medical Inspector General (IG) (BUMED-M00IG) shall include the review and assessment of command programs as part of their inspection program. Specific Medical IG assessment objectives will include:

(1) Review current hazard assessments (HAs) and vulnerability assessments (VAs) to assess whether the results have been adequately addressed and incorporated into the command EM plan, used to drive training and exercise objectives, and reported to the applicable NAVMED Region.

(2) Inspect for adherence to NAVMED FHP EM Program requirements.

q. NAVMED Region commanders shall provide leadership oversight and management to support the implementation of the NAVMED FHP EM Program at all BUMED commanded activities within their respective regions. Additionally, NAVMED Region commanders shall:

(1) Appoint a full-time Regional and Deputy EMO in writing.

(2) Ensure EM program HAs are conducted at least every 3 years and reviewed annually, and that VAs are completed annually, per references (b) and (d).

(3) Ensure the assigned regional EMO and Public Health Emergency Officer (PHEO) participate in the EM Working Group (EMWG) at each CNIC Region within their assigned area of responsibility per reference (f).

r. MTF Commanders, COs, and OICs shall:

(1) Implement and execute an effective EM program consistent with this instruction and applicable references and supporting publications.

(2) Appoint a MEM in writing. MEMs at Tier 1 and 2 facilities shall be assigned as full-time positions. MEMs at Tier 3 and 4 activities may be staffed as collateral duty assignments. The assignment of any collateral duties to MEMs at Tier 1 and 2 facilities, as well as the assignment of additional collateral duties to MEMs at Tier 3 facilities is specifically prohibited.

(3) Ensure the assigned MEM and PHEO attend the host or local USN, USMC, or Joint Base installation EMWG per references (f) and (h).

(4) Ensure the assigned MEM and PHEO attend the NAVMED Region EMWG per reference (e); MEMs should attend in person whenever practical, and when distance or limited travel funds preclude attendance, MEMs shall attend virtually, via telephone or video conferencing.

(5) Commanders, COs, and OICs of stand-alone MTFs and activities shall establish a multi-disciplinary EMWG comprised of command, subordinate activity, tenant commands, and relevant external activity EM representatives and SMEs, to facilitate planning and coordination of EM activities through the MEMs. Tier 4 MTFs and other small BUMED commanded facilities without sufficient manpower to establish their own EMWG shall instead, participate in their host installation and NAVMED Region EMWGs.

(6) Ensure full participation and integration in local EM related training, exercises, and activities that incorporate a medical component or events.

(7) Ensure local staff education and training supports the EM program requirements by updating and maintaining applicable training databases and systems.

s. Non-MTF commanders, COs, and OICs shall assign an EMO in writing, who is responsible for developing a NAVMED FHP EM Program tailored to their facility's specific role and for integrating their EM plan into the local/host installation plan, and if applicable, local civilian community EM programs. Full-time or collateral duty assignments will be appointed at the discretion of the commander, CO, and OIC. EMO appointees, as described in this instruction, should be assigned positions that provide adequate time to fully perform all of the EM duties assigned.

t. All MEMs/EMOs shall:

(1) Execute an effective facility/regional EM program that complies with the requirements established in this instruction, and is functionally aligned as a nested component within the host USN/USMC or Joint Base installation and regional EM programs.

(2) MEMs will be responsible for overall command implementation and management of the NAVMED FHP EM Program. The MEM shall also serve as principle liaison with local medical communities, EM committees, and parent command EM committees. MEMs, EMOs, and other essential EM response personnel shall not be assigned collateral duties such as personnel accountability, other than accounting for subordinate staff members. These emergency essential personnel must be fully committed to leading and coordinating emergency response operations for their assigned activity.

(3) Maintain technical capabilities as described in reference (e) and section 4 of enclosure (1).

(4) Review and validate the facility/regional EM plans annually, revising it every 3 years or more frequently if necessary.

8. Implementation Guidance. This instruction is effective immediately.

9. Records Management. Records created as a result of this instruction, regardless of media and format, shall be managed per reference (o).

10. Reports Exemption. The reporting requirements contained in enclosure (1), section 1, Standard 4, paragraph 2c(5), and section 1, Standard 10, paragraph 5 are exempt from reports control per reference (q), part I, paragraph 3.


P. B. COE
Acting

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26 Jun 2015



NAVY MEDICINE (NAVMED)
FORCE HEALTH PROTECTION (FHP)
EMERGENCY MANAGEMENT (EM) PROGRAM MANUAL

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SECTION 1

EMERGENCY MANAGEMENT PROGRAM STANDARDS

- Ref: (a) SECNAVINST 3400.4
(b) OPNAVINST 3440.17A
(c) OPNAVINST 3440.16D
(d) DoD Instruction 6055.17 of 13 Jan 2009
(e) DoD Instruction 3020.52 of 18 May 2012
(f) CNICINST 3440.17
(g) CNICINST 3440.3
(h) MCO 3440.9
(i) DoD Instruction 6055.01 of 14 Oct 2014
(j) DoD Directive 3025.18 of 29 Dec 2010
(k) DoD Instruction 1400.32 of 24 Apr 1995
(l) BUMEDINST 3500.5
(m) BUMEDINST 7050.1B
(n) National Incident Management System (NIMS)
(o) DoD Instruction 6200.03 of 5 Mar 2010
(p) BUMEDINST 3030.3A
(q) BUMEDINST 3500.3A
(r) BUMEDINST 6200.17A
(s) Navy and Marine Corps Public Health Center, Medical Surveillance Procedures Manual and Medical Matrix (NMCPHC-TM-OM 6260)
(t) National Response Framework
(u) Hospital Incident Command System (HICS) Guidebook
(v) BUMEDINST 3440.12
(w) The Joint Commission – Hospital Accreditation Program, Chapter: Emergency Management
(x) OPNAVINST 5100.23G
(y) DoD Instruction 1322.24 of 6 Oct 2011
(z) MCO 3440.8
(aa) OSHA 3249 Best Practices for Hospital-based First Receivers
(bb) BUMEDINST 6710.71A
(cc) BUMEDINST 3500.6
(dd) BUMEDINST 1500.29A

1. Purpose. Define and align Navy Medicine (NAVMED) Force Health Protection (FHP) Emergency Management (EM) Program standards at all Bureau of Medicine and Surgery (BUMED) commanded activities with standards issued by references (a) through (dd) of this manual.

2. Applicability. All references herein after pertain only to this section.

3. Background

- a. EM replaces the “disaster preparedness” construct previously utilized by NAVMED for contingency planning and preparations.
- b. The close alignment of standards in the NAVMED FHP EM Program with the integration of BUMED commanded activities into installation and regional EM programs will significantly help facilitate interoperability in an all-hazards environment and across the EM spectrum.
- c. The NAVMED FHP EM Program for the purpose within this manual will be referred to as the “EM Program.”

4. Responsibility. Medical treatment facility (MTF) emergency managers (MEMs) and non-MTF emergency management officers (EMOs) shall establish and maintain standards as delineated in this manual. BUMED commanded activity commanders, commanding officers (COs), and officers in charge (OICs) shall adopt and maintain these EM program standards.

Standard 1: Program Management

1. The EM program establishes management guidelines that delineate operational and administrative command responsibilities. BUMED commanded activity MEMs and non-MTF EMOs shall be responsible for preparing for, responding to, recovering from and mitigating the effects of all-hazards emergencies. The EM Program will be measured against existing standards. A process for continuous quality improvement will be instituted and monitored through exercise, assessment, lessons learned, and analysis.
2. BUMED commanded activities shall designate a MEM or EMO as described in this instruction, and per references (a), (b), (f), and (o). NAVMED Region commanders, COs, and OICs shall designate the appropriate number of personnel to properly support and manage the EM Program and staff the medical emergency responder requirements for the host installation EM program. The MEM/EMO shall coordinate and work closely with their Commander, Navy Installations Command (CNIC), U.S. Marine Corps (USMC) or Joint Base regional and installation emergency managers, as well as their support staff.
3. Tenant MTFs and non-MTF activities shall coordinate with host installation EM program managers as outlined in applicable memorandum of understanding or agreement (MOU/MOA). Coordination shall include active participation in EM preparedness, response, and recovery efforts, as required by CNIC or USMC regional and/or host installation EM programs.
4. The diversity in size, staffing and equipment at BUMED commanded activities across the enterprise results in a wide spectrum of EM preparedness and response capabilities, ranging from minimal to robust. Small TRICARE outpatient clinics without any uniform staff and stand-alone NAVMED research facilities are representative of activities with minimal EM capabilities, while large medical centers with emergency rooms and hundreds of staff represent activities with the most robust EM capabilities. Although this instruction applies to all BUMED commanded activities, the level of effort required to establish, sustain, and manage an effective program is

Standard 1: Program Management (Continued)

proportional to the EM preparedness and response capabilities required. Accordingly, the EM program manager (MEM/EMO) assignment is a full-time position at BUMED headquarters (HQ), the NAVMED Region commands and the larger MTFs (Tier 1 and 2). The following table summarizes major program requirements by BUMED activity type:

Table 1.1 EM Program Requirements by Activity Type

Program Requirement	BUMED HQ and Regions	Tier 1-3 MTFs	Tenant Command Tier 4 MTFs and non-MTFs	Stand-alone Tier 4 MTFs and non-MTFs
Assign MEM/EMO	Yes	Yes	Yes	Yes
Establish EM Program	Yes	Yes	Yes	Yes
Participate in host installation EM/OEP program	Yes	Yes	Yes	N/A
Maintain and exercise Mass Notification, Shelter in Place, and Evacuation Plans	Yes	Yes	Yes	Yes
Maintain and exercise a Mass Casualty/Mass Care Plan	N/A	Yes ¹	N/A	N/A
Maintain and exercise a Pandemic Influenza (PI) Response Plan	Yes	Yes	Yes	Yes
Maintain and exercise a COOP Plan	Yes	Yes	Yes	Yes
Ensure a current Vulnerability Assessment (VA) and Hazard Assessment (HA) is maintained	Yes	Yes	Yes	Yes
Maintain EM and PI stockpile equipment and pharmaceuticals	N/A	Yes	N/A	N/A
Ensure required EM training is completed and documented	Yes	Yes	Yes	Yes

¹ Applies to Tier 2 and 3 MTFs required to maintain and field a mass casualty response capability.

Standard 2: Personnel Categorization

1. NAVMED personnel categorization is aligned per reference (b).
2. The EM Program focuses on the preparedness, response, and recovery capabilities of Category 5 personnel to ensure the protection of Category 1-4 personnel, while providing a comprehensive, all-hazards Continuity of Operations (COOP) plan.
3. The following definitions are provided for the five categories of personnel:
 - a. Category 1: Per references (b), (f), and (k), emergency-essential U.S. military personnel, Department of Defense (DoD) civilians, and DoD contractor (or subcontractor) personnel who perform mission-essential functions. All BUMED commanded activity commanders, COs, and OICs will ensure all Category 1 personnel are designated in writing.
 - b. Category 2: Other U.S. personnel, including:
 - (1) U.S. military family members living on or off a military installation.
 - (2) Non-emergency essential U.S. military personnel, USN and USMC or Federal civilian employees, and other persons covered by reference (k).
 - (3) USN/USMC contractor (and subcontractor) employees other than those performing emergency-essential functions.
 - (4) Employees of other U.S. Government agencies (OGAs).
 - (5) Other U.S. Government contractor (and subcontractor) employees.
 - c. Category 3: Other personnel supporting U.S. military operations, including:
 - (1) Personnel (non-U.S. citizens) who are employees of the USN or a USN contractor (or subcontractor), and who are not included in Categories 1 or 2.
 - (2) Foreign military personnel employed by the host nation (HN) government or by contractors of the HN government.
 - d. Category 4: Allied/coalition nation personnel, including HN personnel and third country nationals the U.S. may assist pursuant to an international agreement approved by the Department of State (DoS), combatant commander or as directed by the Secretary of Defense (SECDEF), such as allied/coalition military forces, government officials, and emergency response personnel.
 - e. Category 5: First responders/receivers and support personnel who are U.S. military personnel, DoD civilians, and/or contractor personnel, including, but not limited to:

Standard 2: Personnel Categorization (Continued)

(1) First responders and first receivers, such as: MTF providers, EM personnel; fire and emergency services personnel; hazardous material (HAZMAT) teams; Naval Security Forces (NSF); emergency medical service (EMS) personnel; explosive ordnance disposal (EOD) teams.

(2) EM support personnel, such as: Public Health Emergency Officers (PHEOs); 911 dispatch center personnel; Shore Support Center (SSC), Regional Operations Center (ROC), and Emergency Operations Center (EOC) personnel, as well as Medical Operations Center (MOC), Medical Regional Command Center (MRCC), Hospital Command Center (HCC) personnel; emergency response teams (ERT) and mass care; mass fatality; and mortuary affairs personnel, safety and occupational health (SOH), industrial hygiene (IH), public works, public affairs, supply/logistics, and any others designated to perform tasks in support of the EM Program.

(3) All BUMED commanded activity commanders, COs, and OICs will ensure all Category 5 personnel/billets are clearly identified.

4. The EM Program shall support the ability of Category 1 personnel to sustain all mission-essential functions for at least 12 hours at either their primary or alternate site. The EM Program shall protect Category 2 through 4 personnel primarily through the utilization of evacuation or shelter-in-place procedures coupled with the proper operational employment of organized, trained, equipped, exercised, evaluated, and sustained Category 5 personnel.

Standard 3: MTF Tiered Implementation

1. The EM Program employs a tiered execution strategy to implement a comprehensive EM program.

2. Reference (b) uses tiered response as a program standard for the “all-hazards” EM approach. This tiered response prioritizes resource allocation, financial management, and capability requirements. Each tier equates to a defined capability level that will provide the basis for organizing, training, and equipping resources. MTFs designated to the higher tiers are typically assigned more personnel and equipment than those at lower tiers. Accordingly, they are expected to implement, field and sustain a greater all-hazards EM response capability. MTF EM response capabilities include patient decontamination in a HAZMAT or Chemical, Biological or Radiological (CBR) mass casualty event, mass care in response to a hurricane or similar natural disaster, and the dispensing of medical counter-measures in response to an epidemic or radiological contingency.

3. Activities are divided into four tiers representing high (Tier 1), medium (Tier 2), low (Tier 3) and minimal (Tier 4) response capabilities. Tier levels are based on the following elements:

- a. Installation prioritization per Joint Staff guidance.
- b. Support to power projection or strategic assets.

Standard 3: MTF Tiered Implementation (Continued)

- c. Human capital.
 - d. Scope of Defense Support to Civil Authorities (DSCA) response.
 - e. Geographic (or potential) isolation from additional support capabilities (e.g., distance and dependence upon vulnerable transportation infrastructure like bridges and tunnels).
4. The tier designation determines the type and number of EM response elements required to support the EM Program. Each specific response element is standardized. For example, a decontamination element at a Tier 3 MTF will be organized, trained, and equipped to the same program objectives as a decontamination element at a Tier 1 MTF with the exception that Tier 3 MTFs will have a smaller decontamination element footprint.
- a. Tier 1: Facilities consist of medical centers or large hospitals that are required to provide the most robust EM response capabilities.
 - b. Tier 2: Facilities consist of hospitals or large branch health clinics that are required to provide significant EM response capabilities.
 - c. Tier 3: Facilities consist of branch health clinics and branch medical clinics that are required to provide moderate EM response capabilities.
 - d. Tier 4: Facilities consist of small branch health and medical clinics, dental centers and branch dental clinics, and TRICARE outpatient clinics, which are required to provide minimal EM response capabilities.
5. Decontamination Capability Elements. EM Program response capabilities are organized into functional elements, each with a different but complementary mission.
- a. Patient Decontamination Team Element. The patient decontamination team is responsible for treating casualties contaminated by any CBRN agent or hazardous material, by rapidly and effectively removing or neutralizing the contamination. The focus of the patient decontamination team is to save lives, protect the medical treatment personnel and facility, and protect the environment. Reference (aa) provides detailed guidance and serves as BUMED policy regarding patient decontamination operations.
 - b. Zone Management/Security Team Element. The MTF zone management team is responsible for restricting vehicular and pedestrian access to the MTF in addition to securing the triage staging area outside the MTF.
 - c. Detection Team Element. The detection team assesses the effectiveness of the decontamination procedures on patients that have been processed through the decontamination shelter.

Standard 3: MTF Tiered Implementation (Continued)

d. Patient Transport Team Element. The transport team is responsible for the movement of non-ambulatory casualties through the decontamination process and follow-on transfer to the MTF for continued care.

Note: Two persons carry for short carries (15-30 seconds); anything longer must have a minimum of 4 persons [Occupational and Safety Health Administration (OSHA) Standard].

e. Triage and Treatment Team Element. The triage/treatment team receives and triages casualties prior to their movement into the decontamination shelter. This includes casualties whose contamination status is suspected or unknown, and those who transport themselves. The team provides life-saving medical care and stabilizes casualties prior to decontamination.

f. Patient Administration Team Element. The patient administration team ensures the actions and treatment performed on patients during the decontamination process are properly documented and recorded prior to patient transfer. The team is also responsible for maintaining the “chain of custody” for personal belongings from patients undergoing decontamination. These items will not be individually catalogued, but rather placed in red biohazard plastic bags that will be tagged, numbered, and recorded. Table 3.1 below outlines MTF mass casualty decontamination response capabilities by tier level. Totals indicate the required number of response teams and the minimum number of total personnel needed to perform the designated capability/function in the event of a CBRN/HAZMAT incident.

Table 3.1 MTF Mass Casualty Decontamination Response - Tiered Requirements

Capability Area	Tier 1	Tier 2	Tier 3
Decontamination	4 (12 members each) Total = 48	2 (12 members each) Total = 24	1 (12 members each) Total = 12
Zone Management	4 (4 members each) Total = 16	2 (4 members each) Total = 8	1 (4 members each) Total = 4
Detection	2 (2 members each) Total = 4	2 (2 members each) Total = 4	1 (2 members each) Total = 2
Transport	4 (6 members each) Total = 24	4 (4 members each) Total = 16	2 (4 members each) Total = 8
Triage/Treatment	4 (5 members each) Total = 20	2 (5 members each) Total = 10	1 (5 members each) Total = 5
Patient Administration	3 (2 members each) Total = 6	2 (2 members each) Total = 4	1 (2 members each) Total = 2
TOTAL	118	66	33

Note: Tier 4 MTF and non-MTF response capabilities are not included in the table. Tier level 4 response capability is limited to the employment of CBRN Pharmaceutical Countermeasures (CPCs) at select facilities.

Table 3.2 MTF Patient Decontamination Required Response Capabilities

Patient Decontamination MTF Response Capability	Metric
Decontamination Team Notification	5 minutes
Decontamination Team Muster	10 minutes
Three-line decontamination shelter mission capable and ready to receive patients; a minimum of four personnel have fully donned Personal Protective Equipment (PPE), the shelter is erected with water flowing through the shelter	15 minutes after team muster
Ambulatory patient throughput	24-40 per hour
Non-ambulatory patient throughput	6-10 per hour
Sustained decontamination operations	60-120 minutes

Note: MTFs are required to be capable of fielding the above decontamination response capabilities whenever they are able to receive patients. Tier 1 MTFs with a 24/7 emergency room/inpatient admission capability must be able to field a decontamination capability throughout the same operating schedule.

6. All BUMED MTFs shall review Table 3.3 to determine their assigned EM response capability tier level. The assigned tier level establishes the EM response requirements specific to each facility and determines the metrics for evaluating their EM response capabilities. MTFs that cannot meet the requirements established for their assigned tier level shall submit a request for waiver, long-term exception or permanent exception per section 5 of this manual.

Table 3.3 NAVMED Region East MTF Tier Level Assignments

ACTIVITY NAME	TIER LEVEL
NH PENSACOLA	2
NBHC PENSACOLA NATTC	4
NBHC PENSACOLA NAS	4
NBHC MILTON WHITING FIELD	4
NBHC MERIDIAN	4
NBHC GULFPORT	4
NBHC PANAMA CITY	4
NBHC BELLE CHASSE NAS	4
NBHC MID-SOUTH NSA	4
NBHC CRANE	4
NBHC CID COREY STATION	4
NH JACKSONVILLE	1
NBHC JACKSONVILLE NAS	4
NBHC MAYPORT	3
NBHC KEY WEST	3
NBHC ALBANY	4
NBHC KINGS BAY	3
NHC CORPUS CHRISTI	3
NBHC FORT WORTH JRB	3
NBHC KINGSVILLE	4
NH SIGONELLA	2
NBMC NAVSUPPACT SOUDA BAY	3
NBHC BAHRAIN	3
NH BEAUFORT	3
NBHC PARRIS ISLAND MCRD	4
NBHC BEAUFORT MCAS	4
NH GUANTANAMO	3
NH NAPLES	2
NBMC CAPODICHINO	4
NH ROTA	2
NHC CHARLESTON	3
NDC CHARLESTON	4
NMC PORTSMOUTH	1
NBHC NORFOLK NAVSTA (SEWELLS POINT)	3
NBHC OCEANA	3
NBHC JEB LITTLE CREEK/FORT STORY	3
NBHC NORFOLK NSY	4
NBHC YORKTOWN	4
NBHC CHESAPEAKE NW NSGA	4
NBHC DAM NECK	4

Table 3.3 NAVMED Region East MTF Tier Level Assignments
(Continued)

ACTIVITY NAME	TIER LEVEL
NMC PORTSMOUTH (Continued)	1
NDC MIDLANT NORFOLK	4
TRICARE OUTPATIENT CLINIC VA BEACH	4
TRICARE OUTPATIENT CLINIC CHESAPEAKE	4
FHCC JAMES A. LOVELL	2
NBHC TRANQUILITY	4
NBDC OSBORNE	4
NBHC RED ROVER	4
NBHC FISHER	4
NHC CHERRY POINT	3
NH CAMP LEJEUNE	1
NMBC HADNOT POINT MCB	4
NBMC MCAS NEW RIVER	4
NBMC CAMP GEIGER MCB	4
NBMC WAYNE CARON MCB	4
NBMC CAMP JOHNSON MCB	4
NHC NEW ENGLAND	4
NBMC PORTSMOUTH NH	4
NBHC SARATOGA SPRINGS	4
NBHC GROTON	3
NHC ANNAPOLIS	4
NBHC BANCROFT HALL	4
NBMC PHILADELPHIA NAVAL BUSINESS CENTER	4
NBHC NAVAL WEAPONS STATION COLTS NECK EARLE	4
NBMC MECHANICSBURG	4
NBHC LAKEHURST	4
NHC QUANTICO	3
NBHC WASHINGTON NAVY YARD	4
NBMC NRL WASHINGTON	4
NBMC OCS QUANTICO (CC NAVMEDCL)	4
NBHC QUANTICO TBS (CORE COMP)	4
NBMC SUGAR GROVE	4
NHC PATUXENT RIVER	3
NBHC DAHLGREN	4
NBHC INDIAN HEAD	4
NBHC ANDREWS AFB	4

Table 3.4 NAVMED Region West MTF Tier Level Assignments

ACTIVITY NAME	TIER LEVEL
NH TWENTYNINE PALMS (ROBERT E BUSH)	3
NBHC CHINA LAKE NAVAIRWARCTR	3
BMC BRIDGEPORT CA	4
NH LEMOORE	3
NBDC NAVPGSCOL MONTEREY	4
NMAU MONTEREY	4
NBHC FALLON	3
NH OAK HARBOR	3
NH CAMP PENDLETON	1
NBMC SEAL BEACH	4
NBMC MCB CAMP PENDLETON	4
NBHC POINT MUGU NAS	4
EDSON RANGE/CRUCIBLE CAMP PENDLETON	4
NBMC BARSTOW	4
NBMC SAN NICHOLAS ISL	4
NBMC CAMP DELMAR MCB	4
NBMC SAN ONOFRE	4
NBMC YUMA	3
NACC PORT HUENEME	3
NDC CAMP PENDLETON	4
NBDC DEL MAR	4
NBDC EDSON RANGE	4
NBDC CAMP SAN ONOFRE	4
NBDC 13 AREA	4
NBDC DEL MAR	4
NBDC EDSON RANGE	4
NBDC SAN ONOFRE	4
NBDC CHAPPO	4
NBDC LAS FLORES	4
NBDC LAS PULGAS	4
NBDC MARGARITA	4
NBDC SAN MATEO	4
NBDC HORNO	4
NH BREMERTON	2
NBHC PUGET SOUND NSYD	4
NBHC BANGOR WA SUBASE	3
NBHC EVERETT	2

**Table 3.4 NAVMED Region West MTF Tier Level Assignments
(Continued)**

ACTIVITY NAME	TIER LEVEL
NH YOKOSUKA	2
NBHA HARIO, SASEBO	4
NBHC COMFLEACT SASEBO	3
NBHC IWAKUNI	3
NBHC ATSUGI NAF	3
NBHA CAMP FUJI, HONSHU	3
NBHA YOKOHOMA	4
NBHC CHINHAIE	3
NBHC NSF DIEGO GARCIA	4
NH OKINAWA	1
NBMC MCAS FUTENMA	4
NBMC USAFS TORII STATION	4
NBMC WHITE BEACH	4
NBMC EVANS/CAMP FOSTER	4
NBMC CAMP KINSER	4
NBMC MCB CAMP COURTNEY	4
NBMC CAMP HANSEN	4
NBMC MCB CAMP SCHWAB	4
NDC OKINAWA	4
NBDC CAMP HANSEN	4
NBDC CAMP COURTNEY	4
NBDC CAMP KINSER	4
NBDC MCAS FUTENMA	4
NBDC CAMP FOSTER	4
CAMP SCHWAB DENTAL ANNEX	4
NH GUAM	2
NBDC GUAM	4
NBMC GUAM	4
NHC HAWAII	2
NBHC NSY PEARL HARBOR	4
NBHC WAHIAWA	4
NBHC KANEOHE BAY	3
NBHC CAMP SMITH	4
NBHC BARKING SANDS	4
NMC SAN DIEGO	1
NBHC NAVAL BASE CORONADO	3
NBMC MCAS MIRAMAR	3
NBHC SAN DIEGO NTC	3
NBHC SAN DIEGO MCRD	4

Table 3.4 NAVMED Region West MTF Tier Level Assignments
(Continued)

ACTIVITY NAME	TIER LEVEL
NMC SAN DIEGO (Continued)	1
NBDC NSC SAN DIEGO	4
NBMA NALF SAN CLEMENTE	4
NBHC EL CENTRO	4
NBDC SUBASE SAN DIEGO	4
NBMC NAVBASE SAN DIEGO	3
NBDC NAVBASE SAN DIEGO	4
NBHC RANCHO BERNARDO	4
TRICARE OUTPATIENT CLINIC CLAIREMONT	4
TRICARE OUTPATIENT CLINIC CHULA VISTA	4
TRICARE OUTPATIENT CLINIC EAST COUNTY PCC	4

Standard 4: Assessments

1. The EM Program identifies minimum assessment standards and methods in support of the risk management process throughout the NAVMED enterprise.

2. BUMED commanded activities will participate in appropriate assessments and take for corrective action the recommended findings. These assessments should incorporate information and recommendations from a variety of sources including, but not limited to, Hazard Assessments (HAs), Vulnerability Assessments (VAs), Joint Staff Integrated Vulnerability Assessments (JSIVAs), Chief of Naval Operations Installation Vulnerability Assessments (CNO IVAs), Critical Infrastructure Protection (CIP) planning and assessments, and COOP planning. These assessments will increase the focus on “all-hazards” and assist in resource allocation and prioritization.
 - a. Hazard Assessments (HA). Per references (b), (d), and (f), all BUMED commanded activity commanders, COs, and OICs shall ensure a thorough HA is completed at a minimum of every 3 years or whenever there is a significant change in a local EM risk factor. HAs shall be reviewed annually, assessing the probability, severity and nature of hazards which may impact their operations.

 - b. Vulnerability Assessments (VA). Per references (a), (b), (d), and (f), all BUMED-commanded activity commanders, COs, and OICs, shall ensure an annual threat and vulnerability assessment is conducted to analyze the threats potentially impacting their commands. The threat and vulnerability assessment shall:
 - (1) Focus on the command EM and AT programs.

 - (2) Utilize appropriate subject matter experts (SMEs).

Standard 4: Assessments (Continued)

(3) Consider the range of identified and projected response capabilities needed for a natural or man-made hazard, including a terrorist or criminal act against the installation, its personnel, facilities, and other critical assets.

(4) Identify responses to vulnerabilities, and solutions for enhanced protection of personnel and resources.

(5) Provide vulnerability-based analysis of the command's EM Program.

(6) Ensure critical program requirement gaps identified during vulnerability assessments are formally documented and forwarded to the NAVMED Region and where appropriate, installation commander for mitigation during the budget process.

(7) Classify assessments per the appropriate security classification guidance.

(8) Ensure MEMs and EMOs maximize the use of vulnerability assessments and emergency preparedness related intelligence derived from civil and military law enforcement agencies, public safety (including Anti-Terrorism and Force Protection Officers, where assigned), meteorological, environmental, and public health organizations.

c. EM Response Capability Assessments and Status. Response capabilities for the EM Program are primarily intended for a "first receiver" level. Traditional EM response activities that extend beyond the scope of first receiver level remain the responsibility of the host installation and NAVMED Region commander per references (a) through (f). However, BUMED commanded activities can provide medical response teams to an incident site if requested by an installation or NAVMED Region commander, if specified in an Mutual Aid Agreement (MAA), or if necessary in an "immediate response authority" capacity, as described in Standard 6, paragraph 3i(1). The EMO/MEM will implement a comprehensive readiness assessment process to effectively determine and report the status and operational readiness of required EM response capabilities. The process will assess:

(1) The capability to employ vulnerability assessments along with installation HAs to determine risk posed by all hazards.

(2) The capability to reduce the assessed risk through the implementation of the program.

(3) The availability and readiness of resources required to implement and support response operations, including Functional Response Plans.

(4) The frequency and extent to which plans have been reviewed, trained for, and exercised.

(5) The effectiveness of exercise assessments and after action reports (AARs) and their use in improving the program.

Standard 4: Assessments (Continued)

(6) Written agreements with supporting/supported organizations per references (m) and (o).

(7) The use of operational risk management (ORM).

Standard 5: Interoperability

1. The program requires the use of interoperable standards and methods per references (b) and (d) through (f).

2. Interoperability must include the standardization of systems, procedures, and terms to the maximum extent possible. The goal is compatibility of tactics, techniques, and procedures (TTP), particularly in command, control, and communications (C3). Effective all-hazards EM response relies on interoperability between USN and USMC regional and installation EM assets, and applicable Federal, State, tribal, local or HN EM agencies and departments.

3. All BUMED commanded activity commanders, COs, and OICs or their representatives, shall participate in USN, USMC, and/or Joint Base regional and installation EM planning, training and exercises, and encourage reciprocal participation by these entities in their EM planning, training and exercises.

Standard 6: Preparedness

1. The program establishes minimum preparedness standards as required by references (a) through (h), (o), and (z). These standards include the proper organization, manning and C3 interoperability with Federal, State, local, tribal and HN agencies and departments.

2. The Preparedness Standard is the most important element of the NAVMED EM Program, for while mitigation can make facilities, environments and personnel safer, it does not eliminate risk and vulnerability for all hazards. BUMED commanded activities must be ready to face emergency threats that have not been mitigated below the acceptable threshold. Since emergencies often evolve rapidly and become too complex for effective improvisation, the activity commander, CO, or OIC can only successfully discharge their emergency management responsibilities by taking certain actions beforehand. Preparedness involves establishing authority and responsibility for emergency actions and garnering the resources to support these actions. All BUMED commanded activities must therefore assign appropriate emergency management duties and designate/provide facilities, equipment, and other resources for carrying out assigned duties. This investment in emergency management requires proper resourcing, maintenance, and sustainment. Category 5 personnel must receive proper training and certification, and the facilities and equipment must be maintained in working order per references (e), (i), and (s). To ensure the activity's investment in EM personnel and resources can be relied upon when needed, there must be an effective training and exercise program in place (see Standards 8 and 10). Consideration also must be given to reducing or eliminating the

Standard 6: Preparedness (Continued)

vulnerability of the activity's EM response organizations and resources to the hazards/threats that threaten the jurisdiction (see Standard 4). Accordingly, preparedness measures should not be improvised or handled on an *ad hoc* basis. A key element of preparedness is the development of plans that link the many aspects of the activity's commitment to emergency management (see Standard 7). These efforts receive the largest share of resources and require the largest manpower commitment to develop and execute.

3. The preparedness tasks of planning, training, equipping, exercising, and assessing the FHP EM Program are covered within other standards.

a. Public Health Emergency Officers (PHEO). Per references (b), (o), and (r), MTF commanders, COs, and OICs shall ensure a PHEO is designated in writing and assigned to support the host installation and Navy Region. The PHEO shall serve as an integral part of the installation or Navy regional EM team including the Military Biological Advisory Committee (MBAC) (if established). The PHEO also serves as the principal advisor to the installation and Navy Region commanders in determining the existence of, and required response to a Public Health Emergency (PHE) occurring onboard or potentially affecting USN, USMC, or Joint Base installations or regions.

b. EM Working Group (EMWG). Per references (b) and (o), all BUMED commanded activities shall establish and maintain an EMWG to assist the MEM/EMO in the development, execution, exercise, and assessment of the FHP EM Program. The EMWG shall meet a minimum of once per quarter and will actively participate in USN, USMC, and/or Joint Base regional and installation EM activities and planning programs. BUMED commanded activities that are tenant commands shall participate in the host installation EMWG. For activities with limited personnel assets, subject to the concurrence of their respective NAVMED Region commander or ISIC, participation in the host installation and NAVMED Region EMWGs fully satisfies the requirement to establish and maintain an EMWG.

c. Continuity of Operations (COOP). Reference (p) established the NAVMED COOP Program, the purpose of which is to provide for the continual execution of NAVMED's mission essential functions (MEFs) throughout any emergency or contingency. The focus of the COOP Program is to ensure the capability of all BUMED commanded activities to maintain MEF support or restore MEF support at either their primary site, or at an emergency relocation site, and for their Category 1 personnel to sustain MEF support for up to 30 days before returning to normal operations. The details necessary to develop and implement a local COOP Plan are contained in reference (p).

d. Mass Warning and Notification. Per reference (b), all BUMED commanded activity commanders, COs, and OICs shall implement the capabilities to rapidly warn and notify personnel in the event of an emergency. Category 1 and 5 personnel must receive warning and notification within 5 minutes of an event. Category 2 through 4 personnel must receive warning and notification within 10 minutes of an event. These capabilities should be integrated with the mass warning and notification system(s) employed by the host installation, wherever possible.

Standard 6: Preparedness (Continued)

e. Regional Operations Center (ROC). Per references (r), NAVMED Region commanders are responsible for ensuring that supported Navy and Marine Corps Region and installation are assigned a qualified medical advisor/liaison to serve in the ROCs during emergency activations.

g. Communications. BUMED commanded activities shall implement operable communications across the Category 5 functional areas; interoperable communications are required (see EM Standard 5). MTF commanders, COs, and OICs should pursue procedure-based solutions to interoperability challenges, including the use of liaison officers at ROCs and EOCs as may be needed during emergency activations.

h. Written Agreements. All BUMED commanded activities shall develop Mutual Aid Agreement (MAA) [e.g., Interservice Support Agreement (ISSA), Memorandum of Agreement (MOA), or Memorandum of Understanding (MOU)] with civilian first/emergency responders, including local hospitals and EM agencies, as necessary per references (m) and (o). BUMED commanded activities shall coordinate with CNIC, USMC, and/or Joint Base regional and installation level EM resources, as well as the local (civilian) EM community in the development of MAAs. These agreements shall outline cooperative measures where Category 5 personnel may assist their civilian counterparts and vice versa in responding to and recovering from all-hazards emergencies. MAAs are developed by the activity MEM and reviewed and approved by the NAVMED Regional EMO. All concerned parties must maintain a copy of the MAA for its applicable duration. MAAs are pre-arranged, non-binding agreements between two or more entities, public and/or private, to render human and/or materiel resources or services when resources of one party are not adequate to meet the needs of an emergency. An MAA is sometimes also written as an MOA, MOU, or ISSA. Per references (c) and (j), BUMED commanded activity commanders, COs, and OICs are authorized to provide immediate response support to requests from the civil sector in order to save lives, prevent human suffering, or to mitigate great property damage for periods up to 72 hours from the initial request. References (c) and (j) also approve Navy commanders responding to civil emergencies based upon lawful memorandums of understanding/agreement, mutual aid agreements, inter-Service support agreements, Executive Orders, or other plans. Emergency response and recovery operations involve the principle of mutual assistance. BUMED activity commanders should be prepared to both aid civil authorities and request assistance, if needed, from other services, Federal agencies, and State and local civil authorities within their area. Response actions taken in support of approved, written MAAs do not involve the application of the immediate response authority per references (c) and (j). NAVMED support provided to civil authorities under the immediate response authority or pursuant to MAAs and written agreements is the only support that is authorized to be provided without routing through the established procedures for civil authorities to officially request support from the SECDEF. BUMED commanded activities located overseas may have significant difficulty in achieving signed agreements due to language and procedural barriers. All overseas activities must coordinate their efforts with the appropriate NAVMED Region command, BUMED, and DoS officials.

Standard 6: Preparedness (Continued)

i. Civil-Military (CIV-MIL) Operations. BUMED commanded activities shall coordinate with their region and installation commanders in developing relationships with the appropriate Federal, State, local, tribal and HN EM agencies and departments to identify and update EM points of contact, review emergency protocols, and assess mutual expectations in the event of an emergency affecting a BUMED commanded activity or installation. This task should also include coordination with the EM organizations of nearby military installations including the U.S. Coast Guard, local medical community organizational planning staffs and emergency planning committees. Examples of organizations and committees requiring CIV-MIL coordination include State Emergency Response Commissions (SERCs), Local Emergency Planning Committees (LEPCs), Community Emergency Response Teams (CERTs), and the Metropolitan Medical Response System (MMRS).

(1) Immediate Response Authority. Per references (c) and (j), BUMED commanded activity commanders, COs, and OICs are authorized to provide immediate response to requests from the civil sector in order to save lives, prevent human suffering, or to mitigate great property damage. This type of “immediate response” support to civil authorities by BUMED activity commanders, COs, and OICs does not require prior written agreement, or prior approval. It will not however, supersede the commander’s, CO’s, or OIC’s mission-related duties, or the survival of their personnel or facilities. Prior to committing BUMED assets for immediate response support to civil authorities, BUMED commanded activity commanders, COs, and OICs must first ensure those assets are not required to support mission-essential functions for their activity or the host installation. Coordination with the host installation commander prior to directing any immediate support response is essential during any contingency. When providing support under immediate response authority, the commander, CO, and OIC must:

- (a) Report the incident to BUMED, the NAVMED Region commander and the installation commander as soon as possible.
- (b) Assess mission requirements and the capability of their command to determine the extent of immediate military assistance required.
- (c) Inform the civil authority they must provide a written request that supports the request and identifies the nature of the response as soon as practical.
- (d) Ensure the costs associated with the response effort are documented for reimbursement.

(2) The Metropolitan Medical Response System (MMRS). The MMRS is a locally sponsored, developed, and operated mass casualty response system. The system’s goal is to enhance existing local first responder, medical, public health, and emergency planning to increase capabilities to respond locally to all-hazards incidents including terrorist attacks and other public health emergencies that create, or have the potential to cause mass casualties or casualties requiring unique care capabilities (such as decontamination). The system also

Standard 6: Preparedness (Continued)

increases the jurisdiction's capabilities to manage mass casualty incidents caused by hazardous materials incidents, disease outbreaks, and natural hazards. The MMRS enables a metropolitan area to manage the event until State or Federal response resources are mobilized. The MMRS Planning Committee typically consists of representatives from Federal, State, local, other Service, and/or private stakeholders involved in response to an all-hazards mass casualty incident including fire and emergency services, EMS, HAZMAT teams, MTFs, public health agencies, and law enforcement agencies. MEMs and EMOs are encouraged to actively participate in the respective MMRS Planning Committee(s), wherever appropriate.

j. Personnel. Personnel assigned duties in support of the EM program will be task-organized into capabilities elements per Standard 3. Designated active duty personnel must participate and MEMs/EMOs should avoid assigning staff that are also assigned contingency or augmentation duties with expeditionary or military augmentation platforms.

k. Occupational Examinations. Civilian personnel assigned to duties on any of the response element teams will adhere to the guidelines for the periodicity of occupational exams established in reference (s). Particular attention is directed to the specialty examinations required for hazardous waste and/or emergency responders (section 711) and the respirator user certification exam (section 716).

l. Joint Information Center (JIC). BUMED commanded activities shall coordinate with NAVMED Region and installation staffs to identify and update mutual points of contact for public affairs, risk communications, emergency protocols, and media expectations.

m. MAX Federal Collaborative Tool. The MAX Federal Collaborative Tool (Governance ID 396) is approved by the BUMED Management Control Board as the system of record for use by all BUMED commanded activities in collaborative EM program planning, training, management, and execution. Access may be granted by a government Common Access Card (CAC) or registered logon information.

Standard 7: Planning

1. The EM program establishes minimum planning standards as required by references (b) and (o). Planning is critical for effectively preparing for, responding to and recovering from an all-hazards incident. NAVMED EM programs shall be coordinated with the host installation EM plan for any tenant BUMED commanded activities, and all activities will ensure their plans are coordinated with the USN, USMC, and/or Joint Base regional plan as applicable. Overseas activities will ensure their plans are also coordinated with U.S. DoS and HN contingency plans wherever possible.

2. All BUMED commanded facility EM plans shall be formally reviewed annually, with either a copy of the revised plan, or confirmation the plan was reviewed and no revisions were required, provided to the applicable NAVMED and USN/USMC region command or ISIC following the review. The EM plan should also be coordinated with Federal, State, local, tribal, other-Service, HN, and any other response and recovery partners.

Standard 7: Planning (Continued)

3. Per section 3, paragraph 5 and reference (p), all BUMED commanded activities are required to include their COOP Plan as an annex to their EM Plan. COOP plans will identify the capabilities and standard operating procedures (SOP) for a BUMED commanded activity to continue executing their MEFs during an all-hazards emergency.

4. Per reference (b), Navy Region and installation commanders are required to develop plans and procedures to safely and efficiently move Category 2 through 4 personnel to safe locations, or shelters, or for them to shelter-in-place when evacuation is not possible. Reference (b) establishes the requirements how quickly personnel must be notified and protected in the event of an evacuation or shelter-in-place contingency. BUMED commanded activity commanders, COs, and OICs shall ensure effective evacuation and shelter-in-place plans that protect their personnel are implemented, and that all hands receive initial and recurring training on both evacuation and shelter-in-place procedures. BUMED commanded EMOs and MEMs shall closely coordinate their evacuation and shelter-in-place procedures with their region and host installation EMOs and planners. Evacuation planning, shelter-in-place planning, and shelter development plans should be based on applicable DoD, Department of Homeland Security (DHS), and American Red Cross guidelines. The safe and effective evacuation of non-essential personnel is the primary hazard mitigation and response strategy for our Category 2 through 4 personnel. In overseas locations, evacuations will follow established host USN, USMC, or Joint Base installation evacuation procedures. For overseas facilities not resident on a U.S. military installation, follow established U.S. DoS/Embassy procedures for evacuation. Section 3 provides additional guidance regarding shelter-in-place and evacuation planning.

5. Per reference (l), all BUMED commanded activities shall implement planning for a pandemic contingency.

Standard 8: Training

1. The EM program establishes minimum training standards as required by references (b), (d), (e), (o), (r), and (y). Training standards are based on existing DoD, Occupational Safety and Health Administration (OSHA), National Fire Protection Agency (NFPA), the Joint Commission, and military standards and guidelines as referenced in references (a) and (n). These NAVMED training standards focus on the requirements for Category 1 personnel to maintain mission essential operations, for Category 2-4 personnel to gain hazard awareness and an understanding of warning and response procedures, and for Category 5 personnel to conduct safe and effective force health protection and first receiver operations.

2. BUMED commanded activity MEMs and EMOs shall tailor their EM training programs to mitigate the specific hazards and threats identified in their current HA and VA, as well as correct any deficiencies identified in relevant post-exercise AARs and Lessons Learned submissions. Additionally, they will ensure regional and installation level EM capabilities and resources are incorporated into their training program. Completed EM training requirements shall be documented in the approved learning management system per reference (dd). EM training

Standard 8: Training (Continued)

programs must include realistic exercises, requiring participation from personnel at every level and minimizing simulations to the maximum extent practical, in order to effectively assess the EM program and identify gaps and shortfalls in Doctrine, Organization, Training, Material, Leadership, Personnel and Facilities (DOTMLPF). EM training programs will facilitate a metrics based assessment of the facility's ability to meet its required EM capabilities.

3. The Deputy Chief, Education and Training (BUMED-M7) shall coordinate with Navy Medicine Education and Training Command (NMETC) to ensure resources are effectively employed in executing the NAVMED EM program.

4. In establishing FHP EM program training objectives and developing exercise related Master Scenario Event Lists (MSELs), MEMs, and EMOs will coordinate with the host USN, USMC, or

Joint Base Installation Emergency Manager to identify the installation specific mission essential tasks (METs) that must be supported by the BUMED commanded activity for all-hazards EM preparedness and response. During an EM contingency, the BUMED commanded facility functions in a "supporting" command relationship to the host USN, USMC, or Joint Base installation, which functions as the "supported" command. In this respect, the host installation METs that require first receiver or medical emergency responder support, serve as the training objectives for the BUMED commanded activity.

5. Training Requirements. The emergency preparedness training requirements in the NAVMED EM program are divided into the following categories:

a. Federal Emergency Management Agency (FEMA) Emergency Management Institute (EMI) Training. EMA EMI offers a wide variety of emergency preparedness courses for personnel assigned EM responsibilities, as well as the general public. The majority of these courses are self-paced and offered at no cost on-line to NAVMED personnel. These on-line courses are offered through the FEMA EMI Independent Study Program (ISP) and they can be completed from any computer with internet access. Personnel can access these courses at: <http://training.fema.gov>. All of the FEMA EMI emergency preparedness on-line training courses support the nine mission areas of the National Preparedness Goal, but NAVMED requirements are focused primarily on command and control and incident management. A matrix detailing FEMA course requirements by billet/position is included below at Table 8.1.

Note: A complete listing of all the courses FEMA recommends for NIMS compliance may be found at FEMA's Web site: <http://training.fema.gov>.

b. Emergency Preparedness and Response Course (EPRC). This training is available for NAVMED personnel at the Joint Knowledge Online (JKO) site at: <https://jkodirect.jten.mil>. The following EPRC courses are required training:

(1) Chemical, Biological, Radiological, Nuclear, and Explosives (CBRNE) EPRC Basic Awareness Course (J30P-US261-EPRC). Required for all non-medical/non-security staff and non-essential contractors.

Standard 8: Training (Continued)

(2) CBRNE EPRC Operator/Responder Course (J30P-US260-EPRC). Required for non-clinician first receivers/responders, i.e., general HMs, MTF security, MEMs, and EMOs. Note: the revised format 8-hour “short” course is the current version of this training requirement.

(3) CBRNE EPRC Clinicians Course (J30P-US258-EPRC). Required for clinician first receivers/responders, i.e., physicians, nurses, dentists, veterinarians, physician assistants, independent duty corpsmen, and advanced EMS professionals. Note: the revised format 8-hour “short” course is the current version of this training requirement.

(4) CBRNE EPRC Executive/Commander Course (J30P-US262-EPRC). Required for MTF commanders, COs, and OICs, and the Executive Steering Committee members.

Note: New personnel must complete the requisite EPRC training within 12 months of their first duty assignment. EPRC sustainment training is required every 3 years and consists of completing the course appropriate to the current billet.

c. Defense Support to Civil Authorities (DSCA) Course. This training is available for NAVMED personnel at the JKO site at: <https://jkodirect.jten.mil>. The following DSCA course is required training: Defense Support of Civil Authorities (DSCA) Course Phase I (J3S T-US010). The mission of the DSCA online course is to familiarize DoD and other agency personnel in Defense Support of Civilian Authorities operations. The course introduces national, State, local, and DoD statutes, directives, plans, command and control relationships, and capabilities with regard to DoD support for domestic emergencies and for designated law enforcement and other activities.

d. Defense Medical Readiness Training Institute (DMRTI) Courses. DMRTI offers several important courses targeting specific training requirements within the medical emergency preparedness field. The required DMRTI course is not available on-line or on a distance learning basis, and must be completed in residence. However, with enough interest, the course is potentially exportable in a mobile training format. Additional information about the courses is available at: <http://www.dmrtd.army.mil/>. The following DMRTI course is required training. Public Health Emergency Management (PHEM) Course (DMRTI 6A-F25). The PHEM training program provides PHEOs and MEMs with the technical knowledge and skills needed to respond to public health emergencies and provide emergency assistance to civilian and host nation authorities. This standardized, joint service training ensures PHEOs and MEMs can operate in a variety of environments, including onboard other service/joint installations and facilities. The course consists of pre-requisite training, a 5-day in-residence course at DMRTI, and a continuing education program.

e. NAVMED First Receiver Operations Training (FROT) Course. This course is managed by BUMED-M3B4 and scheduled for MTFs at the NAVMED Region level. The course provides all the background information and technical training needed to qualify personnel for assignment to the MTF patient decontamination team. The course is taught in an exportable

Standard 8: Training (Continued)

team-trainer format at the MTF and consists of approximately 1 day of equipment inventory, system checks and repairs, followed by 1 day of classroom training and 1 day of hands-on equipment training and operation. The course concludes with a timed exercise that assesses the efficacy of the MTF patient decontamination team. The course is currently offered approximately every 6 months at Tier 1 MTFs, every 6-12 months at Tier 2, and once every 12 months at Tier 3 MTFs.

9. Report. MEMs and EMOs will ensure required emergency preparedness course work is completed and captured in the approved learning management system per reference (dd). Completion of any required training outside the approved learning management system, including FEMA EMI courses, and training completed through the Navy or Joint Knowledge On-line (NKO/JKO) portals will necessitate uploading the course completion data manually in the approved learning management system.

Table 8.1 NAVMED Required Emergency Preparedness Training Matrix

Required Courses	All NAVMED Personnel	EMOs/ MEMs	Management Personnel with EM Response Duties	PHEOs/ Asst PHEOs	DECON Team Members
*IS-100/IS-100HCb Introduction to Incident Command System (ICS)	X	X	X	X	
*IS-200/IS-200.HCa Applying ICS to Healthcare Organizations		X	X	X	
*ICS-700.a National Incident Management System (NIMS)		X	X	X	
*ICS-800.b National Response Framework (NRF)		X	X	X	
**J30 P-US258 EPRC Clinicians Course ** J30 P-US260 EPRC Operators Course **J30 P-US261 EPRC Awareness Course **J30 P-US262 EPRC Executive Course	X ¹	X	X ¹	X ^{3,5} X ³	
*J3S T-US010 DSCA Phase I Defense Support of Civil Authorities		X ⁴			
DMRTI 6A-F25 Public Health Emergency Management (PHEM) Course		X ⁴		X	
NAVMED FROT First Receiver Operations Training					X

* On-line course

** On-line course, **required every 3 years**

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- 1 Non-Military, Non-Medical, Non-Security (DoD Civilian and Contract Personnel) are excluded.
 - 2 Medical, Dental, Nurse, and Medical Service Corps Executives (including DoD Civilians).
 - 3 PHEOs and assistant PHEOs serving as clinicians take the Clinicians EPRC course; all others take the Operators EPRC course.
 - 4 Only MEMs assigned to an MTF are required to take the DSC and PHEM courses.
 - 5 Clinicians may complete the Medical Management of Chemical and Biological Casualties (MCBC) or Medical Effects of Ionizing Radiation (MEIR) courses in lieu of the EPRC course.

Standard 9: Equipment and Pharmaceuticals

1. Equipment standards focus on the requirements for Category 5 personnel to conduct safe and effective FHP and first receiver operations. Equipment shall be provided with the appropriate operation, employment and maintenance training. The types and quantities of FHP EM equipment, supplies, and pharmaceuticals will be standardized across BUMED commands and are determined by the designated MTF tier level. Detailed requirements and equipment specifications are contained in reference (v). The MEM is responsible for the overall coordination and management of all EM materials and equipment.
2. The requirements established in this program manual serve as the basis for the procurement, operation, and sustainment of all EM-related equipment. Equipment requirements will continuously be reviewed to ensure the EM equipment and supplies available to BUMED first receivers consist of the most effective, best fit mix of Government off-the-shelf (GOTS), and Commercial off-the-shelf (COTS) tools and equipment available. Reference (v) is updated annually to reflect any required revisions resulting from the equipment review process.
 - a. GOTS equipment employed by NAVMED first receivers during known or suspected CBRN events shall be procured, employed, maintained, and inventoried per applicable Joint-Chemical Biological Defense Program (J-CBDP), J-8/Joint Requirements Office (JRO), Joint Program Executive Office-Chemical, Biological and Decontamination (JPEO-CBD), USN, and USMC guidance.
 - b. Per reference (i), COTS equipment utilized within the scope of the EM program, including CBRN events, shall meet applicable OSHA, National Institute of Occupational Safety and Health (NIOSH), and NFPA standards, guidelines, and criteria (as appropriate), as well as all applicable Federal and military standards and guidelines.
3. BUMED-M4/NMLC shall be responsible for ensuring the current EM equipment requirements are captured and reflected in approved assemblages for all BUMED commanded activities. BUMED will coordinate the selection of EM equipment with CNIC, Naval Sea Systems Command (NAVSEA), and other organizations as required. The Interagency Board's (IAB) Selected Equipment List (SEL) serves as a basis for the selection of CBRN related COTS equipment.
4. BUMED-M8 in collaboration with BUMED-M3B4 shall include procurement costs, life-cycle costs (LCC), and sustainment costs for all EM equipment requirements in their budget and Program Objective Memorandum (POM) submissions.
5. MTF commanders, COs, and OICs shall ensure all assigned EM equipment is reflected in Defense Medical Logistics Standard Support (DMLSS) Automated Information System (AIS) per reference (v). The H199 and H200 assemblages, which are uploaded and located on each MTF DMLSS server, provide a list of required equipment, supplies, and pharmaceuticals that must be maintained by the MTF.

Standard 9: Equipment and Pharmaceuticals (Continued)

6. BUMED-M3B4 will provide MTF equipment program funding. NMLC shall work with BUMED-M3B4 in standardizing the procurement and distribution of the required EM equipment.

7. Approved EM Equipment and Allocation

a. Only approved equipment per reference (v) shall be used for all-hazards EM response. This policy ensures the EM-related equipment being employed by first receivers has been reviewed for compliance with applicable DoD and Federal standards, and the gear meets all BUMED commanded requirements for all-hazards response capabilities and sustainability. The policy also ensures EM response equipment is standardized across all activities, which maximizes training, logistics and sustainment efficiency, and enables first receivers to employ and maintain equipment at any MTF.

b. To facilitate the continuous review and revision process for the list of BUMED-approved and required EM response equipment listed in reference (v). However, this reference and the H199 and H200 assemblages only address technical response equipment and pharmaceuticals. Ancillary equipment such as scissors, towels, sponges, etc., is not standardized and any suitable similar equipment can be employed. NAVMED Regions and MTFs/non-MTFs will review reference (v) annually, to evaluate the efficacy of their EM response equipment requirements and allowances. Additionally, NAVMED Regions and MTFs/non-MTFs are specifically prohibited from procuring EM response equipment not contained in reference (v), or in excess of approved allowances, without explicit prior approval from BUMED-M3B4.

8. EM Response Materials and Equipment

a. All BUMED commanded activities will maintain response materials and equipment in a secure, environmentally controlled protected area(s), which permits ready access and use in a contingency. The equipment can be stored remotely from the MTF facility, but it must be readily accessible at all times and close enough to meet casualty response and readiness requirements, per Table 3.2, page 10 of this manual. In all cases, the actual storage location of the EM material will be entered into the DMLSS. Wherever possible, dual-use EM materials will be rotated with conventional equipment stocks to ensure contingency stocks are maintained at a maximum degree of readiness and minimized level of wear.

b. Calibration kits, batteries, and power adaptors will be maintained by the MTF's Biomedical Equipment Maintenance Division (BIOMED). Hazardous Material (HAZMAT) Locker and Safety Data Sheets will be used as required for items identified as HAZMAT. Tier 3 and 4 MTFs, non-MTFs, and other smaller facilities without assigned biomedical equipment maintenance personnel, shall coordinate with their parent MTF/ISIC to schedule and complete required maintenance.

c. EM response equipment and materials will be considered to have an extended shelf-life and shall not be discarded without the approval of the respective NAVMED Region and BUMED, regardless of the manufacturer's recommended expiration date.

Standard 9: Equipment and Pharmaceuticals (Continued)

d. MEMs are responsible for ensuring all EM technical and ancillary equipment and supplies necessary for an all-hazard EM response is maintained, and are on-hand in a fully operational status per manufacturer specifications (where applicable).

9. Receipt and Inventory Management

a. MTF commanders, COs, and OICs are responsible for ensuring all EM equipment and materials received are properly gained in DMLSS. The Materiel Management Department (MMD) shall monitor on-hand stocks of EM equipment and material by regularly running an Assemblage Status Rollup Report. Additionally, H199 and H200 assemblage status will be monitored remotely by the appropriate NAVMED Region and BUMED.

b. Inventories. MEMs will conduct a 10 percent spot-check inventory of their assigned decontamination team response equipment, materials, and pharmaceuticals (H199 AMAL) each calendar quarter, recording the results in DMLSS in January, April, July, and October. A 100 percent wall-to-wall inventory of the decontamination team response equipment, materials, and pharmaceuticals must be completed annually using the DMLSS-AM physical inventory module, with the results reported to the respective NAVMED Region and recorded in DMLSS. Additionally, a 100 percent wall-to-wall inventory of the PI stockpile equipment and pharmaceuticals (H200 AMAL) must be conducted semi-annually, with the results recorded in DMLSS in April and October. Reference (cc) provides detailed information concerning PI stockpile equipment and pharmaceuticals.

Standard 10: Exercise and Evaluation

1. In order to fulfill Joint Commission requirements, all MTFs with inpatient capabilities must actively participate in a minimum of two EM related Full Scale Exercises (FSEs) per year. MTFs without an inpatient capability will complete a minimum of one EM related exercise per year. Table Top Exercises (TTXs), Functional Exercises (FEs), and other “hands on” EM related training must meet the Joint Commission annual exercise requirements specified for the facility. Activation of EM plans in response to actual contingencies or emergencies may fulfill this requirement. MTFs and non-MTFs shall also participate in local community EM related exercises as often as feasible and in cooperation with their respective NAVMED Region/ISIC. Particular emphasis should be focused on exercises that enhance interoperability with civilian medical counterparts and MOU/MOA EM response partners. Section 3 of this manual contains additional guidance regarding required training using functional response plans.

2. All BUMED commanded activities shall participate in the EM exercise planning process with their NAVMED and USN, USMC, or Joint Base region, host installation, and local community to ensure they have relevant exercise play that will contribute to enhanced EM interoperability, communications, and overall readiness.

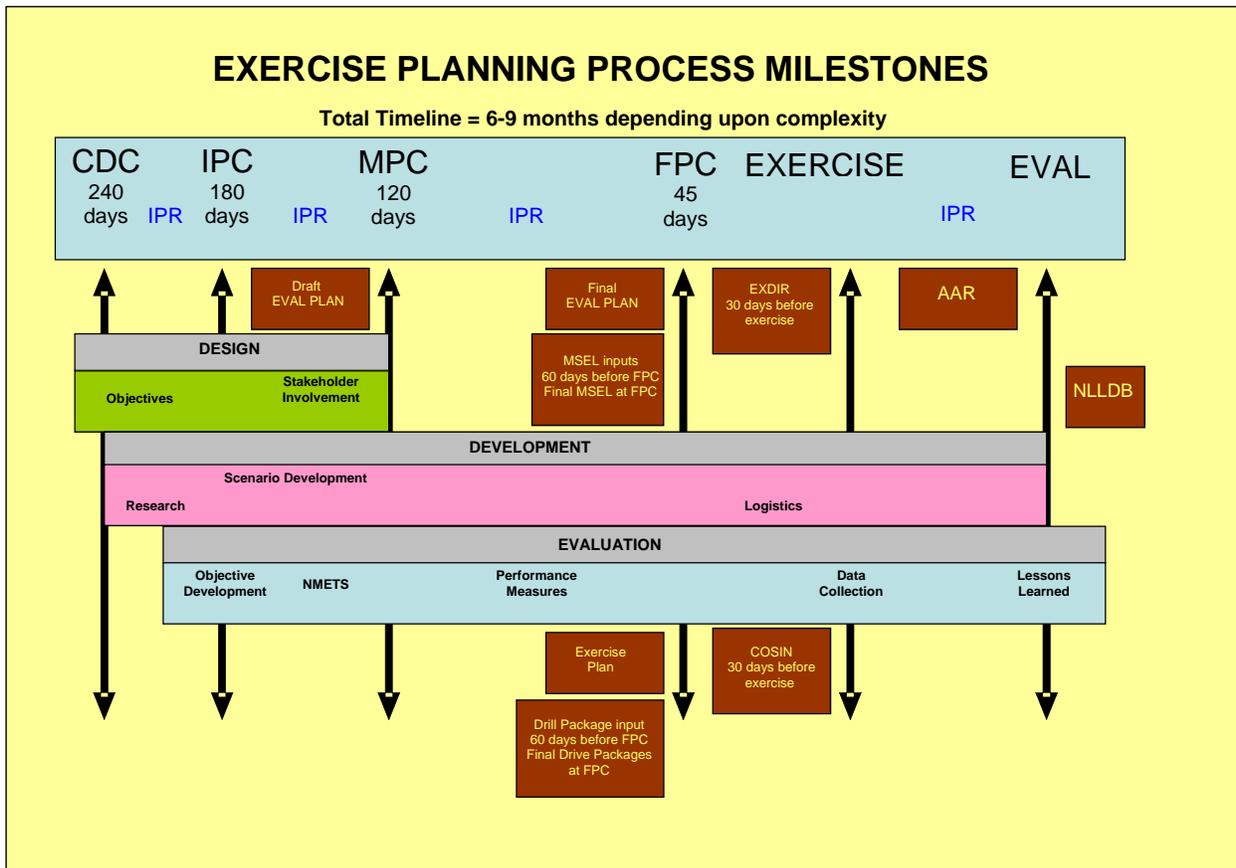
Standard 10: Exercise and Evaluation (Continued)

3. The EM Program uses approved DoD doctrine and planning processes to produce consistent and comparable exercise results. Per reference (d), NAVMED EM exercise planners will be familiar with and whenever possible, will employ federally recognized and standardized Homeland Security Exercise and Evaluation Program (HSEEP) planning processes and tools, Navy Mission Essential Tasks List (NMETL), and uniform assessment criteria to assess existing readiness strengths and target areas for additional training focus. The HSEEP tool kit section of the FEMA web portal provides all of the necessary tools and guidance for exercise program development, execution, and evaluation.

4. Major exercise planning milestones and scenarios are developed during the Concept Development Conference, Initial Planning Conference (IPC), Mid-Planning Conference (MPC) and MSEL Synchronization Conference, and Final Planning Conference (FPC). The major phases of the exercise process are Design, Development, Conduct and Evaluation, and the normal progression of this phased approach is illustrated in Figure 10.1 of this manual. Exercises will incorporate ORM strategies as an integral part of planning and execution. USN shore exercises are aligned and integrated across CNIC's regional and installation levels and to the greatest extent practicable, are integrated with related exercises performed by other services, Federal, State, and/or local agencies. The NAVMED enterprise plays a critical role in CNIC's EM initiative and all BUMED commanded activities shall ensure their EM exercises are aligned and integrated with CNICs/MCICOM exercise program to the maximum extent practical.

5. Per reference (q), BUMED commanded activities will submit formal lessons learned and AARs collected during any formal EM training or exercises to the NAVMED Operational Training Center (NMOTC), via their respective NAVMED region/ISIC, for incorporation into the Navy Operational Medical Lessons Learned Center (NMOLLC) system. The staff at the NMOLLC will ensure that it is submitted to the Joint Lessons Learned Information System (JLLIS) to be archived. AARs shall be maintained for a minimum of 2 years or until the next Joint Commission/Medical Inspector General visit, whichever is longer. Additionally, NAVMED regions will forward copies of all AARs and lessons learned to BUMED-M3B4 within 90 days following completion.

Figure 10.1 Exercise Planning Process Milestones



Standard 11: Prevention and Mitigation

1. The EM program establishes mitigation and prevention standards and tools, and all BUMED commanded activity commanders, COs, and OICs shall employ these tools, as well as effective planning to mitigate the effects natural or man-made hazards will have on their personnel, essential functions, and facilities.
2. Per reference (o), the syndromic surveillance tool in use by the DoD is the Electronic Surveillance System for Early Notification of Community-based Epidemics (ESSENCE). ESSENCE is a system and process for collecting, analyzing, and reporting installation population health, sensitive to significant fluctuations in normal disease rates. Per reference (o), MTFs must actively monitor ESSENCE and coordinate with regional and local civilian public health surveillance systems. Reference (o) requires DoD installations in the U.S. to maintain two trained ESSENCE users (one of whom may be the PHEO), to actively monitor the system. All MTFs shall maintain the capability to investigate and establish whether an infectious disease outbreak is occurring, and develop a case definition for victims of the outbreak. Where the capability exists, BUMED commanded activities shall assist in the identification and confirmation of disease agents, and in the prevention and/or mitigation of morbidity and

Standard 11: Prevention and Mitigation (Continued)

mortality related to any all-hazards event. Additionally, where the capability exists, BUMED commanded activities shall provide additional post-incident assistance to include providing an initial medical site survey, a medical risk assessment, and making recommendations regarding the appropriate respiratory/personnel protection for first responders/receivers.

3. In the event of a CBRN incident, activities shall utilize their cache of CPCs to support designated Category 1 and 5 personnel. Support for CPCs for Category 2 through 4 personnel will be based on guidance from higher authority promulgated through the operational and NAVMED Region commanders at the time of the incident.
4. In the event of a disease outbreak (e.g., pandemic influenza, etc.), MTF commanders, COs, and OICs shall provide support per guidance provided by higher authority at the time of the incident and promulgated through the operational and NAVMED Region commanders. Nothing in this manual supersedes the decision authority of the MTF commander, CO, or OIC to provide immediate response support.
5. Per reference (o), MTF commanders, COs, and OICs are required to ensure that during a public health emergency (PHE), the level of care provided to all enrolled beneficiaries is at a minimum, comparable to local community standards in the context of the PHE. Achieving and maintaining this level of beneficiary care during a PHE may require the implementation of special work schedules, the increased use of Reserve Component members, intermittent employees, re-employed annuitants, contractor personnel and volunteers, and coordination with the TRICARE managed care support contractor. Planning to ensure for the smooth transition of care for MTF-enrolled patients by non-DoD providers, to the extent that is necessary, must be accomplished well in advance of emergency conditions and the agreed-upon arrangements clearly communicated to all enrolled beneficiaries. The prior identification of mission critical personnel will help meet the two seemingly conflicting objectives – meeting operational mission requirements and providing beneficiary care. To fully manage expectations and appropriately educate the beneficiary population on the emergency response plan relating to access to care, it is imperative that risk communication messages and products include instructions pertaining to where to receive care in the event of a public health emergency.
6. In the event of a disease outbreak, MTFs shall be prepared to support mass dispensing and/or immunizing teams to screen and educate patients, dispense pharmaceuticals, and provide post-exposure immunizations. In coordination with the assigned PHEO, MTFs shall be prepared to support the medical recommendations the PHEO makes to the USN, USMC, or Joint Base regional and installation commanders regarding restriction of movement and the evacuation of personnel. Additionally, MTFs shall provide targeted and effective public health related communications for use by the region and installation commanders. These strategic risk communications shall be prepared in advance for generic public health threats (e.g., pandemic influenza), to facilitate rapid dissemination in the event of a PHE. The content of all such communications will be coordinated with the respective NAVMED Region Commands and BUMED (to include BUMED PAO Officer), who will ensure coordination with the Centers for Disease Control and Prevention (CDC) and other Federal, State, local, tribal, and HN public health agencies as needed.

Standard 11: Prevention and Mitigation (Continued)

7. Pharmaceuticals/CPCs. The Pharmacy Department Head at each MTF where CPCs are stored is responsible for the proper safeguarding and dispensing of the CPCs, whether used in preventive or curative medicine. MTFs shall create a normal working stock rotation per reference (v) to minimize expiration and sustainment costs. The stock levels in this program are set at established safety levels and shall not be reduced. MTFs shall take appropriate action by contacting their NAVMED Region to replace items that become unserviceable. In addition, The Food and Drug Administration (FDA) Shelf Life Extension Program (SLEP), which focuses upon deferring drug replacement costs for date sensitive pre-positioned material, shall be used aggressively to reduce replacement costs. CPCs are subject to all of the requirements of the SLEP and per references (bb) and (cc), MTF commanders, COs, and OICs shall ensure at least two personnel are designated as registered users of the web-based SLEP database. Per reference (bb), the SLEP database users shall ensure that all on-hand inventories of stockpiled pharmaceuticals are accurately entered into the SLEP database, and that inventory records are updated every 90 days, even if on-hand quantities have not changed.

a. CPCs shall be maintained in climate-controlled storage that meets the appropriate temperature and security requirements, and CPC antibiotic stocks shall be rotated with MTF “just in time” inventory/working stock.

b. To ensure emergency first receivers are protected against the effects of CBRN exposure, the CPCs must be readily available and appropriate contingency access procedures must be implemented.

c. MTFs maintaining a cache of CPCs for Category 1 and 5 personnel may only issue the nerve agent antidote in advance. The cache of convulsive antidote will only be issued to the host installation and tenant activities upon approval of a distribution plan by their assigned NAVMED Region EMO and PHEO. Antibiotics and radiation exposure antidotes shall remain under MTF control until authorized for release and distribution.

d. MTFs are encouraged to develop an integrated CPCs policy with their host installation and tenant commands with Category 1 and 5 personnel. The policy should address planning for rapid distribution, current threat levels, preparedness activities, pre- and post-incident exposure, distribution plans, provisions for security and access, storage requirements, storage location, administration and handling of CPCs and the recurring updates to their rosters of Category 1 and 5 personnel.

8. The responsibilities outlined in this standard should be carried out in coordination with the responsible Navy Environmental Preventative Medicine Unit and the assigned regional or installation PHEO.

Standard 12: Response

1. The EM program establishes common response standards for all NAVMED Category 5 personnel as required by references (a) through (l), (o), (r), and (z). Response capabilities for the NAVMED EM program are primarily limited to the first receiver level. EM response actions and requirements that extend beyond the scope of first receiver responsibilities remain the responsibility of the host installation and NAVMED Region commanders, as outlined in references (a) through (h), (o), and (z). However, BUMED commanded activities can provide medical response teams to an incident site if requested by an installation or NAVMED Region commander, if specified in an MAA, or if necessary in an “immediate response authority” capacity, as described in Standard 6, paragraph 3i(1).

2. The tiered response organization of the NAVMED EM program mirrors the tiered response concept described in the NRF [reference (t)]. The core elements of a response effort described in the NRF are as applicable to a BUMED activity level response as they are to a national level response, and they consist of:

- a. Gain and maintain situational awareness.
- b. Activate and deploy resources and capabilities.
- c. Coordinate response actions.

Additionally, 10 of the 15 National Planning Scenarios and four of the eight Key Scenario Sets include elements within the BUMED activity EM response capabilities. Specifically, the capability of an MTF to decontaminate and treat patients exposed to radiological, chemical, or biological agents/contaminants, and to respond to a pandemic crisis.

3. NAVMED response standards and actions must be consistent with OSHA, National Institute for Occupational Safety and Health (NIOSH), and NFPA standards, guidelines, and requirements.

4. As described in Section 2 and per references (t) and (u), BUMED commanded activities shall employ the HICS and the Unified Command System (UCS) for all EM contingencies.

5. Per references (b), (f) through (h), (o), and (z), in response to an all-hazards EM contingency, all BUMED commanded activities shall provide first receiver response support to the impacted USN/USMC region and installation to the maximum extent possible. BUMED activity response efforts will include (as needed):

- a. Medical and syndromic surveillance.
- b. Mass casualty care and decontamination.
- c. PHEO support.

Standard 12: Response (Continued)

- d. Triage and treatment.
 - e. Epidemiological support including health surveillance for disease containment.
 - f. Medical logistics support, including dispensing and immunizing teams.
 - g. CBRN CPCs support.
 - h. Environmental health and medical surveillance of potable water, food, air quality and animal health.
 - i. Medical site surveys and risk assessments.
 - j. Recommendations regarding personnel and respiratory protective equipment.
 - k. Transport (where applicable).
 - l. Support for quarantine and restriction of movement.
 - m. Psychological care.
 - n. Medical and public health risk communications.
6. All Tier 1 through 3 MTFs are issued Reactive Skin Decontamination Lotion (RSDL) for use in responding to a known or suspected chemical/HAZMAT exposure contingency. The intended use of the RSDL is for distribution to personnel awaiting decontamination.

Standard 13: Recovery

1. Near term recovery efforts will typically concentrate on re-establishing vital services such as power, communications, water, sewage, etc. These priorities notwithstanding, it is the restoration of the activity's ability to execute its critical missions and deliver essential FHP support that remains paramount. The role of the MEM and EMO during recovery operations remains the same as it is during Response operations: to maintain effective information flow to the chain of command and efficiently manage EM related resources.
2. During recovery operations onboard a Navy or Marine Corps installation, there are a variety of essential elements in which the MTF can expect to have a significant role including:
 - a. Mass casualty treatment, including personnel decontamination.
 - b. Public health support, including public health and environmental assessments, disease and vector control, potable water testing, and support for maintaining public hygiene.

Standard 13: Recovery (Continued)

- c. Public health emergency risk communications and advisories.
 - d. Mental health support.
 - e. Fatality management.
3. NAVMED recovery standards must be consistent with OSHA, NIOSH, NFPA, and other relevant Federal guidelines and standards.
4. Recovery efforts can quickly deplete an activity's EM recovery capabilities and require support from regional, installation, other Service, Federal, State, local, or HN EM recovery organizations. Prior coordination with these agencies and organizations, through the respective NAVMED and USN/USMC regions, will significantly enhance the overall EM recovery capabilities. While recovery efforts and the restoration of critical mission capabilities and support will be of paramount importance following an incident, the fiscal and logistical impact of response and recovery efforts can be enormous. Accordingly, activities and NAVMED Regions must be diligent in accurately capturing and recording the complete scope of response and recovery efforts, to facilitate a post-event accounting of the costs.

Standard 14: Sustainment

1. BUMED HQ will establish the programming, budgeting, and resourcing necessary to develop, execute, and sustain the NAVMED EM program requirements per reference (v). BUMED commanded activities, via their NAVMED regions, shall notify BUMED-M3 EP of any unique EM mission requirements, deficiencies, or new start programs that require unplanned resourcing to fulfill or resolve. BUMED HQ will validate these requests in close coordination with the respective NAVMED Region commander and once confirmed, program for their support.
2. Sustainment Management. The effective sustainment of EM materials, equipment, and pharmaceuticals is a shared responsibility between BUMED activities, the NAVMED Regions, and BUMED. BUMED-M3B4 will establish the life cycle replacement plan for all EM materials, equipment, and pharmaceuticals, based on the most recent information reflected in the Joint Medical Asset Repository (JMAR) system. MEMs shall identify EM material, equipment, and pharmaceuticals deficiencies and coordinate with their respective NAVMED Region to prioritize sustainment, replacement, and maintenance requirements. The replenishment of consumables and procurement of spare parts are the responsibility of the activities. Self-assessment checklists for use by EMOs and MEMs to benchmark the effectiveness of their EM programs have been implemented. Checklists were developed for inpatient capable MTFs, non-inpatient capable MTFs and non-MTFs.

Standard 14: Sustainment (Continued)

3. Equipment Maintenance. The proper maintenance and upkeep of EM/CBRN equipment and materials is the responsibility of the MTFs, and MEMs will ensure their assigned gear is maintained per the manufacturer recommendations and specifications. MEMs will ensure EM/CBRN equipment is properly cleaned and stored, following its use in training events and exercises. Minor equipment repairs are the responsibility of the MTFs. MEMs will ensure extensive repairs or equipment replacement is coordinated with their respective NAVMED Region/ISIC. Additional guidance concerning equipment maintenance and disposition is contained in reference (v).

4. BUMED will use an overarching EM equipment contract to procure the majority of equipment requirements identified on the H199 and H200 assemblages. MTFs that identify EM equipment shortfalls will submit a completed purchase order (DD Form 1149) to BUMED-M3B4 via their respective NAVMED Region.

5. Equipment Disposal. Guidance regarding the disposition of unserviceable EM equipment or equipment that has been superseded or removed from the authorized EM assemblages is contained in reference (v). Required EM equipment or supplies on-hand in quantities greater than the approved assemblage allowance levels will not be deemed “excessive” and will not be disposed. Excess approved equipment and supplies will be maintained until no longer serviceable or declared obsolete by BUMED. With the prior approval of BUMED and the respective NAVMED Region, excess equipment and supplies may be transferred to another MTF to mitigate shortfalls.

6. NAVMED EM Program Recurring Sustainment Requirements. The following table summarizes recurring annual and quarterly requirements essential for the sustainment of all NAVMED EM programs.

Table 14.1 NAVMED EM Program Sustainment Requirements

Requirement	Reference	Periodicity
Review the current Hazard Assessment (HA) (Revised and updated once every 3 years)	Standard 4	Annually
Conduct a Vulnerability Assessment (VA)	Standard 4	Annually
Complete a 100 percent physical inventory of all EM equipment	Standard 9	Annually
Conduct or participate in a minimum of two (inpatient MTFs) or one (outpatient MTFs) EM Full Scale Exercises (FSEs)	Standard 10	Annually
Complete a comprehensive review of the EM Plan	Standard 7	Annually
Review, exercise, and test COOP Plan	Reference (p)	Annually
Complete a minimum of 8 hours of OSHA's Hazardous Waste Operations and Emergency Response (HAZWOPER) training for all decontamination team personnel	Reference (aa) and 29 CFR 1910.120	Once
Review designation letters for the MEM/EMO, PHEO, and all Category 1 personnel	Standard 1 Standard 2 Standard 6	Annually
Review NIMS implementation	Section 2	Annually
Exercise and test the shelter-in-place Functional Response Plan	Section 3	Annually
Exercise and test the evacuation Functional Response Plan	Section 3	Annually
Exercise and test the mass casualty/mass care Functional Response Plan	Section 3	Annually
Exercise and test the pandemic Functional Response Plan	Reference (l)	Annually
Exercise and test the pandemic Functional Response Plan	Reference (l)	Annually
Complete the applicable FHP EM Program Self-Assessment Checklist	Standard 14	Annually
Complete an inventory spot-check of a minimum of 10 percent of EM decontamination response equipment and materials and update DMLSS	Standard 9	Quarterly
Complete a 100 percent inventory of all PI stockpile pharmaceuticals and equipment, and update DMLSS and SLEP	Standard 9 and reference (cc)	Quarterly
Conduct/participate in a meeting of the EMWG	Standard 6	Quarterly
Conduct an operational test of the Mass Warning and Notification System (MWNS) and exercise/test the mass notification and/or personnel accountability Functional Response Plan	Section 3	Quarterly
Exercise, test, and/or conduct training on the mass casualty decontamination plan/procedures and equipment	Section 3	Quarterly

Note: Not all requirements apply to all activities (e.g., Tier 4 MTFs and non-MTF facilities) are not fielded decontamination equipment, and thus the equipment inventory and HAZWOPER training requirements are not applicable.

SECTION 2

COMMAND AND CONTROL

Ref: (a) National Incident Management System (NIMS)
(b) National Response Framework (NRF)
(c) OPNAVINST 3440.17A
(d) Hospital Incident Command System (HICS) Guidebook

1. Purpose. Establish policy regarding NIMS and ensure its efficient and effective use in emergency management planning, response and recovery activities throughout BUMED commanded activities.

2. Applicability. All references herein after pertain only to this section.

3. Background

a. References (a) and (b) establish an all-discipline, all-hazards approach to the management of domestic incidents. Reference (c) requires the implementation of NIMS as the common command and control construct for all U.S. Navy EM response operations. Reference (d) meets NIMS requirements and has been developed with the support of the DHS NIMS Integration Center, Health and Human Services (HHS), the American Hospital Association, and the Joint Commission.

b. When directed, BUMED commanded facilities and personnel provide EM related support to civil authorities during domestic crises and may receive civilian support from mutual aid partners during contingencies. To facilitate efficient and effective cooperative interaction and mutual support during an emergency event, a common operating framework and language were developed. The NIMS and NRF were implemented by the DHS to provide that comprehensive and consistent national framework and operating system to all-hazard incident management at all jurisdictional levels and across functional disciplines.

c. The NIMS Integration Center, Incident Management Systems Integration Division, in collaboration with the Department of HHS, developed implementation activities for hospitals and health care systems to assist them with NIMS implementation and integration. The HICS Guidebook, reference (d), is the result of this collaboration.

d. Required NIMS and Incident Command System (ICS)/HICS training are addressed in Section 1, Standard 8, paragraph 5(a) and Table 8.1.

4. Action. BUMED commanded activity commanders, COs, and OICs shall:

a. Ensure EM plans incorporate NIMS and at MTFs, HICS. At non-MTFs, a NIMS compliant ICS will be incorporated.

b. Ensure HICS is implemented as the only approved ICS in use at MTFs during EM contingencies and training events. MEMs must plan for the use of a similar, NIMS compliant ICS at the host installation/region that will be compatible with, but not identical to HICS. At non-MTFs, EMOs will ensure that a NIMS compliant ICS is implemented for use during EM contingencies and training events.

c. Ensure NIMS and HICS/ICS training is monitored and documented in local training records, approved learning management system, per reference (dd), and other databases as required in Section 1, Standard 8.

d. Ensure the appropriate Job Action Sheets (JASs) per reference (d) are utilized whenever the activity implements HICS/ICS.

e. Ensure personnel serving in positions at the command staff or section chief level understand the relationship of their billet in the HICS/ICS construct, as compared to the conventional military staff structure.

f. Coordinate with USN, USMC or Joint Base regional and installation commanders (as appropriate) in developing relationships with the appropriate Federal, State, local, and tribal EM-related agencies and departments, and in identifying and updating responsible points of contact, emergency protocols, and expectations in the event of an incident. This task should also include local medical community organizational planning via local emergency planning committees.

g. Coordinate with USN, USMC, or Joint Base regional and installation EM personnel, BUMED HQ, and local emergency responders/ receivers in the development of MAAs.

5. Hospital Command Centers (HCCs)

a. Background. To meet Joint Commission requirements, a HCC shall be implemented at all Tier 1 and Tier 2 MTFs to provide commanders, COs, and OICs with a dedicated space and the communications tools necessary to maintain C2 during any incident, and to facilitate the effective implementation of HICS.

b. Responsibility. BUMED commanded activity commanders, COs, and OICs at Tier 1 and Tier 2 MTFs shall designate an appropriately sized space for an HCC.

c. Requirements

(1) The HCC shall be sized appropriately to support the HICS architecture.

(2) The HCC shall be a secured space/facility.

(a) Limit access to authorized personnel.

(b) Capable of supporting sensitive and/or classified discussions and briefings.

(3) The HCC shall provide the required work surfaces, computer stations, and wall displays to support a HICS based planning and response organization.

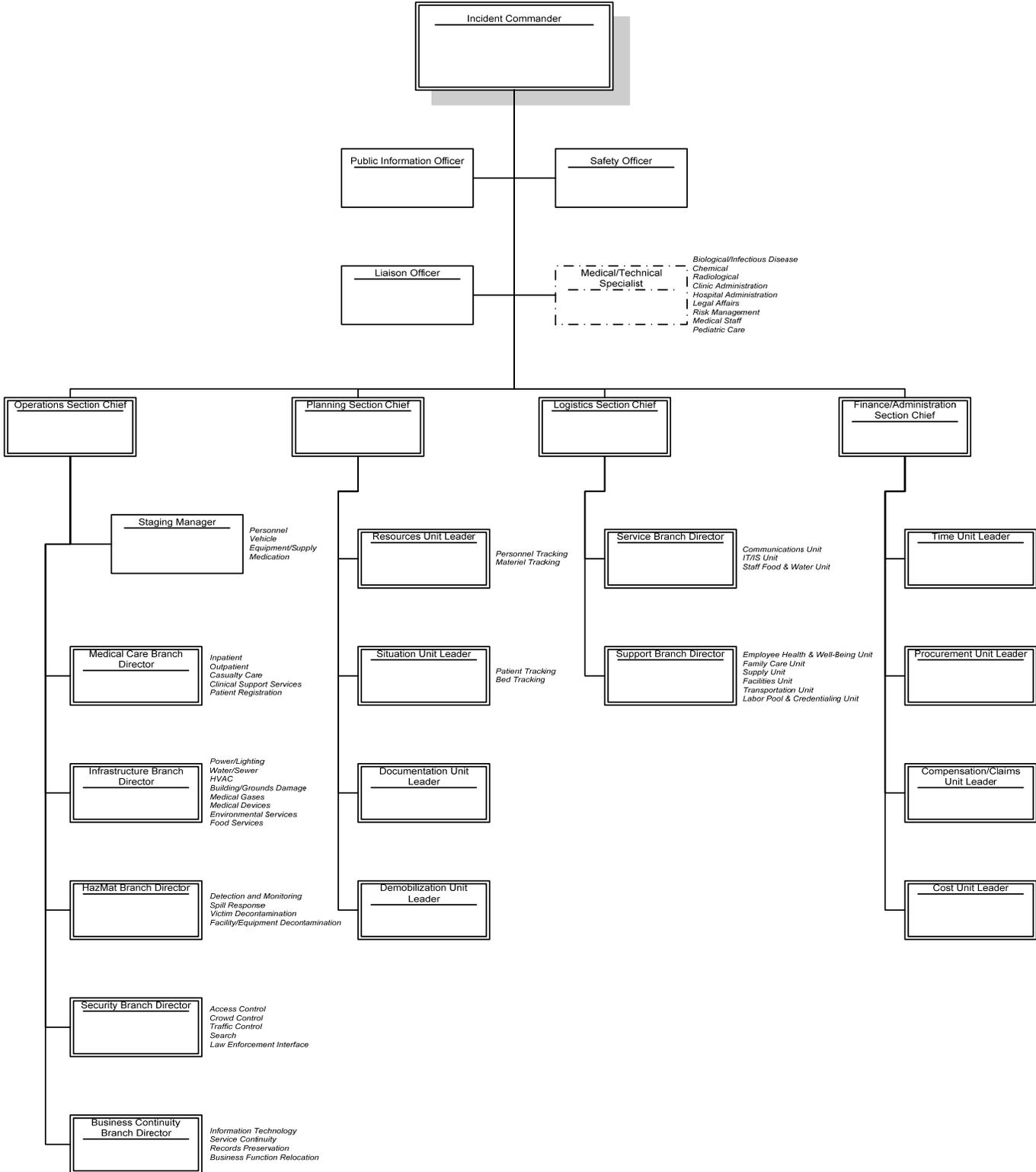
(4) The HCC shall utilize emergency backup power [i.e., Universal Power Supply (UPS)] for the watch floor, HVAC, computers, displays, and IT support equipment. Fuel reservoir size shall be based on potential threats and projected resupply timelines, but as a minimum, emergency power generation will support HCC operations for a minimum of 5 days.

(5) The HCC shall support dual utilization of the space during non-emergency conditions. Dual use functions shall not impede or delay stand up of the HCC. Potential dual use functions may include:

- (a) Computer-Based training (CBT).
- (b) Command planning activities.
- (c) Classified meetings.
- (d) CDO/quarterdeck operations (after-hours).

Figure 2-4.1 HICS 207 – Organization Chart

(Note: A larger version of Figure 2-4.1 can be found in the EM section of the BUMED MAX Federal portal)



SECTION 3

EM SUPPORT AND FUNCTIONAL RESPONSE PLANS

- Ref: (a) SECNAVINST 3400.4
(b) CNICINST 3440.17
(c) DoD Instruction 6200.03 of 5 Mar 2010
(d) OSHA 3249 Best Practices for Hospital-based First Receivers
(e) BUMEDINST 3500.5

1. Purpose. To provide guidance to BUMED commanded activity commanders, COs, and OICs on the content of EM plans.

2. Applicability. All references herein after pertain only to this section.

3. Background. EM planning will be standardized to the maximum extent possible. While EM plans will vary, the format and content should be standardized across all BUMED commanded activities. Maintaining standard formats and content supports capabilities-based planning, standard readiness metrics, streamlined training of personnel, and allows for economies of scale in logistical support and sustainment of the EM program.

4. Responsibility. All BUMED commanded activity commanders, COs, and OICs shall ensure EM planning follows the procedures outlined in this section.

5. Procedures

a. Develop an EM program that meets all the requirements of this instruction.

b. Ensure all the required supporting plans listed below are included in the activity EM plan. Additional annexes applicable to local risk-based hazards may be developed and included as desired.

6. Required Support Plans

a. Command and Control Plan

b. Communications Plan

c. Continuity of Operations Plan

d. Hazard Assessment (HA)

e. Physical Security Plan

f. National Disaster Medical System (NDMS) Plan (Federal Coordinating Centers only)

g. Hazard Mitigation and Recovery Plan

h. Acronyms

7. Functional Response Plans. Functional response plans represent the most critical element of a BUMED facility's EM program. They are the ready references for use by the facility in planning, training, and executing a functional response to any EM contingency. While the variety of potential emergency situations that a BUMED commanded facility may have to respond to are essentially limitless in diversity and scope, the functional response to any contingency can be distilled into one of the following categories:

a. Mass Notification/Personnel Accountability Response. This functional response covers any situation that requires a BUMED commanded facility to rapidly pass critical information to all hands, or to account for the status of all hands. This functional response may precede any of the follow-on functional responses listed below, or it may be a stand-alone contingency response in itself. Example contingencies that may trigger a mass notification or personnel accountability response include any event that requires the facility staff to shelter-in-place, evacuate, and respond to a mass casualty event or be accounted for in the aftermath of destructive weather. Per reference (a), Category 1 and 5 personnel must receive warning and notification within 5 minutes of an event. Category 2 through 4 personnel must receive warning and notification within 10 minutes of an event. These capabilities should be integrated with the mass warning and notification system(s) employed by the host installation, wherever possible.

Note: This response plan requirement applies to all BUMED commanded facilities.

b. Shelter-in-Place Response. This functional response covers any situation that requires a BUMED commanded facility staff to immediately take shelter within the building(s) to avoid potential exposure to injury or hazards. This functional response will always be preceded by a mass notification response, and it may precede a follow-on evacuation or mass casualty response. Example contingencies that may trigger a shelter-in-place response include a terrorist event, hazardous material spill, an active shooter, or unexpected severe weather. CNIC's guidance is that when shelter-in-place procedures are utilized, the goal is to protect a minimum of 90 percent of affected personnel within 15 minutes.

Note: This response plan requirement applies to all BUMED commanded facilities.

c. Evacuation Response. This functional response covers any situation that requires a BUMED commanded facility staff to immediately evacuate the building(s) (and potentially the installation) to avoid potential exposure to injury or hazards. This functional response will always be preceded by a mass notification response and may follow a shelter-in-place response. Example contingencies that may trigger an evacuation response include a terrorist event, hazardous material spill, an active shooter, or unexpected severe weather. The safe evacuation of threatened populations when endangered by a catastrophic event is one of the principle reasons for developing an EM Plan.

Note: This response plan requirement applies to all BUMED commanded facilities.

d. Mass Care/Mass Casualty Response. This functional response covers any situation that requires an MTF to rapidly assemble (and potentially locally deploy) their mass casualty team and prepare to receive casualties. This functional response will always be preceded by a mass notification response and it may follow a shelter-in-place or temporary evacuation response. Example contingencies that may trigger a mass casualty response include a terrorist event, hazardous material spill, a large-scale aircraft or vehicle accident, an active shooter or unexpected severe weather.

Note: This response plan applies to all BUMED commanded facilities required to maintain a mass casualty response.

e. Pandemic/Epidemic Response. This functional response covers any situation that requires an MTF to respond to a pandemic or epidemic contingency. Unlike the other functional response categories, this type of contingency does not occur within a very short time frame, requiring immediate response. Rather, a pandemic or epidemic unfolds over a period of days or potentially weeks, with comparatively significant preparation and response time.

Note: This response plan applies to all BUMED commanded facilities required to maintain a pandemic response.

8. Functional Response Planning. To help align BUMED commanded activity EM programs with BUMED requirements, the following functional response planning elements are provided.

**REQUIRED ELEMENTS FOR A
MASS NOTIFICATION/PERSONNEL ACCOUNTABILITY PLAN**

1. Essential Components. Many of the essential components are common across the functional response plans, which though redundant, enhance familiarity and standardize the responses.

a. Authorization to Initiate. The plan must spell out who can authorize a mass notification or personnel accountability response, both during and outside of normal working hours. Additionally, the plan must account for key personnel being unavailable and include alternates that can initiate the response.

b. Occasions for Initiation. The plan must explain the most common situations that warrant a mass notification or personnel accountability response.

c. Responsibility for Initiation. The plan must detail the personnel/positions responsible for initiating a mass notification or personnel accountability response, and the sequence of events for initiation. For example, the plan could identify the command duty officer (CDO) as the primary recipient of all initial notifications of any emergency from the base dispatch center. The plan must then clearly explain the CDO's responsibility to:

(1) Determine whether a mass notification or personnel accountability response tripwire has been reached; and if so,

(2) Brief leadership on the event and gain approval to execute the notification or accountability response;

(3) Notify the activity's Navy Family Accountability and Assessment System (NFAAS) coordinator to be prepared to validate personnel accountability in NFAAS; and,

(4) Execute the notification, including which additional watch standers will be briefed by the CDO and are responsible to help disseminate the information.

Note: MEMs, EMOs, and other essential EM response personnel should not be assigned personnel accountability duties, other than accounting for subordinate staff members. As specified in the basic instruction, these emergency essential personnel must be fully committed to leading and coordinating emergency response operations and cannot be engaged in personnel accountability reporting for their assigned activity.

d. Methods of Dissemination/Accounting. The plan must explain in detail the systems, in priority sequence, which will be used to disseminate the emergency information or account for personnel. The plan must include the details for the use of redundant and back-up systems for dissemination, in the event primary systems are unavailable or non-operational. Additionally, the plan must include procedures for a mass notification or personnel accountability response in the event telephone communications (cell and land line) and/or electrical systems are non-operational.

e. Pre-planned Messages. The plan must include pre-planned notification messages for the most likely situations that warrant a mass notification or personnel accountability response. The announcements should be pre-reviewed for risk communication, categorized by event type and maintained as a ready reference wherever watch standers are assigned duties to execute a notification response and collocated with the notification systems. The plan should detail standard information to be captured in any initial report the facility receives, as well as the standard information to be disseminated in each category of functional response. For example, the facility may specify the following information elements as mandatory in any Mass Care/Casualty Response notification:

- (1) Type of emergency
- (2) Estimated number of casualties
- (3) Type of casualties (chemical, blast and shrapnel, burns, etc.)
- (4) Status of patients; ambulatory and non-ambulatory
- (5) Mode of transportation being used to transport casualties and number/type of ambulances dispatched
- (6) Estimated time of arrival (ETA) of casualties to the facility.

f. Verification. The plan must spell out the process that will be employed to ensure the notification process is completely effective and that all affected personnel have been notified.

g. Plan for Visitors. The plan must explain the process for ensuring visitors, patients, contractors or other non-staff personnel who may be inside the facility are notified and understand any mandatory instructions. At facilities where a significant portion of the visitor/patient count has a primary language other than English, the plan should include bi-lingual pre-planned announcements for messages applicable to everyone in the facility.

h. Training and Exercises. The plan must include the details regarding recurring mass notification and personnel accountability response training and exercises. BUMED commanded facilities will exercise and test their mass notification and/or personnel accountability response process a minimum of once per quarter.

2. Best Practices

a. Keep it Simple. Complex warning alerts and messages, or an excessive number of announcements add to the confusion during an emergency situation. For this reason, simplicity should be engineered into all levels of a mass notification plan. Mass notification systems are valuable assets for every day, non-emergency communications. Using the facility's public address and intercom systems for both routine and emergency communications makes personnel familiar and comfortable with their use. For example, at the world's largest liquefied natural gas production facility, a single alert tone is used for all emergency situations, although the system is capable of providing hundreds of different tones. In this instance, once the tone sounds it is immediately followed up with detailed voice instructions broadcast over the public address system. By that time, however, the entire facility has already been alerted to the need to take immediate action.

b. Test and Evaluate Plans and Systems Regularly. Facilities should designate a minimum of 1 day each year for all employees to take part in refresher training, and should test and exercise their plans a minimum of once per quarter. Whenever the facility's HA is revised or new notification systems/hardware is installed, notification plans must be reviewed to ensure they remain accurate and that all likely emergency situations are accounted. Additionally, very few if any facilities are employing automated mass warning systems, so the performance of individual operators and watch standers remains a critical component to ensuring quick and instinctive emergency response. Make sure operators and watch standers are trained across departments in how and when to use the system, and to ensure necessary coverage 24/7.

c. Redundant and Alternate Systems Enable Failsafe Performance. The emergency situations and contingencies that trigger a mass notification or personnel accountability response will stress and potentially compromise the primary dissemination systems. Landline and cell sites in the affected area may be overloaded or down, the electrical power grid may be compromised and internet access may be unavailable. Regardless of how well planned and rehearsed a facility's mass notification and personnel accountability plans, if they don't account

for a loss of primary dissemination systems, they fall short of required redundancy. Integrating and practicing the use of alternate dissemination systems and methods that don't rely on utilities, for example bullhorns and messengers, will ensure failsafe performance during any contingency.

d. Standardize Warning Terminology. Effective warnings should use standard terminology that clearly communicates the immediacy, reliability, severity, and scope of the hazard and of the appropriate basic response.

e. Tell Them and Then Tell Them Again. Research shows that a message has to be delivered multiple times in multiple ways for it to be taken seriously and for recipients to act accordingly. Repeating emergency information is necessary for it to be effective. Public address and intercom systems, e-mail, and voice and text messaging, provide everyday functionality and enable the emergency information to be delivered using an array of messaging technologies.

f. Personnel Accountability. Establish a simple, repeatable process for obtaining an accurate count of all assigned personnel, including family members. Identify the personnel or watch standers responsible for executing the accountability response, and the communication methods and procedures to be used, both during and outside normal working hours. Presume any shelter-in-place or evacuation response will require a complete accounting of personnel afterwards. During an actual accountability response, the installation EOC and NAVMED Medical Regional Command Center (MRCC) will typically require a complete muster of assigned personnel, including the names and last known locations of personnel not accounted for.

REQUIRED ELEMENTS FOR A SHELTER-IN-PLACE PLAN

1. Essential Components. Many of the essential components are common across the functional response plans, which though redundant, enhance familiarity and standardize the responses.

a. Authorization to Initiate/Secure. The plan must spell out who can authorize a shelter-in-place response, both during and outside of normal working hours (if the facility is staffed outside normal working hours). Additionally, the plan must identify who can give the "all clear" to secure from a shelter-in-place response, or to shift to an evacuation response. The plan must also account for key personnel being unavailable and include alternates that can initiate/secure the response.

b. Occasions for Initiation. The plan must explain the most common situations that warrant a shelter-in-place response and key considerations for determining whether an evacuation response would be more effective and safer than sheltering-in-place.

c. Responsibility for Initiation. The plan must detail the personnel/positions responsible for initiating a shelter-in-place response, and the sequence of events for initiation. For example, the plan could identify the CDO as the primary recipient of all initial notifications of any emergency from the base dispatch center. The plan must then clearly explain the CDO's responsibility to:

- (1) Determine whether a shelter-in-place response tripwire has been reached; and if so,
- (2) Brief leadership on the event and gain approval to execute the shelter-in-place response (if necessary); and,
- (3) Execute the response, including the mass notification process and which additional personnel/watch standers are responsible for supporting actions (e.g., securing ventilation systems, doors, and windows).

d. Methods of Execution. The plan must explain in detail the systems, in priority sequence, which will be used to disseminate the emergency information, the actions necessary to secure air handling systems, windows and doors, and personnel/watch standers responsible. It must also detail the designated locations and actions needed for all assigned personnel, as well as, any visitors and contractors in the facility to take immediate shelter. The plan must include the details for the use of redundant and back-up systems for dissemination, in the event primary systems are unavailable or non-operational. Additionally, the plan must include procedures for notifying personnel outside or en-route to the facility.

e. Pre-planned Messages and Response Procedures. The plan must include pre-planned notification messages for the most likely situations that warrant a shelter-in-place response. The plan should also require the use of shelter-in-place pre-planned response procedures, which should be placed adjacent to ventilation and air handling systems, entrances and exits, and at selected windows as a ready reference for personnel/watch standers assigned duties to execute a shelter-in-place response. Additionally, the pre-planned procedures should provide instructions for personnel who regularly work with classified or controlled materials (e.g., pharmaceuticals) to secure and protect the materials prior to departing for a designated shelter-in-place location. It should also spell out the procedures for any designated critical personnel who must remain at their posts to secure or operate critical equipment or perform essential duties after a shelter-in-place order.

f. Verification. The plan must spell out the process that will be employed to ensure the shelter-in-place process is completely effective and that all effected personnel have been notified and are properly sheltered. Presume any shelter-in-place response will require a complete accounting of personnel afterwards.

g. Plan for Visitors. The plan must explain the process for ensuring visitors, patients, contractors, or other non-staff personnel who may be inside the facility are notified and understand any mandatory shelter-in-place instructions. At facilities where a significant portion of the visitor/patient count has a primary language other than English, the plan should include bi-lingual pre-planned announcements for messages applicable to everyone in the facility.

h. Training and Exercises. The plan must include the details regarding recurring shelter-in-place response training and exercises. BUMED commanded facilities will exercise and test their shelter-in-place response process a minimum of once per year.

2. Best Practices

a. Keep it Simple. A shelter-in-place response is executed to mitigate a contingency that has occurred or is occurring with little or no warning. Accordingly, for it to be effective, it needs to be executed very quickly by all hands. Complex warning alerts and messages, or an excessive number of announcements add to the confusion during an emergency situation. For this reason, simplicity should be engineered into all levels of a shelter-in-place plan.

b. Test and Evaluate Plans and Systems Regularly. Facilities should designate a minimum of 1 day each year for all employees to take part in refresher training, and should test and exercise their shelter-in-place plan a minimum of once annually. Whenever the facility's HA is revised or new air handling systems, doors or windows are installed, shelter-in-place plans must be reviewed to ensure they remain accurate and that all likely emergency situations are accounted. A shelter-in-place response is an all hands action, so make sure all hands are trained and familiar with how and when to execute a shelter-in-place response. Additionally, to account for personnel that may be on leave or TAD during an event, assign primary and back-up personnel to secure ventilation and air-handling systems, as well as all doors and windows.

c. Redundant and Alternate Systems Enable Failsafe Performance. The emergency situations and contingencies that trigger a shelter-in-place response will stress and potentially compromise the primary response procedures. Landline and cell sites in the affected area may be overloaded or down and the electrical power grid may be compromised. Failsafe performance requires integrating and practicing the use of alternate notification systems and shelter-in-place processes that don't rely on utilities (e.g., securing ventilation and air handling systems locally/ manually) in the event electrical controls fail.

d. Standardize Warning Terminology. Effective warnings should use standard terminology that clearly communicates the immediacy, reliability, severity, and scope of the hazard and of the appropriate basic response.

e. Tell Them and Then Tell Them Again. Research shows that a message has to be delivered multiple times in multiple ways for it to be taken seriously and for recipients to act accordingly. Repeating emergency information is necessary for it to be effective.

f. Is it Shelter-in-Place, Shelter, Safe Haven, or Evacuation? Avoid confusion between these similar sounding contingency options for protecting personnel by explaining the differences in the Shelter-in-place Plan.

(1) Shelter-in-Place consists of providing temporary protection or refuge for personnel within a structure (or vehicle) during an emergency. It is a short-term solution to mitigate the affected personnel's exposure to a hazard such as severe weather or a chemical release, or to a threat such as an active shooter.

(2) A Shelter is a certified, supplied, staffed, and insured public facility where the endangered population may seek temporary protection for a limited duration. Designated shelters will almost always be off-base and will require an evacuation of the BUMED commanded facility in order to employ the safety of an official shelter.

(3) A Safe Haven is a pre-designated facility that is not publicly identified for use as temporary protection. This location is usually not certified, insured, supplied, or regularly staffed. A military installation may designate specific buildings meeting specified structural requirements as safe havens for use by the base population, primarily for severe weather (tornado, hurricane, etc.) contingencies. Use of a safe haven will also require an evacuation of the BUMED commanded facility.

(4) During an Evacuation, an endangered population is directed to use specified evacuation routes and transportation methods to depart a threatened area/location. Evacuation may be to a designated shelter, safe haven, the staff member's residence, or outside the geographic area entirely. Evacuation is covered in detail in the next section.

REQUIRED ELEMENTS FOR AN EVACUATION PLAN

1. Essential Components. Many of the essential components are common across the functional response plans, which though redundant, enhance familiarity and standardize the responses.

a. Authorization to Initiate/Secure. The plan must spell out who can authorize an evacuation response, both during and outside of normal working hours (if the facility is staffed outside normal working hours). Additionally, the plan must identify who can give the "all clear" to secure from an evacuation response. The plan must also account for key personnel being unavailable and include alternates that can initiate/secure the response.

b. Occasions for Initiation. In emergencies with sufficient warning time, evacuation of all or designated personnel is the preferred protection strategy. The plan must explain the most common situations that warrant an evacuation response and key considerations for determining whether a shelter-in-place response would be more effective and safer than an evacuation.

c. Responsibility for Initiation. The plan must detail the personnel/positions responsible for initiating an evacuation response, and the sequence of events for initiation. For example, the plan could identify the CDO as the primary recipient of all initial notifications of any emergency from the base dispatch center. The plan must then clearly explain the CDO's responsibility to:

- (1) Determine whether an evacuation response tripwire has been reached; and if so,
- (2) Brief leadership on the event and gain approval to execute the evacuation response (if necessary); and,
- (3) Execute the response, including the mass notification process and which additional personnel/watch standers are responsible for supporting actions, e.g., directing personnel to designated evacuation routes, etc.

d. Methods of Execution. The plan must explain in detail the systems, in priority sequence, which will be used to disseminate the emergency information and the actions necessary for all

assigned personnel, as well as, any visitors and contractors in the facility to evacuate. The plan must include the details for the use of redundant and back-up systems for dissemination, in the event primary systems are unavailable or non-operational. Additionally, the plan must include procedures for notifying personnel outside or en-route to the facility. For BUMED commanded facilities with an inpatient capability, their evacuation plans must include the evacuation of all (or selected) patients, to include how, when and by whom they will be evacuated. Where applicable, reference the established Federal Coordinating Centers (FCCs), NDMS, and other relevant Mutual Aid Agreements (MAA) for transfer of patients to other medical facilities. Describe where and how patients will be staged while awaiting transport. Execution procedures must plan for providing transportation for the evacuation of non-emergency essential staff or visitors that rely on public transportation, carpooling or similar means of non-independent transportation. They must also plan for evacuating special needs persons with either physical or mental handicaps, including disability challenged persons.

e. Pre-planned Messages and Response Procedures. The plan must include pre-planned notification messages for the most likely situations that warrant an evacuation response. The Evacuation Plan must establish pre-designated assembly areas; locations away from the building/facility/installation where personnel must gather after evacuating to receive critical information and to be accounted for. The designated assembly areas will consist of both physical (another facility, installation, or off-base location such as a hospital) and electronic (cellular telephone number, interactive notification system, Web-site, or collaborative portal) “rally points” to accommodate evacuation from just a single building or facility, or from the entire installation. Additionally, evacuation procedures should provide instructions for personnel who regularly work with classified or controlled materials (e.g., pharmaceuticals) to secure and protect the materials prior to departing for a designated shelter-in-place location. It should also spell out the procedures for any designated critical personnel who must remain at their posts to secure or operate critical equipment or perform essential duties after an evacuation order. The plan must also include procedures for disseminating critical information regarding COOP, the use of alternate facilities and approval to return to duty, to all hands/designated personnel after the evacuation is completed.

f. Verification. The plan must spell out the process that will be employed to ensure the evacuation process is completely effective and that all effected personnel have been notified and are evacuated. Presume any evacuation response will require a complete accounting of personnel afterwards.

g. Plan for Visitors. The plan must explain the process for ensuring visitors, patients, contractors, or other non-staff personnel who may be inside the facility are notified and understand any mandatory evacuation instructions. At facilities where a significant portion of the visitor/patient count has a primary language other than English, the plan should include bilingual pre-planned announcements for messages applicable to everyone in the facility.

h. Training and Exercises. The plan must include the details regarding recurring evacuation response training and exercises. BUMED commanded facilities will exercise and test their evacuation response plans a minimum of once per year. FEs that assess the efficacy of the

facility's Evacuation Plan are the most effective means of identifying potentially critical problems in transportation resources (particularly with non-ambulatory patients) and evacuation routes, including potential bottlenecks and choke points.

2. Best Practices

a. Keep it Simple. An evacuation response is often executed to mitigate a contingency that has occurred or is occurring with minimal warning. Accordingly, for it to be effective, it needs to be executed very quickly by all hands. Complex warning alerts and messages, or an excessive number of announcements add to the confusion during an emergency situation. For this reason, simplicity should be engineered into all levels of an evacuation plan.

b. Test and Evaluate Plans and Systems Regularly. Facilities should designate a minimum of 1 day each year for all employees to take part in refresher training, and should test and exercise their evacuation plan a minimum of once annually. BUMED commanded facilities can combine their mass warning, shelter-in-place, evacuation, and related EM response plan training to enhance efficiency, provided the necessary training objectives are met. Whenever the facility's HA is revised, evacuation plans must be reviewed to ensure they remain accurate and that all likely emergency situations are accounted. An evacuation response is an all hands action, so make sure all hands are trained and familiar with how and when to execute an evacuation response. Additionally, to account for personnel that may be on leave or TAD during an event, assign primary and back-up personnel to any necessary evacuation support duties.

c. Redundant and Alternate Systems Enable Failsafe Performance. The emergency situations and contingencies that trigger an evacuation response will stress and potentially compromise the primary response procedures. Landline and cell sites in the affected area may be overloaded or down and the electrical power grid may be compromised. Failsafe performance requires integrating and practicing the use of alternate notification systems and evacuation processes that don't rely on utilities in the event electrical controls fail.

d. Standardize Warning Terminology. Effective warnings should use standard terminology that clearly communicates the immediacy, reliability, severity, and scope of the hazard and of the appropriate basic response.

e. Tell Them and Then Tell Them Again. Research shows that a message has to be delivered multiple times in multiple ways for it to be taken seriously and for recipients to act accordingly. Repeating emergency information is necessary for it to be effective.

f. Integrate Evacuation Planning. The facility's evacuation procedures must be integrated with their COOP Plan and the movement of Category 1 (critical mission support) and other essential personnel to a designated emergency relocation site (ERS), as well as the continued support of critical missions which may delay or preclude their immediate evacuation. BUMED commanded activities must also ensure their Evacuation Plan is integrated with the host installation's evacuation planning, and that any emergency announcements made in conjunction with the evacuation are first vetted against any related public information broadcasts being issued by the host installation; i.e., ensure your evacuation instructions do not send staff into other hazardous areas or through impassable routes.

g. Evacuation Routes and Teams. Designate primary and secondary evacuation routes and have these routes clearly marked and well lit. Evacuation routes should include pre-event fielding of evacuation route markers and/or signs, which can be easily read during an emergency, including during low light conditions. Ensure all evacuation routes are wide enough to accommodate the number of evacuating personnel and patients in wheelchairs or litters. Ensure the routes remain clear and unobstructed at all times and that they are unlikely to expose evacuating personnel to additional hazards. The use of pre-designated and trained evacuation teams or wardens to supervise and facilitate evacuation routes is an invaluable “best practice” in executing a successful evacuation.

REQUIRED ELEMENTS FOR A MASS CARE/MASS CASUALTY PLAN

1. Background. A mass casualty contingency, particularly one involving the decontamination of patients, is the most demanding and difficult EM response any BUMED commanded activity must be prepared for. A mass casualty event can quickly overwhelm an MTF’s response capability and exhaust available resources. Per reference (b), NAVMED provides the medical support to the Navy’s installation EM program. Accordingly, activities shall coordinate with both their host installation and their NAVMED Region/ISIC to support the installation EM program, and will be prepared to respond with medical support to the maximum extent of their capabilities. As explained in reference (c), when all available resources are insufficient to meet the health care needs of beneficiaries in a public health emergency, the BUMED activity shall use its limited resources to achieve the greatest good for the greatest number. Under these circumstances, “good” is defined as lives saved and suffering alleviated. In an environment of insufficient resources, BUMED commanders shall not require expenditure of resources if treatment likely would prove futile, or if a disproportionate amount of assets would be expended for one individual at the cost of many other lives that could otherwise be saved. Commanders shall ensure the most competent medical authority is available, at the lowest level possible, to make medical judgments of this nature. Decisions involving triage for care and the allocation of medical supplies must take into account the values of personal rights and fairness to all. However, critical mission requirements may require allocation of resources based on operational rather than medical risk. BUMED commanders must communicate regularly and clearly on the resource limitations that exist at their facilities to maximize the communities’ effective response to a public health emergency.

2. Essential Components. Many of the essential components are common across the functional response plans, which though redundant, enhance familiarity, and standardize the responses.

a. Base Mission Support. Outline the activity’s role in supporting the base mission with a clear explanation of installation medical response. Address the activity’s role in supporting a base contingency response.

b. Contributing Organizations. Include all units and organizations (military and civilian) that have a role in the mass care/mass casualty plan or support the activity during contingency response operations. Briefly describe the support provided by these entities, a means of activating support agreements, if applicable, and provide a point of contact with a current address

and telephone number. MOUs/MOAs/MAAs and applicable contracts containing contingency response clauses must be fully coordinated in writing. All contributing organizations identified in the plan should have an opportunity to review and comment on the plan prior to publication.

c. Authorization to Initiate/Secure. The plan must spell out who can authorize a mass care/mass casualty response, both during and outside of normal working hours (if the facility is staffed outside normal working hours). The plan must also account for key personnel being unavailable and include alternates that can initiate/secure the response.

d. Occasions for Initiation. The plan must explain the most common situations that warrant a mass care/mass casualty response.

e. Responsibility for Initiation. The plan must detail the personnel/positions responsible for initiating a mass care/mass casualty response, and the sequence of events for initiation. For example, the plan could identify the CDO as the primary recipient of all initial notifications of any emergency from the base dispatch center. The plan must then clearly explain the CDO's responsibility to:

(1) Determine whether a mass care/mass casualty response tripwire has been reached; and if so,

(2) Brief leadership on the event and gain approval to execute the mass care/mass casualty response (if necessary); and,

(3) Execute the response, including the mass notification process and which additional personnel/watch standers are responsible for supporting actions, e.g., assembling the decontamination team, etc.

f. Pre-planned Messages and Response Procedures. The plan must include pre-planned notification messages for the most likely situations that warrant a mass care/mass casualty response. For example, the facility may specify the following information elements as mandatory in any mass care/casualty response notification:

(1) Type of emergency

(2) Estimated number of casualties

(3) Type of casualties (chemical, blast, and shrapnel, burns, etc.)

(4) Status of patients; ambulatory and non-ambulatory

(5) Mode of transportation being used to transport casualties and number/type of ambulances dispatched

(6) Estimated Time of Arrival (ETA) of casualties to the facility.

g. Methods of Execution. The plan must explain in detail the systems, in priority sequence, which will be used to disseminate the emergency information and the actions necessary for all assigned personnel. Additionally, any mass care/mass casualty response will require a mass notification response that generally includes the evacuation of any visitors and contractors in the facility. The plan must include the details for the use of redundant and back-up systems for dissemination, in the event primary systems are unavailable or non-operational. Additionally, the plan must include procedures for notifying personnel outside or en-route to the facility.

h. Key Assumptions. The following assumptions should be included in the plan, as applicable:

(1) Fire/rescue personnel will respond and assist per their standard operating procedures. Explain the role of fire/rescue in the mass casualty response and focus on explaining what actions the MTF is responsible for, versus the actions fire/rescue is responsible for.

(2) The MTF will have an initial response capability.

(3) The surrounding civilian hospitals will accept patient transfers per TRICARE and support agreements. Identify which local civilian hospitals are integrated into the MTF's mass casualty/mass care plan and explain their role.

(4) Supplies, equipment, and funds will be made available upon implementation of this plan to sustain increased ops tempo.

i. Space Allocation. Include a description and diagram of mass casualty team work spaces as well as anticipated patient flow within the facility during a contingency. Include any mass casualty operations areas that are outside the facility as well, such as patient decontamination or triage.

j. The Mass Care/Mass Casualty Plan must establish pre-designated casualty collection points (CCPs) or casualty receiving areas; locations where assigned mass casualty teams will gather to await the receipt of incoming casualties. Additionally, the plan must establish a decontamination team to include all supporting elements per Standard 3 of Section 1 of this manual.

k. Triage Categories. Include a description of the triage system used on the installation and ensure it complies with DoD and U.S. Navy policy.

l. Medical Command and Control. Describe the responsibilities of the MTF commander, CO, or OIC during a disaster/contingency. List the commander's, CO's, or OIC's responsibilities, including providing command and control over mass casualty team operations and coordinating with the host installation EOC as appropriate. Provide the details of the expected MTF support to the host installation EOC if appropriate. Identify the unit's chain of command, and list key and emergency staff for COOP operations.

Note: The incident commander has tactical control of medical personnel at the incident site.

m. Response Codes. Units that have internal emergency response code systems (code pink for child abduction, code red for fire, etc.) will describe those codes and associated response procedures, noting any deviations from a standard response required during a mass casualty/mass care contingency.

n. Patient Support. Address maximum anticipated patient population during mass casualty/mass care contingencies, including projected changes in availability of medical services, curtailment of routine services during contingency operations, and the resulting patient redistribution. Address enrolled patients as well as potential non-enrolled patients, such as base civil service employees or contractors who may seek care during an emergency. If routine care will not be curtailed, describe the prioritization of routine care.

o. Casualty Management. Describe casualty management for each respective mass casualty/mass care team, to include casualty flow within the facility and transportation of casualties to the MTF and other facilities.

p. Triage. Triage support will be comprised of at least one provider (physician, dentist, PA, or IDC) and one nurse or medical technician to triage patients arriving at the MTF (primary team) and a similar team to provide triage after patient decontamination (secondary team), if decontamination is required. If patient decontamination is not required, the primary triage team will rejoin the secondary triage team to transition into one team. The triage team should be activated at the same time as the patient decontamination team during a HAZMAT or suspected CBRN incident and at the same time as the clinical services teams during all other mass casualty contingencies.

q. Clinical Services. In facilities where there are limited physicians/providers, the MTF commander, CO, OIC, or HCC may designate a single clinical services team to execute the consolidated duties of the minimal, delayed, and immediate clinical support teams (descriptions follow):

(1) Minimal. This team treats patients with minor injuries who require some attention, but whose injuries are so slight that they may not need a physician. Most of these patients can be returned to duty promptly. Include the radiological dose tracking procedures for personnel working outdoors as determined by the local Radiation Safety Officer.

(2) Delayed. This team treats patients whose injuries are significant but not immediately life threatening. Injuries in this category may require surgery or extensive medical care.

(3) Immediate. This team treats patients whose injuries demand immediate medical or surgical intervention to save life or limb.

r. Surgery. The plan must explain surgical support during contingency operations. MTFs that do not have a surgical capability will address how they will manage surgical casualties and where/how they will be transferred for surgical services.

s. Radiology. The plan must explain diagnostic imaging support during contingency operations. Discuss radiology exam prioritization.

t. Laboratory. The plan must explain diagnostic laboratory and transfusion services in support of contingency operations.

u. Pharmacy. The plan must explain pharmacy support and the distribution of medications during contingency operations. Outline the mass prophylaxis plan to support pre- and post-exposure requirements. Outline procedures to request assets from the Strategic National Stockpile (SNS) (in CONUS) or established overseas stockpiles. Establish procedures for a mass prophylaxis distribution process. Include installation distribution priorities, locations, tracking mechanisms, and training requirements. Ensure the installation mass prophylaxis plan addresses procedures for radiological countermeasures as necessary.

v. Nursing Services. The plan must explain nursing services support during contingency operations; ensuring support for patient reception, stabilization, re-triage, and transport are addressed as necessary.

w. NDMS Patient Reception. For MTFs officially tasked to support the patient reception NDMS mission, address the planning for NDMS support including medical administration, communications, logistics, litter-bearers, and transportation. The MTF support may consist of military and/or civilian personnel, depending on the local Federal Coordinating Center (FCC). Describe the MTF's mission in support of NDMS patient reception, including how to receive, triage, and care for patients as they arrive at the patient receiving area, distribute patients to NDMS hospitals, and manage patient movement items.

x. Public Health. Describe support to the PHEO during public health emergencies and installation contingency response. As applicable, describe public health needs assessment techniques and procedures, site selection consultation, communicable and vector-borne disease surveillance, prevention, control, and reporting; food safety and decontamination oversight; food borne illness outbreak investigations and food vulnerability assessments; medical intelligence and health threat assessment.

y. Patient Administration. Describe patient administration functions during mass casualty/mass care contingency scenarios. Describe the plans for patient movement, patient tracking, and status reporting procedures for both patients within the facility and those transported to other area medical facilities.

z. Medical Logistics. Address logistics support planning and requirements for a mass casualty/mass care contingency, to include mass prophylaxis planning and SNS distribution.

aa. Traumatic Stress Response. Describe responsibilities in providing mental health services to patients and providers during mass casualty/mass care contingency response operations.

bb. Facilities Management. Describe facility management activities in ensuring maintenance and repair support, availability of required utilities, and maintenance or repair of

communication assets. Include procedures in response to contingency events, to include but not limited to, oxygen shut-off procedures and locations, HVAC shut-off procedures and locations, power locations, emergency water shut-off, alternate water source, and emergency entry control.

cc. Patient Decontamination. Explain how the MTF, with or without inpatient capability, will provide thorough patient decontamination prior to patients entering the MTF or being transported to off base definitive medical care. Describe the use of permanent fixed-facility and portable decontamination capabilities, as applicable. Describe the Concept of Operations (CONOPS) for patient decontamination during and outside of normal working hours. Include a diagram of the decontamination operations site plan that depicts the location of primary and alternate decontamination sites, the location of the decontamination equipment storage, the location of the water supply (for portable decontamination shelters) and the plan for patient flow from arrival at the MTF, through triage and decontamination, and into the MTF. Reference (d) serves as the BUMED policy regarding patient decontamination operations, and an excellent reference for the manning, equipping and training of the MTF patient decontamination response teams.

dd. Transportation. Describe the plans for patient transportation during a mass casualty event, including any Mutual Aid Agreements (i.e., ISSAs, MOUs, MOAs, and MAAs) for additional vehicle support, or for transportation support from local civilian sources. Include the procedures identified in local ISSAs, MOUs, MOAs, and MAAs for transporting potentially contaminated patients.

ee. Public Information. Identify the plans for providing public information announcements and situation updates to staff, patients, and beneficiaries, including dispersed staff members. Identify the primary and alternate sources of medical public information, the communications systems used to collect and distribute the information, and the approval process for releasing the information. Include the CONOPS for preplanned risk communication and public health information messages, particularly as applicable to pandemic response planning. Also consider providing specific information on alternate sources of care.

ff. Blood Program. Describe procedures necessary to provide blood and blood products for casualty treatment during mass casualty/mass care contingencies. If applicable, indicate agreements with local agencies for obtaining emergency blood supplies. Designated blood donor centers should describe procedures, personnel requirements, and facilities necessary to continue and/or expand blood collection activities. Facilities with in-place frozen blood teams should specify provisions for activation, operation, and resupply.

gg. Plan for Visitors. The plan must explain the process for ensuring visitors, patients, contractors, or other non-staff personnel who may be inside the facility are notified and understand any mandatory evacuation instructions. At facilities where a significant portion of the visitor/patient count has a primary language other than English, the plan should include bi-lingual pre-planned announcements for messages applicable to everyone in the facility.

hh. Training and Exercises. The plan must include the details regarding recurring mass care/mass casualty response training and exercises. BUMED commanded facilities will exercise and test their mass care/mass casualty response plans a minimum of once per year. For those facilities with a patient decontamination capability, the mass casualty decontamination plan/procedures and equipment must be exercised once per quarter, to ensure team continuity and verify decontamination system/equipment performance. FEs that assess the efficacy of the facility's mass care/mass casualty plan are the most effective means of identifying potentially critical problems in transporting, receiving, and triaging casualties.

3. Best Practices

a. Keep it Simple. A mass care/mass casualty response is often executed to mitigate a contingency that has occurred or is occurring with minimal warning. Accordingly, for it to be effective, it needs to be executed very quickly by all hands. Complex warning alerts and messages, or an excessive number of announcements add to the confusion during an emergency situation. For this reason, simplicity should be engineered into all levels of a mass care/mass casualty plan.

b. Test and Evaluate Plans and Systems Regularly. Facilities must exercise and assess their mass care/mass casualty plan a minimum of once annually, and must exercise their mass casualty decontamination plan/procedures once per quarter. BUMED commanded facilities can combine their mass warning, evacuation, mass casualty and related EM response plan training to enhance efficiency, provided the necessary training objectives are met. Whenever the facility's HA is revised, mass care/mass casualty plans must be reviewed to ensure they remain accurate and that all likely emergency situations are accounted. Additionally, to account for personnel that may be on leave or TAD during an event, assign primary and back-up personnel to any necessary mass care/mass casualty support duties.

c. Redundant and Alternate Systems Enable Failsafe Performance. The emergency situations and contingencies that trigger a mass care/mass casualty response will stress and potentially compromise the primary response procedures. Landline and cell sites in the affected area may be overloaded or down and the electrical power grid may be compromised. Fail-safe performance requires integrating and practicing the use of alternate notification systems and evacuation processes that don't rely on utilities in the event electrical controls fail.

d. Standardize Warning Terminology. Effective warnings should use standard terminology that clearly communicates the immediacy, reliability, severity, and scope of the hazard and of the appropriate basic response.

e. Tell Them and Then Tell Them Again. Research shows that a message has to be delivered multiple times in multiple ways for it to be taken seriously and for recipients to act accordingly. Repeating emergency information is necessary for it to be effective.

f. Establish Emergency Credentialing Procedures. A mass casualty emergency is likely to overwhelm a BUMED commanded facility's ability to respond and per reference (c), establishing procedures in advance for the emergency credentialing of health care providers and the integration of volunteers can save time and potentially lives.

g. Integrate Response Planning. A mass casualty emergency is one of the most complex and demanding contingencies that a BUMED commanded facility will ever have to respond to. This type of emergency situation will stress every facet of the facility's capabilities and will inherently involve multiple EM responses including mass notification and evacuation (of non-essential staff and visitors). The facility's mass notification and evacuation procedures must be integrated with their mass casualty plan. BUMED commanded activities must also ensure their mass casualty plan is integrated with the host installation's EM Plan.

REQUIRED ELEMENTS FOR A PANDEMIC/EPIDEMIC PLAN

Essential Components. Reference (e) is the definitive guidance for establishing a Pandemic Response Plan at BUMED commanded facilities. The instruction provides a detailed planning template with requirements for supporting annexes, as well as required components and elements decomposed down to the functional level. Additionally, the instruction provides guidance for developing and implementing supporting mass prophylaxis/ point of distribution and communication/education plans. Rather than attempting to condense and repeat the requirements and guidance contained in the reference in this instruction, MEMs and EMOs at BUMED commanded facilities shall refer to reference (e) for any information regarding establishing, executing, or evaluating a pandemic/epidemic plan.

SECTION 4

NAVMED EMO AND MEM POSITION CLASSIFICATION, QUALIFICATIONS, AND TECHNICAL CAPABILITIES

Ref: (a) DoD Instruction 6200.03 of 5 Mar 2010
(b) Office of Personnel Management (OPM) Position Classification for Program
Manager Series 0301

1. Purpose. To provide guidance regarding the qualifications and technical capabilities per references (a) and (b) for MEMs and EMOs across BUMED activities.
2. Applicability. All references herein after pertain only to this section.
3. Background. Emergency Management as a professional career has been growing in scope and regulation since the creation of the U.S. Department of Homeland Security. Accordingly, NAVMED must ensure fully qualified and technically competent personnel are detailed and/or employed in the primary EM positions of EMOs and MEMs. The effective staffing of these critical positions is the most important component in assuring the effective execution of the BUMED FHP EM program and the successful integration with Federal, State, local, and tribal EM programs.
4. Scope. The guidance and requirements set forth in this section apply to all current and future NAVMED personnel assigned to the primary EM duties of EMO or MEM, even if not specifically titled an EMO or MEM.
5. Action
 - a. BUMED HQ, NAVMED Region Commands and all Tier 1 and 2 MTFs shall assign a qualified commissioned officer or civil service staff member in writing to the duties of a full-time EMO or MEM position. The assignment of any collateral duties to EMOs and MEMs at these commands is specifically prohibited.
 - b. Tier 3 MTFs shall assign a qualified commissioned officer, chief petty officer, or civil service staff member in writing to the duties of a full or part-time MEM position. If a Tier 3 facility assigns an MEM on a part-time (collateral duty) basis, that assignment must be their only collateral duty.
 - c. Tier 4 and non-MTF facilities shall assign a qualified uniformed service member or civil service staff member in writing to the duties of a full or part-time MEM position.
 - d. NAVMED Region Commands and all BUMED commanded facilities shall utilize a BUMED-approved qualification standard for hiring or converting personnel to perform EM functions within NAVMED as civilian employees.

- (1) At BUMED HQ, the recommended grade for an EMO is O-5 (or above)/GS-14.
- (2) At NAVMED Regions, the recommended grade for an EMO is O-4 (or above)/GS-13.
- (3) At the MTF/non-MTF level, the recommended grade for a MEM/EMO is:
 - (a) Tier 1 MTF: O-3 or E-8 (or above)/GS-12.
 - (b) Tier 2 and 3 MTFs: E-7 (or above)/GS-9 (or above).
 - (c) Tier 4 MTF and non-MTF level: any qualified, competent service member or government civilian.
- e. Per reference (a), the following minimum MEM and EMO qualifications are established:
 - (1) Be either a uniformed Service member or DoD civilian employee.
 - (2) Possess qualifications that include experience, training and education in functions essential to effective public health and medical emergency management (e.g., NIMS, NRF).
 - (3) Be capable of obtaining and maintaining an active DoD Secret security clearance.
- f. The following minimum MEM and EMO technical capabilities are established:
 - (1) A minimum of 3 years of experience in emergency management for all civilian, full-time EM positions. Uniformed personnel assigned full-time to EM positions will have prior (formal) EM experience whenever available, and if experienced personnel are not available, uniform personnel with a minimum of 2 years of availability remaining in their assignment.
 - (2) Formal training in NIMS and HICS, including at a minimum: FEMA ISC 100, 200, 700, and 800 level courses.
 - (3) A thorough knowledge of emergency management operations, doctrine, and applicable laws and regulatory requirements, including but not limited to:
 - (a) The National Response Framework, National Incident Management System, National Mitigation Framework, and the National Disaster Recovery Framework.
 - (b) Emergency Management components and infrastructure.
 - (c) Continuity of Operations (COOP).
 - (d) Hospital operations and administration structure, including the Joint Commission, Hospital Accreditation Program guidance regarding EM.

(e) Doctrine regarding communicable disease control, bio-terrorism response, and medical decontamination procedures.

(f) Government (Local, State, and Federal) regulations and roles in disaster response.

(g) Familiarity with internal, affiliate and external partner EM assets and resources including, but not limited to: engineers, scientists, occupational health and safety specialists, integration and inclusion specialists, legal advisors, land managers, security specialists, law enforcement officers, fire safety engineers, medical professionals, community leaders, and public affairs specialists.

(h) Incident command responsibilities to direct response to and recovery from disasters.

(4) An ability to provide technically sound advice on preparedness, response, and recovery activities associated with man-made or natural disasters.

(5) The technical ability to develop, prepare, and implement EM standards, regulations, policies, plans, practices, training, and procedures.

(6) The capability to assess, inspect, and evaluate EM processes, plans, Standard Operating Procedures (SOPs), and guidance for compliance with applicable EM directives, policies, and regulations.

(7) The analytical skills to collect information from diverse sources, apply professional principles in performing analyses, and summarize the information in order to solve problems or develop EM programs that cross departmental/divisional lines.

(8) Excellent decision making skills in stressful situations and the ability to negotiate effective solutions to highly sensitive and challenging problems.

(9) The capability to plan, execute and assess facility-wide EM drills, training, and contingency plans, to include alignment with the Homeland Security Exercise and Evaluation Program (HSEEP).

(10) Demonstrated ability to manage projects, manpower and equipment within applicable guidelines and effectively employ resources within control.

(11) The ability to manage incident command staff and provide accurate, timely information to facility leaders during a contingency response, including managing Emergency Operations Center activation and operations.

(12) The technical capability to determine needed and available EM preparedness, response or recovery related resources (e.g., technical expertise, equipment and support).

(13) Excellent interpersonal, oral and written communications skills.

(14) Demonstrated team building and management skills, and the ability to lead and direct multiple projects and functions.

(15) The ability to operate general office computer and communications equipment.

(16) No certification or licensure required, however, certified emergency manager (CEM) is highly desired.

SECTION 5

PROCEDURES FOR REQUESTING WAIVERS OR EXCEPTIONS TO POLICY

Ref: (a) NTTP 3-07.2.3, Law Enforcement and Physical Security for Navy Installations

1. **Purpose.** To provide guidance regarding the procedures for requesting waivers and exceptions to policy for the requirements established in this instruction.
2. **Applicability.** All references herein after pertain only to this section.
3. **Background.** This section governs the procedures for requesting and approving waivers or exceptions to policy. It mirrors the procedures contained in reference (a) used to request similar waivers or exceptions for established security requirements on Navy installations. Commanders, COs, and OICs at all levels must weigh the risks involved in complying with the requirements and standards contained in numerous instructions. The inability to meet minimum standards and requirements may result in an increased risk to the MTF. Whenever the mandatory requirements of this instruction cannot be met by a BUMED commanded activity subject to the instruction, the activity must request a waiver or exception per this section. Waivers and exceptions to policy will be evaluated based on merit only and must include compensatory measures.
 - a. **Waiver.** A waiver is written temporary relief, normally for a period of 1 year or less, from specific requirements established by this instruction. A waiver will be requested whenever a requirement prescribed in this instruction is not currently achieved, but the condition is correctable within 1 year.
 - b. **Exception.** An exception is written long-term (for a period greater than 12 months) or permanent relief, from specific requirements established by this instruction. An exception will be requested whenever a requirement prescribed in this instruction cannot be achieved, or when attainment of the requirement requires more than 1 year. Exceptions shall also be submitted when corrective actions would be cost-prohibitive.
4. **Scope.** The guidance and requirements set forth in this section apply to all requirements established by this instruction.
5. **Action.** All NAVMED Region and MTF commanders, COs, and OICs shall:
 - a. Submit a request for waiver or exception whenever the mandatory requirements are not achieved and attainment is not expected within 30 days. Requests for waivers and exceptions will be submitted in the format outlined in this section. Blanket waivers and exceptions are not authorized. Waivers and long-term exceptions are self-canceling on the expiration dates stated in the approval letters unless the original approval authority approves an extension. Cancellations do not require BUMED approval.
 - b. Requests for waivers or exceptions will be submitted via the chain of command from the BUMED commanded facility to the NAVMED Region commander to BUMED. The request for

waiver must include a complete description of the problem and alternative procedures, as appropriate. It is important to note the inability to completely meet a requirement is not justification to waive the requirement entirely. For example, manning shortfalls that prevent an MTF from fully staffing a medical decontamination team per Standard 3 of this enclosure would be considered potential justification to field a partially staffed decontamination team and request a waiver from the full staffing requirement. Manning shortfalls would not be justification to ignore the requirement entirely and request it be waived altogether. Waiver approvals will normally be for a period of 12 months and long-term exception approvals will normally be for a period of 36 months. Extensions of the waiver or exception (normally for 12 months) must be requested via the chain of command and approved by BUMED. Waiver and exception extension requests will refer to previous correspondence approving initial and previous extensions, as appropriate.

c. Requests shall be in letter format per the Navy Correspondence Manual. This request will be submitted into the electronic tasker system and routed, via the respective Chain of Command, through the Region to BUMED-M3. All elements of the applicable table below will be specifically addressed. Non-applicable elements will be noted as N/A.

Table 5-5.1 Required Elements for Waivers Request

Element 1	Full name and UIC of the requesting MTF
Element 2	Statement of the waiver requirement and references to the standard and page/paragraph in this instruction that cite the standard that cannot be met
Element 3	Specific description of condition(s) that caused the need for the waiver and reason(s) why applicable standards in this manual cannot be met
Element 4	Identify interim mandatory compensatory measures in effect or planned
Element 5	Describe the impact on mission and any problems that will interfere with safety or operating requirements if the waiver is not approved
Element 6	Identify resources, including estimated cost from which budgeting decisions can be made, to eliminate the waiver
Element 7	Identify actions initiated or planned (local capability or other) to eliminate the waiver and estimated time to complete
Element 8	Provide point of contact to include name, rank/grade, DSN, and commercial telephone numbers

Table 5-5.2 Required Elements for Long-Term Exceptions Requests

Element 1	Full name and UIC of the requesting MTF
Element 2	Statement of the long-term exception requirement and references to the standard and page/paragraph in this instruction that cite the standard that cannot be met
Element 3	Specific description of condition(s) that caused the need for the permanent exception and reason(s) why applicable standards in this manual cannot be met
Element 4	Identify interim mandatory compensatory measures in effect or planned
Element 5	Describe the impact on mission and any problems that will interfere with safety or operating requirements if the long-term exception is not approved
Element 6	Identify resources, including estimated cost from which budgeting decisions can be made, to eliminate the long-term exception
Element 7	Identify actions initiated or planned (local capability or other) to eliminate the long-term exception and estimated time to complete
Element 8	Provide point of contact to include name, rank/grade, DSN, and commercial telephone numbers

Table 5-5.3 Format for Requests for Permanent Exceptions

Element 1	Full name and UIC of the requesting MTF
Element 2	Statement of the permanent exception requirement and reference to the standard and page/paragraph in this instruction that cite the standard that cannot be met
Element 3	Specific description of condition(s) that caused the need for the permanent exception and reason(s) why applicable standards in this manual cannot be met
Element 4	Identify, in detail, compensatory security measures that are being applied
Element 5	Describe the impact on mission and any problems that will interfere with safety or operating requirements if the permanent exception is not approved
Element 6	Provide point of contact to include name, rank/grade, DSN, and commercial telephone numbers

BUMEDINST 3440.10A
26 Jun 2015

SAMPLE WAIVER REQUEST

3440
Serial
Date

From: Officer in Charge, Naval Branch Health Clinic, Naval Air Station, Jacksonville
To: Chief, Bureau of Medicine and Surgery (BUMED-M3)
Via: (1) Commanding Officer, Naval Hospital Jacksonville
(2) Commander, Navy Medicine East

Subj: REQUEST FOR WAIVER TO NAVMED FORCE HEALTH PROTECTION
EMERGENCY MANAGEMENT PROGRAM

Ref: (a) BUMEDINST 3440.10A

Encl: (1) Waiver Request in case of Naval Branch Health Clinic, Naval Air Station,
Jacksonville

1. Per reference (a), enclosure (1) is submitted for consideration.

FI. MI. LASTNAME

**WAIVER REQUEST IN CASE OF NAVAL BRANCH HEALTH CLINIC,
NAVAL AIR STATION JACKSONVILLE**

Element 1. Naval Branch Health Clinic (NBHC), Naval Air Station Jacksonville, Unit Identification Code (UIC) 34566.

Element 2. Request a waiver for the total size of medical response teams as specified in Standard 3.

Element 3. NBHC Jacksonville Naval Air Station (NAS) is a Tier 3 MTF per Table 3.1 of Section 1 and requires a minimum of 33 personnel to fully staff the six medical response teams required. Due to continuing individual augmentee deployments and an ongoing shortfall in hospital corpsmen manning at the E-5 and E-6 levels, the average daily staffing at the facility for the previous 6 months has been 28 full-time personnel, or just under 80 percent of our full allowance. The ongoing shortfall in staffing precludes fielding a minimum of 33 personnel across the six medical response teams.

Element 4. Due to the temporary reduction in manning at the clinic, medical response team personnel have been shifted to fully staff the decontamination, zone management, detection and patient administration teams, and the transport and triage/treatment teams have been partially staffed.

Element 5. All medical response teams are considered fully mission capable and there is no impact on mission, or any problems that will interfere with safety or operating requirements if the waiver is not approved.

Element 6. Once the clinic is able to return to full staffing, the waiver can be eliminated. There are no additional resources or funding required, beyond the already approved manning levels for the clinic.

Element 7. As an interim measure, the clinic is working to identify personnel from other tenant commands that can be assigned to the medical response teams as a collateral duty. We are working to scrub an initial list of candidates and estimate it will take an additional 30 days to fully vet the list, select, and train candidates. However, this augmentation is still considered an interim solution and a waiver will be required until the clinic's full-time staffing is restored to the 90 percent or greater level.

Element 8. Point of Contact: LCDR John Jones, DSN 123-4567, commercial (904) 123-4567.

BUMEDINST 3440.10A
26 Jun 2015

SAMPLE LONG-TERM EXCEPTION REQUEST

3440
Serial
Date

From: Officer in Charge, Naval Branch Health Clinic, Naval Air Station, Jacksonville
To: Chief, Bureau of Medicine and Surgery (BUMED-M3)
Via: (1) Commanding Officer, Naval Hospital Jacksonville, Florida
(2) Commander, Navy Medicine East

Subj: REQUEST FOR LONG-TERM EXCEPTION TO NAVMED FORCE HEALTH
PROTECTION EMERGENCY MANAGEMENT PROGRAM

Ref: (a) BUMEDINST 3440.10A

Encl: (1) Long-Term Exception Request in case of Naval Branch Health Clinic, Naval Air
Station Jacksonville

1. Per reference (a), enclosure (1) is submitted for consideration.

FI. MI. LASTNAME

LONG-TERM EXCEPTION REQUEST IN CASE OF
NAVAL BRANCH HEALTH CLINIC,
NAVAL AIR STATION JACKSONVILLE

Element 1. Naval Branch Health Clinic, Naval Air Station Jacksonville, UIC 34566.

Element 2. A long-term exception is required for the total size of the medical response teams as specified in Standard 3.

Element 3. NBHC Jacksonville NAS is a Tier 3 MTF per Table 3.1 of Section 1 and requires a minimum of 33 personnel to fully staff the six medical response teams. Due to a recent reduction in the clinic's Basic Allowance (BA) for HM manning at the E-5 and E-6 levels, the maximum staffing at the facility under the revised allowance will be 22 full-time personnel, or just under 65 percent of our previous allowance. The decrease in staffing precludes fielding a minimum of 33 personnel across the six medical response teams.

Element 4. Due to the long-term reduction in manning at the clinic, medical response team personnel have been shifted to fully staff the decontamination, zone management, detection and patient administration teams, and the transport and triage/treatment teams have been partially staffed.

Element 5. All medical response teams are considered fully mission capable and there is no impact on mission, or any problems that will interfere with safety or operating requirements if the long-term exception is not approved.

Element 6. If the clinic's HM manning is restored to previous allowance levels, the long-term exception can be eliminated. There are no additional resources or funding required, beyond the restoration of the former HM manning levels for the clinic.

Element 7. As a possible solution, the clinic is working to identify personnel from other tenant commands that can be assigned to the medical response teams as a collateral duty. Establishing MOAs with tenant commands to provide this contingency augmentation is considered the best long-term solution to mitigate the decrease in HM manning allowances. A long-term exception will be required until the clinic's staffing is restored to the previous level, or MOAs are in place to provide the additional personnel to fully staff the medical response teams.

Element 8. Point of Contact: LCDR John Jones, DSN 123-4567, commercial (904) 123-4567.

BUMEDINST 3440.10A
26 Jun 2015

SAMPLE PERMANENT EXCEPTION REQUEST

3440
Serial
Date

From: Officer in Charge, Naval Branch Health Clinic, Naval Air Station, Jacksonville
To: Chief, Bureau of Medicine and Surgery (BUMED-M3)
Via: (1) Commanding Officer, Naval Hospital Jacksonville
(2) Commander, Navy Medicine East

Subj: REQUEST FOR PERMANENT EXCEPTION TO NAVMED FORCE HEALTH
PROTECTION EMERGENCY MANAGEMENT PROGRAM

Ref: (a) BUMEDINST 3440.10A

Encl: (1) Permanent Exception Request in case of Naval Branch Health Clinic, Naval Air
Station Jacksonville

1. Per reference (a), enclosure (1) is submitted for consideration.

FI. MI. LASTNAME

PERMANENT EXCEPTION REQUEST IN CASE OF
NAVAL BRANCH HEALTH CLINIC,
NAVAL STATION MAYPORT

Element 1. Naval Branch Health Clinic, Naval Station Mayport, UIC 34567.

Element 2. A permanent exception is required for the total size of the medical response teams as specified in Standard 3.

Element 3. NBHC Mayport NS is currently a Tier 3 MTF per Table 3.1 of the subject instruction and requires a minimum of 33 personnel to fully staff the six medical responses. Due to the recent decision to consolidate military staffing for this clinic with the staff at NBHC Jacksonville NAS, and to transition the NBHC Mayport NS to a TRICARE Outpatient Clinic (TOC), there will no longer be any military staff assigned to the facility. The elimination of military personnel will preclude fielding any medical response teams from Mayport NS.

Element 4. Due to the permanent elimination of military manning at the Mayport NS clinic, the facility anticipates being changed to a Tier 4 MTF for emergency management response.

Element 5. The change in status from a NBHC to a TOC will eliminate all organic medical response team capabilities at Mayport NS and the clinic will be completely unable to meet any medical response team mission or requirement if the permanent exception is not approved.

Element 6. Point of Contact: LCDR John Jones, DSN 123-4567, Commercial (904) 123-4567.

SECTION 6

ACRONYMS LIST

AAR	After Action Report
AIS	Automated Information System
AT	Antiterrorism
BUMED	Bureau of Medicine and Surgery
C2	Command and Control
C3	Command, Control and Communications
CAC	Common Access Card
CBDP	Chemical and Biological Defense Program
CBRN	Chemical, Biological, Radiological, and Nuclear
CBRNE	Chemical, Biological, Radiological, Nuclear, and Explosives
CBT	Computer-Based Training
CDC	Centers for Disease Control and Prevention
CDC	Concept Development Conference (Figure 10.1)
CDO	Command Duty Officer
CIP	Critical Infrastructure Protection
CIV-MIL	Civil-Military
CNIC	Commander, Navy Installation Command
CNO IVA	Chief of Naval Operations, Integrated Vulnerability Assessment
CO	Commanding Officer
CONOPS	Concept of Operations
COOP	Continuity of Operations
COSIN	Control Staff Instruction
COTS	Commercial-Off-The-Shelf
CPCs	CBRN Pharmaceutical Countermeasures
DHS	Department of Homeland Security
DMLSS	Defense Medical Logistics Standard Support
DMRTI	Defense Medical Readiness Training Institute
DoD	Department of Defense
DoS	Department of State
DSCA	Defense Support of Civil Authorities
EM	Emergency Management/Emergency Manager
EMO	Emergency Management Officer
EMS	Emergency Medical Service
EMWG	Emergency Management Working Group
EOC	Emergency Operations Center
EOD	Explosive Ordnance Disposal
EPRC	Emergency Preparedness and Response Course
ERT	Emergency Response Team
ESSENCE	Electronic Surveillance System for Early Notification of Community-Based Epidemics
FCC	Federal Coordinating Center

FEs	Functional Exercises
FEMA	Federal Emergency Management Agency
FHP	Force Health Protection
FPC	Final Planning Conference
FROT	First Receiver Operations Training
FSEs	Full-Scale Exercises
GOTS	Government Off-The-Shelf
HA	Hazard Assessment
HAZMAT	Hazardous Material
HAZWOPER	Hazardous Waste Operations and Emergency Response
HCC	Hospital Command Center
HHS	Health and Human Services
HICS	Hospital Incident Command System
HN	Host Nation
IAB	Interagency Board
ICS	Incident Command System
IEM	Installation Emergency Manager
IH	Industrial Hygiene
IPC	Initial Planning Conference
ISIC	Immediate Superior In Command
J-CBDP	Joint Chemical Biological Defense Program
JAS	Job Action Sheet
JCIDS	Joint Capabilities Integration Development System
JIC	Joint Information Center
JMAR	Joint Medical Asset Repository
JPEO-CBD	Joint Program Executive Office- Chemical and Biological Defense
JRO	J-8/Joint Requirements Office
JSIVA	Joint Staff Installation Vulnerability Assessments
LCC	Life-Cycle Cost
MAA	Mutual Aid Agreement
MBAC	Military Biological Advisory Committee
MCICOM	Marine Corps Installations Command
MEM	MTF Emergency Manager
MET	Mission Essential Task
MMD	Materiel Management Department
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MPC	Mid-term Planning Conference
MRCC	Medical Regional Command Center
MSEL	Master Scenario Event List
MTF	Medical Treatment Facility
NAS	Naval Air Station
NAVMED	Navy Medicine
NAVSEA	Naval Sea Systems Command
NBHC	Naval Branch Health Clinic

NDMS	National Disaster Medical System
NFAAS	Navy Family Accountability and Assessment System
NFPA	National Fire Protection Agency
NIMS	National Incident Management System
NIOSH	National Institute for Occupational Safety and Health
NKO	Navy Knowledge Online
NLLDB	Navy Lessons Learned Database
NMCPHC	Navy and Marine Corps Public Health Center
NMETC	NAVMED Education and Training Command
NMETL	Navy Mission Essential Task List
NMLC	Naval Medical Logistics Command
NMOLL	NAVMED Operational Lessons Learned
NMOTC	NAVMED Operational Training Center
NRF	National Response Framework
NSF	National Security Forces
NTTP	Navy Tactics, Techniques, and Procedures
OEM	Occupational and Environmental Medicine
OEP	Occupant Emergency Plan
OGA	Other Government Agency
OIC	Officer in Charge
OSHA	Occupational Safety and Health Administration
PHE	Public Health Emergency
PHEO	Public Health Emergency Officer
POM	Program Objective Memorandum
PPE	Personal Protective Equipment
ROC	Regional Operations Center
RSDL	Reactive Skin Decontamination Lotion
SECDEF	Secretary of Defense
SEL	Selected Equipment List
SLEP	Shelf-Life Extension Program
SME	Subject Matter Expertise/Expert
SOH	Safety and Occupational Health
SOP	Standard Operating Procedure
TTP	Tactics, Techniques, and Procedures
UIC	Unit Identification Code
UPS	Universal Power Supply
USMC	United States Marine Corps
USN	United States Navy
VA	Vulnerability Assessment
WMD	Weapons of Mass Destruction