DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
7700 ARLINGTON BOULEVARD
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BUMED INSTRUCTION 3440.10B

From: Chief, Bureau of Medicine and Surgery

Subj: EMERGENCY MANAGEMENT PROGRAM

Ref: See appendix A

1. Purpose. To direct the establishment and implementation of an all-hazards emergency management (EM) program at Bureau of Medicine and Surgery (BUMED) commanded activities; establish the policy, requirements, and responsibilities for EM preparedness, mitigation, response, and recovery necessary to facilitate mission assurance and program effectiveness; and define Navy Medicine (NAVMED) EM support requirements for Defense Health Agency (DHA) managed facilities where Navy is the lead Service element based per the authority and guidance outlined in references (a) through (v). This instruction is a complete revision and must be reviewed in its entirety.

2. Cancellation. BUMEDINST 3440.10A.

3. Scope and Applicability. This instruction applies to all BUMED commanded activities during and after the transfer of facility ownership from BUMED to the DHA. It does not apply to BUMED deployable or expeditionary medical commands or elements. This instruction defines the roles and responsibilities of all BUMED commanded activity commanders, commanding officers (CO), and officers in charge (OIC) to implement and sustain a comprehensive NAVMED EM program as required per references (a) through (e). Responsibility for medical EM response requirements that extend outside the facility and support the host installation, including mass casualty and public health emergency response, remain under the authority of BUMED. BUMED Director, Emergency Preparedness (BUMED-M453) will collaborate with Commander, Navy Installations Command (CNIC), Marine Corps Installations Command (MCICOM), and the DHA to ensure the NAVMED EM program is aligned with the corresponding United States (U.S.) Navy (USN), U.S. Marine Corps (USMC), and DHA stakeholder policies. This instruction establishes the NAVMED EM program within approved billet authorizations to provide 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. The NAVMED EM program complements the capabilities within the mission assurance construct and supports the Joint Commission and other applicable accreditation standards.

4. Background. Effective EM planning is critical to protecting Department of Defense (DoD) assets and facilitating the continuous execution of mission essential functions across all DoD installations. Reference (a) is the principal guidance for EM onboard USN installations and

reference (b) is the counterpart onboard USMC installations. Reference (c) directs medical treatment facility (MTF) commanders and OICs to establish a comprehensive medical EM program. References (d) through (e) directs NAVMED to provide medical support to the Navy's EM program.

5. Records Management

   a. Records created as a result of this instruction, regardless of format or media, must be maintained and dispositioned per the records disposition schedules located on the Department of the Navy Directorate for Administration, Logistics, and Operations, Directives and Records Management Division portal page at https://portal.secnav.navy.mil/orgs/DUSNM/DONAA/ DRM/Records-and-Information-Management/Approved%20Record%20Schedules/Forms/ AllItems.aspx.

   b. For questions concerning the management of records related to this instruction or the records disposition schedules, please contact the local records manager or the Department of the Navy Directorate for Administration, Logistics, and Operations, Directives and Records Management Division program office.

6. Review and Effective Date. Per OPNAVINST 5215.17A, Assistant Deputy Chief for Fleet Support (BUMED-M4) will review this instruction annually around the anniversary of its issuance date to ensure applicability, currency, and consistency with Federal, DoD, SECNAV, and Navy policy and statutory authority using OPNAV 5215/40 Review of Instruction. This instruction will be in effect for 10 years, unless revised or cancelled in the interim, and will be reissued by the 10-year anniversary date if it is still required, unless it meets one of the exceptions in OPNAVINST 5215.17A, paragraph 9. Otherwise, if the instruction is no longer required, it will be processed for cancellation as soon as the need for cancellation is known following the guidance in OPNAV Manual 5215.1 of May 2016.

7. Forms and Information Management Control

   a. Forms. NAVMED 3440/1 Respirator Inspection Checklist is available at https://forms.documentservices.dla.mil/order/.

   b. Information Management Control. The reporting requirements contained in chapter 2, subparagraphs 8b, 9, and 10c of this manual are exempt from reports control per the SECNAV Manual 5214.1 of December 2005, part IV, subparagraph 7k.

G. D. SHAFFER
Acting

Releasability and distribution:
This instruction is cleared for public release and is available electronically only via the Navy Medicine Web site, http://www.med.navy.mil/directives/Pages/BUMEDInstructions.aspx

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CHAPTER 1
INTRODUCTION

1. Definitions

a. BUMED. An agency of the USN that manages health care activities for the USN, USMC, and other Services where assigned and is the echelon 2 headquarters (HQ) command for NAVMED.

b. NAVMED. An enterprise comprised of military and civilian healthcare personnel assigned at BUMED commanded activities. The manpower resource category for all NAVMED personnel assigned to BUMED commanded activities is budget submitting office 18.

c. DHA. A joint, integrated combat support agency enabling the Army, Navy, and Air Force Medical Departments to provide a medically ready force to combatant commands in both peacetime and wartime. At the direction of Congress, the management of medical facilities are transitioning from the Services to the DHA.

d. NAVMED Echelon 3. NAVMED regional commands reporting to BUMED and consisting of Naval Medical Forces Atlantic, formerly NAVMED East; Naval Medical Forces Pacific, formerly NAVMED West; and Naval Medical Forces Support Command, formerly NAVMED Education, Training, and Logistics Command.

e. MTF. 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 operate under the leadership of either a NAVMED commander, CO, or OIC, or a DHA director or supervisor. In some cases, the MTF commander may report to both BUMED and DHA chains of command. At those MTFs led by a DHA director or supervisor, the uniformed Navy and designated government civilian staff will report to a NAVMED commander under either a Navy Medicine Readiness and Training Command (NAVMEDREADTRNCMD) or Navy Medicine Readiness and Training Unit (NAVMEDREADTRNUNIT) organization.

f. NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT. These commands and units are comprised of NAVMED personnel, both uniformed and civilian, assigned to staff a DHA managed MTF. They are led by a uniformed NAVMED CO or OIC and report via a NAVMED chain of command. They are responsible for designating the medical emergency manager (MEM), executing the NAVMED EM program, and supporting the DHA EM program.

g. Non-MTF. Any medical command activity not meeting the definition of an MTF is considered a non-MTF for the purpose of this manual. However, none of the guidance in this manual applies to mobile, expeditionary, afloat, or other deployed personnel.

h. <u>BUMED Commanded Activities</u>. For the purpose of this manual, BUMED commanded activities include budget submitting office 18 MTFs, non-MTFs, NAVMEDREADTRNCMD, and NAVMEDREADTRNUNIT organizations. It does not apply to BUMED deployable or expeditionary medical commands or elements.

i. <u>NAVMED EM Program</u>. Commonly applies to EM preparedness and response requirements that extend outside the facility and provide medical EM support to host installations per references (a) through (e), including mass casualty and public health emergency. EM preparedness and response requirements under this program remain under the authority of BUMED.

j. <u>DHA EM Program</u>. Commonly applies to EM preparedness and response requirements that impact only the staff and capabilities inside the facility. These response actions are limited to those commonly included in an occupant emergency plan (OEP) and consist of mass warning and notification, shelter-in-place (SIP), and evacuation. Although the DHA is responsible for the requirements of their program, key elements of the DHA EM program are included in this manual to provide seamless EM program guidance and eliminate ambiguity regarding responsibilities.

k. <u>MEM</u>. Serves as the lead for EM at NAVMEDREADTRNCMDs, NAVMEDREAD-TRNUNITs, and non-MTFs, including BUMED HQ, echelon 3 commands, school commands, laboratories, detachments, and research facilities, and is the primary point of contact with the host installation EM officer, as well as the EM lead with any local civilian medical facilities and emergency response organizations. MEMs serve a dual role managing and supporting both the NAVMED and DHA EM programs. They coordinate EM planning and preparedness, and assist in the execution of all-hazards EM activities on behalf of the NAVMED commander, CO, OIC, or DHA director or supervisor. MEM duties will be assigned consistent with the guidance in reference (c).

l. <u>EM</u>. An all-hazard risk-based, comprehensive process to prepare for, respond to, and recover from an incident that threatens life, property, operations, or the environment.

m. <u>First Responders</u>. 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.

n. <u>Emergency Responders</u>. 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 NAVMEDREADTRNCMD or NAVMEDREADTRNUNIT.

o. <u>First Receivers</u>. A subset of emergency responders who receive patients for treatment at an MTF. They include clinicians and other medical staff who have a role in receiving and treating patients (e.g., triage, decontamination, clinical services, security, etc.), and those whose roles support these functions (e.g., 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.

2. <u>Responsibilities</u>. All BUMED commanded activities will plan for and prepare to respond to all-hazard emergencies to prevent and mitigate the impact of any contingency on their critical missions or mission essential functions.

a. This manual will serve as the principal guidance within BUMED and across all BUMED commanded activities for implementing all-hazards EM plans.

b. All BUMED commanded activities will develop an all-hazards EM plan that is aligned with and supports the host installation EM plan and meets the requirements of applicable USN, USMC, DHA, and echelon 3 EM policies.

c. Within the United States, its territories, and possessions; commanders, COs, and OICs of BUMED commanded activities will be prepared to assist civil authorities under local immediate response authority or through Defense Support of Civil Authorities (DSCA), as outlined in reference (f).

d. <u>All BUMED commanded activities will</u> implement an approved Incident Command System (ICS).

e. <u>Assistant Deputy Chief, Medical Operations (BUMED-M3B)</u>. Will provide pharmaceutical and medical countermeasure support to the EM program.

f. <u>Assistant Deputy Chief, Fleet Support and Logistics (BUMED-M4B) will</u>:

(1) Ensure full coordination and collaboration across all BUMED commanded activities, and will provide logistics, facilities, safety, industrial hygiene (IH), public health (PH), and anti-terrorism (AT) support for the EM program.

(2) Designate a NAVMED headquarters MEM and a public health emergency officer (PHEO) responsible for the effective integration of enterprise public health emergency management (PHEM) activities and the implementation of the EM program.

g. <u>Director, Emergency Preparedness (BUMED-M453)</u>. Serves as the NAVMED MEM and the program manager for the enterprise EM and continuity of operations (COOP) programs, as well as the BUMED lead and subject matter expert (SME) for mission assurance (MA), DSCA, the National Disaster Medical System (NDMS), DoD Critical Infrastructure Program, and the EM components of Force Health Protection (FHP). Specific responsibilities include:

(1) Develop and execute an overarching, integrated, all-hazards enterprise EM program. Plan, program, and budget for the program's requirements and provide management support, resources, and staff to implement and assess compliance of EM programs effectively at all organizational levels.

(2) Conduct an annual assessment of BUMED HQ and detachments, echelon 3 commands, and selected facility EM programs for compliance and effectiveness. For echelon 3 and parent commands, the review will include an assessment of the commands' ability to exercise effective oversight of the EM programs at their subordinate commands. At NAVMED-READTRNCMDs and NAVMEDREADTRNUNITs, the review will include an assessment of the EM program's compliance with applicable accreditation programs, such as the Joint Commission standards.

(3) Publish an annual schedule of EM program assessments.

(4) Coordinate closely with the EM program counterparts at the Services medical HQ and the DHA, to ensure optimal integration and alignment across the DoD medical enterprise.

(5) Liaise and collaborate with all relevant DoD program offices and Federal agencies as appropriate to further the development of EM standards, coordination, integration, interoperability, and information sharing.

(6) Coordinate with other program offices related to or with equities in the EM program, including AT, PH emergency, and any others, as applicable.

(7) Provide SME support to the Defense Medical Readiness Training Institute (DMRTI) to facilitate the development and execution of the PHEM courses, and any other DMRTI sponsored training related to the EM program.

h. The CO, Navy and Marine Corps Public Health Center will:

(1) Provide occupational and environmental medicine and IH technical and scientific SME reach-back support to the EM program.

(2) Serve as the PH surveillance hub for the EM program.

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

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

i. Director, Administration (BUMED-M09B). Will develop, implement, and execute the OEP and COOP plan for BUMED HQ.

j. <u>BUMED Staff Judge Advocate, (BUMED-M00J)</u>. Will provide legal consultation as needed.

k. <u>Assistant Deputy Chief, Manpower and Personnel (BUMED-M1B)</u>. Will ensure all EM program personnel requirements are established and documented in manpower and personnel systems.

l. <u>Director, Chemical, Biological, Radiological and Nuclear (CBRN) Medical Defense program (BUMED-M53)</u>. Will ensure close coordination with BUMED-M453, on all issues, policies, new technologies, and equipment related to CBRN, pharmaceutical countermeasures, and related doctrine.

m. <u>CO, Naval Medical Logistics Command</u>. Will ensure sufficient resources are allocated to establish and maintain readiness in the area of medical logistics, including:

(1) Ensuring all EM-related assemblages are captured and up to date in the Defense Medical Logistics Standard Support (DMLSS) Automated Information System.

(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).

n. <u>Assistant Deputy Chief, Training and Education (BUMED-M7B)</u>. Will coordinate with Commander, Naval Medical Forces Support Command, to provide comprehensive education and training program support to the EM program.

o. <u>Assistant Deputy Chief, Financial Management (BUMED-M8B)</u>. Will collaborate with BUMED-M453 and follow established processes to ensure funding levels are sufficient to facilitate the execution and sustainment of the EM program to include the storage and phased replacement of EM equipment.

p. <u>Director, Communications (BUMED-M09B7)</u>. Will serve as the point of contact for guidance regarding strategic communications, media inquiries, and public affairs matters related to the EM program.

q. <u>BUMED Medical Inspector General (MEDIG) (BUMED-M00IG)</u>. Will include the review and assessment of designated EM program components as part of their inspection program.

r. <u>NAVMED Echelon 3 Commanders</u>. Will provide leadership, oversight, and management to support the implementation of the EM program at all BUMED commanded activities under their authority and:

(1) Appoint an MEM in writing. The MEM position at echelon 3 commands will be staffed by a full-time Federal civilian EM specialist or active duty military personnel with a minimum tour length of 12 months.

(2) Appoint a PHEO in writing. Echelon 3 commanders will appoint a collateral duty PHEO and ensure their respective CNIC and MCICOM regions are supported by designated PHEOs per references (c) and (g).

(3) Establish an echelon 3 EM working group, and ensure it meets a minimum of once per quarter.

(4) Ensure assigned echelon 3 MEMs and PHEOs participate in CNIC and MCICOM regional EM working group meetings as available per references (a) and (b).

  s. NAVMED commanders, COs, and OICs will:

(1) Implement and execute an effective EM program consistent with this manual, applicable references, and supporting publications. As previously specified, the NAVMED EM program does not apply to deployable or expeditionary medical commands or elements.

(2) Per references (b) through (d), provide the medical and health service support to their host installation EM program, consistent with their capabilities. The scope of required support will vary, with large NAVMEDREADTRNCMDs having significant requirements and non-MTFs providing minimal support. All BUMED commanded facilities are required to ensure their EM plan is coordinated, integrated, and exercised with the host installation.

(3) Appoint a Federal civilian EM specialist or active duty military MEM in writing at echelon 4 and echelon 5 commands to serve for a minimum tour length of 12 months to manage and support the NAVMED, and where applicable, DHA EM programs. MEMs at echelon 3 commands and dual-shelter response NAVMEDREADTRNCMDs, as defined in this manual, will be assigned as full-time positions. The assignment of any collateral duties to MEMs at dual-shelter response NAVMEDREADTRNCMDs, as defined in this manual, is specifically prohibited. MEMs at all other NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs may be staffed as either full-time or primary collateral duty assignments. The assignment of more than one collateral duty to MEMs at single-shelter response NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs, as defined in this manual, is specifically prohibited. MEM assignments at non-MTFs can be full-time or collateral duty at the discretion of the NAVMED commander, CO, or OIC, and all MEM appointees must be provided adequate time to fully perform all of the EM duties assigned.

(4) At NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs, ensure the host installation is assigned a qualified PHEO per references (c) and (h). The PHEO should be appointed in writing by the installation commander and may be assigned from the tenant

NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT if staffing permits, or may be sourced from an alternate MTF with the requisite staff. The NAVMED commander may elect to designate a qualified PHEO to support the MTF, or may share a PHEO with another MTF, but the primary responsibility for tenant NAVMEDREADTRNCMDs and NAVMEDREADTRN-UNITs is to ensure the host installation has PHEO support.

(5) Ensure the MEM and PHEO (if assigned) are designated as "mission essential" staff members.

(6) At NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs, ensure the MEM and PHEO (if assigned) a PHEO attend the host USN, USMC, or Joint Base installation EM working group per reference (c). MEMs at non-MTFs must also attend the host installation EM working group if required or invited.

(7) Ensure the MEM and PHEO (if assigned) attend the echelon 3 EM working group per reference (c); MEMs should attend in person whenever practical, and when distance or limited travel funds preclude attendance, MEMs will attend via telephone or video conferencing.

(8) At MTFs with a patient decontamination response capability per Table 2-3, establish a multi-disciplinary EM working group comprised of command, subordinate activity, and relevant external EM stakeholders to facilitate EM planning and coordination. All other facilities may establish their own EM working group or participate in their host installation and regional EM working groups.

(9) Ensure full participation and integration in host installation, and as applicable, local EM-related training, exercises, and activities that incorporate medical components or events.

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

t. <u>All MEMs will</u>:

(1) Execute effective NAVMED and where applicable, DHA EM programs that comply with the requirements established in this manual and as described in reference (c).

(2) Fulfill the Joint Commission and other applicable EM program accreditation standards.

(3) Ensure the NAVMED and where applicable, DHA EM programs are functionally aligned and integrated within the host USN, USMC, or Joint Base installation and regional or market sector EM programs.

(4) Serve as the principle liaison with local medical EM communities and host installation and parent command EM committees.

(5) Maintain technical capabilities as described in reference (c) and chapter 4 of this manual.

(6) Review and validate the EM plans annually, revising them every 3 years, or more frequently if necessary.

(7) Ensure facility-level hazard vulnerability analyses (HVA) are reviewed and validated annually. The host installation's assessment should be used in the development of the HVA to the maximum extent practical.

CHAPTER 2
EMERGENCY MANAGEMENT PROGRAM STANDARDS

1. Program Management

a. BUMED activity MEMs are responsible for preparing for, responding to, recovering from, and mitigating the effects of all-hazards emergencies. The performance and effectiveness of the EM program will be measured against approved requirements, standards, and benchmarks. A process for continuous quality improvement will be instituted and monitored through exercise, assessment, lessons learned, and analysis.

b. BUMED commanded activities, including the Navy commands and units assigned to a Navy facility managed by the DHA, will designate a MEM as described in this manual and per reference (c). BUMED commanded facilities that have transitioned to the DHA will maintain both NAVMED and DHA EM programs, with the MEM designated by the NAVMED activity, but supporting both BUMED and DHA facility leadership in the execution of the program. This dual reporting status eliminates redundancy in EM staffing and clarifies responsibilities based on EM program elements. As previously described, the scope of the DHA EM program is limited to those elements of EM preparedness and response that impact the staff and capabilities inside the facility. These response elements are those commonly included in an OEP and consist of mass warning, SIP, and evacuation. The NAVMED EM program encompasses the response elements that extend outside the facility and provide medical EM support to the host installation, including mass casualty and PH emergency response. At these DHA facilities, the MEM is responsible for the execution of both NAVMED and DHA EM programs. Echelon 3 commanders, NAVMED COs, and OICs will ensure the appropriate number of personnel are appointed to effectively execute the NAVMED EM program, and where applicable, the DHA EM program as well. At larger MTFs, a full-time MEM is not typically sufficient to manage the entirety of the EM program. At these facilities, additional full-time or part-time staff serving in the role of an assistant or alternate MEM will be necessary to effectively execute all aspects of the program, and in the event the MEM is unavailable during a contingency, the alternate MEM provides invaluable redundancy. Per references (a) and (b), the MEM and alternate MEM (AMEM) will coordinate and work closely with their host USN, USMC, or Joint Base installation, and echelon 3 EM officers.

c. The level of effort required to establish, sustain, and manage an effective program is proportional to the EM preparedness and response capabilities required. Significant changes in authorized manpower will necessitate a re-evaluation of required capabilities. Accordingly, the MEM assignment is a full-time position at NAVMED HQ, echelon 3 commands, and dual-shelter response MTFs as defined in chapter 3. Table 2-1: EM Program Requirements by Activity Type summarizes major program requirements by NAVMED activity:

Program Requirement	NAVMED HQ and Echelon 3 Commands	Dual and Single-Shelter Response NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs	All Other NAVMED Activities
Ensure an MEM is assigned	Yes	Yes	Yes
Establish an EM program	Yes	Yes	Yes
Participate in host installation EM program	Yes (1)	Yes	Yes
Maintain and exercise mass warning and notification, SIP, and evacuation functional response plans	Yes	Yes	Yes
Maintain and exercise a mass casualty plan	Not applicable	Yes (2)	Yes (2)
Maintain and exercise a pandemic influenza response plan	Not applicable	Yes	No
Maintain and exercise a COOP plan	Yes	Yes	Yes
Ensure a current HVA is maintained	Not applicable	Yes	Yes
Maintain EM and pandemic influenza stockpile equipment and pharmaceuticals	Not applicable	Yes	Yes (3)
Ensure required EM training is completed and documented	Yes	Yes	Yes
Ensure lessons learned are completed and submitted along with after action reports (AAR) for all EM responses	Yes	Yes	Yes

Table 2-1 EM Program Requirements by Activity Type

Table 2-1 Notes:
(1) Applies only to echelon 3 commands on host installation; not applicable to HQ and standalone echelon 3 commands.
(2) All dual-shelter response MTFs are required to maintain and field a mass casualty response capability. Single-shelter response MTFs and all other facilities may field a mass casualty response consistent with their capabilities.
(3) MTFs without a patient decontamination response capability may be assigned a requirement to maintain pharmaceutical countermeasures to support host installation category 1 and 5 personnel.

2. Personnel Categorization

    a. BUMED personnel categorization is aligned per reference (d).

    b. The EM program focuses on the preparedness, response, and recovery capabilities of category 5 personnel to ensure the protection of category 1 through 4 personnel, while providing a comprehensive, all-hazards COOP plan.

    c. Definitions provided for the five categories of personnel:

        (1) Category 1. Per reference (d), emergency-essential U.S. military personnel, 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, and that a list of those personnel is provided to the host installation EM officer and updated on an annual basis.

        (2) Category 2. Other U.S. personnel, including:

            (a) U.S. military family members living on or off a military installation.

            (b) Non-emergency essential U.S. military personnel, USN, and USMC or Federal civilian employees, and other persons covered by reference (h).

            (c) USN and USMC contractor and subcontractor employees other than those performing emergency-essential functions.

            (d) Employees of other U.S. Government agencies.

            (e) Other U.S. Government contractor and subcontractor employees.

        (3) Category 3. Other personnel supporting U.S. military operations, including:

            (a) Non-U.S. citizens who are employees of the USN, USN contractor, or USN subcontractor, and who are not included in categories 1 or 2.

            (b) Foreign military personnel employed by the host nation (HN) government or by contractors of the HN government.

        (4) Category 4. Allied and 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, such as allied and coalition military forces, government officials, and emergency response personnel.

(5) Category 5. First responders, receivers, and support personnel who are U.S. military personnel, DoD civilians, and contractor personnel. Category 5 personnel must be designated in writing and consist of:

(a) First responders and first receivers, such as: MTF providers, EM personnel; fire and emergency services personnel; hazardous material (HAZMAT) teams; naval security forces; emergency medical service personnel; or explosive ordnance disposal teams.

(b) EM support personnel, such as: PHEO; 911 dispatch center personnel; shore support center, regional operations center, and emergency operations center (EOC) personnel; medical regional command center and hospital command center personnel; emergency response teams, mass casualty, mortuary affairs personnel, safety and occupational health, IH, public works, public affairs, supply, and logistics; and any others designated to perform tasks in support of the EM program.

d.   The EM program will 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 will protect category 2 through 4 personnel primarily through the utilization of evacuation or SIP procedures, coupled with the proper operational employment of organized, trained, equipped, exercised, evaluated, and sustained category 5 personnel.

3.   NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT Mass Casualty Patient Decontamination Response Capability

a.   NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs are divided into three levels of EM response capabilities: dual and single-shelter patient decontamination response MTFs, and all other MTFs without a patient decontamination response capability. The patient decontamination team equipment set including pharmaceuticals is collectively designated as the H199 assemblage in DMLSS.

b.   While the scope of the patient decontamination response capability varies based on NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT staff size, the components of the response capability are standardized across the enterprise. As a result, decontamination team equipment can be moved between MTFs and once trained, patient decontamination team members can support operations at any patient decontamination capable NAVMEDREADTRN-CMDs and NAVMEDREADTRNUNITs. Table 2-2 establishes the metrics for NAVMED patient decontamination response requirements.

Response Capability	Dual-Shelter Response	Single-Shelter Response
Decontamination team notification	5 minutes	5 minutes
Decontamination team muster	10 minutes	10 minutes
Three-line decontamination shelter is mission capable and ready to receive patients: a minimum of four personnel have fully donned personal protective equipment, the shelter is erected with water flowing through the shelter	Shelter 1: 15 minutes after team muster: Shelter 2: 15 minutes after shelter 1 is mission capable	15 minutes after team muster
Ambulatory patient throughput	60-80 per hour	30-40 per hour
Non-ambulatory patient throughput	12-20 per hour	6-10 per hour
Sustained decontamination operations	60-120 minutes	60-120 minutes

**Table 2-2 NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT
Patient Decontamination Response Capabilities**

c.   Patient decontamination capable NAVMEDREADTRNCMDs and NAVMEDREAD-TRNUNITs must be able to conduct patient decontamination operations throughout their operational work schedule. Accordingly, those dual-shelter response NAVMEDREADTRN-CMDs staffed 24 hours a day, 7 days a week must be able to conduct patient decontamination operations throughout the same 24 hours a day, 7 days a week. They can however, scale down to single-shelter operations during the periods of their work week when they operate with reduced staffing, i.e., overnight and weekends. NAVMEDREADTRNCMDs and NAVMED-READTRNUNITs that are not staffed for a 24 hours a day are not required to conduct patient decontamination operations outside of normal working hours.

d.   Table 2-3 establishes NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT patient decontamination response capability requirements.

NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT Site	Response Capability
NAVMEDREADTRNCMD PENSACOLA FL	Dual-shelter
NAVMEDREADTRNCMD JACKSONVILLE FL	Dual-shelter
NAVMEDREADTRNUNIT MAYPORT FL	Single-shelter
NAVMEDREADTRNUNIT KEY WEST FL	Single-shelter
NAVMEDREADTRNUNIT KINGS BAY GA	Single-shelter
NAVMEDREADTRNCMD CORPUS CHRISTI TX	Single-shelter
NAVMEDREADTRNCMD SIGONELLA IT	Dual-shelter
NAVMEDREADTRNUNIT BAHRAIN	Single-shelter
NAVMEDREADTRNCMD BEAUFORT SC	Dual-shelter
NAVMEDREADTRNUNIT PARRIS ISLAND SC	Single-shelter
NAVMEDREADTRNCMD GUANTANAMO CU	Single-shelter
NAVMEDREADTRNCMD NAPLES IT	Dual-shelter
NAVMEDREADTRNCMD ROTA SP	Dual-shelter
NAVMEDREADTRNCMD CHARLESTON SC	Single-shelter
NAVMEDREADTRNCMD PORTSMOUTH VA	Dual-shelter
NAVMEDREADTRNUNIT NAVSTA NORFOLK VA	Single shelter
NAVMEDREADTRNUNIT NAS OCEANA VA	Single-shelter
NAVMEDREADTRNUNIT LITTLE CREEK VA	Single-shelter
NAVMEDREADTRNCMD GREAT LAKES IL	Dual-shelter
NAVMEDREADTRNCMD CHERRY PT NC	Single-shelter
NAVMEDREADTRNCMD CAMP LEJEUNE NC	Dual-shelter
NAVMEDREADTRNCMD QUANTICO VA	Single-shelter
NAVMEDREADTRNCMD PATUXENT RIVER MD	Single-shelter
NAVMEDREADTRNCMD TWENTYNINE PALMS CA	Single-shelter
NAVMEDREADTRNCMD LEMOORE CA	Single-shelter
NAVMEDREADTRNUNIT FALLON NV	Single-shelter
NAVMEDREADTRNCMD OAK HARBOR WA	Single-shelter
NAVMEDREADTRNCMD CAMP PENDLETON CA	Dual-shelter
NAVMEDREADTRNUNIT PORT HUENEME CA	Single-shelter
NAVMEDREADTRNCMD BREMERTON WA	Dual-shelter
NAVMEDREADTRNUNIT BANGOR WA	Single-shelter
NAVMEDREADTRNUNIT EVERETT WA	Single-shelter
NAVMEDREADTRNCMD YOKOSUKA JA	Dual-shelter
NAVMEDREADTRNUNIT SASEBO JA	Single-shelter
NAVMEDREADTRNUNIT IWAKUNI JA	Single-shelter
NAVMEDREADTRNUNIT ATSUGI JA	Single-shelter
NAVMEDREADTRNCMD OKINAWA JA	Dual-shelter
NAVMEDREADTRNCMD GU	Dual-shelter
NAVMEDREADTRNCMD PEARL HARBOR HI	Single-shelter
NAVMEDREADTRNCMD SAN DIEGO CA	Dual-shelter
NAVMEDREADTRNUNIT NAVBASE SAN DIEGO CA	Single-shelter
NAVMEDREADTRNUNIT MCRD SAN DIEGO CA	Single-shelter

**Table 2-3 NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT
Patient Decontamination Response Requirements**

e.   Per reference (j), all patient decontamination team members assigned a powered air-purifying respirator (PAPR) must be enrolled in a Respiratory Protection Program (RPP) and tracked by the RPP manager. The MEM will provide a complete roster of all patient decontamination team members assigned to use PAPRs to the RPP manager annually and upon any personnel changes to the roster. The first receiver operations training curriculum meets the RPP training requirements as specified in reference (k). In order to meet the requirements of the RPP, active duty patient decontamination team members must have a current periodic health assessment, and government civilian team members require a respirator certification from the occupational health office.

f.   Per reference (j), each patient decontamination team PAPR must be inspected every 30 days using NAVMED 3440/1 Respirator Inspection Checklist. The inspection should be completed in conjunction with monthly maintenance per the manufacturer's instructions. The checklist can be used to record the required unique PAPR identification number, serve as the individual inspection record, and must be maintained for the life of the PAPR.

g.   Most of the H199 patient decontamination team equipment requires periodic maintenance that has been identified by the manufacturer. MEMs are responsible for ensuring periodic maintenance is performed and recorded. Echelon 3 commands may prescribe additional H199 maintenance requirements.

4.   Assessments

a.   NAVMED MEMs will conduct a comprehensive assessment of their all-hazards response readiness annually, including a detailed assessment of their capability to execute all functional response plans, using the EM program self-assessment checklist contained in appendix D. The checklists identify the minimum requirements to effectively execute a capabilities-based EM program. MEMs should regularly review their respective checklist to ensure their EM programs are up-to-date and employ them to proactively identify and correct deficiencies. Completed self-assessments must be reviewed and approved by the NAVMED commander, CO, or OIC, then routed to the designated NAVMED echelon 3 command for review and retention. At MTFs, the completed self-assessments should also be routed to the DHA director or supervisor where applicable. NAVMED echelon 3 MEMs will ensure all assigned facilities complete and submit their EM program self-assessment annually.

b.   BUMED commanded activities will support their host installation during higher echelon EM-related assessments, including MA assessments conducted by the Joint Staff, Chief of Naval Operations, and MCICOM.

c.   NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT personnel must be prepared to provide technical support to the host installation in the completion of all relevant installation EM program assessments.

    d. NAVMED commanders, COs, and OICs will ensure hazards and threats with significant potential to impact their operations have been identified and integrated into their facility's EM planning. The Joint Commission calls this assessment an HVA and for standardization, NAVMED has adopted the Joint Commission terminology. While the nomenclature varies, the purpose of these risk, hazard, and threat assessments are the same; they assist the activity in understanding its vulnerabilities and enabling it to plan for, mitigate, and more effectively respond to the highest priority hazards. The HVA must be reviewed and validated annually; typically by the facility or parent command EM working group. All DoD installations are required to conduct an annual all-hazards (i.e., risk, threat, and vulnerability) assessment, and tenant command BUMED facilities are highly encouraged to use their host installation assessment to the maximum extent practicable in developing their HVA.

5. Interoperability

    a. The EM program requires the use of interoperable standards and methods per reference (m).

    b. Interoperability must include the standardization of systems, procedures, and terms to the maximum extent possible. The goal is compatibility of tactics, techniques, and procedures, particularly in command, control, and communications. Effective all-hazards EM response relies on interoperability between DoD EM assets, and applicable Federal, State, territorial, tribal, local, or HN EM agencies and departments.

    c. All BUMED commanded activities will support and participate in host installation, CNIC, MCICOM, and echelon 3 command EM planning, training, and exercises to the maximum extent practical. This participation will improve EM response capability and interoperability.

    d. Pertaining to C2, all activity commanders, COs, and OICs will:

        (1) Ensure EM plans incorporate National Incident Management System (NIMS) and a NIMS compliant ICS.

        (2) Ensure that an incident command structure is implemented which is consistent with and integrated into the local community's command structure.

        (3) Ensure ICS training is monitored and documented in local training records, an approved learning management system, and other databases as necessary. Required ICS training courses are provided in table 2-4 of this manual.

        (4) Ensure the appropriate job action sheets from the Hospital Incident Command System (HICS) Guidebook are utilized whenever the activity implements HICS. Copies of the job action sheets are available at:
https://emsa.ca.gov/wp-content/uploads/sites/71/2017/09/HICS_Guidebook_2014_11.pdf.

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

(6) Coordinate with USN, USMC, Joint Base installation, or echelon 3 commander; as appropriate, in developing relationships with the appropriate Federal, State, local, territorial, 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.

(7) Coordinate with USN, USMC, Joint Base installation, or echelon 3 EM personnel, BUMED HQ, and local emergency responders and receivers in the development of mutual aid agreements (MAA).

6. Preparedness

a. The EM program establishes minimum preparedness standards for BUMED commanded activities. These standards include the proper organization, manning, and command, control, and communications interoperability with Federal, State, local, territorial, tribal, and HN agencies and departments.

b. The "Preparedness Standard" is the most important element of the EM program and preparedness efforts require the largest share of resources and manpower commitment to successfully execute. BUMED commanded activities must be prepared to respond to any all-hazard emergency. They must assign the requisite personnel, equipment, and resources needed to ensure they are prepared to maintain the required provision of care capabilities throughout any emergency situation. Inpatient NAVMEDREADTRNCMDs have the most demanding requirements to prepare themselves to maintain their provision of care capabilities during an emergency, and conducting the training necessary to effectively care for and move inpatients during an emergency is a critical component of their accreditation process. Category 5 personnel must receive proper training and certification, and EM response equipment must be maintained in working order.

c. Key preparedness elements include:

(1) PHEOs. Per reference (g), all DoD installation commanders must designate a PHEO to serve as the principal advisor on PH emergencies. The PHEO is responsible to advise the installation commander and where applicable, echelon 3 commander in determining the existence of, and any required response to a PH emergency occurring onboard or potentially affecting the installation or region. Reference (e) requires tenant MTFs with the requisite staff to make a qualified individual available to serve as the PHEO for the host installation.

(2) <u>EM Working Group</u>. Per reference (d), all BUMED commanded activities will support their host installation EM working group to the maximum extent practical. Although the Services establish the requirements for an EM working group under their Service-specific EM program, in general, EM working group participation is limited to key tenant commands with significant equity or capabilities, and not all tenant commands participate. The level of support for an installation EM working group will vary from essential: for large inpatient capable NAVMEDREADTRNCMDs, to desirable: at-large clinics that provide patient services, to unnecessary: at the smallest NAVMEDREADTRNUNITs and majority of non-MTFs. The MEM will coordinate with the installation EM officer to determine the extent of EM working group support required from the facility, keeping BUMED and DHA leadership apprised where assigned. Additionally, inpatient capable NAVMEDREADTRNCMDs are required to establish their own internal EM working group, which will meet quarterly to assist the MEM in the development, execution, exercise, and assessment of the NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT EM program. Outpatient NAVMEDREADTRNCMDs, NAVMEDREADTRNUNITs, and non-MTFs are not required to establish their own EM working group, but may elect to. Larger NAVMEDREADTRNCMDs and NAVMEDREAD-TRNUNITs should make every effort to integrate the local county or municipal medical community into their EM working group, to enhance medical EM planning, preparedness, and response.

(3) <u>COOP</u>. All BUMED commanded activities will establish a COOP plan per reference (n). The purpose of every DoD COOP program is to ensure the continual execution of mission essential functions throughout any emergency or contingency. The COOP program ensures the capability of all BUMED commanded activities to maintain essential health service support during a contingency and to rapidly restore any temporarily suspended mission-essential functions capabilities at either their primary site, or at an emergency relocation site. Every BUMED commanded activity must have a COOP plan that addresses how the facility will continue to execute their primary missions during both a short-term and a long-term contingency. Additionally, NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs must coordinate their COOP plans with the host installation and any key tenants, to ensure any command or element that relies on the NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT for critical medical support will have continuous access to that support, or equivalent support; whether from the primary NAVMEDREADTRNCMD, NAVMEDREADTRNUNIT, or a specified alternate care facility. This includes key tenant commands that relocate to safe havens in conjunction with their COOP plan such as large student populations, and aviation squadrons and wings.

(4) <u>Mass Warning and Notification</u>. This is a functional EM response capability covering any emergency situation at a facility that requires the staff to be immediately warned about the emergency and provided essential information they can use in making time critical decisions regarding their personal safety. Per reference (d), all BUMED commanded activities are required to maintain the capability to rapidly warn and notify all personnel in the event of an

emergency. Category 1 and 5 personnel must receive a warning and notification within 5 minutes of an event. Category 2 through 4 personnel including staff, patients, and visitors must receive the initial warning or notification within 10 minutes of an emergency. Mass warning and notification systems will be integrated with host installation based mass warning and notification systems to the maximum extent possible and key staff members (e.g., the MEM and Service element leadership) should be enrolled in the host installation mass warning and notification system. Integration with the installation mass warning and notification system ensures facilities will receive any alert from their host installation, and facilitates the immediate relay of the warning to the entire facility and staff through their mass warning and notification system. Facilities and commands are required to exercise their mass warning and notification systems a minimum of once per quarter, and each exercise must include an assessment of the effectiveness of the system to disseminate the warning to all hands within the required timeframe. Additionally, every test of the mass warning and notification system must be coordinated in advance with the host installation EM officer and security department, to preclude a test being misinterpreted as an actual emergency. Mass warning and notification is discussed in more detail in chapter 3, paragraph 3 of this manual.

(5) EOC Support. Per reference (d), NAVMED commanders, COs, and OICs at NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs are responsible for ensuring supported CNIC and MCICOM regional and installation EOCs are assigned a qualified medical liaison during activations.

(6) Communications. BUMED commanded activities will implement interoperable communications across the category 5 functional areas to the maximum extent possible. Effective emergency communications require redundancy and coordination with the host installation. MEMs will coordinate with the host installation and NAVMED or DHA market sectors regions to leverage all available emergency communication systems. In particular, monthly operational testing of the Enterprise Land Mobile Radio System handsets, satellite phones, and any other EM related communications equipment, where provided, with the host installation first responders is essential. EM communications should be used to the maximum extent possible during training and exercises. Specifically, the training should regularly validate interoperable communications between the MTF and the installation first responders. Per the Joint Commission, the use of other local, redundant emergency communication systems to include amateur radios is encouraged.

(7) Written Agreements. Per reference (o), all BUMED commanded activities are encouraged to develop MAAs with civilian emergency responders and PH entities, including local hospitals, as required, to facilitate an effective all-hazards EM response. BUMED commanded activities will coordinate with CNIC, MCICOM, or Joint Base regional and installation level EM resources, as well as the local (i.e., civilian) EM community in the development of MAAs. These agreements must 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 echelon 3 MEM. 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 to render staff, materiel resources or services when the resources of one party are insufficient to meet the needs of another during an emergency. These agreements are typically in the form of interservice support agreements (ISSA), memorandum of agreement (MOA), or memorandum of understanding (MOU), and regardless of format, all MAAs must be reviewed and approved by the chain of command prior to execution. Copies of all active MAAs must be maintained at the facility level and are common inspection items for the Joint Commission and MEDIG. NAVMED commanders must also coordinate any MAA to provide support to local civilian medical or PH entities with their host installation, to ensure DoD medical resources are prioritized to support critical DoD missions. Reference (f) permits Navy commanders to respond to civil emergencies based upon lawful MOUs, MOAs, MAAs, ISSAs, 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, local, territorial and tribal 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 reference (f) as noted in subparagraph 6c(8)(a) of this chapter. 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 Secretary of Defense. 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 echelon 3, BUMED, and DoS officials.

(8) DSCA. Per reference (f), BUMED commanded activities are encouraged to establish communications with the appropriate local civilian PH and medical EM officials to identify and update EM and PH emergency points of contact, review emergency protocols, and assess mutual expectations, including disaster response in the event of an emergency. The focus of the communications will be to identify and manage expectations for medical EM and PH emergency support during an emergency. Facilities must ensure any agreements, formal or informal, for mutual aid are fully coordinated with their host installation and their market sector, so that critical medical EM and PH emergency support during an emergency is effectively prioritized. This task should also include coordination with the EM staff of nearby military installations including the U.S. Coast Guard, the local medical EM community, and emergency planning committees.

Note: References (f) and (p), allow BUMED commanded activity commanders, COs, and OICs immediate response authority, under imminently serious conditions, and if time does not permit approval from higher authority, to provide medical support to local civilian authorities during a disaster or emergency in order to save lives, prevent human suffering, or to mitigate great property damage. This "immediate response" support to civil authorities by BUMED activity commanders, COs, and OICs does not require prior written agreement or prior approval, but it

must first be requested by local civil authorities before a MTF can provide it. Major disasters can quickly outstrip available medical resources and to ensure critical DoD missions are not adversely impacted, NAVMED commanders must coordinate with their host installation commander before providing medical support to local civilian authorities. When providing support under an immediate response authority, the NAVMED commander must:

(a) Prioritize their medical resources to critical DoD requirements and then address civilian authority requests before responding to a civilian authority's request for assistance.

(b) Ensure any request from civil authorities for immediate assistance directed to the MTF is also routed to the host or supporting installation commander.

(c) Report the incident to respective NAVMED echelon 3 leadership, installation commander, and the National Joint Operations and Intelligence Center, as soon as possible per reference (p).

(d) Ensure the costs associated with the immediate response effort are documented for reimbursement. Coordinate with BUMED or DHA where assigned, for secretarial designee authority for non-beneficiary care when required.

(9) Portal for Readiness and Emergency Preparedness. A comprehensive metrics system created to measure and report the emergency preparedness readiness status of BUMED facilities across EM, pandemic influenza, and COOP programs. The Portal for Readiness and Emergency Preparedness metrics as defined in the data dictionary are aligned with all relevant policy. Hosted on MAX.gov at https://community.max.gov/x/KwCeHg, the Portal for Readiness and Emergency Preparedness system consists of a data entry portal, stoplight dashboards, longitudinal trackers, and consolidated, regional, and individual facility reports. Stoplight colors are connected to the Portal for Readiness and Emergency Preparedness data entry and consist of green, yellow, and red status lights. A blue status light indicates that a metric is not applicable. All BUMED facilities represented in the Portal for Readiness and Emergency Preparedness must ensure their facility-specific data fields are updated as often as required (e.g., following completion of exercises and training, but not less than monthly). Parent facilities are required to ensure all subordinate facilities maintain an up-to-date Portal for Readiness and Emergency Preparedness database.

(10) Emergency Preparedness Assist Visit (EPAV). A comprehensive assessment of all EM-related programs, policies, and capabilities at a BUMED facility, and consists of two phases: a pre-site visit and site visit. The pre-site visit phase consists of a review of the facility's EM-related policy documents, assessments, and the results of the most recent MEDIG and the Joint Commission visits. The following plans and programs are included in the review: EM, pandemic influenza, COOP, mass warning and notification, shelter-in-place, evacuation, and mass casualty response plans; HVAs; and MA programs. The product of the pre-site visit phase is a plan of actions and milestones for use in resolving remaining gaps and shortfalls during the

site visit portion. The primary objective of the site visit phase is to work with key EM program personnel at the facility to validate the findings of the pre-site visit phase and to resolve remaining action items identified in the plan of actions and milestones. EPAVs are conducted annually at all NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs with either an H199 or H200 (i.e., the pandemic influenza stockpile equipment and pharmaceuticals) assemblage and at smaller NAVMEDREADTRNUNITs and non-MTFs as permitted within available funding and time constraints. Copies of NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT and non-MTF checklist templates used for conducting self-assessments and preparing for EPAVs are provided in appendix D and posted on MAX.gov at https://community.max.gov/x/KwCeHg.

(11) <u>EM Program Assessments</u>. Per chapter 1, subparagraph 2g(2) of this manual, the NAVMED MEM will conduct an assessment of NAVMED echelon 3 EM programs annually. This will be a comprehensive assessment of all EM-related programs, policies, and capabilities. These plans and programs will be included in the review: EM, pandemic influenza, COOP, MA, mass warning and notification, SIP, and evacuation. This assessment will also ensure NAVMED echelon 3 commands are providing proper oversight of their subordinate commands' EM-related programs, policies, and capabilities. Echelon 3 EM programs should use the non-MTF checklist for conducting self-assessments and preparing for an EPAV. A copy of the non-MTF checklist is provided in appendix D and posted on MAX.gov at https://community.max.gov/x/KwCeHg.

(12) <u>SIP</u>. A functional EM response capability that covers any emergency situation at a facility that requires the staff to immediately take shelter within the building(s) and secure ventilation systems and building access, to avoid potential exposure to hazardous substances or conditions outside the facility. An EM SIP response must not be confused with a lockdown in response to an active attacker emergency, or a severe weather emergency that requires staff to take shelter. SIP is discussed in more detail in chapter 3, paragraph 3 of this manual.

(13) <u>Evacuation</u>. A functional EM response capability that covers any emergency situation at a facility that requires the staff to immediately execute a controlled evacuation of the facility. Staff are generally very familiar with the process, having participated in fire drills that include an evacuation exercise. Evacuation is discussed in more detail in chapter 3, paragraph 4 of this manual.

7. <u>Planning</u>

a. Planning is critical for effectively preparing for, responding to, and recovering from an all-hazards incident. Coordinated and staffed OEPs and facility EM plans are the cornerstone of the EM program. Both NAVMED and DHA EM programs will be coordinated with the host installation EM plan. At select locations, NAVMED EM plans should also be coordinated with Federal, State, local, territorial, tribal, other-Service, HN, and any other response and recovery partners. Overseas activities will ensure their plans are coordinated with DoS and HN contingency plans wherever possible.

b.   All BUMED commanded activity EM plans will be formally reviewed annually, usually by the local EM working group, and revised a minimum of once every 3 years. The review must be documented locally and recorded in the Portal for Readiness and Emergency Preparedness.

c.   Per paragraph 6 of this chapter and reference (n), 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 for a BUMED commanded activity to continue executing their mission essential functions during an all-hazards emergency.

d.   Per reference (d), 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 SIP when evacuation is not possible. Reference (d) establishes the requirements for how quickly personnel must be notified and protected in the event of an evacuation or SIP contingency. BUMED commanded activity commanders, COs, and OICs must ensure effective mass warning and notification, SIP, and evacuation plans are implemented, and that all hands receive initial and recurring training on all emergency plans and procedures. BUMED commanded MEMs must closely coordinate their mass warning and notification, SIP, and evacuation plans with their region and host installation EM officers and planners. Required elements and best practices for emergency plans are included in chapter 3 of this manual.

e.   Per reference (q), all BUMED commanded activities will implement planning for a pandemic contingency.

8.   <u>Training</u>

a.   Training standards are based on existing DoD, Occupational Safety and Health Administration (OSHA), National Fire Protection Association (NFPA), the Joint Commission, and military standards and guidelines per references (c) and (d). These training standards focus on the requirements for category 1 personnel to maintain mission essential operations, for category 2 through 4 personnel to gain hazard awareness and an understanding of warning and response procedures, and for category 5 personnel to conduct safe and effective FHP and first receiver operations.

b.   MEMs will tailor their EM training programs to mitigate the specific hazards and threats identified in their current HVA, and to correct any deficiencies identified in relevant post-exercise AAR or lessons learned submissions. Additionally, they must ensure their training programs are integrated and coordinated with host installation and echelon 3 training programs. Completed EM training requirements must be documented in the Portal for Readiness and Emergency Preparedness and the approved learning management system per reference (r). EM training programs will facilitate a metrics based assessment of the facility's ability to meet its required EM capabilities.

c. Training Requirements. The emergency preparedness training requirements in the EM program are divided into categories. A matrix detailing the minimum requirements by position is included in Table 2-4.

(1) Federal Emergency Management Agency (FEMA) EM Institute Training. FEMA EM Institute offers a wide variety of emergency preparedness courses for personnel assigned EM responsibilities.

(a) Independent study courses are on-line, self-paced courses offered at no cost. Personnel can access the online courses at https://training.fema.gov/is/crslist.aspx.

(b) ICS-300 and ICS-400 provide training and resources for personnel who require advanced knowledge and application of the ICS. These courses are resident courses generally taught locally and coordinated by local EM agencies. MEMs should contact their region or host installation EM officer for course offerings in their area. ICS-300 and ICS-400 are also available through the DMRTI. Subparagraph 8c(3) of this chapter provides a link for additional information.

(2) DSCA Course. DSCA Phase I Course (J3S T-US010) is required. The mission of the DSCA online course is to familiarize DoD and other agency personnel in DSCA operations. The course introduces Federal, State, local, and DoD statutes, directives, plans, C2 relationships, and capabilities with regard to DoD support for domestic emergencies and for designated law enforcement and other activities. This training is available at: https://jkodirect.jten.mil.

(3) DMRTI Courses. DMRTI offers several resident courses targeting specific training requirements within the medical emergency preparedness field. Additional information can be found at https://health.mil/Training-Center/Defense-Medical-Readiness-Training-Institute.

(a) PHEM Course. The PHEM training program provides PHEOs and MEMs with the technical knowledge and skills needed to respond to PH emergencies and provide emergency assistance to civilian and HN authorities. This standardized, joint service training ensures PHEOs and MEMs can operate in a variety of environments, including onboard other Services and joint installations and facilities. There are two PHEM courses: Basic (DMRTI 6A-F25) and Sustainment (DMRTI-US004B) versions. The Basic Course is required for all newly assigned MEMs and PHEOs, and the Sustainment Course is available for MEMs and PHEOs continuing in their billets longer than 3 years.

(b) PH and Medical Services in DSCA Course (DMRTI-US013). The PH and medical services DSCA course is a 5-day interactive course focusing on inter-governmental and interagency response. The program increases attendee's knowledge and skills through expert presentations, tabletop exercises, and discussions between DoD, Federal, State, and local partners in support of the "National Preparedness Goals." The course targets medical commanders and staff at various levels with EM response duties. This course is recommended for all MEMs, alternate MEMs, PHEOs, alternate PHEOs (APHEOs), Federal Coordinating Center (FCC) coordinators, and management personnel with EM response duties.

(c) FCC and Primary Receiving Area Course (DMRTI-US006). The FCC and Primary Receiving Area Course is a 2.5-day course which provides an orientation to FCC program management and patient reception operations. The focus of the course is patient reception operations utilizing the Department of Veteran's Affairs-DoD contingency plan under the NDMS. This course is required for NDMS program managers and FCC coordinators; and recommended for FCC directors, and primary receiving area staff.

(4) NAVMED First Receiver Operations Training Course. This course is managed and scheduled by BUMED-M453. The course provides technical training needed to qualify personnel for assignment to the NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT mass casualty patient decontamination response team. The course is taught in an exportable team-trainer format at the NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT and is offered approximately every 6 months at dual-shelter and single-shelter NAVMEDREADTRN-CMDs and NAVMEDREADTRNUNITs.

Course	All NAVMED Personnel	MEMs alternate MEMs	PHEOs APHEOs	Decontamination Team Members
Introduction to ICS ***IS-100.c**	X	X	X	X
Applying ICS to Healthcare Organizations ***IS-200.c**		X	X	
Intermediate and Advanced ICS for Expanding Incidents **ICS-300 and ICS-400**		X (1)		
NIMS ***IS-700.b**		X	X	
NRF ***IS-800.c**		X	X	
PHEM Basic Course **DMRTI 6A-F25**		X	X	
PHEM Advanced Course **DMRTI-US004B**		X (2)	X (2)	
DSCA Phase 1 ***J3S T-US010**		X	X	
PH Medical DSCA Course **DMRTI-US013**		X (3)	X (3)	
First Receiver Operations Training **MED-FROT-1**		X (4)		X
FCC and Primary Receiving Area Course **DMRTI-US006**		X (5)		

Table 2-4 NAVMED Required Emergency Preparedness Training Matrix

Table 2-4 Notes:
* On-line course.
(1) ICS-300 and ICS-400 are required for BUMED HQ and echelon 3 MEMs, and MEMs at MTFs with an H199 or H200 assemblage. It is recommended for all other MEMs.
(2) PHEM Advanced is required for all MEMs and PHEOs after completing 4 years serving in their position and every 4 years thereafter.
(3) Recommended for all MEMs, alternate MEMs, PHEOs, and Assistant PHEOs at BUMED HQ, echelon 3 commands, and MTFs with dual-shelter capabilities per Table 2-3.
(4) First receiver operations training is only required for MEMs assigned to MTFs with an H199 assemblage.
(5) Required for NDMS program managers and FCC coordinators. Recommended for FCC directors and primary receiving area staff.

9. Equipment and Pharmaceuticals

a. Equipment and pharmaceutical standards focus on the requirements for category 5 personnel to conduct safe and effective FHP and first receiver operations. Equipment must be provided with the appropriate operation, employment, and maintenance training. The types and quantities of BUMED EM equipment, supplies, and pharmaceuticals will be standardized across BUMED commands and are determined by the designated MTF EM response capability level. Detailed requirements and equipment specifications are contained in reference (s). The MEM is responsible for the management of all EM equipment and pharmaceuticals.

b. The requirements established in this program manual serve as the basis for the procurement, employment, 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 and commercial off-the-shelf (COTS) tools and equipment available. Per reference (m), COTS equipment utilized within the scope of the EM program must 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.

c. BUMED-M4 will ensure the current EM equipment requirements are captured and reflected in approved assemblages for all BUMED commanded activities. BUMED-M453 will coordinate the selection of EM equipment with CNIC, Naval Sea Systems Command, BUMED-M53, and other organizations as required. The interagency board's selected equipment list serves as a basis for the selection of CBRN related COTS equipment.

d. BUMED-M453 will collaborate with BUMED-M8B to include procurement and sustainment costs for all EM equipment requirements in their budget and program objective memorandum submissions.

e. NAVMED commanders, COs, and OICs assigned EM equipment will ensure it is all reflected in DMLSS Automated Information System per reference (s). The H199, H200, and other designated EM related 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.

f. BUMED-M453 will provide funding for EM program equipment. Naval Medical Logistics Command will work with BUMED-M453 in standardizing the procurement and distribution of the required EM equipment.

g. Only BUMED-approved and procured equipment per reference (s) will 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 requirements for all-hazards response capabilities and sustainability. The policy also ensures EM response equipment is standardized across all BUMED activities, which maximizes training, logistics and sustainment efficiency, and enables first receivers to employ and maintain equipment at designated MTFs. Additionally, echelon 3 commands and facilities are specifically prohibited from procuring EM response equipment not contained in reference (s), or in excess of approved allowances, without explicit prior approval from BUMED-M453. Reference (s) and the H199 and H200 assemblages only capture technical response equipment and pharmaceuticals. Ancillary equipment such as scissors, towels, sponges, etc., required for mass casualty patient decontamination operations are not formally specified (an informal procurement summary is available from BUMED-M453 and the echelon 3 commands), and suitable similar equipment can be employed.

h. All BUMED commanded activities will maintain response materials and equipment in a secure, environmentally controlled area to permit ready access and use in a contingency and meet response requirements per Table 2-2. 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. EM program equipment requiring field-level repairs will be serviced by the NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT biomedical equipment maintenance division. HAZMAT locker and safety data sheets will be used as required for items identified as HAZMAT. EM response equipment and materials will be considered to have an extended shelf-life and must not be discarded without the prior approval of the respective echelon 3 and BUMED, regardless of the manufacturer's recommended expiration date. MEMs are responsible for ensuring all required EM technical and ancillary equipment and supplies are on-hand and maintained in a fully operational status per manufacturer specifications.

i. NAVMED commanders, COs, and OICs are responsible for ensuring all assigned EM equipment and materials are properly gained in DMLSS. The materiel management department must monitor on-hand stocks of EM equipment and material by regularly running an assemblage status rollup report. Additionally, the status of EM-related assemblages will be monitored by the respective echelon 3 command and BUMED. MEMs will conduct a 10 percent spot-check

inventory of their assigned decontamination team response equipment, materials, and pharmaceuticals (i.e., H199 assemblage) 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-Assemblage Management physical inventory module, with the results reported to the respective echelon 3 and recorded in DMLSS. Additionally, a 100 percent wall-to-wall inventory of the pandemic influenza stockpile equipment and pharmaceuticals (i.e., H200 assemblage) must be conducted semi-annually, with the results recorded in DMLSS in April and October. References (s) and (t) provide detailed information concerning pandemic influenza stockpile equipment and pharmaceuticals.

10. Exercise and Evaluation

    a.   In order to fulfill the Joint Commission requirements, all NAVMEDREADTRNCMDs with inpatient capabilities must actively participate in a minimum of two EM-related full-scale exercises (FSE) per year. NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs without an inpatient capability will complete a minimum of one EM related exercise per year. Table top exercises, functional exercises (FE), 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 if properly documented. BUMED commanded facilities will also participate in host installation and local community EM-related exercises. Particular emphasis should be focused on exercises that enhance interoperability with civilian medical counterparts and MOU or MOA EM response partners. All BUMED commanded activities will ensure their EM exercises are aligned and integrated with the respective CNIC and MCICOM host installation and echelon 3 exercise programs. Table 2-1 delineates required exercise periodicity.

    b.   The EM program uses approved DoD doctrine and planning processes to produce consistent and comparable exercise results. Per reference (m), EM exercise planners will be familiar with, and whenever practical, will employ federally recognized and standardized Homeland Security Exercise and Evaluation Program planning processes and tools, Navy mission essential task lists, and uniform assessment criteria to assess existing readiness strengths and target areas for additional training focus. Exercises will incorporate operational risk management strategies as an integral part of planning and execution.

    c.   To capture relevant training and exercise data, MEMs must upload all lessons learned and AARs into the Portal for Readiness and Emergency Preparedness on MAX.gov at https://community.max.gov/x/KwCeHg. Additionally, formal lessons learned must be completed and submitted following any actual contingency or emergency that requires the execution of any EM program response. AARs must be maintained for a minimum of 2 years or until the next the Joint Commission or MEDIG visit, whichever is longer. NAVMED echelon 3 commands are responsible for monitoring discrepancies documented in lessons learned and AARs until they are corrected.

11. Prevention and Mitigation

a. The EM program establishes prevention and mitigation standards and tools for use by all BUMED commanded activities to mitigate the effects of natural or man-made hazards.

b. Per reference (c), 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 (c), MTFs must actively monitor ESSENCE and coordinate with regional and local civilian PH surveillance systems. Reference (c) requires DoD installations in the U.S. to maintain two trained ESSENCE users, one of whom should be the PHEO, to actively monitor the system. Where the capability exists, BUMED commanded activities will assist in the identification and confirmation of disease agents, and in the prevention and mitigation of morbidity and mortality related to any all-hazards event. Additionally, where the capability exists, BUMED commanded activities will provide additional post-incident assistance to include providing an initial medical site survey, a medical risk assessment, and making recommendations regarding the appropriate respiratory and personnel protection for first responders and receivers.

c. NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs may be required to maintain or issue pharmaceutical countermeasures to installation personnel following a CBRN or hazardous material incident. MEMs will coordinate with the host installation to ensure pharmaceutical countermeasures requirements are clearly identified to include both storage and dispensing, and that the responsibilities for NAVMEDREADTRNCMD and NAVMEDREAD-TRNUNIT support are understood and incorporated into their EM response plans.

d. NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs are required to ensure the level of care provided to all enrolled beneficiaries is at a minimum, comparable to local community standards in the context of the PH emergency. Achieving and maintaining this level of beneficiary care during a PH emergency 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 of 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 PH emergency.

e. Per reference (q), NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs will be prepared to support mass dispensing and immunizing teams to screen and educate patients, dispense pharmaceuticals, and provide post-exposure immunizations. In coordination with the assigned PHEO, NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs will be prepared to support the medical recommendations the PHEO makes to the USN, USMC, echelon 3, and installation commanders regarding quarantine, restriction of movement and the evacuation of personnel. Additionally, NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs will provide targeted and effective PH-related communications for use by the regional and installation commanders. These strategic risk communications will be prepared in advance for generic PH threats (e.g., pandemic influenzas), to facilitate rapid dissemination in the event of a PH emergency. The content of all PH emergency risk communications will be coordinated with the respective echelon 3 and BUMED in coordination with the DHA who will ensure coordination with Federal, State, local, territorial, tribal, and HN PH agencies, as needed.

f. <u>Pharmaceutical Countermeasures</u>. Per reference (s), the pharmacy department head at each NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT where pharmaceutical countermeasures are stored is responsible for their proper safeguarding and dispensing. NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs will create a normal working stock rotation for H199 assemblage pharmaceuticals per reference (s) to minimize expiration and sustainment costs. H200 assemblage pharmaceuticals must not be issued outside of an actual contingency without express permission from BUMED and echelon 3 commander. The H199 and H200 assemblage pharmaceutical allowances are set at established safety levels and must not be reduced. Per reference (u), NAVMED commanders, COs, and OICs at NAVMEDREAD-TRNCMDs and NAVMEDREADTRNUNITs will ensure at least two personnel are designated as registered users of the Web-based SLEP database. The SLEP database users will ensure all on-hand inventories of stockpiled pharmaceuticals are accurately entered into the SLEP database, and inventory records are updated every 90 days, even if on-hand quantities have not changed. The pharmacy department head will notify the MEM when any H199 or H200 pharmaceuticals have expired, and the MEM will contact their echelon 3 to determine replacement procedures.

(1) Pharmaceutical countermeasures must be maintained in climate-controlled storage that meets the appropriate temperature, humidity, and security requirements.

(2) Pharmaceutical countermeasures must be readily available for use during a CBRN contingency, and appropriate emergency access procedures must be developed and implemented. They must remain under NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT control until authorized for release and distribution. As previously stated, NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs with pharmaceutical countermeasure allowances will develop a distribution plan with their host installation. The plan should address threat levels, preparedness activities, pre- and post-incident exposure, distribution, provisions for security and access, storage requirements, administration, and handling.

12. <u>Response</u>

a. The EM program establishes common response standards for all BUMED category 5 personnel as required by reference (d). These response standards require the MEM to support both the DHA and the NAVMED EM programs. Response capabilities for the NAVMED EM program are 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 as outlined in reference (m). NAVMED commanders, COs, and OICs can provide medical response teams to an incident site if specified in a MOU or MOA, or requested by an installation commander in an "immediate response authority" capacity, as described in paragraph 6 of this chapter.

b. The phased response organization of the EM program mirrors the phased response concept described in the National Response Framework (NRF) at https://www.fema.gov/. 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. They consist of:

(1) Gain and maintain situational awareness.

(2) Activate and deploy resources and capabilities.

(3) Coordinate response actions.

c. NAVMED response standards and actions must be consistent with OSHA, NIOSH, and NFPA standards, guidelines, and requirements.

d. As described in chapter 2, subparagraph 5d and per the NRF and HICS Guidebook, BUMED commanded activities will employ the HICS to the maximum extent practical during EM contingencies.

e. Per references (c) and (d), in response to an all-hazards EM contingency, all BUMED commanded activities will support the impacted host installation commander to the maximum extent practicable. BUMED activity response efforts will include, as needed:

(1) Medical and syndromic surveillance.

(2) Mass casualty response to include patient decontamination, where applicable.

(3) PHEO support.

(4) Triage and treatment.

(5) Epidemiological support including health surveillance for disease containment.

(6) Medical logistics support, including dispensing and immunizing teams.

(7) CBRN pharmaceutical countermeasure support, where applicable.

(8) Environmental health and medical surveillance of potable water, food, air quality, and animal health.

(9) Medical site surveys and risk assessments.

(10) Recommendations regarding personnel and respiratory protective equipment.

(11) Transport, where applicable.

(12) Support for quarantine and restriction of movement.

(13) Psychological care.

(14) Medical and PH risk communications.

f.   The NAVMED response to mass care and mass fatality contingencies is largely limited to providing medical SME consultation. Inpatient NAVMEDREADTRNCMDs may be able to provide limited supplies in support of a mass fatality contingency, and NAVMEDREADTRN-CMDs and NAVMEDREADTRNUNITs may provide limited PH support during a mass care contingency, particularly where the host installation is caring for displaced persons.

g.   NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs with an H199 assemblage are issued reactive skin decontamination lotion for use in responding to a known or suspected HAZMAT exposure contingency. The primary function of the reactive skin decontamination lotion is self-decontamination by patients presenting to the MTF in a CBRN contingency.

13. Recovery

a.   Recovery is the restoration of the activity's ability to execute its critical missions and deliver essential medical and patient care support. The role of the MEM during recovery operations is the same as it is during response operations: to maintain effective information flow to the chain of command and efficiently manage EM-related resources. At the completion of the recovery phase of EM response operations, the facility has returned to a normal operating status, all operational capabilities have been restored, and all logistics stocks depleted during the response have been restored.

b.   During recovery operations onboard a host installation, there are a variety of essential elements in which the NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT can expect to have a role including:

(1) PH support, including PH and environmental assessments, disease, and vector control; potable water testing; and support for maintaining public hygiene.

(2) PH emergency risk communications and advisories.

(3) Mental health support.

c.   Recovery standards must be consistent with OSHA, NIOSH, NFPA, and other relevant Federal guidelines and standards.

d.   Recovery efforts can quickly deplete a facility's EM recovery assets and capabilities, and require additional support from the echelon 3, host installation, and other Service, Federal, State, local, territorial, tribal, or HN EM recovery organizations. Prior coordination with these agencies and organizations to identify points of contact, potential support capabilities, and requirements, will significantly enhance the overall EM recovery capabilities. The fiscal and logistical impact of EM response and recovery efforts can be enormous, and facilities and respective regions or market sectors 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.

14. Sustainment

a.   BUMED HQ will establish the programming, budgeting, and resourcing necessary to develop, execute, and sustain the EM program per reference (s). BUMED commanded activities, via their echelon 3 command, will notify BUMED 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 echelon 3 commander, and once confirmed, program for their support.

b.   Sustainment Management. The effective sustainment of EM materials, equipment, and pharmaceuticals is a shared responsibility between BUMED HQ, NAVMED regions, and BUMED commanded activities. BUMED will establish life cycle sustainment and replacement procedures for all EM materials, equipment, and pharmaceuticals. MEMs will identify EM material, response equipment, and pharmaceutical deficiencies to their respective echelon 3, who will prioritize sustainment, replacement, and maintenance requirements in conjunction with BUMED. The replenishment of consumables and procurement of spare parts are the responsibility of the activities, with appropriate funding from BUMED-M453. A phased replacement program is in place for managing EM response equipment. This program replaces a

small portion of an NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT EM response equipment allowance each year to avoid large portions of equipment expiring or becoming unserviceable simultaneously. It also creates a more consistent funding requirement.

c. Equipment Maintenance. The proper maintenance and upkeep of EM response equipment and materials is the responsibility of the NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT, and MEMs will ensure their assigned gear is maintained per the manufacturer recommendations and specifications. MEMs will ensure EM response equipment is properly cleaned and stored following its use in training events and exercises. Minor equipment repairs are the responsibility of the NAVMEDREADTRNCMD and NAVMED-READTRNUNIT. MEMs will ensure extensive repairs or equipment replacement is coordinated with their respective echelon 3 command. Additional guidance concerning equipment maintenance and disposition is contained in reference (s).

d. 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 (s). No EM program equipment will be disposed of unless it has been designated as unserviceable and approved by the echelon 3 commander. On-hand EM equipment or supplies in quantities greater than the approved assemblage allowance levels (e.g., following an allowance change) will not be disposed. MEMs will contact their regional command to obtain disposition instructions for excess serviceable equipment they can no longer store. With the prior approval of BUMED and the respective echelon 3 command, excess equipment and supplies may be transferred to another NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT or the host installation.

e. EM Program Recurring Sustainment Requirements. Table 2-5 summarizes the recurring annual and quarterly requirements essential for the sustainment of all EM programs.

Requirement	Reference	Periodicity
Review designation letters for the MEM and if applicable, the PHEO and all category 1 personnel	Chapters 1 and 2	Annually
Complete the applicable EM program self-assessment checklist	Chapter 2	Annually
Complete a comprehensive review of the EM plan	Chapters 1 and 2	Annually
Review and validate the HVA	Chapters 1 and 2	Annually
Conduct or participate in a meeting of the EM working group	Chapters 1 and 2	Quarterly
Review EM support to host installation with installation EM officer	Chapters 1 through 3	Annually
Complete OSHA's Hazardous Waste Operations Refresher Training for all patient decontamination team personnel	Reference (k)	Annually

Requirement	Reference	Periodicity
Review, exercise, and test the COOP plan	Reference (n)	Annually
Review, exercise, and test the mass warning and notification response plan	Chapter 3	Quarterly
Review, exercise, and test the shelter-in-place (SIP) response plan	Chapter 3	Annually
Review, exercise, and test the evacuation response plan	Chapter 3	Annually
Review, exercise, and test the mass casualty response plan (at designated NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs)	Chapter 3	Annually
Review, exercise, and test the pandemic response plan (at NAVMEDREADTRNCMDs and NAVMEDREADTRN-UNITs)	Reference (q)	Annually
Conduct or participate in a minimum of two (inpatient NAVMEDREADTRNCMDs) or one (outpatient NAVMEDREADTRNCMDs and NAVMEDREADTRN-UNITs) EM FSE	Chapters 2 and 3	Annually
Complete an inventory spot-check of a minimum of 10 percent of patient decontamination response equipment and materials, and update DMLSS	Chapter 2	Quarterly
Complete a 100 percent physical inventory of all patient decontamination response equipment and materials, and update DMLSS	Chapter 2	Annually
Complete a 100 percent inventory of all pandemic influenza stockpile pharmaceuticals and equipment, and update DMLSS and SLEP	Chapter 2 and Reference (s)	Semi-annually
Conduct a technical review or exercise with the mass casualty patient decontamination team (at NAVMED-READTRNCMDs and NAVMEDREADTRNUNITs with patient decontamination equipment (H199 assemblage))	Chapter 3	Quarterly
Conduct a no-notice mass casualty patient decontamination FSE or functional exercises (FE) (at NAVMEDREADTRNCMDs and NAVMEDREADTRN-UNITs with decontamination equipment)	Chapter 3	Annually

Table 2-5 EM Program Sustainment Requirements

Table 2-5 Note: Not all requirements apply to all activities (e.g., small NAVMEDREADTRN-UNITs and non-MTF facilities are not fielded decontamination equipment, and thus the equipment inventory and hazardous waste operations training requirements are not applicable).

CHAPTER 3
FUNCTIONAL RESPONSE PLANS

1. Overview

    a. Discussion. EM planning will be standardized to the maximum extent possible. While EM plans will vary, the format and content should be standardized across all NAVMED facilities. 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. All BUMED commanded activity commanders, COs, and OICs will ensure EM planning follows the guidelines in this instruction.

    b. Functional Response Plans. Functional response plans represent the most critical element of a 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. The functional response to any contingency can be distilled into one of these categories:

    (1) Mass Warning and Notification Response. This functional response covers any situation that requires a BUMED or DHA commanded facility to rapidly pass critical information to all hands. This functional response may precede any of the follow-on functional responses listed, or it may be a stand-alone contingency response in itself. Example contingencies that may trigger a mass warning and notification response include any event that requires the facility staff to SIP, evacuate, and respond to a mass casualty event or be accounted for in the aftermath of destructive weather. Per reference (d), all assigned EM resources (mission critical, first responder, and first receiver personnel) and at least 90 percent of all other protected personnel must receive specific protective action recommendations via the mass warning and notification system. Category 1 and 5 personnel must receive a warning and notification within 5 minutes of an event. Category 2 through 4 personnel must receive a warning and notification within 10 minutes of an event. These capabilities should be integrated with the mass warning and notification system employed by the host installation, wherever possible.

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

    (2) SIP Response. This functional response covers any situation that requires the staff and visitors inside a BUMED or DHA commanded facility to immediately take shelter within the building(s) to avoid potential exposure to injury or hazards. It is important to distinguish between SIP and lockdown. SIP differs from lockdown in that SIP is focused on protecting personnel from external environmental threats, such as severe weather or a HAZMAT release. A lockdown is executed to protect personnel during an attack from an active attacker or other security threat when the security of the facility has been compromised. For additional details regarding an active attacker response, refer to reference (v) or the AT program guidance of the respective Service host installation. The SIP functional response will always be preceded by a

mass warning and notification response, and it may precede a follow-on evacuation or mass casualty response. Example contingencies that may trigger a SIP response include a terrorist event, HAZMAT spill, or unexpected severe weather. Example contingencies that may trigger a shelter-in-place response include a terrorist event, HAZMAT spill, or unexpected severe weather. When SIP procedures are executed, a minimum of 90 percent of the affected personnel must be notified and sheltered within 15 minutes.

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

        (3) Evacuation Response. This functional response covers any situation that requires the staff and visitors inside a BUMED and DHA commanded facility to immediately evacuate the building(s) to avoid potential exposure to injury or hazards. This functional response will always be preceded by a mass notification response and may follow a SIP response. Example contingencies that may trigger an evacuation response include a terrorist event, HAZMAT spill, an active attacker, or unexpected severe weather. The safe and efficient evacuation of threatened populations endangered during a catastrophic event is one of the principle reasons for developing an EM plan.

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

        (4) Mass Casualty Response. This functional response covers any situation that requires an NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT 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 warning and notification response, and it may follow a SIP or temporary evacuation response. Example contingencies that may trigger a mass casualty response include a terrorist event, HAZMAT spill, a large-scale aircraft or vehicle accident, an active attacker, or unexpected severe weather.

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

        (5) Pandemic and Epidemic Response. This functional response covers any situation that requires an NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT 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 applies to all NAVMEDREADTRNCMDs and NAVMEDREADTRN-UNITs.

c. Support Plans and Components. Ensure all the required supporting plans listed are included in the activity EM plan. Additional annexes applicable to local risked-based hazards may be developed and included, as desired.

(1) COOP,

(2) Primary receiving area plan (FCCs and primary receiving centers only),

(3) HVA.

d. Functional Response Planning. To help align BUMED commanded activity EM programs with BUMED requirements.

2. Required Elements for a Mass Warning and Notification Plan

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

(1) Authorization to Initiate. The plan must spell out who can authorize a mass warning and 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.

(2) Occasions for Initiation. The plan must explain the most common situations that warrant a mass warning and notification or personnel accountability response.

(3) Responsibility for Initiation. The plan must detail the positions responsible for initiating a mass warning and notification 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:

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

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

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

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

Note: MEMs and other essential EM response personnel should not be assigned personnel accountability duties, other than accounting for subordinate staff members. 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 facility.

(4) Methods of Dissemination. 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 warning and notification or personnel accountability response in the event telephone communications (i.e., cell and landlines) and electrical systems are non-operational.

(5) Pre-Planned Messages. The plan must include pre-planned notification messages for the most likely situations that warrant a mass warning and notification. 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 information elements as mandatory in any mass casualty response notification:

(a) Type of emergency.

(b) Estimated number of casualties.

(c) Type of casualties (e.g., chemical, blast and shrapnel, burns, etc.).

(d) Status of patients (e.g., ambulatory and non-ambulatory).

(e) Mode of transportation being used to transport casualties, and number and type of ambulances dispatched.

(f) Estimated time of arrival of casualties to the facility.

(6) 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.

(7) <u>Plan for Visitors</u>. 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 and patient count has a primary language other than English, the plan should include bilingual pre-planned announcements for messages that apply to everyone in the facility.

(8) <u>Training and Exercises</u>. The plan must include the details regarding recurring mass warning and notification training and exercises. BUMED commanded facilities will exercise and test their mass warning and notification and personnel accountability response process a minimum of once per quarter.

   b. <u>Best Practices</u>

(1) <u>Keep it Simple</u>. Complex warning alerts, 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 warning and notification plan. Mass warning and 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 by 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.

(2) <u>Test and Evaluate Plans and Systems Regularly</u>. 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 hazard assessment is revised or new notification systems are 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 employ an automated mass warning and notification system, 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 hours a day.

(3) <u>Redundant and Alternate Systems Enable Failsafe Performance</u>. The emergency situations and contingencies that trigger a mass warning and notification 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 warning and notification plan is, if it does not account for the loss of the primary

notification system, it falls short of the required redundancy. Integrating and practicing the use of alternate dissemination systems and methods that do not rely on utilities, for example bullhorns and messengers, will ensure failsafe performance during any contingency.

(4) 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.

3. Required Elements for a Shelter-in-Place Plan

a. Essential Components. Many of the essential components are common across the functional response plans and enhance familiarity and standardize the responses.

(1) Authorization to Initiate and Secure. The plan must spell out who can authorize an SIP 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 SIP response, or to shift to an evacuation response. The plan must also account for key personnel being unavailable and include alternates that can initiate and secure the response.

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

(3) Responsibility for Initiation. The plan must detail the positions responsible for initiating an SIP 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:

(a) Determine whether an SIP response tripwire has been reached; and if so,

(b) Brief leadership on the event and gain approval to execute the SIP response if necessary; and,

(c) Execute the response, including the mass warning and notification process and which additional personnel or watch standers are responsible for supporting actions (e.g., securing ventilation systems, doors, and windows).

(4) 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 or 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 in route to the facility.

(5) Pre-Planned Messages and Response Procedures. The plan must include pre-planned notification messages for the most likely situations that warrant an SIP response. The plan should also require the use of SIP 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 and watch standers assigned duties to execute an SIP 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 SIP 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 SIP order.

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

(7) 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 SIP instructions. At facilities where a significant portion of the visitor and patient count has a primary language other than English, the plan should include bilingual pre-planned announcements for messages that apply to everyone in the facility.

(8) Training and Exercises. The plan must include the details regarding recurring SIP response training and exercises. BUMED commanded facilities will exercise and test their SIP response process a minimum of once per year.

(9) Heating, Ventilation, and Air Conditioning Shut Down. Specify the procedures for securing the heating, ventilation, and air conditioning system(s) inside the facility to include providing the telephone number for reaching the designated facilities department point of contact, the location of shut-down switches, etc.

b. Best Practices

(1) Keep it Simple. An SIP 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, 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 SIP plan.

(2) <u>Test and Evaluate Plans and Systems Regularly</u>. 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 SIP plan a minimum of once annually. Whenever the facility's hazard assessment is revised or new air handling systems, doors or windows are installed, SIP plans must be reviewed to ensure they remain accurate and that all likely emergency situations are accounted. An SIP response is an all hands action, so make sure all hands are trained and familiar with how and when to execute an SIP response. Additionally, to account for personnel that may be on leave or temporary additional duty (TAD) during an event, assign primary and back-up personnel to secure ventilation and air-handling systems, as well as all doors and windows.

(3) <u>Redundant and Alternate Systems Enable Failsafe Performance</u>. The emergency situations and contingencies that trigger an SIP 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 SIP processes that do not rely on utilities (e.g., securing ventilation and air handling systems manually) in the event electrical controls fail.

(4) <u>Standardize Warning Terminology</u>. Effective warnings should use standard terminology that clearly communicates the immediacy, reliability, severity, and scope of the hazard and of the appropriate basic response. In emergency situations, the use of plain language is more effective than using military terminology or "codes," as BUMED commanded activities often have significant numbers of civilian personnel onboard who may not understand military specific terms.

(5) <u>Is it SIP, Shelter, Safe Haven, Lockdown, or Evacuation</u>? Avoid confusion between these similar sounding contingency options for protecting personnel by explaining the differences in the SIP plan.

(a) <u>SIP</u> 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.

(b) <u>A Shelter</u> 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.

(c) <u>A Safe Haven</u> 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.

(d) <u>Lockdown</u> is a protection strategy used during an active attacker or other security threats. It is a temporary sheltering technique personnel will perform as long as necessary until the threat has ended. The goal of a lockdown is to deny the attacker(s) easy access to buildings or personnel, and to enhance the safety for bystanders while responding security forces engage the attacker(s).

(e) <u>During an Evacuation</u>, an endangered population is directed to use specified evacuation routes and transportation methods to depart a threatened 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 paragraph.

4. <u>Required Elements for an Evacuation Plan</u>

a. <u>Essential Components</u>. Many of the essential components are common across the functional response plans, which though redundant, enhance familiarity and standardize the responses.

(1) <u>Authorization to Initiate and Secure</u>. 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 and secure the response.

(2) <u>Occasions for Initiation</u>. 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 an SIP response would be more effective and safer than an evacuation.

(3) <u>Responsibility for Initiation</u>. The plan must detail the 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:

(a) Determine whether an evacuation response tripwire has been reached; and if so,

(b) Brief leadership on the event and gain approval to execute the evacuation response if necessary; and,

(c) Execute the response, including the mass notification process and which additional personnel or watch standers are responsible for supporting actions (e.g., directing personnel to designated evacuation routes, etc.).

(4) <u>Methods of Execution</u>. 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 in route to the facility. For BUMED commanded facilities with an inpatient capability, evacuation plans must include the evacuation of all or select patients. Where applicable, reference the established FCCs, NDMS, and other relevant MAAs 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.

(5) <u>Pre-Planned Messages and Response Procedures</u>. 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 facility where personnel must gather after evacuating to be accounted for and receive critical information. The designated assembly areas will consist of both physical (e.g., another facility, installation or off-base location such as a hospital) and electronic (e.g., 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 SIP 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, or designated personnel after the evacuation is completed.

(6) <u>Verification</u>. The plan must spell out the process that will be employed to ensure the evacuation process is completely effective. Presume any evacuation response will require a complete accounting of personnel afterwards.

(7) <u>Plan for Visitors</u>. 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 and patient count has a primary language other than English, the plan should include bilingual pre-planned announcements for messages that apply to everyone in the facility.

(8) <u>Training and Exercises</u>. 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.

    b. <u>Best Practices</u>

        (1) <u>Keep it Simple</u>. An evacuation response is often executed to mitigate a contingency that has occurred or is occurring with minimal warning. For it to be effective, it needs to be executed very quickly by all hands. Complex warning alerts, 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.

        (2) <u>Test and Evaluate Plans and Systems Regularly</u>. 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, SIP, evacuation, and related EM response plan training to enhance efficiency. Whenever the facility's hazard assessment is revised, evacuation plans must be reviewed to ensure they remain accurate and that all likely emergency situations are accounted. To account for personnel that may be on leave or TAD during an event, assign back-up personnel to any necessary evacuation support duties.

        (3) <u>Redundant and Alternate Systems Enable Failsafe Performance</u>. 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 do not rely on utilities in the event electrical controls fail.

        (4) <u>Standardize Warning Terminology</u>. Effective warnings should use standard terminology that clearly communicates the immediacy, reliability, severity, and scope of the hazard and of the appropriate basic response.

        (5) <u>Integrate Evacuation Planning</u>. The facility's evacuation procedures must be integrated with their COOP plan. 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).

        (6) <u>Evacuation Routes and Teams</u>. 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 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.

5. Required Elements for a Mass Casualty Plan

a. Background. A mass casualty contingency, particularly one involving the decontamination of patients, is a demanding and difficult EM response. A mass casualty event can quickly overwhelm an MTF's response capability and exhaust available resources. Per reference (d), NAVMED provides the medical support to the Navy's installation EM program. Accordingly, activities will coordinate with both their host installation and their echelon 3 commander or immediate superior in command to support the installation EM program, and will be prepared to respond with medical support to the maximum extent of their capabilities.

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

(1) Installation Mission Support. Outline the activity's role in supporting the installation mission with a clear explanation of installation medical response. Address the activity's role in supporting a contingency response.

(2) Contributing Organizations. Include all units and organizations (i.e., military and civilian) that have a role in the 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, 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.

(3) Occasions for Initiation. The plan must explain the most common situations that warrant a mass casualty response.

(4) Authorization and Responsibility for Initiation. The plan must spell out who can authorize a mass casualty response, both during and outside of normal working hours if the facility is staffed outside normal working hours. The plan must also detail the positions responsible for initiating a 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 installation dispatch center. The plan must then clearly explain the CDO's responsibility to:

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

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

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

(5) Pre-Planned Messages and Response Procedures. The plan must include pre-planned notification messages for the most likely situations that warrant a mass casualty response. For example, the facility may specify this list of information elements as mandatory in any mass casualty response notification:

(a) Type of emergency.

(b) Estimated number of casualties.

(c) Type of casualties (e.g., chemical, blast, shrapnel, burns, etc.).

(d) Status of patients (i.e., ambulatory and non-ambulatory).

(e) Mode of transportation being used to transport casualties, number, and type of ambulances dispatched.

(f) ETA of casualties to the facility.

(6) 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 casualty response will require a mass warning and 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.

(7) Key Assumptions. This list of assumptions should be included in the plan, as applicable:

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

(b) The NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT will have an initial response capability.

(c) The surrounding civilian hospitals will accept patient transfers per TRICARE and support agreements. Identify which local civilian hospitals are integrated into the NAVMED-READTRNCMD and NAVMEDREADTRNUNIT mass casualty plan and explain their role.

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

(8) <u>Space Allocation</u>. 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.

(9) <u>Mass Casualty Plan</u>. Must establish pre-designated casualty collection points or casualty receiving areas (i.e., 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 chapter 2, paragraph 3 of this manual.

(10) <u>Triage Categories</u>. Include a description of the triage system used on the installation, and ensure it complies with DoD and USN policy.

(11) <u>Medical C2</u>. Describe the responsibilities of the NAVMED commander, CO, or OIC during a disaster or emergency situation. List the commander's, CO's, or OIC's responsibilities, including providing C2 over mass casualty team operations and coordinating with the host installation EOC as appropriate. Provide the details of the expected NAVMED-READTRNCMD and NAVMEDREADTRNUNIT 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 only has tactical control of medical personnel at the incident site.

(12) <u>Response Codes</u>. Units that have internal emergency response code systems (e.g., "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 contingency.

(13) <u>Patient Support</u>. Address maximum anticipated patient population during mass casualty 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.

(14) <u>Casualty Management</u>. Describe casualty management for each respective mass casualty team, to include casualty flow within the facility and transportation of casualties to the MTF and other facilities.

(15) <u>Triage</u>. Essential in order to properly sort patients to ensure appropriate care is rendered. NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs with mass casualty reception requirements will use a nationally recognized method of sorting the wounded to ensure rapid identification of needs. NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs should consider training enough triage team members so the same team members are assigned to the decontamination teams. Triage team members who will be assigned to work outside the MTF with the patient decontamination response team and in the warm zone, must complete all required decontamination team member qualifications prior to assignment. Emergency rooms should consider triage procedures to conduct secondary triage prior to committing resuscitative resources.

(16) <u>Clinical Services</u>. In facilities where there are limited providers, the NAVMED commander, CO, OIC, or hospital command center may designate a single clinical services team to execute the consolidated duties of minimal, delayed, immediate, and expectant triage activities performed by the clinical support teams. Descriptions of team activities:

(a) <u>Minimal</u>. The treatment of 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.

(b) <u>Delayed</u>. The treatment of patients whose injuries are significant, but not immediately life threatening. Injuries in this category may require surgery or extensive medical care.

(c) <u>Immediate</u>. The treatment of patients whose injuries demand immediate medical or surgical intervention.

(d) <u>Expectant</u>. The treatment of patients whose injuries overwhelm current medical resources at the expense of treating salvageable patients. These casualties require a staff capable of monitoring and providing comfort measures.

(17) <u>Surgery</u>. The plan must explain surgical support during contingency operations. MTFs that do not have a surgical capability will address the transfer of surgical casualties.

(18) <u>Radiology</u>. The plan must explain diagnostic imaging support during contingency operations. Discuss radiology exam prioritization.

(19) <u>Laboratory</u>. The plan must explain diagnostic laboratory and transfusion services in support of contingency operations.

(20) <u>Pharmacy</u>. Although the nature and magnitude of pharmacy support will vary, the plan must explain any pharmacy support provided during mass casualty response operations, such as resuscitative medications, intravenous fluids, and other pharmaceuticals deemed essential to this response. The plan should also outline the procedures in the event the MTF has to request assets from the Strategic National Stockpile in continental U.S. or established overseas stockpiles, although the details can be included elsewhere in the EM response plan. Procedures for a mass prophylaxis distribution process may be included as part of the mass casualty response plan or may be referenced if already incorporated in a separate pandemic response or disease containment plan.

(21) <u>Dental</u>. For those MTFs with assigned dental support, these staff members often have relevant trauma and triage training and experience, and they represent a valuable resource that should be incorporated into the NAVMEDREADTRNCMD and NAVMEDREADTRN-UNIT mass casualty response plan.

(22) <u>Nursing Services</u>. The plan must explain nursing services support during contingency operations; ensuring support for patient reception, stabilization, re-triage, and transport are addressed as necessary.

(23) <u>Patient Administration</u>. Describe patient administration functions during mass casualty 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.

(24) <u>Medical Logistics</u>. Address logistics support planning and requirements for a mass casualty contingency, to include mass prophylaxis planning and Strategic National Stockpile distribution.

(25) <u>Traumatic Stress Response</u>. Describe responsibilities in providing mental health services to patients and providers during mass casualty contingency response operations.

(26) <u>Facilities Management</u>. 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 heating, ventilation, and air-conditioning shut-off procedures and locations; power locations; emergency water shut-off; alternate water source; and emergency entry control.

(27) <u>Patient Decontamination</u>. NAVMEDREADTRNCMDs and NAVMEDREADTRN-UNITs with a patient decontamination response capability will prepare and execute a dedicated annex describing the concept of operations for patient decontamination during working hours.

(28) <u>Transportation</u>. Describe the plans for patient transportation during a mass casualty event, including any MAAs (i.e., ISSAs, MOUs, and MOAs) 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.

(29) <u>Public Information</u>. 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 concept of operations for pre-planned risk communication and PH information messages, particularly as applicable to pandemic response planning. Also consider providing specific information on alternate sources of care.

(30) <u>Blood Program</u>. Describe procedures necessary to provide blood and blood products for casualty treatment during mass casualty 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 or expand blood collection activities. Facilities with in-place frozen blood teams should specify provisions for activation, operation, and resupply.

(31) <u>Plan for Visitors</u>. 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 and patient count has a primary language other than English, the plan should include bilingual pre-planned announcements for messages that apply to everyone in the facility.

(32) <u>Training and Exercises</u>. The plan must include the details regarding recurring mass casualty response training and exercises. BUMED commanded facilities will exercise and test their mass casualty response plans a minimum of once per year. For those facilities with a patient decontamination capability, the mass casualty decontamination plan or team must be exercised once per quarter to ensure team continuity and verify decontamination equipment performance. Once per year, the patient decontamination team must conduct a no-notice mass casualty decontamination FE or FSE. FEs and FSEs that assess the efficacy of the facility's mass casualty plan are the most effective means of identifying potentially critical problems in transporting, receiving, and triaging casualties.

c. <u>Best Practices</u>

(1) <u>Keep it Simple</u>. A 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, 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 casualty plan.

(2) <u>Test and Evaluate Plans and Systems Regularly</u>. Facilities must exercise and assess their mass casualty plan a minimum of once annually, and must exercise their mass casualty decontamination plan or team once per quarter. Facilities equipped with a decontamination capability must conduct at least one no-notice decontamination drill annually. 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 hazard assessment is revised, 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 back-up personnel to any necessary mass casualty support duties.

(3) <u>Redundant and Alternate Systems Enable Failsafe Performance</u>. The emergency situations and contingencies that trigger a 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. Failsafe performance requires integrating and practicing the use of alternate notification systems and evacuation processes that do not rely on utilities in the event electrical controls fail.

(4) <u>Standardize Warning Terminology</u>. Effective warnings should use standard terminology that clearly communicates the immediacy, reliability, severity, and scope of the hazard and of the appropriate basic response.

(5) <u>Establish Emergency Credentialing Procedures</u>. A mass casualty emergency is likely to overwhelm a BUMED commanded facility's ability to respond. Establishing procedures in advance for the emergency credentialing of health care providers and the integration of volunteers can save time and potentially lives.

(6) <u>Integrate Response Planning</u>. A mass casualty emergency is a complex and demanding contingency to which a BUMED commanded facility may have to respond. This type of emergency situation will stress every facet of the facility's capabilities and will involve multiple EM responses including mass warning and notification and evacuation of non-essential staff and visitors. The facility's mass warning and 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.

6. <u>Required Elements for a Pandemic Response Plan</u>

a. <u>Essential Components</u>. Reference (c) 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 mass prophylaxis or point of distribution and communications plans. Rather than repeating the requirements and guidance contained in the reference, MEMs at BUMED commanded facilities will refer to reference (c) for any information regarding establishing, executing, or evaluating a pandemic response plan.

CHAPTER 4
MEDICAL EMERGENCY MANAGER POSITION CLASSIFICATION,
QUALIFICATIONS, AND TECHNICAL CAPABILITIES

1. Overview. EM as a professional career has been growing in scope and regulation since the creation of the U.S. Department of Homeland Security. Accordingly, BUMED must ensure fully qualified and technically competent personnel are detailed and employed as MEMs. The effective staffing of these critical positions is the most important component in assuring the effective execution of the EM program and the successful integration with Federal, State, local, territorial, and tribal EM programs. The guidance and requirements set forth in this chapter apply to all current and future personnel assigned to the primary EM duty of MEM, even if not specifically titled as an MEM.

2. Requirements

    a. NAVMED HQ, echelon 3 commands, and all dual-shelter response NAVMEDREAD-TRNCMDs and NAVMEDREADTRNUNITs as defined in chapter 3, will assign a qualified commissioned officer or civil service staff member in writing to the duties of a full-time MEM position with a minimum 12 month tour length. Parent command MEMs are responsible for overseeing the execution of EM programs at their respective subordinate commands. The assignment of any collateral duties to MEMs at these commands is specifically prohibited.

    b. Single-shelter response NAVMEDREADTRNUNITs will 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 with a minimum 12 month tour length. If the MEM duties at these MTFs are assigned on a part-time collateral duty basis, that assignment must be the only collateral duty assigned.

    c. All other facilities will assign a qualified uniformed Service member or civil service staff member in writing to the duties of a full or part-time MEM position with a minimum 12 month tour length.

    d. NAVMED echelon 3 commands and all BUMED commanded facilities will utilize BUMED-approved qualification standards for hiring or converting personnel to perform EM functions within NAVMED as civilian employees.

        (1) At NAVMED HQ, the recommended grade for the MEM is O-5 or General Schedule (GS) 14.

        (2) At NAVMED echelon 3 commands, the recommended grade for the MEM is O-4 (or above) or GS-13 (or above).

        (3) At the facility level, the recommended grade for an MEM is:

(a) Dual-shelter response NAVMEDREADTRNCMDs and NAVMEDREADTRN-UNITs: O-3 or GS-12 (or above).

(b) Single-shelter response NAVMEDREADTRNUNITs: O-1 (or above) or GS-11 (or above).

(c) All other facility types: E-5 (or above) or GS-6 (or above). If not available, the command may designate any qualified, competent Service member or government civilian.

e. Per reference (c), the minimum MEM qualifications are established:

(1) Be either a uniformed Service member or DoD civilian employee.

(2) Be capable of obtaining and maintaining an active DoD secret security clearance.

f. The minimum MEM technical capabilities are established:

(1) A minimum of 3 years of full-time EM experience for all civilian, full-time MEM positions. Uniformed personnel assigned full-time to MEM positions will have prior (i.e., formal) EM experience whenever possible, and if experienced personnel are not available, uniform personnel assigned full-time MEM duties will have a minimum of 2 years remaining in their MEM assignment.

(2) Formal training in NIMS and ICS, including at a minimum: FEMA ICS 100, 200, 700, and 800 level courses. Additionally, ICS 300 and 400 are required for full-time civilian MEMs and are recommended for full-time uniform personnel.

(3) A thorough knowledge of EM operations, doctrine, and applicable laws and regulatory requirements, including but not limited to:

(a) The NRF, NIMS, National Mitigation Framework, and the National Disaster Recovery Framework.

(b) DoD MA and COOP programs.

(c) Hospital operations and administration structure, including The Joint Commission Hospital Accreditation Program guidance regarding EM.

(4) Excellent decision making skills in stressful situations with the ability to effectively solve challenging problems in that environment.

(5) The capability to plan, execute, and assess facility-wide EM drills, training, and contingency plans.

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

(7) The ability to provide accurate, timely information to facility leaders during a contingency response, including managing EOC activation and operations.

(8) Excellent interpersonal, oral, and written communication skills.

(9) Working knowledge of EM-related computer software and emergency communication equipment (e.g., Web EOC or command, control, communications, computers, and intelligence; Enterprise Land Mobile Radios; and satellite phones).

(10) No formal certification or licensure is required; formal EM certification is highly recommended for full-time MEM positions.

APPENDIX A
REFERENCES

Ref: (a) CNICINST 3440.17
         (b) MCO 3440.9
         (c) DoD Instruction 6200.03 of 28 March 2019
         (d) OPNAVINST 3440.17A
         (e) SECNAV M-5210.1 of September 2019
         (f) OPNAVINST 3440.16E
         (g) BUMEDINST 6200.17A
         (h) DoD Instruction 1400.32 of 24 April 1995
         (i) BUMEDINST 5100.13F
         (j) OPNAVINST 5100.23G
         (k) 29 CFR 1910.134
         (l) OPNAVINST 3502.8
         (m)DoD Instruction 6055.17 of 13 February 2017
         (n) OPNAVINST 3030.5C
         (o) BUMEDINST 7050.1B
         (p) DoD Directive 3025.18 of 29 December 2010
         (q) BUMEDINST 3500.5
         (r) BUMEDINST 1500.29C
         (s) BUMEDINST 3440.12
         (t) BUMEDINST 3500.6A*
         (u) BUMEDINST 6710.71A
         (v) BUMEDINST F3300.1B*

*Available on NAVMED SharePoint at:
https://esportal.med.navy.mil/bumed/directives/Pages/default.aspx

APPENDIX B
ACRONYMS LIST

AAR	After Action Report
AT	Antiterrorism
BUMED	Bureau of Medicine and Surgery
C2	Command and Control
CBRN	Chemical, Biological, Radiological, and Nuclear
CDO	Command Duty Officer
CNIC	Commander, Navy Installations Command
CO	Commanding Officer
COOP	Continuity of Operations
COTS	Commercial-off-the-Shelf
DHA	Defense Health Agency
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
EOC	Emergency Operations Center
EPAV	Emergency Preparedness Assist Visit
ESSENCE	Electronic Surveillance System for Early Notification of Community-Based Epidemics
FCC	Federal Coordinating Center
FE	Functional Exercises
FEMA	Federal Emergency Management Agency
FHP	Force Health Protection
FSE	Full-Scale Exercise
HAZMAT	Hazardous Material
HICS	Hospital Incident Command System
HN	Host Nation
HQ	Headquarters
HVA	Hazard Vulnerability Analysis
ICS	Incident Command System
IH	Industrial Hygiene
ISSA	Interservice Support Agreement
MA	Mission Assurance
MAA	Mutual Aid Agreement
MCICOM	Marine Corps Installation Command
MEDIG	Medical Inspector General
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding

MTF	Medical Treatment Facility
NAVMEDREADTRNCMD	Navy Medicine Readiness and Training Command
NAVMEDREADTRNUNIT	Navy Medicine Readiness and Training Unit
NAVMED	Navy Medicine
NDMS	National Disaster Medical System
NFPA	National Fire Protection Association
NIMS	National Incident Management System
NIOSH	National Institute for Occupational Safety and Health
NRF	National Response Framework
OEP	Occupant Emergency Plan
OIC	Officer in Charge
OSHA	Occupational Safety and Health Administration
PAPR	Powered Air-Purifying Respirator
PH	Public Health
PHEM	Public Health Emergency Management
PHEO	Public Health Emergency Officer
RPP	Respiratory Protection Program
SIP	Shelter-in-place
SLEP	Shelf-Life Extension Program
SME	Subject Matter Expert
TAD	Temporary Additional Duty
USMC	United States Marine Corps
USN	United States Navy

APPENDIX C
TABLES

APPENDIX D
SELF-ASSESSMENT CHECKLIST TEMPLATES

1. MTF, NAVMEDREADTRNCMD, and NAVMEDREADTRNUNIT EM Program EPAV and Self Assessment Checklist:

Command:	Date:
CO/OIC:	Medical Emergency Manager:
Installation Supported:	Parent Command:
Staff Manning:	Supported Population:

Navy Medicine Emergency Management Program Requirements			
****** Unless exceptions are specified, every line item below requires a 'Y' or 'N' response ******			

Section 1: Personnel			
1. Have these Navy Medicine (NAVMED) Emergency Management (EM) Program personnel requirements been established as specified:	Y	N	N/A
a. Is the dual-shelter MEM a qualified uniformed Service member or civilian assigned full-time in writing without any additional collateral duties? (BUMEDINST 3440.10B, chapter 1, subparagraph 2s(3), pg. 1-6) (DoD Instruction 6200.03 of March 28,2019, section 4.3, pg. 38 and glossary, pg. 48)			
b. Is the single-shelter MEM a qualified uniformed Service member or civilian assigned full or part-time in writing, and if part-time, with EM as their only collateral duty? (BUMEDINST 3440.10B, chapter 1, subparagraph 2s(3), pg. 1-6) (DoD Instruction 6200.03 of March 28,2019, section 4.3, pg. 38 and glossary, pg. 48)			
c. Is the MEM at MTFs, NAVMEDREADTRNCMD, or NAVMEDREADTRN-UNIT without a patient decontamination team a qualified uniformed Service member or civilian assigned in writing? (BUMEDINST 3440.10B, chapter 1, subparagraph 2s(3), pg. 1-6) (DoD Instruction 6200.03 of March 28,2019, section 4.3, pg. 38 and glossary, pg. 48)			
d. Has the NAVMEDREADTRNCMD or NAVMEDREADTRNUNIT designated the appropriate number of personnel to properly support and manage the EM Program? (BUMEDINST 3440.10B, chapter 2, subparagraph 1b, pg. 2-1)			
e. Has a medical liaison (other than the MEM) been assigned to support the host installation Emergency Operations Center (EOC)? (BUMEDINST 3440.10B, chapter 2, subparagraph 6c(5), pg. 2-11)			

f. Has a Public Health Emergency Officer (PHEO) been designated in writing to support the MTF, host installation (and, if applicable, CNIC region)? (BUMEDINST 3440.10B, chapter 1, subparagraph 2r(2) and subparagraph 2s(4), pgs. 1-5 and 1-6) (BUMEDINST 6200.17A, subparagraphs 7b-d, pgs. 2 and 3)			
g. Has the MTF, NAVMEDREADTRNCMD, or NAVMEDREADTRNUNIT assigned two trained users to actively monitor Electronic Surveillance System for Early Notification of Community-based Epidemics (ESSENCE) (or other approved surveillance system)? **APPLIES TO: MTFs, NAVMEDREADTRNCMDs, or NAVMEDREADTRNUNITs located in the continental United States (CONUS)** (BUMEDINST 3440.10B, chapter 2, subparagraph 11b, pg. 2-21)			
h. Is the contact information for the MEM accurate on the MTF, NAVMED-READTRNCMD, or NAVMEDREADTRNUNIT page in MAX.gov? **ALSO APPLIES TO: Alternate MEMs, if assigned** (BUMEDINST 3440.10B, chapter 2, subparagraph 6c(9), pg. 2-13)			
i. Is the contact information for the PHEO accurate on the MTF, NAVMED-READTRACMD, or NAVMEDREADTRNUNIT page in MAX.gov? **APPLIES TO: MTFs, NAVMEDREADTRNCMDs, or NAVMEDREADTRNUNITs required to assign PHEOs; applicable to Alternate PHEOS, if assigned** (BUMEDINST 3440.10B, chapter 2, subparagraph 6c(9), pg. 2-13)			
j. Are EM staff and NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT leadership enrolled in the base or host installation mass warning notification system? **APPLIES TO: Tenant command MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs** (BUMEDINST 3440.10B, chapter 2, subparagraph 6c(4), pg. 2-10)			
k. Is an operational test of the mass warning and notification system being conducted each quarter? **APPLIES TO: All MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs** (BUMEDINST 3440.10B, chapter 2, subparagraph 6c(4), pg. 2-10 and chapter 3, subparagraph 2a(8), pg. 3-5)			
l. Is the assigned satellite phone tested a minimum of once per month? **APPLIES TO: MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs issued satellite phone(s)** (BUMEDINST 3440.10B, chapter 2, subparagraph 6c(6), pg. 2-11)			
m. Are communications checks conducted a minimum of once per month with the host installation first responders on the assigned Enterprise Land Mobile Radios (ELMRs)? **APPLIES TO: Tenant command MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs issued ELMRs** (BUMEDINST 3440.10B, chapter 2, subparagraph 6c(6), pg. 2-11)			

Section 2: Emergency Management Plan			
1. Does the EM Plan contain all of the listed required support plans:	**Y**	**N**	**N/A**
a. COOP Plan? (BUMEDINST 3440.10B, chapter 3, subparagraph 1c(1), pg. 3-3)			
Are all of the minimum program requirements addressed within the COOP plan? (BUMEDINST 3030.4)			
b. Hazard and Vulnerability Assessment (HVA)? (BUMEDINST 3440.10B, chapter 3, subparagraph 1c(3), pg. 3-3)			
c. National Disaster Medical System (NDMS) Patient Reception Area Plan? **APPLIES TO: MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs designated as a Federal Coordinating Center (FCC)** (BUMEDINST 3440.10B, chapter 3, subparagraph 1c(2), pg. 3-2 and NDMS FCC Guide)			
2. Does the EM Plan contain all of the listed functional response plans, are they current, and do they meet all the essential components specified in the NAVMED EM instruction:	**Y**	**N**	**N/A**
a. Mass Warning Notification? (BUMEDINST 3440.10B, chapter 3, subparagraph 1b(1), pg. 3-1)			
b. Shelter-In-Place (SIP)? (BUMEDINST 3440.10B, chapter 3, subparagraph 1b(2), pg. 3-1)			
Does the SIP Response Plan incorporate heating, ventilation, and air-conditioning (HVAC) shut-down procedures, and the point of contact designated to secure the system? (BUMEDINST 3440.10B, chapter 3, subparagraphs 3a(3)(c) and subparagraph 3a(9), pgs. 3-6 and 3-7)			
c. Evacuation? (BUMEDINST 3440.10B, chapter 3, subparagraph 1b(3), pg. 3-2)			
d. Mass Casualty? **APPLIES TO: MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs required to maintain a mass casualty response capability, including all MTFs, NAVMEDREADTRNMDs, and NAVMEDREADTRN-UNITs with a patient decontamination team (PDT)** (BUMEDINST 3440.10B, chapter 3, subparagraph 1b(4), pg. 3-2)			
e. Pandemic or Epidemic? **APPLIES TO: MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs with a pandemic response capability or all those that support a host installation closed point of dispensing (POD) or disease containment plan.** (BUMEDINST 3440.10B, chapter 3, subparagraph 1b(5), pg. 3-2)			

	Y	N	N/A
f. Is the pandemic response plan integrated with the installation's pandemic and public health emergency response plans? (DoD Instruction 6200.03 of March 28, 2019, section 1.2, paragraph d, pg. 5)			
3. Have the listed EM Plan requirements been accomplished:	**Y**	**N**	**N/A**
a. Has a notation been recorded to show that the EM Plan has been revised in the last 3 years (or more frequently, as required)? (BUMEDINST 3440.10B, chapter 1, subparagraph 2t(6), pg. 1-7 and chapter 2, subparagraph 7b, pg. 2-15)			
b. Is the MTF's, NAVMEDREADTRNCMD's, or NAVMEDREADTRNUNIT's EM Plan integrated with the host installation's EM Plan? **APPLIES TO: Tenant command MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs** BUMEDINST 3440.10B, chapter 1, subparagraph 2s(2), pg. 1-6			
c. Is the EM Plan for outside the continental U.S. (OCONUS) MTFs also coordinated with U.S. Department of State and host nation contingency plans, when applicable? **APPLIES TO: OCONUS MTFs/NAVMEDREADTRNCMDs/NAVMEDREADTRNUNITs** (BUMEDINST 3440.10B, chapter 2, subparagraph 7a, pg. 2-14)			
Section 3: Program Management			
1. Are each of the requirements listed for EM Program sustainment being addressed:	**Y**	**N**	**N/A**
a. Does the MTF, NAVMEDREADTRNCMD, or NAVMEDREADTRNUNIT maintain a current HVA? **NOTE: Tenant command MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs may use their respective host installation's HVA, making any local revisions needed** (BUMEDINST 3440.10B, chapter 2, paragraph 14e, Table 2-5, pg. 2-26)			
Has it been updated or reviewed within the last 12 months? (BUMEDINST 3440.10B, chapter 2, paragraph 14e, Table 2-5, pg. 2-26)			
b. Has the MTF, NAVMEDREADTRNCMD, or NAVMEDREADTRNUNIT completed a comprehensive review of the EM Plan annually? (BUMEDINST 3440.10B, chapter 2, paragraph 14e, Table 2-5, pg. 2-26)			
c. Is a record maintained for all patient decontamination team members capturing their most recent OSHA's Hazardous Waste Operations and Emergency Response basic or refresher training? **APPLIES TO: MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs with an H199 assemblage** (BUMEDINST 3440.10B, chapter 2, paragraph 14e, Table 2-5, pg. 2-26)			

d. Is Hospital Incident Command System (HICS) and Incident Command System (ICS) training monitored and documented in local training records and the approved learning management system? (BUMEDINST 3440.10B, chapter 2, subparagraph 5d(3), pg. 2-8)			
e. Has the MEM developed working relationships with local and territorial EM related agencies and departments (e.g., the local healthcare coalition), identifying and updating responsible points of contact, emergency protocols, and expectations in the event of an incident? (BUMEDINST 3440.10B, chapter 2, subparagraph 5d(6), pg. 2-9)			
f. Have dual shelter MTFs, NAVMEDREADTRNCMDs, or NAVMEDREAD-TRNUNITs allocated space for mass casualty team operations and established C2 interoperability with the host installation EOC as appropriate? (BUMEDINST 3440.10B, chapter 3, subparagraphs 5b(8) and 5b(11), pg. 3-13)			
g. Has the MEM used this checklist to conduct an annual EM Program self-assessment? (BUMEDINST 3440.10B, chapter 2, paragraph 14e, Table 2-5, pg. 2-26)			
h. Does the MEM conduct or participate in the meetings of the mission assurance (MA) and EM Working Group for the MTF, NAVMEDREADTRNCMD, NAVMEDREADTRNUNIT, or the host installation? (BUMEDINST 3440.10B, chapter 2, paragraph 14e, Table 2-5, pg. 2-26)			
i. Have MTF, NAVMEDREADTRNCMD, and NAVMEDREADTRNUNIT EM working group meeting minutes been maintained for 2 years? (Command specific per SECNAV M-5210.1 and OPNAVINST 5215.17; the Joint Commission requires 1 year of records)			
2. Does the MEM have a close working relationship with the host CNIC, U.S. Marine Corps, or Joint Base installation emergency management officer and staff? **APPLIES TO: Tenant command NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs** (BUMEDINST 3440.10B, chapter 2, paragraph 1b, pg. 2-1)			

Section 4: Preparedness Training			
1. Are these emergency preparedness training requirements for active duty and civil service personnel up to date: (BUMEDINST 3440.10B, chapter 2, Table 2-4, pg. 2-17) NOTE: * Baseline training completed for command indoctrination ** Initial certification, annual recertification, and quarterly team training	**Y**	**N**	**N/A**
a. *IS-100.c, Introduction to the Incident Command System (ICS) **APPLIES TO: All active duty and civil service personnel**			
b. *IS-200.c, Applying ICS to Healthcare Organizations **APPLIES TO: MEMs, PHEOs, and alternates where assigned**			
c. ICS-300 and ICS-400, Intermediate and Advanced ICS for Expanding Incidents **APPLIES TO: BUMED HQ and echelon 3 MEMs, and MEMs at MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs with an H199 or H200 assemblage; recommended for all other MEMs.**			
d. *ICS-700.b, National Incident Management System (NIMS) **APPLIES TO: MEMs, PHEOs, and alternates where assigned**			
e. *ICS-800.c, National Response Framework (NRF) **APPLIES TO: MEMs, PHEOs, and alternates where assigned**			
f. *J3S T-US010, DSCA Phase I, Defense Support of Civil Authorities **APPLIES TO: MEMs and PHEOs**			
g. DMRTI-US013, Public Health MED DSCA Course **APPLIES TO: MEMs, alternate MEMs, PHEOs, and APHEOs at BUMED HQ, echelon 3 commands, and MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs with dual-shelter capabilities as a Recommendation**			
h. DMRTI-6A-F25, Public Health Emergency Management (PHEM) Basic Course **APPLIES TO: MEMs, PHEOs, and alternates where assigned**			
i. DMRTI-US004B, PHEM Advanced Course **APPLIES TO: MEMs and PHEOs after completing 4 years in position and every 4 years thereafter**			
j. **NAVMED First Receiver Operations Training **APPLIES TO: PDT members and MEMs at MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRN-UNITs with H199 assemblages**			
k. DMRTI-US006 Federal Coordinating Center and Primary Receiving Area Course **APPLIES TO: NDMS program managers and FCC Coordinators as a requirement; recommended for FCC directors and primary receiving area staff**			

Section 5: Exercise and Evaluation			
1. Are these exercise and evaluation requirements addressed:	**Y**	**N**	**N/A**
a. Does the command generate EM-related AARs to capture lessons learned? (BUMEDINST 3440.10B, chapter 2, paragraph 1c, Table 2-1, pg. 2-2)			
b. Are EM-related AARs and lessons learned documented in the Portal for Readiness and Emergency Preparedness on MAX.gov? (BUMEDINST 3440.10B, chapter 2, paragraph 10c, pg. 2-20)			
c. Are EM-related AARs retained for a minimum of 2 years or until the next Joint Commission or MEDIG inspection, whichever is longer? (BUMEDINST 3440.10B, chapter 2, paragraph 10c, pg. 2-20)			
2. Are these exercises conducted within required periodicity:	**Y**	**N**	**N/A**
a. Have two EM-related FSEs been conducted annually at inpatient MTFs, NAVMEDREADTRNCMDs, or one EM-related FSE at outpatient MTFs, NAVMEDREADTRNCMDs, or NAVMEDREADTRNUNITs? (BUMEDINST 3440.10B, chapter 2, paragraph 10a, pg. 2-20)			
b. Has the COOP plan been reviewed and exercised annually? (BUMEDINST 3440.10B, chapter 2, Table 2-1, pg. 2-2)			
c. Has the SIP functional response plan been exercised annually? (BUMEDINST 3440.10B, chapter 2, Table 2-1, pg. 2-2)			
d. Has the Evacuation functional response plan been exercised annually? (BUMEDINST 3440.10B, chapter 2, Table 2-1, pg. 2-2)			
e. Has the Mass Casualty functional response plan been exercised annually? **APPLIES TO: MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs with Mass Casualty response capability, including all MTFs, NAVMEDREADTRNCMDs, and /NAVMEDREADTRNUNITs with PDT capability** (BUMEDINST 3440.10B, chapter 2, Table 2-1, pg. 2-2)			
f. Has the pandemic influenza functional response plan been exercised annually? **APPLIES TO: MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs with** pandemic influenza **response plan** (BUMEDINST 3440.10B, chapter 2, Table 2-1, pg. 2-2)			

	Y	N	N/A
g. Has the mass warning and notification and personnel accountability functional response plan been exercised quarterly? (BUMEDINST 3440.10B, chapter 2, Table 2-1, pg. 2-2)			
h. Has mass casualty patient decontamination team training been conducted quarterly? **APPLIES TO: MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs with a patient decontamination team** (BUMEDINST 3440.10B, chapter 2, Table 2-4, pg. 2-17)			
Section 6: Logistics			
1. Are the listed pandemic influenza, Chemical, Biological, Radiological, Nuclear (CBRN) requirements addressed:	**Y**	**N**	**N/A**
a. Are all H199 and H200 response materials and equipment stored in secure, environmentally protected areas that are immediately available during an emergency? **APPLIES TO: MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs with H199 and H200 assemblages** (BUMEDINST 3440.10B, chapter 2, subparagraph 11f(2), pg. 2-22) (BUMEDINST 3440.12, subparagraph 5d(1), pg. 3)			
b. Are all H199 and H200 pharmaceuticals maintained in climate controlled storage that meets the appropriate temperature, humidity, and security requirements? **APPLIES TO: MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs with H199 and H200 assemblages** (BUMEDINST 3440.10B, chapter, subparagraph 11f(1), pg. 2-22) (BUMEDINST 3440.12, subparagraph 5c(1), pg. 3) (BUMEDINST 3500.6A, subparagraph 5(g)(3) pg. 5)			
c. Are all applicable H199 and H200 pharmaceuticals enrolled into the Joint Medical Asset Repository (JMAR) and Shelf-Life Extension Program (SLEP)? **APPLIES TO: MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs with H199 and H200 assemblages** (BUMEDINST 3440,10B, chapter 2, paragraph 11f, pg.2-22) (BUMEDINST 3440.12, paragraph 5b, pg. 2) (BUMEDINST 3500.6A, subparagraph 5e(5), pg. 4 and subparagraph 9b, pg. 6)			
d. Has the MEM discussed CBRN pharmaceuticals countermeasure (CPC) distribution with the pharmacy department head? **APPLIES TO: MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs with H199 assemblages** (BUMEDINST 3440.10B, chapter 2, paragraph 11f, pg. 2-22) (BUMEDINST 3440.12, subparagraph 5c(3), pg. 3)			

	Y	N	N/A
e. Is all battery powered equipment in the H199 assemblage stored with the batteries removed? **APPLIES TO: MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs with H199 assemblages** (BUMEDINST 3440.12, subparagraphs 5h(1) and (2), pg. 5)			
f. Is all H199 equipment that requires calibration current? **APPLIES TO: MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs with H199 assemblages** (BUMEDINST 3440.12, subparagraphs 5h(1) and (2), pg. 5)			
g. Does the MEM ensure all required periodic maintenance on H199 equipment is being conducted? **APPLIES TO: MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs with H199 assemblages** (BUMEDINST 3440.10B, chapter 2, paragraph 3g, pg. 2-7 and paragraph 14c, pg. 2-25) (BUMEDINST 3440.12, paragraphs 5f and 5h, pg. 5)			
2. Have these inventories been completed: **APPLIES TO: MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs with H199 and H200 assemblages**	**Y**	**N**	**N/A**
a. Has a 100 percent inventory of all EM equipment been completed annually? **APPLIES TO: MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs with H199 and H200 assemblages** (BUMEDINST 3440.10B, chapter 2, Table 2-5, pg. 2-26)			
b. Is the MEM ensuring at least 10 percent of the patient decontamination team equipment is spot checked quarterly? **APPLIES TO: MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs with PDT capability** (BUMEDINST 3440.10B, chapter 2, Table 2-5, pg. 2-27)			
c. Has a 100 percent inventory of all pandemic influenza stockpile (H200) pharmaceuticals and equipment been completed semi-annually, and has an update of the changes been completed in DMLSS and JMAR or SLEP as necessary? **APPLIES TO: MTFs, NAVMEDREADTRNCMDs, and NAVMEDREADTRNUNITs with H200 assemblages** (BUMEDINST 3440.10B, chapter 2, Table 2-5, pg. 2-27)			

2. Non-MTF EM Program EPAV and Self-Assessment Checklist:

Command:	Date:
CO/OIC:	Medical Emergency Manager:
Installation Supported:	Parent Command:
Staff Manning:	Supported Population:

Navy Medicine Emergency Management Program Requirements
****** Unless exceptions are specified, every line item below requires a 'Y' or 'N' response ******

Section 1: Personnel			

1. Have these NAVMED EM Program personnel requirements been established as specified:	Y	N	N/A
a. Is the non-military treatment facility MEM a qualified uniformed Service member or civilian assigned in writing as either a full-time or primary collateral duty? (BUMEDINST 3440.10B, chapter 1, subparagraph 2s(3), pg. 1-6 and chapter 4, paragraph 2c, pg. 4-1) (DoD Instruction 6200.03 of March 28,2019, glossary, pg. 48)			
b. Has the command provided adequate time for the non-military treatment facility MEM to fully perform all of the EM duties assigned? (BUMEDINST 3440.10B, chapter 1, subparagraph 2s(3), pg. 1-6)			
c. Is a verified operational test of the mass warning and notification system being conducted each quarter? (BUMEDINST 3440.10B, chapter 2, subparagraph 6c(4), pg. 2-10 and chapter 3, subparagraph 2a(8), pg. 3-5)			
d. Is the assigned satellite phone tested a minimum of once per month? **APPLIES TO: Non-MTFs issued satellite phone(s)** (BUMEDINST 3440.10B, chapter 2, subparagraph 6c(6), pg. 2-11)			
e. Are communications checks conducted a minimum of once per month with the host installation first responders on the assigned Enterprise Land Mobile Radios? **APPLIES TO: Tenant command non-MTFs issued ELMRs** (BUMEDINST 3440.10B, chapter 2, subparagraph 6c(6), pg. 2-11)			

Section 2: Emergency Management Plan			
1. Does the EM Plan contain all of the required support plans listed:	**Y**	**N**	**N/A**
a. COOP Plan? (BUMEDINST 3440.10B, chapter 3, subparagraph 1c(1), pg. 3-3)			
Are all of the minimum program requirements addressed within the COOP plan? (BUMEDINST 3030.4, subparagraphs 7a(1) through 7a(14), pgs. 3-9)			
b. Hazard and Vulnerability Assessments (HVA)? (BUMEDINST 3440.10B, chapter 3, subparagraph 1c(3), pg. 3-3)			
2. Does the EM Plan contain all of the listed functional response plans and are they satisfactory and up-to-date:	**Y**	**N**	**N/A**
a. Mass Warning Notification? (BUMEDINST 3440.10B, chapter 3, subparagraph 1b(1), pg. 3-1)			
b. Shelter-in-place (SIP)? (BUMEDINST 3440.10B, chapter 3, subparagraph 1b(2), pg. 3-1)			
Does the SIP Response Plan incorporate heating, ventilation, and air-conditioning (HVAC) shut-down procedures and the facility's point of contact? (BUMEDINST 3440.10B, chapter 3, subparagraph 3a(3)(c) and subparagraph 3a(9), pgs. 3-6 and 3-7)			
c. Evacuation? (BUMEDINST 3440.10B, chapter 3, subparagraph 1b(3), pg. 3-2)			
3. Have these EM Plan requirements been accomplished:	**Y**	**N**	**N/A**
a. Is the EM Plan integrated with the host installation's EM Plan? **APPLIES TO: Tenant command non-MTFs** (BUMEDINST 3440.10B, chapter 1, subparagraph 2s(2), pg. 1-6)			
b. Is the EM Plan for outside the continental United States (OCONUS) non-MTFs also coordinated with U.S. Department of State and host nation contingency plans, when applicable? **APPLIES TO: OCONUS non-MTFs only** (BUMEDINST 3440.10B, chapter 2, paragraph 7a, pg. 2-14)			

Section 3: Program Management			
1. Are each of the listed requirements for EM Program sustainment (where applicable) being addressed:	**Y**	**N**	**N/A**
a. Does the non-MTF maintain a current HVA? **NOTE: Tenant command non-MTFs may use their respective host installation's HVA, making any local revisions needed** (BUMEDINST 3440.10B, chapter 2, paragraph 14e, Table 2-5, pg. 2-26)			
Has it been updated or reviewed within the last 12 months? (BUMEDINST 3440.10B, chapter 2, paragraph 14e, Table 2-5, pg. 2-26)			
b. Has the non-MTF completed a comprehensive review of the EM Plan annually? (BUMEDINST 3440.10B, chapter 2, paragraph 14e, Table 2-5, pg. 2-26)			
c. Has the MEM used this checklist to conduct an annual EM Program self-assessment? (BUMEDINST 3440.10B, chapter 2, paragraph 14e, Table 2-5, pg. 2-26)			
d. Does the MEM participate in the host installation's EM Working Group? **APPLIES TO: Tenant command non-MTFs invited to participate in the installation EM working group** (BUMEDINST 3440.10B, chapter 2, paragraph 14e, Table 2-5, pg. 2-26)			
Have non-MTF EM working group meeting minutes been maintained for 2 years? (Command specific per SECNAV Manual 5210.1 and OPNAVINST 5215.17 guidance)			
Section 4: Preparedness Training			
1. Are these emergency preparedness training requirements for active duty and civil service personnel up to date: (BUMEDINST 3440.10B, chapter 2, Table 2-4, pg. 2-17) NOTE: * Baseline training completed for command indoctrination	**Y**	**N**	**N/A**
a. *IS-100.c, Introduction to the Incident Command System (ICS) **APPLIES TO: All active duty and civil service personnel**			
b. *IS-200.HCa, Applying ICS to Healthcare Organizations **APPLIES TO: MEMs, PHEOs, and alternates where assigned**			
c. *ICS-700.b, National Incident Management System (NIMS) **APPLIES TO: MEMs, PHEOs and alternates where assigned**			

	Y	N	N/A
d. *ICS-800.c, National Response Framework (NRF) **APPLIES TO: MEMs, PHEOs, and alternates where assigned**			
e. *J3S T-US010, DSCA Phase I, Defense Support of Civil Authorities **APPLIES TO: MEMs and PHEOs**			
f. DMRTI-US004, Public Health Emergency Management (PHEM) Basic Course **APPLIES TO: MEMs, PHEOs, and alternates where assigned**			
Section 5: Exercise and Evaluation			
1. Are these exercise and evaluation requirements addressed:	**Y**	**N**	**N/A**
a. Does the non-MTF participate in the host installation EM related exercises as often as feasible? **APPLIES TO: Tenant command non-MTFs** (BUMEDINST 3440.10B, chapter 1, subparagraph 2s(2) and subparagraph 2s(9), pgs. 1-6 and 1-7)			
b. Does the non-MTF use a NIMS compliant ICS during EM contingencies and training events? (BUMEDINST 3440.10B, chapter 2, subparagraph 5d(1), pg. 2-8)			
c. Are EM-related AARs retained for a minimum of 2 years or until the next Joint Commission or MEDIG inspection (whichever is longer)? (BUMEDINST 3440.10B, chapter 2, paragraph 10c, pg. 2-20)			
2. Are these exercises conducted within required periodicity:	**Y**	**N**	**N/A**
a. Has the COOP plan been reviewed and exercised annually? (BUMEDINST 3440.10B, chapter 2, Table 2-1, pg. 2-2)			
b. Has the SIP functional response plan been exercised annually? (BUMEDINST 3440.10B, chapter 2, Table 2-1, pg. 2-2)			
c. Has the Evacuation functional response plan been exercised annually? (BUMEDINST 3440.10B, chapter 2, Table 2-1, pg. 2-2)			
d. Has the mass warning and notification functional response plan been exercised quarterly? (BUMEDINST 3440.10B, chapter 2, Table 2-1, pg. 2-2)			