Defense Health Agency

ADMINISTRATIVE INSTRUCTION

NUMBER 6055.02
August 25, 2023

Director J-3

SUBJECT: Emergency Management Program

References: See Enclosure 1.

1. PURPOSE. This Defense Health Agency- Administrative Instruction (DHA-AI), based on the authority of References (a) and (b), and in accordance with the guidance of References (c) through (w), establishes the Defense Health Agency's (DHA) procedures to:

a. Establish and implement the DHA Emergency Management (EM) Program.

b. Establish the policy, requirements, and responsibilities for all-hazards EM preparedness, mitigation, response, and recovery across all DHA-administered facilities and organizations, to facilitate DHA mission assurance and effectiveness for DHA owned assets.

c. Define DHA-administered facility EM support required.

2. APPLICABILITY. This DHA-AI applies to the DHA Enterprise (components and activities under the authority, direction, and control of the DHA), to include assigned, attached, allotted, or detailed personnel. For DHA publications, the terms "market" or "direct reporting market" includes the Hawaii Market unless otherwise noted in the publication. This applies to all published DHA publications, thereby ratifying any actions taken by the Hawaii Market after establishment.

3. POLICY IMPLEMENTATION. It is DHA's policy, pursuant to References (d), (e), and (k) through (v) that:

a. All DHA-administered facilities will establish and maintain effective EM programs to protect patients and preserve health care delivery capabilities to support DoD missions.

b. DHA Health Headquarters (DHHQ) and DHA-administered facilities and organizations have responsibility for the execution of the DHA EM program for DoD occupants (i.e., military

members and civilian employees, visitors, beneficiaries, etc.) and within the DoD-controlled area of DoD-owned, leased, or managed facilities. Military medical treatment facility (MTF) EM programs will adhere to Reference (u) and other applicable EM accreditation standards.

c. Coordination of EM support between DHA and the Military Departments will be facilitated through the Medical Emergency Managers (MEM) assigned at the MTFs and Markets.

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. See Enclosure 3.

6. PROPONENT AND WAIVERS. The proponent of this publication is the DHA Operations, Plans, and Requirements (J-3). When Activities are unable to comply with this publication the activity may request a waiver that must include a justification, including an analysis of the risk associated with not granting the waiver. The activity director or senior leader will submit the waiver request through their supervisory chain to the DHA J-3 to determine if the waiver may be granted by the Director, DHA or their designee.

7. RELEASABILITY. **Cleared for public release**. This DHA-AI is available on the Internet from the Health.mil site at: https://health.mil/Reference-Center/Policies and is also available to authorized users from the DHA SharePoint site at: https://info.health.mil/cos/admin/pubs/SitePages/Home.aspx.

8. EFFECTIVE DATE. This DHA-AI:

a. Is effective upon signature.

b. Will expire effective 10 years from the date of signature if it has not been reissued or cancelled before this date in accordance Reference (c).

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Digitally signed by CROSLAND.TELITA.1017383040
Date: 2023.08.25 15:30:28 -04'00'

TELITA CROSLAND
LTG, USA
Director

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REFERENCES

(a) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013, as amended
(b) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013, as amended
(c) DHA-Procedural Instruction 5025.01, "Publication System," April 1, 2022
(d) DoD Instruction 6055.17, "DoD Emergency Management (EM) Program," February 13, 2017, as amended
(e) DoD Instruction 6200.03, "Public Health Emergency Management (PHEM) Within the DoD," March 28, 2019
(f) DoD Instruction 3020.52, "DoD Installation Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive (CBRNE) Preparedness Standards," May 18, 2012, as amended
(g) DoD Directive 3020.40, "Mission Assurance (MA)," November 29, 2016, as amended
(h) DoD Instruction 3020.45, "Mission Assurance Construct," August 14, 2018, as amended
(i) DoD Directive 3020.26, "DoD Continuity Policy," February 14, 2018
(j) DoD Instruction 3020.42, "Defense Continuity Plan Development," February 17, 2006
(k) DoD Instruction 3001.02, "Personnel Accountability in Conjunction with Natural or Manmade Disasters," May 3, 2010
(l) DoD Instruction 3025.24, "DoD Public Health and Medical Services in Support of Civil Authorities," January 30, 2017
(m) DoD Directive 3025.18, "Defense Support of Civil Authorities (DSCA)," December 29, 2010, as amended
(n) DoD Directive 3020.44, "Defense Crisis Management," June 4, 2007, as amended
(o) DoD Instruction 2000.21, "DoD Support to International Chemical, Biological, Radiological, and Nuclear (CBRN) Incidents," April 5, 2016, as amended
(p) DoD Directive 6200.04, "Force Health Protection (FHP)," October 9, 2004
(q) DHA Administrative Instruction 104, "Continuity Program," June 18, 2019
(r) DHA Administrative Instruction 1025.01, "Military Medical Treatment Facilities Annual Regulatory/Triennial Training Requirements," May 18, 2021
(s) DHA Procedural Instruction 4180.01, "Emergency Power, Standby Generators, and Stored Energy Power Systems," January 5, 2022
(t) DHA Procedures Manual 6025.13, "Clinical Quality Management in the Military Health System Volume 5: Accreditation and Compliance)," August 29, 2019
(u) The Joint Commission Prepublication Standards, "New and Revised Emergency Management Standards," current edition
(v) DHA Administrative Instruction 5015.01, "Records Management Program," February 6, 2020
(w) DoD Instruction 4000.19, "Support Agreements," December 16, 2020

ENCLOSURE 2

RESPONSIBILITIES

1. DIRECTOR, DHA. The Director, DHA will:

a. Support the Assistant Secretary of Defense for Health Affairs with medical, public health, veterinary, and Force Health Protection expertise as needed to execute the DoD EM and Public Health EM (PHEM) programs.

b. Support the Secretaries of the MILDEPs PHEM responsibilities and activities as outlined in Reference (e).

c. Provide technical support to the Surgeons Generals of the MILDEPS, geographic Combatant Commanders, appropriate joint force commanders, DoD agencies and other DoD Components, and the Director, Coast Guard Health, Safety, and Work-Life on coordination of PHEM, as necessary.

d. Appoint both a DHA Emergency Manager and a Public Health Emergency Officer (PHEO) assigned to DHHQ to ensure DHA Direct Report Markets; Small Market and Stand-Alone Military Medical Treatment Facility Organization; Defense Health Agency Regions (known collectively throughout this publication as Markets); MTFs, Dental Treatment Facilities, and Veterinary Treatment Facilities (known collectively as MTFs throughout this publication) coordinate and support medical EM plans in accordance with Reference (d) and Reference (e). Additionally, these appointees will provide advice and assistance to the Director, DHA Markets, Defense Centers for Public Health (DCPH), and MTFs regarding emergency planning requirements, procedures, and initiatives.

2. DIRECTOR OF STAFF, DHA. The Director of Staff will:

a. Direct the development, execution, and resourcing of an overarching, integrated, all-hazards enterprise MTF-based EM Program to preserve clinical health care delivery.

b. Nominate a PHEO at the DHHQ and provide executive-level guidance and oversight of the DHA EM program and provide support to Service EMs and PHEOs during consequence management responses in accordance with Reference (e).

c. Serve as or designate an Executive-level Sponsor to the DHA Emergency Management Steering Group.

3. J-3, DIRECTOR, DHA. The J-3, Director will:

a. Facilitate the effective integration of EM activities within the DHA.

b. Plan, program, and budget for the DHA EM program's requirements and provide management support, resources, and staff to implement and assess compliance of EM programs effectively at all DHA organizational levels.

c. Employ and maintain an EM Specialist responsible for the DHA EM Program Manager role to develop, implement, and sustain the DHA EM program.

d. Identify a fire and emergency services chief consultant at the HQ level to advise on fire and emergency response issues pertaining to the EM Program in accordance with Ref (d).

4. DHA EM PROGRAM MANAGER. The EM Program Manager, also known as the DHA Emergency Manager, will:

a. Conduct an annual assessment of selected DHA Markets, DCPHs, and MTF EM programs for compliance and effectiveness. At Markets, the review will include an assessment of the Markets' ability to exercise effective oversight of the EM programs at their respective MTFs. At MTFs, the review will include an assessment of the EM program's compliance with applicable accreditation programs, such as The Joint Commission (TJC) standards in coordination with Deputy Assistant Director (DAD)-Healthcare Operations and DAD-Medical Affairs. Promulgate an annual schedule of EM program assessments.

b. 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.

c. Coordinate with DHA offices executing programs related to or with equities in the Mission Assurance program, including Antiterrorism, Continuity of Operations (COOP), Security, Public Health (PH), Defense Support of Civil Authorities (DSCA), National Disaster Medical System (NDMS), and any others.

d. Provide subject matter expert (SME) support to the Defense Medical Readiness Training Institute (DMRTI) to facilitate the development and execution of the PHEM courses, and any other EM related training.

e. Coordinate with the DHA Public Health (DHA PH) organization to identify appropriate public health and medical SMEs, to include veterinary SMEs, to advise on public health and medical issues pertaining to the DoD EM program in accordance with Reference (e).

f. Establish and charter a DHHQ-level EM Steering Group (Enclosure 5) to provide means for deliberate, purposeful coordination among members, stakeholders, and leadership while shaping policy for the entire enterprise.

g. Implement procedures for DHA-administered facilities that are tenants on installations to participate fully in the host installation EM program.

h. Ensure any DHA-administered off-installation facility (e.g., leased space) develop emergency action plans in accordance with Reference (d) and provide personnel at these facilities with coverage by mass warning and notification (MWN) systems.

5. MEDLOG DIRECTOR, DHA. The MEDLOG Director will:

a. Oversee policy and procedures for the total life-cycle management for any EM equipment (e.g., protective gear, patient decontamination equipment, etc.) to support internal response operations, to include acquisition, fielding, storage, and replacement functions.

b. Support the Military Departments with their procurement of medical EM equipment and pharmaceuticals - wherever possible, leveraging a joint service approach to procurement.

c. Ensure Defense Medical Logistics Standard Support and Joint Medical Asset Repository system administrators at DHA MTFs provide timely support to the designated MEMs at their facility or subordinate facilities with MTF EM equipment and pharmaceutical inventory.

6. J-7 DIRECTOR, DHA. The J-7 Director will:

a. Develop, implement, and sustain appropriate public health and medical EM training courses, coordinating with the MILDEP to ensure joint DoD medical EM and PHE training courses meet all Service-level requirements.

b. Coordinate with DMRTI to field formal public health and medical EM training courses, including the Public Health Emergency Manager (PHEM) and Public Health & Medical DSCA courses. Ensure a schedule of all DHA sponsored formal EM training is published annually.

7. J-8 DIRECTOR, DHA. The Director will develop and implement procedures to account for the cost of DHA program execution, EM training, exercises, and incident response at DHA-administered facilities.

8. J-1 DIRECTOR, DHA. The J-1 Director will initiate and/or monitor accountability procedures for assigned DHA personnel using the Fourth Estate Personnel Accountability and Assessment System (FEPAAS) or other system of record when directed by the DHA Director or designee in accordance with Reference (d).

9. DIRECTORS, DHA MARKETS. Market Directors will:

a. Provide oversight to ensure the DHA-administered facilities within their assigned Markets develop and execute an overarching, integrated, all-hazards enterprise, MTF-based EM Program to preserve clinical healthcare delivery capabilities.

b. Provide management support, resources, and staff to implement and assess compliance of EM programs effectively at all organizational levels within their assigned Market.

c. Appoint a MEM, in writing, or responsible designee – with training outlined in References (d) and (e), to monitor, facilitate, and coordinate EM actions between the Market, its facilities, and external partners (e.g., federal, regional, State, tribal, local, voluntary and NGO, private industry, or HN partners).

10. DIRECTORS AND OFFICERS IN CHARGE (OIC) AT DHA FACILITIES. Directors and OICs, as applicable, will:

a. Ensure a fully qualified and trained MEM is designated in writing.

b. Ensure any duly appointed MEM delivers the EM technical support necessary to effectively execute the DHA EM program locally and meet the EM requirements for all applicable accreditation programs.

11. DIRECTORS, MTF. MTF Directors will:

a. Implement, execute, and resource an effective EM program consistent with this policy. Develop and maintain an effective facility Emergency Operations Plan (EOP) or Occupant Emergency Plan (OEP) as appropriate and adhere to these requirements:

(1) Ensure EM plans incorporate the National Incident Management System (NIMS) and implement and utilize Hospital Incident Command System (HICS) at MTFs and;

(2) Ensure NIMS training (e.g., incident command system (ICS) 100, 200, 700, and HICS) is provided to Incident Command staff; monitored and documented in appropriate training records. Identified personnel may take a DHA-provided equivalent if available.

b. Designate a MEM, in writing, with training outlined in References (d) and (e), to provide the EM technical support necessary to effectively execute the DHA EM program and meet the EM requirements for all applicable accreditation programs.

c. Be prepared to support the Installation Commander under local Immediate Response Authority or through DSCA, as outlined in References (d), (l), and (m).

d. Be prepared the assist the Installation Commander based on SOFA, Country Agreement, or in support of State Department coordinated (and DoD approved) humanitarian assistance and/or disaster relief (HA/DR) for OCONUS locations, outside US territories and possessions.

12. NON-MTF DIRECTORS AND OICS. Non-MTF (i.e., research facilities, laboratories, program offices) Directors and OICs will:

a. Implement, execute, and resource an effective EM program consistent with this policy. Develop and maintain an effective facility OEP and adhere to the requirements listed in Enclosure 3, paragraph 4(d).

b. Appoint a responsible designee – with training outlined in References (d) and (e), to provide the EM support necessary to effectively execute the DHA EM program and meet the EM requirements for all applicable accreditation programs.

ENCLOSURE 3

PROCEDURES

1. PROGRAM MANAGEMENT.

a. DHA-administered facility MEMs are responsible for developing and maintaining an EM program that prepares the MTF/Market for responding to, recovering from, and mitigating the effects of an all-hazards emergency. 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 by the local Emergency Manager through training, exercise, assessment, lessons learned, and analysis.

b. As described in Enclosure 2, the DHA EM program incorporates those aspects of EM preparedness and response that impact the staff and capabilities inside DHA Components. These response actions are those commonly included in an OEP or EOP and consist of MWN, shelter in place, evacuation, and other actions to address identified vulnerabilities and threats. DHA will continue to support the responsibility for EM response and support requirements that extend outside the DHA-administered facility for medical EM support to the host installation, mass casualty operations and public health emergencies.

c. The MEM will report to the MTF Director or Market Director, or the Director's designee, for EM program requirements when assigned in writing to the MTF/Market. Regardless of assignment, all MEMs responsible for emergency preparedness actions in the MTF/Markets will complete the prescribed training outlined in Reference (e) of this instruction no later than one year after appointment or first available class; whichever is sooner.

d. DHA MTF Directors and OICs will coordinate to manage and support the facility's EM program, including the EM components of any accreditation programs. The MEM will represent the DHA-administered facility on any host installation EM working groups, coordinating with the host installation EM Officer (EMO), local emergency planning committee, and other community partners (e.g., local health authorities, volunteer organizations, etc.) regarding any EM related training, assessments, special events, or contingencies that could impact the DHA-administered facility, ensuring both the facility's DHA and Service element leadership are briefed.

e. Market Directors and their staff will monitor and support the EM program established at their respective MTFs. Support will include resourcing, professional guidance, and additional EM coverage when needed. At sites where the Market staff are also the staff assigned and responsible for the MTF, the Market's staff will be included as part of the host facility's functional response plans and will not require separate plans for the Market. However, the Market's staff may require a separate COOP plan to effectively address its Market functions even if the office and emergency relocation site are co-located with a host facility's site. The Markets are not required to establish their own EM program but are responsible for ensuring all

the facilities within their area of responsibility are complying with the DHA EM program requirements.

Table 1: EM Program Requirements

Program Requirements	DHHQ	Markets	All DHA-Administered Facilities
Appoint MEM or responsible designee to DHA-administered facilities	Yes	Yes	Yes
Establish an EM program	Yes	N/A	Yes
Maintain and exercise MWN, shelter-in-place, and evacuation functional response plans	Yes	Yes	Yes
Maintain and exercise a COOP plan	Yes	Yes	Yes
Ensure a Hazard Vulnerability Assessment (HVA) is maintained	Yes	Yes	Yes
(*Note: this is not an all-inclusive list of all the requirements a MTF is expected to maintain.*)			

2. ASSESSMENTS.

a. MEMs at DHA-administered facilities will support their host installation during higher echelon EM-related assessments involving the MTF. These assessments may include Mission Assurance assessments conducted by the Joint Staff, Defense Agencies, and the Military Departments. Small Market and Stand-alone Organization (SSO) facilities will support assessment activities of DoD Components with purview over their identified geographic location; to include DHA Markets and Offices with authority, direction, and control over prescribed functional areas within the DHA-administered facility.

b. DHA MTF Directors and OICs will support their host installation in the completion of all-hazards risk, threat, vulnerability, and consequence assessments as required to adequately protect the MTF. The scope of support required from DHA-administered facilities will vary, with larger MTFs having more significant requirements.

c. DHA-administered facilities will ensure the following activity level assessments are completed, either by the lead Service element, the host installation, or the DHA staff:

(1) HVA. DHA Directors 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 DoD uses the overarching title of risk management and a two-part process comprised of a risk assessment, followed by risk reduction planning as described in reference

(d). TJC calls this assessment an HVA and for standardization, the DHA has adopted the TJC terminology. While the nomenclature varies, the purpose of these risks, hazards, and threat assessments are the same in that 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 every two years, typically by the facility or parent command EM Working Group (EMWG). As all DoD installations are required to conduct an annual all-hazards (i.e., risk, threat, and vulnerability) assessment, installation based DHA-administered facilities are highly encouraged to use their host installation assessment to the maximum extent practicable in developing their HVA.

(2) EM Program Response Readiness Self-Assessment. DHA-administered facility MEMs will conduct a comprehensive assessment of their all-hazards response readiness annually, to include a detailed assessment of their capability to execute all functional response plans. The self-assessment must be reviewed and approved by the Market Director(s) or Site Supervisor, then routed to the designated Market MEM for review and retention. Market MEMs will ensure all assigned facilities complete and submit their EM response readiness self-assessment annually. An EM program self-assessment checklist is included in Enclosure 4.

3. INTEROPERABILITY.

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

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 Host Nation (HN) EM agencies and departments. For these reasons, the MTFs are required to adopt the Hospital Incident Command System (HICS) into its emergency planning and response efforts.

c. DHA-led activities will support and participate in host installation and DHA Market EM planning, training, and exercises to the maximum extent practical. The Markets should maintain any existing agreements and supporting partnerships related to EM support to and from the host installation. This support and participation will improve EM response capability and interoperability.

4. EM CERTIFICATION AND CREDENTIALING.

a. Certification and credentialing are essential attributes of an EM program in accordance with Reference (d).

b. Certification encourages EM professionals to enhance their career development, broaden and expand their expertise of EM, and demonstrate requisite skills and knowledge. All assigned

emergency managers are strongly encouraged to seek (when and where available) Service-specific certifications, educational institution-sponsored, or other duly recognized certifications.

c. Credentialing validates the identity and attributes of individuals or members of response and recovery resources against DoD-specific competency standards and supports effective management of critical assets. It supports effective and appropriate access control to an incident site as well as attainment of essential and common qualifications throughout the organization. DHA credentialing focuses on identification of emergency managers.

d. Market and MTF Directors will develop and implement a credentialing method that allows for the quick identification and unmitigated access of an assigned MEM or responsible designee to both the installation and the MTF during an emergency or crisis event. The method should be codified in written policy known to installation emergency response and security staff and installation leadership. Pre-existing policies and procedures that already meet this requirement will not be superseded by this instruction. Markets and MTFs that do not meet this requirement will have up to one year from the signing of this instruction to implement an appropriate method. *Note: The Assistant Secretary of Defense –Sustainment has been identified to establish a standardized credentialing program as outlined in Reference (d). DHA will issue policy and guidance once this program has been fully developed and implemented.*

5. PREPAREDNESS.

a. The DHA EM program establishes the minimum preparedness standards for DHA-administered facilities to align with DoD and Federal preparedness standards. These standards include the organization; manning; and Command, Control, and Communications interoperability with federal, state, local, territorial, tribal, HN agencies and departments, and accrediting civilian organizations. The military Services may establish additional preparedness related requirements for their installations that may impact DHA-administered facilities which are tenants on an installation. DHA Directors and OICs will ensure the assigned MEM is tracking all host installation EM preparedness requirements that may specifically impact the Markets and keep Markets' leadership apprised of compliance.

b. Public health and medical preparedness efforts for chemical, biological, radiological, nuclear, and high-yield explosives (CBRNE) events will meet the standards and capability requirements provided in Reference (f). These actions will be integrated and synchronized with installation CBRNE preparedness activities to support effective and unified response operations. Accordingly, DHA-administered facilities must be prepared to respond to any all-hazard emergency. Preparedness involves establishing authority and responsibility for emergency actions and garnering the resources to support these actions. All DHA-administered facilities must assign appropriate personnel, equipment, and other resources, as needed, to ensure their preparedness to maintain the required provision of care capabilities throughout any emergency.

c. Inpatient capable Markets have the most demanding requirements to prepare themselves to maintain their provision of care capabilities during an emergency, and their training and capabilities to effectively care for and move inpatients during an emergency is a critical

component of their accreditation process. All duly accredited Markets will adhere to the standards outlined in this publication.

d. Per Reference (d), DoD installation commanders are required to develop and maintain EM plans and procedures that can rapidly notify all personnel in the event of an emergency, that safely and efficiently move personnel to designated safe locations or shelters, and that enable them to shelter-in-place when evacuation is not possible. Accordingly, DHA Directors and OICs must ensure effective MWN, shelter-in-place and evacuation plans are implemented, closely coordinated with the host installation, and all hands receive initial and recurring training on emergency plans and procedures. MEMs assigned at DHA-administered facilities must ensure their MWN, shelter-in-place, and evacuation plans are closely coordinated with the host installation.

e. Key preparedness elements include:

(1) MWN. This is a functional EM response capability covering any emergency at a DHA-administered 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 DHA-administered facilities are required to develop maintain the capability to rapidly warn and notify all personnel in the event of an emergency. Alert notifications requiring immediate action must be sent within 2 minutes of incident notification and verification with at least 90% of all personnel including staff, patients, and visitors receiving the initial warning or notification within 10 minutes of its initiation. DHA-sponsored MWN systems will be integrated with host installation based MWN systems to the maximum extent possible and key DHA staff members (e.g., the MEM, Security, DHA, and Service element leadership) should be enrolled in the host installation MWN system, to ensure they receive any alerts directly from the host installation. In accordance with Section 5, paragraph 5.5 of Reference (d), enrollment in a DHA-sponsored MWN system is mandatory for all civilians, uniform personnel, and contractors under the authority, direction, and control of DHA. Stand-alone DHA-administered facility personnel also be enrolled in a DHA-sponsored MWN system regardless of geographical location or proximity to a local installation or Market. DHA-administered facilities are required to exercise their MWN 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 personnel within the required timeframe. Additionally, every test of a DHA-sponsored MWN system must be coordinated in advance with the host installation EMO and security department, to preclude a test being misinterpreted as an actual emergency. MWN is discussed in more detail in paragraph 13 below.

(2) Shelter-in-Place. Shelter-in-Place is a functional response capability that covers any emergency at a DHA-administered facility requiring 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. A shelter-in-place response must not be confused with a lockdown in response to an active attacker emergency, or a severe weather emergency that requires staff, patients, and visitors to take shelter. Shelter-in-place is discussed in more detail in Paragraph 12 below.

(3) Evacuation. Evacuation is a functional response capability that covers any emergency at a DHA-administered facility that requires the staff to immediately execute a controlled evacuation of the facility. Staff must be familiar with the process and participate in fire drills that include an evacuation exercise. Evacuation is discussed in more detail in Paragraph 12 below.

(4) COOP. DHA-administered facilities – with exception of co-located Market offices - will establish a COOP plan per Reference (q). The purpose of every DoD COOP program is to ensure the continual execution of mission essential functions throughout any emergency or contingency. The DHA COOP program ensures the capability of all DHA-administered facilities to maintain essential health service support during a contingency and to rapidly restore any suspended mission essential function capabilities at either their primary site or at an emergency relocation site. Every DHA-administered facility 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, MTFs must coordinate their COOP plans with the host installation and any key tenants, to ensure any element that relies on the MTFs for critical medical support will have continuous access to that support, or equivalent support. Conversely, the plan should also codify the support the host installation or key tenant will provide to the MTF when the COOP plan is activated. The MEM must work with the host command and installation EMOs to ensure contingency plans account for continued essential medical support, whether by the primary MTF, or a specified alternate care facility.

(5) PHEO. Per Reference (e), all DoD installation commanders must designate a PHEO to serve as the principal advisor on PHEs. The PHEO is responsible for advising the installation commander and, where applicable, the next echelon commander in determining the existence of and any required response to a PHE occurring onboard or potentially affecting the installation or their area of responsibility. Reference (e) requires tenant Markets/MTFs – to include DHA Regions – with the requisite staff to nominate a qualified individual available to serve as the PHEO for the host installation in accordance with Reference (e). Installations and facilities outside of existing Market boundaries requiring PHEO coverage may assign an Assistant PHEO in coordination with DHA PH in collaboration with the SSO Director. The PHEO will collaborate closely with the MEM in preparing for, declaring, responding to, and recovering from a public health emergency.

(6) EMWG. Inpatient-capable MTFs are required to establish their own internal EMWG that will meet quarterly, or as otherwise needed, to assist the MEM in the development, execution, exercise, and assessment of the MTF's EM program. Outpatient MTFs and non-MTFs are not required to establish their own EMWG but may elect to develop a coordination group to address similar matters on a lesser scale. All DHA MTFs may integrate EMWG into other functional area groups if separate minutes are maintained for EM matters. Larger Market/MTFs should make every effort – coordinated with the installation EM – to integrate the local county or community medical community into their EMWG, to enhance medical EM planning, preparedness, and response. Additionally, DHA-administered facilities will support their host installation EMWG. Although the Services establish the requirements for an EMWG under their service-specific EM program, in general, EMWG participation is limited to key tenant organizations with significant equity or capabilities; not all tenant organizations

participate. The MEM will coordinate with the installation EM to determine the extent of EMWG support required from the DHA-administered facility, keeping the respective DHA Market apprised.

(7) Communications. The importance of interoperability was emphasized in Paragraph 3, above, and DHA-administered facilities will implement interoperable EM communications to the maximum extent possible. Effective emergency communications require redundancy and coordination with the host installation. MEMs assigned to DHA-administered facilities will coordinate with the host installation and supervising DHA Market to leverage all available emergency communication systems. Monthly testing of portable handsets, satellite phones, and any other EM related communications equipment – provided by DHA or host installation – should be tested with MTF staff and the host installation first responders. Emergency communication procedures should be used to the maximum extent possible during training and exercises. Specifically, the training should regularly validate interoperable communications between the MTFs and the installation first responders.

(8) Written Agreements. DHA-administered facilities are encouraged to develop memorandums of understanding (MOU) and mutual aid agreements (MAAs), as appropriate and in accordance with Reference (b) and Reference (w), with other federal agencies, or State, local, or tribal governments, as required to facilitate an effective MTF-based all-hazards EM response to preserve clinical healthcare delivery capabilities. This includes agreements with State and local law enforcement agencies in accordance with References (d), (e), (f) and DoDI 6055.06, "DoD Fire and Emergency Services (F&ES) Program," October 2, 2019. MAAs are non-reimbursable. MOUs 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 inter-service support agreements, Memorandum of Agreement (MOA) or MOU, and regardless of format; all newly formed agreements must be reviewed and approved by the next higher headquarters (Market Director's designee or SSO, the Agreements and Partnerships Office (APMO) and installation leadership prior to execution). Copies of all active agreements must be maintained at the facility level and are common inspection items for TJC and Inspector General. Market Directors must also coordinate any agreements to provide support to local civilian medical or public health entities with their host installation, to ensure DoD medical resources are prioritized to support critical DoD missions.

(9) DSCA. Per References (e), (l), and (m), DHA-administered facilities are required to establish communications with host installations and community partners should an emergency arise, especially in regions, states, or foreign countries where hazards are likely to occur or where man-made threats are high. The focus of the communications will be to identify and manage expectations for medical EM and PHE support during an emergency. DHA-administered facilities must ensure any agreements for mutual aid are coordinated with their host installation and their Markets (if applicable), so critical EM and PHE support during an emergency is effectively prioritized. Moreover, DHA entities and MILDEPs will support efforts to ensure and maintain preparedness of NDMS resources. The supported efforts may include:

(a) DHA Operations Center providing twenty-four hours a day, seven days a week operational support to the affected Market(s) during an NDMS event; ensuring expedient coordination of resources and SME support as directed by DHA leadership. The Operations Center will also maintain a common operating picture of the event and coordinate requested support from our inter-agency partners to alleviate additional burdens that may be generated by the event. The DHA Emergency Manager will assist in addressing any NDMS and EM issues presented to the Operations Branch and interact directly with the Markets, MILDEPs NDMS and other interagency EM points of contact as appropriate.

(b) The Markets will ensure their assigned Emergency Manager coordinates and supports the MEM during NDMS activities where applicable by appropriate authority. The Market EMs – working with MEMs, are responsible for ensuring situational awareness for presently occurring events; facilitating requests from NDMS; receiving and gathering data needed for a common operating picture; responding to support requests for the Markets; and ensuring the reporting of NDMS resource preparedness to DHA Operations and the DHA Emergency Manager through established communication channels.

(10) Immediate Response Authority. As specified in References (l) and (m), in response to a request for assistance from a civil authority, under imminently serious conditions and if time does not permit approval from higher authority, the DHA Director may authorize immediate medical support to local civilian authorities to save lives, prevent human suffering, or to mitigate great property damage. This "immediate response" support to civil authorities does not require prior written agreement or approval, but MTF leaders must first notify the DHA Director and receive approval prior to providing support. Immediate response authority does not permit actions that would subject civilians to the use of military power that is regulatory, prescriptive, proscriptive, or compulsory. When providing support under an immediate response authority, the DHA Director must:

(a) Unless directed by higher authority, exercise judgment based on available information and resources in determining the maximum allowable distance from the facility the immediate response may take place, considering challenges such as sustainment, transportation, communications, mission impact, and increased risk.

(b) Ensure any request from civil authorities for immediate assistance are directed to the supporting installation commander.

(c) Report the incident to the DHA Operations Center and the installation commander – if not already reported. The DHA Operations Center will report the incident to the National Joint Operations and Intelligence Center immediately, as per Reference (m).

(d) An immediate response shall end when the necessity giving rise to the response is no longer present (e.g., when there are sufficient resources available from State, local, and other Federal agencies to respond adequately and that agency or department has initiated response activities) or when the initiating DHA Director or a higher authority directs an end to the response. The DHA official leading a response under immediate response authority shall

reassess whether there remains a necessity for the Department of Defense to respond under this authority as soon as practicable but, if immediate response activities have not yet ended, not later than 72 hours after the request for assistance was received.

(e) Support provided under immediate response authority should be provided on a cost reimbursable basis, where appropriate or legally required, but will not be delayed or denied based on the inability or unwillingness of the requester to make a commitment to reimburse the Department of Defense.

(11) Patient decontamination responsibilities. Army Emergency First Responder Program, In-Place Patient Decontamination (IPPD) or First Receiver Operations Training, depending on originating Service, is an essential capability DHA MTFs informally inherited to deliver effective treatment to our Service members and eligible beneficiaries when needed. The MTF's decontamination capability should match the capacity and complexity of the program resources it chooses to employ. MTF Directors will ensure appropriate decontamination training is provided and maintain the ability to decontaminate self-presenting victims, impending patients, and staff with existing equipment, personnel, and resources available at the MTF. Mass decontamination of ambulatory and non-ambulatory victims will remain the responsibility of the military Services in accordance with Reference (f). MTFs with coordinated support from the installation will continue to assist with mass decontamination operations for victims expected to receive treatment from the MTF.

(12) EM program preparedness assessment. EM program preparedness assessments are a comprehensive assessment of all DHA MTF EM-related programs, policies, and capabilities at a DHA-administered Facility or Market, conducted by DHHQ EM staff and DAD-Health Care Operations and DAD-Medical Affairs, per existing DHA policies.

6. PLANNING.

a. Planning is critical for effectively preparing for, responding to, and recovering from an all-hazards incident. Coordinated and staffed occupant emergency plans and facility EM plans are the cornerstone of the DHA EM program. DHA-administered facility EM plans and MTF EM inputs to installation plans will be coordinated with the host installation EM and reviewed annually by the Markets or DHA EM as needed to ensure compliance and viability of the EM program. Where appropriate, DHA EM plans in stand-alone facilities and activities 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 Department of State and HN contingency plans as appropriate.

b. All DHA-administered facility EM plans will be formally reviewed annually by the MTF Director or designee and revised in accordance with References (r) and (v).

c. DHA-administered facilities are required to reference their COOP plan in their EM plan.

d. DHA-administered inpatient facilities are responsible for maintaining patient evacuation and contingency patient movement plans, and they should be included as an annex in the Markets EM plan.

7. TRAINING FOR MTF AND MARKET STAFF.

a. Training standards are based on existing DoD, Occupational Safety and Health Administration (OSHA), National Fire Protection Agency (NFPA), TJC, military standards, and guidelines per References (r) through (v).

b. DHA-administered facilities and organizations 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 after action report (AAR) or lessons learned submissions. Training for MTFs, and respective Markets, will be an essential part of the exercise planning cycle and critical to adequately preparing for external exercises and real-world events.

c. Additionally, DHA-administered facilities and organizations must ensure their training programs are integrated and coordinated with their host installation and the training outlined in this instruction. Completed EM training requirements must be documented in established databases developed by the local MEM and the J-7.

8. EXERCISES AND EVALUATIONS.

a. To fulfill exercise and evaluation requirements in References (r) and (v), all DHA Markets/MTFs with inpatient capabilities must actively participate in a minimum of two all-hazards full-scale exercises (FSE) per year. MTFs without an inpatient capability will complete a minimum of one EM related exercise per year. Tabletop exercises, functional exercises, and other "hands on" all-hazards training must meet TJC 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. DHA Markets/MTFs will also participate in host installation and local community all-hazards exercises. Emphasis should be focused on exercises (e.g., mass casualty exercises or mass prophylaxis operations) that enhance interoperability with civilian medical counterparts and MOU or MOA EM response partners. All DHA-administered facilities will ensure their EM exercises are aligned and integrated with the host installation and Market sector exercise programs.

b. DHA led activities will submit formal lessons learned or an AAR to their installation inspection team (as appropriate) and respective Market office for review and approval, following all formal all-hazards training or exercises. Formal lessons learned will be completed and submitted following any actual contingency or emergency that requires the execution of any EM plan response. AARs will be maintained in accordance with Reference (v). Additionally, Markets in coordination with DAD-Medical Affairs and DAD-Health Care Operations are responsible to track all EM response discrepancies identified in AARs until they are corrected.

9. PREVENTION AND MITIGATION.

a. The EM program – in coordination with other DHA Directorates – will establish prevention and mitigation standards for use by all DHA-administered facilities and organizations to mitigate the effects of natural or man-made hazards within two years after the signing of this instruction.

b. Per Reference (e), the syndromic surveillance tool in use by the DoD is the Electronic Surveillance System for Early Notification of Community-based Epidemics (ESSENCE). ESSENCE is DoD's syndromic surveillance tool that monitors and provides alerts for rapid or unusual increases in the occurrence of infectious diseases and biological outbreaks. Per reference (e), MTFs must actively monitor ESSENCE and coordinate with regional and local civilian public health surveillance systems. Reference (e) requires DoD installations to conduct appropriate syndromic surveillance to assess threats to public health.

c. DHA MTFs may be required to maintain or issue pharmaceutical countermeasures to installation personnel following a CBRNE or hazardous material incident. MEMs will coordinate with the host installation to ensure clinically required pharmaceutical countermeasures are clearly identified to include both storage and dispensing and the responsibilities for MTF support are understood and incorporated into MTF and installation EM response plans.

d. MTF Directors are required to ensure during a PHE, the level of care provided to all enrolled beneficiaries is at a minimum, comparable to local community standards in the context of the PHE. Achieving and maintaining this level of beneficiary care during a PHE may require the implementation of special work schedules, the increased use of Reserve Component members, intermittent employees, re-employed annuitants, contractor personnel and volunteers, and coordination with the TRICARE managed care support contractor in accordance with Reference (e). Planning to ensure for the smooth transition of care for MTF-enrolled patients by non-DoD providers, to the extent that is necessary, must be accomplished well in advance of emergency conditions and the agreed-upon arrangements clearly communicated to all enrolled beneficiaries. The prior identification of mission critical personnel will help meet the two seemingly conflicting objectives, meeting operational mission requirements and providing beneficiary care. To fully manage expectations and appropriately educate the beneficiary population on the emergency response plan relating to access to care, it is imperative that risk communication messages and products include instructions pertaining to where to receive care in the event of a PHE.

e. Per Reference (e), MTFs will coordinate with appropriate installation agencies to determine the support requirements in installation plans for mass prophylaxis, disease containment, mass casualty, and public health emergency response. MTFs will be prepared to support the medical recommendations to the host installation or superior commanders regarding restriction of movement (e.g., quarantine, isolation) and the evacuation of personnel.

f. Additionally, MTFs will coordinate with the DHA Communications Division in the development of targeted and effective public health-related communications for use by

installation(s), the Markets, and during a public health emergency (PHE). These strategic risk communications will be prepared in advance for generic public health threats (e.g., pandemic influenza, toxin events, etc.) and adapted in the event of a PHE to facilitate rapid dissemination. Per Reference (e), the military installation commander will direct the PHEO, MTF director, and other relevant personnel to coordinate on the development and distribution of these communications. The PHEO will ensure coordination with federal, state, local, territorial, tribal, and HN public health agencies as needed.

10. RESPONSE.

a. The EM program establishes requirements for all DHA-administered facilities outlined in sections 13 and 14 of Enclosure 3, as well as those standards required by TJC. These response actions are commonly included in an EOP or OEP and consist of at a minimum: MWN, shelter in place, and evacuation. EM response actions and requirements that extend outside the DHA-administered facilities and provide medical EM support to the host installation, including mass casualty and public health emergency support, must be done in coordination with the Services. MEMs support the DHA-administered facility Director or Site Supervisor for the DHA EM program and provide coordinated support to the Installation Commander for the installation's EM program.

b. DHA MTF Directors can provide medical response support to local civilian authorities in an "immediate response authority" capacity, as described in the Preparedness paragraph 5.e (10), above. However, medical response outside the MTF should be coordinated with the Installation Commander.

c. The response measures of the DHA EM program mirror the response measures concept described in Reference (d) of this publication. The core elements of the response measures described in Reference (d) are applicable to DHA internal operations for an emergency response. They consist of the following:

(1) Ensure the protection of the facility's mission, personnel, infrastructure, and environment.

(2) Activate the incident command structure and support the installation's unified command as appropriate.

(3) Coordinate response actions and plans with the installation, local governments, federal agencies, and HN authorities as appropriate.

d. DHA EM program requirements and actions must be consistent with statutory and regulatory guidance, including OSHA, National Institute for Occupational Safety and Health, and NFPA standards, guidelines, and TJC requirements.

e. As described in the Paragraph 3 above, DHA inpatient capable MTFs will employ HICS during EM contingencies.

f. Per References (d) and (e), in response to an all-hazards contingency, DHA Components may support the impacted host installation commander.

g. The DHA MTF response to mass care and mass fatality contingencies is based on the capabilities of the MTF to provide emergency care. Inpatient MTFs may be able to provide limited supplies in support of a mass fatality contingency, and MTFs may provide limited public health support during a mass care contingency, particularly where the host installation is caring for displaced persons. Nonetheless, MTFs must ensure response activities do not significantly degrade operations and are coordinated through their Market leadership.

11. RECOVERY.

a. Recovery is the restoration of the activity's ability to execute its critical missions and deliver essential medical and patient care support. At the completion of the recovery phase of response operations, the facility has returned to an acceptable normal operating status, most operational capabilities have been restored and depleted logistics stocks have been restored to a fully mission-capable operational level.

b. During recovery operations within a host DoD installation, there are a variety of essential elements in which an MTF can expect to have a role including:

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

(2) PHE risk communications and advisories.

(3) Mental health support.

c. Recovery standards must be consistent with OSHA, National Institute for Occupational Safety and Health, National Fire Protection Association (NFPA), and other relevant federal law guidelines, and standards.

d. Recovery efforts can quickly deplete a facility's recovery assets and capabilities, and require additional support from the host installation, Market sector, or DHA Medical Logistics. Prior coordination with the various support organizations to identify points of contact, potential support capabilities, and requirements will significantly enhance the overall recovery capabilities. The fiscal and logistical impact of response and recovery efforts can be enormous, and DHA Components 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.

12. SUSTAINMENT.

a. The following table summarizes recurring annual and quarterly (e.g., January, April, July, and October) requirements conducted by MTFs that are essential for the sustainment of DHA EM programs.

Table 2: MTF EM Program Sustainment Requirements.

Training Requirement	Frequency
Complete a comprehensive review of the EM plan	Biennially
Review and validate the HVA	Biennially
Complete the applicable EM program self-assessment checklist	Annually
Conduct or participate in a meeting of the EMWG (if applicable)	Quarterly
Review and exercise the COOP plan	Annually
Review and exercise the mass notification and personnel accountability functional response plan and associated external systems	Biannually
Review annually and exercise every two years the shelter-in-place functional response plan	Annually / Biennially
Review annually and exercise every two years the evacuation functional response plan	Annually / Biennially
Conduct a minimum of one all-hazards Full-Scale Exercises	Annually

13. EM FUNCTIONAL RESPONSE PLAN GUIDELINES.

a. Overview. It is important that DHA EM planning be standardized to the extent possible. 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. The following will ensure EM planners operate within the needed standardization and follow the guidelines in this instruction.

b. MWN and Personnel Accountability Response. This functional response covers any situation that requires a DHA-administered facility to rapidly pass critical information to all personnel or to account for the status of all hands. This functional response may precede any of the follow-on functional responses listed below, or it may be a stand-alone contingency response. For example, contingencies that may trigger a MWN or personnel accountability response include any event that requires the facility staff to shelter-in-place, evacuate, 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 population must receive specific protective action recommendations via the MWN system within 10 minutes of an event. For accountability, all DoD military, civilian personnel, and contract support personnel whose normal place of duty is within the MTF will enroll in the FEPAAS or other designated system of record for expediting accountability during exercises or emergencies.

c. Shelter-in-Place Response. This functional response covers any emergency at a DHA-administered 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. A shelter-in-place response must not be confused with a lockdown in response to a security related emergency, or a severe weather emergency that requires staff to take shelter. A lockdown is executed to protect personnel during an active attacker situation or other security threat, when the security of the facility has been compromised. For additional details regarding an active attacker response, refer to the Antiterrorism Program guidance (DHA-AI 78) published by DHA in September 2022. Severe weather-related sheltering plans are similar to shelter-in-place plans, but typically do not require securing ventilation systems and focus on getting staff to designated safe haven or shelter-approved spaces within the facility. The shelter-in-place functional response will always be preceded by a MWN response, and it may precede a follow-on evacuation response. Example contingencies that may trigger a shelter-in-place response include a terrorist event, man-made threat (e.g., active shooter), hazardous material, or technological hazard event. For DHA-administered facilities, when shelter-in-place procedures are executed, a minimum of 90 percent of the protected personnel must be notified and sheltered within 10 minutes. *Note: This response requirement applies to all DHA-administered facilities*.

d. Evacuation Response. This functional response covers any situation that requires the staff and visitors inside a DHA-administered 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. Example contingencies that may trigger an evacuation response include a fire, hazardous material spill, or unexpected severe weather. The safe and efficient evacuation of threatened populations endangered during a catastrophic event is one of the primary reasons for developing an EM plan. Note: This response requirement applies to all DHA-administered facilities.

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

(1) COOP (reference only for classified portions but may be a stand-alone document).

(2) HVA.

(3) Communication Plan (e.g., use of radios, runners, overhead systems).

(4) Emergency Action Plans (e.g., algorithms for power outage, fire, active shooter).

(5) Applicable requirements identified in References (r), through (v).

14. REQUIRED ELEMENTS FOR EM FUNCTIONAL RESPONSE PLANS.

a. Mass Warning and Personnel Accountability.

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

(2) Authorization to Initiate. The plan must spell out who can authorize or terminate a MWN 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.

(3) Occasions for Initiation. The plan must explain the most common situations that warrant a MWN or personnel accountability response.

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

(a) Determine whether a MWN or personnel accountability response criteria has been reached; and if so,

(b) Execute the notification, including which additional personnel will be briefed by the Designated Official (DO) – in accordance with DHA's Physical Security Program – and are responsible to help disseminate the information.

(c) Brief leadership on the event and continue to execute the notification or accountability response.

(d) Notify the installation DO to be prepared to validate personnel accountability in Service and DoD systems (i.e., FEPAAS or other designated system). 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 should not be engaged in personnel accountability reporting for their assigned DHA-administered facility other than in an advisory role.

(5) Methods of Dissemination. The plan must explain in detail the systems in priority sequence that 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 MWN or personnel accountability response in the event telephone communications (e.g., cell and landlines) and electrical systems are non-operational.

(6) Pre-Planned Messages. The plan must include pre-planned notification messages for the most likely situations that warrant a MWN or personnel accountability response. The announcements should be pre-approved for risk communication, categorized by event type, and maintained as a ready reference wherever personnel are assigned duties to execute a notification response and collocated with the notification systems.

(7) Verification. The plan must spell out the process that will be employed to ensure the notification or accountability process is completely effective and that all affected personnel have been notified and/or accounted for.

(8) Plan for Visitors. The plan must explain the process for ensuring visitors, patients, contractors, or other non-staff personnel who may be inside the facility are notified and understand any mandatory instructions. At facilities where a significant portion of the visitor 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.

(9) Training and Exercises. The plan must include the details regarding recurring MWN and personnel accountability response training and exercises. DHA-administered facilities will exercise and test their MWN, and personnel accountability response process a minimum of twice per year (e.g., January, July or Fiscal Year Quarter 2 and Quarter 4).

b. Shelter-in-Place.

(1) Essential Components. Many of the essential components are common across the functional response plans to enhance familiarity and standardize the responses.

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

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

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

(a) Determine whether a shelter-in-place response criteria has been reached; and if so,

(b) Brief leadership on the event and gain approval to execute the shelter-in-place response if necessary; and,

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

(5) 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 the host installation, as well as personnel outside or returning to the facility.

(6) Pre-Planned Messages and Response Procedures. The plan must include pre-planned notification messages for the most likely situations that warrant a shelter-in-place response. The plan should also require the use of shelter-in-place pre-planned response procedures, 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 a shelter-in-place response. Additionally, the pre-planned procedures should provide instructions for personnel who regularly work with classified or controlled materials (e.g., pharmaceuticals) to secure and protect the materials prior to departing for a designated shelter-in-place location. It should also spell out the procedures for any designated critical personnel who must remain at their posts to secure or operate critical equipment, perform critical patient care, or perform essential duties after a shelter-in-place order.

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

(8) Plan for Visitors. The plan must explain the process for ensuring visitors, patients, contractors, or other non-staff personnel who may be inside the facility are notified and understand any mandatory shelter-in-place instructions. Facilities with a significant portion of

non-English speaking visitors and patients must include an appropriate bilingual, pre-planned announcement for messages.

(9) Training and Exercises. The plan must include the details regarding recurring shelter-in-place exercises based upon a variety of natural, technological, and human-caused scenarios. DHA-administered facilities will exercise and test their shelter-in-place response process every two years. Annual reviews will still be required to make appropriate updates.

c. Evacuation.

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

(2) Authorization to Initiate and Secure. The plan must spell out who can authorize (and otherwise; terminate) 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.

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

(4) Responsibility for Initiation. 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 DO as the primary recipient of all initial notifications for any emergency from the base dispatch center. The plan must then clearly explain the DO's responsibility to:

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

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

(c) Brief leadership on the event and provide updates regarding the event when safety permits.

(5) Methods of Execution. The plan must explain in detail the systems in priority sequence that 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 returning to the facility. For DHA MTFs with an inpatient capability, evacuation plans must include the evacuation of patients to include those undergoing in-progress clinical procedures and intensive care unit patients. Execution procedures must plan for evacuation transportation for the 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.

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

(7) Verification. 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.

(8) Plan for Non-DoD Personnel. 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. Facilities with a significant portion of non-English speaking visitors and patients must include an appropriate bilingual, pre-planned announcement for messages.

(9) Training and Exercises. The plan must include the details regarding recurring evacuation response training and exercises. DHA-administered facilities will exercise and test their evacuation response plans a minimum of once per year. Full-scale exercises 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.

ENCLOSURE 4

EM PROGRAM READINESS SELF-ASSESSMENT CHECKLISTS

1. DHA MTF EM Program Readiness Self-Assessment Checklist:

Section 1: Personnel			
1. Have the following DHA Emergency Management (EM) Program personnel requirements been established as specified:	**Y**	**N**	**N/A**
a. Do you have a MEM designated to perform EM responsibilities as a primary function or an additional duty for the DHA-administered facility?			
b. Is a method in place to allow for the immediate identification of the MEM and unmitigated access to the installation and MTF during an emergency or crisis event?			
c. Has a Public Health Emergency Officer (PHEO) been designated in writing to support the host installation in accordance with DoDI 6200.03?			
d. Has the MTF assigned trained users to actively monitor ESSENCE or other approved surveillance systems? **APPLIES TO: MTFs located in the continental United States**			
e. Are DHA MTF staff enrolled in the DHA-provided Mass Warning Notification (MWN) system? **APPLIES TO: installation based MTFs**			
f. Has verified an operational test of the Mass Warning and Notification System (MWNS) is being conducted twice a year?			
g. Are communications checks conducted a minimum of once per month with the host installation first responders on an assigned or provided communication device (i.e., hand-held radio, dedicated land line, etc.)? **APPLIES TO: installation based MTFs issued ELMRs or equivalent**			
Section 2: EM Plan			
1. Does the EM Plan contain all the following required Support Plans:	**Y**	**N**	**N/A**
a. Continuity of Operations (COOP) Plan (reference only)?			
b. Hazard and Vulnerability Assessment (HVA)?			

2. Does the EM Plan contain all the following Functional Response Plans, are they current, and do they meet all the essential components specified in the DHA EM instruction:	Y	N	N/A
a. Mass Warning and Notification (MWN)?			
b. Shelter-In-Place (SIP)?			
1) Does the SIP Response Plan incorporate heating, ventilation, and air-conditioning (HVAC) shut-down procedures and the facility's point of contact?			
c. Evacuation?			
b. Meet applicable Elements of Performance required by TJC?			
3. Have the following 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 two years (or more frequently, as required)?			
b. Does the MTF's EM Plan support the host installation's EM Plan? **APPLIES TO: installation based MTFs**			
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**			
Section 3: Program Management			
1. Are each of the following requirements for EM Program sustainment being addressed:	**Y**	**N**	**N/A**
a. Does the MTF maintain a current hazard and vulnerability assessment (HVA)? **NOTE: installation based MTFs may use their respective host installation's HVA, making any local revisions needed**			
1) Has it been updated or reviewed within the last 24 months?			
b. Has the MTF completed a comprehensive review of the EM Plan biennially in accordance with Reference (y) and this instruction?			

c. Has the MEM used this checklist to conduct an annual EM Program self-assessment?			
d. Does the MEM conduct or participate in the meetings of the EM Working Group (EMWG) for the MTF and/or the host installation?			
1) Have EMWG meeting minutes retained in accordance with Reference (aa)?			
Section 4: Preparedness Training			
1. Are the following emergency preparedness training recommendations for active duty and civil service personnel up to date: 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: active duty and civil service personnel with a response role**			
b. *IS-200 C, Applying ICS Basic Incident Command System for Initial Response **APPLIES TO: MEMs, PHEOs, active duty, and civil service personnel with a response role**			
c. *ICS-700.B, An Introduction to the National Incident Management System **APPLIES TO: MEMs, PHEOs, active duty, and civil service personnel with a response role**			
d. *ICS-800.D, National Response Framework, An Introduction **APPLIES TO: MEMs and PHEOs**			
e. *HICS, Hospital Incident Command System **APPLIES TO: MEMs, PHEOs, active duty, and civil service personnel with a response role**			
f. DMRTI-US004, Public Health EM (PHEM) Basic Course **APPLIES TO: MEMs, PHEOs and alternates where assigned**			
Section 5: Exercise and Evaluation			
1. Are the following Exercise and Evaluation requirements addressed:	**Y**	**N**	**N/A**

a. Does the leadership team generate EM-related AARs to capture lessons learned?			
b. Are EM-related AARs retained in accordance with Reference (aa)?			
2. Are the following exercises conducted within required schedule:	**Y**	**N**	**N/A**
a. Have one EM-related full-scale exercises (FSEs) been conducted annually at inpatient MTFs or outpatient MTFs?			
b. Has the SIP functional response plan been exercised biennially?			
c. Has the Evacuation functional response plan been exercised biennially?			
d. Has the MWN functional response plan been exercised twice a year?			

2. DHA Non-MTF EM Program Readiness Self-Assessment Checklist:

Section 1: Personnel			
1. Have the following DHA Emergency Management (EM) Program personnel requirements been established as specified:	**Y**	**N**	**N/A**
a. Do you have an Emergency Manager designated to perform EM responsibilities as a primary function or an additional duty for the DHA-administered facility?			
b. Are you able to verify functional tests of the MWNS being conducted each quarter?			
Section 2: EM Plan			
1. Does the EM Plan contain all the following required Support Plans:	**Y**	**N**	**N/A**
a. Continuity of Operations (COOP) Plan (reference only)?			
b. Hazard and Vulnerability Assessments (HVA)?			

2. Does the EM Plan contain all the following Functional Response Plans and are they satisfactory and up to date:	Y	N	N/A
a. Mass Warning Notification?			
b. Shelter-in-place (SIP)?			
1) Does the SIP Response Plan incorporate heating, ventilation, and air-conditioning (HVAC) shut-down procedures and the facility's point of contact?			
c. Evacuation?			
3. Have the following EM Plan requirements been accomplished:	**Y**	**N**	**N/A**
a. Does the EM Plan support the host installation's EM Plan? **APPLIES TO: installation based non-MTFs**			
b. Is the EM Plan for outside the continental U.S. (OCONUS) non-MTFs – excluding Alaska and Hawaii – also coordinated with U.S. Department of State and host nation contingency plans, when applicable? **APPLIES TO: OCONUS non-MTFs only**			
Section 3: Program Management			
1. Are each of the following requirements for EM Program sustainment (where applicable) being addressed:	**Y**	**N**	**N/A**
a. Does the non-MTF maintain a current hazard and vulnerability assessment (HVA)? **NOTE: installation based non-MTFs may use their respective host installation's HVA, making any local revisions needed**			
1) Has it been updated or reviewed within the last 24 months?			
b. Has the non-MTF completed a comprehensive review of the EM Plan annually in accordance with Reference (d) and this instruction?			
c. Has the Emergency Manager used this checklist to conduct an annual EM Program self-assessment?			

d. Does the EM POC participate in the host installation's EM Working Group (EMWG)? **APPLIES TO: installation based non-MTFs invited to participate in the installation EMWG**			
Section 4: Preparedness Training			
1. Are the following emergency preparedness training recommendations for active duty and civil service personnel up to date: 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 Basic Incident Command System for Initial Response **APPLIES TO: MEMs, PHEOs, active duty, and civil service personnel with a response role**			
c. *ICS-700.B, An Introduction to the National Incident Management System **APPLIES TO: MEMs, PHEOs, active duty, and civil service personnel with a response role**			
d. *ICS-800.D, National Response Framework, An Introduction **APPLIES TO: MEMs and PHEOs**			
d. *HICS, Hospital Incident Command System **APPLIES TO: MEMs, PHEOs, active duty, and civil service personnel with a response role**			
e. DMRTI-US004, Public Health EM (PHEM) Basic Course **APPLIES TO: MEMs, PHEOs and alternates where assigned**			
Section 5: Exercise and Evaluation			
1. Are the following 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: installation based non-MTFs**			
b. Are EM-related AARs retained for a minimum of two years or until the next DHA IG inspection?			
2. Are the following exercises conducted within required periodicity:	**Y**	**N**	**N/A**
a. Has the SIP functional response plan been exercised biennially?			
b. Has the Evacuation functional response plan been exercised biennially?			
c. Has the MWN functional response plan been exercised twice a year?			

ENCLOSURE 5

DHA EMERGENCY MANAGEMENT STEERING GROUP

1. PURPOSE AND RESPONSIBILITIES.

a. The purpose of this Enclosure is to establish the mission, membership, roles, responsibilities, and procedures of the Defense Health Agency Emergency Management Steering Group (DHA EMSG). The DHA EMSG will serve as the body responsible for assessing and developing recommendations to improve the DHA emergency management program by development and refinement of standardized program requirements, career development and training and certification opportunities.

b. The DHA EMSG's authority is based on Reference (d) and applicable policies set by OSD(HA) and the DHA.

c. The purpose of the DHA EMSG is to proactively identify issues impacting the execution and improvement of the emergency management program within the DHA headquarters, DHA Components, and DHA-administered facilities.

d. The DHA EMSG will report discoveries and provide recommendations to the Executive Sponsor. The DHA EMSG will:

(1) Evaluate current DoD policy and guidance governing emergency management to include, but not limited to: Mass Warning and Notification, Public Health Emergency Management, Defense Support of Civil Authorities, Immediate Response Authority, Credentialing, Emergency Preparedness and Response, and changes in regulatory requirements and recommend actions to resolve DHA program gaps and/or inconsistencies;

(2) Identify and facilitate the integration of emergency management best practices from our Service and Interagency partners;

(3) Identify and socialize credentialing and training opportunities for assigned emergency management personnel;

(4) Identify a cadre of personnel to provide subject matter expertise during DHA-led emergency management training events and, during impending or current emergencies and disasters impacting the enterprise; and

(5) Review After Action Reports of events that had an unfamiliar or unexpected impact on DHA headquarters or DHA global operations to identify areas of improvement or codify effective actions not in policy.

2. MEMBERSHIP. The DHA EMSG will be comprised of the following Principal Members in the rank of GS-14/O-5 or above:

a. Executive Sponsor: DHA Director of Staff or executive designee (SES or Flag Officer)

b. Chairperson: DHA Emergency Management Program Manager (SME)

c. DHA J-1 (SME)

d. DHA J-3, Security (SME)

e. DHA MEDLOG (SME)

f. DHA J-5 (SME)

g. DHA J-6 (SME)

h. DHA J-7, Education and Training (SME)

i. DHA J-8 Finance and Facilities (SME)

j. HEALTH CARE OPS, Healthcare Operations Support Division (SME)

k. MEDICAL AFFAIRS, Accreditation & Compliance (SME)

l. DHA PHEO (SME)

m. DHA COOP Program Manager (SME)

n. DHA OGC (SME)

o. Market-level MEMs (SME)

p. Adjunct Members will serve as additional DoD subject matter experts (SMEs) and support members from the Services and other organizations – to include contract employees when required by the contract – but not limited to:

(1) BUMED EM Director (SME)

(2) MEDCOM EM Program Manager (SME)

(3) AFMRA Chief, BioDefense (SME)

(4) DHA EM Contract Support Personnel (SME / admin)

3. MEETING MANAGEMENT. Meetings shall be held at least quarterly. Additional meetings may be held at the discretion of the Chairperson, DHA EMSG, and may occur using available conferencing technology (teleconferences or video teleconferences).

a. The DHA EMSG Chairperson shall:

(1) Develop and manage the meeting agenda. Members may submit new recommendations or initiatives in writing to the Chair for inclusion in the next meeting agenda.

(2) Ensure meeting minutes are taken at each meeting. Review minutes prior to release to the DHA EMSG members for additional comments within five business days. Identified changes and/or comments will be incorporated and reviewed by the working group. The final version of the minutes shall be maintained by the DHA EM Program Management Office. A copy of meeting minutes will be provided to the Executive Sponsor of the DHA EMSG.

(3) Ensure all members have pre-briefs/read-a-head materials no later than 48 hours prior to meeting to facilitate timely coordination and decision-making.

(4) Ensure prompt execution of deliverables (e.g., material updates) and DHA EMSG communication items throughout the year in coordination with the DHA EMSG members.

(5) Provide briefings and/or status report of DHA EMSG deliverables and recommendations to the Executive Sponsor or DHA Executive Leadership as directed.

(6) Provide status and report of DHA EMSG group deliverables, and DHA EMSG recommendations to the Executive Sponsor.

(7) Present follow-up requests and directives from the Executive Sponsor or DHA Executive Leadership to the DHA EMSG members.

(8) Charter and appoint a lead for sub-Working Groups as needed.

b. The DHA EMSG members will:

(1) Review and vote approve/disapprove meeting minutes (the majority vote governs);

(2) Preview issues and read-ahead materials prior to the meeting;

(3) Coordinate within their Directorates and Offices, and other DoD Components as appropriate, on applicable DHA EMSG matters;

(4) Complete tasks as assigned and provide status reports as required;

(5) Make recommendations for appointment of additional DoD SMEs to the DHA EMSG; and

(6) Make recommendations for participation by organizations external to DoD for specific meetings, when applicable.

c. Administrative Management:

(1) The DHA J-3 will ensure the DHA EMSG has the appropriate manpower and resources to carry out all functions identified in this charter.

(2) Recommendations will be made by consensus. If decisions cannot be reached by the DHA EMSG, the issues will be forwarded to the Executive Sponsor for decision. When necessary, the issue will move to DHA Executive Leadership, in coordination with DHA J-3, for decision. Adjunct Members do not have a vote.

(3) Each member and/or their organization is responsible for providing consistent representation in DHA EMSG meetings and providing position/input to documents, recommendations and/or decisions.

(4) The DHA EMSG may invite SMEs to attend meetings, as applicable, and/or establish sub-working groups of SMEs to evaluate DoD public Health emergency management training. The DHA EMSG may also request ad hoc SMEs from DoD and external agencies to the DHA EMSG, when appropriate.

4. DELIVERABLES.

a. Reports and minutes will be made available to the DHA J-3, Executive Sponsor, or DHA Director of Staff via the DHA EMSG Chairperson.

b. Final reports, results of assessments, requirements identified, meeting minutes, and recommendations for doctrine updates will be reviewed and/or further developed by the DHA J-3 and the DHA EMSG before submission to DHA Executive Leadership.

c. Final reports and recommendations for doctrine updates will be forwarded by the DHA EMSG Chairperson, via Executive Sponsor for approval prior to submission to the Office of Primary Responsibility (OPR).

5. DURATION. This Working Group will remain in effect until terminated or superseded in this or other applicable publication (e.g., by Policy Memorandum).

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

AAR	After Action Report
AD	Assistant Director
AT	Antiterrorism
CBRNE	chemical, biological, radiological, nuclear, and high-yield explosives
COOP	Continuity of Operations
DAD	Deputy Assistant Director
DCPH	Defense Centers for Public Health
DHA	Defense Health Agency
DHA-AI	Defense Health Agency-Administrative Instruction
DHA IG	Defense Health Agency Inspector General
DHHQ	Defense Health Agency Headquarters
DMRTI	Defense Medical Readiness Training Institute
DO	Designated Official
DSCA	Defense Support of Civil Authorities
ELMRS	Enterprise Land Mobile Radio System
EM	Emergency Management
EMO	Emergency Management Officer
EMS	Emergency Medical Service
EMWG	Emergency Management Working Group
EOP	Emergency Operations Plan
ESSENCE	Electronic Surveillance System for Early Notification of Community-Based Epidemics
FE	Functional Exercise
FEPAAS	Fourth Estate Personnel Accountability and Assessment System
FHP	Force Health Protection
FSE	full-scale exercise
HAZMAT	Hazardous Material
HICS	Hospital Incident Command System
HN	Host Nation
HQ	Headquarters
HVA	Hazard Vulnerability Assessment
ICS	Incident Command System

MAA	Mutual Aid Agreement
MEM	Medical Emergency Manager
MILDEP	Military Department
MOA	Memorandum of Agreement
MOU	memorandums of understanding
MTF	Medical Treatment Facility
MWN	Mass Warning and Notification
MWNS	Mass Warning and Notification System
NDMS	National Disaster Medical System
NFPA	National Fire Protection Agency
NIMS	National Incident Management System
OEP	Occupant Emergency Plan
OIC	Officer in Charge
OSHA	Occupational Safety and Health Administration
PHE	public health emergency
PHEM	Public Health Emergency Management
PHEO	Public Health Emergency Officer
SME	Subject Matter Expert
SO	Senior Official
TJC	The Joint Commission

PART II. DEFINITIONS

all-hazards emergency. A threat or an incident, natural or manmade, that warrants action to protect life, property, the environment, and public health or safety, and to minimize disruptions of government, social, or economic activities. It includes natural disasters, cyber incidents, industrial accidents, pandemics, acts of terrorism, sabotage, and destructive criminal activity targeting critical infrastructure.

credentialing. The authentication and verification of the training, certification, and identity of designated first responder, first receiver, and emergency responder personnel. DHA credentialing focuses on training and subsequent identification.

Designated Official. DHA-administered facility assigned personnel appointed or identified as the responsible person(s) to alert personnel or lead and activate an emergency response.

devolution. The capability to transfer statutory authority and responsibility for essential functions from an agency's primary operating staff and facilities to other agency employees and facilities, and to sustain that operational capability for an extended period.

EM. 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.

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

First Receivers. First receivers are 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, in-place patient 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.

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

Hospital Incident Command System. A methodology for using ICS in a hospital / healthcare environment.

MEM. The point of contact for medical EM serves as the DHA lead for the EM program at MTFs and non-MTF level and is the primary point of contact with the host installation EMO, as well as the EM lead with any local civilian medical facilities and emergency response organizations.

MTF. A military medical treatment facility operated by DHA that may provide inpatient or outpatient care to active-duty military, eligible TRICARE beneficiaries, and others as designated. MTF capabilities vary from limited acute care clinics to teaching and tertiary care medical centers. MTFs are under the authority, direction, and control of the DHA Director while uniformed Service Members are under administrative control of a commander, CO, or OIC. Service installation commanders, and in some instance regional commanders, have direct coordination authority with MTFs and may have tactical control over uniformed personnel provided by DHA in direct support.

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