

**SENATE ALL-HAZARDS MEDICAL PREPAREDNESS AND RESPONSE
HEARING/ROUNDTABLE**

1. Effective medical response to a national catastrophe requires a sufficient number of medical personnel. Establishing alternative care sites will only be effective if they are staffed with trained health care providers. Currently, the federal government possesses several mechanisms to support this activity – National Disaster Medical System (NDMS), ESAR-VHP, Medical Response Corps, and the Commissioned Corps. How should the recruiting, credentialing, training, and managing of permanent and temporary federal health care providers best be accomplished? How can the federal government best organize and deploy health care providers to assist in the response to a national emergency?

a. How should the recruiting, credentialing, training, and managing of permanent and temporary federal health care providers best be accomplished? The medical response to a national catastrophe begins first and foremost with state and local first responders. The federal government must anticipate and be prepared to rapidly respond if state and local governments are not able to mount an effective response, even before a formal request for federal assistance is received. The mechanisms to provide federal health care provider resources are through the National Disaster Medical System (NDMS), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), the Medical Reserve Corps, and the Public Health Service Commissioned Corps. However, the Defense Department, to the extent health care resources and providers are not deployed on other global missions, can provide additional health providers to supplement the workforce. DoD needs to synchronize these assets and capabilities with the overarching coordinating body. Specific recommendations include:

i. Recruiting

1. Recruiting from retired or currently unemployed but qualified volunteer providers within the community and state
2. Making use of reserve military medical and nursing providers and other responders, as well as an expanded group of allied health professionals, such as veterinarians, dentists and dental auxiliary providers, pharmacists, and students in training

ii. Credentialing

1. HHS, working with state government and specialty/professional associations, needs to continue to build a robust and comprehensive federal health care providers database
2. HHS needs to continue to research regulations to cross-credential Federal providers, including DoD providers during times of crisis/national emergency
3. HHS needs to continue to develop ESAR-VHP and other databases to allow for online validation of credentialing

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requirements to facilitate rapid certification of medical professional volunteers

4. HHS attorneys need to work with the states' Attorneys General to ensure federally credentialed providers do not require additional credentialing when deployed within any given individual state

iii. Training

1. HHS needs to determine what types of providers are required in catastrophic events and provide guidance to the remainder of the ESF#8 partners and recommended training standards
2. Train an expanded group of providers, such as veterinarians, dentists and other allied health professionals to provide "triage" and basic care requirements
3. Create a system to train a pool of non-medical responders to support health and medical care operations (e.g., military personnel at sea are all trained in BLS and basic responder care to act as first responders). Note: Although the "best possible care" will be delivered during a mass casualty event, the "standards of care" may be different than what can be provided during daily routine scenarios.
4. Determine processes to reallocate providers from non-emergency care and non-emergency sites to emergency response assignments and from unaffected regions to affected regions (this will involve identifying skill sets of each practitioner group [such as paramedics and nurse midwives], so as to optimize reassignment potential)

- b. *How can the federal government best organize and deploy health care providers to assist in the response to a national emergency?* Collectively, federal agencies, including DoD, have many trained medical personnel who can be called upon to respond to a mass casualty event. The problem is a need for improved coordination, consistency in policies and procedures, and regular simulations/exercises. The National Incident Management System should be used to affect clear command and control and provide improved situational awareness to the healthcare situation at the site of the disaster. Specific recommendations include:

- i. HHS should work with the ESF#8 partners, including DoD, to develop capabilities based concepts vice pre-established units (e.g. Federal Medical Stations)
- ii. DoD should include HHS, VA and DHS/FEMA and other ESF#8 partners in its determination of capabilities, including interagency deployable capabilities
- iii. DoD should work the Services and the interagency partners to develop and more broadly apply Unit Type Codes (UTC's) which identify capabilities, team readiness, and deployment status.

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- 2. The medical preparation for, and response to disasters requires significant logistical support - medical supplies, pharmaceuticals, transportation, medical evacuation, etc. What is the most effective way to optimally support a federal medical response? Which federal agency should take the lead?**
- a. What is the most effective way to optimally support a federal medical response?*
- i. DHS/FEMA needs to provide the overall construct of logistical support to include the infrastructure available for public health and medical requirements
 - ii. Establish an ESF #8 logistics coordinator (like the Strategic National Stockpile) that will
 1. Establish medical supply chains and support capabilities to prioritize, acquire, distribute, and redirect assets based on HHS guidance
 2. Monitor and report the status of critical medical materiel and items during emergency response operations
 3. Coordinate logistics support from commercial suppliers
 4. Assess emergency response capability
 5. Plan and build deployable sets
 - a. Plan and coordinate return, re-use, or disposal of assets after the contingency is over
 - iii. The idea of establishing a Federal Medical Materiel Coordination Group (FMMCG) was originally proposed as a result of Sept. 11, 2005 and the anthrax scare when one federal agency negotiated their own contract price for antibiotics, but failed to include other federal agencies. The FMMCG is designed to establish procedures for coordinating and allocating critical medical materiel items among the different federal agencies seeking the same products in the event of an all-hazards catastrophe. Once established, this coordination group would represent the federal agencies engaged in acquisition and management of medical materiel to support emergency operations. It would focus on defining criteria that elevates allocation decisions for medical materiel items across federal agencies. This group would work to develop the above requirements to feed into the existing FEMA logistics management and distribution processes. The lessons learned from Hurricane Katrina for medical logistics could be resolved with this FMMCG.
 - iv. Patient movement and evacuation of displaced persons should be removed from this function and “managed” through ESF#1/ Department of Transportation (DoT). All requests should come through the NRCC to determine the most efficient use of transportation assets, to include the use of pre-existing transportation contracts to move patients that do not require medical care during

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movement. A national (federal, state, local) system for evacuee and patient transport, regulation, and tracking should be developed that begins at the incident site, follows the evacuee/patient to intermediary locations (e.g. hospitals, nursing homes, rehabilitation centers, etc.), to final disposition (e.g. home). Transportation assets at Federal, State and local levels need to be coordinated and visible, and related communication needs to occur throughout all levels.

- b. *Which federal agency should take the lead?*
 - i. DHS/FEMA Logistics should develop standard processes to accomplish the above for all ESF's.
 - ii. DHHS should be the lead Federal agency, as detailed in ESF #8. DHHS should plan, exercise and coordinate a medical response. If the catastrophe is beyond their capability, DoD *could be* considered to assume the lead. However, this should be a Presidential decision based on:
 1. the extent to which State and local first responders are effectively managing the situation
 2. the extent to which Federal civilian responders are able to effectively manage the problem
 3. the nature of existing relationships in the jurisdictions affected
 4. the nature of existing relationships between the military and the States affected
- 3. National medical preparation and response to mass casualties is dependent upon integrating multiple components, including a private health care delivery system.**

- a. *What steps must be taken to foster a more coordinated response that includes a strong public-private partnership?* Steps begin with aggressive regional, State, and private sector coordination between the ESF 8 functional lead and appropriate parties. Lack of pre-event planning can result in an ineffective, inefficient and dysfunctional response. Local healthcare providers and agencies should be knowledgeable of local requirements and assets available on scene. The Federal response should be geared to supporting those requirements and filling gaps at the State or regional levels, when requested.

Under the NORTHCOM model, Joint Regional Medical Planning Offices (JRMPOs) exist in peacetime to coordinate medical support to local and State civilian authorities. This effort is being expanded by FEMA and DHHS and should continue to be expanded to include all Federal agencies and the private sector.

- i. Messages should be developed that clearly include the private health care industry as our partner

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- ii. Incentives should be developed to recruit private industry and academia to provide assistance
- iii. Reimbursement strategies for loss of elective surgery (the main source of hospital income) need to be developed to ensure solvency
- iv. Legal considerations should be evaluated to ensure the ability to view all types of patient data, location, status, etc. during a catastrophic event
- v. HHS, in coordination with the other NDMS partners, should re-evaluate NDMS to potentially expand its functions to include the private sector and make recommendations on the adequacy and feasibility of utilizing the current NDMS structure to support catastrophic events. Inclusion of other ESF#8 supporting Departments/agencies within NDMS should be considered (e.g. DOT).