



Regional Emergency Support Function #8 Health, Mental Health, and Medical Services

Regional Coordinating Organization

Metropolitan Washington Council of Governments

Local Coordinating Jurisdictions

Alexandria
Arlington County
Bowie
College Park
District of Columbia
Fairfax
Fairfax County
Falls Church
Frederick County
Gaithersburg
Greenbelt
Loudoun County
Rockville
Montgomery County
Prince George's County
Prince William County
Takoma Park

District of Columbia Health, Mental Health, and Medical Services Organizations

District of Columbia Department of Health
DC Fire and EMS
DC Office of the Chief Medical Examiner
DC Office on Aging
DC Emergency Management Agency
DC Department of Mental Health
DC Health and Human Services
Metropolitan Police Department
D.C. Public Schools

Maryland Health, Mental Health, and Medical Services Organizations

Maryland Institute of Emergency Medical Services Systems
Maryland Department of Health and Mental Hygiene
Maryland Emergency Management Agency

Maryland State Police
Maryland Office of the Chief Medical Examiner
Maryland Local Health Departments
 Montgomery County Department of Health and Human Services
 Prince George's County Health Department
 Frederick County Health Department
County Public Schools

Virginia Health, Mental Health, and Medical Services Organizations

Community Services Boards in all jurisdictions
Virginia Department of Mental Health,
 Mental Retardation and Substance Abuse Services
Virginia Office of the Chief Medical Examiner
Virginia Department of Emergency Management
Virginia Department of Health
Northern Virginia Emergency Medical Services Council
Virginia State Police
Virginia Park Police
Virginia Local Health Departments
 Arlington County Health Department
 Fairfax County Health Department
 City of Alexandria Health Department
 Prince William County Health District
 Loudoun County Health Department
County Public Schools

Private-sector Coordinating Organizations

National Capital Region—Emergency Response (NCR–ER)
Greater Washington Board of Trade

Private-sector Health, Mental Health, and Medical Services Organizations

DC Hospital Association:
 Children's National Medical Center
 Columbia Hospital for Women
 George Washington University Hospital
 Georgetown University Hospital
 Greater Southeast Community Hospital
 Hadley Memorial Hospital
 Howard University Hospital
 Malcolm Grow Medical Center
 National Naval Medical Center
 National Rehabilitation Hospital
 Providence Hospital
 The Psychiatric Institute of Washington
 Riverside Hospital
 Saint Elizabeth's Hospital—Department of Mental Health

Sibley Memorial Hospital
Veterans Affairs Medical Center
Walter Reed Army Medical Center
Washington Hospital Center
Maryland Hospital Association
Montgomery County Hospital Groups:
Washington Adventist Hospital
Holy Cross Hospital
Montgomery General Hospital
Suburban Hospital
Shady Grove Adventist Hospital
Prince George's County Hospital Groups:
Fort Washington Hospital Center
Prince George's Hospital Center
Greater Laurel Regional Hospital
Doctors Hospital
Southern Maryland Hospital
Virginia Hospital Association
American Psychological Association
American Psychiatric Association
American Public Health Association
American Medical Association
National Association of Social Workers
Mental Health Crisis Network (Metro Chapter NASW)
American Red Cross (National Capital Chapter)
Metropolitan Washington Public Health Assessment Center
State Pharmaceutical Associations
Specialty Nursing Associations
Academic Institutions and Boards of Education
Northern Virginia Emergency Response Coalition:
Regional Hospital Members:
Virginia Hospital Center—Arlington
Inova Alexandria Hospital
Inova Fair Oaks Hospital
Inova Mount Vernon Hospital
Inova Fairfax Hospital/Inova Fairfax Hospital for Children
Inova Emergency Care Center—Fairfax
Inova Emergency Care Center—Reston
Inova Healthplex—Springfield
HCA Reston Hospital
HCA Northern Virginia Community Hospital
Loudoun Hospital
Potomac Hospital
Prince William Hospital
DeWitt Army Hospital

Funeral Directors Associations
Clinical Pastoral Resources
Specialty Medical Societies
State Medical Societies
Local Medical Societies
Private Physicians
Managed Care Organizations

Federal Government Health, Mental Health, and Medical Services Organizations

U.S. Department of Health and Human Services
 Office of the Assistant Secretary for Public Health Emergency Preparedness
 Office of Public Health Preparedness
 National Institutes of Health
 Centers for Disease Control and Prevention
 Food and Drug Administration
 Office of Emergency Preparedness
Federal Emergency Management Agency
 Office of National Preparedness
Office of Homeland Security
Department of Defense
Executive Branch Medical Units
U.S. Capitol, Office of the Attending Physician
All federal police forces

I. Introduction

A. Purpose

The Regional Emergency Support Function (R-ESF) #8—Health, Mental Health, and Medical Services facilitates communication, cooperation, and coordination among local and state jurisdictions concerning regional health, mental health, and medical services issues and activities before, during, or after a regional incident or regional emergency.

B. Scope

R-ESF #8 is intended to focus on information regarding disruptions of health, mental health, and medical services with local and state impacts requiring inter-jurisdictional coordination. R-ESF #8 also coordinates necessary information to determine health, mental health, and medical needs across the region as the result of a regional incident or regional emergency. Coordination with R-ESF #1—Transportation and R-ESF #2—Communications Infrastructure, are critical to ensure effective delivery of services.

II. Policies

- A.** R-ESF #8 will not usurp or override the policies of any federal agency, state government, or local government or jurisdiction.
- B.** The Metropolitan Washington Council of Governments (COG) Health Officials Committee will facilitate coordination among member organizations to ensure that R-ESF #8 procedures are appropriately followed and are in concert with the stated missions and objectives of the RECP.
- C.** Essential Elements of Information (EIs) will be conveyed through the Regional Incident Communication and Coordination System (RICCS) as required by the incident.
- D.** R-ESF #8 will provide a liaison to R-ESF #5 as necessary.

III. Situation

A. Regional Emergency Condition

1. If an anomaly is noticed by the jurisdictions through their bio-surveillance systems, preventive actions can be undertaken, reducing the impact on the region.

2. The regional health, mental health, and medical community will experience disruptions in the delivery of routine services. Such an incident could be the result of natural disasters, technological events, or human causes (all hazards). Local health, mental health, and medical activities could be hampered by damaged facilities, equipment, infrastructure, disrupted communications, etc. Additionally, the regional incident or regional emergency could create a significant surge in demand for regional health, mental health, and medical resources.
3. A regional incident or regional emergency could produce a large concentration of specialized injuries, illness, mass casualties, fatalities, and other problems that could overwhelm the healthcare community within the region.
4. Critical and long-term patients in existing hospital or health care facilities may need immediate relocation from these facilities if they are damaged or inoperable.
5. If the regional incident or regional emergency lasts for several days or weeks, there could be a severe impact on health, mental health, and medical services capabilities. Contributing factors that must be considered include complications and issues regarding relocation, shelters, vector control, potable water, and wastewater and solid waste management.

B. Planning Assumptions

1. Planning partners will include public and private organizations.
2. The RECP will promote inter- and intra-jurisdictional cooperation and coordination while preserving the unique characteristics and operating procedures of each member jurisdiction.
3. The resources routinely available within the affected emergency area will be inadequate to clear casualties from the scene or treat them in nearby health care facilities. Two high priority areas, which will impact the delivery of healthcare services and necessary medications, are transportation and communication.
4. Medical re-supply will be needed throughout the emergency area, based on the requirements of the affected jurisdictions.
5. A terrorist release of WMD may lead to toxic water/air/land environments that threaten surviving populations and response personnel, including exposure to hazardous chemicals, biological agents, radiological substances, and contaminated water supplies and food products.
6. Central reporting of testing results, and management and dissemination of this information, is key to mitigating the response.

7. Assistance in maintaining the continuity of health, mental health, and medical services will be required, especially for citizens with long-term and ongoing health care needs. Health, mental health, and medical services will be financially impacted.
8. The stress, loss, and pain caused as a result of a regional incident or regional emergency may result in the region's mental health system becoming overwhelmed, producing urgent need for mental health crisis counseling for emergency victims, response personnel, their families, and the general public.
9. Any WMD incident will lead to a potentially large magnitude of health issues as well as require multi-jurisdictional and inter-agency coordination and entail addressing long-term psychological needs.
10. Delivery of multi-lingual messages, and the availability of personnel with multi-lingual skills, is critical due to diversity of the population throughout the region.
11. During an incident a large number of providers may themselves be affected and therefore unable to provide care to others.
12. A biological event may occur unannounced, only becoming apparent over time.
13. Horizontal and vertical communications will be necessary to ensure an effective response before, during, and after a regional incident or regional emergency.

IV. Concept of Coordination

A. General

1. Both major and minor regional incidents or regional emergencies involving health and mental health will be cause for convening R-ESF #8.
2. Local jurisdictions that participate in R-ESF #8 will coordinate and execute their respective health, mental health, and medical authorities and program responsibilities before, during, and after the regional incident or regional emergency.
3. The R-ESF #8 function will collect, analyze, synthesize, and disseminate information concerning regional health, mental health, and medical related issues, including disease surveillance, facilitated through RICCS as appropriate.

4. Requests for information regarding emergency regional health, mental health, and medical issues will be referred to the R-ESF #8 liaison for R-ESF #5 through the RICCS. The liaison will coordinate with the health, mental health, and medical services regional partners, including with R-ESF #6—Mass Care.
5. A regional approach to preparing for and managing a “shelter in place” decision is developed and pre-event distribution of information is implemented.

B. Organization

R-ESF #8 will operate under the leadership of the COG Health Officials Committee:

COG Health Officials Committee

District of Columbia Department of Health
Maryland Department of Health and Mental Hygiene
Virginia Department of Health
Arlington County Health Department
City of Alexandria Health Department
Fairfax County Health Department
Frederick County Health Department
Loudoun County Health Department
Montgomery County Department of Health and Human Services
Prince George’s County Health Department
Prince William County Health District

(Note: One or more federal agencies are regularly invited to attend.)

The mission of public health is to prevent disease and promote community-wide health. Local, state and federal public health officials are mandated to protect their respective jurisdictions *as a whole* from disease or injury. By contrast, private healthcare providers have a primary responsibility for the welfare of each *individual* patient. Although the public and private health sectors share several overlapping objectives, it is essential to recognize the distinctions in roles and responsibilities. Ideally, the various sectors of the healthcare community will work in concert with one another.

C. Notification

Upon notification by any jurisdiction of a regional incident or regional emergency, RICCS will provide a communication platform to support the coordinated response of the participating agencies. RICCS provides for the multi-directional flow of communications. Communications will be made in cooperation with R-ESF #2—Communications Infrastructure.

1. RICCS notification is for informational purposes only. RICCS is designed to facilitate the ability of all sections of the healthcare community to communicate with one another and with the public in an emergent situation.
2. RICCS is not intended to usurp everyday channels of communication but rather to facilitate the coordination of communication when the system must be expanded to deal with an unusual situation.
3. It is anticipated that different types of incidents will result in notification messages being transmitted among members of R-ESF #8 through the RICCS. Notification of R-ESF #8 concerning regional incidents or emergencies involving chemical, nuclear, radiological, explosive, and natural hazards such as floods and tornadoes will likely be originated by other R-ESFs (such as R-ESFs #4, #9, and #10). Bio-event notification of R-ESF #8 will likely take place among R-ESF #8 participants.
4. In a bio-event, the initial case(s) is reported by the hospital/private practitioner to the local health department, which in turn notifies the COG Health Officials Committee. This body is responsible for ensuring that appropriate notifications regarding the event are made through the RICCS for regional incidents and regional emergencies.
5. Subject matter and type of incident will drive the participation in the RICCS conference call. Additional members will be included from the participating organizations as determined by the COG Health Officials Committee.

D. Coordination

In addition to bio-events, there are other situations that will require convening R-ESF #8. These situations include contaminated water supply, hazardous materials spill, an explosion, etc.

1. Initial Actions

Four-Level Risk Assessment Module:

The health communication and coordination process for regional incidents and regional emergencies involving a bio-event will follow a four-level risk assessment module, as follows:

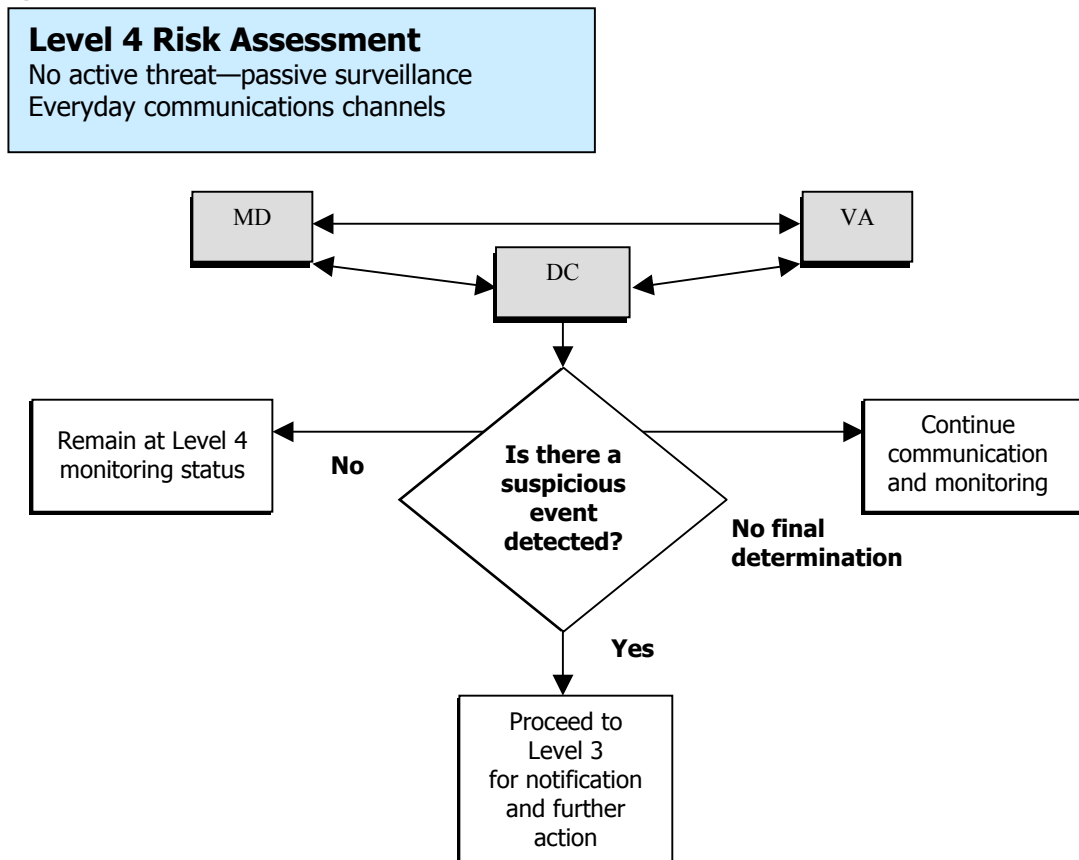
Risk Level 4	No active threat
Risk Level 3	Potential bio-event
Risk Level 2	Possible bio-event
Risk Level 1	Confirmed bio-event

This risk assessment module has been adapted from the one used in the Federal Response Plan (FRP). Comparable four-level risk assessment modules are being incorporated into various health response plans throughout the NCR, including the Metropolitan Washington Council of Governments West Nile Virus Response Plan.

Risk Level 4

- Local and state health departments maintain on-going passive surveillance in accordance with existing local, state and federal requirements.
- State epidemiologists in Maryland, Virginia and the District of Columbia regularly share disease-related data.
- Hospitals and private practitioners maintain communication with their local health departments through established lines of communication and reporting systems, including identifying and reporting all reportable diseases as mandated, as well as any anomalies.
- If an anomaly is detected, the NCR moves to Risk Level 3.

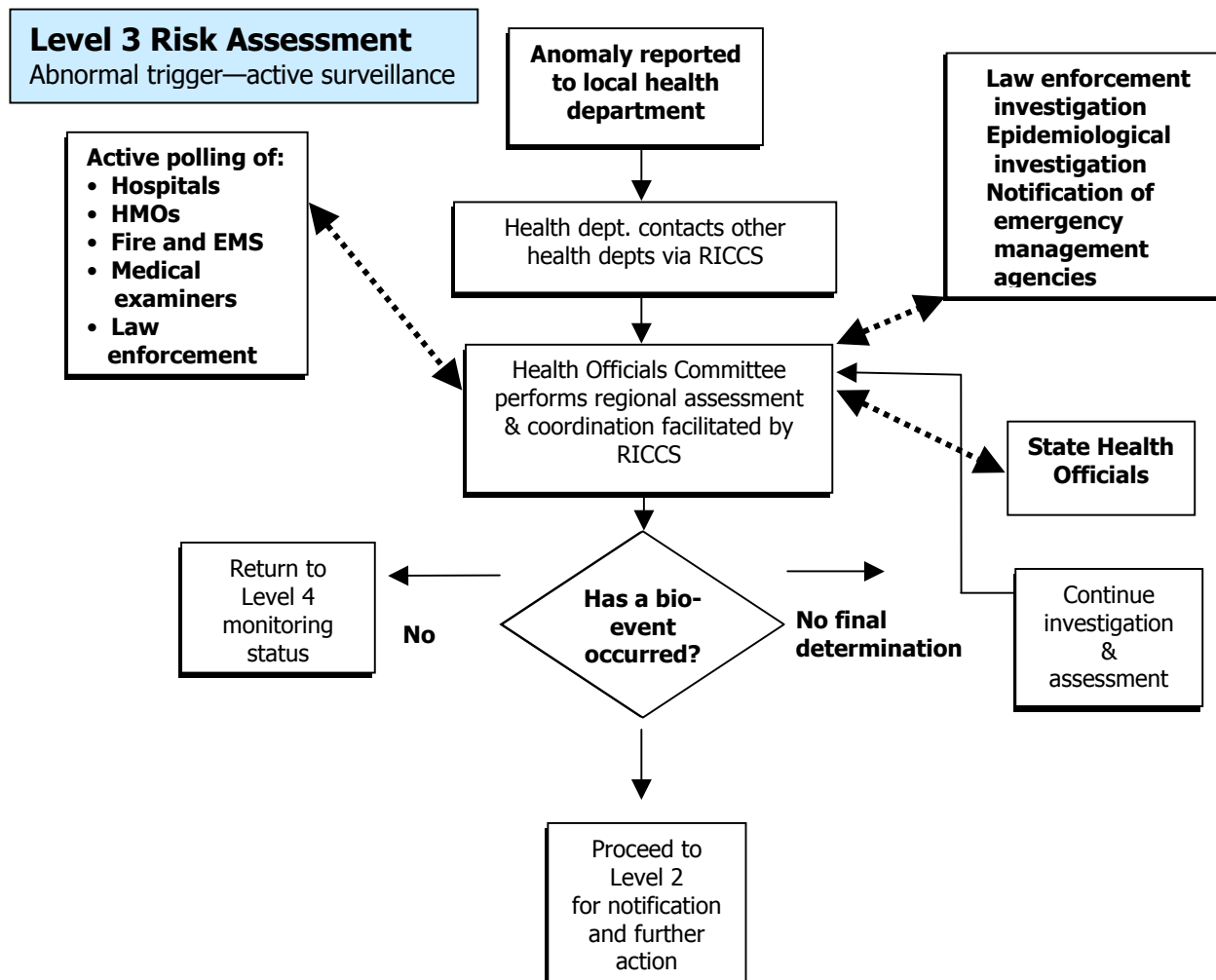
Figure 8-1: Level 4 Risk Assessment



Risk Level 3

- An anomaly is detected and reported to a local or state health department.
- A local or state health official requests notification of the Health Officials Committee through the RICCS and the committee coordinates a regional assessment.
- Local and state health departments commence active surveillance and enhanced communications with local sentinel hospitals, HMOs, medical examiners, fire and EMS, and law enforcement officers.
- Emergency management agencies are notified.
- Epidemiological investigations and law enforcement investigations commence.
- Hospitals and private practitioners maintain communication with their local health departments through established lines of communication and reporting systems.
- Local and state officials will make a determination as to whether a bio-event has occurred once the investigation is conclusive. If a bio-event has occurred, the National Capital Region moves to Risk Level 2.

Figure 8-2: Level 3 Risk Assessment



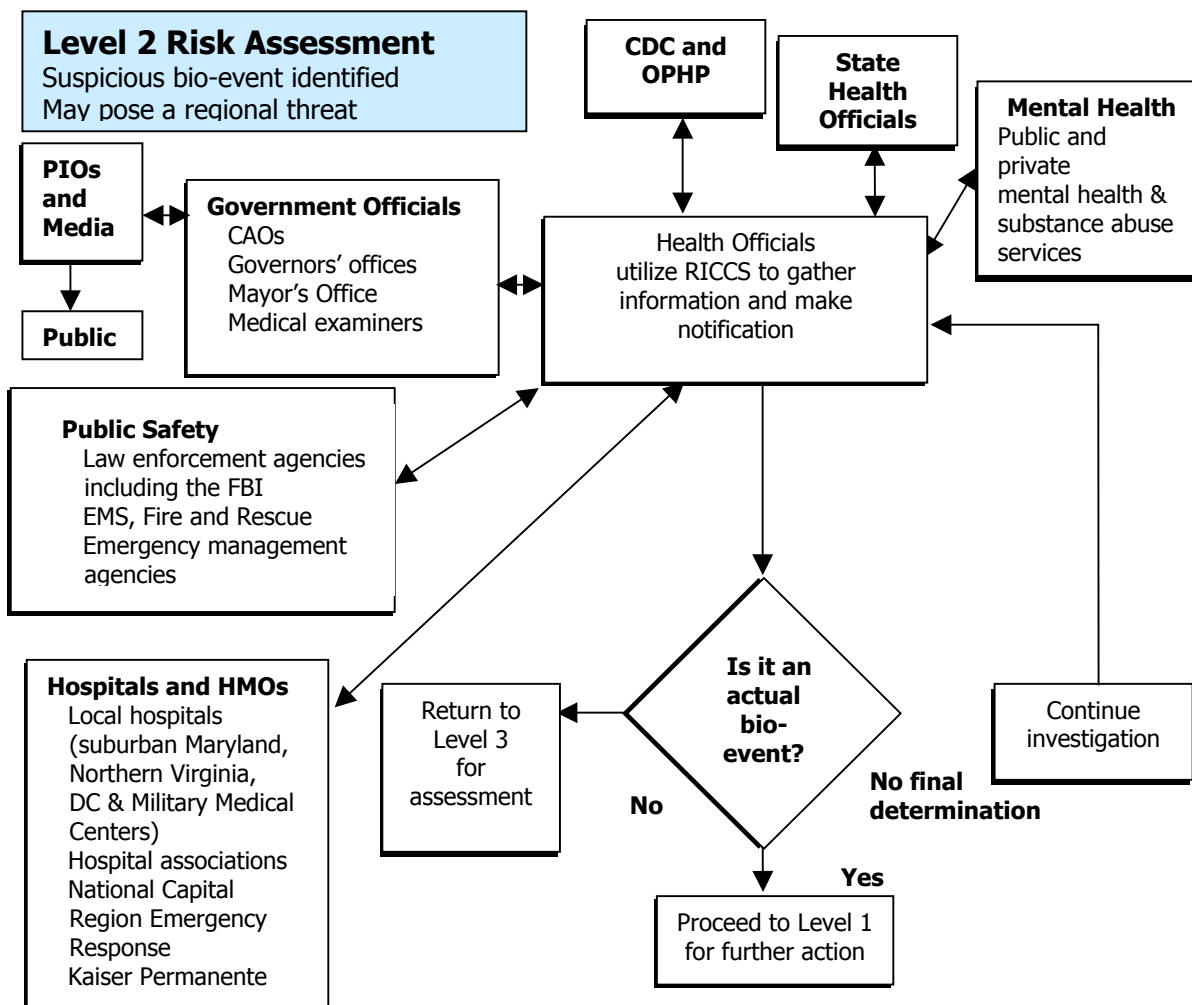
2. Continuing Actions

Risk Level 2

- A bio-event has been identified that may pose a regional threat.
- The local and state health officials utilize the RICCS to share information among public and private health sectors to determine the regional public health significance and threat of the bio-event.
- A regional epidemiological investigation is expanded and active surveillance throughout the National Capital Region continues.
- Local health departments follow current requirements and report to appropriate local, state and federal agencies.

- Private providers receive notification from health departments, medical societies, the CDC Health Alert Network, HMOs and other existing information-management systems.
- Hospital emergency departments receive alert notifications from health departments, hospital associations, and H-MARS.
- Mental health service providers are notified.
- Public health officials will brief key elected officials and decision-makers, who will then determine what information will be shared with the public, when to brief them, and the potential need for a declaration of a State of Emergency. (The public can be given appropriate information and instructions via the Emergency Alert System (EAS).)
- If a bio-event of regional significance is confirmed, the National Capital Region moves to Risk Level 1.

Figure 8-3: Level 2 Risk Assessment



Risk Level 1

- A bio-event of regional significance has been confirmed.
- EEIs are gathered from the relevant communication clusters through the RICCS, including those health EEIs listed in Figure 8-4 below.
- If the appropriate authorities declare a presidential State of Emergency, the FRP is activated and the FBI and FEMA will be included in the communication and coordination process.

Figure 8-4: Level 1 Risk Assessment

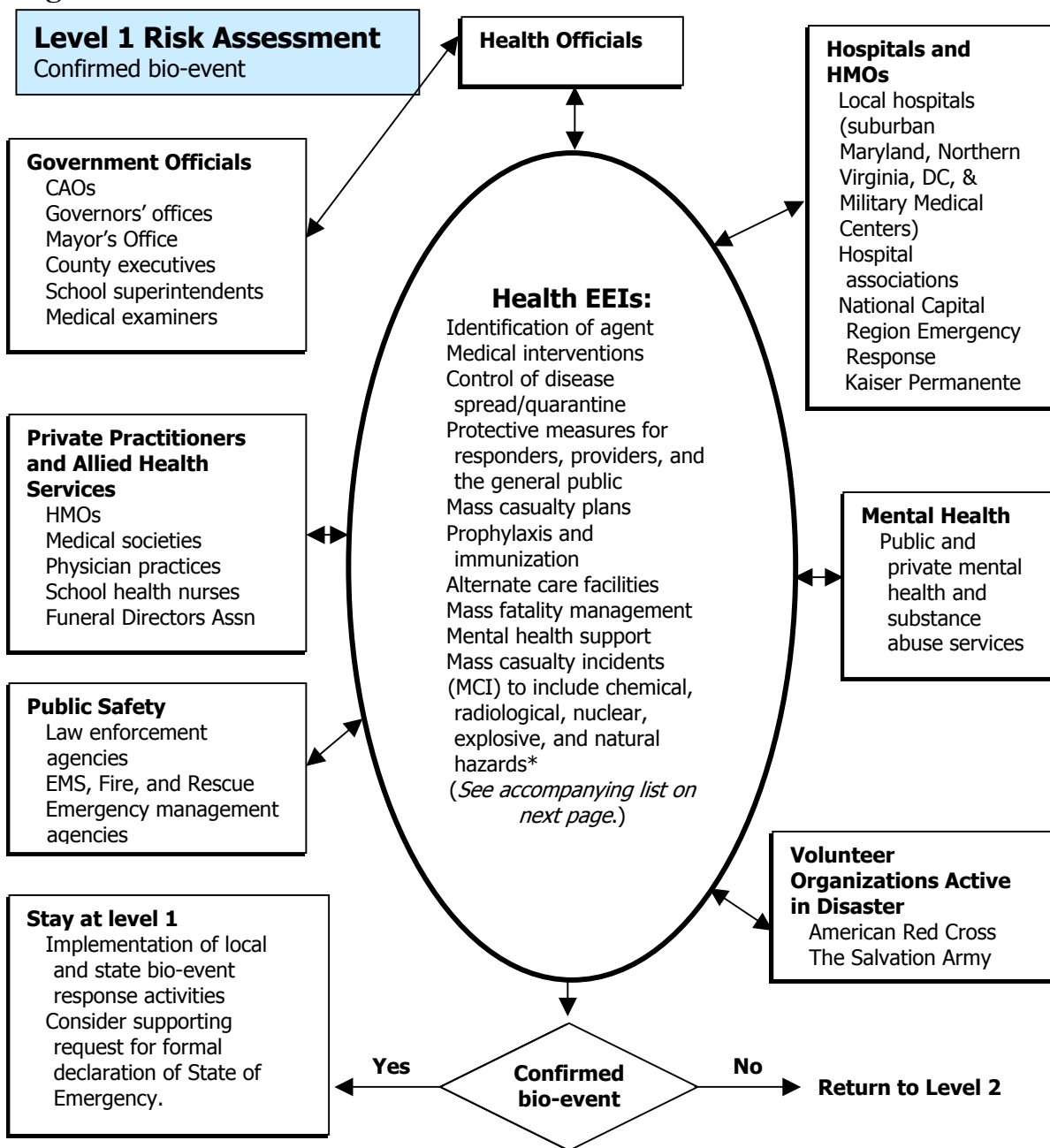


Figure 8-4: Level 1 Risk Assessment, continued

**Health EEIs (continued):
*List of Chemical, Radiological,
Nuclear, Explosives, and Natural
Hazards EEIs***

Casualty counts
Need to request State and Federal medical assets—
DMATs, DMORTS, NMRT, etc.
Status of EMS personnel and services—support
needed
Supporting/staffing casualty collection points
Assessment of in-patient capacity
Bed-tracking systems—types of beds available
Availability of medical resources—personnel,
equipment, supplies
Patient tracking and locator systems
Family reunification/relocation
Fatality tracking, identification and management
Patient evacuation from scene
Relocation and/or discharge of patients to alternate
sites (NDMS)
Identification of agent by HazMat
Hospital decontamination and personal protective
equipment capability
National Pharmaceutical Stockpile—logistics
Security at fixed facilities
Need for “field hospitals”
Subject matter expertise in any of the above hazards
Ability of medical community to maintain “status quo”

3. Stand Down

At the point where the regional incident or regional emergency is no longer affecting more than one jurisdiction, nor requires inter-jurisdictional communication and coordination, a notification will be made through RICCS and a stand down debriefing conference call will take place.

As there may be many long-term sequelae that require regional attention there may need to be regional communication on an ongoing basis for some incidents.

4. After-action Critique

Within four weeks of stand down of the regional health incident or emergency, information for an after action critique will be gathered by the participating organizations and the Health Officials Committee will convene a meeting of interested persons to share lessons learned.

V. Responsibilities

A. R-ESF #8 Participating and Supporting Agencies

The primary purpose of the R-ESF #8 is to facilitate communication and coordination among jurisdictions before, during, and after regional incidents and regional emergencies. Health, mental health, and medical services partners coordinating in a regional response will use RICCS to facilitate communication and coordination of information and response to a regional incident or regional emergency.

B. Essential Elements of Information

1. One of the primary purposes of the RECP is to facilitate the exchange of information among the signatory agencies during emergency situations. R-ESF #5—Information and Planning is responsible for the exchange, analysis, reporting and dissemination of regional information. R-ESF #5 contains detailed information about the process of information exchange and describes regional EEs, which have been determined as the minimum essential information categories to satisfy coordination needs among the R-ESFs and through RICCS.
2. In the event of a regional incident or regional emergency, with R-ESF #8—Health, Mental Health, and Medical Services, state, local, and regional agencies will be able to exchange information (to the best of their ability) about many topics, including, but not limited to:

Jurisdictions involved;
Status of health, mental health, and medical, resources, personnel, equipment, supplies and facilities impacted by the incident/threat of incident;
Actual/potential (social, economic, political) impacts on the function and/or jurisdiction;
Other R-ESFs potentially impacted;
Overall resource shortfalls, response needs and priorities;
Relevant historical and demographic information;
Short term, medium and long-range response and recovery plans;
Recommendations for emergency ingress/egress for responders;
Assessment of health/medical needs, including in-patient capacity;
Health surveillance, including infectious disease surveillance;
Patient identification, tracking and evacuation requirements;
In-hospital care;
Food/drug/medical device safety;
Worker health/safety;
Radiological/chemical/biological hazards consultation and technical assistance, decontamination of victims and health and medical personnel;
Mental health care for victims, asymptomatic possibly exposed individuals, response personnel, health and medical personnel, general public, persons already in treatment, and persons concerned about possible exposure;
Public health informational/risk communication on public health issues, to include protective actions recommendations (PARs);
Vector control;
Potable water/wastewater and solid waste disposal testing;
Veterinary services and animal control;
Victim identification;
Credentialing requirements;
Liability issues and concerns;
Patient tracking/locator capabilities;
ESF #6—Mass Care issues concerning schools, children, family assistance centers, family reunification centers, and foster care; availability of Crime Victim Compensation Funds;
ESF #4—Firefighting issues concerning injuries and medical emergencies (including status of emergency medical services personnel, activities and needs);
ESF #10—Hazardous Materials concerning injuries and medical emergencies, decontamination options and information for hospitals on agent(s) identified;
ESF # 1—transportation issues dealing with access to care and transport of supplies and personnel;

Agricultural services and related issues;
Veterinary services and related issues;
National Pharmaceutical Stockpile—issues concerning reception, placement, distribution, security and dispensing;
Distribution of prophylactic medications and immunizations; and
Security services at health, mental health, and medical facilities.

VI. Preparedness Cycle

A. Planning

1. Planning includes a comprehensive review of existing capabilities and an analysis of strengths and gaps;
2. Roles and responsibilities during an incident are defined and communications interfaces developed so that all sectors of the healthcare community can receive the identical information without compromising patient confidentiality;
3. This enables effective decision-making and communication thereof to both healthcare providers and the public;
4. Agent fact sheets with appropriate instructions are developed in advance and made available for dissemination to providers and the community in the event of an incident;
5. A regional approach to locating, storing, managing and disbursing supplies from the National Pharmaceutical Stockpile is developed;
6. R-ESF #8 and COG are responsible for assisting with the R-ESF #8 preparedness cycle; and
7. The COG Health Officials Committee will facilitate coordination among member organizations to ensure that R-ESF #8 procedures are appropriately followed and are in concert with the stated missions and objectives of the RECP.

B. Training

1. Ongoing training presented by different organizations is codified and published so that all members of the healthcare community can attend the appropriate classes; and

2. Classes will include those provided by the different institutions and academic entities in the National Capital Region as well as State and Federal and distance learning opportunities.

B. Exercises

1. Exercises, both local and regional, are conducted on a regular basis and the participation of the different jurisdictions is solicited to create a coordinated regional response structure;
2. These will be tabletop, functional and/or field exercises that will exercise all elements of the healthcare community in conjunction with their counterparts in other emergency response agencies; and
3. Multi-disciplinary, multi-agency cooperation is a key component of an effective response mechanism.

C. Evaluation

After-action reports (AARs) will be developed for both real (e.g. October Anthrax) and notional (e.g., DC EMA Flu Exercise, Montgomery County NPS Retreat) events.

E. Corrective Action

Lessons learned from exercises and real world experiences will be captured and entered into a database where they will be available on request by the member jurisdictions.

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