

Certified Emergency Manager® Application Essay

By Jack Vilardi

1. **Introduction:** As the newly appointed Medical Readiness Officer, I have been tasked to design a comprehensive disaster/emergency management program for a notional Air Force Medical Group located in central Alabama. This organization is an outpatient medical clinic serving the needs of 20,500 enrollees, which include active duty military members, reservists, dependent family members and military retirees. Our annual budget for this facility is \$27,000,000, with a significant portion of our emergency management funding coming from different, non-medical sources.
2. **Problem Statement:** The Medical Group has recently completed an Operational Readiness Inspection conducted by the Air Force Inspection Agency and learned that our Comprehensive Emergency Management program isn't comprehensive at all; nor does it comply with Homeland Security Presidential Directive 5, which calls for the establishment of a single, all-hazards, national system for managing domestic incidents.
3. **Objective:** To align the Medical Group's Medical Contingency Response Plan (MCRP) with the Air Force Incident Management System (AFIMS), which incorporates key elements of the National Incident Management System (NIMS) and the NRF to meet the intent of national policy and DoD guidance.
4. **Intended Outcome:** Once the new Emergency Management program is designed and implemented, the Medical Group will own a program that:
 - a. Complies with all federal, state, local and military directives
 - b. Is properly staffed and resourced
 - c. Encourages open communication and relationship building between the Med Group, other Air Force Base agencies, and our surrounding local communities - long before the actual

emergency occurs. We can do this through joint exercises and training, constructive post incident/exercise discussions, and other mutually beneficial events. You should not be meeting your EM community counterparts for the first time *during the middle of a Response*.

- d. Incorporates an intrinsic means of maintaining all-hazard readiness *for an indefinite period of time* through an effective system of training, exercise, evaluation and process review

5. **Human Resources:** The first personnel I would identify are the members of our planning team. The Medical Group Commander would, of course, be the group leader, with the Medical Readiness Officer appointed the lead planner. Additionally, we would require active participation from the following group members within our unit:

- a. Medical Chief of Staff – experienced medical provider and expert on our medical capabilities
- b. Public Health Officer – to advise on the vulnerabilities of our food and water supplies as well as the disease-related hazards associated with EM
- c. Bioenvironmental Engineer – expert on Chemical, Biological, Radiological and Nuclear threats and effects
- d. Mental Health Officer – expert on the short and long term psychological effects of each Emergency Management phase on responders, leaders and victims
- e. Anti-Terrorism expert – trained in the latest tactics and techniques used by terrorists
- f. Logistics Officer – to assist with the acquisition, maintenance and storage of necessary supplies/equipment
- g. Facility Manager – to ensure we identify applicable federal, state and local regulations including OSHA requirements, fire codes, environmental policies and unit policies

After speaking with Firefighters and Security Forces personnel on base, it is clear they are all way ahead of the Medical Group in terms of adopting the NRF. We would coordinate closely with the following Air Force Base personnel and agencies to improve our compliance:

- a. Security Forces (police)
- b. Fire Chief
- c. Communications Officer
- d. Public Affairs Officer
- e. Judge Advocate (legal)

Since our objective is to better comply with NIMS and the NRF, coordination with the non-military individuals and organizations listed below would be essential as we develop our plan:

- a. Local community elected officials
- b. Civilian police, fire and medical first responders
- c. Surrounding hospitals and shelters
- d. Alabama National Guard
- e. Transportation companies, food distribution centers, pharmacies, etc., as appropriate
- f. FEMA and AEMA (Alabama Emergency Management Agency)

6. **Necessary Actions:** Once we have the right personnel on board, the Commander would issue our Mission Statement. This would define the purpose of the plan as well as the authority and structure of the group. The Commander would also make it clear that every member of the medical group will be involved in all four phases of Emergency Management.

Next, we will begin our Hazard Vulnerability Assessment (HVA). Timeline for completion is 15 days.

Our objectives would be to:

- a. Identify the hazards associated with our specific unit
- b. Assess and prioritize those hazards based on
 - i. the likelihood of occurrence
 - ii. the severity/impact of each event
- c. Identify our capabilities and shortfalls

- d. Provide recommendations to the lead planner accordingly

Without revealing classified information, here is a general list of hazards we face on this base:

- a. Weather related hazards including hurricanes, tornados, flood, lightning and hail.
- b. Terrorist attacks, to include those involving CBRN
- c. Major aircraft, weapon or ground vehicle accidents – both on and off base
- d. Infectious biohazards
- e. Hostage situations/hijackings/bomb threats
- f. Food and Water vulnerability
- g. Perimeter breach

Specific challenges we've come across while planning at a military medical facility include the following:

- a. Not only do we need to provide safety and security during all hazards for our personnel, we also need a plan to assist our base and surrounding communities with medical manpower, equipment and supplies. Many of these events could involve any combination of the following:
 - i. Assisting personnel on this Air Force Base
 - ii. Allowing personnel from outside the gate entry for treatment
 - iii. Sending personnel and equipment off-base to assist in the local community
- b. Defense Support to Civilian Authorities (DSCA) – when, how and for how long we are authorized to respond during emergencies/disasters in the local community. Several Department of Defense Directives spell this out, but local leaders and many military commanders are unclear regarding those guidelines. This leads to unrealistic expectations and occasional animosity on both sides

Now that we've identified and assessed our hazards, it is time to write the plan. Timeline for completion is 30 days. The MCRP will clearly define the following:

- a. Mitigation - How we intend to reduce those risks we've identified during our HVA
- b. Preparedness - Our plan to keep equipment and personnel ready for all hazards
- c. Response - Actions to save lives and minimize damage in a disaster or emergency situation
- d. Recovery - How we will help return our community to normal

Our first step in writing our plan is to review any existing plans. This Air Force Base has 32 base-level plans to include a Comprehensive Emergency Management Plan, Base Security Plan and guidance on using the Strategic National Stockpile. The current MCRP, while identified as deficient, still offers some help. We'll definitely need to modify out-dated terms used prior to the implementation of AFIMS. The EOC used to be called the Crisis Action Team (CAT), for example, and the Incident Commander was called the On-Scene Commander (OSC)

Next we will review official guidance to ensure we are in compliance:

- a. Federal Guidance (FEMA training resources, NIMS, NRF)
- b. State Guidance (AEMA office in Clanton, AL is filled with friendly and helpful experts)
- c. Local Guidance (EM professionals from the surrounding communities)
- d. Military guidance (AFI 41-106, AFD 10-8, DODD 3025.1, 3025.15)

The basic plan is supplemented by several annexes. Each annex describes a response team designed with specific Emergency Support Function (ESF) capabilities and responsibilities. Examples of teams include the Bioenvironmental Engineering team, Mental Health Crisis Response Team and Clinical Triage team. A subject matter expert in each field is required to write, submit and review each annex annually. The annexes include personnel/equipment requirements for that team, training requirements, individual responsibilities for each team member, and response checklists for each applicable scenario.

Once we've compiled a draft of the basic plan and annexes, we will distribute it for review by our group members and other affected agencies. Timeline for coordination is 30 days. This can be a time consuming and frustrating process:

- a. Some personnel feel they are too busy to review the plan. They just don't see Emergency Management as a priority
- b. Other people don't like to think about bad things that could happen, so they procrastinate or fail to thoroughly review to plan
- c. Personnel are resistant to change. It will take extensive training and exercising to get Air Force personnel familiar with NIMS terms

For these reasons, and many others, it is essential for the commander to continually emphasize the importance of this plan and everyone's role in it.

In accordance with Air Force Instruction 41-106, Unit Level Management of Medical Readiness Programs, the Medical Readiness office will coordinate the MCRP for review annually among all parties concerned with its content. Additionally, this AFI requires a re-write of the MCRP every three years, or whenever a significant portion of the document is changed during review. All reviews/rewrites must be reported in the bi-monthly Medical Readiness Staff Function (MRSF) meeting. Other items that are captured in this meeting include:

- a. Training, manpower, supply and equipment status of Disaster response teams
- b. Annual training and exercise calendar
- c. Exercise findings - with personnel assigned to ensure retraining and reevaluation

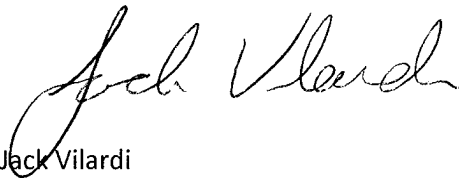
Effectively monitoring, reporting and tracking our EM program is the only way to ensure we are properly prepared. The commander must enforce compliance and adherence to deadlines.

7. **Material and Financial Resources:** Our problem doesn't require a great deal of additional money,

just re-direction in planning, training and command emphasis. That being said, whenever we try to acquire funding, there is never enough money to go around and everyone feels their programs are the most deserving of scarce funds. The Air Force Emergency Manager must be extremely knowledgeable in his/her field and be a good salesman, since the commander makes spending decisions based on how well each member pleads his/her case. Being a military medical unit introduces an additional financial dynamic. The DoD is very specific about how we can spend Defense Health Program (DHP) dollars. Much of our EM funding must come from non-medical, higher headquarters sources. All the more reason we must know our jobs and how to sell the importance of financing the Emergency Management program.

Our planning team may also identify some long-term projects (pop-up barriers at vehicle entrances, surveillance cameras, raised curbs, etc.) to recommend to the command. These could require additional funding or occupational space not currently available. Even though these modifications will not be included in our current MCRP, their identification and implementation should certainly be part of our Emergency Management planning. It is best to introduce these needs as new business in our Readiness staff meetings and financial planning meetings to ensure they are tracked and addressed.

I verify that I have independently completed this essay.

A handwritten signature in black ink, appearing to read "Jack Vilardi". The signature is written in a cursive style with a large initial "J".

Jack Vilardi

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