

# NDMS Newsletter



October 2011

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## Next Issue Topic Request

If you would like to submit an article for the next issue, please send your topic to [NDMSSupport@hhs.gov](mailto:NDMSSupport@hhs.gov) by November 23, 2011.

## Welcome to NDMS Acting Director, Pete Brewster

I am pleased to announce that Peter Brewster has accepted the position of Acting Director of the National Disaster Medical System, within the Division of Mass Care, OPEO, ASPR, effective September 12, 2011.

Pete brings a wealth of experience and a broad management skill set to this new role as the Acting Director of NDMS.

He is currently the Director of Education, Training, and Exercises for the Office of Emergency Management, Veterans Health Administration (VHA), the largest integrated health care system in the United States. VHA operates 140 VA Medical Centers and over 1,400 outpatient clinics in all fifty states and U.S. territories. In his current position, Pete is responsible for providing policy and guidance for emergency management education, training, evaluation, and performance improvement for VHA. He is involved with Federal and NFPA technical committees that provide research, standards, guidance, education, training, evaluation, and performance improvement for the health system and emergency management communities.

Pete joined VHA in 1990 at the start of Operation Desert Shield from his previous position as an Emergency Management Coordinator with the Consolidated City of Indianapolis Marion County. During his time with the City, Pete handled the medical, utilities, and communications functional areas, and was instrumental in helping develop Indiana's FEMA Urban Search and Rescue Task Force. He worked with the National Park Service and United States Forest Service while in Wyoming and was active in technical climbing, wild land search, and emergency medical services.

Pete has a Bachelors of Science from the University of Wyoming, and a Certificate in Public Management from the Indiana University-Purdue University at Indianapolis.

*Written by RADM Clare Helminiak, MD*

## A Message from NDMS Acting Director, Peter Brewster



It is the greatest honor of my career to have been asked to serve as the Acting Director of the National Disaster Medical System (NDMS). I believe in, and have worked to help establish effective public safety, medical and health systems at the local, State and Federal levels since the early 1980s. I have supported NDMS since 1987; first, as an Emergency Management Coordinator for the Consolidated City of Indianapolis/Marion County, Indiana; and, then with the Department of Veterans Affairs in both a training role, and in an Area Emergency Manager/Federal Coordinating Center role. I have gotten to know many of you through the years at the annual training summit and I will enjoy working closer with you over the next several months. What is clear to me is that everyone here is committed to making a difference for the victims of disasters, a huge order that requires team work to fulfill the mission of ASPR/OPEO/NDMS.

*Written by Peter Brewster*

## Farewell to Jack W. Beall

NDMS Director, Jack W. Beall, retired on August 27, 2011

Jack Beall proudly ended his 51 years in public service on August 27, 2011. He started his career and served in the fire service for thirty

four years before moving to NDMS where he has served the last seventeen years of his career. Jack began his NDMS career on January 3, 1994 in Logistics, moved to Operations and eventually served as Director.

As Director, he led the NDMS through Hurricane Katrina where NDMS personnel treated 168,000 patients. Following Hurricane Katrina he led the NDMS through the transition from Homeland Security and FEMA to Health and Human Services. Jack's greatest attributes are his belief in the people working with and for him and his ability to allow individuals to succeed and prosper.

Three days after Jack joined the NDMS in 1994, he embarked on his first deployment to the Northridge, CA earthquake. Ironically, three days prior to Jack's retirement Washington, DC had a 5.9 earthquake!

*Submitted by Tim Walton*



## Program Development Branch Updates

### Recruitment

The Program Development Branch has started attending conferences in order to help the teams fill vacancies on their teams.

Recently, PDB staff went to the Emergency Nurses Conference and over 106 emergency nurses expressed interest in becoming an employee of NDMS. PDB will be sending the names and email addresses to the Administrative Officers and the Team Commanders shortly.

PDB is also attending other conferences in hopes of recruiting for applicants for the NDMS teams. Just to name a few in the coming months:

American Society of Anesthesiologists

American College of Surgeons

American Association of Respiratory Therapists

Critical Care Transport Medicine Conference

After each conference, PDB will come back and prepare a spreadsheet of applicants who are interested in joining NDMS to send to the teams.

*Submitted by Kathy Harrod, PDB*

### Integrated Training Summit



Date: May 21-25, 2012

Pre Summit Workshops: May 21-22

Main Summit: May 23-25

Location: Nashville, TN

The Summit website is:

[www.integratedtrainingsummit.org](http://www.integratedtrainingsummit.org)

Currently we are seeking abstracts for sessions, workshops and posters.

Session deadline: October 16, 2011 (been extended from Oct 2)

Poster deadline: March 16, 2012

*Submitted by Leslie Beck, PDB*

## Congrats to.....Michelle Labelle Lake, NVRT 2



Michelle Labelle Lake, AHT, has won the 2011 National Association of Veterinary Technicians of America 'Technician of the Year' Award! Michelle has been a member of NVRT-2 for many years. She provides the team with invaluable knowledge in emergency medicine and wildlife care. She is founder of the Wildlife Intensive and Critical Care Unit which provides all rehabilitation efforts for wildlife but focuses on intensive and critical care needs of individual animals. She also works as a CVT, VTS (ECC) at the Animal Emergency Clinic and Referral Center in Oakdale, MN.

*Submitted by Karen Iovino, DVM*

## Brandon Walters; FL-5 DMAT

### 2011 Florida EMT of the Year



Brandon Walters is a long standing active employee of NDMS. During his involvement with FL-5 DMAT, he has deployed to many disasters, as well as training events. Brandon was recently named the 2011 Florida EMT of the Year. Brandon is currently employed with Sunstar EMS located in Pinellas County Florida and has served since 2003. During his tenure at Sunstar he has fulfilled the positions of EMT, Field Training Officer, CPR and EVOC Instructor and is currently an active alternate on the Critical Care Transport Team. Brandon is an active preceptor for St. Petersburg College's EMS program, training EMT students.

On January 24, 2011 Brandon was working on the road as an EMT with his Paramedic partner. At 0728 they were dispatched for two officers down. Original dispatch information had reported that the scene was safe for EMS entry. Upon Brandon and his partner's arrival to the scene, they were presented with multiple police officers on scene with reports of two officers shot with an unknown location of those officers. While approaching the house with a stretcher fully loaded with gear, Brandon and his partner came under fire from the suspect. Police returned fire and Brandon and his partner took cover behind a police car located in front of the home. When more police units arrived on scene, Brandon and his partner were safely escorted to a nearby home for cover. As the second EMS crew arrived on scene, Brandon coordinated ambulance staging for transport with St. Petersburg police and identified the best place to retrieve the wounded officers.

During this time they had active shots being fired and Brandon, his partner, the second arriving EMS unit and 3 police officers were taking shelter nearby. Police informed them that they would only be able to extract the patients from the rear of the building. Brandon decided to use the ambulance as a barricade for the EMS crews. He moved into the driver's seat and slowly drove the ambulance toward the rear of the house, as his partner and the second EMS crew walked along the side of the unit using it as a form of cover from the shots being fired from the attic. Arriving at the rear of the house, Brandon was able to position his ambulance providing a fast and easy route off the scene. The second critically wounded officer was pulled from the house and immediately attended to by Brandon, his partner and Fire Rescue. Once initial care was started, the patient was loaded in the ambulance and Brandon drove to the hospital alongside a police escort. Despite their best efforts, the police officer did not survive his injuries.

Brandon's use of the ambulance to provide cover while relocating the EMS team provided safety to his co-workers and prevented additional units from being brought into the scene. Brandon is not trained in tactical EMS nor has he been predisposed to this type of call. It is a combination of his bravery, ability to remain calm and his forethought to reposition a transport unit that provided the ability to transport the patient with maximum safety and minimal delays.

Brandon is currently enrolled in a paramedic training program to further his ability to care for patients in his community, as well as the people of the United States through his work with NDMS.

*Submitted by Kevin McGillicuddy*

## Dr. David McCann; FL-1 DMAT



Natural disasters are unstoppable, but so was Dr. David McCann. Fatigue never seemed to slow the Chief Medical Officer for FL-1 DMAT. McCann, an associate professor of family medicine at McMaster University, died August 8, 2011, after a brief battle with pancreatic cancer. He was 50.

Dr. McCann was a well-traveled disaster doctor. He went to New York to help in the aftermath of the 9/11 terrorist attacks and later deployed to states such as Mississippi, Louisiana and Florida for hurricane relief. His most recent – and most challenging – assignment was post-earthquake Haiti in 2010.

Gary Kruschke's, Commander of FL-1 DMAT, enduring memory is McCann cradling a hungry, dehydrated Haitian child in his arms, coaxing fluid into her. "There were times we'd be picking up babies off the ground who hadn't eaten in a week," recalled Kruschke. "(McCann) was always there. Every time you'd walk by, he'd have another child in his arms." Gary recalled his friend charging out of a locked-down U.S. embassy in earthquake ravaged Haiti last year – despite orders to stay inside – to save a young child struck by a car. "As soon as Doc heard a child was hurt, he was running. I got my butt chewed over that," said a chuckling Kruschke, "I didn't mind ... That was Doc. He did what he felt was best."

The doctor's expertise made a big difference at home in Hamilton, Canada, too, according to Brent Browett, director of the city's ambulance service. McCann, a family physician at the Stonechurch Family Health Centre, was also the city's deputy "incident manager" for health sector emergency management services. "His legacy is helping us completely reorganize the way we conduct business (in emergency management)," said Browett, who first met McCann during the H1N1 virus scare in 2009.

"He had obvious theoretical expertise, but also that wealth of pragmatic, on-the-ground experience gained dealing with various natural disasters." Browett made McCann an honorary EMS chief in June, while the public health department renamed its emergency operations centre in his honor.

McMaster University, his employer, also fast-tracked his appointment as an associate professor in July, said Dr. David Price, chair of the department of family medicine. Price recalled a "larger than life" doctor who was passionate about teaching. "He never tired of telling me (teaching) was the best job he'd ever had," Price said. The disaster management expert insisted his workplace become better prepared for emergencies, Price said, by adding more equipment such as defibrillators in teaching units.

Only a month before he died, McCann remained more concerned about others than himself, Kruschke said. "He kept calling and offering to resign as the team's chief medical officer," he said. "I said 'no way: resignation not accepted' ... This was a man who deserved to die with his boots on."

Dr. McCann has impacted the lives of the FL-1 DMAT team employees and will be sincerely missed, but his legacy will live on.

## PARS: Personnel Accountability Reporting System

The RMS-PARS programs now deliver Accountability and IAPs for the IRCT and ESF-8 response teams!

If you have been on a recent deployment, training, or conference call, you have probably heard the term PARS (Personnel Accountability Reporting System) mentioned. On June 1 the first version of RMS-PARS was released providing a new tool developed for personnel accountability and the creation of Incident Command System (ICS) forms including Incident Action Plans (IAP). The PARS program ties directly into the Resource Management System (RMS) and allows the tracking of a responder from the time they are deployed until the time they arrive back home.

When an event occurs and an incident entry is created in RMS, the roster/deployment process is initiated. Every step is time stamped and captured in RMS by the following process:



The approved response rosters are downloaded into the PARS program.

As teams or individual personnel are traveling, they notify Field Operations via telephone (1-800-USA-NDMS) or via email ([OPEO-FieldOperations@hhs.gov](mailto:OPEO-FieldOperations@hhs.gov)). Field Ops then enters these movements into RMS-PARS and monitors personnel until they arrive at the response mobilization center, Incident Response Coordination Team (IRCT) location, or designated staging area. When the team arrives at one of these locations, the IRCT Resource Unit Leader (RUL) will check-in the team or individual resource via the PARS system. The RUL verifies who on the roster has arrived, assigns them to a location, gives them a status category (On-Scene, Staging, Billeting) and checks them into the response venue.

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# PARS: Personnel Accountability Reporting System

During the deployment, every individual's location is verified by the RUL several times during each operational period. Personnel are checked in and out of the worksite at the beginning and end of each shift, and are listed at their billeting location when off duty. This process continues until a person is placed in demobilizing status and the "control" of the resource goes back to the Emergency Management Group (EMG) and Field Operations. Field Operations then monitors the location of each responder along their return trip, until they arrive at their home station and are fully demobilized from the event.

PAR Timer Disabled

**RMS - PARS**  
Personnel Accountability Reporting System

John Caprio  
Online

2011 IRCT PARS Training 01  
Event: Sat Sep 24, 2011 11:28:20 / DC: Sat Sep 24, 2011 11:28:20  
Last Sync: 09/23/2011 13:55:59

Sync Data Logoff

Event Accountability IAP / ICS Forms Maintenance

Locations Counts Resources Demobilizing IRCT Map Attendance Search Go

Excel Control: All Include Empty Locations Include Demob All Teams

Location Name	On Site	Enroute	Staged	Billeting	Total
Capital Med	10				10
DHHS			5		5
Gallery	10				10
Hart	5				5
IRCT PARS Training 01	20				20
Rayburn	5				5
<b>Totals</b>	<b>50</b>		<b>5</b>		<b>55</b>

During the beta testing phase, response teams and the IRCT personnel provided valuable feedback that led to the development and enhancement of a very robust and accurate system. At any given point of time, a resource's location and status can now be accessed by a simple mouse click, and this information can be viewed in real time both at the IRCT and at Headquarters.

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# PARS: Personnel Accountability Reporting System

## 2011 IRCT PARS Training 01

Event: Sat Sep 24, 2011 11:30:29 / DC: Sat Sep 24, 2011 11:30:29

Sync Data

Logoff

Last Sync: 09/23/2011 13:55:59

Event	Accountability	IAP / ICS Forms	Maintenance
Locations	Counts	Resources	Demobilizing
IRCT	Map	Attendance	
<input type="text" value="Search"/> <input type="button" value="Go"/>			
<input type="button" value="Excel"/> <input type="button" value="Control: All"/> <input type="button" value="Include Empty Counts"/> <input type="button" value="Include Demob"/>			
<b>Controller Count</b>			
Control Name	On Site	Enroute	Staged
EMG	50		5
<b>Totals</b>	<b>50</b>		<b>5</b>
<b>Agency Count</b>			
Agency Name	On Site	Enroute	Staged
NDMS	45		5
OFRD	5		
<b>Totals</b>	<b>50</b>		<b>5</b>
<b>Team Count</b>			
Team Name	On Site	Enroute	Staged
NDMS / None	1		
NDMS / CA4			5
NDMS / FL6	5		
NDMS / IRCT-A	10		
NDMS / LRAT	9		
NDMS / MA2	5		
NDMS / NC1	5		
NDMS / NJ1	5		
NDMS / NM1	5		
OFRD / RIST	5		
<b>Totals</b>	<b>50</b>		<b>5</b>
<b>Roster Count</b>			
Roster Name	On Site	Enroute	Staged
CA-4 Strike Team	1		5
FL-6 Strike Team	5		
IRCT 1	10		
LRAT 1	9		
MA-2 Strike Team	5		
NC-1 Strike Team	5		
NJ-1 Strike Team	5		
NM-1 Strike Team	5		
OFRD Strike Team 1	5		
Non-Rostered Single Resource			0
<b>Totals</b>	<b>50</b>		<b>5</b>

All of the working locations of an event are plotted on a map and automatically uploaded into the Med Map software program. This enables the Fusion Cell to provide extensive data and map production for real-time and subsequent mission planning purposes.

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# PARS: Personnel Accountability Reporting System

The screenshot shows the PARS web application interface. At the top, there are navigation tabs: Locations, Counts, Resources, Demobilizing, IRCT, Map, and Attendance. A search bar is located on the right. Below the tabs, there is a control menu with a print icon and a dropdown menu set to 'Control: All'. A 'Include Empty Locations' button is also present. The main area is a map of Washington, DC, showing several location markers with numbers 5 and 10. The sidebar on the right contains the following information:

- Gallery**
  - street
  - Washington, DC 20004
  - LAT: 38.8895 / LNG: -77.0091
- Team Members**
  - On Site: 10
  - Enroute: 0
  - Staged: 0
  - Billiting: 0
- Cloudy**
  - Temp: 70 °F
  - Humidity: 87 %
  - Wind: NE 3 mph
- 5-Day Forecast**
  - Mon: Partly Cloudy, High: 80 / Low: 71
  - Tue: Scattered Thunderstorms, High: 77 / Low: 68
  - Wed: Sunny, High: 79 / Low: 64
  - Sat: Cloudy, High: 79 / Low: 70
  - Sun: Scattered Thunderstorms, High: 77 / Low: 70

Another tool in PARS is the ability to produce the IAP. Now, all sections within the IRCT can complete their specific portion of the IAP, which reduces the amount of time it takes to produce the document. An electronic copy in pdf format will be transmitted to all of the Team Commanders in the field, with a hard copy to follow. The IAP will have a standard ICS look and uniformity, so it will appear in a consistent format, no matter which IRCT team is deployed. The program also exports the data needed for the HHS Situation Report directly into Web EOC, thus drastically reducing the time spent completing these reports. In turn, this allows the Planning Section more time to focus on contingency and demobilization planning.

An ESF-8 wide accountability policy will be released in the very near future. It will outline the step-by-step deployment process and reporting requirements for all ESF-8 responders, so that the goal of maintaining 100% accountability for all resources throughout a deployment is realized.

PARS will continue to expand and add features to improve the entire ESF-8 response to an event!

For questions or additional information, please contact [John.Caprio@hhs.gov](mailto:John.Caprio@hhs.gov)

*Written by John Caprio and Bryan Scyphers*

# OH-1 Team Provides Family Support While Deployed Operation Irene 2011

*Written by Jay MacNeal, DO, MPH and Tamara MacNeal, MA, LPCC*

*Submitted by Richard Hess RN-BC, CCM, CNLCP*

Hurricane Irene did considerable damage along its path, and many are still recovering. Dr. Jay MacNeal, a Medical Officer on OH-1, was rostered for the month. He had recently moved to New Haven, CT to complete an EMS/Disaster Medicine Fellowship at Yale. He was not anticipating the training being so real, and didn't think that he might actually be on the receiving end of a disaster. When the predicted path of the storm was tracking towards his home, the tough decision was made to evacuate his family North of the impact area. Moving out of their home, the family chose Hartford, CT as their safe haven.

About this time, Dr. MacNeal was activated with his DMAT team, and told to report to Hartford, CT and meet his team. Back at Yale, while doing their own emergency planning for the storm, Dr. D'Onofrio and Dr. Cone were fully supportive, and helped with schedule coverage in the ED for Dr. MacNeal. The MacNeal family was fortunate to be able to move out of harm's way, but they were staying at a hotel about a mile from the DMAT staging hotel, as hotel rooms were at a premium in the area.

After a discussion with the team commander, efforts were made to move the MacNeal family to the same hotel with Dr. MacNeal and the OH-1 team. It was felt riding the storm out with family in the same hotel would be a much better experience for all involved. A room was secured by Dr. MacNeal, and the family was reunited.

While riding out the storm, awaiting mission assignment, and doing "just in time" training, the MacNeal children quickly got acquainted with OH-1 team employees. The children were interactive, and quick to make new friends. Several of our team employees had children who were starting school during the deployment. Their thoughts were clearly on what they were missing at home, but at the same time having children around made this hardship easier on them.

Many of the team employees spent time playing soccer or just talking with the children. A highlight of this was a scavenger hunt in which Dr. MacNeal's daughter judged ballet routines performed by some seasoned OH-1 employees.

"My wife is very strong, and has become accustomed to me being gone during medical school, residency, and previous DMAT deployments. She could have easily taken care of the two kids and a newborn in a hotel setting, or moved further inland with our family. However, my OH-1 family took such good care of her and the kids that further movement wasn't needed. The team and then the "Dirty Dozen" (12 member Strike Team) were there for my wife and kids. They helped her during the deployment, played with the kids, helped her pack, and even signed a soccer ball for the kids. As a physician, I am constantly providing care for others. It was certainly appreciated when others provided care to my family" said Dr. MacNeal

When we had orders to deploy some of our team to Vermont, Dr. MacNeal went with the team. This left his wife at the hotel with three small children, including a 3 month old baby. "I was absolutely amazed at how the team unselfishly helped my wife at the hotel. My teammates went above and beyond in supporting my family," said Dr. MacNeal

Mrs. McNeal provided these additional insights: "After 9 years of marriage, I have become accustomed to Jay being deployed on DMAT missions. It has never been easy, but I respect and admire that he is so eager to help those in need. This particular deployment was different in that our family was in the path of the imminent storm. Jay was able help relocate our family to a hotel down the road from the OH-1 team, but it was quite scary to think that I would have to endure the storm with three children by myself. I cannot describe the relief when I heard that his team wanted to move us to their hotel so we could be a family while Jay was staging. Shortly after the storm hit, Jay found out that he was being sent on a mission to Vermont. This left me with our three children alone again.

(continued next page)

## OH-1 Team Provides Family Support While Deployed

While I knew that I could handle it on my own, the idea was overwhelming. I didn't know when the electricity would be restored at our house and the kids were getting restless in the hotel room. Much to my surprise, the strike team that remained opened their hearts and took us in. Several members offered to play with the kids so I could rest, they brought us food, and they helped us pack and loaded our car when we checked out. I was truly overwhelmed by their kindness and generosity. One member told me "let us help you, this is our job on our missions". While I know that Jay being deployed again will not be easy, I now have a better understanding of his "team": They are a family to him and they have become family to us."

Drs. John. Lewton PhD and John Laux PhD were on site as the team's mental health officers.

Dr. Laux opined that the reciprocal care and compassion evidenced between the OH-1 team and Dr. MacNeal's family paralleled the manner in which team employees approach their respective roles as health care providers. "It is no surprise to me that a group of people who have dedicated their professional lives to attending to other's needs would so enthusiastically bond with the MacNeal family" said Dr Laux. "Plus, those kids are cute as buttons. Who wouldn't be compelled to spend time with them?"

Dr. Lewton, rostered as Deputy Commander, said that the experience provided a valuable team-building activity for those on the deployment, and also provided a healthy outlet for projection of emotion among the OH-1 employees who are parents themselves.



Team employees Nichole Borck, Justin Pearce, and Anita Briggs spend some quality time with the MacNeal children.

"The irony of a Team Doc who was also a refugee with his family was undeniable. It did, however, increase the empathy factor for team members in thinking about all the other evacuees who were not living with a DMAT".

The password secured OH-1 Family Website was viewed over 1,200 times (1279) during the deployment and demobilization. We received some of the following comments from those utilizing this resource:

"It was so nice to be able to login and find out what the team was up to."

"What a wonderful way to keep us in touch with our family members during a mission."

I like that there's a secure place we can go to make sure everything is OK."

The primary mission of the DMAT is to provide compassionate medical care to the victims of disaster, in any All Hazards environment that might be encountered. To complete these missions, DMAT personnel must provide "first line" force protection for each and every member of a team that is deployed. Developing an environment where the sense of family and service to each other in addition to the passion for delivering disaster medical care is a foundational cornerstone. Once established, this enhanced support system reinforces and bolsters each individual's as well as the team's; morale and ability to complete their assigned missions. In addition, caring for our families left behind and providing them with the positive reinforcement of the safety of their loved ones via secure online; non-sensitive situational information and daily updates, extends that sense of true "family" and "well being". This supportive environment enables the DMAT responder to serve our country in it's time of need with 100% focus of purpose. The OH-1 DMAT has developed interpersonal tools for its responder family members and internet tools for the use of its supporting families left behind. These tools when combined provide not only a vital mentally healthy environment, spirited camaraderie and a sense of unity, but they also enable this extended DMAT family to truly exemplify the true spirit of compassionate care for all.

## Overview - Incident Response Coordination Team (IRCT)

The primary responsibility of the Incident Response Coordination Team is to manage the HHS ESF-8 field response. When a request for assistance is approved, HHS\ASPR\OPEO EMG Operations will deploy an IRCT to provide liaison, support, and make recommendations for subsequent missions.



During the initial Alert and Activation Phases, the EMG/SOC maintains coordination and control of all resources. When the IRCT becomes operational, the EMG/SOC will delegate command and control (C2) and support of resources to the IRCT Commander. The EMG coordinates the response at the national level, and the IRCT manages the field response.

When the IRCT arrives on the scene, it immediately integrates into the Federal response and the local incident management team. The IRCT's role is to ensure availability, qualifications, and capabilities of HHS resources needed to complete the mission assignment.

The assets and response teams managed by the IRCT provide a wide range of services, and may include an assessment of public health/medical needs, health surveillance, medical care, response personnel, patient care and evacuation, blood/blood products, medications, mass fatality management, veterinary medical support, behavioral health care and public health information

## IRCT FAQs

### Who is deployed as a member of the IRCT?



Members of the IRCT come from a wide range of HHS responders. IRCT positions are filled by Regional Emergency Coordinators (RECs), NDMS intermittents, USPHS OFRD, CDC, VA, FDA, ACF, BARDA, and NIH. CAPT Melissa Sanders, Program Coordinator and CAPT John Smart, Deputy Program Coordinator, are responsible for the Incident Response Coordination Team and the Regional Emergency Coordination Program. In addition, each of the 5 IRCT regions is managed by a Leadership Group.

### What is the IRCT organizational structure?

The organization of the IRCT follows NIMS/ICS principles. Leadership is provided by an ESF-8 Lead, Incident Commander, Deputy IC, Chief Medical Officer, Liaisons, Public Information Officer, Safety Officer and the four general sections - Operations, Planning, Administration and Finance, and Logistics.

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## IRCT FAQs

### How does IRCT interface with NDMS response teams?

**ESF-8 Lead** - has overall responsibility for Federal public health and medical response operations in the affected region, provides leadership intent and directs the IRCT Commander, is usually a Supervisory or Senior REC.

**IC and Deputy IC** - provides comprehensive support to all field elements and directs all IRCT activities.

**CMO** - oversees delivery of medical services by ESF-8 healthcare professionals, serves as the Subject Matter Expert (SME) on medical issues, and provides oversight for all issues concerning quality of medical care, capacity to support the incident and medical issues pertaining to patient movement.

**Liaison Officer** - coordinates the activities and situational awareness exchanges between the IRCT and other deployed ESF-8 partner agencies ( CDC, VA, ACF, DOD, FEMA, NTSB) or state EOCs and health departments.

**PIO** - develops/distributes materials and messages about the incident and its public health implications to the news media, addresses misinformation, and coordinates videographers and photographers assigned to document the response.

**Safety Officer** - responsible for developing the response Hazard Exposure Risk Assessment (HERA) and the Health and Safety Plan (HASP) for field response.

**Operations** - manages all field tactical operations, communicates the Operational Objectives/Tactics defined by the IRCT directly to the Team Commanders for implementation of the IAP.

**Planning** - utilizes the PARS system as teams arrive in theater to track personnel accountability, oversees incident data gathering/analysis, maintains situational awareness, facilitates creation of IAPs within the IRCT and provides a copy of IAP to deployed Team Commanders.

**Administration and Finance** - ensures compliance with HHS financial reporting and accounting policies for timekeeping, workers' compensation/claims, incident cost tracking, coordinates travel of response personnel, and provides Federal Travel Regulation (FTR) guidance.

**Logistics** - provides facilities, communication services, equipment, pharmacy services, ground transportation and supplies to deployed teams via the tasker request process.

### When has the IRCT deployed during 2011?

The IRCT has been busy in 2011. It has responded to 20 incidents, including 6 National Special Security Events. The IRCT has managed over 60 deployed ESF-8 response teams which included over 1150 responders.

### How can the IRCT communicate better with you?

In future newsletter articles, additional aspects of the IRCT will be communicated to field personnel in order to foster a more complete understanding of the interface and inter relationships between the IRCT and Field Response Teams. If you have a suggestion for a future topic or unanswered questions, please email your ideas to [Marsha.Myers@hhs.gov](mailto:Marsha.Myers@hhs.gov) and I will forward to the appropriate IRCT subject matter expert.

*Written by Marsha Myers*

## Chasing her Dream...by Marzena Mulawka

Ever since I was little, I have chased a dream of living in New York City and a career in Forensic Science. In December 2010, everything fell into place in my life. I learned that I was accepted and could start the process for DMORT FACT. I wrote my Master's thesis on a uniform protocol for the identification of unidentified human remains and crucial information from this research was published twice internationally shortly thereafter. More importantly, people were getting identified, dating as far back as the 1970s, as a result of the research I performed for my thesis. I knew I had a gift in this field and decided to go on to more school and get my PhD in NYC. Having everything set up - housing, starting school, and doing some research with the NYC Office of the Chief Medical Examiner, I planned to get on the road to NYC just after a trip to Australia and the 2010 New Year. I remember the excitement when I was finally about to be living my lifelong dream and the day I finally got on the road with my car packed full of everything that mattered to me in my life. Little did I know that my life was about to have a drastic change.

On the evening of January 3, 2010, the day I set out for NYC, my life changed forever. I was driving from Chicago to NYC and while entering Pennsylvania, 20 miles from stopping at a place to stay to get some rest, two semi-trucks boxed me in. While attempting to move lanes, I felt a jolt from behind, which caused my car to spin out of control, and I slammed into the edge of a guardrail with it entering on the driver's side. My car bounced off of the guardrail, barrel rolled in the air a few times, and landed on all four tires facing West when I had been traveling East. The driver's side door had been pushed through the car into the passenger side. Not knowing anything was wrong with my legs, I remained calm and unbuckled my seatbelt and pulled myself out through the window. I pulled myself through the snow away from traffic and down an embankment before I realized that my legs weren't working and I could not get up and walk. My cell phone had broken during the accident. Luckily, a couple, now whom I call my Guardian Angels, had been driving behind the accident and saw everything.

They stopped to render me aid and called 911.

They packed snow into both of my bleeding legs and tried to help me keep warm during the 2-hour wait for paramedics to arrive. The entire two hours, I remained calm and did not even realize that my right leg had been amputated, left leg was crushed, and that I had lost 4 out of 6 liters of blood. When an ambulance finally arrived, I was transported to a local hospital. There was no Trauma Center at that hospital and I was prepared to be life-flighted to Pittsburgh. Unfortunately, the weather had gotten so bad that a helicopter was unable to arrive at the hospital I was at. I was then transported via ambulance for another hour trip down to the University of Pittsburgh Medical Center. Despite major injuries to both of my legs, it was found that my vertebrae, pelvis, and sacrum had all been broken. Miraculously, I had no injuries to my upper body, spine, head, or face; and I had remained conscious the entire time.

After eight surgeries, titanium rods and screws, bone, muscle, and skin grafts, as well as five months of hospitalization, I learned how to walk again on my left leg and a prosthetic leg. Ten months to the day after my accident, I got behind the wheel for the first time and drove.

My name is Marzena (Mary-Ann) Mulawka and I am on DMORT FACT as a Medical Investigator. I am so happy to finally be part of the team. In October of 2010, I officially moved to NYC and I am currently working full-time as a Criminalist in Missing and Unidentified Persons DNA for the NYC OCME Forensic Biology Laboratory and have collateral duties for the NYC OCME Special Operations Division. I commute and walk the streets of Manhattan on my own everyday. I am also learning how to run again in Central Park and my stamina is getting better each week. I know I survived for a reason, and I know exactly what that reason is - to be the voice for unidentified persons and help their families get answers and guidance in the worst possible moments of their lives.

## Presidential Policy Directive 8

### National Preparedness Goal

The Presidential Policy Directive 8 calls for development and maintenance of a National Preparedness Goal defining the core capabilities necessary to prepare for the specific types of incidents posing the greatest risk to the security of the Nation. The Goal establishes prioritized objectives to mitigate specific threats and vulnerabilities – including regional variations of risk – and emphasizes actions intended to achieve an integrated, layered, accessible and all-of-Nation/whole community preparedness approach while optimizing the use of available resources.

The Department of Homeland Security, in coordination with other executive departments and agencies, and in consultation with state, local, tribal and territorial governments, the private and non-profit sectors and the general public, has developed and submitted the first edition of the National Preparedness Goal to the President on September 23, 2011.

### National Preparedness System

Presidential Policy Directive 8 also requires a description of the National Preparedness System – an integrated set of guidance, programs and processes, enabling the Nation to meet the National Preparedness Goal – due November 24, 2011. Designed to guide domestic efforts of all levels of government, the private and nonprofit sectors and the public, the National Preparedness System includes guidance for planning, organization, equipment, training and exercises needed to build and maintain domestic capabilities in support of the National Preparedness Goal.

The System will include a series of integrated national planning frameworks covering prevention, protection, mitigation, response and recovery and be built upon scalable, flexible and adaptable coordinating structures. These frameworks are intended to align key roles and responsibilities to deliver capabilities and provide a unified, integrated, accessible system with common terminology due June 30, 2012. The National Preparedness System includes interagency and departmental operational plans that support each national planning framework with corresponding planning guidance for state, local, tribal and territorial governments.

Other key aspects of the National Preparedness System described in the Directive include:

- Resource guidance, including arrangements enabling the ability to share personnel;
- Equipment guidance, aimed at nationwide interoperability;
- National training and exercise program guidance; and
- Recommendations and guidance for businesses, communities, families and individuals.

The Directive also calls for a comprehensive approach to assess preparedness and submit findings in the **National Preparedness Report**. The approach involves measuring operational readiness against target capability levels identified in the Goal.

*Submitted by OPEO Planning*

## Fusion Forum Announcement

We are announcing our upcoming Fusion Forum on November 3, 2011 after the Annual American Public Health Association (APHA) meeting in Washington, DC, titled *Maximizing SLTT Situational Awareness Synergies through Emerging Technologies*. Attached is the complete meeting announcement and details.

Representatives from SLTT organizations will discuss:

- the technologies, tools, and collaborative efforts that have enhanced their public health situational awareness and response capabilities
- the challenges and emerging issues that their organizations face with gaining situational awareness

The deadline for registration is October 21, 2011. Find more info about this meeting at [www.phe.gov/about/opeco/fusionforum](http://www.phe.gov/about/opeco/fusionforum)

Please share this information with others who might be interested in this Forum.

Direct all questions regarding this meeting to [fusion.info@hhs.gov](mailto:fusion.info@hhs.gov).

*Submitted by Diana Boss, Fusion Cell*

## OPEO Logistics - New Personnel

Please welcome the newest members to Logistics:

LT Angelo S. Malakasis is an active duty officer in the United States Public Health Service serving as an Information Technology Specialist within Logistics Operations. Prior to starting with ASPR/OPEO LT Malakasis served as a Systems Administrator for the Program Support Center \ Commissioned Corps Systems Branch, Rockville, MD. LT Malakasis has deployed as a member of Rapid Deployment Force #2 and has also deployed as an IRCT Logistics Officer; so although new as a full-time member of ASPR/OPEO he is not new to the OPEO response mission. He graduated from the University of Maryland in 2006 with a B.S. degree in Information Systems Management. While he was a student he worked for DHHS as a network analyst as a civilian employee and then joined the Commission Corps.

Todd Thomson is a Logistics Management Specialist. Prior to starting with HHS in August 2011, Todd worked for the National Geospatial-Intelligence Agency (NGA) as a Logistics Staff Officer working on both CONUS and OCONUS missions. Prior to NGA, Todd worked at FEMA in the Logistics Management Directorate from 2005-2010 as a Traffic Management Specialist with primary emphasis on fleet management, implementing a database to track the lifecycle of more than 2000 pieces of rolling stock. Todd is also an Army Logistics Officer in the Army Reserves with 17 years of service and currently assigned to the Defense Logistics Agency at Fort Belvoir, VA. Since 2003, Todd has been mobilized twice in support of the Global War on Terror. His first mobilization was as a Company Commander of a transportation unit supporting base operations at Fort Dix, NJ and his second deployment was to Baghdad, Iraq as the primary staff logistics officer for the Psychological Operations Task Force. Todd lives in Loudoun County, VA with his wife Robyn, and two beautiful daughters Aynsley, and Brynnly.

Randy Ivall is an active duty Air Force officer and is completing a Logistics/Readiness Operations Fellowship with ASPR/OPEO. After receiving his commission and attending Officer Training School, Randy was assigned to the 375 Medical Group (MDG), Scott AFB, IL in 2000 where he was assigned as the Chief of Financial Management Element. In 2002 he moved across base to the 375 Aeromedical Evacuation Squadron (AES) and served as Deputy Flight Commander of Readiness and Plans. There he was responsible for all training and development of squadron aeromedical contingency operations plans. In 2004, Randy transferred to the 15 MDG, Hickam AFB, HI and served as a Medical Logistics Flight Commander, where he was responsible for the management of all 15 MDG War Reserve Material (WRM) and materiel management activities. In 2006, Randy transferred to the Thirteenth Air Force at Hickam AFB, where he served as the Chief of Contingency Operations and Plans and was responsible for developing medical guidance, plans, and execution courses of action in support of United States Pacific Command (USPACOM). Following this tour, Randy was assigned to Headquarters United States Air Force, as the Chief of Readiness Development, Office of the Surgeon General, Ft Detrick, MD. While there, he provided consultative leadership in support of over 39,000 personnel across 74 Military Treatment Facilities (MTFs) and was responsible for the logistics life-cycle management of 120 Air Force Medical Service (AFMS) contingency equipment allowance standards valued at \$314M. Throughout his career, Randy has had multiple deployments in support of the Global War on Terror, to include tours in Afghanistan, Kosovo, Kuwait, and the southern Philippines. Randy is married to the former Angela L. Kujola and they have two beautiful daughters, Kaitlyn and Olivia.