
UNIT IX: PLANNING HEALTH AND MEDICAL NEEDS IN A TERRORIST INCIDENT

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HEALTH AND MEDICAL PREPAREDNESS OVERVIEW

In the event of a terrorist incident, especially one involving biological agents, the public health community will have a special role in preventing illness and injury. Early detection and control of such an incident will depend on the local, State, and Federal public health system and health care workers.

To prepare for and respond effectively to a biological threat or event, the public health department must be capable of:

- **Hazard analysis:** Identifying the types of biological events that might occur in the community.
- **Health surveillance, epidemiologic investigation, and laboratory diagnosis and characterization:** Identifying the type or nature of an event when it happens.
- **Emergency response planning:** Planning emergency activities in advance to ensure a coordinated response to the consequences of credible events, and building capabilities necessary to carry out those responses effectively.
- **Consequence management:** Implementing the planned response quickly and efficiently and recovering from the incident.

ESSENTIAL PUBLIC HEALTH FUNCTIONS

There are 10 essential functions that public health organizations—whether local, State, or Federal—must be able to perform to handle threatened or actual terrorist incidents involving biological agents. Those functions are shown in the graphic below. The 10 functions can be grouped into three phases of response: preparedness, active investigation, and emergency response.



HEALTH AND MEDICAL PREPAREDNESS OVERVIEW (CONTINUED)

Preparedness

- **Policy and plan development:** Working with emergency planning officials to develop practical, realistic, and effective emergency response plans, policies, and procedures appropriate for preparing for and responding to biological events.
- **Workforce preparation:** Provision of a competent and trained public and personal health care workforce prepared for biological events.
- **Surveillance:** Continuous monitoring of community health status to facilitate rapid detection of a biological event.

Active Investigation

- **Diagnosis and investigation:** This function includes rapid *diagnosis* of infectious disease and environmental health problems and *epidemiological investigation* to determine the distribution of cases and source(s) of disease outbreak. The epidemiological investigation spearheaded by public health must be coordinated with the *criminal investigation* conducted by law enforcement.

Emergency Response

- **Information and education:** Rapid and effective public health communication about specific health issues related to a biological threat or event. Public education about the potential threats should begin before an incident and be coordinated with the emergency management agency.
- **Coordination and communication:** Mobilization of State and local partnerships for dealing with potential and actual biological incidents.
- **Access to services:** Linking people to needed personal health services during a biological event.
- **Enforcement:** Enforcement of laws and regulations that protect health and ensure safety.
- **Evaluation:** Ongoing evaluation of the effectiveness, accessibility, and quality of public health programs that would respond to a biological incident.

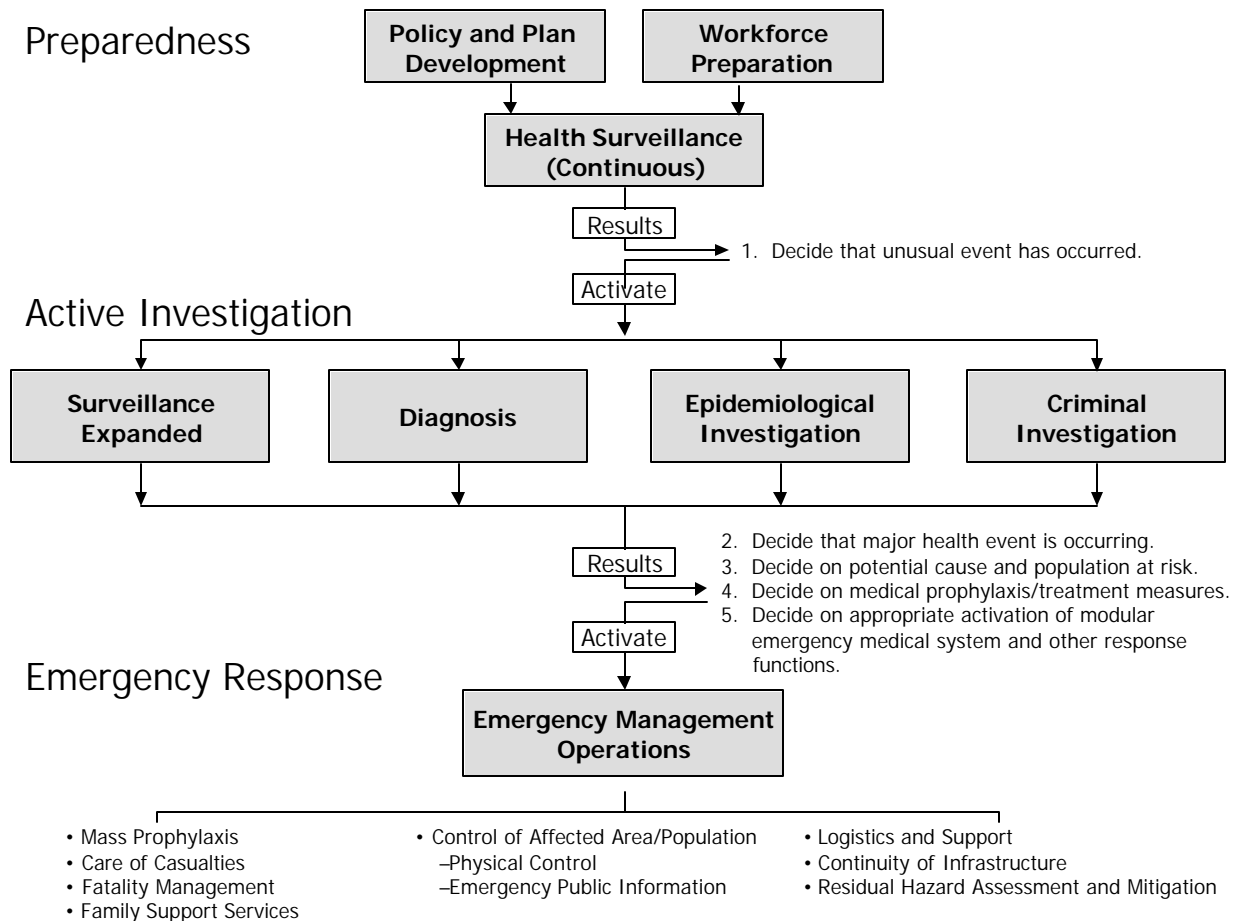
And finally, linking and supporting all the other phases and functions, is the tenth function:

- **Research:** Participation in research into health problems resulting from exposure to biological agents (e.g., links with academic institutions, capacity for epidemiologic and economic analyses of an event). Research links and supports all the other functions.

The chart¹ on the next page illustrates the relationships between these phases and functions and the decisions that trigger them.

¹ Adapted from *Improving Local and State Agency Response to Terrorist Incidents Involving Biological Weapons*, Department of Defense, 2000.

HEALTH AND MEDICAL PREPAREDNESS OVERVIEW (CONTINUED)

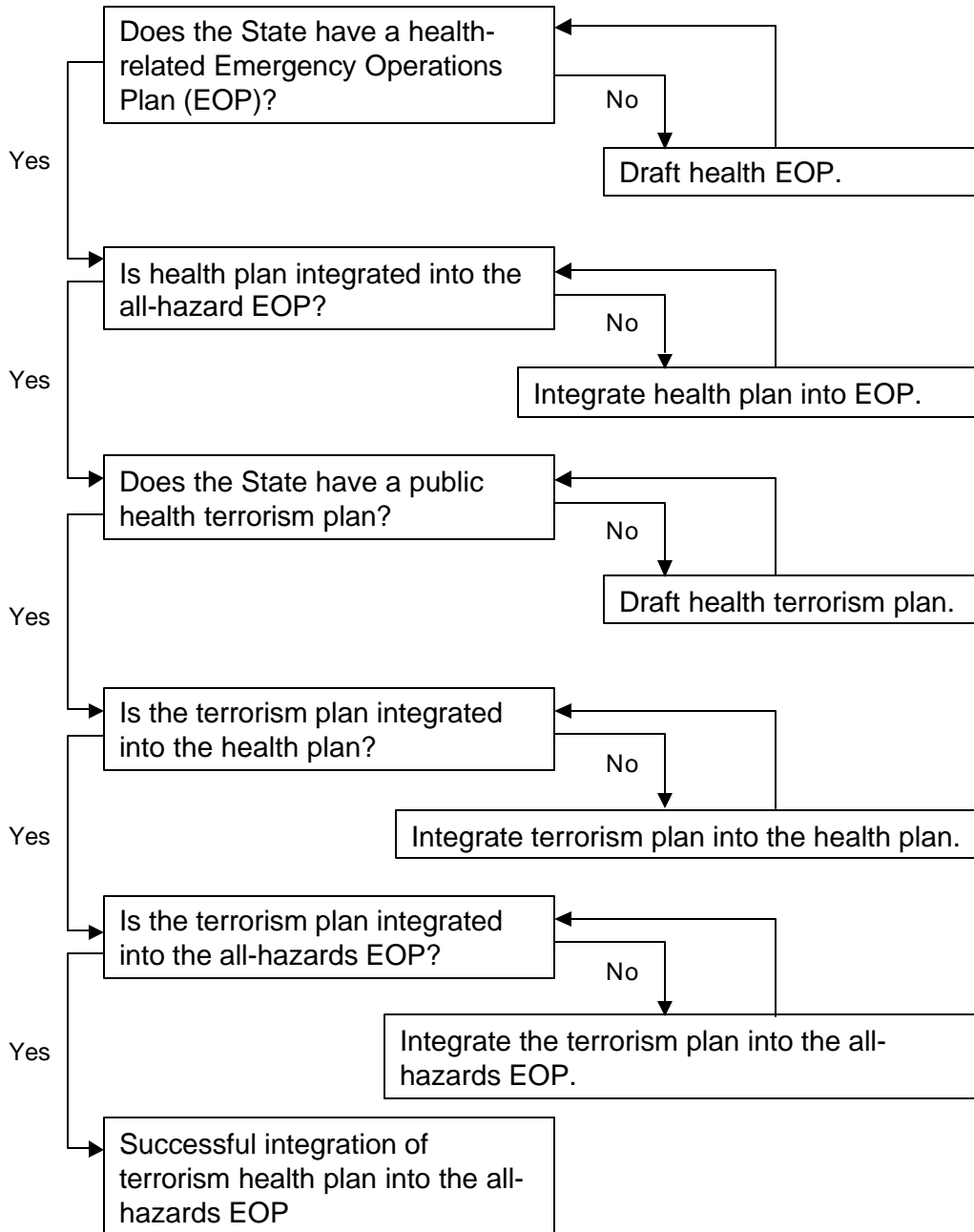


The following flow chart² lists questions to help health departments analyze their emergency preparedness planning needs.

² *The Public Health Response to Biological and Chemical Terrorism: Interim Planning Guidance for State Public Health Officials.* U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, July 2001, page 67.

HEALTH AND MEDICAL PREPAREDNESS OVERVIEW (CONTINUED)

PLANNING FLOW CHART FOR HEALTH DEPARTMENT



PUBLIC HEALTH PLANNING AND POLICY DEVELOPMENT CHECKLIST (CONTINUED)

PLANNING QUESTIONS	YES	NO
PLANNING PARTNERS (CONTINUED)		
b. State:		
▪ Public Health Department	<input type="checkbox"/>	<input type="checkbox"/>
▪ Emergency management officials	<input type="checkbox"/>	<input type="checkbox"/>
▪ Veterinarians	<input type="checkbox"/>	<input type="checkbox"/>
▪ National Guard	<input type="checkbox"/>	<input type="checkbox"/>
▪ State laboratories	<input type="checkbox"/>	<input type="checkbox"/>
▪ American Red Cross	<input type="checkbox"/>	<input type="checkbox"/>
▪ Other volunteer groups	<input type="checkbox"/>	<input type="checkbox"/>
c. Federal:		
▪ Department of Health and Human Services	<input type="checkbox"/>	<input type="checkbox"/>
▪ Centers for Disease Control and Prevention	<input type="checkbox"/>	<input type="checkbox"/>
▪ Office of Emergency Preparedness	<input type="checkbox"/>	<input type="checkbox"/>
▪ Food and Drug Administration	<input type="checkbox"/>	<input type="checkbox"/>
▪ FBI	<input type="checkbox"/>	<input type="checkbox"/>
▪ FEMA	<input type="checkbox"/>	<input type="checkbox"/>
▪ Department of Agriculture	<input type="checkbox"/>	<input type="checkbox"/>
▪ Environmental Protection Agency	<input type="checkbox"/>	<input type="checkbox"/>
▪ Department of Defense	<input type="checkbox"/>	<input type="checkbox"/>
▪ Department of Veteran's Affairs	<input type="checkbox"/>	<input type="checkbox"/>
2. Has a bioterrorism coordinator been designated to oversee the preparedness planning process and serve as liaison to response partners?	<input type="checkbox"/>	<input type="checkbox"/>
3. Can the coordinator be contacted 24 hours per day?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have mutual aid agreements between the local public health agency and other partners been reviewed and updated as necessary?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the plan integrated with other community emergency response plans and the State's plan?	<input type="checkbox"/>	<input type="checkbox"/>
6. Are all public health partners aware of the connections between the public health response plan and the plans they have developed?	<input type="checkbox"/>	<input type="checkbox"/>

PUBLIC HEALTH PLANNING AND POLICY DEVELOPMENT CHECKLIST (CONTINUED)

	YES	NO
SCOPE OF THE PLAN		
1. Does the plan:		
a. Identify key partners and their roles in investigating and responding to a public health emergency?	<input type="checkbox"/>	<input type="checkbox"/>
b. Include protocols and guidance for:		
▪ Which events should be investigated?	<input type="checkbox"/>	<input type="checkbox"/>
▪ How to investigate them?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Whom to contact?	<input type="checkbox"/>	<input type="checkbox"/>
▪ How and when to disseminate information for appropriate action?	<input type="checkbox"/>	<input type="checkbox"/>
EVALUATION		
1. Is the public health response included in tabletop exercises, simulations, or other methods of testing the plan?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have response procedures been tested recently?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are lessons learned from exercises cycled into the policy and procedures?	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH AND MEDICAL EXPERT CALL-DOWN LIST

CONTACT	AGENCY	PHONE	FAX	PAGER
Biological:				
Chemical:				
Radiological:				
Explosives:				
Other:				

HEALTH SURVEILLANCE CHECKLIST

Public health surveillance should operate continuously to improve the chances of early detection of unusual medical events. Initial, non-specific detection of activity above an established baseline should be set up to trigger expanded surveillance and other response actions. Continual surveillance is key to timely response.

PLANNING QUESTIONS	YES	NO
1. Has the department responsible for health surveillance and reporting been identified?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has a health surveillance plan been developed for detecting unusual medical events?	<input type="checkbox"/>	<input type="checkbox"/>
3. Can the local public health agency link with data from a variety of sources, including (check those that apply):		
▪ Other local, State, and Federal public health agencies?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Clinicians?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Laboratories?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Poison centers?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Medical examiners?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Other health response partners?	<input type="checkbox"/>	<input type="checkbox"/>
4. Is there a 24-hour/day system (e.g., hotline) for reporting suspicious diseases or symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have medical baselines been established which, when exceeded, will trigger active investigation?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do those responsible for health surveillance have access to information on health hazards in the community and an accurate assessment of the risk they pose to the public's health?	<input type="checkbox"/>	<input type="checkbox"/>
7. Is a system in place for continuous monitoring of indicators that may signal a public health emergency?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have protocols been developed for expanding surveillance when key indicators exceed thresholds, including:		
▪ Polling emergency rooms?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Polling pediatricians, infectious disease doctors, and infectious control practitioners?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Polling veterinarians?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Initiating local, State, and Federal emergency response systems based on information received by local surveillance activities?	<input type="checkbox"/>	<input type="checkbox"/>

FATALITY MANAGEMENT CHECKLIST

Fatalities are likely to occur following a terrorist incident, and they may occur in large numbers with a lethal agent (e.g., smallpox). Contaminated remains could present health concerns and may need to be disposed of according to established protocols.

PLANNING QUESTIONS	YES	NO
1. Have those responsible for fatality management decisions and systems been identified?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are the coroner and other morgue personnel protected from infection or contamination?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has a fatality management plan been developed that includes protocols for processing mass fatalities, including: <ul style="list-style-type: none"> ▪ Rapid central processing of fatalities? ▪ Expanding existing morgue facilities (e.g., using refrigerated trucks or rail cars for long-term storage until final disposition)? ▪ Transporting and decontaminating remains? ▪ Identification and record keeping of the deceased (e.g., fingerprinting, photographing)? ▪ Next of kin notification? ▪ Safe handling procedures for those who handle fatalities? 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4. Are there provisions for obtaining additional resources if local mortuary systems become overwhelmed, including: <ul style="list-style-type: none"> ▪ Accessing additional resources from mutual aid partners? ▪ Accessing Federal resources (Disaster Mortuary Teams)? 	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
5. Are there provisions for families of the deceased, including: <ul style="list-style-type: none"> ▪ Managing a high volume of relatives seeking deceased relatives? ▪ Considering religious concerns of relatives in disposition of remains? 	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
6. Are there provisions for alternate means of disposition of large numbers of remains, including: <ul style="list-style-type: none"> ▪ Mass cremation (incineration sites, record keeping, memorialization)? ▪ Mass burial (interment site, record keeping, memorialization)? ▪ Temporary interment until final disposition (interment site, record keeping, transfer protocols)? ▪ Release of remains to families for normal disposition? 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

FATALITY MANAGEMENT CHECKLIST (CONTINUED)

PLANNING QUESTIONS	YES	NO
7. Does the medical examiner or coroner have protocols for balancing the interests of	<input type="checkbox"/>	<input type="checkbox"/>

evidence preservation with decontamination of remains in a biological incident?	
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CARE OF CASUALTIES CHECKLIST

Planning for care of casualties must consider not only those actually exposed to an agent but the “worried well”—individuals who believe that they have been exposed but have not. The worried well may magnify the number of patients by as much as 15 times. Although many of them will fall out of the patient count in time, they will require triage and evaluation and will seek medical assistance during the most critical time of the incident.

PLANNING QUESTIONS	YES	NO
PATIENT CARE		
1. Have provisions been made to expand existing medical care facilities and services to accommodate large numbers of casualties and “worried well” through such measures as:		
▪ A triage system tailored to terrorist incidents?	<input type="checkbox"/>	<input type="checkbox"/>
▪ A modular patient care system that can expand (e.g., into neighborhood satellite facilities) and contract as patient numbers require?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Use of volunteers and “physician/nurse extenders” to extend treatment to large numbers of victims?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are there provisions for patient evacuation (moving seriously ill or injured patients from the affected area to medical care locations)?		
3. Have protocols been developed for proper documentation of the treatment of victims, including:		
▪ Methods for tracking patients’ treatment and movement in the health care system?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Documenting health care administered at mass care centers?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Sharing victim identification with law enforcement personnel to assist in locating them for later follow-up if needed?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Allowing law enforcement personnel to interview victims at medical facilities to support the criminal investigation?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Providing information to family members?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are there provisions to ensure patient access to needed services, including:		
▪ Access to health services by non-English-speaking people?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Access to health services by the uninsured?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Community access to critical health services, including chronic care (e.g., dialysis), during an emergency?	<input type="checkbox"/>	<input type="checkbox"/>

DIAGNOSIS AND INVESTIGATION CHECKLIST

If health surveillance indicates that an unusual medical event may be occurring, local officials should have established procedures for confirmation and definitive diagnosis of the unknown. Preliminary medical/veterinary diagnosis of suspected samples is often done locally, followed by validation by qualified laboratories if initial diagnosis indicates a potential biological agent. An epidemiological investigation is then conducted to determine the distribution of cases and sources of disease outbreak. The criminal investigation (aimed a gathering evidence to aid in apprehending the responsible individuals or groups) should be coordinated with the epidemiological investigation.

PLANNING QUESTIONS	YES	NO
DIAGNOSIS		
1. Have procedures been established for confirmation and definitive diagnosis of diseases uncovered through health surveillance?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do the procedures include protocols for: <ul style="list-style-type: none"> ▪ Initial diagnosis at qualified local, State, or academic laboratories? ▪ Obtaining veterinary diagnosis (as applicable)? ▪ Reporting results to the public health department? ▪ Validation of potential biological agents by qualified field laboratories (e.g., CDC or U.S. Army Medical Institute of Infectious Diseases)? ▪ Rapid notification of key people (senior elected official, emergency manager, law enforcement, State epidemiologist, State laboratory director)? 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3. Does the local EOP identify the State public health laboratory and include a list of all member laboratories in the jurisdiction, including each laboratory's capability level and 24/7 contact information?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have the identified laboratories received guidelines for: <ul style="list-style-type: none"> ▪ Chain of custody procedures from State public health officials and/or the local FBI field office? ▪ Rapid reporting of suspected bioterrorism-related threat agents to local and State health departments and local, State, and Federal law enforcement? 	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
5. Is a system in place to safely and efficiently transport biological and chemical samples between laboratories?	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PHARMACEUTICAL STOCKPILE PROGRAM³

The National Pharmaceutical Stockpile (NPS) is a national repository of pharmaceuticals and medical supplies that may be needed in the event of a biological or chemical terrorist incident. The NPS Program is designed to supplement and resupply State and local public health agencies in the event of a biological or chemical terrorist incident anywhere, at any time within the U.S. or its territories.

NPS ASSETS

The Centers for Disease Control and Prevention (CDC) and its Federal partners analyze and prioritize the potential biological and chemical agents of terrorism to determine NPS contents, which include:

- Antibiotics.
- Chemical antidotes.
- Antitoxins.
- Life-support medications.
- IV administration and airway maintenance supplies.
- Medical/surgical items.

The NPS assets are organized in two ways:

- **Push Packages:** These are caches of pharmaceuticals, antidotes, and medical supplies designed to address a variety of biological or chemical agents. They are positioned in secure regional warehouses ready for delivery anywhere in the continental U.S. within 12 hours after a Federal decision to deploy. (CDC also plans to reach sites beyond the continental U.S. in 12 hours, although delivery may take longer in some circumstances.)
- **Vendor Managed Inventory (VMI):** If an incident requires additional assets, follow-up VMI supplies will be shipped to arrive within 24 to 36 hours. They can be tailored to provide assets specific to the suspected or confirmed agent(s).

³ Adapted from *The Public Health Response to Biological and Chemical Terrorism: Interim Planning Guidance for State Public Health Officials*, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, July 2001, Appendix II.

NATIONAL PHARMACEUTICAL STOCKPILE PROGRAM (CONTINUED)

DEPLOYMENT

The decision to deploy NPS assets may be based on evidence of the overt release of an agent, credible intelligence information, or epidemiological indicators (i.e., unusual disease numbers or patterns) of a possible attack.

To receive NPS assets, the affected State can request the deployment of the NPS directly from the Director of CDC, who has the authority (in consultation with the Surgeon General, Secretary of DHHS, FEMA, and FBI) to deploy the NPS.

Push Packages can be immediately loaded for transport to the local area. The CDC will coordinate with State and local officials while the NPS is en route, so that stockpile assets can be efficiently received and distributed upon arrival at the site.

The NPS is not a first response tool, because of the delays between the onset of an event and receipt of NPS assets. However, State and local emergency management personnel and health officials can use the NPS to bolster their response to a biological or chemical terrorist incident.

EDUCATION AND PLANNING GUIDANCE

In coordination with various governmental departments and agencies, the NPS program provides training to State and local health care providers, first responders, and State and local governments on the NPS mission and operations. They have also established guidance for developing stockpile-related SOPs.

For more information, contact:

National Pharmaceutical Stockpile Program
4770 Buford Highway NE
Mailstop F-23
Atlanta, GA 30341-3724
(770) 488-7516

HEALTH AND MEDICAL COORDINATION CHECKLIST

Emergency response to a terrorist incident will require the coordinated efforts of numerous response partners. Cooperative partnerships and systems and protocols for interagency coordination and communication must be in place before a crisis occurs.

PLANNING QUESTIONS	YES	NO
1. Has the person(s) responsible for the following been identified?		
<ul style="list-style-type: none"> ▪ Assessing the public health consequences of a terrorist incident ▪ Initiating interagency notification 	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
2. Is the health department emergency operations function included in the EOC?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have public health employees responsible for staffing the EOC been designated?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have procedures been established for coordinating local, State, and Federal public health response efforts during a biological emergency (e.g., are medical command centers linked to the unified command, JOC, and EOC)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has it been determined under what conditions the Health and Medical Annex will be activated?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have local health care resources (e.g., beds, staffing, ventilators, vacant hospital buildings) that may be needed following a terrorist incident been identified?	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH AND MEDICAL RESOURCES CHECKLIST

Having a workforce that is trained to recognize indicators of a possible bioterrorism incident and to respond quickly and effectively is essential for early detection and response. The ability to meet projected staffing requirements—both for specialized expertise and surge staffing—is equally important.

PLANNING QUESTIONS	YES	NO
1. Has a needs assessment been conducted of the bioterrorism-related competencies and training needs of the public health workforce and response partners?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have resource needs for a biological event been projected, including:		
▪ Supplementary and auxiliary staffing:		
• Epidemiologic investigation personnel?	<input type="checkbox"/>	<input type="checkbox"/>
• Preventive services personnel?	<input type="checkbox"/>	<input type="checkbox"/>
• Medical treatment personnel?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Specialized equipment and supplies (e.g., labs, test kits, pharmaceuticals)?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Technical assistance?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is there adequate surge capacity of staff to meet emergency needs in the event of biological attack?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have existing procedures for surge staffing been reviewed in light of recent changes in hospital administration, including “just-in-time” staffing and reduction of hospital beds?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have the following teams been established and briefed on their mission, roles, responsibilities, and authorities?		
▪ Rapid-response epidemiologic team	<input type="checkbox"/>	<input type="checkbox"/>
▪ Rapid-response laboratory team	<input type="checkbox"/>	<input type="checkbox"/>
▪ Real-time surveillance set-up team (emergency or specialized)	<input type="checkbox"/>	<input type="checkbox"/>
6. Have all public health personnel been trained for a bioterrorism response?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have appropriate health care providers received bioterrorism-updated reportable diseases lists?	<input type="checkbox"/>	<input type="checkbox"/>
8. Are all levels of public health surveillance personnel (physicians, veterinarians, lab technicians, surveillance data entry clerks, etc.) trained to recognize indicators of covert bioterrorism events?	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH AND MEDICAL RESOURCES CHECKLIST (CONTINUED)

PLANNING QUESTIONS	YES	NO
9. Is bioterrorism-related in-service training or grand rounds provided for the medical community?	<input type="checkbox"/>	<input type="checkbox"/>
10. Is bioterrorism training coordinated with other Federal, State, and local health programs ⁴ to ensure integration of bioterrorism preparedness and response activities?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do response partners collaborate on educational activities for the general public or general medical community related to bioterrorism preparedness?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does the EOP address: <ul style="list-style-type: none"> ✓ Performing triage? ✓ Expedient decontamination of victims before transport? ✓ Keeping response team members informed about the signs, symptoms, health risks, and self-aid treatment options associated with exposure to the hazard? ✓ Performing mass vaccination of population at risk? ✓ Quarantine? ✓ Designation of medical treatment facilities capable of decontaminating and providing definitive treatment for victims? ✓ Collecting, decontaminating, and disposing of human remains? 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

⁴ May include:

- Health Alert Network
- Emergency Preparedness Information Exchange (Epi-X)
- Emerging Infections Program
- Epidemiology and Laboratory Capacity program
- Information Network for Public Health Officials
- Assessment Initiative
- Hazardous Substances Emergency Events Surveillance
- influenza surveillance
- Local Metropolitan Medical Response Systems (MMRS) and other emergency response programs

