



The Johns Hopkins Office of Critical
Event Preparedness and Response

Johns Hopkins Institutions' Unified Command

September 11, 2009
V. 3.2

Introduction

The Johns Hopkins Office of Critical Event Preparedness and Response (CEPAR) is routinely involved in emergency planning, but is only required to elevate its operational status and take on management responsibilities to address cross-cutting issues during an emergency when the potential impact of the crisis affects multiple members of the Johns Hopkins Institutions. This document describes the leadership structure for the Institutions during such events.

In considering top-level decision making, the Johns Hopkins Institutions (JHI), *de facto*, have three distinct constituents: the Johns Hopkins University (JHU), the Johns Hopkins University Applied Physics Laboratory, LLC (JHU-APL),¹ and the Johns Hopkins Health System/Johns Hopkins Medicine (JHHS/JHM). Emergency planning and response occurs at several levels across the Institutions:

- JHI as a whole (highest “global” level)
- Major constituents (JHU, JHU-APL, JHHS/JHM)
- Campus or other geographic cluster of affiliates
- Each individual division or unit, hospital, or other component organization of a single member (lowest “local” level)

By definition, planning for cross-cutting issues and activities occurs in a top-down fashion, driven by institutions-wide requirements, mandates, policies and procedures. In contradistinction, response actions are more often dependent on local entities affected by the emergency.

Model of Disaster Management - The ICS

As part of the National Incident Management System (NIMS)² mandated by Homeland Security Presidential Directive (HSPD)-5,³ all organizations involved in disaster response activities must use a paramilitary command structure called the Incident Command System (ICS). Hospitals and health systems receiving federal preparedness grants clearly fall within this mandate. While universities are not mandated to use an ICS, they are considered important components of the communities in which they are located, and thus an NIMS approach, including an ICS, is highly recommended.⁴

ICS was developed in the early 1970s to manage rapidly moving wildfires and to address the following problems:

- Too many people reporting to one supervisor
- Different emergency response organizational structures
- Lack of reliable incident information
- Inadequate and incompatible communications
- Lack of structure for coordinated planning among agencies
- Unclear lines of authority
- Terminology differences among agencies
- Unclear or unspecified incident objectives

¹ Considered a separate, critical entity given its national security role

² <http://www.fema.gov/emergency/nims/compliance/2008.shtm>

³ <http://www.whitehouse.gov/news/releases/2003/02/20030228-9.html>

⁴ FEMA. <http://www.fema.gov/emergency/nims/faq/compliance.shtm#5>

An ICS enables integrated communication and coordination by establishing a manageable span of control. The System divides disaster management into five functions essential for emergency response operations: Command (with a single Incident Commander or Unified Command [see Figure 1]), and four sections: Operations, Planning, Logistics, and Finance/Administration.⁵

The modular organization of the ICS allows the organization to scale their efforts and apply the parts of the ICS structure that best meet the demands of the incident. For example, some incidents will not require the activation of Planning, Logistics, or Finance/Administration sections, while others will require all of them to be established and functional. If there is a need to expand the System, positions exist within the ICS framework to meet virtually any need.

JHI and the Use of the ICS

Three hospitals in JHM have been using a version of ICS since the 1990s.⁶ More recently, the three components of the Johns Hopkins Institutions have agreed to adopt the ICS to serve as the infrastructure for its enterprise-wide emergency response operations. The ICS provides a logical organizational structure that supports all entities of the enterprise to work together to respond effectively to multiple levels of emergencies. While not all of the components of the JHI are considered “first response” entities, adoption of the ICS allows the enterprise to interface with all of its components in a more efficient and effective manner.

The JHI components and their sub-units (e.g., schools, hospitals) operate daily with significant independence. In the event of an emergency, each member manages its own response, in harmony with the general emergency management philosophy of local response. This means that, independent of the scope of the incident, each affected affiliate activates its own internal ICS. When such activation occurs, CEPAR should be notified.

During a critical event requiring significant coordination, CEPAR will utilize an Institutions-wide ICS to address cross-cutting issues. *The CEPAR ICS is the umbrella structure used to unite the individual ICSs of JHI affiliates for this purpose.* Implementation of an Institutions-wide ICS does not supplant the ICS structure at individual entity or campus levels. Rather, it is an “overlay” to ensure uniformity of response, appropriate resource-sharing, and efficient and effective management of those aspects of the response that cut across multiple members.

ICS Leadership: Single Command vs. Unified Command

A traditional ICS has a single Incident Commander at the top of its chain-of-command structure. This is by far the most common approach for on-scene acute incident response. A single person assumes command responsibility, typically across functional units, agencies, and organizations.

However, it is sometimes desirable to use a command approach in which joint top-level decision making occurs. **Unified Command** (UC) is a structure that brings together the Incident Commanders of the major entities involved in a given event in order to provide an effective, consistent response. At Johns Hopkins this model is modified. Executive leaders, rather than Incident Commanders, are brought together as Unified Commanders. The UC explicitly links the entities responding to a given incident, and provides a

⁵ National Response Team ICS/UC Technical Assistance Document. Available at <http://www.nrt.org/Production/NRT/NRTWeb.nsf/PagesByLevelCat/Level2ICS/UC?Opendocument>.

⁶ A fourth hospital has recently been added to JHM, but has not yet been fully integrated.

forum for these entities to make top-level consensus decisions. The UC is responsible for overall management of the incident. The UC directs incident activities, including development and implementation of overall objectives and strategies, and approves ordering and releasing of resources. Members of the UC work together to develop a common set of incident objectives and strategies, share information, maximize the use of available resources, and enhance the efficiency of the individual response organizations.

Unified Command Structure and Personnel

The following diagram depicts the ICS of the JHI with a UC leadership:

Figure 1. Unified Command



As noted, because ICS was originally designed for on-scene event management, some modifications have been made to the Johns Hopkins Institutions’ ICS. For leadership and decision-making at the Institutions-wide level, there is no direct “scene management” per se; therefore, the primary role of the four Section Chiefs becomes coordination and communication between the entities for the respective defined functions (Operations, Planning, Logistics and Finance/Administration).

The UC shall be filled as a team by the highest leadership of the JHU, JHU-APL, Health System, and CEPAR. The personnel who fill the other JHI ICS functions are CEPAR personnel. Table 1 below depicts one likely depiction of Unified Command.

Unified Command and Decision Making

With the different perspectives on the UC come the potential for disagreements and most of these are likely to be resolved through an understanding of the underlying issues. Contentious issues may arise, but the UC framework provides a forum and a process to resolve problems, derive solutions, and arrive at definitive decisions. If situations arise where members of the UC cannot reach consensus, the UC

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member representing that JHI entity with primary jurisdiction over the issue (e.g., University or Health System President, APL Director) would normally make the final decision. *Final decisions would rest with the highest authority responsible for the JHI entity in question.*

Unified Command and Emergency Operations Center

When possible, the UC will be established and convened in the CEPAR Emergency Operations Center at CEPAR HQ on the Mt. Washington campus. However, given that UC members are likely situated in distinct geographical areas, and its leadership has many roles and responsibilities during a catastrophic event, it may be prudent that the UC be convened in a “virtual command center” using teleconferencing. CEPAR is responsible for the assurance of the occurrence and integrity of such communications.

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Table 1. Unified Command*

| POSITION | TITLE | NAME |
|---|--|---|
| Unified Command* | President, JHU CEO JHM President, JHHS Director, APL Director, CEPAR | R. Daniels E. Miller R. Peterson R. Roca G. Kelen |
| Subject Matter Experts (SMEs) | | |
| Biological/Infectious Disease | Director, JHH Epidemiology & Infection Control | T. Perl |
| Chemical | Associate Director, Health Safety & Environment, JHU | J. Schaefer |
| Legal/Risk Management | Vice President & General Counsel, JHHS Associate General Counsel, JHU | J. Pollak G. St. Ours |
| Radiological | Deputy Director, CEPAR | J. Links |
| Safety/Security Officer | Vice President Corporate Security, JHMI Executive Director Safety & Security, JHU (or their direct designees) Representatives from other affiliates as appropriate | H. Koffenberger E. Skrodzki |
| Public Information Officer | Executive Director, Marketing & Communications, JHU Executive Director of Communications and Public Affairs (As per established agreements and Joint Information Center plan) Others as appropriate | J. Rodgers D. O’Shea |
| Liaison Officer | Director of Operations, CEPAR | D. Whyne |
| Operations Chief, Health Systems | Associate Director, Health System Preparedness, CEPAR | C. Catlett |
| Operations Chief, University | Deputy Director, CEPAR | J. Links |
| Planning Chief | Director of Training, CEPAR Research Associate, CEPAR | E. Hsu M. Thanner |
| Logistics Chief | Executive Director, CEPAR | J. Scheulen |

*Note: Senior Unified ICS positions as depicted here represent one likely possibility, and would depend on the actual event and institutional components involved in management and response.