



**National Disaster Medical System**  
**Federal Coordinating Center**  
**Guide**  
**April 2014**

## Foreword

Federal Coordinating Centers (FCCs) provide a unique and significant resource to the Nation through the four-agency partnership of the National Disaster Medical System (NDMS). The purpose of this guide is to provide Federal Coordinating Center (FCC) Directors, Coordinators, and Staff an educational resource to develop plans and to conduct FCC training, and operations.

The basis for this guide is the 2005 Federal Partner's Memorandum of Agreement for the NDMS, and the 6 August 2009, NDMS Concept of Operations (CONOPS). Therefore, this document reflects FCC operations within the NDMS as of this date. This guide is not policy, and hence it is not to be considered authoritative or prescriptive.

The responsibility to update this guide resides with the NDMS Directorate Staff. It is intended to be reviewed and updated on a periodic basis. The guide may be updated in whole, or may be updated in part by updating only those chapters or annexes needing revision.

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23 APR 2014

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Date

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## Table of Contents

Foreword .....	2
Table of Contents .....	4
1. Introduction .....	6
1.1. The NDMS Frame of Reference.....	6
1.2. The National Response Framework (NRF) .....	6
1.3. Emergency Support Function #8 (ESF #8) .....	7
1.4. National Incident Management System (NIMS) .....	7
1.5. The Incident Command System (ICS).....	8
1.6. The National Disaster Medical System (NDMS).....	8
1.7. NDMS Governance Structure.....	9
2. NDMS Operational Overview .....	10
3. FCC Structure, Program Elements and Activation .....	17
3.1. Structure and Elements.....	17
3.2. FCC Alert and Activation .....	18
3.3. Mission Assignment Process .....	18
3.4. FCC Activation Stages .....	19
3.5. Patient Regulation to the FCC.....	21
4. FCC Operations .....	22
4.1. Introduction .....	22
4.2. Understand the FCC Director/Coordinator Roles and Responsibilities (See Annex A) .....	22
4.3. Facilitate / Maintain Medical Facility Enrollment and Community Support (see Annex B) .....	23
4.4. Solicit and Organize Community Participation .....	23
4.5. Collect/Report Medical Facility Bed Availability (see Annex C) .....	24
4.6. Coordinate Patient Reception Area Plans (see Annex D) .....	24
4.7. Coordinate Training and Exercises (see Annex E).....	25
4.8. Coordinate Local Patient Reception Operations (see Annex F) .....	25
4.9. Coordinate Discharge and Return of Patients (see Annex G) .....	25
4.10. Coordinate Financial Management (see Annex H).....	26
4.11. Coordinate Logistical Support (See Annex I) .....	26
4.12. Facilitate Communications (see Annex J) .....	27
4.13. Coordinate Critical Information Requirements (See Annex K) .....	27
4.14. Coordinate Public Affairs (See Annex L).....	27
4.15. List of Remaining Annexes:.....	27
Annex A: Summary of Federal Coordinating Center (FCC) Director and FCC Coordinator Duties .....	28
Annex B: Facilitate and Maintain Medical Facility Enrollment and Community Support .....	34
Annex C: Collect and Report Medical Facility Bed Availability.....	38
Annex D: Patient Reception Area Plans .....	44
Annex E: Training and Exercises.....	54
Annex F: Coordinate Local Patient Reception Operations .....	60
Annex G: Patient Discharge and Return .....	71
Annex H: Financial Guidance .....	72

Annex I: Logistical Support.....	83
Annex J: Communications .....	91
Annex K: Critical Information Requests .....	94
Annex L: Public Affairs .....	96
Annex M: Glossary of Terms and Acronyms .....	99
Annex N: Point of Contact List .....	112
Annex O: References List .....	113
Annex P: Map of Current FCCs .....	115
Annex Q: FCC PRA Self-Assessment.....	116
Annex Q: Exercise Evaluation Guide .....	132
Annex R: Mission Assignment Example .....	155

# 1. Introduction

The mission of a Federal Coordinating Center (FCC) is to receive, triage, stage, track and transport inpatients, affected by a disaster or national emergency, to a participating National Disaster Medical System (NDMS) medical facility capable of providing the required definitive care. An FCC also has the potential to receive military patients should the Department of Defense (DoD) Health System and the Department of Veterans Affairs (VA) Contingency Hospital System be overwhelmed during a military contingency.

An FCC is defined as a federal facility (DoD or VA) located in a metropolitan area of the United States, responsible for day to day coordination of planning, training, and operations in one or more assigned geographic NDMS Patient Reception Areas (PRA). NDMS participating medical treatment facilities (MTF) should be within a 5 miles of the managing FCC.

## 1.1. The NDMS Frame of Reference

In order to fully understand the role of the FCC in the NDMS, it is important to understand the federal response structure under the National Response Framework (NRF).

Homeland Security Presidential Directive 5 (HSPD-5), "Management of Domestic Incidents," directed the Secretary of the Department of Homeland Security (DHS) to develop the NRF, and to develop and administer a National Incident Management System (NIMS). The HSPD-5 also requires all federal departments and agencies to adopt and use NIMS in incident management programs and activities and to make adoption of NIMS a condition for federal preparedness assistance (through grants, contracts, and other activities).

This next section will summarize the NRF, the Emergency Support Function (ESF) #8 Public Health and Medical Services Annex, how the principles of the National Incident Management System (NIMS), the Incident Command Structure (ICS) are interwoven throughout, and the basics of the NDMS.

## 1.2. The National Response Framework (NRF)

Effective response to an incident is a shared responsibility of governments at all levels, the private sector, and Non-Governmental Organizations (NGOs) and individual citizens. The **National Response Framework** commits the federal government, in partnership with local, Tribal, territorial, and state governments and the private sector, to complete both strategic and operational plans for the incident scenarios specified in the *National Preparedness Guidelines*. The *Framework* presents the key response principles, participants, roles, and structures that guide the Nation's response operations.

The NRF is comprised of a core document, the Emergency Support Function (ESF) Annexes (ESF #8 Annex is described below), Support and Incident Annexes, and Partner Guides. These documents are available at the **NRF Resource Center**, <http://www.fema.gov/emergency/nrf/>.

### **1.3. Emergency Support Function #8 (ESF #8)**

The Public Health and Medical Services Annex of the NRF provides the mechanism for coordinated federal assistance to supplement state, Tribal, and local resources in response to a public health and medical disaster, potential or actual incidents requiring a coordinated federal response, and/or during a developing potential health and medical emergency.

ESF #8 is coordinated by the Secretary of the Department of Health and Human Services (HHS) principally through the Office of the Assistant Secretary for Preparedness and Response (ASPR). HHS coordinates ESF #8 using resources primarily available from within the Department and other ESF #8 support agencies and organizations as outlined in the NRF, including the DoD, VA, and the DHS.

HHS may request DoD support to provide movement of seriously ill or injured inpatients, both the DoD and VA to operate and staff NDMS FCCs, and to process and track patient movements from collection points to their final destination reception facilities.

As patients are discharged from the receiving medical facilities, HHS will coordinate the safe return of the evacuated patients to their place of origin once the danger has resolved. The coordinated effort between the NDMS partners is codified in legislation, the NRF and within various formal agreements.

### **1.4. National Incident Management System (NIMS)**

The NRF builds on the National Incident Management System (NIMS). NIMS represents a core set of doctrines, concepts, principles, terminology, and organizational processes that enables effective, efficient, and collaborative incident management.

Together, the NRF and NIMS help to ensure that all response partners use standard command and management structures that allow for scalable, flexible, and adaptable operational capabilities. More information about NIMS can be accessed at the Federal Emergency Management Agency (FEMA) Independent Study website at <http://training.fema.gov/emiweb/is/is700alst.asp>.

It is important that FCC Directors, Coordinators, and staff understand the principles of NIMS. NIMS establishes a standardized and systematic approach to emergency management. We in the federal sector must understand these principles and understand our role in supporting state, local, Tribal and territorial response efforts and especially of the Incident Command System (ICS).

## 1.5. The Incident Command System (ICS)

A basic component of NIMS is command and management using the Incident Command System (ICS). The premise is that incidents are generally handled at the lowest jurisdictional level possible. Incidents begin and end locally, and most incidents are managed entirely at the local level.

Local responders use the ICS to manage response operations. The ICS is a management system designed to enable effective incident management by integrating a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure.

It is important for FCC Directors, Coordinators, and staff to understand the basic structure and principles of the ICS as the emergency responders at the local, regional, and State levels all use the ICS and NIMS. More information about the ICS can be accessed at the FEMA Independent Study Website at <http://training.fema.gov/EMIWeb/IS/IS100B.asp>.

## 1.6. The National Disaster Medical System (NDMS)

The statutory mission of the NDMS, as part of ESF #8, is to organize a coordinated effort by the NDMS Federal Partners (DHS, HHS, DoD, and the VA), working in collaboration with the states and other appropriate public or private entities to provide health services, health-related social services, other appropriate human services, and appropriate auxiliary services to respond to the needs of victims of a public health emergency, and to be present at locations, for limited periods of time, when such locations are at risk of a public health emergency. This is in accordance with Public Law 107-188, Section 2811<sup>1</sup>. The NDMS will also support patient treatment requirements from military contingencies if the DoD Military Health System and VA Contingency Health System become overwhelmed.

The NDMS is composed of three components serving the following goals:



<sup>1</sup> <http://www.gpo.gov/fdsys/pkg/PLAW-107publ188/pdf/PLAW-107publ188.pdf>

1. **Medical Response**: Provide supplemental health and medical assistance in domestic disasters at the request of state and local authorities. The NDMS serves the federal response by providing disaster medical care to the nation. The NDMS will temporarily supplement federal, state, Tribal, territorial, and local capabilities by funding, organizing, training, equipping, deploying, and sustaining a specialized and focused range of public health and medical deployable capabilities. The HHS NDMS Website can be accessed at <http://www.phe.gov/preparedness/support/medicalassistance/Pages/default.aspx#ndms>.
2. **Patient Movement**: Conduct patient movement activities to evacuate patients who cannot be cared for in the disaster area to designated locations elsewhere in the nation. The patient movement system includes the movement, regulating, tracking, and return of patients identified by the state or local authorities.
3. **Definitive Care**: Provide a nationwide network of voluntary, pre-identified, non-federal medical facilities capable of providing definitive care for the victims of disaster or military contingency that exceeds the medical care capabilities of the affected local, state, or federal medical system.

## 1.7. NDMS Governance Structure

**NDMS Directorate Staff** – Consists of one official from each of the four partner agencies. The Directorate Staff, chaired by HHS, will provide general oversight, management and supervision of the NDMS. The Directorate Staff may appoint or charter work groups or coordination groups as necessary.

## 2. NDMS Operational Overview

The NDMS generally supports domestic emergencies and disasters within the ESF #8 structure of the NRF. However, the NDMS may be called upon to support international response operations. HHS is the primary agency for ESF #8. Under ESF #8, HHS is responsible for overall coordination of medical response, patient movement, and definitive medical care.

The NDMS may be activated in one of three ways:

- 1. Robert T. Stafford Disaster Relief and Emergency Assistance Act:** In the event of a domestic peacetime disaster, the Governor of an affected state, on advice of local or county authorities, may request federal assistance under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act. The State requests assistance from FEMA. FEMA accepts the request and tasks the appropriate ESF, which in this case, is ESF #8.
- 2. The Public Health Service Act:** A State Health Officer or Health Preparedness Director may also request NDMS activation by the HHS in a public health emergency situation without Presidential Disaster Declaration. However, the state may be liable for costs incurred in this type of activation.
- 3. Overseas and Domestic Military Contingency Emergency:** When the number of military patients exceed, or are expected to exceed, the capability of the DoD Military Healthcare System (MHS) and VA-DoD Contingency Hospital System, the NDMS may be activated by request of the Assistant Secretary of Defense, Health Affairs, ASD(HA). The ASD(HA) notifies the HHS Secretary's Operations Center (SOC) and alerts Veterans Health Administration (VHA)/Office of Emergency Management (OEM) through the VA Under Secretary of Health (USH). ASD(HA) will request from HHS to activate the definitive care component of the NDMS. At the request of the ASD/HA, HHS will authorize the activation of the NDMS and the alert of FCCs. The ASD(HA) will notify the Services to alert select DoD FCCs, and VHA/OEM will alert select VA FCCs. ASD(HA) will also notify the National Military Command Center (NMCC) and the Joint Chiefs of Staff, who will request appropriate patient evacuation support from United States Transportation Command (USTRANSCOM) through United States Northern Command (USNORTHCOM). There will also be communication between the ASD(HA) and the DoD Joint Director of Military Support (JDOMS) informing them of actions taken. Once activated, the FCCs will initiate PRA operations and patient reception plans. DoD covers costs associated with this activation and the VA will assume the costs of activation of their FCCs.

## 2.1. NDMS Components

### 2.1.1. Medical Response

The first element of the NDMS is medical response. The primary NDMS resources providing supplemental medical assistance are the Disaster Medical Assistance Teams (DMATs). DMATs are deployable NDMS teams comprised of professional and para-professional medical personnel designed to provide medical triage, treatment, and preparation for evacuation, using a standard equipment cache to conduct medical operations in response to a disaster or other major emergency. DMATs are supported by a cadre of logistical and administrative staff and are self-sustaining for up to 72 hours.

DMATs are foremost a community resource for supporting local and state emergency health and medical responders. They are assets that may be used to provide disaster medical response within their home state, and are also national resources that can be called upon to provide interstate aid. DMATs at a disaster site provide pre-hospital and/or emergency medical services. A DMAT may be utilized, if available, in support of a local NDMS PRA to provide patient staging services. The basic DMAT is deployed in 24, 35 and 50 person increments, including physicians, nurses, technicians, and other allied personnel. DMAT personnel have intermittent federal appointments to facilitate their activation, analogous to the National Guard model within each state. This intermittent status affords the DMAT personnel certain liability coverage and a salary while called into service.

Medical sheltering is a capability that is included in the Medical Response component. When requested, HHS can mobilize beds and staff to support medical shelter operations. The U.S. Public Health Service (USPHS) is the primary resource for staffing (For more information on the USPHS, see <http://www.usphs.gov/aboutus/>). Staffing models also include personnel from the VA and DoD.

The Medical Reserve Corps (MRC) is comprised of organized medical and public health professionals who serve as volunteers to respond to natural disasters and emergencies. Although primarily a community based capability, used by local authorities as a local resource, MRC units are provided specific areas to target that strengthen the public health infrastructure of their communities by the U.S. Surgeon General. The MRC program provides the structure necessary to deploy medical and public health personnel in response to an emergency, as it identifies specific, trained, credentialed personnel available and ready to respond to emergencies<sup>2</sup>.

FCCs may assist with planning efforts, but generally are not responsible for coordinating the evacuation of patients out of an affected area.

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<sup>2</sup> <https://www.medicalreservecorps.gov/HomePage>

### 2.1.2. Patient Movement

The second key element of the NDMS is patient movement. In the event that the local, regional, and state medical systems within a disaster area are overwhelmed, there may be a need for a system to move patients out of the disaster area prior to or after the event. Moving patients includes patient evacuation, medical regulating, en route medical care, and tracking/inpatient visibility.

When the NDMS is activated to move patients, the DoD coordinates this movement in collaboration with other ESF #8 partners, as required. USTRANSCOM's Global Patient Movement Integration Center (GPMIC) is the single manager for the movement of NDMS patients. The GPMIC is a Joint activity reporting directly to the USTRANSCOM Command Surgeon and serves as DoD's single manager for the development of policy and standardization of procedures and information support systems for global patient movement. The GPMIC orchestrates, and maintains "global oversight" of the Theater Patient Movement Requirements Centers (TPMRCs). The GPMIC orchestrates, and maintains "global oversight" of the Theater Patient Movement Requirements Centers (TPMRCs) in coordination with the geographic Combatant Commands (COCOM) and external intergovernmental organizations as required. This includes accepting requests for movement of NDMS patients out of the disaster area, regulating patients to designated FCC PRA locations, and coordinating patient transportation. When DoD conducts patient movement, it is generally accomplished by air; however, DoD may use sea or ground transportation depending upon situation and available assets.

The patient tracking function is accomplished using an HHS system called the Joint Patient Assessment and Tracking System (JPATS). JPATS will track all patients being moved by ESF #8/NDMS from the point of entry into the patient movement system, to the NDMS partner medical facility, and back home to their originating location.

#### 2.1.2.1. *Transportation by Air*

This is generally accomplished through U.S. Air Force's Air Mobility Command (AMC), the air component of USTRANSCOM. The Aeromedical Evacuation System (AES) administered by AMC has unique aeromedical evacuation (AE) capabilities. It is used for the transportation of DoD patients and can be expanded when required. To support NDMS operations, the USTRANSCOM Theater Patient Movement Requirements Center Americas (TPMRC-A) formulates evacuation missions in conjunction with the Headquarters, 618th Air Force Tanker/Airlift Control Center (TACC) (See Appendix 1 to Annex F for information on medical regulating). These missions are based on patient and medical equipment requirements, the location of available definitive care, and the availability of aircraft, AE crews, and Critical Care Air Transport Teams (CCATT).

The following are some DoD AE capabilities the FCC Director/Coordinator should be aware of:

- The **C-130 Hercules** forms the backbone of DoD intra-theater patient movement in the Continental United States (CONUS). This aircraft has the unique capability of not requiring an improved runway for takeoff or landing. It can land on short stretches of interstate highway, in a desert region, or an open field, weather and soil conditions permitting. The C-130 can be readily configured in accordance with AFI11-2C-130V3ADDA, C-130 Operations Configuration/Mission Planning (litter and patient/passenger seat availability varies). The planning factors for a standard load is 50 litter patients.
- The **C-17 Globemaster III** fly long distances and land in remote airfields in rough, land-locked regions, can take off from a 7,600-ft. airfield, carry a payload of 160,000 pounds, fly 2,400 nautical miles, refuel while in flight and land in 3,500 ft. or less on a small unpaved or paved airfield in day or night. The C-17 can be configured to accommodate 36 litter and 54 ambulatory patients and attendants.
- **Critical Care Air Transport Teams (CCATT)** provide specialized care, in conjunction with AE crews, to evacuate critical patients requiring advanced care during transportation. Recognized as clinical experts, these teams are medically responsible for their patients and function under the in-flight direction of the Medical Crew Director (MCD) and Pilot-in-Command (PIC). The CCATT physician is clinically responsible for care given to CCATT-assigned patients and may be asked to assist or advise on the care of the other patients.

**NOTE: In some instances, the National EMS/Ambulance Contract may be activated for federal movement of patients. This contract provides 25 fixed and rotary winged aircraft for each of the four contracted zones in the U.S. These aircraft are limited in their capacity and can safely move a few patients at a time. FCCs may receive patients transported using this capability.**

#### **2.1.2.2.      *Transportation by sea***

This may be accomplished through DoD, the United States Coast Guard (USCG)/Department of Transportation (DOT), commercial companies, or through other agencies, as applicable.

#### **2.1.2.3.      *Transportation by ground***

This may be accomplished through the Military Surface Deployment and Distribution Command, DOT, commercial companies, or through other agencies, as applicable.

The **Ambulance Bus (AMBUS)** is organic to the table of allowance for contingency hospitals and aeromedical staging squadrons. It is considered War Reserve Material (WRM) asset and if available, may be used. The AMBUS has an inherent capability to transport 12 litters, or a combination of litters and ambulatory patients from 4 litters and 24 ambulatory patients up to 12 litters and 0 ambulatory patients. FCCs requiring AMBUS's are encouraged to contact the MEFPK Management Branch; Medical Readiness Division; HQ Air Mobility Command at 618-229-6952.

**VA Dual Use Vehicles (DUVs)** are operated by numerous VA medical centers nationwide. Both small and large versions of the DUVs routinely carry VA beneficiary passengers and patients, and can be reconfigured when required. Small DUVs can transport a maximum of 14 ambulatory, 6 wheelchairs, 3 ambulance gurneys, 9 low-acuity litter patients, 2 critical patients, or combinations thereof. Large DUVs can transport up to 30 ambulatory, 10 wheelchairs, 5 ambulance gurneys, 15 low-acuity litter patients, 4 critical patients, or combinations thereof. FCCs requiring DUVs are encouraged to contact the VHA/OEM at 304.264-4800.

### 2.1.3. Definitive Medical Care

The third component of NDMS is definitive medical care. Patients evacuated from a disaster area for definitive medical care arrive at the respective FCC's PRA. The PRA generally operates from a pre-identified airfield, bus station or railhead. Patients are off-loaded, triaged and staged at the PRA pending further disposition and ground transport to a local NDMS partner medical facility.

The NDMS CONOPS, dated August 2009, defines definitive medical care as, "to the extent authorized by NDMS, in the particular public health emergency, medical treatment or services beyond emergency medical care, initiated upon inpatient admission to an NDMS medical facility and provided for injuries or illnesses resulting directly from a specified public health emergency, or for injuries, illnesses and conditions requiring non-deferrable medical treatment or services to maintain health when such medical treatment or services are temporarily not available as a result of the public health emergency."

Definitive medical care is rendered by a nationwide network of voluntarily participating, pre-identified, partner medical facilities. The network includes an ability to track available beds by medical specialty. In a public health emergency, these services provide definitive medical care for victims. In a military health emergency, NDMS partner medical facilities provide backup to the available military and VA medical services for military beneficiaries. In the case of DoD and VA hospital services, use in a public health emergency is contingent on availability and appropriate approval. FCCs monitor the status of available NDMS beds at NDMS partner medical facilities.

Once patients are distributed to NDMS partner medical facilities, it is the responsibility of HHS' responsibility to coordinate the discharge and transportation of patients returning to their point of origin, or other destinations, as authorized. The **Service Access Teams (SAT)**, consisting of individuals from the USPHS, is the HHS team responsible for:

- a. Tracking and monitoring patient status;
- b. Providing information to family members;
- c. Coordinate lodging and human services needs of discharged and non-medical attendants;
- d. Facilitate the return movement of patients and non-medical attendants;
- e. Coordinate the return/disposition of remains.

NDMS partner medical facilities are reimbursed for the care they provide in accordance with the signed NDMS Definitive Medical Care Memorandum of Agreement. See Annex G.

NDMS payment will end when one of the following occurs, whichever comes first: completion of medically indicated treatment as defined by the Centers for Medicare and Medicaid Services diagnostic related group, based on ICD-9 (and ICD-10 when available) codes (maximum of 30 days); voluntary refusal of care; return to originating facility or other location for follow on care.

#### **2.1.3.1. DoD and VA Memorandum of Understanding**

In response to the Public Law 97-174, a Memorandum of Understanding (MOU) was executed between the Secretary of Defense and the Administrator of the Veterans Administration (presently the Secretary of Veterans Affairs), specifying each agency's responsibilities<sup>3</sup>. The VA agreed to serve as the Secondary Support Center (SSC) for DoD and to furnish health services to armed forces on active duty on a higher priority than was done previously.

#### **2.1.3.2. Differences Between NDMS FCCs and Primary Receiving Center Centers**

Primary Receiving Centers (PRCs) are MTFs or VA Medical Centers (VAMCs) designated to receive sick and wounded military personnel returning from overseas armed conflict or national emergency. PRCs are designated in accordance with the VA-DoD Contingency Hospital System under 38 USC, Section 8110<sup>4</sup>. By contrast, Federal Coordinating Centers (FCCs) are MTFs or VA Medical Centers (VAMCs) designated to coordinate the reception of sick and injured patients resulting from either domestic disasters and emergencies or from military contingencies, and

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<sup>3</sup> MOU signed on November 2006 and amended in September 2013.

<sup>4</sup> <http://www.gpo.gov/fdsys/pkg/USCODE-2011-title38/pdf/USCODE-2011-title38-partVI-chap81-subchapl-sec8110.pdf>

the treatment of such patients in non-federal facilities in the reception area.

Note that the main difference between the FCC and the PRC mission:

The mission of an **FCC** is to coordinate the planning, training, exercising and operations of one or more NDMS PRAs. FCCs may receive, triage, stage, track and transport inpatients, ***affected by a disaster, to a participating NDMS medical facility capable of providing the required definitive care.*** The patients will more than likely not be eligible for care in a federal treatment facility, i.e., military, family members, or other beneficiaries.

The mission of a **PRC** is to ***receive and treat sick and wounded military personnel returning from armed conflict or national emergency.***

The following Table compares and contrasts the FCC and the PRC.

	<b>FCC</b>	<b>PRC</b>
<b>Scenario</b>	Disaster	Armed conflict or disaster
<b>Patients</b>	Civilians	Uniformed service members
<b>Funding</b>	Stafford Act, Economy Act	DoD
<b>Patient Reception Team</b>	Can be made up of Military Treatment Facility, VA and local civilian partners	Generally the MTF or VA staff
<b>Regulating</b>	USTRANSCOM Regulating and Command and Control Evacuation System (TRAC2ES)	TRAC2ES
<b>Destination Medical Facility</b>	Partner civilian NDMS member medical facilities	MTF or VA hospital

More information about the DoD/VA Contingency Plan can be found on the VAH Office of Emergency Management website at <http://www1.va.gov/emshg/page.cfm?pg=151>.

### 3. FCC Structure, Program Elements and Activation

This chapter will focus on the structure and program elements of the FCC as well as provide an overview of FCC alert and activation.

#### 3.1. Structure and Elements

- 3.1.1. **FCC** – A facility located in a metropolitan area of the United States, responsible for day-to-day coordination of planning and operations in one or more assigned geographic NDMS PRAs.
- 3.1.2. **PRA** – A geographic locale containing one or more airfields, bus stations, or airfields; adequate patient staging facilities; and adequate local patient transport assets to support patient reception and transport to local voluntary, pre-identified, non-federal, acute care hospitals capable of providing definitive care for victims of a domestic disaster, emergency, or military contingency.
- 3.1.3. **FCC Director** – A DoD, VA, or other principal staff member responsible for the management of an FCC and associated NDMS PRAs.
- 3.1.4. **FCC Coordinator** – A DoD, VA or other principal staff officer assigned to assist the FCC Director.
- 3.1.5. **Patient Reception Team (PRT)** – A multi-function group consisting mainly of clinical staff, but also including appropriate support from medical administration and communications personnel, logistics personnel, and people acting as litter bearers and drivers. The team may consist of military and/or civilian personnel, depending on the local FCC.
- 3.1.6. **NDMS Steering Committee** – A committee, established by the FCC, consisting of local hospital, medical, public health, public safety, emergency management, and emergency medical services officials, representatives of voluntary organizations, and elected officials organized in an NDMS PRA to assist in the preparation of local NDMS operating plans, planning, and execution of system exercises. It is also important to have ESF #6 representation on the steering committee to assist in planning for housing and feeding of non-medical attendants who may accompany NDMS patients.

### 3.2. FCC Alert and Activation

When a state determines the need to move patients from the disaster area, it requests assistance from FEMA. FEMA accepts the request, after validation from the regional Federal Health Official (HHS), and tasks the appropriate ESF. In this case, that ESF will be ESF #8, where HHS is the lead and coordinating federal agency.

For impending patient movement requirements, the HHS Emergency Management Group (EMG) convenes the ESF #8 Patient Movement Coordination Cell (PMCC). The PMCC is composed of a representative(s) from the NDMS patient movement partners (e.g., FCC AEMs, state health departments, Regional Emergency Coordinators (REC), SAT staff, interagency partners, etc.) during patient movement and reception planning and operations involving FCCs. The PMCC coordinates and integrates NDMS operational planning, alerts, activations, and de-activations in order to establish and maintain an NDMS patient movement common operating picture for HHS and the interagency partners. The PMCC will determine the frequency for contingency bed reporting requirements, which will typically be every 24-hours during patient movement activity.

When FCCs are required, the **PMCC will determine which FCCs are to be alerted** and eventually activated. The PMCC will notify the VA and DoD FCC Program Managers in writing (email or ESF #8 Warning Order) of the selected FCCs, who in turn will inform the FCCs and their associated PRAs of the potential activation. NDMS will deploy NDMS response teams as applicable. The decision to alert/activate FCCs is a collective decision by the PMCC and done with full consultation with the RECs and involved states.

### 3.3. Mission Assignment Process

Upon federal, state, Tribal, territorial, or local request, a mission assignment (MA) is generated by FEMA. The MA will articulate which FCCs are to be activated, and will also include a funding citation and a signature authorizing funding. The MA will be transmitted to DoD and VA points of contact in the form of a Request for Assistance (RFA).

DoD Process: The Request for Assistance (RFA) comes to the DoD through the Secretary of Defense's (SECDEF) Executive Secretary (EXECSEC). The EXECSEC forwards the RFA (in the form of the FEMA MA) to the Office of the Assistant Secretary of Defense for Homeland Defense and America's Security Affairs (OASD(HD&ASA)) and the Joint Director of Military Support (JDOMS). The RFA/FEMA MA is forwarded to the SECDEF for approval. Upon the SECDEF's approval, JDOMS coordinates and forwards Execute Orders (EXORDs) and/or Operations Orders (OPORDs) to the applicable Combatant Commands (e.g., U.S. Northern, Pacific, or Southern Command) and/or to the military Services (i.e., Army, Navy and Air Force) as applicable, to direct activation of DoD assets such as DoD FCCs. The Combatant Command issues a Fragmentary Order (FRAGO) to the

standing EXORD for Defense Support of Civilian Authorities (DSCA) to alert and/or activate the DoD FCCs.

For an example of an MA to the DoD to activate an FCC, see Annex S. It is important to note that generally the MA will request capabilities to provide patient movement and reception and not necessarily to activate a specific FCC:

VA Process: The VA Undersecretary for Health (USH/VA) will activate VA FCCs once notified by HHS.

**NOTE:** For a more comprehensive explanation of NDMS activation, please refer to the NDMS CONOPS, dated August 2009.

### 3.4. FCC Activation Stages

#### 3.4.1. FCC Alerted

This status implies that should patient requirements dictate the need for NDMS beds, a PRA under management of this FCC could be among the next to receive patients, however, patients are currently NOT being regulated to this PRA. This status does not necessarily authorize reimbursement of FCC and/or PRA expenses incurred preparing for possible reception of patients. Ideally, FCCs will have at least a 24-hour notice of patient arrival.

In the case of DoD FCCs, the standing Chairman, Joint Chiefs of Staff EXORD delegates the authority to USNORTHCOM to place DoD FCCs on Prepare to Deploy Order (PTDO) for up to seven days. PTDO is equivalent to Alert for the FCC. When needed, USNORTHCOM will issue a FRAGO to the EXORD, which would include placing forces on PTDO.

In this Alert status, FCC Directors should:

- Validate the Alert Status with higher headquarters;
- Ensure state/local departments of health are informed of their FCC's selection;
- Conduct periodic bed reporting in accordance with GPMIC instructions;
- Maintain daily monitoring of TRAC2ES;
- Establish communications with all PRT leaders, GPMIC, NDMS partner medical facilities, and other elements involved with FCC operations;
- Validate PRAs throughput, i.e., ability to receive, triage, and distribute patients to member medical facilities.

### 3.4.2. FCC Activated

This status implies that FCC reimbursement for all patient reception activities (i.e., establishing the FCC for patient movement, treatment, tracking, and discharge activities) is authorized. It signifies that patients are to be regulated, or have been regulated to a PRA under management of this FCC. Patients can be expected to arrive within 24 hours.

In the case of the DoD FCCs, when it is imminent that the alerted FCCs will receive patients, USNORTHCOM would issue another FRAGO to the EXORD, which would include activation of named FCCs.

In this status, responsibilities of the FCC Directors include:

- Validate the activation status with higher headquarters;
- **Ensure state/local departments of health are informed of their FCC's activation;**
- Establish communications with GPMIC;
- Continually monitor TRAC2ES to determine arrival time(s) and medical condition of patients;
- Conduct periodic TRAC2ES bed and throughput reporting in accordance with GPMIC instructions (e.g., daily);
- Pre-position required equipment and a minimum cadre of personnel at the PRA;
- Ensure PRT members are notified and standing by to assemble at the PRA.
- Ensure ground transportation assets are prepared to transport patients;
- Ensure receiving member medical facilities are prepared to receive patients;
- Ensure other support elements are prepared to assemble at the PRA in accordance with the FCC/FCC/PRA Plan;
- Track all expenses;
- Provide situation reports (SITREPS) as requested, ensuring Health Insurance Portability and Accountability Act (HIPAA) compliance;
- Capture after action review (AAR) items;

Prior to the arrival of patients, the FCC Director activates the FCC/PRA Plan (See **Annex D**), and ensures that local triage teams, litter bearers, administrative teams, patient staging teams, and transportation assets are alerted. Upon the arrival of patients, the FCC Coordinator notifies the TPMRC-A. The FCC Coordinator, or other designated agency or individual, will then further regulate and coordinate the movement of the patients to local NDMS participating medical facilities.

### **3.5. Patient Regulation to the FCC**

Once patient evacuation has been determined to be necessary and an ESF #8 MA or Sub-Tasking has been issued, the TPMRC-A will issue bed-reporting instructions to those FCCs alerted or activated for patient reception. The TPMRC-A will receive medical information about patients and then determine medical equipment needed for ground or air transport.

The TPMRC-A will regulate patients from the Aerial Port of Embarkation (APOE), located within the disaster site, to the Aerial Port of Debarkation (APOD), located within the PRA.

TPMRC-A is not responsible for coordinating transport of patients to State Regional Evacuation Points (REPs). In the disaster area, the TPMRC-A will coordinate movement of patients out of REPs. If forward movement will be required via air, the TPMRC-A will regulate patients from the APOE, co-located with the REPs, to the APOD near the FCC's PRA airport(s). Specific patient movement and reception missions are coordinated directly between the TPMRC-A and the FCC. Close monitoring on TRAC2ES by the FCC is extremely important upon alert and activation.

**(NOTE:** This process does not exclude the possibility that the requirement for immediate evacuation could be so great that the scope of patient movement information collected and furnished could be minimal.)

Local patient reception and distribution operations are then coordinated directly between the FCC and the local participating NDMS member medical facilities, as well as other local support organizations required to support patient reception operations.

## 4. FCC Operations

### 4.1. Introduction

NDMS FCCs have critical roles to play in the successful organization and operation of the system in the local community or communities for which they have been assigned responsibility. These critical roles are summarized as follows:

- Understand Roles and Responsibilities (Annex A);
- Facilitate/Maintain Medical Facility Enrollment and Community Relations (Annex B);
- Collect/Report Medical Facility Bed Availability Data (Annex C);
- Coordinate NDMS Patient Reception Area Plans (Annex D);
- Coordinate Training and Exercises (Annex E);
- Coordinate Local NDMS Patient Reception Operations (Annex F);
- Coordinate Discharge and Return of Patients (Annex G);
- Coordinate Financial Management (Annex H);
- Coordinate Logistical Support (Annex I);
- Facilitate Communications (Annex J);
- Coordinate Critical Information Requirements (Annex K);
- Coordinate Public Affairs (Annex L).

### 4.2. Understand the FCC Director/Coordinator Roles and Responsibilities (See Annex A)

Although all NDMS FCCs are coordinated by either MTFs or VAMCs, the role of the NDMS FCC transcends those affiliations. In many ways the NDMS FCC represents the federal government, in working with the civilian medical community as well as state, local and/or Tribal authorities.

The FCC Director has overall control and responsibility for this program. The FCC Director appoints and/or identifies the FCC Coordinator who is responsible for the day-to-day operation and readiness of this program. They should approach their communities and geographic PRAs as local agents for the broad federal coalition that comprises the NDMS.

Annex A provides a comprehensive list of roles and responsibilities for the FCC Director and Coordinator as they pertain to developing PRA plans, training and exercising, and conducting FCC operations.

### **4.3. Facilitate / Maintain Medical Facility Enrollment and Community Support (see Annex B)**

FCC Coordinators are the essential link in obtaining and maintaining community participation in the NDMS. As such, they must be sensitive and responsive to the unique economic, governmental, organizational, and political characteristics of their local communities and tailor/adapt briefings presentations, meeting sites, and protocol considerations accordingly.

The FCC seeks voluntary commitments of beds from non-federal medical facilities accredited by the Joint Commission (JC), DNV Healthcare Inc., Healthcare Facilities Accreditation Program (HEAP), the American Osteopathic Association (AOA), or other accrediting organization as directed by NDMS.

FCC Coordinators are encouraged, with the advance consultation and concurrence of the participating medical facility Administrator or Chief Executive Officer, to obtain news media coverage of the agreement signing ceremony.

### **4.4. Solicit and Organize Community Participation**

Each FCC should have a community-based NDMS Steering Committee. While federally coordinated, the NDMS is built on local, regional, and state resources, emergency planning and structures. It is vitally important to actively involve State and local health associations and emergency management agencies, hospital councils, medical societies, and local Emergency Medical Services (EMS) in planning for patient reception operations. The FCC Coordinator should collaborate with local, regional, and state disaster emergency services agencies, hospitals, and disaster medical and public health services officers. Also influential in local disaster services are public safety officials, including both police and fire services. The FCC Coordinator should maintain an up-to-date list of resources and participants in the NDMS, with means of contact during and after normal working hours.

Major metropolitan areas of the nation are served by emergency medical transport services in their jurisdictions, and many have regional coordinating networks and disaster management responsibilities that parallel those of the NDMS. In areas not served by regional EMS agencies, local or district public health officers may be responsible for disaster medical services.

Public sector emergency and disaster services personnel have many organizations of their own, notably disaster councils, emergency services associations, rescue and paramedic associations, and associations of communications officers. Where such organizations are based in the NDMS area, their support should be sought.

The academic community also has several potential sources of support. Academic medical centers frequently serve as trauma centers for the region. Prominent faculty members may be recognized as community leaders in emergency medical care. Many such medical centers have organized response teams for local disasters and might be favorably inclined to affiliate with the NDMS. Community colleges may

possess emergency medical technician training programs (basic and advanced), and their faculties may also be involved in support of local disaster response.

The military reserve community is another potential source of support. The endorsement of prominent Reservists and National Guardsman who occupy positions of influence in the civil community may be helpful. Many of these are leaders of the local health care community. It is important to note that National Guard units may not be included in the PRA reception plans without first establishing a memorandum of agreement with the State Adjutant General.

Additional resource support may be sought from local businesses that may be directly involved in disaster response assets, such as pharmaceuticals, medical/surgical supplies, medical gases, uniforms, communications equipment, EMS equipment and vehicles. Local sporting goods stores, Army-Navy stores, or large chain stores may also be willing and able to support various aspects of the NDMS.

Several voluntary agencies exist principally to serve emergency needs. Among these is the American Red Cross whose chapters span the nation. In many areas, other agencies such as the Salvation Army and other faith based organizations, such as Saint Vincent DePaul Society are also active in disaster relief and should be considered as potential supporters of the NDMS.

Early in the organizational and planning process, the assistance of these voluntary agencies will mainly be in the form of identifying leaders of the community emergency response network and other important contacts who should be educated about the NDMS. Later, as planning progresses, such supporters can be enlisted to assist in the promotion of the program, enrolling institutional participants, recruiting capable sponsorship, identifying leadership for NDMS response teams, and training of hospital personnel and response team members.

#### **4.5. Collect/Report Medical Facility Bed Availability (see Annex C)**

When activated, FCCs receive specific instructions directly from Service or VA channels on the reporting of beds immediately available. Upon receipt of instructions, the FCC Coordinator collects immediate bed availability data from each participating NDMS medical facility and reports to GPMIC using the established form provided in **Annex C**. The FCC may also have to plan for the use of local or state EMS electronic reporting systems.

#### **4.6. Coordinate Patient Reception Area Plans (see Annex D)**

The FCC Director is responsible for ensuring the development, exercise, and evaluation of local PRA plans. Each PRA under the management of the FCC should have a separate FCC/PRA Plan, and these should be coordinated in order to evaluate overlapping requirements for limited resources. Each PRA plan should address, as a minimum, the following areas:

- Concept of Operations;

- PRA Alert and Activation;
- FCC operations;
- Bed Availability Reporting;
- Medical Regulating;
- Patient Reception and Staging;
- Transportation;
- Patient Administration;
- Patient Movement Items Management;
- Training and Exercises;
- Financial Claims Processing;
- Public Relations and Media Information;
- Communications.

#### **4.7. Coordinate Training and Exercises (see Annex E)**

The FCC Director ensures that FCC staff, FCC Steering Committee, as well as applicable federal, state, Tribal, territorial, and local government and private sector personnel receive appropriate training in the operation of the FCC and PRA(s). The FCC Coordinator ensures that representatives of the participating NDMS member medical facilities, as well as representatives of local emergency management agencies, EMS agencies, public safety, police and fire services, are provided annual orientation to the PRA plan. The FCC Coordinator ensures that FCC staff and other individuals designated to augment the FCC staff annually receive detailed education and training on their specific duties. Although some FCCs will conduct comprehensive exercises more frequently, FCC Directors should conduct a full-scale patient reception exercise at least once every three years.

#### **4.8. Coordinate Local Patient Reception Operations (see Annex F)**

#### **4.9. Coordinate Discharge and Return of Patients (see Annex G)**

HHS has the overall responsibility to return NDMS patients to their point of origin or other destinations, as authorized. The FCC may be called upon to assist as a liaison between the NDMS medical facility and the HHS SAT representative. Transportation will be provided under the provisions of the original HHS MA or sub-tasking, or as directed by HHS unless covered by the patient's health care insurer, or the patient does not accept transportation arranged by the federal government.

Patients requiring continuing care are returned as soon as appropriate care is available in the area from which they were evacuated and when the patient can be transported safely.

**NOTE:** The return of patients includes their non-medical attendants and/or service animals that may have accompanied the patient out of the disaster area. Patients requiring continuing health care or observation must be accepted by a physician, at their home location, prior to being returned. Patients not requiring medical care en route will be provided the most appropriate transportation arranged by the federal government.

The SAT is responsible for arranging the safe return of the patient remains. However, the FCC may be called upon to assist in arranging for the return of the remains of patients who expire during their NDMS-sponsored care to the custody of family or another legally responsible person.

Upon release of patients from the NDMS responsibility, any records of patients' care, and/or disposition of remains that may be held by the FCC are sent to the NDMS at the following address:

NDMS Chief Medical Officer  
ASPR – OEM / NDMS  
200 C Street, SW  
Washington, DC 20024

#### **4.10. Coordinate Financial Management (see Annex H)**

FCC financial management consists of the following:

- Developing budgets and coordinating fiscal information to support FCC training, equipment and exercises.
- Tracking expenditures during operations.
- Billing the appropriate authority for reimbursement of expenditures.
- Providing liaison service between HHS and the NDMS member medical facilities to ensure financial reimbursement for care, if required.

#### **4.11. Coordinate Logistical Support (See Annex I)**

The FCC Director will be responsible for consolidating the administrative cost and expenditures for all logistical support during activation. This would include PRA support supplies, patient support equipment, pharmaceutical requirements, procurement and delivery costs, and all such direct and indirect costs associated in the logistical support of the FCC and the NDMS PRA. There needs to be some process to capture, track, and validate all expenditures for supplies, equipment, and services associated with the PRA. Future reimbursements will be dependent upon this process.

#### **4.12. Facilitate Communications (see Annex J)**

The FCC Coordinator is responsible for planning, testing, and coordinating communication procedures, processes, and equipment to support local patient reception and distribution operations. Planning must include backup processes in the event that primary systems are disabled by the disaster/event. The role of volunteers should not be overlooked in the area of communications. Local HAM and MARS radio operators can provide an invaluable service and often have existing communications equipment in place or available for disaster response.

#### **4.13. Coordinate Critical Information Requirements (See Annex K)**

The FCC may be called upon to provide information updates to various agencies to include their higher command, the NDMS, the HHS Incident Response Coordination Team (IRCT), HHS Regional Emergency Coordinators (RECs), DoD, etc. Annex K provides the types of questions the FCC should be able to answer before, during, and following operations.

#### **4.14. Coordinate Public Affairs (See Annex L)**

The activation of an FCC is a newsworthy event. FCC Directors and coordinators must be prepared for media presence and inquiries. Annex L provides some basic guidelines to assist.

#### **4.15. List of Remaining Annexes:**

Annex M: Acronyms and Definitions

Annex N: Points of Contact List

Annex O: References

Annex P: Map of Current FCCs

Annex Q: FCC Self-Assessment

Annex R: Exercise Guide

Annex S: Mission Assignment Example

# **Annex A: Summary of Federal Coordinating Center (FCC) Director and FCC Coordinator Duties**

## **Purpose:**

The purpose of this annex is to summarize the duties, for both the FCC Director (or his/her designee) and the FCC Coordinator, as they pertain to developing plans, conducting training and assessments, and engaging in patient reception operations.

## **1. FCC Director Roles and Responsibilities**

The FCC Coordinator is the field representative for the FCC and is responsible for coordinating local plans, exercises, and other functional activities to ensure the day-to-day operational readiness of the local FCC program. This includes recruiting and maintaining the standard NDMS Provider MOA appendix to this annex with area medical facilities, developing and maintaining a collaborative relationship with local or regional EMS organizations, government agencies, and other organizations appropriate for involvement in NDMS operations.

### **a. Plan**

- Appoint and/or identify the FCC Coordinator responsible for developing the FCC/FCC/PRA Plan, conducting the day-to-day operations and ensuring FCC readiness (See Annex Q for FCC Self-Assessment checklist);
- Ensure the establishment and maintenance of the support of area medical facilities, local health associations, EMS, emergency management agencies, hospital councils, medical societies, volunteer organizations, public safety, and other government agencies, within the State or local area.

### **b. Train and Assess**

- Ensure the development, exercise and evaluation of local FCC/FCC/PRA Plans;
- Ensure a full-scale exercise at least once every two years that tests the FCC/PRA plan of the FCC and the supporting partners.
- Ensure an annual exercise, during non-full-scale exercise years, to test selected tasks of the FCC/PRA plan;
- Ensure that FCC staff, as well as applicable federal, state, and local government and private sector personnel receive appropriate orientation or training in the operation of the FCC;
- Conduct an After Action Review/Report (AAR) at the conclusion of the FCC full-scale exercise.

### **c. Operate**

- Activate local FCC/PRA plans as indicated in activation notifications;
- Ensure that bed availability reporting, as well as reception, sorting, staging, transportation and hospitalization of arriving patients occurs efficiently;
- Provide administrative support for patient control and proper patient accounting.

## **2. FCC Coordinator Roles and Responsibilities**

### **a. Plan**

- Lay the groundwork by researching existing community emergency medical response plans, MOAs among local health care and/or EMS organizations, points of contact (POC) lists, bed reports, and exercise AARs;
- Develop the FCC/FCC/PRA Plan, conduct the day-to-day operations and ensure FCC readiness (ref: Annex Q: Self-Assessment);
- Identify and recruit local non-federal medical facilities for NDMS enrollment and participation;
- Study the FCC area of responsibility and identify potential primary and alternate locations that will serve as PRAs;
- Establish and maintain active participation of local support facilities/activities (e.g., local non-federal medical facilities, state and local health associations, EMS, emergency management agencies, hospitals councils, medical societies, public safety, police and fire services, and local Medical Reserve Corps);
- Establish and maintain NDMS Provider Memorandum of Agreement (MOA) for Definitive Medical Care, Attachment 1 to the NDMS Federal Partner's MOA. For DoD FCCs, copies of the Definitive Medical Care MOA will be forwarded to designated offices in accordance with DoD Directive (DoDD) 6010.22;
- Provide HHS/ASPR with contact information to NDMS member medical facilities in order to facilitate medical claims processing.
- Maintain an up-to-date list of local NDMS resources and contact information for participants;
- Identify primary and alternate airfields by GEO (geographic coordinates) code in coordination with USTRANSCOM. Coordinate utilization and memorandums of agreement (with the airfield managers) as necessary;

- Manage/coordinate FCC communication procedures, processes and equipment to support local patient reception and distribution operations;
  - Identify local emergency services communications or tracking systems and ensure integration into the FCC operations;
  - Develop Public Awareness/Affairs Plan to publicize FCC events and local partnerships;
  - Ensure that a PRT is developed for each PRA, and that each PRT remains viable through training and exercises;
  - Ensure logistical planning and support to equip the PRA and PRT requirements (ref: Annex D);
  - Ensure a tracking mechanism is in place to capture logistical expenses associated with an FCC alert and activation;
  - Ensure support contracts for ancillary services are drafted, coordinated, validated and reviewed annually;
  - Ensure that adequate workspace and network connectivity are available for a JPATS team;
  - Ensure that the FCC Patient Admin Section is trained on JPATS and that the FCC Patient Admin Section and JPATS teams are working in coordination with each other's mission to track patients.
  - Provides the GPMIC with primary and alternate points of contact to ensure 24-hour availability;
  - Ensures FCC maintains accounts in TRAC2ES and conducts bed reports in accordance with instructions;
  - Alerts member medical facilities when the PRA is alerted or activated;
  - Canvasses member medical facilities for the ability to participate in bed reporting and patient reception.
- NOTE:** It is understood that local conditions may preclude the participation of a member medical facility in a particular NDMS contingency;
- Receives bed-reporting instructions from GPMIC through Service or VA channels, as appropriate;
  - Reports PRA bed availability totals to the GPMIC in accordance with instructions.

## **b. Train and Assess**

- Ensure that representatives of participating NDMS partner medical facilities (through the NDMS Steering Committee), as well as representatives of local emergency management agencies, EMS, public safety, police, and fire services, are provided annual orientation to the PRA plan;
- Ensure that FCC staff and other individuals designated to augment the FCC staff annually receive detailed education and training on their specific duties;
- Develop, exercise and evaluate local FCC/PRA Plans;
- Identify PRA roles and responsibilities for participating State and local health associations, EMS, emergency management agencies, hospital councils, medical societies, public safety, police and fire services, and local Medical Reserve Corps (MRC);
- Participate in nationwide periodic NDMS and ad-hoc local bed reporting exercises. Ensure the FCC maintains active TRAC2ES and Joint Patient Assessment Tracking System accounts;
- Ensure local medical facilities are trained and notified of bed reporting requirements;
- Provides training to member medical facilities on the materials in this annex. This includes providing a means by which member medical facilities can report available beds to their local FCC in a timely manner;
- Participates in nationwide NDMS and ad-hoc local bed reporting exercises;
- Conduct FCC Self-Assessment annually utilizing Annex J. Notify higher headquarters within 24-48 hours if the FCC mission capability has changed significantly.

## **c. Operate**

- Collect bed availability data from each participating non-federal medical facility and report to the TPMRC-A as directed;
- Ensure that open communications and liaison are established with GPMIC for the receipt of regulating decisions, evacuation mission information and patient medical data, as applicable;
- Provide GPMIC with primary and alternate points of contact to ensure 24-hour availability, as needed. Notify the FCC Director, the PRT, local EMS coordinators, all affected medical facilities, higher headquarters, and all

other applicable agencies and individuals when PRA alert status has been received;

- Notify the FCC Director, the PRT, local EMS coordinators, all affected medical facilities, higher headquarters, and all other applicable agencies and individuals are notified when activation has occurred;
- Notify the FCC Director, the PRT, local EMS coordinators, all affected medical facilities, higher headquarters, and all other applicable agencies and individuals are notified when patients are regulated to the FCC;
- Ensure the PRA tracks patient movement as requested by local and federal agencies and patient administrative personnel are trained as necessary in all applicable patient tracking systems. The federal tool that will be used to track patients will be JPATS and the overall responsible party for tracking patients at the PRA will be the FCC Coordinator who may delegate that tracking functionality to the JPATS team (when available);
- Assist federal patient movement teams as needed to ensure accurate patient tracking data;
- Once Alerted, establish and maintain procedures to obtain vehicles and personnel within 6 hours to transport patients in the PRA. Once activated the FCC and PRA must be operational and capable to receive patients within 6 hours. Arrange local transportation to move patients from reception sites onward to local participating NDMS member medical facilities;
- The administrative accountability for NDMS patients remains with the FCC. If available the JPATS Team will be responsible to entering patient tracking data into the JPATS system;
- DHHS is responsible for providing disaster case management and patient return discharge planning;
- Maintain the location and status of each patient receiving definitive care in the PRA;
- Ensure patient accountability and destination is updated in patient movement tracking systems at the local, State, and federal level as dictated by local policy;
- Provide referral assistance to the HHS Service Access Team, which is responsible for repatriation as needed to coordinate the return of NDMS patients who require en route medical care, as directed by your organization;

- Provide liaison assistance to HHS Service Access Teams or their designated representative by providing contact information to participating NDMS member medical facilities to facilitate medical claims processing, as required;
- Collect expenditures for support services (such as ambulance service) and provide them through their chains of command.

## **Annex B: Facilitate and Maintain Medical Facility Enrollment and Community Support**

### **Purpose:**

The purpose of this annex is to assist the FCC in recruiting and maintaining the support of hospitals and area agencies in PRAs.

### **1. Responsibilities**

The FCC Director is responsible for encouraging area medical facilities' participation in the NDMS, and for establishing and maintaining the support of government agencies, volunteer organizations, and others within the PRA.

### **2. Procedures**

The FCC Coordinator seeks voluntary commitments of beds from non-federal accredited medical facilities.

The FCC enrollment effort should target local general acute care inpatient medical facilities, although other bedded medical facilities should be considered, especially if they express a desire to participate or possess key specialty beds. In general, NDMS participating medical facilities should be within one hour or less or 50-mile radius of the PRA. Medical facilities beyond a 50-mile radius may be accepted for enrollment at the discretion of the FCC Director.

A medical facility volunteering to participate in the NDMS completes the NDMS Definitive Medical Care MOA, Attachment 1 to the NDMS Federal Partner's MOA. The MOA should be signed by the Chief Executive Officer (CEO) of the participating NDMS medical facility, and the FCC Director as the local representative of the NDMS. The FCC Director may delegate this authority in writing to the FCC Coordinator. This agreement should be prepared in two copies; one for the NDMS files of the FCC, and one for the participating medical facility. MOAs have a formal expiration date of five years after they have been signed, and should be reviewed annually to ensure the signatories are current.

As part of the MOA, participating medical facilities agree to participate in training and exercises of the NDMS. Various accrediting bodies require medical facilities offering emergency services or are community-designated disaster receiving stations conduct at least one patient influx exercise per year. NDMS drills and exercises can be an ideal method of satisfying this requirement.

### **3. Program Development**

Although the NDMS is a federally coordinated program, FCC programs are built on the voluntary commitment of the local health care community.

FCC Coordinators should:

- Identify and recruit local non-federal medical facilities for NDMS enrollment and participation;
- Draft an information package to provide to prospective enrolling medical facilities, including an introductory letter from the FCC Director, a copy of the FCC Guide, and an NDMS Provider MOA ready for signature.

FCCs should schedule introductory meetings, as appropriate, and provide an overview of the NDMS to potential participating facilities. The FCC Coordinator must be prepared to describe to a potential participant the reason why their support and participation are critical to the success of the program, emphasizing mutual support locally, as well as nationally, and goodwill in the community.

FCC Coordinators are encouraged, with the advance consultation and concurrence of the participating medical facilities administrator or CEO, to obtain news media coverage of the MOA signing ceremony.

The success of an FCC program also requires the active participation of numerous organizations that volunteer their support for the NDMS. Local agencies and organizations that should be considered for participation in the FCC program include:

- Medical facilities and medical associations;
- Local, county, regional and State emergency management agencies;
- Local, county, and State agencies with ESF #8 (Health and Medical Services) responsibilities;
- State Adjutant General and local Air National Guard units, Army National Guard units and/or other State militia;
- Emergency medical services agencies;
- Radio Amateur Communications for Emergency Services (RACES) and Amateur Radio Emergency Services (ARES) organizations;
- Non-Governmental Organizations (American Red Cross, Salvation Army, et. al.);
- Airport and port authorities;
- Area transportation agencies;
- Local military or veterans' organizations;
- Volunteer organizations;
- Medical/education training institutions;
- Businesses;

- Others, as appropriate.

#### 4. Community Relations

FCC Coordinators may employ various methods to establish and maintain a mutually beneficial relationship with the communities in which they operate. By taking an active interest in the well-being of its community, the FCC gains a number of long-term benefits in terms of community support, loyalty, and good will. The FCC Coordinator should utilize existing relationships within the community to the maximum extent possible. Doing so will avoid duplication of effort, increase coordination among the involved parties, and engender positive visibility for the NDMS program. Examples of organizations that may already exist within the community include:

- **NDMS Steering Committee** – A committee, established by the FCC, consisting of local medical facility, medical, public health, public safety, emergency management and emergency medical services officials, ESF #6 representatives, representatives of voluntary organizations, and elected officials organized in an NDMS PRA to assist in the preparation of local NDMS operating plans, planning, and execution of system exercises.
- **Local Emergency Planning Committee (LEPC)** – Originally designed to plan for chemical hazards, LEPCs now include planning for a variety of disasters that may affect the community, i.e., "All-Hazards" planning.
- **Metropolitan Medical Response System (MMRS)** – Assists highly populated jurisdictions to develop plans, conduct training and exercises, and acquire pharmaceuticals and personal protective equipment, to achieve the enhanced capability necessary to respond to a mass casualty event caused by a weapons of mass destruction terrorist act. Memberships typically include representatives from emergency management, medical, public health, law enforcement, fire, and EMS.
- **Local hospital council/State hospital associations** – In many communities, these groups have an emergency management sub-council or association and can assist the FCC Coordinator with the local NDMS program from the medical facility standpoint.
- **State-wide Bioterrorism Advisory Committees** – include representatives from (included but not limited to):
  - State and local health departments and government;
  - Emergency Management Agencies;
  - EMS;
  - Office of Rural Health;

- Police, fire department and emergency rescue workers and occupational health workers;
- Other health care providers, including university, academic medical and public health;
- Community health centers;
- Red Cross and other voluntary organizations;
- The hospital community (to include VAMC and military hospitals).
- **State-wide Hospital Bio-preparedness Planning Committee** – Affiliated with the State-wide bioterrorism advisory committee) whose composition includes representation from (but not limited to):
  - Emergency Medical Services;
  - Emergency Management Agencies;
  - Office of Rural Health;
  - State hospital associations;
  - Veterans Affairs and military hospitals;
  - Primary care associations.

Meetings of the groups described above provide the FCC Coordinator with the opportunity to interact with representatives of other organizations, provide training regarding the local NDMS plan, and proactively promote the NDMS program as a whole.

**NOTE:** FCC Coordinators are encouraged to utilize existing committees/relationships to accomplish the coordination.

## Annex C: Collect and Report Medical Facility Bed Availability

### Purpose:

The purpose of this annex is to assist the FCC in collecting and reporting medical facility bed availability and throughput for use by the NDMS, through the GPMIC, Scott Air Force Base, Illinois, during NDMS activities.

### 1. Definitions

**Available Beds** – It is recognized that NDMS medical facility bed availability is dynamic, often changing hour by hour to meet the demands for local health care services. NDMS member medical facilities will report the number of beds that they will voluntarily commit to the reception of NDMS patients at the time of the FCC request. The numbers of beds reported are those to which the TPMRC-A can immediately regulate patients. During FCC alert or activation, the FCC may require frequent updates to NDMS medical facility bed availability reports to ensure currency and accuracy of bed capacity and capability. Available beds must include supporting space, equipment, medical material, ancillary and support services and staff to operate under contingency circumstances. Excluded are transient patient beds, bassinets, incubators, and labor and recovery beds. Beds are reported in categories as defined by NDMS and as instructed by GPMIC.

**Bed Report** – The Bed Report is the FCC's submission to GPMIC of all NDMS facilities' capacity (the number of patients that a facility can accommodate at a given point in time) within a PRA (exercise or real time) to receive, admit, and treat patients evacuated as a result of NDMS operations. GPMIC will relay bed reports to HHS Fusion Center ([fusion@hhs.gov](mailto:fusion@hhs.gov)) when complete.

- **Steady State Planning Requirements** – GPMIC requires a bi-monthly report. The schedule is published annually by the NDMS Directorate Staff. FCCs will submit the reports as required to GPMIC. The NDMS Bed Report Rollup report is maintained on the United States Northern Command (USNORTHCOM) Surgeon Medical Operations Cell website: <https://operations.noradnorthcom.mil/default.aspx>. You must have an account and CAC to access this.
- **Contingency Bed-Reporting Requirements** – Bed reports will be required every twenty-four (24) during contingencies as directed by the interagency PMCC. FCCs will submit the reports as required by the interagency PMCC.

**Capability** – The maximum number of patients a facility can accommodate.

**Category** – One of the specific areas of medical care used to identify the nature of a patient's illness/injury as well as to identify the capability/capacity of a

medical facility. The seven (7) contingency categories (as well as their TRAC2ES codes in parentheses) are:

- **Critical Care (CC)** – Adult patients requiring sophisticated intervention to restore or maintain life processes to their dynamic equilibrium. This involves the requirement to provide immediate and/or continuous attention and monitoring using specialized facilities, equipment, and personnel. Critical care beds are generally defined as those in licensed intensive care units.
- **Medical/Surgery (MM-SS)** – Patients having, or suspected of having, medical illness or disorders, as well as patients having, or suspected of having, diseases or injuries normally treated by surgery, not coming within the purview of a more specific medical specialty. Medical/surgical beds are generally defined as those licensed, certified, or otherwise authorized, with adequate space, equipment, medical materiel and ancillary support services, and staff to operate under normal circumstances. Excluded are transient patient beds, bassinets, incubators, labor beds, and recovery beds.
- **Psychiatry (MP)** – Patients who require specialized psychiatric care in a medical treatment facility, including patients with disorders defined by the American Psychiatric Association as severe mental illness (schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, or autism). Psychiatric beds are generally defined as those supported by a licensed psychiatrist, or a licensed registered nurse, social worker, psychologist or professional counselor when those services are part of a treatment plan authorized by a licensed psychiatrist.
- **Burns (SBN)** – Patients having burn injuries meeting the American Burn Association's (ABA) burn unit referral criteria, including (but not limited to) partial thickness burns of 10% or more of the total body surface; all patients with third-degree burns of 10% or more of the total body surface; or patients with significant burns involving the face, hands, feet, genitalia, perineum or major joints. Burn beds are generally defined as those associated with burn centers on the joint ABA and American College of Surgeons (ACS) verification list.
- **Pediatrics (MC)** – Patients having, or suspected of having, diseases or injuries requiring the services of pediatric health care providers. Pediatric beds are generally defined as those supported by a licensed pediatrician.
- **Pediatric ICU (PICU)** – PICU patients are those critically ill or injured, including those requiring ventilator support, aged 17 years or younger. PICU beds are generally defined as those that can support critically ill or injured patients, including those requiring ventilator support, aged 17 years or younger.

- **Negative pressure / isolation (NPU)** – NPU patients are those requiring a separate room or area provided with negative airflow and respiratory isolation. NPU beds are generally defined as those providing negative airflow and respiratory isolation.

**Medical Regulating** – Medical regulating is a casualty management system designed to coordinate the movement of patients from site of injury or onset of disease through successive roles of medical care to an appropriate MTF. During this process GPMIC/TPMRC-A matches NDMS patients to a designated FCC PRA based upon bed availability reporting. In turn, the FCC matches each NDMS patients with a bed in an NDMS partner medical facility that has the necessary health service support capabilities.

**Patient Movement Coordination Cell (PMCC)** – For impending patient movement requirements, the HHS Emergency Management Group (EMG) convenes the ESF #8 Patient Movement Coordination Cell (PMCC). The PMCC is composed of a representative(s) from the NDMS patient movement partners (e.g., FCC AEMs, state health departments, Regional Emergency Coordinators (REC), SAT staff, interagency partners, etc.) during patient movement and reception planning and operations involving FCCs. The PMCC coordinates and integrates NDMS operational planning, alerts, activations, and de-activations in order to establish and maintain an NDMS patient movement common operating picture for HHS and the interagency partners.

When FCCs are required, the **PMCC will determine which FCCs are to be alerted** and eventually activated. The PMCC will notify the VA and DoD FCC Program Managers in writing (email or ESF #8 Warning Order) of the selected FCCs, who in turn will inform the FCCs and their associated PRAs of the potential activation. NDMS will deploy NDMS response teams as applicable. The decision to alert/activate FCCs is a collective decision by the PMCC and done with full consultation with the RECs and involved states.

**Throughput** – The maximum number of patients that can be received at the NDMS PRA, off-loaded, staged, triaged, transported, and admitted to the destination medical facility (or participating NDMS medical facility) within any 24-hour period. This is an estimate derived from various considerations such as reception site and local transportation limitations, personnel limitations for patient reception, staging and transport, as well as any other relevant factors.

## 2. Responsibilities

The FCC Director ensures accurate bed availability and throughput reporting to the GPMIC. To accomplish this, the FCC Coordinator:

- Provides training to member medical facilities on the materials in this annex. This includes providing a means by which member medical facilities can report available beds to their local FCC in a timely manner.

- Provides the GPMIC with primary and alternate points of contact to ensure 24-hour availability.
- Ensures FCC maintains accounts in TRAC2ES and conducts bed reports in accordance with instructions
- Participates in nationwide NDMS and ad-hoc local bed reporting exercises.
- Alerts member medical facilities when the PRA is alerted or activated.
- Canvasses member medical facilities for the ability to participate in bed reporting and patient reception.

**NOTE:** It is understood that local conditions may preclude the participation of a member medical facility in a particular NDMS contingency.

- Receives bed-reporting instructions from GPMIC through Service or VA channels, as appropriate.
- Reports PRA bed availability totals to the GPMIC in accordance with instructions.

### 3. Non-federal Bed Availability

As written in the NDMS Definitive Medical Care MOA, non-federal medical facilities agree to report the number of beds available, upon request. It is recognized that actual bed availability will vary at the time alert or activation.

Another factor that may determine bed availability is the number of medical staff with duplicate privileges at other medical facilities in the area or with Armed Forces Reserve or National Guard. The number of staff having other commitments may affect the number of available beds; particularly during NDMS activation in support of military contingency operations. Therefore, it is advisable that local participating medical facilities factor in the potential loss of these medical staff.

### 4. Bed Reporting Procedures

GPMIC maintains a database of DoD, VA, and non-federal participating NDMS medical facility capacity available to support NDMS alert and activation. In response to NDMS events, the Patient Movement Coordination Cell will solicit bed reports to facilitate medical regulating as the situation dictates.

When alerted or activated, FCCs will receive specific instructions from the DoD or VA channels for reporting of throughput and bed availability. The instructions typically include the time period during which reports are to be sent, the format to be followed, the mode of reporting, and points of contact. Upon receipt of instructions, the FCC Coordinator collects throughput and bed availability data

from each participating NDMS facility, consolidates the information for the PRA and reports to GPMIC. Reports are submitted to GPMIC via TRAC2ES. If TRAC2ES is unavailable, bed reports may be submitted by voice, fax, or e-mail using formats provided by GPMIC.

In preparing to report bed availability to GPMIC, FCCs will use the template located at Appendix A to this annex. FCCs with multiple PRAs must ensure that bed reports are submitted separately for each PRA.

## **5. Determination of Bed Availability**

When GPMIC regulates patients to a PRA, the patients might not arrive immediately. It is possible that subsequent bed reports are submitted before previously regulated patients arrive. The FCC Coordinator will account for patients regulated but not received in order to not overstate the number of beds available. The FCC Coordinator should consider coordinating patients distribution to a particular medical facility prior to actual patient arrival and reception.

## **6. Determination of FCC Throughput**

In addition to the total count of beds in the various categories, consideration must also be given to the “throughput” ability of the PRA. Although throughput is an estimate, it is critical to planning for patient movement to a PRA. For instance, it is not logical to regulate 250 patients to a PRA if only 100 patients can be received, triaged, transported, and admitted to participating medical facilities in a timely manner. That is not to say that only 100 beds should be reported. Both figures (bed availability and throughput) are important to GPMIC’s ability to plan effectively.

Factors that should be considered that effect throughput include:

### **1. Determination of FCC Throughput**

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Factors to be considered that effect throughput include, but are not limited to:

- Type, quantity and availability of ground transport resources.
- Patient reception team staffing, to include JPATS team if requested/assigned.

- Medical facility surge tolerance; will vary by facility. Patient processing time and available resources may limit the amount of patients a facility can accept in a short time-frame, regardless of available beds.
- Airfield operations, to include hours of operation, ramp/hanger availability, aircraft servicing and access control.
- Ground operations intervals: How long will it take to deplane, transport patients to participating medical facilities and reset for next arriving flight? This is an important detail when factoring for sustained operations (for example, refueling vehicles, feeding your teams and restocking all apply to this factor).

## Annex D: Patient Reception Area Plans

### Purpose:

The purpose of this annex is to assist FCC Directors and Coordinators in developing and managing patient reception plans and activities for assigned PRAs.

### Responsibilities:

The FCC Director is responsible to ensure the development, exercise, and evaluation of local PRA plans and PRT plans.

The FCC Coordinator is responsible to develop, train and equip a PRT for each PRA. The FCC Coordinator notifies all agencies involved about the alert and/or activation of activities directly affecting the assigned PRA(s).

#### 1. Plan Development. (Refer to Appendix 1 to Annex A: FCC/PRA Plan Template)

The development of PRA plans is critical to the viability of the NDMS. The key to success is the thoroughness and effectiveness of local planning. Each local NDMS community is unique. The degree of sophistication of community disaster planning and the availability of resources that can be incorporated into the PRA plan will vary widely. Each PRA plan must be tailored to its community. Local planning cannot be accomplished without the support, involvement, and coordination of the local medical and emergency planning communities. Most communities have an Airport Disaster Plan or a similar Mass Casualty Incident Plan. These should be used as a basis for the FCC/PRA Plan. At a minimum, the same people and organizations involved in the development of existing emergency response plans should help develop, test, and manage the FCC/PRA Plan.

### PRA Plan:

#### 1. Concept of Operations

- a. Provide a concise mission statement.
- b. Define the PRA, area of responsibility.
- c. Describe the roles and responsibilities of principle agencies, teams, and individuals.
- d. Identify all applicable references, including the NRF as well as all applicable local and State disaster plans.
- e. Identify applicable State and local governmental and non-governmental bodies, including local EMS agencies.

- f. Identify primary and alternate airfields, railheads, ports, bus terminals, and any other place patients will be received at and distributed from.
  - g. Identify local resources for transporting patients.
  - h. Identify all NDMS facilities patients will be distributed to. Reference the MOA the FCC has with the NDMS facilities.
- 2. FCC Alert/Activation (Refer to NDMS CONOPS, Section II, Activation and Requests for Federal Support)**
- a. Define who is responsible to put the FCC on ALERT or ACTIVATE status after a valid MA has been received.
  - b. Describe the processes for notifying the FCC staff.
  - c. Describe the processes for notifying the PRA, all applicable State, local governmental and non-governmental bodies, and EMS agencies.
  - d. Describe the processes for procuring resources for transporting patients.
  - e. Describe the processes for notifying NDMS facilities.
  - f. Describe the process for notifying primary and alternate facilities where patients will be received and then distributed.
  - g. Post all recall rosters and POC contact lists in this portion of the plan; describe the process to keep this information current.
- 3. FCC Operations (Refer to NDMS CONOPS, Section III, Operations)**
- a. Describe FCC staff roles, responsibilities and shift schedules.
  - b. Describe FCC internal communications, logs, reports, etc.
  - c. Describe "Access Control" to the FCC.
- Bed Availability Reporting (Refer to Annex C)**
- d. Provide definitions of terms, including the list of medical categories.
  - e. Describe the processes for collecting initial and recurring bed reports, including "throughput".
  - f. Describe the bed reporting procedure into TRAC2ES; describe how to establish an account; list persons who have accounts.
- 4. Medical Regulating and Patient Evacuation to the PRA**
- a. Describe the role of the GPMIC and the TPMRC-A.

- b. Describe the processes and procedures for coordinating patient movement missions between GPMIC/TPMRC-A and the FCC.

## 5. Patient Reception and Staging

- a. Describe the patient reception site(s). Patients arriving from disaster sites will generally be received at a single reception site in the PRA (e.g., an airfield, rail or bus terminal). The site needs to facilitate the off-loading of patients, the immediate evaluation and triage of patients, and the staging of litter and ambulatory patients prior to transport to NDMS facilities. Close coordination is required with DoD, civil authorities, EMS providers, city emergency planners, and other agencies and organizations to ensure access to the site, adequate staffing, security, environmental control (heat, water, light), provision for food and drink, and communications.
- b. Describe the roles and responsibilities of a PRT. The PRT is a multi-function group and consists mainly of clinical staff, but should also include appropriate support from medical administration, communications personnel, logistics personnel, litter bearers and vehicle drivers. The team leader should be a person with appropriate medical background. This team can be based out of a federal facility (VA or DoD) and/or comprised of volunteers from community organizations, NDMS response team personnel, U.S. Public Health Service (PHS) Officers, or local EMS.

## 6. Transportation

- a. Describe resources, procedures and contact information to obtain vehicles, drivers and other personnel to transport patients from the reception site(s) to local participating NDMS member medical facilities. It is important that all vehicles be assessed for their patient carrying capability, inventoried, and tabulated in the patient transportation plan. Additionally, advanced coordination should be made with the authorities that will make these vehicles and personnel available. Military vehicles that are scheduled to move to a theater of operations or are committed to a potential military mobilization effort should NOT BE included as patient transportation assets during military contingencies or DSCA events. Resources might include:
  - Ambulances, other vehicles and personnel from local EMS, DoD, VA, and/or local medical facilities' ambulances and ambulance buses
  - Commercial, governmental or other vehicles available that are wheelchair accessible or otherwise configured to accommodate litter patients
  - Other commercial vehicles (e.g., airport limousines or buses)

- Military and other governmental general use trucks, vans, school buses, etc.
  - FEMA National Ambulance Contract (HHS).
- b. Describe the roles, processes and procedures for managing and tracking the use of local transport resources. Tracking will include using ICS Standard Forms for tracking resources.
  - c. Identify primary and alternate routes from the patient reception site(s) to local medical facilities. Ensure advance coordination with local law enforcement agencies is made in the event that traffic control and additional security are needed.

## 7. Patient Administration

- a. Describe the roles and responsibilities of the FCC Coordinator. The FCC Coordinator assumes the administrative responsibility to:
  - Track patient information inbound to the PRA.
  - Track patient information from point of arrival in the PRA (entrance into the NDMS).
  - Track patient information to entrance to the NDMS facility.
  - Track patient admissions status to the NDMS facility.
  - Track patient movement within the NDMS.
  - Track patient discharge from the NDMS.
  - In the case of military patients, track the patient status through the point the military patient is returned to the responsible Service.
  - Coordinate with the JPATS Teams and SAT Teams, if assigned.

**NOTE:** SAT CONOPS WILL NEED TO BE DISTRIBUTED TO REVIEW COMMITTEE

- b. Describe the roles and responsibilities of GPMIC Liaisons and Military Patient Administration Team (MPAT), and USTRANSCOM Joint Patient Movement Enablers (JPME) if available.
- c. Identify contact information for each participating NDMS medical facility for normal operating hours and after regular working hours.
- d. Describe the roles and responsibilities of each participating NDMS medical facility. The patients' day-to-day medical management and care will be accomplished by the medical staff of that facility. The NDMS facility will provide medical care using its own procedures and forms. The

participating NDMS medical facility should provide information to the FCC Coordinator, to include a daily admission and disposition list (indicating the expected length of stay) and a narrative summary upon discharge of the patient.

- e. Describe the roles, processes and procedures for tracking patients in the PRA. Ensure that the following information is included in the tracking system adopted by the FCC:
  - Unique patient ID Number (e.g., Driver's License, SSN Card, Student ID, wrist band bar code, unique triage tag identifier etc.)
  - Last Name
  - First Name
  - Gender
  - Date of Birth or Age
  - Health Status
  - Bed Type
  - Disposition/Destination Locations
- f. Describe the roles, processes and procedures for tracking patients in the PRA.
  - REGISTRATION
  - UPDATES
  - TRANSFERS
  - INCOMING

**NOTE:** JPATS teams and SATs will be deployed to FCCs that are receiving patients. The process of tracking patients belongs to the JPATS team. However, FCCs should be prepared to support patient tracking at the FCC and once the patients are distributed to the NDMS partner medical facilities.

## 8. Patient Movement Items Management

Describe the processes to procure, track and return patient movement items (PMI).

PMI equipment packages and Deployable Patient Movement Item Tracking System (PMITS) kits can be requested and augmented with personnel from the DoD in the event of surge and sustained requirements. This will allow the pre-position of medical equipment required for multi-modal transportation and

equipped to provide the same tracking and recycling support capability as permanent PMI centers. When required, Services can coordinate with the USTRANSCOM Command Surgeon and Headquarters Air Mobility Command, Command Surgeon's Office (HQ AMC/SGXM) to request PMI equipment and deployable tracking systems to help track and recycle equipment assets.

PMI is tracked using PMITS, a system of systems, developed and supported by the Defense Medical Logistics Standard System (DMLSS). The use of PMITS is mandatory for asset visibility and tracking of PMI to provide accurate information to allow proactive support to deployed organizations. HQ AMC/SGXM is responsible for PMITS operational control, advice, and counsel. PMITS utilizes bar code technology to scan PMI and share PMI data with other authorized users of the system. Bar codes will be issued at PMI centers and designated units or by HQ AMC/SGXM using established bar code guidelines in accordance with PMI Bar Coding Methodology and Codes. All users will ensure bar code labels are attached to all PMI equipment assets prior to use and or patient movement. The bar code label should have the AMC/SGXM phone number, 1-877-286-1931, on it. If the label is worn or does not have the phone number, contact the nearest PMI center or AMC/SGXM to obtain a new label immediately. Non-PMI equipment will not be tracked in this system unless coordinated with USTRANSCOM and HQ AMC/SGXM (e.g., HHS/MAC-ST owned equipment).

PMI must be returned promptly from an medical facility to prevent an equipment shortage in the disaster area. Once patient care is transferred from the PM system to an medical facility or other such provider, it is critical that the PMI equipment be returned to the closest PMI Center **or PMI cell at the FCC**. Services must ensure all medical personnel are trained to not only recognize PMI but to also understand and execute recycling PMI back to PMI Centers. Medical facilities will decontaminate and clean PMI equipment before returning it to another facility, PMI center and/or cell, or transportation point. To reduce medical equipment shortfalls experienced during a contingency, NDMS planners must ensure that detailed procedures are established to resupply, refurbish, and properly recycle PMI. **The FCC Director will ensure a central location is identified for collecting PMI from the PRA and space for the PMI Cell to operate out of.** Medical facilities recycling PMI should contact HQ AMC/SGXM COM 1-877-286-1931 to arrange return of PMI equipment.

#### USAF Patient Movement Item Centers

60th Medical Support Squadron PMI Center Travis AFB, CA

Shipping Address:

Travis PMI Center

102 Bodin Circle Bldg 795

Travis AFB, CA 94535-1800

DSN Phone: 799-7976      Commercial Phone: (707) 423-7976

FAX: (707) 423-2313

375th Medical Group PMI Center Scott AFB, IL

Shipping Address:

375th MDSS/SGSL/PMI Center

120 South Adams Street, Bldg 4020

Scott AFB, IL 62225-5300

DSN Phone: 576-1173      Commercial Phone: (618) 256-1173

FAX: (618) 256-1175

779th Medical Group PMI Center Andrews AFB, MD

Shipping Address:

Andrews PMI Center

3244 Tennessee Avenue

Andrews AFB, MD 20762-5184

DSN Phone: 857-7957      Commercial Phone: (240) 857-7957

FAX: (240) 857-7951

## 9. Miscellaneous

- a. Making provisions for **service animals** (care, holding, and feeding). Service animals are working animals, not pets. Notify state/county Animal Control on the animal species, weight, size and numbers to be supported. State and county restrictions may restrict or prohibit certain animals which pose unavoidable safety and/or public health concern.
  - Ensure there is a provision to properly contain the animals in temporary kenneling/containment facilities.
  - Ensure plans address proper care and feeding of a potentially diverse service animal population.
  - Veterinarian support will be required in the event the animal is injured or ill.
  - Ensure FCC personnel make an effort to collect/maintain service animals' identification card, medical treatment/immunization records or other written documentation (if available).
- b. Make provisions for **weapons** and **narcotics storage**.
  - Weapons: Plans should include a safe location for the "clearing barrel" for weapons inadvertently transported with the patients. A secure area with monitored access will need to be established. If the weapon is a military weapon, call the closest military installation for retrieval. If it is not a military weapon, call local law enforcement to retrieve the weapon. Document the disposition of the weapon on a hand receipt and keep a copy for your records.

- Narcotics/Controlled Medications Storage: Narcotics/Controlled medications transported with patients stay with patients. All narcotics/controlled medications will be counted by two people, noting the name, amount, and dosage. This information is to be documented in the patient's chart. When the patient departs the FCC/PRC, ensure the medications depart with the patient. A signature of both the person receiving the medications and the person relinquishing the medication is required within the patient's chart.
- c. Make provisions for the deceased. Plans should be developed in coordination with the state, territorial, or local medical examiner or coroner who will maintain jurisdiction over both military and civilian fatalities, including mass casualty events. The individual with jurisdiction has authority to order and perform an investigation to include an autopsy or an appropriate medico-legal examination on human remains. Any deceased patient will be transported as soon as possible to local authorities.
  - d. Make provision or be prepared to support Traumatic Stress Response Team (TSRT). The TSRT's primary function is to consult with leadership or other responders and provide initial response when groups or individuals expect to be, or have been, exposed to potentially traumatic stress. The primary goal of TSRTs is to foster resiliency in those exposed to potentially traumatic stress. TSRTs (1) serve as trauma response consultants to unit leaders; (2) prepare personnel likely to be exposed to potentially traumatic events; and (3) provide screening, education, psychological first aid, and referral for those exposed to potentially traumatic events. TSRT serves to enhance resilience to potentially traumatic events. Designated TSRTs, in close coordination with unit leaders, provide TSR services. Pre-Exposure Preparation (PEP) services are provided to unit and community members whenever potentially traumatic events are anticipated. Assistance will be available after potentially traumatic civil and military events.

## 10. Pets Planning Guidance

**Reference:** Section 403(a)(3) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5170b(a) (Public Law 109-308, the Pets Evacuation and Transportation Standards Act). "Federal agencies may on the direction of the President, provide assistance essential to meeting immediate threats to life and property resulting from a major disaster [including] any work or services essential to saving lives and protecting and preserving property or public health and safety, including the provision of rescue, care, shelter, and essential needs to individuals with household pets and service animals; and to such pets and animals."

### Background Data:

- Per the U.S. Census Bureau, there are approximately 314M people in the U.S.
- Per the ASPCA, there are approximately 78M dogs and 86M cats in the U.S.
- For every 100 people in the U.S., there are approximately 25 dogs and 27 cats.

**Assumptions:**

- For every evacuation mission with 50 patients received at an FCC, there will be 13 dogs and 14 cats.
- The length of stay for each patient and pet is 30 days.
- Medical treatment of pets will not take priority over medical treatment for people.

**FCC Planning Guidance:** Each FCC/PRA Plan should include provisions for:

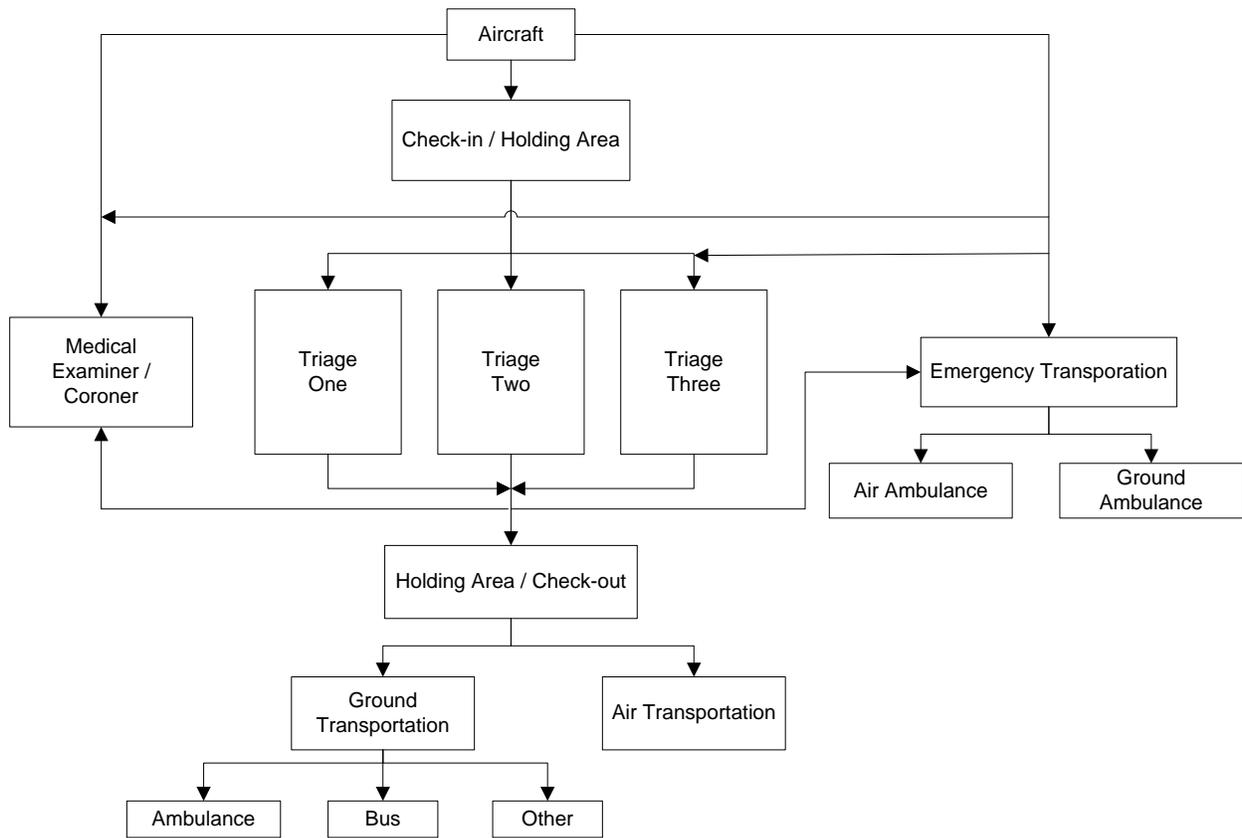
- Receiving, identifying, tracking, transporting, and housing for up to 30 days a number of pets equal to five times their daily throughput.
- Reuniting pets with owners as soon as practical or with patients' next of kin in the event that the patient dies while within the PRA.

**Resources:**

- Medical Reserve Corps units ([www.medicalreservecorps.gov](http://www.medicalreservecorps.gov))
- Local humane organizations
- County or State animal response organizations
- Post or Base Veterinarian
- National Alliance of State Animal and Agricultural Emergency Programs ([www.NASAAEP.org](http://www.NASAAEP.org))
- American Veterinary Medical Association ([www.avma.org](http://www.avma.org))

See Annex Q for FCC FCC/PRA Plan Self-Assessment

Following is a Diagram of Patient Reception Area



## Annex E: Training and Exercises

### Purpose:

The purpose of this guide is to provide planners, emergency management officers, FCC Directors and Coordinators, participating NDMS member medical facilities, and all others involved at the local, state, Tribal, territorial, and federal levels with suggested training and exercise information for FCCs. These recommendations are intended to help them in their efforts to plan for and assist state and local authorities in planning for the medical impacts of a disasters or national emergency, and to provide support to the DoD and VA medical systems in caring for casualties evacuated back to the United States from overseas armed conflicts.

As with any planning effort, the development of the FCC FCC/PRA Plan does not cease with its publication. Planning is a dynamic process. Once created, it must be periodically exercised to provide feedback to correct deficiencies or to adjust the plan with changing circumstances. Exercises are used to coordinate requirements and plans in a scenario-based environment so units can train with realistic conditions. Training events and exercises should be executed to meet and/or exceed minimum requirements.

### 1. Training

Training provides first responders, homeland security/defense officials, emergency management officials, private and non-governmental partners, federal, inter-agency partners and other personnel with the knowledge, skills, and abilities needed to perform key tasks required by specific capabilities. Organizations should make training decisions based on information derived from assessments, strategies, after action reports, and plans.

An exercise and training program should be developed and implemented to create awareness across the FCC PRA and to enhance the skills of individuals' assigned FCC functions or responsibilities. This should include participating medical facilities and other local authorities involved in patient reception operations.

The FCC Director, or Coordinator, should provide an annual orientation of the FCC/PRA Plan to the FCC staff and FCC Steering Committee.

**Table 1, titled National Disaster Medical System Federal Coordinating Center Training Recommendations** is a list of recommended courses for those associated with the NDMS FCC system. This table should not be considered an all-inclusive list of training recommendations, but rather a guide to be thoroughly examined on the basis of facility, local, State, and/or federal needs. At least annually, the FCC Director should ensure that FCC Coordinators and other individuals designated to augment the FCC staff receive detailed education and training on their specific duties. Training of individuals can be didactic, practical, online or self-study.

## 2. RECOMMENDED TRAINING OPPORTUNITIES

		Training Course	Course #	Position	Federal Coordinating Center Director	Federal Coordinating Center Coordinators	Primary Reception Area Staff
		Introduction to Incident Command System	IS - 100.a		X	X	X
		Introduction to the ICS for Healthcare/Medical Facilities	IS - 100.HC		X	X	X
		ICS for Single Resources & Initial Incidents	IS - 200.a		X	X	X
		Applying ICS to Healthcare Organizations	200.HC		X	X	X
		NIMS An Introduction	IS - 700.a		X	X	X
		Intermediate ICS for Expanding Incidents	G - 300		X	X	
		National Response Framework, An Introduction	IS - 800.b		X	X	X
		Advanced ICS Command & General Staff	G - 400		X	X	
		EOC Management and Operations	IS - 775		X	X	
		NIMS Multiagency Coordination System (MACS)	IS - 701		X	X	
		NDMS Federal Coordinating Center Operations	IS - 1900		X	X	X
		An Introduction to Exercises	IS - 120.a		X	X	
		Emergency Support Function (ESF) #8 – Public Health and Medical Services	IS - 808		X	X	X
		<a href="http://www.usarnorth.org/public/home.cfm?CFID=44311&amp;CFTOKEN=54134823">ARNORTH Distance Learning Program:</a>	DSCA		X	X	
		TRAC2ES Web Based Training (GPMIC) *	TRAC2ES			X	X
		FCC / PRC Advanced Operations Workshop **	FCC / PRC Workshop		X	X	
		FCC / PRC Basic Operations Course **	FCC / PRC Operations Course		X	X	
		Joint Patient Assessment and Tracking System	JPATS			X	X

Table 1: National Disaster Medical System Federal Coordinating Center Training Recommendations

### 3. Exercises

Although some FCCs may conduct comprehensive exercises more frequently, FCC Directors are strongly encouraged to conduct a full-scale patient reception exercises. DoD FCCs should plan to conduct patient reception exercises every two years. VA FCCs should plan to conduct patient reception exercises every three years. Each medical facility or agency participating in the NDMS should be afforded an opportunity to participate in these exercises. Exercises should be designed to meet external disaster drill accreditation criteria. Exercises should be sufficiently comprehensive to permit an assessment of participating medical facilities/agencies ability to perform according to the area FCC/PRA Plan. Exercises should test PRA operations (i.e., patient reception, off-loading, triage and staging at airfields, bus or rail terminals, etc.; transportation of patients; patient reception at participating medical facilities; patient tracking and communications). It is recommended that scenarios be changed for each exercise, rotating between natural disasters, terrorist incidents, and military contingencies.

Performance data, key issues and lessons learned should be observed and collected during plan execution exercises. The post-exercise evaluation stage is particularly significant, as it provides input to guide development of the next training cycle and modifications to the FCC/PRA Plan. By utilizing the FCC self-assessment, the FCC can determine its training proficiency in each task. This FCC self-assessment can also help identify issues that are beyond the Director's or the Coordinator's ability to resolve. The FCC Directors will gather the lessons learned and observations, and make the corrective actions necessary to implement changes to their FCC/PRA Plan.

Exercises should be tailored to simulate the conditions of a disaster. This is essential to test personnel in their use of equipment and to establish smooth coordination and working relationships within the teams and with other teams and partner facilities.

One recommendation to assist each FCC with the development of their exercise is to utilize the Homeland Security Exercise and Evaluation Program (HSEEP) to develop, plan and report observations/recommendations. HSEEP is a capabilities- and performance-based exercise program that was developed to provide common exercise policy and program guidance that constitutes a national standard for exercises. HSEEP is designed to be adaptable to any exercise program, regardless of the nature and composition of its sponsoring agency or organization, and to the full spectrum of exercise scopes and scenarios and should be utilized by the FCC Director and Coordinator to develop their exercise. This includes consistent terminology, design process, evaluation tools, and documentation standards. HSEEP reflects community best practices as well as lessons learned from previous and existing exercise programs. More information

and templates for exercise development and after action reports are located at <http://hseep.dhs.gov>.

The HSEEP guidelines suggest it is important that those involved in exercise development consider the development of a multi-year training and exercise plan. The objective of the multi-year training and exercise plan is to coordinate training and exercises to prevent duplicating efforts, to prevent overextending resources, and to maximize the efficacy of any local available training and exercise appropriations.

The following additional guidance on conducting full-scale FCC exercises is provided for consideration:

**Medical Regulating:** Prepare to exercise the regulating of patients to at least several NDMS member facilities in the PRA. Consider exercising with 50 to 75 mannequin or live “patients”, including litter, wheel chair and ambulatory types. Consider a blend of patient populations, e.g., 5 percent of the patients play DoD active duty members, and 5 percent play VA beneficiaries. Consider a taxing blend of patient types, e.g., 75 percent will play inpatients categorized as medical/surgical, critical care, burn, pediatric, psychiatric, pediatric critical care patients or patients requiring isolation; while 25 percent play nursing home residents and/ or special medical needs patients.

**Receiving:** Exercise the unloading of litter, wheelchair and ambulatory patients from a C-130 or C-17 aircraft. The aircraft may be either a static display, or may be flown in especially for the exercise. Assume that the aircraft will not be available at the last moment, and plan for a substitute, e.g., either a locally available C-130 static or mock-up fuselage; a locally procured bus; an ambulance/bus; or a Dual Use Vehicle (DUV).

**Staging:** Exercise the triage and staging of patients at the PRA primary or alternate airfield. Plan to exercise the entire Patient Reception Team, to include a complement of fire department, decontamination, social services, security, animal control and other PRT components.

**Disposition & Tracking.** Exercise the ability to decide on destination facilities in the community for each patient, and the ability to orchestrate the operations of the agencies involved in patient reception, e.g., the triage officer, the transportation coordination officer, the patient administration officer, the ambulances and the destination facilities. The tracking systems that must be used as a part of the exercise include the TRANSCOM Regulating and Command & Control Evacuation System (TRAC2ES) and the Joint Patient Assessment and Tracking System (JPATS).

**Transportation:** Exercise the ability to transport to and unload patients at several destination facilities.

**Aircraft:**

- Seek incorporation of a C-130 or C-17 aircraft from Air National Guard or USAF Reserve sources, i.e., squadrons with unit training funds that are looking for opportunities to participate. Consider that, even if aircraft are scheduled to support the FCC exercise, there is a possibility that an aircraft will not be available at the last moment due to mechanical, weather, or other reasons.
- Have an ambulance bus or VA Dual Use Vehicle available as a back-up to or a substitute for the aircraft, and does not have one available locally, assume a cost of \$4K to bring one in.

**Hangar:** (or other shelter). \$5K

**Ambulances:**

- Consider 10 or 15 ambulances at perhaps \$200/hour each for 4 hours.
- Consider 1 bus at \$50/hour for 4 hour.

**Command/Control:**

- Local jurisdiction may contribute their command/control vehicle(s) and communications equipment to participate in the exercise. Consider \$100/hour for 4 hours.
- Exercise control may be provided by local FCC staff, or by other personnel to be brought in. Consider travel costs for 2 controllers at \$1,500 each.

**Personnel:** Potential overtime costs for ~ 175 persons could include:

- Clinical PRT personnel. 30 people at \$75/hour for 4 hours.
- PRT support personnel. 25 people at \$75/hour for 4 hours.
- "Patients". 50 to 75 patients from Civil Air Patrol, local nursing or medical technical schools, Scouts, etc., at no direct cost.
- Fire Department. 30 personnel at \$75/hour for 4 hours.
- Security. 5 local policemen at \$75/hour for 4 hours.
- Social Services. 2 persons at \$75/hour for 4 hours.
- Animal Control. 2 persons at \$75/hour for 4 hours.

- **Decontamination.** While patients are expected to be decontaminated prior to evacuation, consider exercising some contingency decontamination capability. Consider 5 persons at \$75/hour for 4 hours.

**Food:** Consider \$15 per person for the day, for ~ 175 people.

**Toilets:** Consider portable units, if required, perhaps \$500.

#### **4. Training and Exercise Funding**

FCCs may submit budget request for exercise and training through their respective chains of command. All FCCs may consider developing exercise opportunities through collaboration with the community. In the event that the FCC does not have the funding to conduct an exercise they can coordinate with other installations, local community, state, or other federal entities to participate with them during one of their exercises.

## **Annex F: Coordinate Local Patient Reception Operations**

### **Purpose:**

FCC Directors implement PRA plans as required by the specific activation notification. This may include, at full activation, alerting all member medical facilities and all elements of the local patient reception and ground transport programs. FCC Directors may find it advisable to initiate local bed reporting in anticipation of receiving bed reporting instructions from GPMIC.

FCC Coordinators should ensure that open communications and liaison are established with GPMIC for the receipt of regulating decisions, evacuation mission information, and patient medical data, when available. See Appendix 1 to this Annex for general information on medical regulating. FCC Coordinators should ensure that the FCC Director, the PRT, local EMS coordinators, all affected medical facilities, higher headquarters, installation commanders, and all other applicable agencies and individuals are notified when patients are regulated to the FCC. Depending on the information received from GPMIC, the FCC may elect to begin the process of regulating patients to specific local medical facilities prior to the arrival of the patients. The FCC Coordinator ensures that reception, sorting, triage, staging, transportation, and hospitalization of arriving patients occurs efficiently. This includes being able to match the individual patient requirements for care with bed capabilities as reported by the participating NDMS member medical facilities. Accordingly, this implies close coordination between the PRT, local EMS coordinators, the FCC, and GPMIC.

If available, Disaster Medical Assistance Teams (DMAT) may be deployed locally or from other metropolitan areas to support FCC patient reception and distribution of patients to participating NDMS member medical facilities. All DMATs are managed by the HHS Office of the Assistant Secretary for Preparedness and Response (ASPR). Requests for DMAT support for local patient reception operations should be forwarded through chains of command to the HHS Regional Emergency Coordinator (REC). Understand that DMATs may not be available to support FCC PRA operations.

### **Aeromedical Patient Reception Operations at the APOD:**

If patients arrive via USTRANSCOM aeromedical evacuation (AE) assets, once the aircraft lands, the aircraft load master is the authority on the ground around the aircraft. The Load Master will direct vehicle movement and marshal vehicles to the aircraft. No movement up to the aircraft will take place unless directed by the Load Master. Once the Load Master directs the Patient Reception Team (PRT) representative onto the aircraft, the Medical Crew Director (MCD) and AE crew will communicate and direct all matters pertaining to patient care and deplaning in and around the aircraft. It is important to understand who is responsible for the patient and when. When the patient is in and around the aircraft—the patient belongs to the AE crew. Once unloaded from the aircraft and staged, responsibility for the patients transfers to the PRT.

Upon arrival of patients, the PRT medical leader should receive a manifest and medical briefing from the aircraft's MCD, or from the ambulance, bus or train's senior medical attendant. This briefing will help to ensure that the most severe cases are off-loaded first for immediate transportation or stabilization.

The Flight Nurse will give a report to the appropriate personnel and turn over any documentation, x-rays, equipment and medications. The AE Technician (AET) will sign over patient baggage to PRT personnel and will direct/assist with unloading of the baggage. In the interest of time, and if possible, have one or two individuals dedicated to working with the AET to unload bags. Someone will have to sign for the bags and remove them quickly (helps to get them out of the way since they are normally stored on the ramp--one less obstacle). While the nurses are doing the patient hand-off, personnel should be removing the baggage.

The Charge Medical Technician (CMT) will coordinate with the Load Master to direct vehicle drivers and ground personnel. He/she will direct procedures for deplaning and securing patients for transport. The individual coordinating the litter bearers will need to get instructions from the CMT to ensure everyone understands hand signals, litter bearer requirements, and from whom they will take direction.

When everything is set to unload the patients, the PRT will see a series of hand signals. The AE crew will be very directive as to where they want the team to go, where to walk, how to remove litters from stanchions and how to carry the litters. Here are some of the hand signals the PRT will see:

1. Thumbs-up = "Go"
2. Crossed arms = "Stop —don't come on board the aircraft"
3. Palms pushing down toward the ground = "Slowdown"

The aircraft/flight line environment can be very loud. The AE crew will be just as loud with their direction on where to go and what to do. You may hear "COME TO ME" "COME THIS WAY" "YOU'VE GOT THE INSIDE, I'VE GOT THE OUTSIDE" referring to the litter stanchion. As long as you see a thumbs up—things are good to go. For the most part—if the AE crew is yelling loudly at you to come "this way" they are not being rude—merely directive. But if you hear "TIME OUT," "KNOCK IT OFF," or "STOP" then please do—there is a safety violation or some other issue that must be immediately addressed.

Factors to consider for Litter Bearers: Adequate manpower is essential to unload a large patient load. Some patients can be carried with a 2-man carry; however, any time a litter will be lifted, a 4-person carry is required. It is absolutely essential that your teams are trained in proper litter lifting and carrying techniques. Particularly unsafe is walking backwards, switching hands behind the back, or using only two litter bearers. Consider the heat of the summer, the number of patients and whether there are heavy patients. Litter bearers tire out quickly. Consider using wheeled litters, gators, AMBUSes, or something similar to move the patients from the plane to the reception area. Litters and/or patients can be placed on top of and secured to

ambulance gurneys, but they must be hand carried off the aircraft and may not be rolled off the ramp. This also requires a 4-person lift. Another thing to consider is the height of your litter bearers. For example, it is not a good mix for a 4-person team to have a 6 foot 4 inch tall person and two short people trying to maneuver a litter. You have to take care of your litter bearers—feed them and water them.

Following the briefing, patients are either moved directly to awaiting transportation and taken to a medical facility, and/or off-loaded and transferred to a patient staging/holding facility based upon the severity of injuries, practicality, and availability of transport. In either case, trained and experienced personnel are required to unload the vehicle, identify, examine, sort, accompany, and transport the patients to the medical facilities.

### **Patient Movement Items (PMI)**

PMIs are specific medical equipment and durable supplies that must be available to support patient movement. Examples of PMIs include ventilators, litters, patient monitors, and pulse oximeters. The purpose of the PMI system is to support patient movement through pre-positioning, exchanging, and recycling of PMIs so that original MTF's capability is not degraded. The originating MTF will identify, on the patient movement request, any special medical equipment for transport. The MTF cannot necessarily provide PMIs for patients. PMIs accompany a patient throughout the chain of movement, from the originating MTF (or APOE) to the destination MTF. Medical planners must ensure that PMIs are available at the correct location and ready for use, and PMI centers are established (establishment of theater PMI centers and cells is the responsibility of the USAF).

PMI levels will be established based on the worst three days of patient movement, either based on planning factors for initial setup or usage over a period of time of continuous operations. Centers, cells, and nodes track, receive, and refurbish (based on local capability) PMIs to ensure availability for patient movement. Patient movement centers can be augmented with personnel and equipment from the other Services; liaison personnel may also be assigned. At the time an MTF initiates a patient movement request requiring PMIs, the PMI center, cell, and/or node will initiate action for the replenishment or exchange of in-kind PMIs.

**(NOTE:** In DSCA scenarios, the PMI is provided at the APOE and not by the originating medical facility).

The handling and return of this equipment to the PMI Centers requires the coordination of GPMIC, aeromedical crews, the PRA PRT, the destination NDMS medical facility(s), and the DoD MTF nearest to the PRA. The FCC plays a key role in facilitating coordination and communication among these organizations operating in a PRA, in order to facilitate the return of PMI to the nearest DoD medical treatment facility or nearest PMI Center, refer back to Annex D. Also, during a contingency or domestic incident, the USAF may establish a PMI Cell in the vicinity of the PRA in order to assist with the tracking, refurbishment, redistribution and

return of PMI collected from destination medical facilities. **The FCC Director will identify a location for PMI equipment to be collected and for the PMI Cell to operate out of the FCC.**

### **Administrative Responsibility**

The FCC provides administrative support for patient control and proper patient accounting. The FCC ensures that a tracking system is operational in order to maintain the location and status of each NDMS patient in the region. If possible, an estimated length of stay should be determined for each NDMS patient. If the PRA is activated for a military contingency, the FCC Coordinator ensures that data is provided to the nearest DoD MTF.

The FCC assumes administrative responsibility for patients processed through the PRA. This responsibility begins upon notification of patients being regulated to the PRA. For military contingencies the responsibilities ends when the patient is either discharged, deceased, transferred out of the PRA, returned home or, in the case of military patients, returned to the responsible service personnel system for processing and assignment to a military unit, or discharge from active duty, as appropriate. If available, a DoD liaison may be dispatched to the FCC to assist in coordinating administrative actions for military patients. Liaisons will be appointed at the time of the event. Specific LNO contact information will be provided at the initiation of patient movement operations. For domestic contingencies (i.e., ESF #8 responses), this responsibility will cease upon admission to the destination facility and the SAT.

FCC is responsible for ensuring that transportation is arranged to move patients from arrival sites onward to local participating NDMS member medical facilities. The FCC should have procedures to obtain vehicles and personnel on relatively short notice to transport arriving patients.

FCC should coordinate with the HHS Service Access Team to ensure housing and feeding for non-medical attendants who may accompany NDMS patients. They should also have a plan for a patient's service animals.

The medical staff of participating NDMS member medical facilities provides patient medical care. Participating NDMS member medical facilities may be asked to provide the following to the FCC Coordinator (or the SAT for domestic scenarios):

- A daily bed availability report.
- A daily admission and disposition list of NDMS patients (indicating the expected length of stay).
- A release of information authorization. A chain of custody for medical records must be considered.
- A narrative summary upon discharge of each NDMS patient.



## **PRA Security**

The FCC should coordinate with the airport, bus terminal, or area security personnel to ensure adequate security of the PRA. Security for the perimeter of an airfield PRA will generally be provided by the security force that provides these services during normal operations, e. g., military or airport police. Security at a non-airfield PRA (e.g., a train depot), will need to be augmented by law enforcement authorities from the local jurisdiction. Both situations should be included in the FCC/PRA Plan.

In addition, the FCC should ensure that a security checkpoint between the aircraft (or other patient transport vehicle) and the triage operation. Experience has shown that patients may arrive with weapons or other contraband not suitable for introduction into the patient care environment, but might have been missed prior to boarding the transport vehicle.

## **Public Affairs**

FCC PRA operations tend to be big news in the local community. Since NDMS operations are conducted in concert with civil authorities and civilian organizations, the interagency environment brings an expanded need for clear cooperation, coordination, and unity of effort and messaging among the members of the FCC. Annex L provides detailed considerations for public affairs.

## Appendix 1 to Annex F: Medical Regulating

### Purpose:

Medical regulating is the coordination and control of moving patients to participating NDMS member medical facilities which are best able to provide the required care. This system is designed to ensure the efficient and safe movement of patients.

### Purpose of Medical Regulating:

Medical regulating entails identifying the patients awaiting evacuation, locating the available beds, and coordinating the transportation means for movement. Careful control of patient evacuation to appropriate medical facilities is necessary to:

- Effect an even distribution of cases;
- Ensure adequate beds are available for current and anticipated needs;
- Route patients requiring treatment to the appropriate participating NDMS medical facility.

The following factors influence the scheduling of patient movement:

- Patient's medical condition (stabilized to withstand evacuation);
- Availability of evacuation means;
- Locations of NDMS facilities with required capabilities;
- Current bed status of NDMS facilities;
- Adequate through-put capability at the FCC;
- Number and location of patients by diagnostic category;
- Location of airfields, seaports, and other transportation hubs;
- Communications capabilities (to include radio silence procedures).

### Medical Regulating Terminology

As medical regulating may include coordination with other agencies, it is necessary to use the correct terminology. These terms include:

- Patient Administrator – The patient administrator (PAD) accomplishes the medical regulating function at the medical facility level. Medical regulating functions include consolidating all evacuation requests within the PRA. The PAD is also responsible for keeping GPMIC apprised of the current beds available in the PRA.
- GPMIC – The GPMIC is a joint agency located at Scott Air Force Base and established by USTRANSCOM. The GPMIC receives requests from

the Theater Patient Movement Requirement Centers (TPMRCs). The primary role of the GPMIC is to apportion patient movement assets to the TPMRCs, collaborate and integrate proposed TPMRC patient movement plans and schedules, and communicate lift and bed requirements. The destination medical facility is determined based on the patient's medical needs, the available transportation resources, and NDMS medical facility capabilities.

- Joint Patient Movement Requirements Center (JPMRC) – The JPMRC provides patient movement requirements, center-type domain, and automatic information system support and operations. The JPMRC is responsible for patient movement operations within its area of responsibility and coordinates movement requirements center for patient movement with the GPMIC.
- Aeromedical Evacuation System (AES) — A system that provides:
  - a. Control of patient movement by air transport;
  - b. Specialized medical aircrew, medical crew augmentees, and specialty medical attendants and equipment for inflight medical care;
  - c. Facilities on or in the vicinity of air strips and air bases for the limited medical care of in transit patients entering, en route via, or leaving the system;
  - d. Communication with originating, destination, and en route medical facilities concerning patient transportation. AE forces provide a rapid, flexible, incremental, mobile response. Unit type code (UTC) is employed to provide command, control, communications, patient care, and system support.

Significant components of the AES include the following:

- Aeromedical Evacuation Command Squadron – The AE command squadron provides C2 of all assigned AES forces and can deploy in advance of other AE components to arrange support requirements for AE forces. The command squadron advises other personnel/agencies on AE operations, capabilities, and requirements and provides procedural and technical guidance for attached and transiting AE elements.
- Aeromedical Evacuation Crew Members (AECMs) – AECs perform in-flight medical care, are experts on aircraft configuration, and provide the operational interface between the patient, medical equipment, and aircraft systems.
- AE Operations Team (AEOT) – The AEOT may be integrated into the air mobility control center (a permanent en route C2 function). AEOTs are located at strategic airlift hubs or en route locations to support aircrews,

equipment, and launch and recover operations. AEOT provides direct supervision and crew management for assigned, attached, and transiting AE crews and CCATTs in conjunction with the TACC/AMOCC, AECT and base operations, as applicable. The AEOT supports AE missions through assigned aircraft configuration, and equipment to include CRAF support, patient loading interface, and resupply of in-flight kits, medications, and patient liquid oxygen. They may assist staging facility with enplaning and deplaning.

- Aeromedical Evacuation Control Team – The AECT is located within the AMD of the AOC and is responsible for current AE operational planning, tasking, and mission execution to the theater. Once a transport to bed plan is received, the AECT coordinates airlift and AE assets to meet AE requirements. The AECT tasks the appropriate airlift wings through the airlift control team (ALCT) and air tasking order (ATO) and passes mission information to the PMRC. This team also coordinates airlift with air mobility element, AMC TACC, or theater AMOCC to meet AE requirements for their operational area.
- Aeromedical Evacuation Liaison Team (AELT) – The AELT is a two-person team that establishes the initial bridge to the Aeromedical Evacuation system and allows for immediate patient movement. The AELT is composed of one Flight Nurse and Medical Service Corps (2-person Communications Team tasked separately), and provides a direct communications link and immediate coordination between the user service and the AES. The AELT is located at any level where Air Force fixed-wing requests are initiated. It verifies and coordinates with the AECT for patient movement requirements, physiology of flight issues, and patient flight/movement requirements. It also assists with patient preparation for flight and directs patient on-load activities to include communication with Contingency Response Element or Group (CRE/CRG).
- Aeromedical Evacuation Communications Team – Provides communication augmentations to any AE UTC when mission needed communications are unavailable.
- EnRoute Patient Staging System (ERPSS) – The ERPSS is a USAF staging facility employed at forward airfields to provide a temporary staging capability for preparation of patients being evacuated to NDMS member medical facilities. The ERPSS is employed to ensure patients are prepared for aircraft loading.

The primary means of moving patients is USAF aircraft. With the elements of the AES, it is possible to find AELTs at each APOD. The PMRC monitors patient evacuation requests and passes requirements to the AELT. At the same time they pass airlift requirements to the AECT, seeking an aircraft to perform the evacuation mission. The AELT requests the PMRC/AECT to move patients. Included in the request are the Originating Medical Facility (OMF) and the

destination airfields. The airfields selected are those serving the medical facilities designated to receive patients.

The AECT is a component of the AES and performs the mission of coordinating the movement of and providing in-flight medical care to patients while under the USAF control. The AECT receives patient movement requirements from the TPMRC and works with the airlift control team (ALCT) in the AOC to meet the evacuation requirements. The AOC coordinates the forward movement of patients aboard USAF aircraft.

### **Enroute Patient Staging System**

The ERPSS is a 13-person, mobile, tented, temporary staging facility deployed to provide supportive patient care and administration. Each ERPSS is capable of a throughput of 40 patients per 24 hours and should be able to sustain this tempo for 72 hours before augmentation is required and is not intended to hold patients overnight or for an extended period.

- Provide supportive medical care when not augmented by the CCATTs. (When augmented by CCATTs, continued stabilization of patients can be accomplished. Aeromedical evacuation crews and CCATTs fly airlift missions to provide in-flight patient care.)
- Confirm sending facility has prepared patients for evacuation.
- In coordination with the OMF, ensures patient evacuation manifests are completed.

Upon evacuation, the OMF is responsible to provide an adequate quantity of medications for patients' transit time to the regulated destinations.

The ERPSS staff also establishes liaison with the OMF. The AELT is composed of one medical service corps officer for administrative assistance and a flight nurse. The AELT provides the initial interface between the user service and the AES. The AELT is located at any level where Air Force fixed-wing requests are operating.

### **Limitations of the United States Air Force Aeromedical Evacuation System**

There are a number of limitations that are inherent in the current system. These include the following:

- Absence of biological weapon and chemical weapon agent decontamination ability.
- The ERPSS does not have the capability to provide patient meals.
- The AE UTCs (ERPSS/AELT/AEOT/COMM. AECS, etc.) rely on the user service for all other logistical support.

- The AECT can facilitate a 30-days medical resupply package at the ERPSS.
- AE Crews and support staff are limited and dependent on current contingency operations.
- AES relies heavily on Air Reserve Component (ARC) with 88% of AE forces in ARC and 12% in Regular Air Force.

## Annex G: Patient Discharge and Return

### Domestic Contingencies:

HHS has the overall responsibility to return NDMS patients to their point of origin or other destinations, as authorized. The FCC may be called upon to assist as a liaison between the NDMS partner medical facilities and the HHS representative/Service Access Team (SAT).

The SAT will **facilitate the movement** of NDMS evacuees to their homes/communities or to another final destination as determined by the patient that has not been impacted by the disaster/emergency/incident. The SAT will collaborate with the NDMS facility Discharge Planner when the patient is ready for discharge. When discharge is pending, the SAT will begin to coordinate the return of patients and accompanying non-medical attendants evacuated by NDMS. These individuals will be allowed to return when:

1. They are well enough to travel;
2. The evacuated state has declared that it is safe to return; and/or
3. There is an appropriate receiving facility.

If a federally evacuated ESF#8 patient dies during the response operation, the SAT will **coordinate the return/disposition of remains** with the local and state medical examiner's office and the patient's family.

### For Military Contingencies:

DoD liaison may be dispatched to the FCC to assist in coordinating administrative actions for military patients. Liaisons (LNO) will be appointed at the time of the event. Specific LNO contact information will be provided at the initiation of patient movement operations.

## Annex H: Financial Guidance

### Purpose:

The purpose of this annex is to provide additional guidance regarding the funding and reimbursement process for training, equipping, and exercising of FCCs and their Patient Reception Area(s); for medical care, transportation, and other costs related to patient reception operations; and for claims reimbursement processing.

### 1. Patient Reception Area (PRA) Pre-Activation Expenses

(6) **Exercise Funding.** Generally, there are no dedicated separate monies available within the VA or DoD to support exercises (e.g., money to reimburse local ambulance companies, or for food for exercise volunteers, or rental of portable toilets, etc.). VA Area Emergency Managers (AEMs) are provided an annual budget and may use some of these funds to pay for limited expenses for patient reception exercises. Regular expense approval procedures are to be followed. In addition to regular monies, VA requests for specific exercise expenses may be submitted through channels to the VHA Office of Emergency Management (OEM) for funding. DoD FCCs should follow Service or facility procedures to request funding for exercise costs.

(7) **Pre-Activation Costs.** There is generally no funding available for pre-activation costs (such as rental charges to set up in a hangar or to procure equipment). FCCs should be cautioned not to obligate funds for leases or other ongoing charges related to the PRA without proper authority. However, negotiating no-cost, stand-by plans to be enacted upon NDMS activation may be warranted, when authorized by appropriate contracting officials. Stand-by no-cost contracts may be useful to meet pre-event planning requirements (see Appendix 1 to Annex H).

### 2. PRA Activation and Operational Expenses

The Mission Assignment or Sub-Tasking will specifically stipulate funding scope and authority (e.g., whether from DoD or HHS).

(6) The FCC Director, or the designated fiscal authority, will collect bills for appropriate charges for those services incurred by the FCC during PRA operations. Bills for goods and services born by FCCs will generally be paid by the FCC Director and forwarded to HHS/ASPR, for reimbursement through agency channels. Expenses related to the operation of the PRA should be supported by the Mission Assignment or Sub-Tasking (See FEMA reimbursement Procedures. Required forms can be found at link to website: <http://www.fema.gov/help/forms.shtm>.) If the PRA is activated, expenses incurred as a result of this activation are eligible for reimbursement.

- (7) FCCs may coordinate, through their chains of command, a request for HHS direct support (e.g., DMATs or U.S. Public Health Service (PHS)) for PRA operations. However, FCC coordinators should refrain from relying on HHS assets as a primary source of PRT personnel. DMATs are subject to deployment by HHS. The HHS Secretary's Operation Center (SOC) manages DMAT operations. If the FCC needs DMAT, or PHS assistance, they must forward a request, through agency channels, to HHS. As in all requests for outside assistance, VA and DoD must be able to show the need for the request.
- (8) Civilian personnel costs are also eligible for reimbursement under some conditions. For example, if a city fire department provided personnel to help with triage, these costs would generally be eligible for reimbursement. It is the responsibility of the FCC to keep accurate records as costs accrue. It is suggested that all agencies that request reimbursement for personnel costs provide estimates on a daily basis as they occur.
- (9) Civil service personnel costs are also eligible for reimbursement under some conditions. Regular shifts worked by personnel at a PRA instead of the normal duty station are generally not eligible for reimbursement. However, overtime, weekends and holiday expenses may be eligible for reimbursement.
- (10) Expenses for the use of hangars, including electricity, water, security, and other related expenses are generally eligible for reimbursement. These costs must conform to expenses for similar services in the area.
- (11) Expenses for the use of office supplies, furniture rental, equipment rental, computers, faxes, and other related operations expenses are generally eligible for reimbursement. These costs must conform to expenses for similar services in the area. Usually, expenses for equipment rental and furniture rental are appropriate, but purchase of these items may require written justification. Other costs (such as costs to transport a patient reception team) that cannot be assigned to individual patients but are necessary to the operation of the PRA, are generally eligible for reimbursement, so long as they can be justified as necessary. Documentation is critical.
- (12) Discharged patients and non-medical attendants (e.g., accompanying family members) who have been discharged will be the responsibility of the Service Access Team (SAT). For more information about the roles and responsibilities of the SATs, contact HHS Patient Movement at [hhsatientmovement@hhs.gov](mailto:hhsatientmovement@hhs.gov).
- (13) Payments for direct services from the Salvation Army, Red Cross, or other Non-Governmental Agency (NGA) are generally eligible for reimbursement as long they are justified as necessary for the health and/or welfare of the patient such as toiletries or food. Documentation is critical.

### 3. Basic Provisions of Financial Claims Processing

- (6) All claims for financial reimbursement associated with NDMS patient movement, reception, and treatment are subject to the provisions of the FEMA Mission Assignment or Sub-Tasking, the appropriate DoD authorization, or other authorizing document.
- (7) NDMS member facilities identify whether or not the patient maintains a primary and/or secondary third party payer for medical care (i.e., insurance carrier, Medicare, Medicaid, etc.) and will first submit billing for patient care services to the patient's identified third party payer(s) for reimbursement.
- (8) NDMS will be payer of last resort to any other existing medical coverage, except Medicaid, which by law is payer of last resort. Compensation for NDMS-related claims will be reimbursed at rates, in accordance with the Definitive Medical Care MOA.
- (9) HHS provides medical claims processing services for the NDMS, to support participating facilities, providers and qualified beneficiaries affected by a national disaster.
- (10) Any claims presented for processing must identify the disaster/contingency associated.

### 4. Responsibilities for Financial Claims Processing

#### (6) The FCC Director or the FCC Coordinator:

- Provide HHS/ASPR with contact information to NDMS member medical facilities in order to facilitate medical claims processing.
- Provide patient validation data to HHS. See paragraph 9 below.
- Collects appropriately billed charges for support services incurred by the FCC during patient reception operations, and provides them to HHS/ASPR for reimbursement.

#### (7) NDMS member facilities:

- Will be required to identify patients' primary and secondary third party payers and submit billing for patient care services to the patient's identified third party payer(s) for reimbursement.
- Submit Affidavit of Non-insurance for uninsured patients and submit associated final bills for payment directly to the appropriate HHS/ASPR Fiscal Intermediary.

All protected health information should be safeguarded in accordance with the Health Insurance Portability and Accountability Act of 1996.

**(8) Claims:**

- **Medical Care of NDMS Patients**

The Mission Assignment or Sub-Tasking will authorize the reimbursement of NDMS member medical facilities, physicians and other care providers who provide NDMS patients with medical care required resulting from circumstances surrounding the disaster or emergency.

- **Claims for Medical Care of Military Beneficiaries**

TRICARE will directly reimburse NDMS member medical facilities, physicians and other care providers for healthcare services provided to patients who are beneficiaries of the Military Healthcare System (MHS) in accordance with the payment rules stated in Title 32 to the Code of Federal Regulations (32 CFR), Part 199. Final bills for payment are submitted by NDMS member medical facilities, physicians and other care providers to the appropriate TRICARE Managed Care Support Contractor for the patient's command.

- **Claims for Transportation of Civilians**

Costs for transporting NDMS patients to the receiving medical facilities will be authorized according to the Mission Assignment or Sub-Tasking which allows for all FCC/PRA operational activity expenses. Claims for reimbursement for transportation of civilian patients are submitted to HHS/ASPR in accordance with the Mission Assignment or Sub-Tasking.

- **Claims for Transportation of Military Beneficiaries**

TRICARE will directly reimburse costs associated with transporting NDMS patients to the receiving medical facilities. Call 1-800-TRICARE (874-2273) for the region nearest your location for claims submission details.

**5. Patient Validation and Tracking Data Collection**

(6) If TRAC2ES and JPATS have system failures and are unable to generate electronic records, use (table/attachment/etc.).

<b>Name of disaster, emergency or contingency</b>	
<b>FCC name, address, telephone number</b>	
<b>Patient name</b>	
<b>Patient date of birth</b>	
<b>SSN (or other unique patient identifier if SSN not available)</b>	
<b>FEMA registration number</b>	
<b>Admitting medical facility name, address, phone number</b>	
<b>Date of arrival at the PRA</b>	
<b>Date of medical facility admission</b>	
<b>Diagnostic category</b>	
<b>Type of patient (i.e., directly injured/victimized by incident or indirectly affected, relocated or displaced due to the incident)</b>	

(7) FCCs will keep a hard copy record of patients processed through the FCC for historical purposes for three years.

(8) In the event that a claimant/receiving facility argues that a patient has been inadvertently omitted from the NDMS patient roster, the fiduciary/contractor shall contact the appropriate FCC to resolve.

## 12. Military Patient Case Management

Case management of active duty personnel in civilian medical facilities is done daily across the nation. Case managers coordinate issues with the attending physician. Some of the issues addressed are: determining the type of care provided, transfers to another facility, required notifications, and expected date of discharge. Many times these activities are performed by the active duty medical center nearest the medical facility in question. It may also be done by the TRICARE Contractor in an FCC's area. In particular, inter-facility transfers of active duty patients that might be affected under existing TRICARE contracts are not coordinated through GPMIC.

## 13. FCC Expense Tracking

The table below may assist the FCC in planning for expense tracking.

FCC Expense	Example	Actual cost (per day)  **ensure costs conform to expenses for similar services in the area	Total Cost
Civilian personnel costs	City fire department providing PRT or EMS support, Civilian personnel from Medical Treatment Facility on the PRT who incur overtime		
VA personnel costs	VA personnel overtime cost		
Patient Transportation	Costs associated with moving the patient from PRA to NDMS medical facility.		
Transportation Costs (not associated with patient transport)	Costs to transport the patient reception team to the PRA		
Costs associated with housing and feeding the patient reception team	Per diem for hotel, meals and incidentals while at the PRA		
Facility usage	Rental, including electricity, water, security, etc		

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Office supplies			
Furniture rental			
Equipment rental	Items such as computers, faxes, etc.		
Costs associated with patient delay in transportation	Hotel, Food		
Costs associated with services necessary for the health and/or welfare of the patient such as toiletries or food.	Services from the Salvation Army, Red Cross, or other Non-Governmental Agency (NGA)		

## Appendix 1 to Annex H – GAO NO-COST CONTRACTS FREQUENTLY ASKED QUESTIONS

March 13, 2008

### 1. Can an agency use a no-cost contract to acquire something for which its appropriation is not otherwise legally available?

There is no GAO case law addressing a situation like this. If an agency enters into a no-cost contract that permits the vendor to provide a service for which the agency's appropriation is not otherwise legally available, the no-cost contract would not violate the Anti-deficiency Act's voluntary services prohibition because the agency incurs no financial liability. However, the agency should take into consideration that it, indeed, does receive a service in return, for example, for permitting the vendor to provide food to the agency's guests even though the agency's appropriation is not legally available to pay for the food.

### 2. If we assume that the event and circumstances meet the criteria for using appropriated funds to provide food at an agency-sponsored conference, may an agency instead enter into a no-cost contract for conference services, including the provision of food?

Yes. The agency may contract for this service using a no-cost contract. For example, the contract could be structured such that providing food or refreshments to conference participants is part of an overall contract for planning and support services.

An agency may use appropriated funds to provide meals and light refreshments to federal government (as well as nonfederal) attendees and presenters at a formal conference that furthers the agency's statutory mission if the conference meets the following criteria: (1) meals and refreshments are incidental to the conference, (2) attendance at the meals and when refreshments are provided is important for the host agency to ensure attendees' full participation in essential discussions, lectures, or speeches concerning the purpose of the conference, and (3) the meals and refreshments are part of a formal conference that includes not just the discussions, speeches, or other business that may take place when the meals and refreshments are served, but also includes substantial functions occurring separately from when the food is served. A formal conference typically involves topical matters of interest to, and participation of, multiple agencies and/or nongovernmental participants. In addition, other indicators of a formal conference include registration, a published substantive agenda, and scheduled speakers or discussion panels. See B-300826, Mar. 3, 2005.

In this situation, the agency could use a traditional contract in which it pays the contractor to provide lunch at no cost to the attendees, or it could use a no-cost contract where the attendees (or possibly their employers) would bear the cost. In B-308968, Nov. 27, 2007, GAO cautioned that in structuring a no-cost contract there are other considerations beyond compliance with fiscal laws that an agency should take into account so that the effectiveness of the conference is not compromised, including, for

example, who may approve and sign such contracts, the ultimate cost to the government as a whole, and possible conflicts of interest.

### **3. May an agency use a no-cost contract to acquire property as opposed to a service?**

The no-cost contracts GAO has addressed have been for various types of services, including real estate brokerage, travel, conference planning, concession, relocation assistance, haircuts for military recruits, ferryboat transportation, and workers compensation insurance coverage. GAO reviewed many of these contracts in the context of our bid protest function. GAO has also issued a number of appropriations law decisions involving no-cost contracts. At issue in the decisions was whether the no-cost contract violated the Anti-deficiency Act's voluntary services prohibition. The voluntary services prohibition, by its own terms, would not be applicable if property, rather than services, were being provided. GAO has not issued a decision involving a no-cost contract to acquire property.

### **4. May an agency use a no-cost contract to accomplish an activity or function that is mission-related or specifically required by the agency's appropriations act or authorizing legislation?**

GAO has not specifically looked at no-cost contracts from this perspective. However, based on B-308968, Nov. 27, 2007, we would find it difficult to make a distinction between mission-related or required statutory activities and other agency activities.

As discussed in B-308968, when an agency enters into a no-cost contract it does not violate the Anti-deficiency Act's voluntary services prohibition because the agency incurs no financial liability and there is no expectation of payment on the part of the vendor. If an agency enters into a no-cost contract for the provision of a service, whether the service is mission related or statutorily required, or is another type of agency activity, the agency does not incur a financial liability for the service and thus does not violate the voluntary services provision. Of course, an agency, as a matter of policy, can decide the situations in which it is willing to entertain a no-cost contract.

### **5. How do the federal procurement laws apply to an agency's use of a no-cost contract?**

Statutory requirements for competition, such as the Competition in Contracting Act (CICA), apply to procurements by federal agencies for property or services. 10 U.S.C. § 2303; 41 U.S.C. § 253. Thus, as a threshold matter, to be subject to these requirements, the agency must be acquiring property or services. Determining whether competition requirements apply to a particular procurement for a no-cost contract for property or services will depend on the agency involved. CICA does not apply to no-cost contracts of military agencies, see 10 U.S.C. § 2303; *Century 21—AAIM Realty, Inc.*, B-246760, Apr. 3, 1992, 92-1 CPD ¶ 345; *Gino Morena Enterprises*, B-224235, Feb. 5, 1987, 87-1 CPD ¶ 121, but it does apply to no-cost contracts of civilian agencies. See 41 U.S.C. § 253; *Gourmet Distributors*, B-259083, Mar. 6, 1995, 95-1 CPD ¶ 130.

Federal Acquisition Regulation (FAR) requirements apply only to acquisitions by the government of supplies or services with appropriated funds. *Fidelity and Casualty Co. of New York*, B-281281, Jan. 21, 1999, 99-1 CPD ¶ 16; FAR, 48 C.F.R. §§ 1.104, 2.101. Consequently, the FAR does not apply to no-cost procurements conducted by either a defense or civilian agency.

Regardless of the applicability of CICA or FAR, GAO's jurisdiction to consider protests by interested parties challenging procurements conducted by federal agencies extends to all procurements for property or services. In the context of challenges to no-cost contracts for concession services at the National Parks, we have found that in some cases the procurement action was outside of our jurisdiction. Specifically, we have held that concession contracts that do not require the delivery of goods or services to the government (or that require the delivery of goods or services of only de minimizing value to the government) are not contracts for the procurement of property or services within the meaning of CICA and do not fall within our Office's bid protest jurisdiction. *White Sands Concessions, Inc.*, B-295932, Mar. 18, 2005, 2005 CPD ¶ 62, *recon. denied*, B-295932.2, Apr. 12, 2005 (concession contract for the operation of a gift shop and snack bar at a National Park Service visitor center); *Crystal Cruises, Inc.*, B-238347, Feb. 1, 1990, 90-1 CPD ¶ 141 at 2, *aff'd*, B-238347.2, June 14, 1990, 90-1 CPD ¶ 560 (concession permits for five cruise ship entries into Glacier Bay National Park and Preserve). Where a contract authorizing the provision of concession services also requires the delivery of goods or services of more than *de minimis* value to the government, however, the contract is one for the procurement of property or services within the meaning of CICA, and, as such, is encompassed within our bid protest jurisdiction. *Great South Bay Marina, Inc.*, B-293335, July 13, 2005, 2005 CPD ¶ 135.

## **6. May an agency play a role in determining the fee the no-cost contractor charges its customers?**

Yes, agencies may play a role in determining fees charged by contractors acting under authority of a no-cost contract. Agencies should not "lose sight of [their] objectives for a particular event," and should ensure that in minimizing costs, they do not act to "compromise the effectiveness of [a] conference," or "undermine the achievement of agency goals." B-308968, Nov. 27, 2007. Although utilizing a no cost contract may alleviate financial burdens and may not violate the Anti-deficiency Act, agencies contemplating use of such contracts should consider the cost to the government as a whole, especially when many attendees to a conference will be government employees. *Id.*

**7. May either the agency or the no-cost contractor bar a person from attending a conference if the person has not paid the contractor?**

The collection of a fee charged by the vendor is a matter between the vendor and the individual. However, the conference is, in fact, the agency's conference, not the vendor's, and the agency is the host, not the vendor. For the same reasons why we suggest that an agency should play a role in determining the fee that the vendor charges, we would suggest that an agency should have some influence in acceptable collection tools.

## Annex I: Logistical Support

### Purpose:

Provide an overview of the logistical requirements for NDMS patient reception operations.

### 1. Responsibilities

A FCC representative must serve as a logistics planner; the following are items that may be required to continue logistical support for the FCC:

- On request, procures and delivers initial supplies and equipment to the NDMS Patient Reception Area.
- Supports future resupply efforts to support continued FCC operations with onsite personnel.
- Obtains additional logistical support vehicles and drivers, if requested.
- Periodically, inspects and maintains the support and medical equipment, and any automation support equipment.
- Maintains caches of materiel to support FCC operations.

The FCC Director will be responsible for consolidating the administrative cost and expenditures for all logistical support during activation. This would include PRA support supplies, patient support equipment, pharmaceutical requirements, procurement and delivery costs, and all such direct and indirect costs associated in the logistical support of the FCC and the NDMS Patient Reception Area. There needs to be some process to capture, track, and validate all expenditures for supplies, equipment, and services associated with the PRA. Future reimbursements will be dependent upon this process.

### 2. Assumptions

- Medical logistical support is available and methods of re-supply and transport are maintained through governmental or contractor provided support.
- Utility infrastructure supporting medical facilities and FCC will be sufficient to provide uninterrupted service.
- Funding (Mission Assignment) will be available for logistics and facility support services to include procurement of supplies, equipment, maintenance, repairs, and contract personnel.

### 3. Concept

There are two general areas of logistics: Non-medical logistics and medical Logistics. Non-medical logistics are those supplies and equipment needed for staging the NDMS patients. Medical logistics refers to the supplies and equipment required for patient care at the patient reception area of the FCC. Both logistical areas impose several requirements for support. The initial operation should be supported from supplies that are positioned and are available for immediate response. Both medical and non-medical supplies are required and must be replenished as needed. The FCC personnel at the local PRA site will be initially totally dependent on its own patient support resources. Additional logistics support items can be purchased once the mission assignment has been approved. The additional supplies that are used to support the FCC after its activation will need to be documented and tracked for later reimbursement authorized by the MA.

#### **Non-Medical Logistics planning considerations:**

- Space large enough for the supplies and ideally the space will be environmentally controlled.
- Shelter with consideration of power, lighting, and a plan to fuel support equipment such as power generators.
- Food and shelter should consider the different cultures of potential NDMS patients (the elderly, children, religious groups, etc.).
- Some arriving patient's clothing may not be suitable for weather conditions at the PRA. This could possibly drive a requirement for coats, blankets, or might require a heavy clothing swap-out for lighter clothes and clothing storage requirement. Also consider all possible patient gown requirements.
- PRT requirements such as uniforms, foul weather gear, personal protective equipment, and ICS vests.
- Sanitation requirements for personnel hygiene and toilets, not only for the FCC staff, but the need for increased use as NDMS patients and additional support personnel arriving to support the FCC.
- Hazardous medical waste, such blood products, sharps, pathological, and other waste that is considered to include hazards material.
- Weapons/contraband management. Patients may arrive at the PRA with contraband. Procedures to address should be considered.
- Items include office supplies, automation and computer support equipment. Also consider using equipment that the FCC uses on a

regular basis to ensure software updates and compatibility with other automation systems, such as printers, that are supporting the FCC.

- The FCC logistical plan and its implementation may require additional transportation and drivers beyond the FCC capability to support. This would include vehicle and civilian ambulance assets. Plan for adding more space for vehicles, personnel and patients during a surge and what plan for additional logistics would be required to support the increase.

#### **Medical Logistics planning considerations:**

- Medical supplies and pharmaceuticals. PRAs should have enough supplies on hand to match the FCC's throughput. (See below for suggested medical supplies to handle a throughput of 50 patients in 24 hours). Consider pre-packaging supplies (and stored in a climate controlled area) available for movement to the PRA within 6 hours.
- There needs to be an ALS capability at the PRA.

#### **Patient Movement Items (PMI):**

Specific Global Patient Movement Joint Advisory Board (GPMJAB) approved and DoD tested and Safe to Fly (STF) certified medical equipment and durable supplies required to support the patient during evacuation are referred to as Patient Movement Items (PMI). Examples of PMI include ventilators, litters, patient monitors, and pulse oximeters. The function of the PMI system is to support in-transit patients, to exchange in-kind PMI without degrading medical capabilities, provide in-transit visibility of PMI, and to provide prompt recycling of PMI. The handling and return of equipment to the PMI system requires a reliable supporting logistics infrastructure to ensure that PMI are available and serviceable. The plan for a PMI exchange system including the return of AE equipment and PMI to the MTF of origin should be addressed in the NDMS disaster plan.

Contingency PMI cells can also be established and augmented with personnel from the DoD in the event of surge and sustained requirements.

Organizations are encouraged to maintain initial quantities of approved PMI in-kind equipment in their medical assemblages, kits/sets/outfits, table of allowance, or allowance standards, in-house stores, etc. This will ensure standardization and the PMI programs ability to seamlessly support patient movement. This capability is critical to enabling the PMI system to properly recycle/replace medical equipment in medical assemblages and to ensure their designed operational capability is not diminished due to equipment shortfalls.

Timely recycling is essential to maintain and contain our total inventory investment. Key to successful patient treatment and movement is ensuring medical equipment assets are available for patient treatment, tracked in

transit, and recycled to medical treatment facilities. All DOD customers are responsible for tracking and returning PMI assets to the closest PMI Center. See attached list for PMI Center addresses.

PMI equipment is tested and certified for use on applicable service rotary and fixed-wing aircraft by the joint airworthiness certification-testing agency, and service en-route care teams (i.e., AF AE Crews and Critical Care Air Transport Teams) will be trained to operate PMI equipment items. An AF Form 4033, PMI/AE Certification Label is required to designate airworthiness certification for all PMI equipment. This is a joint label and must be affixed to each piece of PMI certified equipment.

The USAF is the PMI program execution agency responsible for resourcing, maintaining, and recycling PMI to support contingency operations for patient movement. HQ AMC/SGXM is the program management, execution, and action office for the Air Force. PMI equipment is placed on the patient by the sending medical treatment facility.

NDMS planners will ensure PMI is part of the adaptive planning process and that USTRANSCOM and its air component are partners in the PMI planning process.

PMI is tracked using PMITS which utilizes bar code technology to scan PMI and share PMI data with other authorized users of the system. Bar codes will be issued only at PMI centers and designated units or by HQ AMC/SGXM using established bar code guidelines in accordance with PMI Bar Coding Methodology and Codes. All users will ensure bar code labels are attached to all PMI equipment assets prior to use and or Patient Movement. The bar code label should have the AMC/SGXM phone number, 1-877-286-1931, on it. If the label is worn or does not have the phone number, contact the nearest PMI center or AMC/SGXM to obtain a new label immediately. Non-PMI equipment will not be tracked in this system unless coordinated with USTRANSCOM and HQ AMC/SGXM.

PMI must be returned promptly, from Medical Treatment Facilities (MTFs) to prevent an equipment shortage in the disaster area. Once patient care is transferred from the PM system to an MTF or other such provider, it is critical that the PMI equipment be returned to the closest PMI Center. DoD organizations must ensure all medical personnel are trained to not only recognize PMI but to also understand and execute recycling PMI back to PMI Centers. MTFs will decontaminate and clean PMI equipment before returning it to another facility, PMI center and/or cell, or transportation point. To reduce medical equipment shortfalls experienced during a contingency NDMS Planners must ensure that detailed procedures are established to resupply, refurbish, and properly recycle PMI. **The FCC Director will identify a location for PMI equipment to be collected and for the PMI Cell to operate out of the FCC.**

MTFs recycling PMI to PMI Centers will obtain the Transportation Access Code (TAC) to pay for shipping from their Service Medical Logistics office.

Once activated, the FCC will need to ensure that the NDMS member medical facilities can be contacted. This will require maintaining phone numbers and contact information of the medical facilities to help return the PMI equipment.

Contact HQ AMC/SGXM for PMI questions and return of PMI equipment at 1-877-286-1931. Three Air Force PMI Centers and their points of contact are listed on page 48 of this document.

## FCC Caches

The following equipment and supplies are designed to support a PRA patient reception daily throughput of 50 patients, and are recommended for consideration:

Item	NSN or Part Number (PN)	Qty	Potential Source
Litter, Folding, Rigid Pole 91.6" Nominal, Adjustable Handles 90 - 94.4", Aluminum Pole, Polypropylene Cover.	6530-01-380-7309 Or PN: 100049	35	Arizona Industries for the Blind 3013 W. Lincoln Street Phoenix, AZ 85009-5704
Litter, Oversized, 90" x 31" x 6" [Folded 45"x9"x7"].	6530-01-552-7708 Or PN: 60-0023	15	North America Rescue, Inc. 35 Tedwell Court Greer, SC 29650-4791
Carrier, Litter, Wheeled, attendant Operated	6530-01-220-7186 Or PN: PSC-HE	10	Rapid Rescue Products 5717 Sellger Drive Norfolk, VA 23502
Support, Litter, Folding, Lightweight, 31.5" High	6530-00-660-0034	50	ISO Group 770 Technology Drive West Melbourne, FL 32904
Strap, Litter, Webbing, Patient Securing	6530-00-784-4205 Or PN: 101037	100	Arizona Industries for the Blind 3013 W. Lincoln Street Phoenix, AZ 85009-

		5704
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Mattress, Litter	6530-01-548-0262	50	
Blanket, Bed, Wool, 66" x 90", Shrink Resistant, 4 lb Nominal, or Blanket, Bed, Cotton Thermal Weave White 66" x 90"	7210-00-715-7985 or 7210-00-139-5779 or PN: 2446690	100	Phoenix Textile Corp. 21 Commerce Drive O'Fallon, MO 63366-4431
Sheet, Bed, Disposable 96" x 60", 100 per package	7210-00-144-6082	1 pkg	
Pillow, Pneumatic, 16.5" x 13"	7210-00-299-8520	50	
Pillowcase, Non-woven Cloth, 31.25-31.75" x 20.25-20.75", Disposable, 10 per package	6532-01-531-7257	5 pkg	
Back Rest, Litter Non-Adjustable, Aluminum / Cotton Duck	6530-00-299-8353	10	
Rod, Intravenous Irrigation Container, Adjustable 18" - 43" High	6530-00-792-6000	25	
Plug, Ear, Noise Protection, Vinyl Foam, 400 pair per package	6515-00-137-6345	2 pkg	GSA Global Supply
Goggles, Sun Wind Dust, Single-Aperture	8465-01-328-8268	50	Stemaco Products, Inc. 2211 Ogden Road Rock Hill, SC 29730
Gloves		50 pr	
Belts, Light Reflective	GFLR041301	50	Sayre Enterprises, Inc
Cot, Folding 2 per carton	7105-00-935-0422	10 ctn	
Moulage Kits	PN: 27-1501 27-1502	1	Training For Life via GSA

Tables, Folding 6'x2'		6	
Chairs, Folding, 4 per carton		7 ctn	
Vests, ICS as required		37	TACTRON, INC
Board, Dry erase		3	
Bullhorn		1	
Trailer, 18'	KD7X18WT2	1	Haulmark via GSA
<b>Total</b>			

## Annex J: Communications

### Purpose:

The purpose of this annex is to assist the FCC in establishing and managing communication processes and equipment in regard to patient reception operations. One of the most common gaps noted in after-action reports in FCC operations is the lack of communication coordination with local entities. The FCC coordinator should ensure communication networks are compatible and integrated with local community resources, State agencies and systems. The FCC coordinator should ensure the FCC has access to and knowledge/technical skill in local and State emergency operations programs and systems.

### 1. Recommended Equipment and Frequency of Testing

The following list is provided to illustrate types of communication equipment that may be useful in running an efficient FCC. It should be used as a guideline for developing individual equipment lists ultimately resulting in effective communications during contingency operations.

Type of Equipment	Quantities	Maintenance Frequency
Laptop computers with internet access (cellular modem access and alpha paging software)	2	As needed
Printer	1	As needed
Scanner/Fax machine	1	As needed
Satellite phone with auxiliary antenna	2	Monthly
Cellular phone with backup batteries	2	As needed
Local Fire EMS Radio with charger and extra battery	2	As needed

Weather radio with battery backup	1	Weekly
JPATS Scanner	2	Quarterly
Pager	2	As needed
Shared Resources (SHARES) HF radio program	1	Monthly
Government Emergency Telecommunications Service (GETS) Card	1	Monthly
Hospital Emergency Administration Radio (HEAR) (as required)	1	Monthly
Locked cargo boxes with wheels or luggage carriers (to transport and store equipment)	As needed	N/A

The following should be considered:

- Use the above equipment list as a guide; it is not meant to be inclusive and each FCC should develop a list specific for their location.
- Prepare for contingencies. For example, expect to have periods of intermittent or no electricity where you need to resort to tracking and documenting on paper (e.g., TRANSCOM Regulating and Command and Control Evacuation System (TRAC2ES) Uploadable Contingency Spreadsheet (TUCS) and JPATS reports).
- It is critically important to maintain and update your equipment, including the software, and most importantly to know how to use it. Best practices include utilizing the computers, radios, phones, and accessories identified

for use by FCCs on a frequent basis to insure familiarity with the systems and to maintain appropriate software updates.

- Since TRAC2ES and JPATS is a web-based system, internet access is needed. Ensure internet access is established at the PRA.

## 2. Training

The FCC Coordinator should be familiar with equipment setup operations and troubleshooting. Equipment manuals and maintenance/testing schedules should be readily available.

## Exercising

FCC communications equipment utilization and operation should be built as part of the FCC exercises.

## 3. Information Systems

Several individuals within the FCC (e.g., FCC Directors and Coordinators) should have access to the following sites/accounts:

- TRANSCOM Regulating and Command and Control Evacuation System (TRAC2ES): <https://www.trac2es.transcom.mil/>
- JPATS: For training module, <https://teams2.hhs.gov/PETSDev/protected/home.do>. For real-world operations, <https://asprwebapps.hhs.gov/jpats/protected/home.do;jsessionid=F012C26D5B82630BB19CC5B625E51A39>. For JPATS field support (e.g., helpdesk), contact [NDMSHelpDesk@hhs.gov](mailto:NDMSHelpDesk@hhs.gov).
- DHS FEMA Lessons Learned Information Sharing (LLIS): the national network of Lessons Learned and Best Practices for emergency response providers and homeland security officials. LLIS.dhs.gov's secure, restricted-access information is designed to facilitate efforts to prevent, prepare for and respond to acts of terrorism and other incidents across all disciplines and communities throughout the U.S. LLIS.dhs.gov houses an extensive catalog of AARs as well as an updated list of homeland security documents from DHS, and other local, state, Tribal, territorial and federal departments/agencies/organizations (<https://www.llis.dhs.gov>)

## Annex K: Critical Information Requests

### Purpose:

The FCC should be prepared to discuss or report the following types of information quickly from a variety of requestors (phone, email, formal formats, etc).

### Following is a listing of some critical information requirements FCCs may have to answer during each phase of operations:

**ALERT:** Should patient requirements dictate the need for NDMS beds, a PRA under management of this FCC could be among the next to receive patients.

- Is the FCC currently able to perform the impending mission? If not, why and how can it be mitigated? (Consider personnel equipment, training, logistics, communications, accessibility, airfield status, local and regional considerations, etc.)
- What is the FCC throughput?
- Is the FCC able to receive patients within 6 hours of activation? If not, give an estimation.
- What is your current bed count: number and types of beds available?

**ACTIVATION:** This status implies that FCC reimbursement for all patient reception activities is authorized. It signifies that patients are to be regulated, or have been regulated to a PRA under management of this FCC. Patients can be expected to arrive within 24 hours.

- How many patients are expected and when? Number of litter, ambulatory, critical care, medical surgical, burn, psychiatric, and pediatric?
- How many and what acuity of patients have been regulated and/or have arrived at the PRA?
- How many of each bed category does the FCC have remaining? (Keep this count throughout the operation).
- What was the actual time the FCC received the first patients?
- How many and what category of patients have been transported to which NDMS member medical facilities?
- How many patients have been received?
  - What types of acuities?
  - Litter or ambulatory?
  - Which NDMS member medical facilities?

**DEACTIVATION:** Once the FCC has been deactivated, the FCC may be called upon to provide historical information:

- How many and what categories of patients were received at the PRA?
- How many patients are still in NDMS member medical facilities? Which medical facilities?
- How many patients were discharged from NDMS member medical facilities?
- What equipment/supplies were used and require reimbursement?
- What was the cost to the facility for reduction of staff in order to stand up and operate the patient reception team? Did the facility reduce clinic hours, cancel surgeries, etc.?
- Of the medical facilities asking for reimbursement, did they receive it in a timely manner?
- What discharge planning information facilitation is required between the NDMS medical facility's case managers and HHS?
- Have you collected after action report items from the FCC and the NDMS partner medical facilities (e.g., medical facility satisfaction, lack of resources, etc.)?

## Annex L: Public Affairs

### Purpose:

This annex provides guidance for Public Affairs (PA) in support of FCC operations. Since FCC operations are conducted in concert with civil authorities and civilian organizations, the interagency environment brings an expanded need for clear cooperation, coordination, and unity of effort.

### Responsibilities:

**The FCC Director** should designate personnel to perform PA duties, to include media relations, community relations, sharing of FCC information, and providing PA training for the FCC.

Consider the makeup of existing FCC personnel with PA experience and expertise when selecting PA designees. Personnel designated should have appropriate PA training. This includes personnel from federal, state, and local agencies such as the FEMA, State Division of Emergency Management (DEM), local law enforcement, Public Information Officers (PIO) and marketing manager of participating agencies.

**The PA Designee** report directly to the FCC director and provides PA support staff to the FCC. The goals of PA are:

- Inform local, state, and national community of the FCC operations through interaction with the media.
- Provide an archive information.
- Prepare staff and key personnel for speaking engagements with the media.

### Operations:

PA personnel should avoid unintentional release of sensitive, medical or classified information. Consider safety, procedural and operational mishaps and incidents which may draw negative media attention.

PA Tasks during FCC active operations:

- Prepare all informational materials for the media. This should include information about participating agencies supporting the FCC operation.
- Establish a designated area for PA activities.
- Perform media escort activities to control media access to acquire footage and interview of FCC personnel and/or patients.
- Attend FCC staff meetings, when possible, to maintain situational awareness.

- Assume the responsibility for responding to media and community queries.
- Coordinate with spokespersons from FEMA, State, and local agencies when conducting press conferences, writing media releases and informing key leaders of the FCC operations.
- Serve as point of contact for Hometown News Releases (DD Form 2266).

PA will need to ensure they have the proper resources to do their work. This might include personal computers, printers, blank CD, CD writers, digital cameras, batteries, DVD recorders and power access. Consider providing communications equipment such as mobile radio, a dedicated FAX machine, and internet connectivity.

### Resources for more information:

The **Defense Information School** units of instruction created for public access and presented for informational purposes only can be found at the Web address listed below. These units cover a wide variety of public affairs disciplines. However, reading these units does not constitute an enrollment into any course offered by the Defense Information School.

<http://www.dinfos.dma.mil/#&panel1-1>

FEMA's **National Preparedness Directorate** (NPD) has developed an online Course Catalog that provides searchable, integrated information on courses provided or managed by FEMA's Center for Domestic Preparedness (CDP), Emergency Management Institute (EMI), and National Training and Education Division (NTED).

### **FEMA Emergency Management Institute (EMI)**

(<http://training.fema.gov/EMICourses/docs/FY14%20Catalog.pdf>) courses available are as follows:

#### **Advanced Professional Series (APS)**

G0290 Basic Public Information Officers Course

#### **External Affairs-State/Local/Federal Resident Courses**

E0388 Advanced Public Information Officers Course

E0389 Master Public Information Officer

#### **State/Local/Tribal Field-Delivered Courses**

G0289 Public Information Officer Awareness Training

G0290 Basic Public Information Officers Course

G0291 Joint Information System/Center Planning for Tribal, State, and Local Public Information Officers

**Independent Study Courses**

IS-0029 Public Information Officer Awareness

IS-0702.a National Incident Management System Public Information Systems

**Incident Command System Resident Courses**

E0952 NIMS ICS All-Hazards Public Information Officer Course

E0953 NIMS ICS All-Hazards Public Information Officer Train-the-Trainer

**Integrated Emergency Management Resident Courses**

E0388 Advanced Public Information Officers Course

## Annex M: Glossary of Terms and Acronyms

### 1. Terms:

**Activated Federal Coordinating Center:** This status indicates reimbursement for all patient reception activities is authorized. It signifies patients may be, or have been regulated to a PRA under management of this FCC.

**Alerted Federal Coordinating Center:** Should patient requirements dictate the need for NDMS beds, an alerted PRA under management of an FCC could be among the next to receive patients. However, patients are currently NOT being regulated to this PRA. ***This status does not necessarily authorize reimbursement*** of FCC and/or PRA expenses incurred preparing for possible reception of patients.

**Air Mobility Command (AMC):** One of the three component commands of USTRANSCOM. AMC is the lead command for Air Force aeromedical evacuation.

**Aeromedical Evacuation:** AE provides time-sensitive en route care of regulated casualties to and between medical treatment facilities, using organic and/or contracted aircraft with medical aircrew trained explicitly for this mission.

**Ambulances:** Patient transport vehicles come with ALS and/or BLS capability and with appropriate care providers given the patient condition. It is the responsibility of the FCC to coordinate the transport (and en-route care providers) from the FCC to the receiving facility.

**Ambulance Bus (AMBUS):** The ambulance bus is organic to the military table of allowance for contingency hospitals and the patient staging system. The AMBUS has an inherent capability to transport a combination of litter and ambulatory patients, and provide a basic life support capability.

**Available Beds:** Beds vacant as of 2400 hours of the previous day of the report, to which patients can be regulated and transported.

**NDMS Bed Report:** A medical facility's capacity to receive, admit, and treat patients from a contingency, or the submission of a FCC's capacity, including all available NDMS beds, for admission.

**Burns (SBN):** Patients having burn injuries meeting the American Burn Association's (ABA) burn unit referral criteria, including (but not limited to) partial thickness burns of 10% or more of the total body surface; all patients with third-degree burns of 10% or more of the total body surface; or patients with significant burns involving the face, hands, feet, genitalia, perineum or major joints. Burn beds are generally defined as those associated with burn centers on the joint ABA and American College of Surgeons (ACS) verification list.

**C-130 Hercules:** The backbone of the DoD AES in the Continental United States (CONUS). This aircraft has the unique capability of not requiring an improved runway for takeoff or landing. It can land on short stretches of interstate highway, in a desert region, or an open field, weather and soil conditions permitting. The C-130 can be readily configured for AE by using seat and litter provisions stowed in the cargo compartment. For deliberate planning purposes, the C-130 standard load is 50 patients.

**Capacity:** The number of patients a medical facility can accommodate at a given point in time.

**Category:** One of the specific areas of medical care used to identify the patient's clinical requirements as well as identify the bed availability of the receiving medical facility.

**Critical Care (CC):** Adult patients requiring sophisticated intervention to restore or maintain life processes to their dynamic equilibrium. This involves the requirement to provide continuous care and monitoring using specialized facilities, equipment and personnel.

**Critical Care Air Transport Teams (CCATT):** Air transport teams providing specialized care, in conjunction with AE crews, to evacuate critical patients requiring advanced care during transportation. Recognized as clinical experts, these teams are medically responsible for their patients. The CCATT physician is clinically responsible for care given to CCATT-assigned patients and may be asked to assist or advise on the care of the other patients.

**Definitive Medical Care:** To the extent authorized by HHS in the particular public health emergency, medical treatment or services beyond emergency medical care, provided by an NDMS member facility for injuries or illnesses resulting directly from a specified public health emergency, or for injuries, illnesses and conditions requiring essential medical treatment or services to maintain health when such medical treatment or services are temporarily not available as a result of the public health emergency.

**Disaster Medical Assistance Team (DMAT):** The primary NDMS resource to provide supplemental medical assistance. DMAT members are individuals who have volunteered to be intermittent NDMS federal employees of HHS. The basic DMAT is a group composed of about 35 to 50 physicians, nurses, technicians, and other allied personnel, coming together and training as a unit.

**Emergency Management Group (EMG):** The HHS Headquarters level group operating in the HHS Secretary's Operations Center (SOC) and responsible for the coordination of all national Emergency Support Function (ESF) # 8 activities during a response to a disaster, major emergency, or National Special Security Event.

**Emergency Support Function (ESF):** ESFs have proven to be an effective way to bundle and manage resources to deliver core capabilities. The Federal ESFs bring together the capabilities of Federal departments and agencies and other national-level assets. ESFs are not based on the capabilities of a single department or agency, and the functions for which they are responsible cannot be accomplished by any single department or agency. Instead, Federal ESFs are groups of organizations that work together to deliver core capabilities and support an effective response. These functions represent those types of federal assistance which the State likely will need most because of the overwhelming impact of a catastrophic event on local and State resources.

**Enroute Patient Staging System (ERPSS):** The ERPSS provides rapid response patient staging, limited holding and AE crew support capability. Normally located at or near airheads capable of supporting mobility airlift, the ERPSS is modularly designed capability designed to provide forward support from the ERPSS 10-bed to ERPSS 100-bed capabilities. For contingency planning, the throughput of the ERPSS-10 is 40 patients per 24 hours. The ERPSS includes a capability to receive patients, provide supportive patient care, and meet administrative requirements on the ground while awaiting AE airlift. CCATTs can be assigned to forward based ERPSS's to enhance rapid evacuation of stabilized patients.

**EXORD:** Execution Order which outlines ESF #8 support to FEMA for disaster operations.

**Federal Coordinating Center (FCC):** A facility located in a metropolitan area of the United States, responsible for day-to-day coordination of planning and operations in one or more assigned geographic NDMS Patient Reception Areas (PRA).

**Federal Coordinating Center Coordinator:** A DoD, VA or other principle staff officer assigned to assist the FCC Director.

**Federal Coordinating Center Director:** A military medical treatment facility commander, medical center director, or other individual responsible for the management of an FCC and associated NDMS PRAs.

**Global Patient Movement Integration Center (GPMIC):** The joint activity reporting directly to the Commander, US Transportation Command, the DoD single manager for the strategic and continental United States regulation and movement of uniformed services and other authorized patients. The GPMIC provides medical regulating and aeromedical evacuation scheduling for the continental United States and inter-theater operations and provides support to the theater patient movement requirements centers. The GPMIC coordinates with supporting resource providers to identify available assets and communicates transport to bed plans to the appropriate transportation agency for execution.

**Incident Command System (ICS):** The ICS is a management system designed to enable effective and efficient domestic incident management by integrating a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to enable effective and efficient domestic incident management. A basic premise of ICS is that it is widely applicable. It is used to organize both near-term and long-term field-level operations for a broad spectrum of emergencies, from small to complex incidents, both natural and manmade. ICS is used by all levels of government—federal, state, Tribal, territorial and local—as well as by many private-sector and nongovernmental organizations. ICS is also applicable across disciplines. It is normally structured to facilitate activities in five major functional areas: command, operations, planning, logistics, and finance and administration. CS online resource center:  
<http://training.fema.gov/EMIWeb/IS/ICSResource/index.htm>

**Joint Director of Military Support (JDOMS):** The Joint Director of Military Support serves as the action agent for planning and executing DoD's Defense Support of Civilian Authorities (DSCA) within the United States.

**Joint Patient Assessment and Tracking System (JPATS):** JPATS is part of the HHS Disaster Medical Information Suite. It is a web-based system for tracking patients across the continuum of care.

**Local Emergency Planning Committee (LEPC):** Originally designed to plan for chemical hazards. LEPCs now include planning for a variety of disasters that may affect the community, i. e., "All-Hazards" planning.

**Medical Regulating:** Medical regulating is a casualty management system designed to coordinate the movement of patients from site of injury or onset of disease through successive roles of medical care to an appropriate MTF. (see DoD Joint Publication 4-02, Health Service Support, [http://www.dtic.mil/doctrine/new\\_pubs/jp4\\_02.pdf](http://www.dtic.mil/doctrine/new_pubs/jp4_02.pdf))

**Medical/Surgery (MM-SS):** Patients having, or suspected of having, medical illness or disorders, as well as patients having, or suspected of having, diseases or injuries normally treated by surgery, not coming within the purview of a more specific medical specialty. Medical/surgical beds are generally defined as those licensed, certified or otherwise authorized, with adequate space, equipment, medical materiel and ancillary support services, and staff to operate under normal circumstances.

**Memorandum of Agreement (MOA) for Definitive Medical Care:** The Definitive Medical Care MOA is an agreement between the NDMS Federal Partners and the Provider (receiving medical facility) whereby they agree to plan jointly for the transportation, admission, treatment, discharge, and return of all patients transferred to the Provider's facility under the NDMS.

**Mission Assignment (MA):** DHS/FEMA uses the mission assignment as a work order to direct completion by a Federal agency of a specified task pursuant to a Stafford Act declaration. DHS/FEMA may issue mission assignments to other federal agencies to: 1) address a state's request for federal assistance to meet unmet emergency needs; or 2) support overall federal operations pursuant to, or in anticipation of, a Stafford Act declaration. The mission assignment is issued to an agency by using FEMA Form 90-129, Mission Assignment (see Attachment 1) with, as applicable, funding, funding limitations, the requirements of the task(s) to be performed, completion date, and state cost-share requirements.

When the State has exhausted its resources and requires federal assistance, it does so through FEMA. At the request of the State, a mission assignment is generated by FEMA. The mission assignment will articulate which FCCs are to be activated.

**Mobile Acute Care Team (MAC-T):** The MAC-T provides personnel and equipment to meet specific operational requirements. This 18-person team is comprised of clinicians, team command and logistical support. The clinical component is comprised of physicians, physician assistants, nurse practitioners, registered nurses, respiratory therapists, pharmacists, and paramedics—all members of existing Disaster Medical Assistance Teams (DMAT). The MAC-T's composition is optimized for **critical care delivery**. The MAC-T is not designed to be a stand-alone asset. The team requires outside logistics support to operate.

**Enroute Patient Staging System (ERPSS):** The ERPSS provides rapid response patient staging, limited holding, and AE crew support capability. Normally located at or near airheads capable of supporting mobility airlift, the ERPSS is designed to provide forward support with the smallest footprint. It is made up of a three person alert AEC, communications, liaison, and patient care teams. For contingency planning, patient throughput is 40 patients per 24 hours. The ERPSS includes a capability to receive patients, provide supportive patient care, and meet administrative requirements on the ground while awaiting AE airlift. CCATTs can be assigned to forward based ERPSSs to enhance rapid evacuation of stabilized patients.

**National Ambulance Contract:** FEMA's plan to provide a comprehensive EMS response to federally declared disasters. This contract provides a full array of ground ambulance, air ambulance and para-transit services to supplement the federal and military response to a disaster, act of terrorism or other public health emergency.

**National Disaster Medical System Partners MOA:** This document implements the statutory provisions of Title 42, Section 2811 of the United States Code. The MOA is signed by the four federal partners and identifies the components of the NDSM while indicating roles and responsibilities for the partners. It also includes the standard memorandum of agreement between the NDMS and participating medical facilities.

**National Disaster Medical System Steering Committee:** A committee, established by the FCC, consisting of local medical facility, medical, public health, public safety, emergency management and emergency medical services officials, representatives of voluntary organizations, and elected officials organized in an NDMS PRA to assist in the preparation of local NDMS operating plans, planning, and execution of system exercises.

**National Incident Management System (NIMS):** The National Incident Management System (NIMS) provides a systematic, proactive approach to guide departments and agencies at all levels of government, nongovernmental organizations, and the private sector to work seamlessly to prevent, protect against, respond to, recover from, and mitigate the effects of incidents, regardless of cause, size, location, or complexity, in order to reduce the loss of life and property and harm to the environment. NIMS works hand in hand with the National Response Framework (NRF). NIMS provides the template for the management of incidents, while the NRF provides the structure and mechanisms for national-level policy for incident management. NIMS Web address: [http://www.fema.gov/pdf/emergency/nims/NIMS\\_core.pdf](http://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf)

**National Response Framework:** The *National Response Framework (NRF)* presents the guiding principles that enable all response partners to prepare for and provide a unified national response to disasters and emergencies – from the smallest incident to the largest catastrophe. The *Framework* defines the key principles, roles, and structures that organize the way we respond as a Nation. It describes how communities, Tribes, territories, states, the federal government, and private-sector and nongovernmental partners apply these principles for a coordinated, effective national response. The *National Response Framework* is always in effect, and elements can be implemented at any level at any time. National Response Framework online resource center: <http://www.fema.gov/emergency/nrf/>.

**NDMS member medical facilities:** Medical facilities are those providers and institutions approved by HHS to receive reimbursement for care provided as outline in the Definitive Medical Care Memorandum of Agreement.

**Non-medical Attendants:** A non-medical person who escorts the patient to assist in daily life skills until the patient is admitted to the destination medical facility.

**Patient Movement Items (PMI):** A select set of DoD approved medical equipment and durable supplies required to support the patient during evacuation are referred to as Patient Movement Items (PMI). Examples of PMI include ventilators, litters, patient monitors, and pulse oximeters.

**Patient Reception Area:** A geographic locale containing one or more airfields, bus stations, or airheads; adequate patient staging facilities; and adequate local patient transport assets to support patient reception and transport to local voluntary, pre-identified, non-federal, acute care medical facilities capable of

providing definitive care for victims of a domestic disaster, emergency, or military contingency. Generally, these medical facilities should be within 50 mile radius.

**Patient Reception Team (PRT):** A multi-function group consisting mainly of clinical staff, but also including appropriate support from medical administration and communications personnel, logistics personnel, and people acting as litter bearers and drivers.

**Pediatrics (MC):** Patients having, or suspected of having, diseases or injuries requiring the services of pediatric health care providers. Pediatric beds are generally defined as those supported by a licensed pediatrician.

**Pediatric ICU (PICU):** PICU patients are those critically ill or injured, including those requiring ventilator support, aged 17 years or younger. PICU beds are generally defined as those that can support critically ill or injured patients, including those requiring ventilator support, aged 17 years or younger.

**Negative pressure/isolation (NPU):** NPU patients are those requiring a separate room or area provided with negative airflow and respiratory isolation. NPU beds are generally defined as those providing negative airflow and respiratory isolation.

**Prepare to Deploy Order (PTDO):** In the case of DoD FCCs, the Chairman, Joint Chiefs of Staff standing EXORD delegates the authority to USNORTHCOM to place DoD FCCs on Prepare to Deploy Order (PTDO) for up to seven days. PTDO is equivalent to Alert for the FCC. When needed, USNORTHCOM will issue a Modification Order (MOD) to the EXORD, which would include placing forces on PTDO.

**Primary Receiving Center (PRC):** A PRC is a Military Treatment Facility (MTF) or VA Medical Center (VAMC) designated for coordinating and/or providing treatment to sick and wounded military personnel returning from armed conflict or national emergency.

**Psychiatry (MP):** Patients who require specialized psychiatric care in a medical treatment facility, including patients with disorders defined by the American Psychiatric Association as severe mental illness (e.g., schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, or autism). Psychiatric beds are generally defined as those supported by a licensed psychiatrist, or a licensed practice registered nurse, social worker, psychologist or professional counselor when those services are part of a treatment plan authorized by a licensed psychiatrist.

**Throughput:** The maximum number of patients that can be received at the NDMS patient reception area, off-loaded, staged, triaged, transported and admitted to the destination medical facility (or medical facilities of the NDMS) within any 24-hour period. This is an estimate, subjectively derived from various considerations such as reception site and local transportation limitations,

personnel limitations for patient reception, staging and transport, as well as any other factors deemed relevant.

**USARNORTH:** US Army North (USARNORTH), as the Joint Force Land Component Command (JFLCC) and the Army Service Component Command (ASCC) to US Northern Command, conducts Homeland Defense (HD), Civil Support (CS) operations and Theater Security Cooperation (TSC) activities in order to protect the American people and our way of life.

## 2. Acronyms

AE	Aeromedical Evacuation
AES	Aeromedical Evacuation System
AKO	Army Knowledge Online
AMC	Air Mobility Command
APOD	Aerial Port of Debarkation
APOE	Aerial Port of Embarkation
AOR	Area of Responsibility
ARC	American Red Cross
ARES	Amateur Radio Emergency Services
ASD(HA)	Assistant Secretary of Defense(Health Affairs)
ASD(HD&ASA)	Assistant Secretary of Defense (Homeland Defense & America's Security Affairs)
ASPR	Assistant Secretary for Preparedness and Response (HHS)
CAPT	Captain (U.S. Navy)
CC	Critical Care (bed reporting category)
CCP	Casualty Collection Point
CEO	Chief Executive Officer
COI	Community of Interest
CONOPS	Concept of Operation
CONUS	Continental United States
CS	Civil Support

CSU	Clearing Staging Unit
DCO	Defense Coordinating Officer
DFO	Disaster Field Office
DEM	Division of Emergency Management
DHS	Department of Homeland Security
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Operational Response Team
DoD	Department of Defense
DRG	Diagnosis Related Group
DSCA	Defense Support to Civil Authorities
DVA	Department of Veterans Affairs
EMG	Emergency Management Group
EMS	Emergency Medical Services
EPC	Emergency Planning Committee
ERPSS	En-Route Patient Staging System
ESF	Emergency Support Function
ESF #1	Emergency Support Function #1 – Transportation
ESF #6	Emergency Support Function #6 – Mass Care
ESF #8	Emergency Support Function #8 – Health and Medical Services
EXORD	Execute (or Execution) Order
FCC	Federal Coordinating Center
FCO	Federal Coordinating Officer
FEMA	Federal Emergency Management Agency
FRS	Family Radio System
FY	Fiscal Year
GETS	Government Emergency Telecommunications Service

GPMIC	Global Patient Movement Integration Center
HAM	Amateur Radio Operators
HAZMAT	Hazardous Materials
HEAR	Hospital Emergency Administration Radio
HD	Homeland Defense
HF	High Frequency
HHS	Department of Health and Human Services
HLS	Homeland Security
HSEEP	Homeland Security Exercise and Evaluation Program
IAW	In accordance with
IRCT	Incident Response Coordination Team
JCS	Joint Chiefs of Staff
JDOMS	Joint Director of Military Support
JFO	Joint Field Office
JLFCC	Joint Land Forces Component Command
JPATS	Joint Patient Assessment and Tracking System
JPMT	Joint Patient Management Team
JPRT	Joint Patient Reporting Team
LEPC	Local Emergency Planning Committee
LFA	Lead Federal Agency
LLIS	Lessons Learned Information System
MA	Mission Assignment
MAC T	Mobile Acute Care Team
MARS	Military Affiliate Radio System
MC	Pediatrics (bed reporting category)
MHS	Military Health System

MM/SS	Medical/Surgical (bed reporting category)
MMRS	Metropolitan Medical Response System
MOA	Memorandum of Agreement
MOD	Modification Order
MOU	Memorandum of Understanding
MP	Psychiatry (bed reporting category)
MSC	Military Sealift Command
MST	Management Support Team
MTF	Military Medical Treatment Facility
NDMS	National Disaster Medical System
NECC	National Emergency Coordination Center
NLE	National Level Exercise
NMCC	National Military Command Center
NPU	Negative Pressure Isolation Unit
NOK	Next of Kin
NRCC	National Response Coordination Center
NRF	National Response Framework
NVRT	National Veterinary Response Team
OASD/HA	Office of the Assistant Secretary of Defense, Health Affairs
OEM	Office of Emergency Management
OPLAN	Operations Plan
OPORD	Operations Order
OSC	Operations Support Center
PA	Public Affairs
POC	Point of Contact
PICU	Pediatric ICU

PIO	Public Information Officers
PMCC	Patient Movement Coordination Cell
PMI	Patient Movement Items
PMITS	PMI Tracking System
PMR	Patient Movement Request
PRA	Patient Reception Area
PRC	Patient Reception Center
PRS	Patient Reception Site
PRT	Patient Reception Team
PTDO	Prepare to Deploy Order
RACES	Radio Amateur Communications for Emergency Services
REC	Regional Emergency Coordinator
REP	Regional Evacuation Point
RRCC	Regional Response Coordination Center
SAT	Service Access Team
SBN	Burns (bed reporting category)
SLTT	State, Local, Tribal, and Territorial
SOC	Secretary's Operations Center (HHS)
TACC	Tanker Airlift Control Center
TRAC2ES	TRANSCOM Regulating And Command and Control Evacuation System
UPS	Uninterruptible Power Supply
USARNORTH	United States Army North
USC	United States Code
USD	Under Secretary of Defense
USH/VA	Under Secretary for Health, Department of Veterans Affairs
USJFCOM	U.S. Joint Forces Command

USNORTHCOM	U.S. Northern Command
USTRANSCOM	U.S. Transportation Command
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VHF	Very High Frequency
WebEOC	Web Based Emergency Operations Center

## Annex N: Point of Contact List

### 1. Army MEDCOM:

24 Hour OPSCENTER21: [EOC.OPNS@amedd.army.mil](mailto:EOC.OPNS@amedd.army.mil) 703-681-8052

### 2. Air Force:

HAF/SG3XO

Main office number: 703-697-9075

CAT Desk: 703-693-5674 (only answered when CAT is activated)

On-Call BB (Can be reached 24/7): 202-445-0705

### 3. Navy: BUMED MOC

[BUMED.MOC@med.navy.mil](mailto:BUMED.MOC@med.navy.mil)

202-215-0062

### 4. GPMIC 24 hour OPS DESK (618) 229-4200

### 5. National Operations Center (NOC)

Department of Homeland Security

Watch Desk general communication: [NOC.SWO@dhs.gov](mailto:NOC.SWO@dhs.gov)

For sensitive communications: [communicationsNOC.SWO.Restricted@dhs.gov](mailto:communicationsNOC.SWO.Restricted@dhs.gov)

### HHS SOC

SOC Email [hhs.soc@hhs.gov](mailto:hhs.soc@hhs.gov)

SOC 24 hour number 202-619-7800

NDMS: 1-800-872-6367

### 6. VA:

VHA Office of Emergency Management Duty Officer

304-264-4800

## Annex O: References List

### 1. REFERENCES:

- a. National Response Framework (NRF), May 2013
- b. Robert T. Stafford Disaster Relief and Assistance Act, 42 U.S.C. 5121 et seq
- c. Public Law 97-174, VA and DoD Health Resources Sharing and Emergency Operations Act (4 May 1982)
- d. Public Law 107-188, Public Health Security and Bioterrorism Preparedness and Response Act of 2002
- e. MOA, National Disaster Medical System (24 October 2005); currently under revision
- f. MOA between VA and DoD Regarding the Furnishing of Health-Care Services to Members of the Armed Forces in the Event of a War or National Emergency (16 November 2006)
- g. DoD Directive 5136.01, Assistant Secretary of Defense for Health Affairs (June 4, 2008)
- h. DoD Instruction 6000.11, Patient Movement (4 May 2012)
- i. DoD Directive 6010.22, National Disaster Medical System (NDMS) (24 November 2003); currently under revision
- j. HSPD 5 Homeland Security Presidential Directive 5 Management of Domestic Incidents, February 2003
- k. HSPD 8 Homeland Security Presidential Directive 8 National Preparedness, December 2003
- l. HSPD 21 National Strategy for Public Health and Medical Preparedness October 2007
- m. Homeland Security Exercise and Evaluation Program (HSEEP) Vol. I-III, April 2013
- n. FY 2013 Overview: Homeland Security Grant Program (HSGP) State Homeland Security Program

### 2. WEBSITES:

Army Knowledge Online (AKO): <https://www.us.army.mil/>

Defense Information School Public Affairs Training:  
[http://www.dinfos.osd.mil/dinfosweb/adl/elearn/ContentModuleMenu\\_public.asp?courseTPI=PAOQC-ADL-NR](http://www.dinfos.osd.mil/dinfosweb/adl/elearn/ContentModuleMenu_public.asp?courseTPI=PAOQC-ADL-NR)

Defense Medical Readiness Training Institute: <http://www.dmrti.army.mil/>

Defense Threat Reduction Agency: <http://www.dtra.mil/>

Department of Defense Issuances: <http://www.dtic.mil/whs/directives/>

Department of Health and Humans Services: <http://www.hhs.gov/>

Department of Homeland Security State Contacts and Grant Award information at <http://ipv6.dhs.gov/xgot/grants/>.

Department of Veterans Affairs: <http://www.va.gov/>

Department of Veterans Affairs Office of Emergency Management (OEM) (internal website):: <https://VAww.visn5.portal.va.gov/sites/ro/emshg/default.aspx>

Department of Veterans Affairs Office of Emergency Management (OEM) (external website): <https://VAww.visn5.portal.va.gov/sites/ro/emshg/external/default.aspx>

FEMA Lessons Learned Information System (LLIS): <https://www.llis.dhs.gov>

FEMA National Exercise Program: <http://www.Fema.gov/national-exercise-program>

FEMA Training Website: <http://training.fema.gov/IS/>

HHS ASPR NDMS: <http://www.hhs.gov/aspr/oepo/ndms/index.html>

Homeland Security Information Network: <https://auth.dhs.gov/oam/hsinlogin>

Joint Patient Assessment and Tracking System Logon:

- For training module, <https://teams2.hhs.gov/PETSDDev/protected/home.do>
- For real-world operations, <https://asprwebapps.hhs.gov/jpats/protected/home.do;jsessionid=F012C26D5B82630BB19CC5B625E51A39>

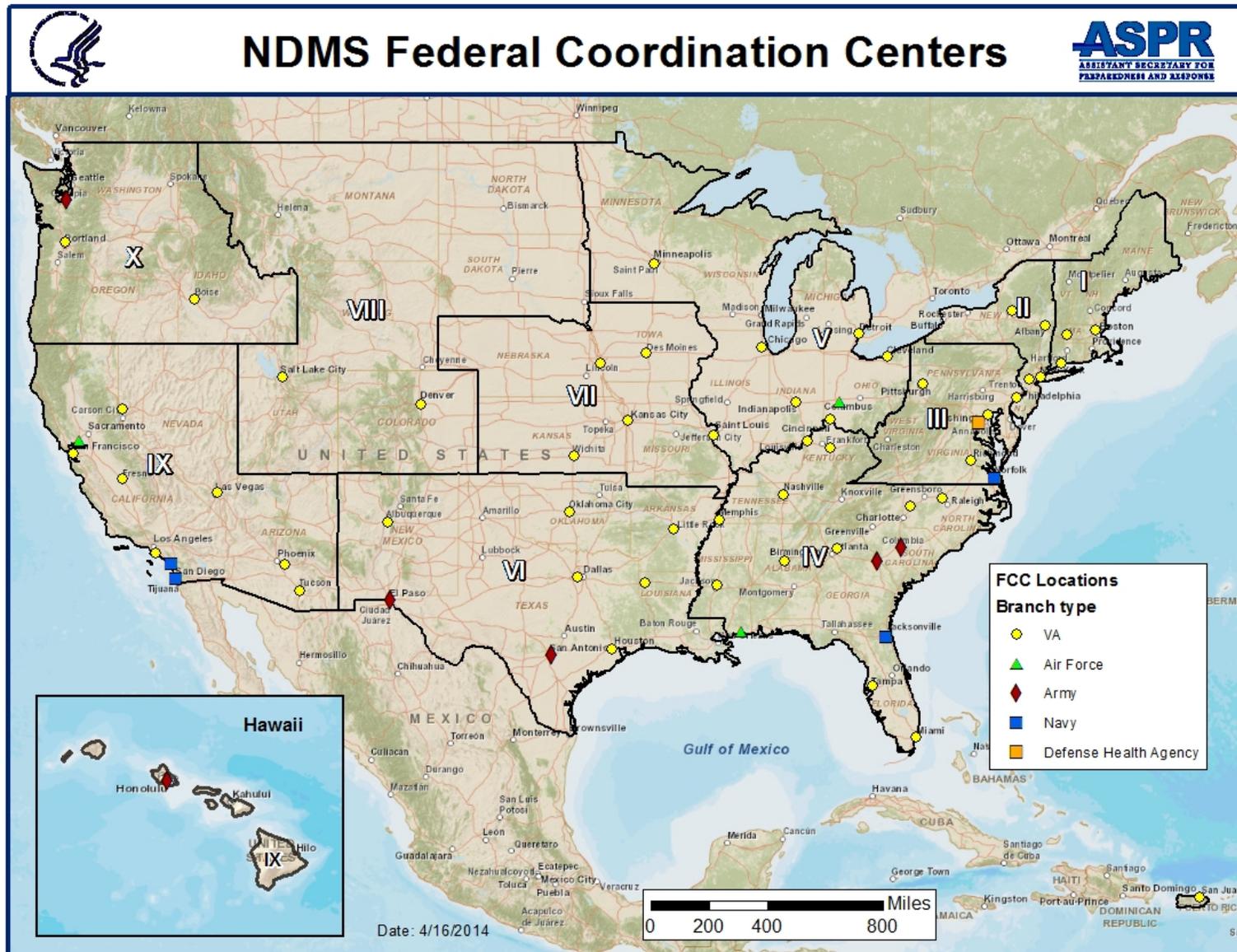
National Response Framework Resource Center:  
<http://www.fema.gov/emergency/nrf/>

TRANSCOM Regulating Command & Control Evacuation System (TRAC2ES):  
<https://www.trac2es.transcom.mil/>

USNORTHERN Command: <http://www.northcom.mil/>

USARNORTH: <http://www.arnorth.army.mil/>

# Annex P: Map of Current FCCs



## Annex Q: FCC PRA Self-Assessment

PRA Location / Area of Responsibility: \_\_\_\_\_

\_\_\_\_\_

FCC Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

FCC Area Coordinator: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

FCC Director's Review:

\_\_\_\_\_

\_\_\_\_\_

Name

Signature

\_\_\_\_\_

Date

## I. FCC Command, Control & Communications

1. How many full time and/or augmentation personnel are assigned or detailed to the FCC that manages this PRA? \_\_\_\_\_

2. Does the FCC manage more than one PRA?  Yes  No  Unknown

3. If the FCC manages more than one PRA, are sufficient personnel dedicated to manage operations at each PRA?  Yes  No  Unknown

4. Are key FCC staff members subject to military mobilization?  Yes  No  Unknown

5. Are sufficient financial resources available to maintain, train, equip, and exercise the FCC?  Yes  No  Unknown

6. Are sufficient administrative resources (e.g., space, furniture, supplies) available to maintain, train and exercise the FCC?  Yes  No  Unknown

7. Is sufficient information technology (computer resources) available to maintain, train and exercise the FCC?  Yes  No  Unknown

8. Are sufficient primary and alternative communications available to the FCC?  Yes  No  Unknown

9. Does the FCC maintain contact with the following?

a. Local NDMS Steering Committee  Yes  No  Unknown

- b. Local volunteer organizations (e.g., the American Red Cross, Salvation Army)  Yes  No  Unknown
- c. Local Emergency Medical Services  Yes  No  Unknown
- d. Local Public Health Authorities  Yes  No  Unknown
- e. DoD Theater Patient Movement Requirements Center-Americas  Yes  No  Unknown
10. Have tracking mechanisms been established to account for expenses incurred to support FCC staff training, exercises, equipping, and operations?  Yes  No  Unknown
11. Have tracking mechanisms been established to account for expenses incurred to support local patient reception and distribution operations?  Yes  No  Unknown
12. Are lines of authority, roles and responsibilities for the FCC staff, the Patient Reception Team(s), and other local authorities, companies and agencies documented?  Yes  No  Unknown
13. Are FCC message control measures and required notifications adequately established?  Yes  No  Unknown
14. Have TRAC2ES accounts been established and maintained for sufficient numbers of FCC staff personnel?  Yes  No  Unknown
15. Have JPATS accounts been established and maintained for sufficient numbers of FCC staff personnel?  Yes  No  Unknown

16. Have contacts been established with the TRICARE Regional Offices or with the nearest military treatment facility?

17. Have sufficient resources available to support augmenting teams (i.e., JPATS, SATs, PMITs)?  Yes  No  Unknown

18. Is sufficient support provided by a local NDMS Steering Committee?

19. Have procedures been established to guide media relations?  Yes  No  Unknown

20. Is accurate FCC contact information (such as the FCC Area Coordinator, 24/7 FCC phone numbers, and addresses) maintained in TRAC2ES?  Yes  No  Unknown

21. Are there sufficient primary and alternative means of communications maintained among the FCC, Patient Reception Team(s), NDMS facilities, and other local POCs?  Yes  No  Unknown

22. Has a PRA plan been developed?  Yes  No  Unknown

23. Has a PRA plan been reviewed/updated on an annual basis?  Yes  No  Unknown

24. Has the PRA plan been integrated into community emergency preparedness plans?  Yes  No  Unknown

25. What agencies constitute and/or support the local NDMS Steering Committee?

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**Comments:**

**What is the “Plan of Action” to remedy all NO answers:**

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**What is the “Plan of Action” to investigate all applicable UNKNOWN answers:**

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## II. Patient Reception and Distribution

### 1. Does the PRA plan address following areas?

a) Contact information for Patient Reception Team(s)  Yes  No  Unknown

b) Plans and procedures for recall and mustering of Patient Reception Team(s)  Yes  No  Unknown

(1) Identification of local ambulance resources, inventories, capabilities, points of contact, phone numbers, written agreements or contractual requirements (if any)  Yes  No  Unknown

(2) Identification of local bus or taxi resources, inventories, capabilities, points of contact, phone numbers, written agreements or contractual requirements (if any)  Yes  No  Unknown

(3) Identification of equipment and supplies to support patient care (such as litters, blankets, bandages, etc.)  Yes  No  Unknown

(4) Patient Reception Team(s) plans, processes and procedures for unloading patients  Yes  No  Unknown

(5) Patient Reception Team(s) plans, processes and procedures for staging, holding and re-triaging patients at the airfield, bus and/or train terminal(s)  Yes  No  Unknown

- (6) Resources to support the Patient Reception Team(s): Meals, Water, Bathing and Toilet Facilities, Sleeping Arrangements, Team-Member Transportation  Yes  No  Unknown
- (7) Night and/or weekend operations  Yes  No  Unknown
- (8) Inclement weather contingencies  Yes  No  Unknown
- (9) Processes and procedures for patient identification and tracking within the PRA  Yes  No  Unknown
- (10) Record keeping within the PRA  Yes  No  Unknown

2. What commercial or military airfields support the PRA?

Primary Airfield: \_\_\_\_\_

Secondary Airfield: \_\_\_\_\_

Tertiary Airfield: \_\_\_\_\_

3. Are these primary airfields accurately reflected in TRAC2ES?  Yes  No  Unknown

4. Have primary and alternative airfield authorities been coordinated with regarding the following?

- a) Identification of key points of contact / contact information  Yes  No  Unknown

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- (1) Designated patient unloading and staging area(s)  Yes  No  Unknown
- (2) Any security issues / access to patient unloading and staging area(s)  Yes  No  Unknown
- (3) Potential airfield closures or other operational constraints  Yes  No  Unknown
- b) Patient unloading equipment storage, access and use  Yes  No  Unknown
- c) Coordination with airfield medical facilities / personnel (if applicable)  Yes  No  Unknown
- d) Do you have qualified airfield drivers?  Yes  No  Unknown
- e) Have your airfield authorities identified a minimum of two parking spaces for aircraft that are within 100 feet to your PRA?  Yes  No  Unknown
5. Have bus and train terminal authorities been coordinated with regarding the following?
- a) Identification of key points of contact / contact information  Yes  No  Unknown
- b) Designated patient unloading and staging area(s)  Yes  No  Unknown
- c) Any security issues / access to patient unloading and staging area(s)  Yes  No  Unknown

d) Potential terminal closures or other operational constraints  Yes  No  Unknown

e) Patient unloading equipment storage, access and use  Yes  No  Unknown

f) Coordination with terminal medical facilities/personnel (if applicable)  Yes  No  Unknown

6. Have procedures been outlined to coordinate patient follow-on moves and/or return of patients to destinations outside the PRA by either the SAT or PRA?  Yes  No  Unknown

**(NOTE:** The SAT has developed checklists and documents to support the process of case management, discharge and patient return. Go to [URL] for access to the toolbox).

7. Are guidelines in place to help to estimate the "THROUGHPUT" (the number of NDMS patients that can be received, off-loaded, staged, triaged, transported and admitted to the destination NDMS facility within a 24-hour period)?  Yes  No  Unknown

8. Has the local community been consulted on normal daily community ambulance use, to base ambulance availability estimates for calculating "THROUGHPUT"?  Yes  No  Unknown

9. Has the estimated "THROUGHPUT" been tested in an exercise within the past three years?  Yes  No  Unknown

10. Have the factors that limit the sustainability of this PRA's THROUGHPUT been identified and mitigated to the  Yes  No  Unknown

extent possible?

11. What additional resources, authorities or processes would be useful to improve, expand or further sustain the patient reception and distribution capabilities for this PRA?

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**Comments:**

**What is the “Plan of Action” to remedy all NO answers:**

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**What is the “Plan of Action” to investigate all applicable UNKNOWN answers:**

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### III. Definitive Medical Care

1. Have all local appropriate facilities within the PRA (usually within 50 miles and/or one hour drive) been contacted and invited to join the NDMS within the past five years?  Yes  No  Unknown

2. Are signed Memorandums of Agreement (MOAs) maintained for all participating NDMS facilities?  Yes  No  Unknown

3. How many MOAs signed within the last five years are on file for this PRA? \_\_\_\_\_

4. Has a PRA plan been developed and coordinated with all participating NDMS facilities?  Yes  No  Unknown

5. Have the following been *considered* by participating NDMS facilities?

a) In-service training on expansion of inpatient capacity to support NDMS?  Yes  No  Unknown

b) Cancellation of elective surgeries in order to make additional beds available?  Yes  No  Unknown

c) Inpatient discharge protocols to create additional beds?  Yes  No  Unknown

d) Facility plans for expansion?  Yes  No  Unknown

e) Expanded staff availability?  Yes  No  Unknown

- f) Calculated loss of clinical / support staff due to Reserve Mobility Status Activation and/or other federal, state, Tribal, territorial or local obligations?  Yes  No  Unknown
6. Do participating NDMS facilities understand the role of the SAT, if applicable?  Yes  No  Unknown
7. Do participating NDMS facilities know how to contact the nearest military medical treatment facility(s)?  Yes  No  Unknown
8. Are contingency plans in place to coordinate food, lodging and transport for NDMS patients requiring outpatient services?  Yes  No  Unknown
9. Are contingency plans in place to coordinate food, lodging and transport for NDMS non-medical attendants and/or family members?  Yes  No  Unknown
10. Are local information packets available for distribution to NDMS patients, non-medical attendants and/or family members?  Yes  No  Unknown
11. What additional resources, authorities or processes would be useful to improve or expand definitive care capabilities for this PRA?
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**Comments:**

**What is the “Plan of Action” to remedy all NO answers:**

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**What is the “Plan of Action” to investigate all applicable UNKNOWN answers:**

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#### IV. Training & Exercises

1. Does the FCC maintain a training and exercise plan and/or calendar for this PRA?  Yes  No  Unknown
2. Are FCC PRA training and exercise objectives articulated in the and exercise plan and/or calendar?  Yes  No  Unknown
3. Did the FCC formulate a training and exercise budget request in the past year and submit to appropriate authorities?  Yes  No  Unknown
4. Did the FCC provide an orientation to the PRA plan to all representatives of the NDMS member facilities within the past year?  Yes  No  Unknown
5. Did the FCC provide an orientation to the PRA plan to representatives of local emergency management agencies, EMS agencies, police, and fire services within the past year?  Yes  No  Unknown
6. Have NDMS facilities participated in a large-scale NDMS patient reception exercise within the last three years?  Yes  No  Unknown
7. Have all NDMS facilities participated in a patient reception exercise, tabletop, functional area drill, team training, or other PRA-related event in the past year?  Yes  No  Unknown
8. If the answer to question 7 is no, what percent of all NDMS facilities have participated in a patient reception exercise, tabletop, functional area drill, team training, or other PRA-related event in the past year? \_\_\_\_\_

9. Did the FCC ensure that individuals designated to augment the FCC staff received detailed education and training on their specific duties within the past year?  Yes  No  Unknown
10. Have sufficient numbers of FCC personnel received sufficient TRAC2ES training to accomplish their FCC duties?  Yes  No  Unknown
11. Have sufficient numbers of FCC personnel received sufficient JPATS training to accomplish their FCC duties?  Yes  No  Unknown
12. Have sufficient numbers of FCC personnel received training with any specialized communications equipment  Yes  No  Unknown
13. Did the FCC conduct group training exercises or drills within the past year to ensure the preparedness of teams (e.g., the Patient Reception Team)?  Yes  No  Unknown
13. Did the FCC's PRA team participate in a full-scale NDMS patient reception exercise in this PRA at least once in the past three years?  Yes  No  Unknown
14. Has a PRA plan been subject of a detailed table-top exercise?  Yes  No  Unknown
15. Are training events documented?  Yes  No  Unknown
16. Are deficiencies and lessons learned during exercises tracked and reviewed for closure?  Yes  No  Unknown

**Comments:**

**What is the “Plan of Action” to remedy all NO answers:**

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**What is the “Plan of Action” to investigate all applicable UNKNOWN answers:**

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## Annex Q: Exercise Evaluation Guide

### Introduction:

The Exercise Evaluation Guide (EEG) is intended to assist exercise evaluators by providing them with consistent standards and guidelines. It accomplishes several goals. It streamlines data collection; enables a thorough assessment of target capabilities and objectives; supports development of the After Action Report / Improvement Plan (AAR/IP); and provides a consistent process for assessing preparedness through exercise activities.

Evaluators use EEGs before and during exercise observation because they provide evaluators with the activities, tasks, and performance measures associated with a target capability. Information in the EEG is intended to follow the activities and tasks to be accomplished for each capability. The Analysis Form is designed to allow evaluators to record the degree to which a prescribed tasks or performance measures are completed or met during the exercise. Exercise evaluators do not rate performance. The EEG is neither a grading tool nor a scorecard. Rather, evaluators are asked to objectively record the full, partial, or non-completion of each task.

The EEG also facilitates the development of effective AAR/IPs. By relating capabilities to activities, tasks, and performance measures, EEGs establish the foundation for Improvement Plans that can strategically target personnel, planning, organization and leadership, equipment and systems, training and exercises, and assessments and corrective actions pertaining to identified shortcomings in the targeted capabilities.

The attached Evaluation & Analysis Forms provide evaluators with specific performance measures to be assessed.

**NOTE:** This Evaluation Annex is intended to be tailored to the FCC. FCCs should use any of these elements and are free to add or delete as needed.

### NDMS PATIENT RECEPTION OPERATIONS TARGET CAPABILITIES

#### NDMS Federal Coordinating Center (FCC) Command Center Management

Capability Definition: NDMS FCC Command Center Management is the capability to provide multi-agency coordination for NDMS incident management by activating and operating a FCC Command Center for pre-planned or no-notice events. NDMS FCC Command Center management includes activation, notification, staffing, coordination of efforts among NDMS member medical facilities and community emergency response organizations, and maintenance of information and communication necessary for patient reception operations.

**Exercise Objective 1: Establish and maintain a NDMS FCC Command Center organization in response to a NDMS alert and activation.**

Performance Tasks and Measures/Metrics:

**Activity: Direct NDMS FCC Command Center Operations**

Definition: In response to NDMS notification of incident, activate, staff and organize the NDMS FCC Command Center in accordance with established plans and standard operating procedures; plan, direct, and coordinate information and activities internally within the VA or DoD Medical Center and externally with NDMS member medical facilities and patient reception support organizations; coordinate logistical support to maintain an operationally functioning Command Center until deactivation.

**Critical Tasks**

1	Establish organization / operation of the NDMS FCC Command Center.
2	Identify appropriate NDMS medical facility and patient reception support organization Liaison Officers and coordinate participation in Command Center activities.
3	Alert and request response from FCC Command Center personnel
4	Brief incoming personnel.
5	Designated Incident Commander assigns command staff roles and responsibilities.
6	Ensure appropriate maintenance and rest cycles are included in resource (personnel and equipment) management activities.

**Activity: Gather and Provide Information**

Definition: Upon establishing NDMS FCC Command Center operations, gather, organize, and document incident situation and resource information from all sources to maintain situational awareness within the Command Center.

**Critical Tasks**

1	Collect, analyze, and disseminate situation information and intelligence.
2	Monitor applicable communications and information systems.
3	Coordinate with external agencies to collect / share data on incident situation.
4	Make proper connections with involved NDMS member medical facilities and support organizations.

**Activity: Coordinate and Support Critical Resource Logistics**

Definition: Identify, inventory, and request mobilization of critical resources required to support NDMS patient reception; accurately track and record human and material resources throughout the event.

**Critical Tasks**

1	Identify critical resource requirements; determine if FCC can support requirements or requirements or request need to request support for external agencies.
2	Collect NDMS medical facility bed availability reports.
3	Collect patient reception support organization resource availability information.
5	Coordinate on-going patient reception site resource and logistics requirements.
6	Track all costs associated with NDMS patient reception operations.

**NDMS Patient Triage, Staging and Transportation**

Capability Definition: NDMS Patient Triage, Staging and Transportation is the capability to appropriately receive in-coming NDMS patients, provide feasible and necessary pre-hospital triage and treatment, to transport patients to an appropriate NDMS facility, and to maintain accurate tracking and accountability of all NDMS patients.

**Exercise Objective 2: Establish and maintain procedures for the effective and appropriate receipt, triage, staging, transport and tracking of NDMS patients.**

Performance Tasks and Measures/Metrics:

**Activity: Implement NDMS Patient Reception Procedures**

Definition: Provide for the overall management of in-coming NDMS patients to include triage, staging and provision of necessary care while awaiting transport, transportation to an appropriate NDMS facility, and patient tracking procedures.

**Critical Tasks**

1	Coordinates triage, interim patient care capabilities, and transportation.
2	Establish and organize triage, patient holding areas, and transportation areas.
3	Ensures appropriate support resources are in place.
4	Ensures patient tracking and accountability procedures are in place.
5	Ensures currency of NDMS medical facility bed availability report.

6	Proper litter lifting and carrying techniques are reviewed prior to aircraft arrival.
7	Upon aircraft arrival, receive patient manifest and briefing from the Medical Crew Director.
8	MCD directs patient off-loading.
9	Process patients through triage to appropriate holding areas.
10	Provide necessary and appropriate patient assessment / treatment while waiting transport
11	Regulate patients to an appropriate receiving NDMS facility.
12	Initiate patient tracking procedures.
13	Notify receiving NDMS facilities of patients en route.
14	Conduct debriefing of patient reception operations following conclusion of each event.

### JOINT PATIENT ASSESSMENT TRACKING SYSTEM INTEGRATION

Capability Definition: Joint Patient Assessment Tracking System Integration is the capability to access the web-based national patient tracking system and the ability to retrieve / enter information related to patient movement, general condition, unique medical care requirements needed for transport, and current disposition.

**Exercise Objective 3: Integrate Department of Health & Human Services, Joint Patient Assessment Tracking System (JPATS) Team and patient tracking processes into Patient Reception Site operations.**

Performance Tasks and Measures/Metrics:

#### **Activity: Operate JPATS at the Patient Reception Site**

**Definition:** Establish JPATS connectivity with the ability to retrieve / enter applicable patient movement and tracking information.

#### **Critical Tasks**

1	Establish internet connectivity at the patient reception site.
2	Log into and run JPATS program.
3	Retrieve patient information from JPATS.
4	Enter patient's current disposition (e.g. NDMS facility) and condition into JPATS.

5	Ensure provision to track patients manually.
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## NDMS FACILITY OPERATIONS

Capability Definition: NDMS facility operations includes the ability of a facility to support NDMS patient reception and definitive care operations.

**Exercise Objective 4: Provide an opportunity for NDMS facilities to exercise elements of their Emergency Operations Plan related to medical surge and an influx of NDMS patients.**

Performance Tasks and Measures/Metrics:

### ***Activity: Establish Medical Surge Capacity to Receive NDMS Patients***

**Definition:** Upon receiving NDMS alert and/or activation notification, identify patient reception capacity and establish the capability to receive an influx of NDMS patients.

#### ***Critical Tasks***

1	Submit recurring NDMS bed availability reports as requested by the FCC.
2	Communicate disposition to the SAT and FCC
3	Participate in the AAR process post exercise or real world operation.

#### **Attachments:**

- NDMS FCC Command Center Evaluation & Analysis Form
- NDMS Patient Reception Site Evaluation & Analysis Form
- NDMS Medical Facility Evaluation & Analysis Form
- Exercise Participant Feedback Form

**NDMS Patient Reception “Full Scale” Exercise**  
**NDMS FCC Command Center Evaluation & Analysis Form**

Evaluator Name / Location: \_\_\_\_\_

**Objective: Establish and maintain a NDMS FCC Command Center organization that is effective and efficient in response to a NDMS alert and activation.**

**Activity: Direct NDMS FCC Command Center Tactical Operations**

**Definition:** In response to NDMS notification of incident, activate, staff and organize the NDMS FCC Command Center in accordance with established plans and standard operating procedures; plan, direct, and coordinate information and activities internally within the VA or DoD Medical Center and externally with NDMS member medical facilities and patient reception support organizations; coordinate logistical support to maintain an operationally functioning Command Center until deactivation.

**Critical Tasks**

1	Establish organization / operation of the NDMS FCC Command Center.
2	Identify appropriate NDMS medical facility and patient reception support organization Liaison Officers and coordinate participation in Command Center activities.
3	Ensure appropriate maintenance and rest cycles are included in resource (personnel and equipment) management activities.
4	Transition from response to recovery.

<b>Performance Measures</b>	<b>Metric</b>	<b>Yes</b>	<b>No</b>	<b>Partial</b>
The NDMS FCC Command Center is activated upon notification of incident.	Yes / No			
The NDMS FCC Command Center is appropriately staffed to meet incident demands.	Yes / No			
Liaison Officer for NDMS member medical facilities and patient reception support organizations are identified.	Yes / No			

**Activity Analysis / Observations**

Strengths:

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Areas for Improvement:

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Additional Comments:

**Activity: Activate NDMS FCC Command Center Tactical Operations**

Definition: In response to NDMS alert and/or activation, perform incident notifications, recall of essential personnel, and stand-up of command center systems to provide a fully staffed and operational Command Center.

**Critical Tasks**

1	Activate the FCC Command Center.
2	Alert/request response from FCC Command Center personnel
3	Brief incoming personnel.
4	Designated Incident Commander assigns command staff roles and responsibilities.

<b>Performance Measures</b>	<b>Metric</b>
Time in which the Command Center is fully staffed.	Indicate minutes to be fully staffed
Time in which incoming staff are briefed and assigned.	Indicate minutes for staff arrival

<b>Activity Analysis / Observations</b>
<p>Strengths:</p> <ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> </ul>
<p>Areas for Improvement:</p> <ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> </ul>
<p>Additional Comments:</p>

### **Activity: Gather and Provide Information**

Definition: Upon establishing NDMS FCC Command Center operations, gather, organize, and document incident situation and resource information from all sources to maintain situational awareness within the Command Center.

#### **Critical Tasks**

1	Collect, analyze, and disseminate situation information and intelligence.
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2	Monitor applicable communications and information systems.
3	Coordinate with external agencies to collect / share data on incident situation.
4	Make proper connections with involved NDMS member medical facilities and support organizations.

<b>Performance Measures</b>	<b>Metric</b>
Connectivity has been verified with applicable external agencies, NDMS member medical facilities and patient reception support organizations.	Yes / No
Time in which the Command Center produces an incident action plan (IAP) defining a schedule and setting the operational period.	Indicate time from when the Command Center become operational to when an IAP is developed
Time in which the Command Center produces and distributes a situation report.	Indicate time from when the Command Center becomes operational to when a situation report is developed
FCC Command Center conducts situation briefing conference calls with NDMS member medical facilities and support organizations.	Yes / No

<b>Activity Analysis / Observations</b>
Strengths: <ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> </ul>
Areas for Improvement: <ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> </ul>
Additional Comments:

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**Activity: Coordinate and Support Critical Resource Logistics**

Definition: Identify, inventory, and request mobilization of critical resources required to support NDMS patient reception; accurately track and record human and material resources throughout the event.

**Critical Tasks**

1	Identify critical resource requirements; determine if FCC can support requirements or requirements or request need to request support for external agencies.
2	Collect NDMS medical facility bed availability reports.
3	Collect patient reception support organization resource availability information.
4	Complete Patient Reception Operational Capabilities Assessment
5	Coordinate on-going patient reception site resource and logistics requirements.
6	Track all costs associated with NDMS patient reception operations.

<b>Performance Measures</b>	<b>Metric</b>
Time in which NDMS medical facility bed availability report is completed.	Indicate time from when the bed availability report was requested to when the final report is received
Time in which operational capabilities assessment is completed.	Indicate time from when the Command Center become operational to when the operational capabilities assessment was completed
Patient reception expense tracking procedures in place.	Continuous

Reimbursement procedures in place for expenses incurred by external support organizations.	Continuous
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**Activity Analysis / Observations**

Strengths:

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Areas for Improvement:

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Additional Comments:

**NDMS Patient Reception “Full Scale” Exercise**  
**NDMS Patient Reception Site Evaluation & Analysis Form**

**Evaluator Name / Location:**

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**Objective: Establish and maintain a Patient Reception Site command and organization that is managed safely, effectively and efficiently through the ICS framework.**

***Activity: Establish Patient Reception Site Incident Command***

**Definition: Establish incident command, patient reception team, facilities and resources at the patient reception necessary to support arrival of in-coming aircraft and NDMS patients.**

***Critical Tasks***

1	Conduct an initial assessment of patient reception site facilities with Saint Clair EM.
2	Establish the incident command structure to manage patient reception operations and objectives.
3	Observe the site and identify/evaluate hazards as it pertains to the safety of all personnel; perform an incident safety analysis
4	Establish a Patient Reception Site Command Post with communications with the FCC Command Center, NDMS member medical facilities and applicable support organizations.
5	Designated Reception Site Commander assigns command staff roles and responsibilities and conducts a staff meeting to include current situation, operations and safety briefing.
6	In-coming patient reception team personnel receive a situation briefing, operations and safety briefing.

<b><i>Performance Measures</i></b>	<b><i>Metric</i></b>	<b><i>Yes</i></b>	<b><i>No</i></b>	<b><i>Partial</i></b>
Time in which patient reception site incident command staff is identified and incident operations established.	Indicate time required to establish incident command operations.			
Safety analysis conducted.	Yes / No			

Reception Site Commander conducts a command staff meeting / situation briefing at the start of each operational period.	Yes / No			
Patient reception team members receive an operational brief and safety briefing at the start of each operational period.	Yes / No			

<b>Activity Analysis / Observations</b>
Strengths: <ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> </ul>
Areas for Improvement: <ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> </ul>
Additional Comments:

**Activity: Conduct Resource Management**

Definition: Implement procedures to ensure the provision and tracking of all patient reception personnel and resources.

<b>Critical Tasks</b>	
1	Implement processes to track and assign patient reception team personnel.
2	Monitor performance of patient reception team staffing plan and adjust as needed to improve effectiveness and efficiencies.
3	Monitor utilization of supplies and equipment; establish resupply procedures with the FCC Command Center.

<b>Performance Measures</b>	<b>Metric</b>	<b>Yes</b>	<b>No</b>	<b>Partial</b>
Time in which personnel tracking and accountability procedures are established.	Indicate time required to establish tracking procedures			
Frequency with which staffing effectiveness is monitored.	Continuous.			
Time in which resupply procedures are established.	Indicate time required to establish tracking procedures			

<b>Activity Analysis / Observations</b>
<p>Strengths:</p> <ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> </ul>
<p>Areas for Improvement:</p> <ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> </ul>
<p>Additional Comments:</p>

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**Objective: Establish and maintain procedures for the effective and appropriate receipt, triage, staging, transport and tracking of NDMS patients.**

***Activity: Implement NDMS Patient Reception Procedures***

**Definition:** Provide for the overall management of in-coming NDMS patients to include triage, staging and provision of necessary care while awaiting transport, transportation to an appropriate NDMS medical facility, and patient tracking procedures.

***Critical Tasks***

1	Operations Section Chief coordinates triage, interim patient care capabilities, and transportation with the Medical Director and Operations Branch Directors.
2	Establish and organize triage, patient holding areas, and transportation areas.
3	Logistics Section Chief ensures appropriate support resources are in place.
4	Plans/Admin Chief ensures patient tracking and accountability procedures are in place.
5	Transportation Branch Director has current NDMS medical facility bed availability report.
6	Proper litter lifting and carrying techniques are reviewed prior to aircraft arrival.
7	Upon aircraft arrival ICS Site Commander, Medical Director and Deputy Medical Director receive patient manifest and briefing from the Medical Crew Director.
8	Aircraft crew member directs patient off-loading.
9	Process patients through triage to appropriate holding areas.
10	Provide necessary and appropriate patient assessment / treatment while waiting transport
11	Regulate patients to an appropriate receiving NDMS medical facility.
12	Initiate patient tracking procedures.
13	Notify receiving NDMS medical facility of patients en route.
14	Conduct debriefing of patient reception operations following conclusion of each

event.
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<b>Performance Measures</b>	<b>Metric</b>	<b>Yes</b>	<b>No</b>	<b>Partial</b>
Time in which reception team areas are staffed, organized and prepared to receive patients.	Indicate time required for patient reception team members to arrive and organize into sections			
Patient reception team sections and units are appropriate staffed and equipped.	Yes / No			
Patients awaiting transportation are monitored with appropriate treatment interventions as necessary	Yes / No			
Patients are regulated to a receiving NDMS medical facility in a timely manner	Yes / No			
Patient tracking procedures and data management systems are operational.	Yes / No			
Litter lifting / carrying is accomplished in a safe manner	Yes / No			
Section Chiefs debrief personnel	Yes / No			

<b>Activity Analysis / Observations</b>
Strengths: <ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> </ul>
Areas for Improvement: <ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> </ul>

Additional Comments:

**Objective: Integrate Department of Health & Human Services, Joint Patient Assessment Tracking System (JPATS) Team and patient tracking processes into Patient Reception Site operations.**

***Activity: Operate JPATS at the Patient Reception Site***

Definition: Establish JPATS connectivity with the ability to retrieve / enter applicable patient movement and tracking information.

***Critical Tasks***

1	Establish secure internet connectivity at the patient reception site.
2	Log into and run JPATS program.
3	Retrieve patient information from JPATS.
4	Enter patient's current disposition (e.g. NDMS medical facility) and condition into JPATS.

<b><i>Performance Measures</i></b>	<b><i>Metric</i></b>	<b><i>Yes</i></b>	<b><i>No</i></b>	<b><i>Partial</i></b>
Secure internet connectivity established at the patient reception site.	Yes / No			
Assigned patient reception team members able to retrieve in-coming patient information from JPATS.	Yes / No			
Assigned patient reception team members able to enter patient disposition information into JPATS.	Yes / No			

**Activity Analysis / Observations**

Strengths:

- 
- 
- 

Areas for Improvement:

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- 
- 

Additional Comments:

**NDMS Patient Reception “Full Scale” Exercise**  
**NDMS Medical Facility Evaluation & Analysis Form**

**Evaluator Name / Location:**

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**Objective: Provide an opportunity for NDMS member medical facilities to exercise elements of their Emergency Operations Plan related to medical surge and an influx of NDMS patients.**

***Activity: Establish Medical Surge Capacity to Receive NDMS Patients***

**Definition: Upon receiving NDMS alert and/or activation notification, identify patient reception capacity and establish the capability to receive an influx of NDMS patients.**

***Critical Tasks***

1	Provide facility coordination and response support using an incident command structure and associated processes.
1	Submit NDMS bed availability reports as requested by the FCC Command Center.
2	As appropriate, implement emergency operations plans related to mass influx of patients.
3	Maintain accurate accountability and tracking of NDMS patients.

<b><i>Performance Measures</i></b>	<b><i>Metric</i></b>
An incident command structure was implemented.	Yes / No
NDMS bed availability report submitted within requested timeline.	Yes / No
Amateur radio communications established with the patient reception site.	Yes / No
In-coming patients were evaluated and assigned to an appropriate ward with assigned admitting physician.	Yes / No
Mechanisms are in place to track and report patient status to the FCC Command Center.	Yes / No

**Activity Analysis / Observations**

Strengths:

- 
- 
- 

Areas for Improvement:

- 
- 
- 

Additional Comments:

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**NDMS Patient Reception “Full Scale” Exercise  
Exercise Participant Feedback Form**

Please enter your responses in the form field or checkbox after the appropriate selection.

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_  
(optional)

**Agency:** \_\_\_\_\_

Player     Facilitator     Observer     Evaluator

**Part I: Recommendations and Corrective Actions**

Based on the exercise today and the tasks identified, list the top three strengths and/or areas that need improvement.

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Is there anything you saw in the exercise that the evaluator(s) might not have been able to experience, observe, and record?

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Identify corrective actions that should be taken to address the issues identified above.

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List any applicable equipment, training, policies, plans, and procedures that you feel should be reviewed, revised, or developed.

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**Part II: Assessment of Exercise Design and Conduct**

Please rate, on a scale of 1 to 5, your overall assessment of the exercise relative to the statements provided below, with 1 indicating strong disagreement with the statement and 5 indicating strong agreement.

Assessment Factor	Strongly Disagree			Strongly Agree	
	1	2	3	4	5
The exercise was well structured and organized.					

The exercise scenario was plausible and realistic.	1	2	3	4	5
The facilitator/controller(s) was knowledgeable about the area of play and kept the exercise on target.	1	2	3	4	5
Participation in the exercise was appropriate for someone in my position.	1	2	3	4	5
The participants included the right people in terms of level and mix of disciplines.	1	2	3	4	5
This exercise allowed my agency/jurisdiction to practice and improve NDMS patient reception related capabilities.	1	2	3	4	5
After this exercise, I believe my agency/jurisdiction is better prepared to deal successfully with the scenario that was exercised.	1	2	3	4	5

**Part III: Participant Feedback**

Please provide any recommendations on how this exercise or future exercises could be improved or enhanced.

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## Annex R: Mission Assignment Example

FEDERAL EMERGENCY MANAGEMENT AGENCY  <b>MISSION ASSIGNMENT (MA)</b>	See Reverse for Paperwork Burden Disclosure  Notice	<b>O.M.B. NO. 3067-0278</b>  <b>Expires November 30, 2007</b>
<b>I. TRACKING INFORMATION (FEMA Use Only)</b>		
State: Texas Incident 2008082602-Hurricane Gustav		Action Request #: 159-106829
Program Code/Event #: 7220SU-Hurricane Gustav		Date/Time Rec'd: 08/29/2008 00:12
<b>II. ASSISTANCE REQUESTED</b> <input type="checkbox"/> See Attached		
Assistance Requested: Activate the El Paso FCC: Start: Operations to begin Saturday Morning 8-30 cdt. End: Operations to end 8-31 at 1200		
Quantity: 1 (each)	Date/Time Required: 08/30/2008	Internal Control #:
Delivery Location: El Paso FCC, 5005 Piedras Street, El Paso, TX 79920		
Initiator/Requestor Name: John Smith	24-hour Ph #s:	24-hour Fax #s: Date: 8/29/08
POC Name: Jack Doe	24-hour Ph #s:	24-hour Fax #s: Date: 8/29/08
* State Approving Official (Required for DFA and TA):		Date:
<b>III. INITIAL FEDERAL COORDINATION (Operations Section)</b>		
Action to:	<input type="checkbox"/> ESF #:  <input checked="" type="checkbox"/> Other:	Date/Time: 8/28/08 23:48  Priority: <input checked="" type="checkbox"/> 1 Lifesaving <input type="checkbox"/> 2 Life sustaining <input type="checkbox"/> 3 High <input type="checkbox"/> 4 Medium <input type="checkbox"/> 5 Normal
<b>IV. DESCRIPTION (Assigned Agency Action Officer)</b> <input type="checkbox"/> See Attached		
Mission Statement: Your agency is responsible for submitting a Mission Assignment Monthly Progress Report to FEMA to include cost data when Mission Assignments take more than 60 days to complete, including billing. The Mission Assignment Monthly Progress Report can be accessed and submitted on-line at <a href="http://www.fema.gov/ofm/ofed_agencies.shtm">http://www.fema.gov/ofm/ofed_agencies.shtm</a> .		
The above designated DoD FCC will take all necessary steps to conduct activities for Patient Reception Center Operations as described in the FCC Guide for an activated FCC. These activities shall include: Conduct bed reporting in accordance with GPMIC instructions, Maintain daily monitoring of TRAC2ES, Establish communications with GPMIC, member medical facilities, and any other elements involved in FCC operations; Validate PRA throughput and undertake any other actions necessary to conduct patient reception operations		
Assigned Agency: DoD (Department of Defense)	Projected Start Date: 8/30/08	Projected End Date: 8/31/08
X New or <input type="checkbox"/> Amendment to MA #:	Total Cost Estimate: \$ 250,000.00	
Assigned Agency POC Name: DCO	Phone and fax #s:	
<b>V. COORDINATION (FEMA Use Only)</b>		
Type of MA: <input type="checkbox"/> Direct Federal Assistance	<input type="checkbox"/> Technical Assistance	<input type="checkbox"/> Federal Operations Support
State Cost Share (0%, 10%, 25%)	State Cost Share (0%)	State Cost Share (0%)
State Cost Share Percent: %	State Cost Share Amount: \$	
Fund Citation: 2008-06-7550SU - XXXX - 250_1 - D	Appropriation code: 58X0104	

Mission Assignment Coordinator (Preparer): Name of Coordinator		Date: 8/29/08
** FEMA Project Officer/Branch Chief (Program Approval): Name of Approver		Date: 8/29/08
** Comptroller/Funds Control (Funds Review): Signature of Reviewer		Date: 8/29/08
<b>VI. APPROVAL</b>		
* State Approving Official (required for DFA and TA):		Date:
** Federal Approving Official (required for all): Name of Federal Approver		Date: 8/29/08
<b>VII. OBLIGATION (FEMA Use Only)</b>		
Mission Assignment #: 7550SU-TX-DOD-38	Amt. This Action: \$ 250,000.00	Date/Time Obligated:
Amendment #:	Cumulative Amt. \$ 250,000.00	Initials:
* Signature required for Direct Federal Assistance and Technical Assistance MAs.		
** Signature required for all Mas.		
<b>EXAMPLE</b>		

FEMA Form 90-129, Oct 02

REPLACES ALL PREVIOUS EDITIONS