National Disaster Medical System

Federal Coordinating Center Guide

June 2010

Foreword

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 operations.

The basis for this guide is the 2005 Federal Partner's Memorandum of Agreement for the National Disaster Medical System (NDMS), and the August 6, 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 an annual basis. The guide may be updated in whole, or may be updated in part by updating only those chapters or annexes needing revision.

Comments or recommended changes to this guide may be sent by non-Federal users to the Department of Health and Human Services at the following address:

Director, National Disaster Medical System (NDMS)
330 Independence Avenue, SW
Room G-644
Washington, DC 20201

Comments or recommended changes to this guide may be sent by Department of Defense users to the Office of the Assistant Secretary of Defense (Health Affairs) (OASD/HA) NDMS Action Officer at the following address:

Force Health Protection and Readiness Programs
TRICARE Management Activity
Office of the Assistant Secretary of Defense (Health Affairs)
Attention: NDMS Action Officer
5113 Leesburg Pike, Suite 901
Falls Church, VA 22041

Comments or recommended changes to this guide may be sent by Department of Veterans Affairs users to the following address:

Department of Veterans Affairs (VA)
Emergency Management Strategic Healthcare Group
VA Medical Center
Route 9, Bldg 203B
Martinsburg, WV 25401

Table of Contents

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) inpatient hospital 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 and/or Puerto Rico, responsible for day to day coordination of planning and operations in one or more assigned geographic NDMS Patient Reception Areas (PRA).

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 Homeland Security 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, 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, including the DoD, VA, and the Department of Homeland Security (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.

The NDMS, based on the Memorandum of Agreement between HHS, DoD, VA, and DHS, is an asset utilized by ESF #8.

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.

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.

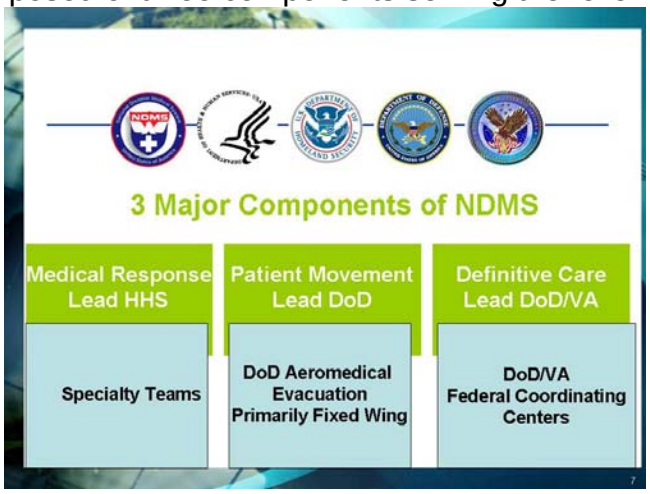
Local responders use the ICS to manage response operations. The ICS is a management system designed to enable effective incident management by integrating a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure.

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/IS100A.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. 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:



1. **Deployable, medical response teams**: 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, Tribal, State, 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.hhs.gov/aspr/opeo/ndms/index.html.

2. **Patient movement**: Evacuate inpatients who cannot be cared for in the disaster area to designated locations elsewhere in the nation.

3. **Definitive care**: Provide a nationwide network of voluntary, pre-identified, non-Federal acute care hospitals capable of providing definitive care for the victims of domestic 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 Senior Policy Group – Consists of representatives from the HHS Assistant Secretary for Preparedness and Response (Chair), the DHS Assistant Secretary, Office of Health Affairs; the Assistant Secretary of Defense for Health Affairs; and the VA Under Secretary for Health. This group determines policy and goals for the NDMS.

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. 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 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 and alerts the USH/VA. At this point, the ASD(HA) will notify the Services to activate select DoD FCCs, and the USH/VA to activate 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. The activated FCCs will initiate PRA operations and patient reception plans. DoD covers costs associated with this activation.

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 aide. DMATs at a disaster site provide pre-hospital and/or emergency medical services. A DMAT may be utilized, if available, in a local NDMS PRA to provide patient staging services. The basic DMAT is composed of about 35 people, including physicians, nurses, technicians, and other allied personnel. DMAT personnel have intermittent Federal appointments to facilitate their activation.

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

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 hospitalized patients out of the disaster area prior to or after the event. Moving in-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. The DoD USTRANSCOM Defense Distribution Operations Center is the single manager for the movement of NDMS in-patients. This includes accepting requests for movement of NDMS patients out of the disaster area, regulating patients to designated FCC PRA locations, tracking patients between disaster area and definitive care reception sites, 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.

2.1.2.1. Transportation by Air

This is generally accomplished through the USTRANSCOM's Air Mobility Command (AMC). The Aeromedical Evacuation System (AES) administered by AMC has unique aeromedical evacuation (AE) capabilities. It is used day-to-day for the transportation of DoD patients and can be expanded when required. To support NDMS operations, the USTRANSCOM Global Patient Movement Requirements Center (GPMRC) 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 and AE crews. The following are some 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 C-130 using Configuration AE-2 can hold a maximum of 72 litters, depending on the availability and serviceability of inherent equipment and the model of the aircraft. The C-130 in configuration n-P-1 can hold 92 sidewall and center aisle seats with seat belts on 20-inch centers or a variety of combinations of litter and ambulatory. For deliberate planning purposes, the C-130 standard load is 50 patients.

- **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 mission clinical director and aircraft director. 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.

- To support military contingencies, the DoD, in cooperation with the Department of Transportation (DOT) and U.S. commercial airlines, can activate the medical component of the Civil Reserve Air Fleet (CRAF). The Boeing 767, the primary aircraft of the AE segment of CRAF, can be configured for 87 litters within 72 hours after the aircraft is made available for use by USTRANSCOM.

- The **Ambulance Bus** (AMBUS) is organic to the table of allowance for contingency hospitals and aeromedical staging squadrons. 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.

2.1.2.2. Transportation by sea

This may be accomplished through the Military Sealift Command, the U.S. Coast Guard, 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.

2.1.3. Definitive Medical Care

The third component of NDMS is definitive 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 Patient Reception Site (PRS). Patients are off-loaded, triaged and staged at the PRS pending further medical regulating and ground transport to a local NDMS hospital.

The NDMS CONOPS, dated August 2009, defines definitive 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 hospital 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."

NDMS payment will end when one of the following occurs, whichever comes first: completion of medically indicated treatment (maximum of 30 days); exhaustion of Diagnosis Related Group (DRG) payment schedule; voluntary refusal of care; return home or to point of origin/fiscally comparable location or to destination of choice for patient (whichever costs less).

Definitive care is rendered by a nationwide network of voluntarily participating, pre-identified, non-Federal hospital services. 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 non-Federal hospitals 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 NDMS patients treated at medical facilities associated with their FCC.

NDMS hospitals are reimbursed for the care they provide in accordance with the signed NDMS Memorandum of Agreement. See Annex G.

HHS is responsible for coordinating the discharge and transportation of patients returning to their point of origin, or other destinations, as authorized. Patients requiring continuing care are returned as soon as appropriate care is available in the area from which they were evacuated and the patient can be transported safely. See Annex G.

2.1.3.1. DoD and VA Contingency Plan

A distinct mission of the DoD and VA system is highlighted with the DoD/ VA Contingency Plan, which assigns a separate mission to VA and DoD medical treatment facilities outside of the NDMS.

The DoD/VA Contingency Plan was developed in response to a stated need to accommodate a major influx of military casualties. As a result, a new law (Public Law 97-174) gave the VA a new mission: to serve as the principal health care backup to DoD in the event of war or national emergency that involves armed conflict. In addition to the contingency mission, this public law amended Title 38, United States Code (U.S.C.), to promote greater peacetime sharing of health care resources between VA and DoD.

In response to the law, 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 under the law.

The VA agreed to serve as the primary medical backup systems 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 FCC and VA/DoD Contingency Hospital System

The difference between FCC structure and function in NDMS and the Patient Reception Center structure and function in the VA/DoD Contingency Hospital System: every Federal Coordinating Center also serves as a 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. This designation stemmed from the VA/DoD Health Resources Sharing and Emergency Operation Act (Public Law 97-174), enacted on May 4, 1982.

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 inpatient hospital 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.

	FCC	PRC
Scenario	Disaster	Armed conflict or disaster
Patients	Civilians	Uniformed service members
Funding	Stafford Act, Economy Act	DoD
Patient Reception Team	Can be made up of Military Treatment Facility, VA and local civilian partners	Generally the MTF or VA staff
Regulating	TRAC2ES	TRAC2ES
Destination Hospital	Partner civilian NDMS hospitals	MTF or VA hospital

More information about the DoD/VA Contingency Plan can be found on the VA Emergency Management Strategic Health Care Group 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 and Puerto Rico, 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 the State determines the need to move patients from the disaster area, it requests assistance from FEMA. FEMA accepts the request and tasks the appropriate ESF, which in this case is ESF #8.

For impending patient movement requirements, the HHS SOC Emergency Management Group (EMG) convenes the Patient Movement Coordination Group (PMCG). The PMCG is composed of a representative(s) from each NDMS partner during patient movement and reception planning and operations involving FCCs. The PMCG coordinates and integrates NDMS operational planning, alerts, activations, and de-activations in order to establish and maintain an NDMS common operating picture.

When FCCs are required, the HHS SOC/Office of Preparedness and Emergency Operations will notify the NDMS Operations Branch to alert, activate, and deploy NDMS response teams as applicable. The NDMS Operations Branch informs the ASD(HA) and USH/VA, who in turn inform their respective FCCs that their PRAs may be alerted and/or activated. FCCs, and their associated PRAs, may be activated regionally, incrementally and/or all together, and may similarly be de-activated regionally, incrementally and/or all together as appropriate and as situations evolve.

3.3. Mission Assignment Process

Upon State 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 RFA comes to the DoD through the Secretary of Defense's Executive Secretary (EXECSEC). The EXECSEC forwards the RFA (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 Secretary of Defense for approval. Upon Secretary of Defense 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 Modification Order (MOD) to the standing EXORD for Defense Support of Civilian Authorities to alert and/or activate the DoD FCCs.

Following is an example of an MA to the DoD to activate an FCC. 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:

FEDERAL EMERGENCY MANAGEMENT AGENCY **MISSION ASSIGNMENT (MA)** **EXAMPLE**	See Reverse for Paperwork Burden Disclosure Notice	**O.M.B. NO. 3067-0278** **Expires November 30, 2007** **EXAMPLE**

I. TRACKING INFORMATION (FEMA Use Only)

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

II. ASSISTANCE REQUESTED

❑ 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:	

III. INITIAL FEDERAL COORDINATION (Operations Section)

Action to:	❑ ESF #: X Other:	Date/Time: 8/28/08 23:48	Priority: X 1 Lifesaving ❑ 2 Life sustaining	❑ 3 High ❑ 4 Medium ❑ 5 Normal

IV. DESCRIPTION (Assigned Agency Action Officer)

❑ 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 **http://www.fema.gov/ofm/ofed_agencies.shtm**.

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 GPMRC instructions, Maintain daily monitoring of TRAC2ES, Establish communications with GPMRC, member hospitals, 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 ❑ Amendment to MA #:	Total Cost Estimate: $ $250,000.00	
Assigned Agency POC Name: DCO	Phone and fax #s:	

V. COORDINATION (FEMA Use Only)

Type of MA: ❑ Direct Federal Assistance State Cost Share (0%, 10%, 25%) ❑ Technical Assistance State Cost Share (0%) ❑ Federal Operations Support 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

VI. APPROVAL

* State Approving Official (required for DFA and TA):	Date:
** Federal Approving Official (required for all): Name of Federal Approver	Date: 8/29/08

VII. OBLIGATION (FEMA Use Only)

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.		
EXAMPLE		

FEMA Form 90-129, Oct 02

REPLACES ALL PREVIOUS EDITIONS

VA Process: The VA Undersecretary for Health (USH/VA) will activate VA FCCs.

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. FCCs could expect about 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 MOD to the EXORD, which would include placing forces on PTDO.

In this Alert status, FCC Directors should:

- Validate the Alert Status with higher headquarters.
- Conduct periodic bed reporting in accordance with GPMRC instructions.
- Maintain daily monitoring of USTRANSCOM Regulating and Command and Control Evacuation System (TRAC2ES).
- Establish communications with all PRT leaders, GPMRC, NDMS hospitals, and other elements involved with FCC operations.
- Validate PRAs throughput, i.e., ability to receive, triage, and distribute patients to member hospitals.

3.4.2. FCC Activated

This status implies that FCC reimbursement for all patient reception activities, i.e., 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 MOD to the EXORD, which would include activation of named FCCs.

In this status, FCC Directors should:

- Validate the activation status with higher headquarters.
- Establish communications with GPMRC.
- Continually monitor TRAC2ES to determine arrival time(s) and medical condition of patients.
- Conduct periodic TRAC2ES bed and throughput reporting in accordance with GPMRC 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 hospitals are prepared to receive patients.
- Ensure other support elements are prepared to assemble at the PRA in accordance with the 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 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 GPMRC. The FCC Coordinator, or other designated agency or individual, will then further regulate and coordinate the movement of the patients to local NDMS participating hospitals.

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 GPMRC will issue bed-reporting instructions to those FCCs alerted or activated for patient reception. GPMRC will receive medical information about patients and then determine medical equipment needed for ground or air transport.

The GPMRC will regulate patients from the Aerial Port of Embarkation (APOE), located near the disaster site, to the Aerial Port of Debarkation (APOD), located near the PRA.

While GPMRC is not responsible for coordinating transport of patients to State Regional Evacuation Points (REPs) in the disaster area, GPMRC will coordinate movement of patients out of REPs. If movement will be via air, the GPMRC will regulate patients from the REP at the APOE, located near the REP, to the APOD near the FCC's PRA airport(s). Specific patient movement and reception missions are coordinated directly between the GPMRC 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 information collected and furnished would be minimal.)

Local patient reception and distribution operations are then coordinated directly between the FCC and the local participating NDMS hospitals, 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 Hospital Enrollment and Community Relations (Annex B)
- Collect/Report Hospital 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 Hospital 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 hospitals accredited by the Joint Commission (JC), DNV Healthcare Inc., or the American Osteopathic Association (AOA).

FCC Coordinators are encouraged, with the advance consultation and concurrence of the participating hospital 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 religious affiliated 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 Hospital Bed Availability (see Annex C)

As part of initial enrollment in the NDMS, non-Federal hospitals indicate in the NDMS Memorandum of Agreement (MOA) a total "minimum" and "maximum" number of beds to be committed. The initial MOA minimum and maximum bed availability is used for operational planning purposes. It is recognized that actual bed availability will vary at the time of alert or activation.

When activated, FCCs receive specific instructions directly from the DoD GPMRC on the reporting of beds immediately available. Upon receipt of instructions, the FCC Coordinator collects immediate bed availability data from each participating NDMS hospital and reports to GPMRC. 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 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, 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 hospitals, 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 hospital and the HHS 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 the patient can be transported safely. 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 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
330 Independence Avenue, SW
Room G-644
Washington, DC 20201

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 hospitals 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 J 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 K provides some basic guidelines to assist.

4.15. List of Remaining Annexes:

Annex M: Acronyms and Definitions
Annex N: POC List
Annex O: References
Annex P: Map of current FCCs
Annex Q: FCC Self Assessment

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 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

a. Plan

- Appoint and/or identify the FCC Coordinator responsible for developing the PRA Plan, conducting the day-to-day operations and ensuring FCC readiness.
- Establish and maintain the support of area hospitals, 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 PRA Plans.
- Conduct a full-scale exercise at least once every three years that tests the PRA plan of the FCC and the supporting partners.
- Conduct 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.

c. Operate

- Activate local 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

- Develop the PRA Plan, conduct the day-to-day operations and ensure FCC readiness.
- Establish and maintain active participation and support of local non-Federal acute care hospitals, State and local health associations, EMS, emergency management agencies, hospitals councils, medical societies, public safety, police and fire services, and local Medical Reserve Corps.
- Recruit local non-Federal in-patient hospitals for NDMS enrollment and participation.
- Establish and maintain NDMS Provider MOA for Definitive Medical Care, Attachment 1 to the NDMS Federal Partner's MOA.
- Maintain an up-to-date list of local NDMS resources and contact information for participants.
- Identify primary and alternate airfields and coordinate utilization and memorandums of agreement as necessary.
- Manage 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.
- Ensure a tracking mechanism is in place to capture logistical expenses associated with an FCC alert and activation.

b. Train and Assess

- Ensure that representatives of participating NDMS hospitals, 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 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.
- 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 hospitals are trained and notified of bed reporting requirements.
- Conduct FCC Self-Assessment annually utilizing Annex J, preferably after the annual exercise.
- Notify higher headquarters if the FCC mission capability has changed significantly.

c. Operate

- Collect bed availability data from each participating non-Federal hospital and report to the GPMRC, as directed.
- Ensure that open communications and liaison are established with GPMRC for the receipt of regulating decisions, evacuation mission information and patient medical data, as applicable.
- Provide GPMRC 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 hospitals, 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 hospitals, 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 hospitals, 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.
- Assist Federal patient movement teams as needed to ensure accurate patient tracking data.
- Establish and maintain procedures to obtain vehicles and personnel on relatively short notice to transport patients in the PRA.
- Arrange local transportation to move patients from reception sites onward to local participating NDMS hospitals.
- Assume administrative accountability for NDMS patients arriving in the PRA.
- 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 Repatriation 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 Repatriation Teams or their designated representative by providing contact information to participating NDMS hospitals to facilitate medical claims processing, as required.
- Provide patient validation and tracking data to the HHS or their designated representative.
- Collect appropriately billed charges for support services (such as ambulance service) incurred by the FCC during patient reception operations, and provide them through their chains of command to DHS/FEMA for reimbursement.
- Track FCC operations expenditures and provide information to DHS/ FEMA for reimbursement.

Annex B: Facilitate and Maintain Hospital 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 hospitals' participation in the NDMS, and for establishing and maintaining the support of government agencies, volunteer organizations, and others within the PRA.

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 hospitals, developing and maintaining a collaborative relationship with local or regional EMS organizations, government agencies, and other organizations appropriate for involvement in NDMS operations.

2. Procedures

The FCC Coordinator seeks voluntary commitments of beds from non-Federal accredited hospitals.

The FCC enrollment effort should target local general acute care inpatient hospitals operating 100 beds or more, although smaller hospitals should be considered, especially if they express a desire to participate or possess key specialty beds. In general, NDMS participating hospitals should be within the PRA that would be the likely arrival location of NDMS patients. This is to help ensure that local ground transport of patients to a participating NDMS hospital will require one hour or less. Hospitals beyond a 50-mile radius may be accepted for enrollment at the discretion of the FCC Director.

A hospital volunteering to participate in the NDMS completes the NDMS Provider MOA for Definitive Medical Care, Attachment 1 to the NDMS Federal Partner's MOA. The MOA should be signed by the Chief Executive Officer (CEO) of the participating NDMS hospital, 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 hospital. While MOAs do not have a formal expiration date, they should be reviewed annually and renewed every three years to ensure the signatories are current.

As part of the MOA, participating hospitals agree to participate in training and exercises of the NDMS. The Joint Commission (JC) requires hospitals that offer emergency services or are community-designated disaster receiving stations conduct at least one patient influx exercise per year. Additionally, hospitals with a defined role in their community's response plan must participate in at least one community-wide exercise annually. NDMS drills and exercises can be an ideal method of satisfying both of these requirements.

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:

- 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.
- Study the FCC area of responsibility and identify potential primary and alternate locations that will serve as PRAs.
- Identify potential medical facilities in the area.
- Draft an information package to provide to prospective enrolling hospitals, 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 hospitals. 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 hospital 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:

- Hospital 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 hospital, 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 association**s—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 hospital 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.

Annex C: Collect and Report Hospital Bed Availability

Purpose:

The purpose of this annex is to assist the FCC in collecting and reporting Throughput and Beds Availability for use by the NDMS, through the GPMRC, Scott Air Force Base, Illinois, during NDMS activities.

1. Definitions

Available Beds – It is recognized that NDMS hospital bed availability is dynamic, often changing hour by hour to meet the demands for local health care services. NDMS hospitals 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 GPMRC can immediately regulate patients. During FCC alert or activation, the FCC may require frequent updates to NDMS hospital 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 instructed by GPMRC.

Bed Report – The Bed Report is the FCC's submission to GPMRC 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.

- Steady State Planning Requirements—GPMRC requires a bi-monthly report. The schedule is published annually by the NDMS Directorate Staff. FCCs will submit the reports as required by GPMRC. The NDMS Bed Report Rollup report is maintained on the 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—GPMRC issues the unscheduled request. FCCs will submit the reports as required by GPMRC.

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 hospital. The five 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.

Medical Regulating - The actions and coordination necessary to arrange for the movement of patients through the levels of care. During this process GPMRC 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 hospital that has the necessary health service support capabilities

Throughput - The maximum number of patients that can be received at the NDMS PRA, off-loaded, staged, triaged, transported, and admitted to the destination hospital (or participating NDMS hospital) 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 GPMRC. To accomplish this, the FCC Coordinator:

- Provides training to member hospitals on the materials in this annex. This includes providing a means by which member hospitals can report available beds to their local FCC in a timely manner.
- Provides the GPMRC 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 hospitals when the PRA is alerted or activated.
- Canvasses member hospitals 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 hospital in a particular NDMS contingency.
- Receives bed-reporting instructions from GPMRC through Service or VA channels, as appropriate.
- Reports PRA bed availability totals to the GPMRC in accordance with instructions.

3. Initial Bed Availability

As part of initial enrollment in the NDMS, non-Federal facilities indicate in the NDMS MOA a total "minimum" and "maximum" number of inpatient beds that could be made available to NDMS. The "minimum" represents the number of beds the facility could make available within 24 hours of notification of NDMS activation. Normally, the "minimum" is the average daily staffed and equipped capacity of the hospital minus the average daily patient census. The "maximum" is the number of beds that could be made available within 72 hours. The "maximum" represents the facility's judgment as to staffed and equipped beds that could be provided if additional, optional planning considerations are implemented. The initial NDMS MOA minimum and maximum bed availability is used primarily for operational planning purposes. 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 hospital staff with duplicate privileges at other hospitals 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 hospitals factor in the potential loss of these medical staff.

4. Bed Reporting Procedures

GPMRC maintains a database of DoD, VA, and non-Federal participating NDMS hospital capacity available to support NDMS alert and activation. In response to NDMS events, GPMRC is prepared to immediately solicit bed reports to facilitate medical regulating, as directed by the USTRANSCOM Surgeon General or as requested by HHS.

When alerted or activated, FCCs will receive specific instructions from the GPMRC via Service 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 GPMRC. Reports are submitted to GPMRC via TRAC2ES. If TRAC2ES is unavailable, bed reports may be submitted by voice, fax, or e-mail using formats provided by GPMRC. Regardless of the means of reporting, these reports include two key elements: Bed Availability and Throughput.

In preparing to report bed availability to GPMRC, FCCs with multiple PRAs must ensure that bed reports are submitted separately for each PRA. NOTE: FCC Coordinators should coordinate “first in, first out" privileges for evacuation aircraft with the Federal Aviation Association at all PRA APODs.

5. Determination of Bed Availability

When GPMRC 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 must ensure an accounting method is in place to account for patients regulated but not received in order to not overstate the number of beds available. The method used depends upon whether the FCC Coordinator assigns regulated patients to a particular hospital prior to actual patient arrival and reception.

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 hospitals 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 GPMRC's ability to plan effectively.

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.

1. Responsibilities. (Refer to Annex A)

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 that directly affect the assigned PRA(s).

2. Plan Development.

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 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 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. PRA Alert/Activation (Refer to NDMS CONOPS, Section II, Activation and Requests for Federal Support)

a. Define who is responsible to put the PRA 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 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.

4. Bed Availability Reporting (Refer to Annex C)

a. Provide definitions of terms, including the list of medical categories.
b. Describe the processes for collecting initial and recurring bed reports, including “throughput”.
c. Describe the bed reporting procedure into TRAC2ES; describe how to establish an account; list persons who have accounts.

5. Medical Regulating and Patient Evacuation to the PRA

a. Describe the role of the GPMRC.
b. Describe the processes and procedures for coordinating patient movement missions between GPMRC and the FCC.

6. Patient Reception and Staging

a. Describe the patient reception site(s). Patients arriving from disaster sites or from military contingencies 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 physician or other 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.

7. 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 hospitals. 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:

    i. Ambulances, other vehicles and personnel from local EMS, DoD, VA, and/or local medical facilities' ambulances and ambulance buses
    ii. Commercial, governmental or other vehicles available that are wheelchair accessible or otherwise configured to accommodate litter patients
    iii. Other commercial vehicles (e.g., airport limousines or buses)
    iv. Military and other governmental general use trucks, vans, school buses, etc.
    v. FEMA National Ambulance Contract (HHS).

b. Describe the roles, processes and procedures for managing and tracking the use of local transport 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.

8. Patient Administration

a. Describe the roles and responsibilities of the FCC Coordinator. The FCC Coordinator assumes the administrative responsibility to:

   i. Track patient information inbound to the PRA.
   ii. Track patient information from point of arrival in the PRA (entrance into the NDMS).
   iii. Track patient information to entrance to the NDMS facility.
   iv. Track patient admissions status to the NDMS facility.
   v. Track patient movement within the NDMS.
   vi. Track patient discharge from the NDMS.
   vii. In the case of military patients, track the patient status through the point the military patient is returned to the responsible Service.

b. Describe the roles and responsibilities of GPMRC Liaisons and Military Patient Administration Team (MPAT), if available.
c. Identify contact information for each participating NDMS hospital for normal operating hours and after regular working hours.
d. Describe the roles and responsibilities of each participating NDMS hospital. 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 hospital 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:

   i. ID Number
   ii. ID Type (i.e., Driver's License, SSN Card, Student ID etc)
   iii. Last Name
   iv. First Name
   v. Sex
   vi. Date of Birth
   vii. Nationality

f. Describe the roles, processes and procedures for tracking patients in the PRA.

   i. REGISTRATION
   ii. UPDATES

iii. TRANSFERS
iv. INCOMING

9. 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 USTRANCOM Surgeon General and Headquarters Air Mobility Command, Command Surgeon's Office (HQ AMC/SGXL) to request PMI equipment and deployable tracking systems to help track and recycle equipment assets.

PMI is tracked using PMITS 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. PMITS is a system of systems under DMLSS. HQ AMC/SGXL 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 only at PMI centers and designated units or by HQ AMC/SGXL 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/SGXL 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/SGXL to obtain a new label immediately. Non-PMI equipment will not be tracked in this system unless coordinated with USTRANSCOM and HQ AMC/SGXL.

PMI must be returned promptly from an MTF 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. 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. 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. MTFs recycling PMI should contact HQ AMC/SGXL 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**

10. Training and Exercises (Refer to Annex E)

a. Identify the requirements and objectives for annual training of individuals.
b. Identify the requirements and objectives for annual table top or minor training exercise annually.
c. Identify the requirements and objectives for the major training exercise every three years.

11. Financial Claims Processing (Refer to Annex H)

a. Describe basic procedures for data collection, claims processing, and reimbursement.
b. Describe roles and responsibilities of the FCC Coordinator and participating NDMS hospitals.

12. Public Relations and Media Information (Refer to Annex L)

a. Identify local media resources.
b. Describe rules, limitations and processes for preparing information for release.
c. Identify local agencies and individuals authorized to release information.
d. Develop a communications strategy.

13. Communications (Refer to Annex J)

a. Identify primary and alternate means of communication among, and provide a detailed contact list for the following (for normal operating hours as well as for after regular working hours):

   i. The FCC
   ii. Appropriate headquarters elements or agencies
   iii. GPMRC
   iv. Local authorities and agencies
   v. Patient reception site authorities
   vi. Patient reception teams
   vii. Patient transport agencies
   viii. All participating NDMS facilities
   ix. Others as required

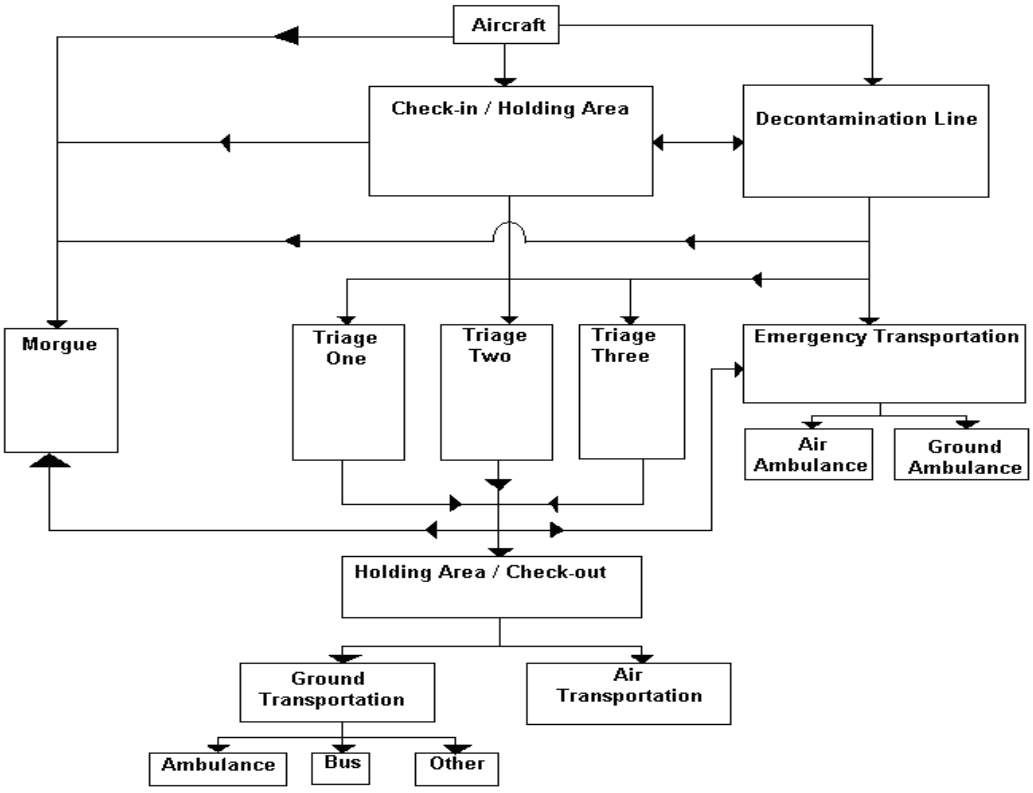
b. Provide an inventory of primary and alternate communications equipment and supplies.
c. Pre-Coordinate Frequencies.
d. Pre-Coordinate Satellite Channels.

14. Miscellaneous

a. Make provisions for animals (care, holding, and feeding).
b. Make provisions for weapons and narcotics storage.
c. Make provisions for mentally disturbed and bariatric patients.
d. Make provisions for the deceased.

See Annex Q for FCC PRA Plan Self Assessment

Following is a Diagram of Patient Reception Area (next page):


Aircraft
Check-in / Holding Area
Decontamination Line
Morgue
Triage One
Triage Two
Triage Three
Emergency Transportation
Air Ambulance
Ground Ambulance
Holding Area / Check-out
Ground Transportation
Air Transportation
Ambulance
Bus
Other

Annex E: Training and Exercises

Purpose:

The purpose of this guide is to provide planners, emergency management officers, FCC directors and coordinators, participating NDMS hospitals, and all others involved at the local, State, and Federal levels with suggested training and exercise information for FCCs. It is hoped that the recommendations will help them in their efforts to plan for and assist State and local authorities in dealing with the medical impacts of major peacetime disasters and to provide support to the DoD and VA medical systems in caring for casualties evacuated back to the United States from overseas conventional armed conflicts.

Training should be a continuous process with special accelerated training courses offered in anticipation of or during hazardous periods or emergency crisis situations. Type and degree of training will vary with tasks to be accomplished during preparedness, response or recovery phases. The annex aims to present planners and others with approaches and strategies for training enabling them to provide the most efficient, effective, and coordinated response.

1. RESPONSIBILITIES

The FCC Director must ensure that FCC staff, PRA PRT members, applicable Federal, State and local government, and private sector personnel receive appropriate training and education in the operation of the FCC. The FCC Director should follow respective Department guidance regarding frequency and type of exercises.

2. GENERAL PROVISIONS

As with any planning effort, the development of the 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.

3. 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 education 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 hospitals and other local authorities involved in patient reception operations.

The FCC Director, or Coordinator, should provide an annual orientation to the PRA Plan to representatives of the FCC staff, FCC Steering Committee, participating NDMS hospitals, as well as representatives of local emergency management agencies, EMS agencies, and police and fire services.

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.

4. RECOMMENDED TRAINING OPPORTUNITIES

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

	Training Course	Introduction to Incident Command System	Introduction to the ICS for Healthcare/Hospitals	ICS for Single Resources & Initial Incidents	Applying ICS to Healthcare Organizations	NIMS An Introduction	Intermediate ICS for Expanding Incidents	National Response Framework, An Introduction	Advanced ICS Command & General Staff	EOC Management and Operations	NIMS Multiagency Coordination System (MACS)	NDMS Federal Coordinating Center Operations	An Introduction to Exercises	Emergency Support Function (ESF) #8 – Public Health and Medical Services	ARNORTH Distance Learning Program: http://www.usarnorth.org/public/home.cfm?CFID=44311&CFTOKEN=54134823	TRAC2ES Web Based Training (GPMRC) *	Annual HHS Integrated Training Summit **	FCC / PRC Workshop ***	FCC / PRC Operations Course ****	Joint Patient Assessment and Tracking System http://teams.hhs.gov/jpatstraining/
	Course #	IS - 100.a	IS - 100.HC	IS - 200.a	IS - 200.HC	IS - 700.a	G - 300	IS - 800.b	G - 400	IS - 775	IS - 701	IS - 1900	IS – 120.a	IS - 808	DSCA	TRAC2ES	Summit	FCC / PRC Workshop	PRC Operations Course	JPATS
Position																				
Federal Coordinating Center Director		X	X	X	X	X		X		X		X	X	X				X		
Federal Coordinating Center Coordinators		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Primary Reception Area Staff		X	X	X	X	X		X				X		X		X				X
FEMA Independent Study Courses can be found at http://training.fema.gov/IS/crslist.asp																				

* In order to complete this TRAC2ES WBT course, students will have to first set up a TRAC2ES WBT account by contacting the DoD Global Patient Movement Requirements Center (GPMRC) at 618.229-7193. With a Username and Password provided by GPMRC, students will log on at https://trac2eswbt.trac2es.transcom.mil <https://trac2eswbt.trac2es.transcom.mil/>

** NDMS / ESF #8 Annual Training Summit dates are variable and to be determined (TBD)

*** FCC / PRC Workshop is typically provided during the HHS ESF #8 Integrated Training Summit.

5. EXERCISES

Although some FCCs may conduct comprehensive exercises more frequently, FCC Directors are strongly encouraged to conduct a full-scale patient reception exercise at least once every three years. Each hospital 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 hospitals/agencies ability to perform according to the area 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 hospitals; 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 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.

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.

6. TRAINING AND EXERCISE FUNDING

VA FCCs may submit budget requests through their chain of command to the Emergency Management Strategic Healthcare Group (EMSHG). 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. Listed below are a few examples as to how the FCCs can obtain funding to conduct an exercise:

- FCCs can work with their local partners to explore or pursue grant opportunities that may be available through DHS to support training and exercises. To locate your state's MMRS points of contact, go to the DHS State Contacts and Grant Award information at http://www.dhs.gov/xgovt/grants/index.shtm.

- USTRANSCOM conducts a National level patient movement exercise biannually. This exercise is typically linked with the National Level Exercises (NLE) and can be found on the NLE schedule. To assist with preplanning and coordination with these large scale exercises, it is imperative to coordinate through appropriate channels to USTRANSCOM to involve the respective FCCs in this large scale exercise. www.fema.gov/about/training/exercises.shtm

A central location to store and access FCC lessons learned will be created using DHS Lessons Learned Information Sharing (LLIS). The website can be accessed at: https://www.llis.dhs.gov/index.do

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Annex F: Coordinate Local Patient Reception Operations

FCC Directors implement PRA plans as required by the specific activation notification. This may include, at full activation, alerting all member hospitals 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 GPMRC. FCC Coordinators should ensure that open communications and liaison are established with GPMRC 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 hospitals, 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 GPMRC, the FCC may elect to begin the process of regulating patients to specific local hospitals prior to the arrival of the patients. The FCC Director 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 hospitals. Accordingly, this implies close coordination between the PRT, local EMS coordinators, the FCC, and GPMRC.

If available, DMATs may be deployed locally or from other metropolitan areas to support FCC patient reception and distribution of patients to participating NDMS hospitals. All DMATs are managed by the HHS Office of the Assistant Secretary for Preparedness and Response. Requests for DMAT support for local patient reception operations should be forwarded through chains of command to the HHS SOC. Each DMAT should have the capability to operate a nominal 80-patient staging site at an airport or remote clearing operation in a disaster area. Multiple DMATs can be brought together to provide a higher level of medical capability in the form of an NDMS Clearing Staging Unit (CSU). PHS Officers can also be deployed to support patient reception and distribution. Requests for PHS Officers in support of local patient reception operations should be forwarded through chains of command to the HHS SOC.

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 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). So, 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. Whoever will be 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 deplane 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 = "Slow down"

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 deplane a large patient load. Some patients can be carried with a 2-man carry; however, any time a litter will be lifted above waist-high, a 4-person carry is required. Other factors requiring a 4-person carry or more include: inclement weather, carrying a litter over a long distance, uneven surfaces, or heavy patients. 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 for heavier patients. Another important factor to consider is just how many litter bearers you have and what distance you have to carry. Consider the heat of the summer, the number of patients and whether there are heavy patients. Litter bearers tire out quickly. Consider using 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. It is also not good send up a 5 foot tall person to help bring a patient down from the top tier in a C-130. 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 hospital, 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 hospitals.

Patient Movement Items (PMI)

PMI medical equipment and supplies is a standard set of pre-designated equipment assets used by the DoD to support a patient during evacuation. PMI must be certified for use in DoD aircraft by DoD testing agencies. When a patient requires evacuation, it is the originating hospital's responsibility to provide the PMI required to support the patient during evacuation. PMI often accompanies a patient through numerous stops and layovers from the originating hospital to the destination hospital. The PMI system supports in-transit medical capability without removing equipment from patients, works to exchange in-kind PMI without degrading medical capabilities, and should provide prompt recycling of PMI. The handling and return of this equipment to the Air Force PMI Centers requires the coordination of GPMRC, aeromedical crews, the PRA PRT, the destination NDMS hospital(s), and the DoD medical treatment facility 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 Air Force PMI Center, refer back to Annex D. Also, during a contingency or domestic incident, the U.S. Air Force 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 hospitals.

Administrative Responsibility

The FCC Director provides administrative support for patient control and proper patient accounting. The FCC Coordinator 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 Director assumes administrative responsibility for patients. This responsibility begins upon a patient's arrival and continues until authorization for NDMS care ceases. This may include 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. The return of civilian NDMS patients is the responsibility of HHS. If available, a Military Patient Administration Team (MPAT) may be dispatched to the FCC to assist in coordinating administrative actions for military patients.

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

FCC Coordinators should coordinate with ESF #6 representatives 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 hospitals provides patient medical care. Participating NDMS hospitals may be asked to provide the following to the FCC Coordinator:

- 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 narrative summary upon discharge of each NDMS patient.

PRA Security

The FCC Coordinator 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 PRA Plan.

In addition, the FCC should consider establishing 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

GENERAL

Medical regulating is the coordination and control of moving patients to participating NDMS hospitals 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 hospitals 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 hospital.

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.
- 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 hospital level. Medical regulating functions include consolidating all evacuation requests within the PRA. The PAD is also responsible for keeping GPMRC apprised of the current beds available in the PRA.

- GPMRC -- The GPMRC is a joint agency located at Scott Air Force Base and established by USTRANSCOM. The GPMRC receives requests from the Theater Patient Movement Requirement Centers (TPMRCs). The primary role of the GPMRC 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 hospital is determined based on the patient's medical needs, the available transportation resources, and NDMS hospital 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 GPMRC.

- 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 Comm 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.

- Mobile Aeromedical Staging Facility—The MASF is a USAF staging facility employed at forward airfields to provide a temporary staging capability for preparation of patients being evacuated to NDMS hospitals. The MASF is employed to ensure patients are prepared for aircraft loading.

- Contingency Aeromedical Staging Facility—The CASF, similar to the MASF, is a USAF staging facility. The CASF, which provides greater capability and longer holding periods than the MASF, is a fixed facility.

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 hospitals 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.

MOBILE AEROMEDICAL STAGING FACILITY

The MASF is a 13-person, mobile, tented, temporary staging facility deployed to provide supportive patient care and administration. Each MASF 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.

Mobile aeromedical staging facilities—

- 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 MASF 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 MASF does not have the capability to provide patient meals.
- The AE UTCs (MASF/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 MASF.
- 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

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 hospital and the HHS representative.

HHS will publish a Patient Discharge and Return CONOPS: TBD

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

a. **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 Emergency Management Strategic Healthcare Group (EMSHG) for funding. DoD FCCs should follow Service or facility procedures to request funding for exercise costs.

b. **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 contracts may be useful to meet pre-event planning requirements.

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).

a. 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. If the PRA is activated, expenses incurred as a result of this activation are eligible for reimbursement.

b. FCCs may coordinate, through their chains of command, a request for DMATs or PHS assistance for PRA operations. However, FCC coordinators should refrain from relying on DMATs as a source of PRT personnel. DMATs are subject to

deployment by HHS. The HHS 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.

c. 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.

d. VA or civilian personnel costs are also eligible for reimbursement under some conditions. Regular shifts worked by personnel at a PRA instead of the normal VA duty station are generally not eligible for reimbursement. However, overtime, weekends and holiday expenses are eligible for reimbursement.

e. 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.

f. 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.

g. Patients may be held at a staging facility, at the PRA, at a mass care facility, or even at a hotel near the airfield as they wait for transportation to another facility, their unit of record, or to their home of record. Costs associated with this delay in transportation are generally eligible for reimbursement. These costs could include: hotel expenses, food, toiletries, clothing, ground transportation and/or commercial airfare. However, if adequate facilities are offered and those facilities are turned down or refused, generally no reimbursement is allowed.

h. 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

a. 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.

b. 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.

c. 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 contracted at the time of the disaster for the disaster related diagnoses.

d. HHS provides medical claims processing services for the NDMS, to support participating hospitals, providers and qualified beneficiaries affected by a national disaster.

4. Responsibilities for Financial Claims Processing

a. The FCC Director or the FCC Coordinator:

- Provide HHS with contact information to NDMS member hospitals in order to facilitate medical claims processing.
- Provide patient validation data to HHS. See paragraph 10 below.
- Collects appropriately billed charges for support services incurred by the FCC during patient reception operations, and provides them to HHS/ASPR for reimbursement.

b. NDMS member hospitals:

- 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.
- Provide a daily bed availability report, a daily admission and disposition list (indicating the expected length of stay) to the FCC Director.
- Provide a narrative summary upon discharge, transfer or death of patients to the FCC Director.
- Submit Affidavit of Non-insurance for uninsured patients and submit associated final bills for payment directly to the appropriate Fiscal Intermediary.

Any disclosure of patient information must comply with applicable records confidentiality statutes. All protected health information should be safeguarded in accordance with the Health Insurance Portability and Accountability Act of 1996.

5. Claims for Medical Care of NDMS Patients

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

6. Claims for Medical Care of Military Beneficiaries

The DoD will directly reimburse NDMS member hospitals, 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 hospitals, physicians and other care providers to the appropriate TRICARE Managed Care Support Contractor for the patient's command.

7. Claims for Transportation of Civilians

Costs for transporting NDMS patients to the receiving hospitals 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.

8. Claims for Transportation of Military Beneficiaries

Costs for transporting NDMS patients to the receiving hospitals will be authorized in the Mission Assignment or Sub-Tasking and will be reimbursable to the FCC. Claims for reimbursement for transportation of beneficiaries of the Military Healthcare System (MHS) will be submitted to the Military Medical Support Office (MMSO), P.O. Box 886999, Great Lakes, IL 60088-6999, at (888) 647-6676. The URL for the MMSO is http://www.tricare.mil/tma/MMSO/index.aspx

9. Patient Validation and Tracking Data Collection

a. The following elements must be submitted by the FCC to HHS or their designated representative as soon as possible, but no later than within seven days of the patient's arrival in the FCC PRA:

Name of disaster, emergency or contingency	
FCC name, address, telephone number	

Patient name	
Patient date of birth	
SSN (or other unique patient identifier if SSN not available)	
FEMA registration number	
Admitting hospital name, address, phone number	
Date of arrival at the PRA	
Date of hospital admission	
Diagnostic category	
Type of patient (i.e., directly injured/victimized by incident or indirectly affected, relocated or displaced due to the incident)	

b. Within seven days of the patient's release from NDMS care, the FCC must provide HHS or designated representative with the date of discharge, transfer or release.

c. In the event that a claimant argues that a patient has been wrongfully omitted from the NDMS patient roster, the contractor shall refer the provider to the appropriate FCC. If the FCC agrees with the claimant and notifies the HHS/ASPR Government Task Lead (GTL) and the contractor in writing to this effect, then the contractor shall adjust the claim and issue appropriate payment at the next scheduled disbursement cycle.

12. Military Patient Case Management

Case management of active duty personnel in civilian hospitals 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 hospital 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 GPMRC.

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 hospital.		
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		
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)		

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 on site 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 at least 20 US. Air Force aircraft compatible litters with stands and linen for immediate use at the NDMS Patient Reception Center.

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.
- Sufficient logistics and facility maintenance personnel will be available through governmental or contractor provided support.
- Utility infrastructure supporting hospitals and FCC will be sufficient to provide uninterruptible service.

- Funding (Mission Assignment) will be available for logistics and facility support services to include procurement of supplies, equipment, maintenance, repairs, and contract personnel.

- The population of patients supported may include DoD, government employees, civilians, contractors, and could include both local military and VA beneficiaries.

- During a national emergency or when directed, logistics supply thresholds for those items listed in Appendix 1 may require adjustments to permit for increased stock levels in support of a patient surge requirement.

3. Concept

There are two general areas of logistics: Patient Staging Logistics and Patient Support Logistics. Patient Staging Logistics are the supplies and equipment needed for staging the NDMS patients. Patient Support 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.

Patient Staging 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.
- Waste management, such as medical waste, blood products, sharps, pathological, radiological, and other waste that is considered to include hazards material.

Patient Support Logistics planning considerations:

Both medical and non-medical supplies are required and must be replenished as needed. Items include office supplies, automation and computer support equipment, medical supplies and pharmaceuticals, blood, bio-medical maintenance, and patient movement items. Consider using pre-positioned medical supplies and 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.

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.

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/SGXL 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/SGXL 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/SGXL 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/SGXL to obtain a new label immediately. Non-PMI equipment will not be tracked in this system unless coordinated with USTRANSCOM and HQ AMC/SGXL.

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. 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 hospitals can be contacted. This will require maintaining phone numbers and contact information of the hospitals to help return the PMI equipment.

Contact HQ AMC/SGXL 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 45 of this document.

4. References:

DoD:

- AR 40-61, Medical Logistics Procedures and Policies, January 2005.
- AR 735-5, Property Accountability, January 1998.
- AR 710-2, Inventory Management Supply Policy Below the Wholesale Level, October 1997.
- DA Pam 710-2-1, Using Unit Supply System (Manual Procedures) December 1997.
- Field Manual (FM) 100-19, Domestic Support Operations, July 1993.
- Field Manual (FM) 100-23-1, HA--Multi-service Procedures for Humanitarian Assistance Operations, October 1994.
- Joint Publication 4-02, “Doctrine for Health Service Support in Joint Operations”, 31 October 2006.

Annex J: Communications

Purpose:

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 that the communications network is compatible and integrated with local community resources, State agencies and systems. The FCC coordinator should ensure that the FCC has access to and knowledge/technical skill in local and State emergency operations programs and systems. The purpose of this annex is to assist the FCC in establishing and managing communication processes and equipment in regard to patient reception operations.

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	Quantity Recommended	Maintenance Frequency
Laptop computers with internet access (cellular modem access and alpha paging software)		As needed
Printer		As needed
Fax machine		As needed
Satellite phone with auxiliary antenna		Monthly
Cellular phone with backup batteries		As needed
VHF 7-10 channel, 5-watt handheld radio with charger and extra battery		As needed
Family Radio System (FRS)		As needed
Weather radio with battery backup		Weekly
Pager		As needed
Uninterruptible Power Supply (UPS)		Semi-annual
Auxiliary power		Quarterly

Shared Resources (SHARES) HF radio program		
Government Emergency Telecommunications Service (GETS) Card		Monthly
Hospital Emergency Administration Radio (HEAR)		
Amateur ham radio clubs		
Calling Card		Monthly
Locked cargo boxes with wheels or luggage carriers		
Telephone cords with connectors		
Computer cables and connectors		
Extension cords with surge protectors		
Electrical toolkit with flashlight		
Batteries		

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.
- 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.

2. Training

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

3. Exercising

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

4. Information Systems

FCC directors and coordinators may wish to gain accounts and become members of the following online communities and portals:

- Department of Defense on-line portals provide access to information, forms, and email. Membership is restricted to eligible personnel (active, reserve, civilian, retired, and guests).

  1. Homeland Defense Operations Portal in Army Knowledge online (AKO): https://operations.noradnorthcom.mil/default.aspx (Account required)

  2. USNORTHCOM External Portal in Army Knowledge Online (AKO): https://registration.noradnorthcom.mil/gateway/default.aspx

- Homeland Security Information Network: HSIN is a comprehensive, nationally secure and trusted web-based platform able to facilitate Sensitive But Unclassified (SBU) information sharing and collaboration between Federal, State, local, tribal, private sector, and international partners. The HSIN platform was created to interface with existing information sharing networks to support the diverse Communities of Interest (COI) engaged in preventing, protecting from, responding to, and recovering from all threats, hazards and incidents under the jurisdiction of the Department of Homeland Security. http://www.dhs.gov/xinfoshare/programs/gc_1156888108137.shtm

- TRANSCOM Regulating and Command and Control Evacuation System (TRAC2ES): https://www.trac2es.transcom.mil/

- 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 Federal, State, and local 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, local and regional considerations.)
- What is the FCC throughput?
  - Has this changed since the last report?
- How soon after activation can the FCC receive the first patient load? i.e. 4, 6, 8, 10 hours?
- What is your current bed count: number and types of beds available?
- If FEMA funds are authorized under a Surge Account, be prepared to document the cost to preposition equipment and supplies to reduce time required after activation to receive the first patient load.

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 hospitals?
- How many patients have been received?
  - What types of acuities?
  - Litter or ambulatory?
  - Which NDMS hospitals?

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 hospitals? Which hospitals?
- How many patients were discharged from NDMS Hospitals?
- 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 hospitals asking for reimbursement, did they receive it in a timely manner?
- Within seven days of the patient's release from NDMS care, the FCC must provide HHS or their designated representative with the date of discharge, transfer or release.
- What discharge planning information facilitation is required between the NDMS hospital's case managers and HHS?

Annex L: Public Affairs

Purpose:

This annex suggests considerations for FCC responsibilities to conduct Public Affairs (PA) duties in support of NDMS FCC operations. 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 among the members of the FCC.

Responsibilities:

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

Consider the makeup of existing FCC personnel who may have PA experience and expertise when selection PA designees. This could include personnel from federal, state, and local agencies such as the Federal Emergency Management Agency (FEMA), State Division of Emergency Management (DEM), local law enforcement, Public Information Officers (PIO) and marketing manager of participating agencies.

The PA Designee should report directly to the FCC director and provides PA support staff to the FCC. Some of the goals of PA should be:

- Inform local, state, and national community of the NDMS operations through interaction with the media.
- Document the FCC operations.
- Provide historical archive information for future training exercises.
- Prepare staff and key personnel for speaking engagements with the media.

Operations:

Areas of PA concern include being mindful to secure sensitive or classified information. Avoid the 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.
- Develop and operate a PA center adjacent to the FCC operation area.
- Perform media escort activities, which may include allowing the media to acquire footage and interviews from the operations and PRA processing area.

- Attend FCC staff meetings, when possible, to maintain situational awareness.
- Ensure PA staff have the opportunity to interact with civilian partner senior staff.
- Assume the responsibility for responding to media and community queries.
- Coordinate with spokespersons from FEMA, State, and local agencies in 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).
- (Form can be submitted by the military personnel who participated in the operation).

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.osd.mil/dinfosweb/adl/elearn/ContentModuleMenu_public.asp?courseTPI=PAOQC-ADL-NR

Annex M: Glossary of Terms and Acronyms

1. Terms:

Activated Federal Coordinating Center: 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 12-24 hours.

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. FCCs could expect at least 24-hour notice of patient arrival.

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

Aeromedical Evacuation: The time sensitive mission critical movement of regulated casualties to and between Medical Treatment Facilities, using USAF organic and/or contracted fixed-wing mobility airframes, with AE aircrew trained explicitly for this mission.

Ambulance Bus (AMBUS): The ambulance bus is organic to the military table of allowance for contingency hospitals and aeromedical staging squadrons. 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.

Available Beds: Beds that are vacant as of 2400 hrs of the day previous to the day of the report, to which GPMRC can regulate and to which patients can immediately be transported. They must be in a functioning medical treatment facility set up and ready for all aspects for the care of a patient. Available beds must include supporting space, equipment, medical material, ancillary and support services and staff to operate under normal circumstances. Excluded are transient patient beds, bassinets, incubators, and labor and recovery beds. Beds are reported in categories as instructed by GPMRC.

Bed Report: The submission of a hospital's real-time capacity to receive, admit, and treat patients from a disaster or war, or the submission of a FCCs capacity, including all available NDMS beds, for hospitalization.

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. It can hold a maximum of 74 litters, depending on the availability and serviceability of inherent equipment and the model of the aircraft, 92 ambulatory patients and/or medical crew members, or a variety of combinations of litter and ambulatory. For deliberate planning purposes, the C-130 standard load is 50 patients.

Capability: The maximum number of patients a facility can accommodate.

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

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 hospital.

Civil Reserve Air Fleet (CRAF): Identified airlift platforms, provided upon contract activation, from commercial airlines specifically to perform/support the USTRANSCOM patient movement mission.

Critical Care (CC): Adult or pediatric 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.

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 and function under the in-flight direction of the mission clinical director and aircraft director. 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.

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 37 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. It is led by the Incident Manager and is composed of Operations, Planning, Logistics, and Administrative Sections.

Emergency Support Function (ESF): A functional area of response activity established to facilitate coordinated Federal delivery of assistance required during the response phase to save lives, protect property and health, and maintain public safety. 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.

EXORD: Joint Staff Execution Order which outlines the DoD support to FEMA for disaster operations.

Federal Coordinating Center: A facility located in a metropolitan area of the United States, or Puerto Rico, 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 Requirements Center (GPMRC): A 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 GPMRC 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 GPMRC coordinates with supporting resource providers to identify available assets and communicates transport to bed plans to the appropriate transportation agency for execution.

Health and Human Services: The Department of Health and Human Services (HHS) is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. HHS Website: http://www.hhs.gov/

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, local, and tribal—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: The actions and coordination necessary to arrange for the movement of patients through the levels of care. During this process, GPMRC matches patients to a designated FCC PRA based upon bed availability reporting. In turn, the FCC matches each NDMS patient with a bed in a NDMS hospital having the necessary health service support capabilities.

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.

Mission Assignment (MA): 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. The MA will be will be transmitted to DoD and VA points of contact in the form of a Request for Assistance (RFA).

Mobile Aeromedical Staging Facility (MASF): The MASF provides rapid response patient staging, limited holding, and AE crew support capability. Normally located at or near airheads capable of supporting mobility airlift, the MASF 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 MASF 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 MASFs 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 MOA: A standard MOA, signed by the four Federal Partners, indicating roles and responsibilities for the partners. It also includes a standard memorandum of agreement between the NDMS and participating hospitals.

National Disaster Medical System 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.

National Disaster Medical System Senior Policy Group: Consists of representatives from the HHS Assistant Secretary for Preparedness and Response (Chairman), Under Secretary, Department of Homeland Security, Emergency Preparedness and Response (Chairman); the Assistant Secretary of Defense (Health Affairs); and the VA Under Secretary for Health. This group determines policy and goals for the NDMS.

National Disaster Medical System 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.

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

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, 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/.

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 hospital.

Patient Movement Items (PMI): Specific Global Patient Movement Joint Advisory Board (GPMJAB) 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 hospitals capable of providing definitive care for victims of a domestic disaster, emergency, or military contingency. Generally, these hospitals 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.

Prepare to Deploy Order (PTDO): 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 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 (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.

Staffed Bed: An accommodation in a functioning medical treatment facility that is currently set up and ready in all respects for the care of a patient. It must include supporting space, equipment, medical materiel, ancillary and support services, and staff to operate under normal circumstances. Excluded are transient patient beds, bassinets, incubators, labor beds, and recovery beds.

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 hospital (or hospitals 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. Website: http://www.5tharmy.army.mil/

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
CRAF	Civil Reserve Air Fleet
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
ERT-A	Emergency Response Team - Advanced
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
GPMRC	Global Patient Movement Requirements 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
IBA	Irving Burton Associates, Inc.
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
LEPC	Local Emergency Planning Committee
LFA	Lead Federal Agency
LLIS	Lessons Learned Information System
MA	Mission Assignment
MARS	Military Affiliate Radio System
MC	Pediatrics (bed reporting category)
MCPS	Medical Claims Processing System
MIACG	Medical Interagency Coordination Group
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)
MPAT	Military Patient Administration Team
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

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
OPEO	Office of Preparedness and Emergency Operations
OPLAN	Operations Plan
OPORD	Operations Order
OSC	Operations Support Center
PA	Public Affairs
POC	Point of Contact
PIO	Public Information Officers
PMCG	Patient Movement Coordination Group
PMI	Patient Movement Items
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
SBN	Burns (bed reporting category)
SHARES	Shared Resources
SLTT	State, Local, Tribal, and Territorial
SOC	Secretary's Operations Center (HHS)
TACC	Tanker Airlift Control Center
TJC	The Joint Commission
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 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
   202-215-0062

4. **GPMRC 24 hour OPS DESK** (618) 229-4200

5. **National Operations Center (NOC)**

   Department of Homeland Security
   Watch Desk general communication: NOC.SWO@dhs.gov
   For sensitive communications: communicationsNOC.SWO.Restricted@dhs.gov

6. **HHS SOC**

   SOC Email hhs.soc@hhs.gov
   SOC 24 hour number 202-619-7800
   http://www.hhs.gov/aspr/opeo/operations/index.html
   NDMS: 1-800-872-6367

7. **VA:**

   VHA EMSHG Duty Officer
   304-264-4800

Annex O: References List

1. REFERENCES:

a. National Response Framework (NRF), January 2008
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)
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 (9 September 1998); currently under revision
i. DoD Directive 6010.22, National Disaster Medical System (NDMS) (21 January 2003); currently under revision
j. HSPD 5 Homeland Security Presidential Directive 5 Management of Domestic Incidents, Feb 2003
k. HSPD 8 Homeland Security Presidential Directive 8 National Preparedness, Dec 2003
l. HSPD 21 National Strategy for Public Health and Medical Preparedness Oct 2007
m. Homeland Security Exercise and Evaluation Program (HSEEP) Vol. I-III, February 2007
n. FY 2009 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

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://www.dhs.gov/xgovt/grants/index.shtm.

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

Department of Veterans Affairs Emergency Management Strategic Health Care Group (EMSHG): http://www1.va.gov/emshg/page.cfm?pg=151

Department of Veterans Affair's EMSHG Directory: http://www1.va.gov/EMSHG/page.cfm?pg=65

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

FEMA National Exercise Program: http://www.Fema.gov/about/training/exercises.shtm

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

HHS ASPR NDMS: http://www.hhs.gov/aspr/opeo/ndms/index.html

HHS 2010 Integrated Training Summit: http://www.hhstrainingsummit.org/

Homeland Security Information Network: http://www.dhs.gov/xinfoshare/programs/gc_1156888108137.shtm

Joint Patient Assessment and Tracking System Logon: http://teams.hhs.gov/PETS/protected/home.do

Joint Patient Assessment and Tracking System Training Website: http://teams.hhs.gov/jpatstraining/

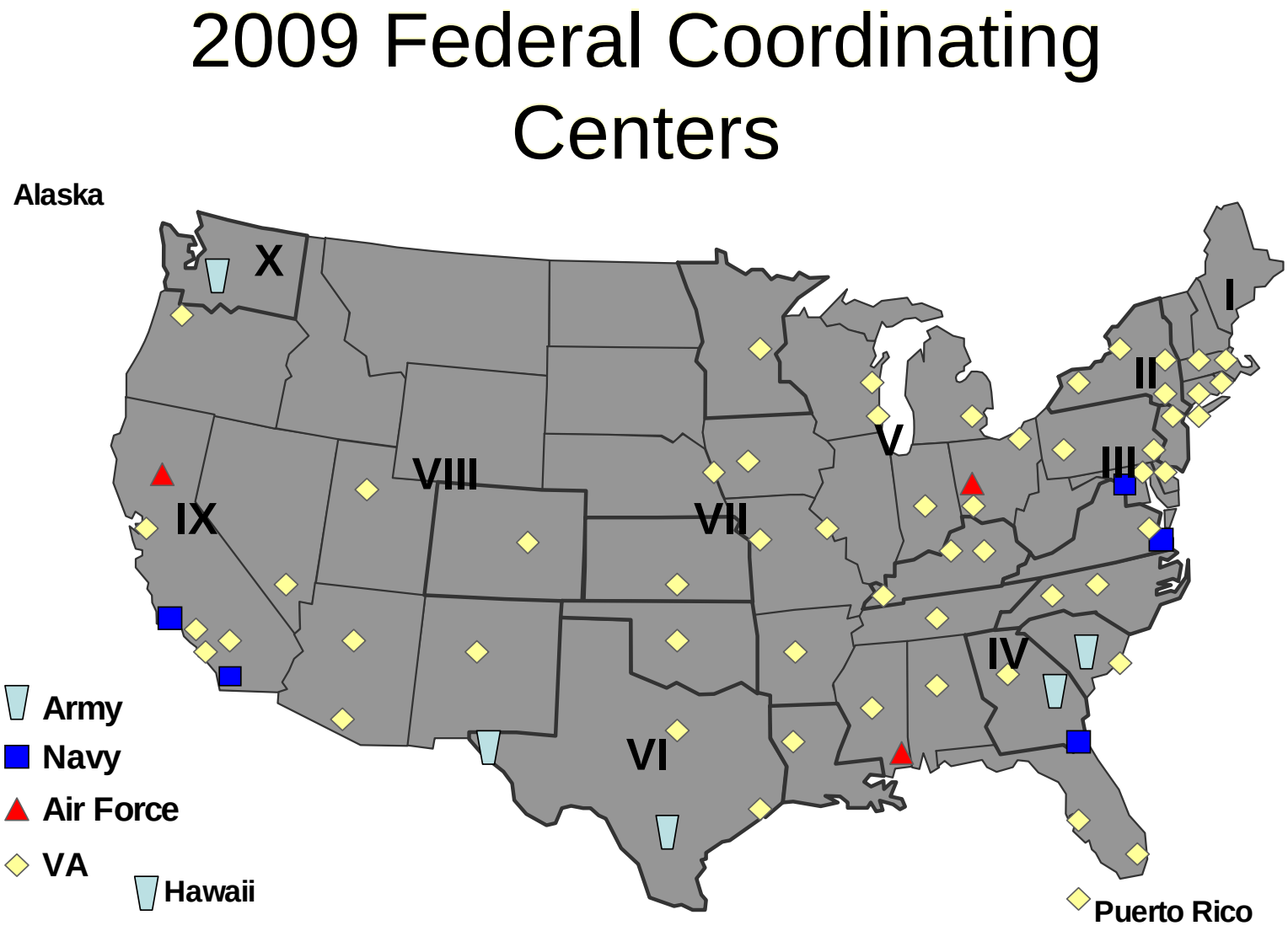
National Response Framework Resource Center: http://www.fema.gov/emergency/nrf/

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

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

USARNORTH: http://www.usarnorth.org/public/home.cfm?CFID=44311&CFTOKEN=54134823

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 Global Patient Movement Requirements Center ☐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 ☐Yes ☐ No ☐ Unknown

reception and distribution operations?

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 for sufficient numbers of FCC staff personnel? ☐Yes ☐ No ☐ Unknown

15. Have contacts been established with the TRICARE Regional Offices? ☐Yes ☐ No ☐ Unknown

16. Is sufficient support provided by USNORTHCOM Joint Regional Medical Planners? ☐Yes ☐ No ☐ Unknown

17. Is sufficient support provided by a local NDMS Steering Committee? ☐Yes ☐ No ☐ Unknown

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

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

20. 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

21. Has a PRA plan been developed? ☐Yes ☐ No ☐ Unknown

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

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

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

_____

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

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

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

b. Identification of patient movement items ☐Yes ☐ No ☐ Unknown

c. Identification of additional patient movement requirements such as litters and blankets, etc. ☐Yes ☐ No ☐ Unknown

d. Patient Reception Team(s) plans, processes and procedures for patient unloading patients ☐Yes ☐ No ☐ Unknown

e. 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

f. Resources to support the Patient Reception Team(s): Meals, Water, Bathing and Toilet Facilities, Sleeping Arrangements, Team-Member Transportation, ☐Yes ☐ No ☐ Unknown

g. Night and/or weekend operations ☐Yes ☐ No ☐ Unknown

h. Inclement weather contingencies ☐Yes ☐ No ☐ Unknown

i. Processes and procedures for patient identification and tracking within the PRA ☐Yes ☐ No ☐ Unknown

j. 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

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 airfield closures or other operational constraints ☐Yes ☐ No ☐ Unknown

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

f. Coordination with airfield medical facilities/personnel (if applicable) ☐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? ☐Yes ☐ No ☐ Unknown

7. Are guidelines in place to help to estimate the maximum "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 extent possible? ☐Yes ☐ No ☐ Unknown

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 three 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 three years are on file for this PRA? _____

4. What is the total minimum number of beds available (according to MOAs) for this PRA? _____

5. What is the total maximum number of beds available (according to MOAs) for this PRA? _____

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

7. 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 or Local obligations? ☐ Yes ☐ No ☐ Unknown

8. Have any special procedures been established for admission and disposition of NDMS patients at participating NDMS facilities? ☐ Yes ☐ No ☐ Unknown

9. Do participating NDMS facilities understand the role of the Military Patient Administration Team (MPAT), if applicable? ☐Yes ☐ No ☐ Unknown

10. Do participating NDMS facilities know how to contact the nearest military medical treatment facility(s)? ☐Yes ☐ No ☐ Unknown

11. Are contingency plans in place to coordinate food, lodging and transport for NDMS patients requiring outpatient services? ☐Yes ☐ No ☐ Unknown

12. Are contingency plans in place to coordinate food, lodging and transport for NDMS non-medical attendants and/or family members? ☐Yes ☐ No ☐ Unknown

13. Are local information packets available for distribution to NDMS patients, non-medical attendants and/or family members? ☐Yes ☐ No ☐ Unknown

15. 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? ☐Yes ☐ No ☐ Unknown

3. Did the FCC formulate a training and exercise budget request in the past year? ☐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 all 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 training with any specialized communications equipment ☐Yes ☐ No ☐ Unknown

12. 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 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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