



**National Disaster Medical System  
Federal Coordinating Center  
Guide  
June 2018**

## FOREWORD

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

The basis for this guide is DoD Instruction (DoDI) 6010.22 (14 April 2016) National Disaster Medical System (NDMS), the 2005 Federal Partner's Memorandum of Agreement for the NDMS, and the 6 August 2009, NDMS Concept of Operations (CONOPS). FCC operations will be in accordance with the NDMS Federal Coordinating Center Guide. This guide is not policy, and hence it is not to be considered authoritative or prescriptive.

NDMS serves a dual role of support in domestic emergencies, under the lead agency responsibility of the Department of Health and Human Services; and military health emergencies, under the lead agency responsibility of the Department of Defense.

The DoD will provide available resources to support the NDMS during U.S. national emergencies or U.S. domestic disasters in accordance with Title 42, U.S.C., the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013, the NDMS Federal Partners Memorandum of Agreement, or as directed by the President.

The responsibility to update this guide resides with the Department of Defense (DoD) and the Department of Veterans Affairs (VA). It is intended to be reviewed and updated on a periodic basis. The guide may be updated in whole, or may be updated in part by updating only those chapters or annexes needing revision.



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## HOW TO USE THE RECORD OF CHANGES SHEET

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<b>CHAPTER</b>	<b>RECORD OF COMMENTS OF CHANGE REQUESTED</b>

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## 1. INTRODUCTION

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

An FCC is defined as a federal facility (DoD or VA) located in a metropolitan area of the United States, responsible for day to day coordination of planning, training, and operations in one or more assigned geographic NDMS Patient Reception Areas (PRA). NDMS participating medical treatment facilities should be within a reasonable distance for patient transportation given the local road network and predominate traffic conditions (generally within a 75 mile radius of the managing FCC). At the discretion of the FCC Director, hospitals with specialty capability; i.e. children's hospital, burn, spine, Level I Trauma, etc. be added to the network outside the 75-mile radius.

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

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

### 1.2. The National Response Framework (NRF)

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

The NRF is comprised of a core document, the Emergency Support Function (ESF) Annexes, Support and Incident Annexes, and Partner Guides. These documents are available at the NRF Resource Center. The ESF pertinent to NDMS is ESF #8, Public Health and Medical Services.

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.

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. 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.

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

The NRF describes the principles, roles and responsibilities, and coordinating structures for delivering the core capabilities required to respond to any incident and further describes how response efforts integrate with those of the other mission areas. The NRF is always in effect, and elements can be implemented at any time. The structures, roles, and responsibilities described in the NRF can be partially or fully implemented in the context of a threat or hazard, in anticipation of a significant event, or in response to an incident. The NRF provides the mechanism for coordinated federal assistance to supplement state, Tribal, territorial and local resources in response to a public health and medical disaster, potential or actual incidents requiring a coordinated federal response, and/or during a developing potential health and medical emergency.

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

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

DoD NDMS patient movement and reception pertains to patient evacuation from ports of embarkation to ports of debarkation via a Federal Coordinating Center (FCC) to an NDMS hospital.

NDMS civilian hospitals serve as a backup to military treatment facilities when both DoD and Department of Veterans Affairs (VA) hospitals are at capacity during a military health emergency.

The DoD medical evacuation system is organized, trained, and equipped for the evacuation of wartime casualties. This population is normally not synchronous with the types of patients generated from a civilian disaster scenario. DoD will provide medical evacuation for patients identified in the U.S. Transportation Command (USTRANSCOM) Patient Movement Automated Information System bed categories within the capacity of the evacuation system at execution.

The NDMS is a federally coordinated healthcare system and partner of the Department of Health and Human Services, Department of Homeland Security (DHS)/Federal Emergency Management Agency (FEMA), Department of Defense (DOD), and Veterans Affairs (VA).

The NDMS generally supports domestic emergencies and disasters within the ESF #8 structure of the NRF. Under ESF #8, HHS is responsible for overall coordination of medical response, patient movement, and definitive medical care.

#### 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.

#### 1.5. The Incident Command System (ICS)

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.

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



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

Medical Response Lead to HHS (Specialty Teams); Patient Movement Lead (DoD), (which includes FEMA Contract Aeromedical Evacuation Primarily Fixed Wing); Definitive Care Lead (DoD/VA) (DoD/VA Federal Coordinating Centers).

- (1) **Medical Response:** HHS is the lead component for NDMS for medical response/supplemental health requirements. HHS provides supplemental health and medical assistance in domestic disasters at the request of state and local authorities; i.e. State, Local, Tribal, and Territorial Government Coordinating Council. The NDMS serves the federal response by providing disaster medical care to the nation. The NDMS will temporarily supplement federal, state, Tribal, territorial, and local capabilities by funding, organizing, training, equipping, deploying, and sustaining a specialized and focused range of public health and medical deployable capabilities.
- (2) **Patient Movement:** DoD is the LFA (lead federal agency) to coordinate patient movement/evacuation of patients who cannot be cared for in the disaster area to designated locations elsewhere in the nation. Federal Emergency Management Agency (FEMA) may also contract civilian air ambulances to support this mission. The patient movement responsibility includes the movement, regulating, and tracking to receiving NDMS partner facility.
- (3) **Definitive Care:** DoD/VA are the LFAs to provide a nationwide network of voluntary, pre-identified, non-federal medical facilities (NDMS partner facility) capable of providing definitive care for the victims of disaster or military contingency exceeding the medical care capabilities of the affected local, state, or federal medical system. This is coordinated through Federal Coordinating Centers.

## 1.7. ESF #8 Governance Structure

As described in Section 1.3, NDMS is a part of the overall structure of ESF #8. The following paragraphs describe governance of ESF #8 and the NDMS.

**ESF #8 Coordination Group Senior Leader Council (ESF #8 CG SLC):** The ESF #8 CG SLC provides general oversight, management, and supervision of ESF #8 and the NDMS. The ESF #8 CG SLC consists of senior officials from 12 Federal departments and the Environmental Protection Agency, the General Services Administration, and the U.S. Agency for International Development. The ESF #8 CG SLC is chaired by the HHS Deputy Assistant Secretary for Preparedness and Response, Director of the Office of Emergency Management.

**ESF #8 CG Working Groups:** Working Groups will be established as either standing Functional Area Working Groups or temporary ad-hoc working groups designated for specific issues and disband upon completion of the assigned task. Working groups will present their findings to the ESF #8 CG SLC for review and/or approval.

**Action Officer Review Group:** Comprised of senior action officers from the membership of the ESF #8 CG SLC. All products/information/briefings from the working groups will be reviewed by the Action Officer Review Group prior to presentation to the ESF #8 CG SLC.

### **1.8. NDMS Oversight and Integration into ESF #8**

**NDMS Senior Policy Group (SPG):** The SPG will be a component of, but not subordinate to, the ESF #8 CG SLC composed of the members from the four NDMS partner agencies (DHS, HHS, VA, and DoD) and will oversee preparedness and response activities that are specific to the NDMS.

**NDMS Directorate Staff (DS):** The NDMS DS will be a component of, but not subordinate to, the Action Officer Review Group composed of the members from the four NDMS partner agencies and will provide general oversight, management, and supervision of the NDMS.

The NDMS Federal Partners, through the NDMS Directorate Staff and Senior Policy Group will be the core decision-makers for any actions or recommendations on topics defined in the NDMS Federal Partners Memorandum of Agreement.

Nothing precludes the NDMS Federal Partners from coordinating during a response on topics defined in the NDMS Federal Partners Memorandum of Agreement.

## 2. NDMS OPERATIONAL OVERVIEW

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

The NDMS may be activated in one of three ways:

- 1. Robert T. Stafford Disaster Relief and Emergency Assistance Act:** In the event of a domestic peacetime disaster, the Governor of an affected state, on advice of local or county authorities, may request federal assistance under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act. The State requests assistance from FEMA. FEMA accepts the request and tasks the appropriate ESF, which in this case, is ESF #8.
- 2.** In accordance with Chapter 68 of Title 42, U.S.C. (also known and referred to in this issuance as “The Stafford Act”) or Section 1535 of Title 31, U.S.C. (also known and referred to in this issuance as “The Economy Act”), requests for NDMS assistance will be processed in accordance with DoDD 3025.18 and the National Response Framework (NRF). Such assistance is provided on a reimbursable basis under these acts.
- 3. The Public Health Service Act:** A State Health Officer or Health Preparedness Director may also request NDMS activation by HHS in a public health emergency situation without Presidential Disaster Declaration. The Secretary of the Department of Health and Human Services (HHS) may, under section 319 of the Public Health Service (PHS) Act determine that: a) a disease or disorder presents a public health emergency; or b) that a public health emergency, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. Under these circumstances, the HHS Secretary may declare a Public Health Emergency. However, the state may be liable for costs incurred in this type of activation.
- 4. Overseas and Domestic Military Contingency Emergency:** When the number of military patients exceed, or are expected to exceed, the capability of the DoD Military Healthcare System (MHS) and VA-DoD Contingency Hospital System, the NDMS may be activated by request of the Assistant Secretary of Defense, Health Affairs, ASD(HA). The ASD(HA) notifies the HHS Secretary’s Operations Center (SOC) and alerts Veterans Health Administration (VHA)/Office of Emergency Management (OEM) through the VA Under Secretary of Health (USH). ASD(HA) will coordinate with HHS to activate the definitive care component of the NDMS. At the request of the ASD/HA, HHS will authorize the activation of the NDMS and the alert of FCCs. The ASD(HA) will notify the Services to alert select DoD FCCs, and VHA/OEM will alert select VA FCCs. ASD(HA) will also notify the National Military Command Center (NMCC) and the Joint Chiefs of Staff, who will request appropriate patient evacuation support from United States Transportation Command (USTRANSCOM) through United States Northern Command (USNORTHCOM). VA initially pays for costs of the patient reception site (PRS) operations, before being reimbursed by DoD via the Economy Act. The PRS is the actual reception site of the FCC where patient care and regulating occurs. There will also be

communication between the ASD (HA) and the DoD Joint Director of Military Support (JDOMS) informing them of actions taken. Once activated, the FCCs will initiate PRS operations and patient reception plans. DoD covers costs associated with this activation and the VA will assume the costs of activation of their FCCs. (Joint Publication 3-28; Defense Support of Civil Authorities). VA must receive reimbursement for non-veteran care. In a situation that brings military members to a PRC, the VA system can easily be overwhelmed and will need community resources.

## **2.1. NDMS Components**

### **2.1.1. HHS Public Health and Medical Services Support**

#### **Medical Response**

The first component of the NDMS is medical response. NDMS provides supplemental medical response with the Disaster Medical Assistance Teams (DMATs) DMATs are responsible for providing medical care and support during public health emergencies such as natural and technological disasters, acts of terrorism, and disease outbreaks, as well as in support of National Special Security Events (NSSEs). DMATs are deployed to supplement federal, state, local, Tribal, territorial, and insular area medical resources upon request of proper authorities, and when local, state, and mutual aid resources are overwhelmed or otherwise not available. DMATs at a disaster site provide pre-hospital and/or emergency medical services. A DMAT may be utilized, if available, in support of a local NDMS PRS to provide patient staging services.

DMAT members are permanent excepted-service federal employees utilized on intermittent basis acting under official orders. Team members receive protection under the Uniformed Services Employment Reemployment Rights Act (USERRA), Federal Tort Claims Act (FTCA) and Workers' Compensation under the Federal Employees Compensation Act (FECA), and are compensated, traveled and billeted based on Civil Service classifications and standards associated with a declared event and/or incident. DMAT personnel have both liability coverage and a salary when called into service. DMATs are an all-hazards response resource incorporating scalable deployment configuration sizes with specific clinical, non-clinical and leadership personnel. Teams are capable of performing a wide range of patient-care functions in a variety of mission scenarios, including but not limited to:

- Emergency Department Decompression
- Inpatient Care Augmentation
- Supporting patient movement
- Stabilization and transfer of all patients including critically ill/injured and nursing home patients
- Staffing Casualty/Patient Collection Points
- Triage services
- Mass prophylaxis
- Assist at Aerial Ports of Embarkation (APOEs)

DMATs are supported by a cadre of logistical and administrative staff and are self-sustaining for up to 72 hours.

- (1) Upon a state request, HHS may provide a Federal Medical Station (FMS). The FMS is an HHS deployable healthcare facility providing surge beds to support healthcare systems anywhere in the U.S. impacted by disasters or public health emergencies. FMS are not mobile and cannot be relocated once established. The U.S. Public Health Service (USPHS) is the primary resource for staffing; however, there are also staffing models that include personnel from the VA and DOD.

The Medical Reserve Corps (MRC)

- (2) The Medical Reserve Corps (MRC) is comprised of organized medical and public health professionals who serve as volunteers to respond to natural disasters and emergencies. They prepare for and respond to natural disasters, such as wildfires, hurricanes, tornados, blizzards, and floods, as well as other emergencies affecting public health, such as disease outbreaks. The MRC program provides the structure necessary to deploy medical and public health personnel in response to an emergency, as it identifies specific, trained, credentialed personnel available and ready to respond to emergencies.

### **2.1.2. Patient Movement (PM)**

DoD is the LFA responsible for PM which is the second component of NDMS. In the event that the local, regional, and state medical systems within a disaster area are overwhelmed, there may be a need for a system to move patients out of the disaster area prior to or after the event. Moving patients includes patient evacuation, medical regulating, enroute medical care, and tracking/inpatient visibility.

When the NDMS is activated to move patients, DoD coordinates this movement in collaboration with other ESF #8 partners, as required. USTRANSCOM's Global Patient Movement Requirements Center (GPMRC) is the single manager for the movement of NDMS patients. The GPMRC is a Joint activity reporting directly to the USTRANSCOM Command Surgeon and serves as DoD's single manager for the development of policy and standardization of procedures and information support systems for global patient movement. This includes accepting requests for movement of NDMS patients out of the disaster area, regulating patients to designated FCC PRS locations, and coordinating patient transportation. When DoD conducts patient movement, it is generally accomplished by fixed wing aircraft.

The patient tracking function is accomplished using an HHS system called the Joint Patient Assessment and Tracking System (JPATS). JPATS will track all patients being moved by ESF #8/NDMS from the point of entry into the patient movement system, to the NDMS partner medical facility, and back home to their originating location. As patients are discharged from the receiving medical facilities, HHS will coordinate the safe return of the evacuated patients to their place of origin once the danger has resolved. The coordinated effort between the NDMS partners is codified in legislation, the NRF and within various formal agreements. In some instances, most likely during initial patient movement, patient information may not be immediately



entered into JPATS and it would be the FCC's responsibility to create the record.

### 2.1.2.1. Transportation by Air

DoD is the LFA responsible for patient evacuation and accomplishes this through the U.S. Air Force's Air Mobility Command (AMC), the air component of USTRANSCOM. The Aeromedical Evacuation System (AES) administered by AMC has unique aeromedical evacuation (AE) capabilities. It is used for the transportation of DoD patients and can be expanded when required. Civilian air ambulances utilize airplane or helicopters specifically designed to move patients to and from healthcare facilities and accident scenes. Aircrews provide comprehensive emergency and critical care to all types of patients during aeromedical evacuation. Patient load is normally one but some aircraft can carry two, either low acuity or high acuity (critical care). To support NDMS operations, the USTRANSCOM Theater Patient Movement Requirements Center America's (TPMRC-A) formulates evacuation missions in conjunction with the Headquarters, 618th Air Force Tanker/Airlift Control Center (TACC) (See Appendix 2 to Annex D for information on medical regulating). These missions are based on patient and medical equipment requirements, the location of available definitive care, and the availability of aircraft, AE crews, and Critical Care Air Transport Teams (CCATT).

Patient capabilities given below are for military patients, it is anticipated the capabilities for NDMS movements will be smaller. The following are some DoD AE capabilities the FCC Director/Coordinator should be aware of:

- The **C-130 Hercules** forms the backbone of DoD intra-theater patient movement in the Continental United States (CONUS). This aircraft has the unique capability of not requiring an improved runway for takeoff or landing. It can land on short stretches of interstate highway, in a desert region, or an open field, weather and soil conditions permitting. The C-130 litter and patient/passenger seat availability varies. It can be readily configured in accordance with C-130 Operations, Configuration/Mission Planning (AFI 11-2C-130V3 ADDA). The planning factors for a standard load are 50 litter patients. For DSCA, the prevalence of bariatric and other patient characteristics the ratio is: 35 pts/C-130. The C130H has 10 stanchions (31-34 pts); C130 J (extended) has 12 Stanchions, 50-60 pts-planning factors is 40-48 non-critical litter pts.
- The **C-17 Globemaster III** fly long distances and land in remote airfields in rough, land-locked regions, can take off from a 7,600-ft. airfield, and land in 3,500 ft. or less on a small unpaved or paved airfield in day or night. The C-17 can be configured to accommodate 36 litter (with Litter Stanchion Augmentation set) and 54 ambulatory patients and attendants.
- **Critical Care Air Transport Teams (CCATT)** provides specialized care, in conjunction with AE crews, to evacuate critical patients requiring advanced care during transportation. Recognized as clinical experts, these teams are medically responsible for their patients and function under the in-flight direction of the Medical Crew Director

(MCD) and Pilot-in-Command (PIC). The CCATT physician is clinically responsible for care given to CCATT-assigned patients and may be asked to assist or advise on the care of the other patients.

#### **2.1.2.1.1. FEMA National Ambulance Contract – Air Transport Platforms**

The National EMS Disaster contract by Federal Emergency Management (FEMA) is through a competitive request for proposal (RFP) process. The contract covers four zones as defined by FEMA which encompasses all 48 States in the contiguous U.S. These are five-year contracts with annual options to renew. Maximum deployment for each zone includes 300 ground ambulances (typically a 60%/40% ALS/BLS split), 25 air ambulances, helicopter and/or fixed wing and enough para-transit vehicles to transport 3,500 people.

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

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

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

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

This may be accomplished through DOT, commercial companies, or through other agencies, as applicable. DoD ground/sea PM has not been validated for NDMS civilian patients.

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

**2.1.2.3.2. VA Dual Use Vehicles (DUVs)** are operated by numerous VA medical centers nationwide. Both small and large versions of the DUVs routinely carry VA beneficiary passengers and patients, and can be reconfigured when required. Small DUVs can transport a maximum of 14 ambulatory, 6 wheelchairs, 3 ambulance gurneys, 9 low-acuity litter patients, 2 critical patients, or combinations thereof. Large DUVs can transport up to 30 ambulatory, 10 wheelchairs, 5 ambulance gurneys, 15 low-acuity litter patients, 4 critical patients, or combinations thereof. FCCs requiring DUVs are encouraged to contact the VHA/OEM at 304.264-4800; if that number is not

answered, to the VHA/OEM Watch Desk at 202-461-0268 or 202-461-0269

### 2.1.3. Definitive Medical Care

DoD/VA are the LFAs for NDMS definitive medical care as the third component of NDMS definitive medical care. Patients evacuated from a disaster area for definitive medical care arrive at the respective FCC's Patient Reception Site (PRS). The patients are delivered to the PRA at the Aerial Port of Debarkation (APOD). Movement of outpatients that require on-going medical services, e.g., dialysis, chemotherapy, etc., will require HHS assistance as it is responsible for lodging and other wrap-around services in the destination city, not the FCC (as this is a continuation of the social case management aspect. The Service Access Team (SAT) - an HHS component - should be the lead). This may be taken care of through the ESF #8 coordination group. DoD is responsible for coordination at the disaster site and the FCC is responsible for the operation of the PRS site for DoD executed PM. The patients are then moved to appropriate definitive care facilities in the local area. The HHS Service Access Teams (SAT Teams) arrange the return of the patients back to their origin or other acceptable location. The PRA is a geographic locale containing one or more airfields, ports, terminals, or patient staging facilities with local patient transport assets to support patient reception and transport to the NDMS Partner Facility capable of providing definitive care for victims of a public health emergency or military contingency located within a 75-mile radius of the treatment facility.

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

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

Once patients are distributed to NDMS partner medical facilities, it is the responsibility of HHS to coordinate the discharge and transportation of patients returning to their point of origin, or other destinations, as authorized. The HHS team that directs these activities is the SAT. This team consists of individuals from the USPHS. They are responsible for:

1. Tracking and monitoring patient status
2. Providing information to family members

3. Coordinate lodging and human services needs of discharged and nonmedical attendants
4. Facilitate the return movement of patients and non-medical attendants
5. Coordinate the return/disposition of remains
6. Facilitate the recovery and return of patient movement items from NDMS facilities to DoD.

NDMS partner medical facilities are reimbursed for the care they provide in accordance with the signed NDMS Definitive Medical Care Memorandum of Agreement (MOA) in effect at that time.

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

### **2.1.3.1. Definitive Medical Care during Military Health Emergency (DoD/VA)**

In response to the VA/DOD Health Resources Sharing Act, Public Law 97-174, a Memorandum of Understanding (MOU) was executed between the Secretary of Defense and the Administrator of the Veterans Administration (presently the Secretary of Veterans Affairs), specifying each agency's responsibilities.<sup>1</sup> The VA agreed to serve as the Secondary Support Center (SSC) for DoD and to furnish health services to armed forces on active duty on a higher priority than was done previously.

### **2.1.3.2. Differences between NDMS FCCs and Primary Reception Centers**

Primary Reception Centers (PRCs) are MTFs or VA Medical Centers (VAMCs) designated to receive sick and wounded military personnel returning from overseas armed conflict or national emergency. PRCs are designated in accordance with the VA-DoD Contingency Hospital System.

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 PRSs. FCCs may receive, triage, stage, track and transport inpatients, *affected by a disaster, to a participating NDMS Partner* medical facility *capable of providing the required definitive care*. The patients will more than likely not be eligible for care in a federal treatment facility, i.e., military, family members, or other **beneficiaries**.

The mission of a **PRC** is to **receive and treat sick and wounded military**

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<sup>1</sup> MOU signed on November 2006 and amended in September 2013.

**personnel returning from armed conflict or national emergency.**

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

	<b>FCC</b>	<b>PRC</b>
<b>Scenario</b>	Disaster	Armed conflict or disaster
<b>Patients</b>	Civilians	Uniformed service members
<b>Funding</b>	Stafford Act, Economy Act	DoD
<b>Patient Reception Team (PRT)</b>	Can be made up of Military Treatment Facility, VA and local civilian partners	Generally the MTF or VA staff
<b>Patient Reception Area (PRA)</b>	Geographic area within the 75-mile radius of the FCC	
<b>Patient Reception Site</b>	Patient Reception Site: the location where patient reception operations are conducted, i.e. airfield. PRS is commonly used when referring to the reception site	
<b>Regulating</b>	USTRANSCOM Regulating and Command and Control Evacuation System (TRAC2ES); JPATS	TRAC2ES
<b>Destination Medical Facility</b>	NDMS Partner medical facilities	MTF or VA hospital

More information about the DoD/VA Contingency Plan can be found on the VAH Office of Emergency Management website

### 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

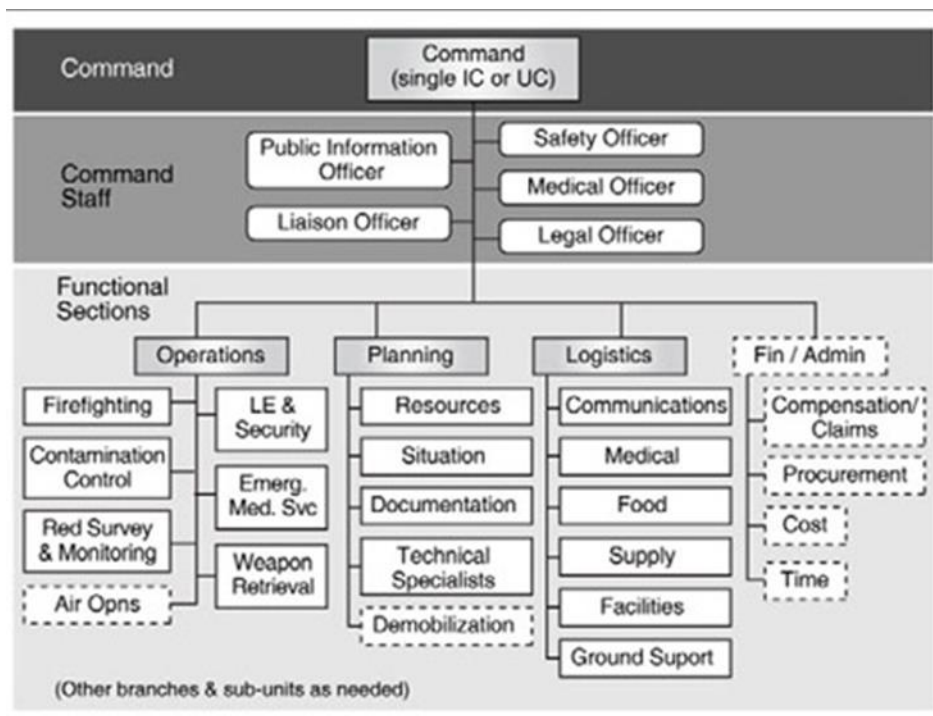
**3.1.1. FCC** – A facility responsible for day-to-day coordination of planning and operations in one or more assigned geographic NDMS PRSs; DoD Medical Treatment Facilities (MTFs) or VA Medical Centers are responsible for the operation of an FCC.

**3.1.2. PRA** – A geographic locale containing one or more airfields or bus stations; 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 located within a reasonable distance for patient transportation given the local road network and predominate traffic conditions (generally within a 75 mile radius of the managing FCC).

**3.1.3. FCC Director** – A DoD, VA, or other principal staff member responsible for the management of an FCC and associated NDMS PRSs.

**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.



Hospital Incident Command System (HICS) above. HICS is a methodology for using incident command system (ICS) in a hospital/healthcare environment. HICS assists hospitals to improve their emergency management planning, response, and recovery capabilities for planned and unplanned events. The HICS structure describes: command & general staff positions as well as the recommended Patient Reception Team (PRT) members composition and responsibilities, an ICS structure that can be used (not required to follow that specific structure, but as an example for each FCC to ensure they have all required staff filled, accounted for and in their plan)

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 PRS to assist in the preparation of local NDMS operating plans, planning, and execution of system exercises. It is also important to have ESF #6 (Mass Care, Emergency Assistance, Temporary Housing and Human Services Annex) representation on the steering committee to assist in planning for housing and feeding of non-medical attendants who may accompany NDMS patients.

### 3.2. FCC Alert and Activation

When a governor determines the state does not have enough resources to move hospital inpatients out of a potential disaster area (pre-event) or after a disaster has struck (post-event), he/she requests assistance from FEMA (Stafford Act). FEMA accepts the request, and after validation from the HHS's regional Federal Health Official, tasks the appropriate ESF.

In this case, that ESF will be ESF #8, where HHS is the lead Federal Agency (LFA).

In a non-Stafford Act event, e.g., a public health emergency, the state would request assistance from HHS. HHS will accept the request after validation from the HHS's regional Federal Health Official and send a Request for Assistance (RFA) to the appropriate agencies for support.

For impending patient movement requirements, the HHS Emergency Management Group (EMG) convenes the ESF #8 Patient Movement Coordination Task Force (PMCTF) which is the new terminology which replaces the previous PMCC. The PMCTF is composed of representatives from the NDMS patient movement partners (e.g., HHS, DHS/FEMA, DoD, VA FCC Area Emergency Managers (AEMs), state health departments, HHS Regional Emergency Coordinators (RECs), HHS SAT staff, etc.). The PMCTF coordinates and integrates NDMS operational planning, alerts, activations, and de-activations in order to establish and maintain an NDMS patient movement common operating picture for HHS and the NDMS partners. The PMCTF will determine the frequency for contingency bed reporting requirements, which will typically be every 24 hours during patient movement activity.

When FCCs are required, the PMCTF will determine which FCCs are to be alerted and eventually activated. The PMCTF will notify the VA and DoD FCC Coordinator in writing (email or ESF #8 Warning Order) of the selected FCCs, who in turn will inform the FCCs and their associated PRSs of the potential activation. NDMS will deploy NDMS response teams as applicable. The decision to alert/activate FCCs is a collective decision by the PMCTF and done with full consultation with the RECs and involved states. An additional step in the activation process is required to DoD FCCs. The U.S. Northern Command (USNORTHCOM), as the military command responsible for Defense Support to Civil Authorities, will publish orders activating the DoD FCCs.

Upon federal, state, Tribal, territorial, or local request for patient movement to NDMS definitive care and when a disaster declaration has occurred, a mission assignment (MA) is generated by FEMA for FCC assistance for patient reception. The MA will articulate which FCCs are to be activated, duration of the expected patient reception mission, 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). The receiving agency will, in turn, alert and/or activate the appropriate FCCs as agreed. When a state determines the need to move patients from the disaster area, it requests assistance from FEMA. FEMA accepts the request, after validation from the regional Federal Health Official (FHO), and tasks the appropriate ESF. In this case, that ESF will be ESF #8, where HHS is the lead and coordinating federal agency. In a non-Stafford Act event, HHS generates RFAs for the appropriate agencies to support activation and movement.

### **3.2.1 Mission Assignment Process**

#### **3.2.1.1 How the Department of Defense becomes involved in Defense Support of Civil Authorities (DSCA)**

When an incident occurs (hurricane, earthquake), response begins at the local level. If the local resources become overwhelmed, the state then provides assistance. If state resources are overwhelmed they will normally request assistance via the



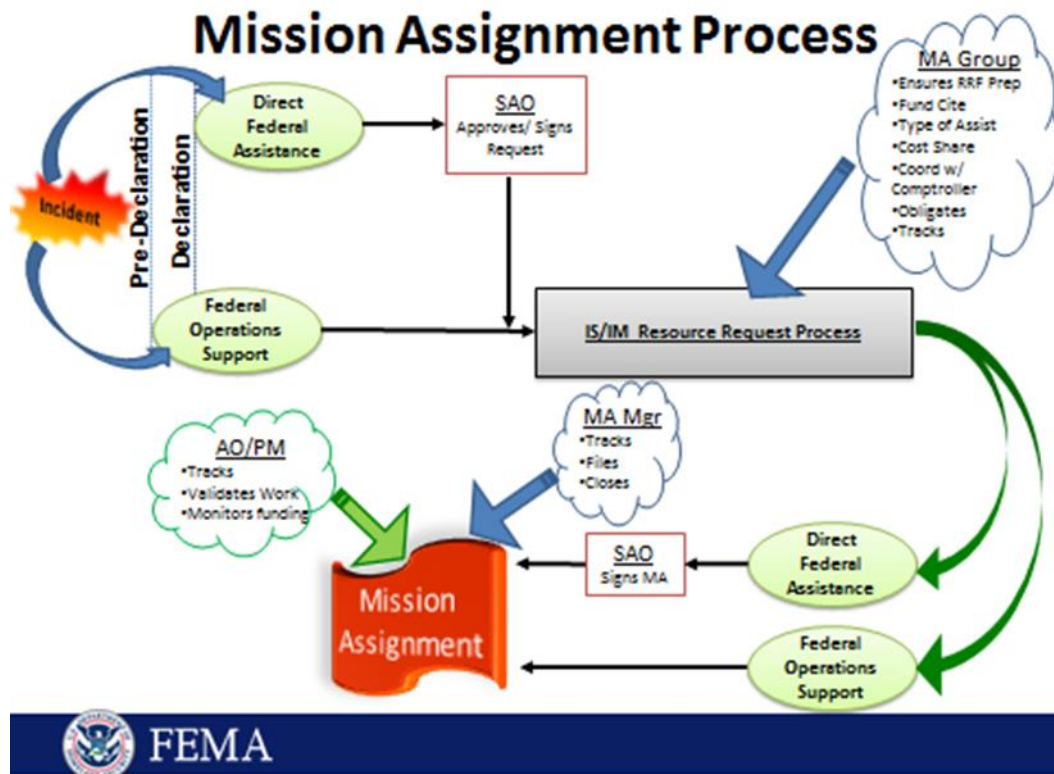
Emergency Management Assistance Compact (EMAC), from other states. If the states cannot support or become overwhelmed the governor will then inform the President and request Federal support. Should the President issue a disaster declaration FEMA will typically become the primary agency (PA) in charge. The PA will initiate a Request for Assistance (RFA) for DoD capabilities which normally goes to the Joint Field Office (JFO). The Defense Coordinating Officer (DCO) reviews and validates any requests for DoD assistance. The validated RFA is sent to the Joint Director of Military Support (JDOMS) and is processed through the office of the SECDEF. The Assistant Secretary of Defense (Homeland Defense and Global Security) approves the RFA and upon approval by FEMA, becomes an approved Mission Assignment (MA). Joint Staff issues an Execution Order (EXORD) to the Combatant Command (CCMD) and other applicable Defense agencies. The COCOM then tasks and deploys units in accordance with the CCMDs EXORD and Deployment Orders (DEPORDs).

### **3.2.1.3 Pre-Scripted Mission Assignments (PSMA)**

Mission Assignments that are drafted, but not issued, during the preparedness stage are referred to as Pre-Scripted Mission Assignments (PSMA) that are statement of work templates and used for contingency planning.

PSMAs are:

- Developed to facilitate rapid response
- To standardize development of mission assignments prior to and during disaster operations
- Not a shopping list of Federal resources
- Are much more specific than normal MAs



For DoD, the MA goes to NORTHCOM or PACOM (as appropriate). Since the DoD FCCs are on the Standing Joint Chiefs of Staff DSCA EXORD, the Geographic Combatant Command can place a DoD FCC on Prepare to Deploy (PTDO) status and subsequently alert and activate the FCC. The military service to which the FCC belongs uses the NORTHCOM order as the basis for orders to the FCC. Due to the time required to publish orders, the FCC Coordinator or Director may have to request a VOCO (Verbal Order of the Commanding Officer) in order to be prepared in time to receive patients. The DoD FCC must have a MA. (For an example of an MA to the DoD to activate an FCC (Annex R)). It is important to note that generally the MA will request capabilities to provide patient movement and reception and not necessarily to activate a specific FCC:

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

The VA Mission Assignment includes: the process for working with POCs from VA and VHA to determine which FCCs would be alerted and/or activated, and using Pre-Scripted Mission Assignments (PSMAs) to HHS, and from HHS to VA for Mission Assignment Sub-tasking's, confirmation of attached funds, acceptance of sub-tasking at VA level, and issuance to VHA. VA will probably not receive a MA directly, but receive a MA sub-tasking through HHS, after HHS receives a valid MA from FEMA for Alert or Activation of an FCC. VA OSP and VHA OEM will determine the MA sub-tasking is accurate, properly funded and will then make decision to accept the sub-tasking from HHS.

### 3.2.2 FCC Alerted

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

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

In this Alert status, FCC Directors should:

- Validate the Alert Status with higher headquarters
- Ensure state/local departments of health are informed of their FCC's selection
- Conduct periodic bed reporting in accordance with PMCTF instructions
- Maintain daily monitoring of TRAC2ES
- Establish communications with all PRT leaders, GPMRC, NDMS partner medical facilities, and other elements involved with FCC operations
- Validate PRSs throughput, update throughput in TRAC2ES.
- Ensure state/local Emergency Management is informed of their FCC's selection. State/local emergency management is the main coordinating point for all resources, including ESF 8, needed to operate an FCC. This needs to be a formal part of the FCC Alert process.
- Pre-position required equipment and a minimum cadre of personnel at the PRS (patient reception Site)
- Receiving member hospitals are prepared to receive patients should maintain in Activation in case a FCC goes straight to Activation

### 3.2.3 FCC Activated

This status ensures that FCC reimbursement for all reasonable patient reception activities. It signifies that patients are to be regulated, or have been regulated to a PRS under management of this FCC. Patients can be expected to arrive within 24 hours.

One of the planning factors should be to identify the operational hours of the FCC and expectations for either 8 hour, 12 hour or 24 hour patient reception requirements. This will help to save costs by providing better planning factors for staff costs and partner/stakeholder participation at the PRS. Understand that these hours may change during the operation, but unless there is constant 24/7 patient movement ongoing, the requirement should be communicated down to the FCCs so they can coordinate with state/local partners.

In addition, if an FCC is open 24/7 for sustained periods that needs to be a consideration - if an FCC is open for more than 2 weeks (or 3 or 4 months), it may

have impacts to state and local partners supporting that FCC.

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

In this status, responsibilities of the FCC Directors include:

- Validate the activation status with higher headquarters
- Ensure state/local departments of health are informed of their FCC's activation
- Coordination with stakeholders and local jurisdictions
- 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 PMCTF instructions (e.g., daily)
- Pre-position required equipment and a minimum cadre of personnel at the PRS
- PRT members are notified and follow FCC plan procedures for readiness to receive patients
- Ensure ground transportation assets are mobilized to transport patients
- Ensure receiving NDMS partner facilities are mobilized to receive patients
- Ensure other support elements are prepared to assemble at the PRS in accordance with the FCC/PRS Plan
- Track all expenses
- Provide situation reports (SITREPS) as requested, ensuring Health Insurance Portability and Accountability Act (HIPAA) compliance
- Capture after action review (AAR) items

Prior to the arrival of patients, the FCC Director activates the FCC/PRS Plan (Annex D), and ensures local triage teams, litter bearers, administrative teams, patient staging teams, and transportation assets are alerted. Upon the arrival of patients, the FCC Coordinator notifies the TPMRC-A. The FCC Coordinator, or other designated agency or individual, will then further regulate and coordinate the movement of the patients to local NDMS participating medical facilities. The TPMRC-A will regulate patients from the Aerial Port of Embarkation (APOE), located within the disaster site, to the Aerial Port of Debarkation (APOD), located within the PRS. Specific patient movement and reception missions are coordinated directly between the TPMRC-A and the FCC.

### 3.3. Patient Regulation to the FCC

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

## 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. The listed Annexes identify specific requirements required to execute the FCC mission:

- Summary of the FCC Director/Coordinator Roles and Responsibilities (Annex A)
- Facilitate/Maintain Medical Facility Enrollment and Community Relations (Annex B)
- Collect/Report Medical Facility Bed Availability Data (Annex C)
- Coordinate Patient Reception Area Plans (Annex D)
- Coordinate Training and Exercises (Annex E)
- Coordinate Local NDMS Patient Reception Operations (Appendix 1, Annex D)
- Coordinate Discharge and Return of Patients (Annex F)
- Coordinate Financial Management (Annex G)
- Coordinate Logistical Support (Annex H)
- Facilitate Communications (Annex I)
- Coordinate Critical Information Requirements (Annex J)
- Coordinate Public Affairs (Annex K)
- Glossary of Terms and Acronyms (Annex L)
- Point of Contact List (Annex M)
- References List (Annex N)
- Map of Current FCCs (VA/DoD) (Annex O)
- FCC/PRS Self-Assessment (Annex P)
- Exercise Evaluation Guide (Annex Q)
- Mission Assignment Example (Annex R)

### 4.2. Summary of the FCC Director/Coordinator Roles and Responsibilities (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 when working with the civilian medical community as well as state, local and/or Tribal and Territorial 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 PRSs 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 PRS plans, training and exercising, and conducting FCC operations.

#### **4.3. Facilitate/Maintain Medical Facility Enrollment and Community Support (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. 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.

#### **4.4 Collect/Report Medical Facility Bed Availability (Annex C)**

When activated, FCCs receive specific instructions directly from Service or VA channels on the reporting of beds immediately available. Upon receipt of instructions, the FCC Coordinator collects immediate bed availability data from each participating NDMS medical facility and reports to GPMRC using the established form provided in Annex C (TRAC2ES Bed Report). The FCC may also have to plan for the use of local or state EMS electronic reporting systems.

#### **4.5 Coordinate Patient Reception Area Plans (Appendix 1, Annex D)**

The FCC Director is responsible for ensuring the development, exercise, and evaluation of local PRS plans. Patient reception and distribution operations are coordinated directly between the FCC Patient Reception Team (PRT) and local medical control operations or local participating NDMS member medical facilities. Each PRS under the management of the FCC should have a separate FCC/PRS Plan, and these should be coordinated in order to evaluate overlapping requirements for limited resources. Each PRS plan should address, as a minimum: concept of operations, PRS alert and activation, FCC operations and areas covered in annexes C through R.

#### **4.6 Coordinate Training and Exercises (Annex E)**

The FCC Director ensures that FCC staff, NDMS Steering Committee, as well as applicable federal, state, Tribal, territorial, and local government and private sector personnel receive appropriate training in the operation of the FCC and PRS(s). The FCC Coordinator ensures that representatives of the participating NDMS partner

medical facilities, as well as representatives of local emergency management agencies, EMS agencies, public safety, police and fire services, are provided annual orientation to the PRS 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, DoD FCC Directors should conduct a full-scale patient reception exercise at least once every two (2) years. VA FCCs should conduct similar exercise every three (3) years.

#### **4.7 Coordinate Discharge and Return of Patients (Annex F)**

HHS has the overall responsibility to return NDMS patients to their point of origin or other destinations, as authorized.

#### **4.8 Coordinate Financial Management (Annex G)**

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 partner medical facilities to ensure financial reimbursement for care, if required.

#### **4.9 Coordinate Logistical Support (Annex H)**

The FCC Director will be responsible for consolidating the administrative cost and expenditures for all logistical support during activation. This would include PRS 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 PRS. Processes to capture, track, and validate all expenditures for supplies, equipment, and services associated with the PRS needs to be established. Future reimbursements will be dependent upon this process.

#### **4.10 Facilitate Communications (Annex I)**

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 Military Auxiliary Radio System (MARS) radio operators can provide an invaluable service and often have existing communications equipment in place or available for disaster response.

#### **4.11 Coordinate Critical Information Requirements (Annex J)**

The FCC may be called upon to provide information updates to various agencies to include their higher command, the NDMS, the HHS Incident Response Coordination

Team (IRCT), HHS Regional Emergency Coordinators (RECs), DoD, etc. Annex K provides the types of questions the FCC should be able to answer before, during, and following operations.

#### **4.12 Coordinate for patient Movement Item Retrieval (Appendix 3 to Annex D)**

##### **4.3.10 Coordinate Public Affairs (See Annex K)**

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



## **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 his/her designee) and the FCC Coordinator, as they pertain to developing plans, conducting training and assessments, and engaging in patient reception operations.

### **FCC DIRECTOR ROLES AND 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 area supported by the FCC.

#### **a. Plan**

- i. Ensure that bed availability reporting occurs efficiently.
- ii. Ensure that the reception, sorting, staging, transportation and hospitalization of arriving patients occur efficiently.

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

- i. Ensure the development, exercise and evaluation of local FCC/PRS plans.
- ii. Ensure a full-scale exercise at least once every two years that tests the FCC/PRS plan of the FCC and the supporting partners. (VA FCCs test their plans every three years).
- iii. Ensure an annual exercise, during non-full-scale exercise years, to test selected tasks of the FCC/PRS plan.
- iv. Ensure that FCC and PRS staff receives appropriate training in the operation of the FCC and/or the PRS.
- v. Conduct an After Action Review/Report (AAR) at the conclusion of the FCC full-scale exercise.

#### **c. Operate**

- i. Activate local FCC/PRS plans as indicated in activation notifications.
- ii. Ensure that bed availability reporting, as well as reception, sorting, staging, transportation and hospitalization of arriving patients occurs efficiently.
- iii. Provide administrative support for patient control and proper patient accounting.
  
- ix. Assist federal patient movement teams as needed to ensure accurate patient tracking data.
- x. Account for patient accountability and destination and that it is updated in patient movement tracking systems at the local, state, and federal level as dictated by local policy.
- xi. Collect expenditures for ancillary services (such as ambulance service) and provide them through their chains of command.

## FCC COORDINATOR ROLES AND RESPONSIBILITIES

- a. **Plan:** In addition to day-to-day operations, the FCC Coordinator will:
  - i. Identify and recruit local non-federal hospitals for NDMS enrollment and participation.
  - ii. Study the FCC area of responsibility and identify potential primary and alternate locations that will serve as PRSs and coordinate utilization and memorandums of agreement (with the airfield managers) as necessary.
  - iii. Establish and maintain active participation of local support NDMS hospitals/activities (e.g., local non-federal 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).
  - iv. Provide HHS/ASPR with contact information to NDMS hospitals in order to facilitate medical claims processing.
  - v. Manage/coordinate FCC communication procedures, processes and equipment to support local patient reception and distribution operations.
  - vi. Identify local emergency services communications or tracking systems and ensure integration into the FCC operations.
  - vii. Develop Public Awareness/Affairs Plan to publicize FCC events and local partnerships.
  - viii. Execute support contracts for ancillary services (such as port-a-potties and feeding) are drafted, coordinated, validated and reviewed annually.
  - ix. Assist federal patient movement teams as needed to ensure accurate patient tracking data.
  - x. Account for patient accountability and destination and that it is updated in patient movement tracking systems at the local, state, and federal level as dictated by local policy.
  - xi. Collect expenditures for ancillary services (such as ambulance service) and provide them through their chains of command.
- b. **Train and Assess**
  - i. Develop, exercise and evaluate local FCC/PRS plans.
  - ii. Coordinate with the representatives of participating NDMS partner medical facilities (through the NDMS Steering Committee), as well as representatives of participating State and local health associations, EMS, emergency management agencies, hospital councils, medical societies, public safety, police and fire services, and local Medical Reserve Corps (MRC) are provided annual orientation (or training) to the PRS plan they support and the FCC Guide in general. Ensure the FCC maintains active TRAC2ES and Joint Patient Assessment Tracking System accounts.
  - iii. Train the FCC staff and other individuals designated to augment the FCC staff annually receive detailed education and training on their specific duties.
  - iv. Coordinate with local NDMS partner facilities to train and are notified of NDMS hospital bed reporting requirements.
  - v. Participates in nationwide NDMS and ad-hoc local bed reporting

exercises.

- vi. Conduct FCC Self-Assessment annually utilizing Annex (R). Notify higher headquarters within 24-48 hours if the FCC mission capability has changed significantly.

**c. Operate**

- i. Collect bed availability data from each participating non-federal medical facility and report to the TPMRC-A as directed.
- ii. Coordinate open communications and liaison are established with GPMRC for the receipt of regulating decisions, evacuation mission information and patient medical data, as applicable.
- iii. Provide GPMRC with primary and alternate points of contact to ensure 24-hour availability, as needed.
- iv. Notify the FCC Director, the PRT, local EMS coordinators, all affected medical facilities, higher headquarters, and all other applicable agencies and individuals when PRS alert status has been received.
- v. Coordinate for the PRS tracks patient movement as requested by local and federal agencies and maintain the location and status of each patient receiving definitive care.
- vi. Assist federal patient movement teams as needed to ensure accurate patient tracking data.
- vii. Once alerted, responsible for establishing and maintaining procedures to obtain vehicles and personnel within 12 hours to transport patients in the PRA.
- viii. Once activated, responsible to have the FCC and PRS operational and capable to receive patients within 6 hours.
- ix. Arrange local transportation to move patients from reception sites onward to local participating NDMS partner medical facilities responsible for the administrative accountability for NDMS patient's remains with the FCC. If available, the JPATS Team will be responsible to entering patient tracking data into the JPATS system. Until JPATS/SAT teams arrive at the FCC, the FCC staff is responsible for all data entry into JPATS system. Primary point of contact (POC) for data entry remains with the JPATS team.
- x. Responsible for patient accountability and destination is updated in patient movement tracking systems at the local, State, and federal level as dictated by local policy.
- xi. Provide referral assistance to the HHS Service Access Team, which is responsible for repatriation as needed to coordinate the return of NDMS patients who require enroute medical care, as directed by your organization. Provide liaison assistance to HHS Service Access Teams or their designated representative by providing contact information to participating NDMS partner medical facilities to facilitate medical claims processing, as required.
- xii. Collect expenditures for support services (such as ambulance service) and provide them through their chains of command. If no FCC Coordinator has

been appointed, the FCC Director will ensure these and all other day-to-day activities are achieved.

## **ANNEX B: FACILITATE AND MAINTAIN MEDICAL FACILITY ENROLLMENT AND COMMUNITY SUPPORT**

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

### **1. Responsibilities**

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

### **2. Procedures**

The FCC enrollment effort should target local general acute care inpatient medical facilities, although other bedded medical facilities should be considered, especially if they express a desire to participate or possess key specialty beds. In general, NDMS participating medical facilities should be within a reasonable distance for patient transportation given the local road network and relevant traffic conditions (generally within a 75 mile radius of the managing FCC). Medical facilities beyond this distance may be accepted for enrollment at the discretion of the FCC Director.

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

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

### **3. Program Development**

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

FCC Coordinators should:

- Identify and recruit local non-federal medical facilities for NDMS enrollment and participation;
- Draft an information package to provide to prospective enrolling medical facilities,

including an introductory letter from the FCC Director, a copy of the FCC Guide, and an NDMS Provider MOA ready for signature.

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

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

The 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 PRS reception plans without first establishing a memorandum of agreement with the State Adjutant General).

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

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

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

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

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

**NDMS Steering Committee** – A committee, established by the FCC, consisting of local medical facility, medical, public health, public safety, emergency management and emergency medical services officials, ESF #6 representatives, representatives of voluntary organizations, and elected officials organized in an NDMS PRS 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 weapons of mass destruction (WMD) terrorist act. Memberships typically include representatives from emergency management, medical, public health, law enforcement, fire, and EMS.
- **Local hospital council/State hospital associations** – In many communities, these groups have an emergency management sub-council or association and can assist the FCC Coordinator with the local NDMS program from the medical facility standpoint.
- **State-wide Bioterrorism Advisory Committees** – include representatives from (included but not limited to):
  - State and local health departments and government
  - Emergency Management Agencies
  - EMS
  - Office of Rural Health
  - Police, fire department and emergency rescue workers and occupational health workers
  - Other health care providers, including university, academic medical and public health
  - Community health centers
  - Red Cross and other voluntary organizations
  - The hospital community (to include VAMC and military hospitals)
- **State-wide Hospital Bio-preparedness Planning Committee** – Affiliated with the State-wide bioterrorism advisory committee) whose composition includes representation from (but not limited to):
  - Emergency Medical Services
  - Emergency Management Agencies
  - Office of Rural Health
  - State hospital associations
  - Veterans Affairs and military hospitals
  - Primary care associations

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

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



## ANNEX C: COLLECT AND REPORT MEDICAL FACILITY BED AVAILABILITY

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

### 1. Definitions

**Available Beds** –NDMS partner medical facilities will report the number of beds that they will voluntarily commit to the reception of NDMS patients at the time of the FCC request. The numbers of beds reported are those to which the TPMRC-A can immediately regulate patients. 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. Available beds are reported in categories as defined by NDMS and as instructed by GPMRC.

**Bed Report** – The capacity (the number of patients that a facility can accommodate at a given point in time) for NDMS facilities' within a PRS (exercise or real time) to receive, admit, and treat patients evacuated as a result of NDMS operations. When activated, the PMCTF will determine the contingency bed reporting requirements. During FCC alert or activation, the FCC may require frequent updates to NDMS medical facility bed availability reports to ensure currency and accuracy of bed capacity and capability. GPMRC will relay bed reports to HHS Fusion Center ([fusion@hhs.gov](mailto:fusion@hhs.gov)) when complete.

- FCCs will submit the reports as required per HHS/ASPR which directs the bed report exercises every 3 months. (It is not a GPMRC requirement). Letter states it is determined by NDMS Directorate staff to 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 medical facility. The seven (7) contingency categories (as well as their TRAC2ES codes in parentheses) are:

- **Critical Care (CC)** – Adult patients requiring sophisticated intervention to restore or maintain life processes to their dynamic equilibrium. This involves the requirement to provide immediate and/or continuous attention and monitoring using specialized facilities, equipment, and personnel. Critical care beds are generally defined as those in licensed intensive care units.
- **Medical/Surgery (MM-SS)** – Patients having, or suspected of having, medical illness or disorders, as well as patients having, or suspected of having, diseases or injuries normally treated by surgery, not coming within the purview of a more specific medical specialty. Medical/surgical beds

are generally defined as those licensed, certified, or otherwise authorized, with adequate space, equipment, medical materiel and ancillary support services, and staff to operate under normal circumstances. Excluded are transient patient beds, bassinets, incubators, labor beds, and recovery beds.

- **Psychiatry (MP)** – Patients who require specialized psychiatric care in a medical treatment facility, including patients with disorders defined by the American Psychiatric Association as severe mental illness (schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, or autism). Psychiatric beds are generally defined as those supported by a licensed psychiatrist, or a licensed registered nurse, social worker, psychologist or professional counselor when those services are part of a treatment plan authorized by a licensed psychiatrist.
- **Burns (SBN)** – Patients having burn injuries meeting the American Burn Association's (ABA) burn unit referral criteria, including (but not limited to) partial thickness burns of 10% or more of the total body surface; all patients with third-degree burns of 10% or more of the total body surface; or patients with significant burns involving the face, hands, feet, genitalia, perineum or major joints. Burn beds are generally defined as those associated with burn centers on the joint ABA and American College of Surgeons (ACS) verification list.
- **Pediatrics (MC)** – Patients having, or suspected of having, diseases or injuries requiring the services of pediatric health care providers. Pediatric beds are generally defined as those supported by a licensed pediatrician.
- **Pediatric ICU (PICU)** – PICU patients are those critically ill or injured, including those requiring ventilator support, aged 17 years or younger. PICU beds are generally defined as those that can support critically ill or injured patients, including that requiring ventilator support, aged 17 years or younger.
- **Negative pressure / isolation (NPI)** – NPI patients are those requiring a separate room or area provided with negative airflow and respiratory isolation. NPI beds are generally defined as those providing negative airflow and respiratory isolation.

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

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

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

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

## 2. Responsibilities

- The FCC Director ensures accurate bed availability and throughput reporting to the GPMRC. To accomplish this, the FCC Coordinator:
- Provides training to member medical facilities on the materials in this annex. This includes providing a means by which member medical facilities can report available beds to their local FCC in a timely manner.
- Provides the 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 NDMS partner medical facilities when the PRS is alerted or activated.
- Canvasses partner medical facilities for the ability to participate in bed reporting and patient reception.
- Receives bed-reporting instructions from GPMRC through Service or VA channels, as appropriate.

- Reports FCC bed availability totals to the GPMRC in accordance with instructions.

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

### **3. Non-federal Bed Availability**

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

Another factor affecting bed availability is the number of medical staff with duplicate privileges at other medical facilities in the area or who serve in the 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. Local participating medical facilities should factor in the potential loss of medical staff with other commitments. .

### **4. Bed Reporting Procedures**

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

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

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

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

## 6. Determination of FCC Throughput

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

- Type, quantity and availability of ground transport resources and critical care equipment.
- Patient reception team staffing, to include JPATS team if requested/assigned.
- Medical facility surge tolerance; will vary by facility. Patient processing time and available resources may limit the amount of patients a facility can accept in a short time-frame, regardless of available beds.
- Airfield operations, to include hours of operation, ramp/hanger availability, aircraft servicing and access control.
- Ground operations intervals – Many important details need to be considered when factoring for sustained operations. These items include, but are not limited to: deplaning time, transportation time to move patients to participating medical facilities, reset time for next arriving flight, refueling vehicles, feeding your teams and restocking will apply to this factor.

## **ANNEX D: COORDINATE 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 PRSs.

### **RESPONSIBILITIES:**

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

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

### **PRS PLAN:**

#### **1. Plan Development. (Appendix 1 to Annex D)**

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

#### **2. Concept of Operations**

- a. Provide a concise mission statement.
- b. Define the PRS, 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 to which patients will be distributed. Reference the MOA the FCC has with the NDMS facilities.

### **3. FCC Alert/Activation (NDMS CONOPS, Section II, Activation and Requests for Federal Support)**

- a. Define who is responsible to put the FCC on ALERT or ACTIVATE status after a valid MA has been received.
- b. Describe the processes for notifying the FCC staff.
- c. Describe the processes for notifying the PRS, 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.

### **4. FCC Operations (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.

### **5. Bed Availability Reporting (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.

### **6. Medical Regulating and Patient Evacuation to the PRS**

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

### **7. Patient Reception and Staging**

- a. Describe the patient reception site(s). Patients arriving from disaster sites will generally be received at a single reception site in the PRA (e.g., an airfield, rail or bus terminal). The site needs to facilitate the off-loading of patients, the immediate evaluation and triage of patients, and the staging of litter and ambulatory patients prior to transport to NDMS facilities. Close coordination is required with DoD, civil authorities, EMS providers, city emergency planners, and other agencies and organizations to ensure access to the site, adequate staffing, security, environmental control (heat, water, light), provision for food and drink, and communications.

- b. Describe the roles and responsibilities of a PRT. The PRT is a multi function group and consists mainly of clinical staff, but should also include appropriate support from medical administration, communications personnel, logistics personnel, litter bearers and vehicle drivers. The team leader should be a person with appropriate medical background. This team can be based out of a federal facility (VA or DoD) and/or comprised of volunteers from community organizations, NDMS response team personnel, U.S. Public Health Service (PHS) Officers, or local EMS.
- c. Medical equipment training and PMI handling.

## 8. 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 partner medical facilities. It is important that all vehicles be assessed for their patient carrying capability, inventoried, and tabulated in the patient transportation plan. Additionally, advanced coordination should be made with the authorities that will make these vehicles and personnel available. Military vehicles that are scheduled to move to a theater of operations or are committed to a potential military mobilization effort should NOT BE included as patient transportation assets during military contingencies or DSCA events. Resources might include:
  - Ambulances, other vehicles and personnel from local EMS, DoD, VA, and/or local medical facilities' ambulances and ambulance buses
  - Commercial, governmental or other vehicles available that are wheelchair accessible or otherwise configured to accommodate litter patients
  - Other commercial vehicles (e.g., airport limousines or buses)
  - Military and other governmental general use trucks, vans, school buses, etc.
  - FEMA National Ambulance Contract (HHS) (ground and air).
- b. Describe the roles, processes and procedures for managing and tracking the use of local transport resources. Tracking will include using ICS Standard Forms for tracking resources. (ICS Form 218, Support Vehicle/Equipment Inventory).
- 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.

## 9. Patient Administration

- a. Describe the roles and responsibilities of the FCC Coordinator.
  - As noted in Annex A, the FCC Coordinator is responsible to ensure the PRS tracks patient movement as requested by local and federal agencies.



- This function covers several items and will be accomplished using the JPATS tool. The FCC Coordinator has overall responsible for tracking patients at the PRS. It is important to note that JPATS teams (and SATs) will be deployed to FCCs that are receiving patients. However, FCCs should be prepared to support patient tracking at the FCC and once the patients are distributed to the NDMS partner medical facilities in the event the JPATS and/or SAT teams are unavailable.
- Ship JPATS Cache to FCC as soon as the Alert happens, even if it beats the Team (JPATS/SAT), it will be onsite and available for them upon arrival.

**During any FCC activation, JPATS and SAT Teams should always be activated (one JPAT and one SAT team at each FCC). Any time an FCC is activated, JPATS and SAT teams should be present before federal patients are received. JPATS and SAT Teams should be identified and travel to the FCC during the Alert phase.**

1) Patient registration information required in JPATS:

- a) Unique patient ID Number (e.g., Driver's License, SSN Card, Student ID, wrist band bar code, unique triage tag identifier etc.);
- b) Last Name;
- c) First Name;
- d) Gender
- e) Date of Birth or Age;
- f) Health Status;
- g) Bed Type;
- h) Disposition/Destination Locations

2) Patient tracking entries requirements

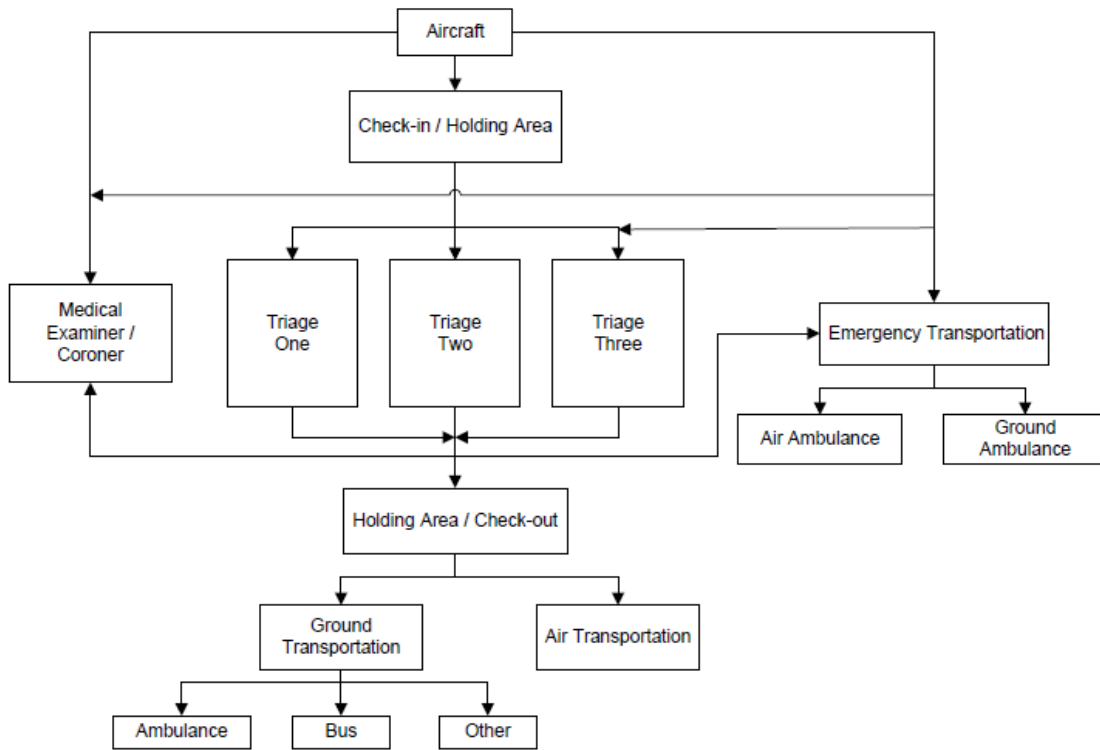
- a) Inbound to the PRS;
- b) Arrival at the PRS
- c) Transfer to the NDMS facility;
- d) Status at arrival to the NDMS facility;
- e) Movement within the NDMS;
- f) Discharge from the NDMS;
- g) In the case of military patients, track the patient status through the point the military patient is returned to the responsible Service.

\*Coordinate with the JPATS Teams and SAT Teams, if assigned.

- b. Describe the roles and responsibilities of GPMRC Liaisons and Military Patient Administration Team (MPAT), and USTRANSCOM Joint Patient Movement Enablers (JPME) if available.
- c. Identify contact information for each participating NDMS medical facility for normal operating hours and after regular working hours.

- d. Describe the roles and responsibilities of each participating NDMS medical facility. The patients' day-to-day medical management and care will be accomplished by the medical staff of that facility. The NDMS facility will provide medical care using its own procedures and forms. The participating NDMS medical facility should provide information to the FCC Coordinator, to include a daily admission and disposition list (indicating the expected length of stay) and a narrative summary upon discharge of the patient.
- e. Describe the roles, processes and procedures for tracking patients in the PRS. Ensure that the following information is included in the tracking system adopted by the FCC:
- Unique patient ID Number (e.g., Driver's License, SSN Card, Student ID, wrist band bar code, unique triage tag identifier etc.)
  - Last Name
  - First Name
  - Gender
  - Date of Birth or Age
  - Health Status
  - Bed Type
  - Disposition/Destination Locations
- f. Describe the roles, processes and procedures for tracking patients in the PRS.
- Registration
  - Updates
  - Transfers
  - Incoming

**FOLLOWING IS A SAMPLE DIAGRAM OF PATIENT RECEPTION AREA**



## APPENDIX 1 TO ANNEX D: COORDINATE LOCAL PATIENT RECEPTION OPERATIONS

### Purpose:

FCC Directors implement PRS plans as required by the specific activation notification. This may include, at full activation, alerting all member medical facilities and all elements of the local patient reception and ground transport programs. FCC Directors may find it advisable to initiate local bed reporting in anticipation of receiving bed reporting instructions from 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 2 to this Annex for general information on medical regulating. FCC Coordinators should ensure that the FCC Director, the PRT, local EMS coordinators, all affected medical facilities, higher headquarters, installation commanders, and all other applicable agencies and individuals are notified when patients are regulated to the FCC. Depending on the information received from GPMRC, the FCC may elect to begin the process of regulating patients to specific local medical facilities prior to the arrival of the patients. The FCC Coordinator ensures that reception, sorting, triage, staging, transportation, and hospitalization of arriving patients occurs efficiently. This includes being able to match the individual patient requirements for care with bed capabilities as reported by the participating NDMS partner medical facilities. Accordingly, this implies close coordination between the PRT, local EMS coordinators, the FCC, and GPMRC.

- If available, Disaster Medical Assistance Teams (DMAT) may be deployed locally or from other metropolitan areas to support FCC patient reception and distribution of patients to participating NDMS partner medical facilities. All DMATs are managed by the HHS Office of the Assistant Secretary for Preparedness and Response (ASPR). Requests for DMAT support for local patient reception operations should be forwarded through chains of command to the HHS Regional Emergency Coordinator (REC). Understand that DMATs may not be available to support FCC PRS operations. A DMAT is a group of professional and para-professional medical personnel (supported by a cadre of logistical and administrative staff) designed to provide medical care during a disaster or other event. NDMS recruits personnel for

specific vacancies, plans for training opportunities, and coordinates the deployment of the teams. DMATs are designed to be a rapid-response element to supplement local medical care until other Federal or contract resources can be mobilized, or the situation is resolved.

- DMATs deploy to disaster sites with sufficient supplies and equipment to sustain themselves for a period of 72 hours while providing medical care at a fixed or temporary medical care site. The personnel are activated for a period of two weeks.

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

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

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

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

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

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

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

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

Factors to consider for Litter Bearers: Adequate manpower is essential to unload a large patient load. Some patients can be carried with a 2-man carry; or if a heavier patient, then a 4-person carry is required. It is absolutely essential that your teams are trained in proper litter lifting and carrying techniques. Consider the heat of the summer, the number of patients and whether there are heavy patients. Litter bearers tire out quickly. Consider using wheeled litters, gators, AMBUS’s, or something similar to move the patients from the plane to the reception area. Litters and/or patients can be placed on top of and secured to ambulance gurneys, but they must be hand carried off the aircraft and may not be rolled off the ramp. This also requires a 4-person lift. Another thing to consider is the height of your litter bearers. For example, it is not a good mix for a 4-person team to have a 6 foot 4

inch tall person and two short people trying to maneuver a litter. You have to take care of your litter bearers— Ensure there is adequate food and water for your litter bearers. It is essential to stay hydrated.

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

\*Procedures to be followed for patients moved to the APOD by the National Ambulance Contract vendor have not been established.

### **Public Affairs**

FCC PRS 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 2 to Annex D: MEDICAL REGULATING

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

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

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

The following factors influence the scheduling of patient movement:

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

### Medical Regulating Terminology

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

- Patient Administrator – The patient administrator (PAD) accomplishes the medical regulating function at the medical facility level. Medical regulating functions include consolidating all evacuation requests within the PRS. The PAD is also responsible for keeping GPMRC apprised of the current beds available in the PRS.
- 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 medical facility is determined based on the patient's medical needs, the available transportation resources, and NDMS medical facility capabilities.



- Joint Patient Movement Requirements Center (JPMRC) – The JPMRC provides patient movement requirements, center-type domain, and automatic information system support and operations. The JPMRC is responsible for patient movement operations within its area of responsibility and coordinates movement requirements center for patient movement with the 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, enroute via, or leaving the system
  - d. Reception of 1-2 patients per national contract aircraft has difference planning factors that reception of DOD aircraft.
- Enroute Patient Staging System (ERPSS) – The ERPSS is a USAF staging facility employed at forward airfields to provide a temporary staging capability for preparation of patients being evacuated to NDMS partner medical facilities. The ERPSS is employed to ensure patients are prepared for aircraft loading.

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

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

### **Enroute Patient Staging System**

The ERPSS-10 is a 13-person, mobile, tented, temporary staging facility deployed to provide supportive patient care and administration. Each ERPSS is capable of a throughput of 40 patients per 24 hours and should be able to sustain this tempo for 72 hours before augmentation is required and is not intended to hold patients overnight or for an extended period.

- Provide supportive medical care when not augmented by the CCATTs. (When augmented by CCATTs, continued stabilization of patients can be accomplished. Aeromedical evacuation crews and CCATTs fly airlift missions to provide in-flight patient care.)

- Confirm sending facility has prepared patients for evacuation.
- In coordination with the OMF, ensures patient evacuation manifests are completed.

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

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

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

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

- Absence of biological weapon and chemical weapon agent decontamination ability.
- The ERPSS does not have the capability to provide patient meals, radiology, laboratory, blood bank, etc.
- The AE UTCs (ERPSS/AELT/AEOT/COMM. AECS, etc.) rely on the user service for all other logistical support.
- The AECT can facilitate a 30-days medical resupply package at the ERPSS.
- AE Crews and support staff are limited and dependent on current contingency operations.
- AES relies heavily on Air Reserve Component (ARC) with 88% of AE in crews in ARC and 12% in Regular Air Force.

## APPENDIX 3 TO ANNEX D: PATIENT MOVEMENT ITEMS MANAGEMENT

### Patient Movement Items (PMI)

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

PMI equipment packages and Deployable Patient Movement Item Tracking System (PMITS) kits can be requested and augmented with personnel from the DoD in the event of surge and sustained requirements. This will allow the pre-position of medical equipment required for multi-modal transportation and equipped to provide the same tracking and recycling support capability as permanent PMI centers. When required, Services can coordinate with the USTRANSCOM Command Surgeon and Headquarters Air Mobility Command, Command Surgeon's Office (HQ AMC/SGXM) to request PMI equipment and deployable tracking systems to help track and recycle equipment assets. PMI is tracked using PMITS, a system of systems, developed and supported by the Defense Medical Logistics Standard System (DMLSS). The use of PMITS is mandatory for asset visibility and tracking of PMI to provide accurate information to allow proactive support to deployed organizations. HQ AMC/SGXM is responsible for PMITS operational control, advice, and counsel. PMITS utilizes bar code technology to scan PMI and share PMI data with other authorized users of the system. Bar codes will be issued at PMI centers and designated units or by HQ AMC/SGXM using established bar code guidelines in accordance with PMI Bar Coding Methodology and Codes. All users will ensure bar code labels are attached to all PMI equipment assets prior to use and or patient movement. The bar code label should have the AMC/SGXM phone number, 1-877-286-1931, on it. If the label is worn or does not have the phone number, contact the nearest PMI center or AMC/SGXM to obtain a new label immediately. Non-PMI equipment will not be tracked in this system unless coordinated with USTRANSCOM and HQ AMC/SGXM (e.g., HHS/MAC-ST owned equipment).

FCC Coordinators are responsible for coordination of PMI recovery within their PRS. DHHS Service Action Teams (SATs), if required and available, will collect PMI and coordinate with the PMI Recycling Teams for recovery of PMI. FCC logistics teams will work with PMI Recycling teams to return PMI to AE staging bases, or nearest PMI centers.

PMI must be returned promptly from a medical facility to prevent an equipment shortage

in the disaster area. Once patient care is transferred from the PM system to a medical facility or other such provider, it is critical that the PMI equipment be returned to the closest PMI cell at the FCC. FCC PRT members must be trained to execute recycling PMI back to PMI Cell. Medical facilities will decontaminate and clean PMI equipment IAW local infection control guidelines. The FCC Director will ensure a central location is identified for collecting PMI from the PRS and space for the PMI Cell to operate out of. Medical facilities recycling PMI should contact HQ AMC/SGXM COM 1-877-286-1931. Questions regarding recycling PMI should be directed to the HQ, AMC.

#### 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

#### Miscellaneous

- a. Make provisions for **weapons** and **narcotics storage**.
  - Weapons: Plans should include a safe location for the “clearing barrel” for weapons inadvertently transported with the patients. A secure area with monitored access will need to be established. If the weapon is a military weapon, call the closest military installation for retrieval.
  - If it is not a military weapon, call local law enforcement to retrieve the weapon. Document the disposition of the weapon on a hand receipt and keep a copy for your records.
  - Narcotics/Controlled Medications Storage: Narcotics/Controlled medications

transported with patients stay with patients. All narcotics/controlled medications will be counted by two people, noting the name, amount, and dosage. This information is to be documented in the patient's chart. When the patient departs the FCC/PRC, ensure the medications depart with the patient. A signature of both the person receiving the medications and the person relinquishing the medication is required within the patient's chart.

- b. Make provisions for the **deceased**. Plans should be developed in coordination with the state, territorial, or local medical examiner or coroner who will maintain jurisdiction over both military and civilian fatalities, including mass casualty events. The individual with jurisdiction has authority to order and perform an investigation to include an autopsy or an appropriate medico-legal examination on human remains. Any deceased patient will be transported as soon as possible to local authorities.
- c. Make provision or be prepared to support **Traumatic Stress Response Team (TSRT)**. The TSRT's primary function is to consult with leadership or other responders and provide initial response when groups or individuals expect to be, or have been, exposed to potentially traumatic stress. The primary goal of TSRTs is to foster resiliency in those exposed to potentially traumatic events. TSRTs (1) serve as trauma response consultants to unit leaders; (2) prepare personnel likely to be exposed to potentially traumatic events; and (3) provide screening, education, psychological first aid, and referral for those exposed to potentially traumatic events. TSRT serves to enhance resilience to potentially traumatic events. Designated TSRTs, in close coordination with unit leaders, provide TSR services. Pre-Exposure Preparation (PEP) services are provided to unit and community members whenever potentially traumatic events are anticipated. Assistance will be available after potentially traumatic civil and military events.

d. **Pets and Service Animal Planning Guidance**

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

Making provisions for **service animals** (care, holding, and feeding). Service animals are working animals, not pets. Notify state/county Animal Control on the animal species, weight, size and numbers to be supported. State and county restrictions may restrict or prohibit certain animals which pose unavoidable safety and/or public health concern.

- Ensure there is a provision to properly contain the animals in temporary kenneling/containment facilities.
- Ensure plans address proper care and feeding of a potentially diverse service

animal population.

- Veterinarian support will be required in the event the animal is injured or ill.
- Ensure FCC personnel make an effort to collect/maintain service animals' identification card, medical treatment/immunization records or other written documentation (if available).

**Background Data:**

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

**Assumptions:**

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

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

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

**Resources:**

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

\*See Annex P for FCC/PRS Plan Self-Assessment

## Annex E: TRAINING AND EXERCISES

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

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

### 1. Training

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

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

The FCC Director, or Coordinator, should provide an annual orientation of the FCC/PRS Plan to the FCC NDMS Steering Committee.

## 2. Exercises

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

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

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

One recommendation to assist each FCC with the development of their exercise is to utilize the Homeland Security Exercise and Evaluation Program (HSEEP) to develop, plan and report observations/ recommendations. HSEEP is a capabilities- and performance-based exercise program that was developed to provide common exercise policy and program guidance that constitutes a national standard for exercises. HSEEP is designed to be adaptable to any exercise program, regardless of the nature and composition of its sponsoring agency or organization, and to the full spectrum of exercise scopes and scenarios and should be utilized by the FCC Director and Coordinator to develop their exercise. This includes consistent terminology, design process, evaluation tools, and documentation standards. HSEEP reflects community best practices as well as lessons learned from previous and existing exercise programs. The HSEEP guidelines suggest it is important that those involved in exercise development consider the development of a multi-year training and exercise plan. The objective of the multi-year training and exercise plan is to coordinate training and exercises to prevent duplicating efforts, to prevent overextending resources, and to maximize the efficacy of any local available training and exercise appropriations.

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



- 3. Medical Regulating:** Prepare to exercise the regulating of patients to at least several NDMS partner facilities in the PRA. - Plan to exercise the entire Patient Reception Team. Also, include personnel from the fire department, decontamination team, social services, security, animal control and any other organization that supports the PRS. Consider exercising with 50 to 75 mannequin or live “patients”, including litter, wheel chair and ambulatory types. Consider a blend of patient populations, e.g., 5 percent of the patients play DoD active duty members, and 5 percent play VA beneficiaries. Consider a taxing blend of patient types, e.g., 75 percent will play inpatients categorized as medical/surgical, critical care, burn, pediatric, psychiatric, pediatric critical care patients or patients requiring isolation; while 25 percent play nursing home residents and/ or special medical needs patients.

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

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

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

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

**Aircraft:**

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

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

**Ambulances:**

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

**Command/Control:**

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

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

- Clinical PRT personnel. 30 people at \$75/hour for 4 hours
- PRT support personnel. 25 people at \$75/hour for 4 hours
- “Patients”. 50 to 75 patients from Civil Air Patrol, local nursing or medical technical schools, Scouts, etc., at no direct cost
- Fire Department. 30 personnel at \$75/hour for 4 hours.
- Security. 5 local policemen at \$75/hour for 4 hour
- Social Services. 2 persons at \$75/hour for 4 hours
- Animal Control. 2 persons at \$75/hour for 4 hours
- Decontamination. While patients are expected to be decontaminated prior to evacuation, consider exercising some contingency decontamination capability. Consider 5 persons at \$75/hour for 4 hours.

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

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

**4. Training and Exercise Funding**

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

## ANNEX F: PATIENT DISCHARGE AND RETURN

### DOMESTIC CONTINGENCIES:

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

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

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

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

### FOR MILITARY CONTINGENCIES:

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

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

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

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

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

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

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

## ANNEX G: 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.

### PRIMARY RECEPTION SITE (PRS) PRE-ACTIVATION EXPENSES

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

**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 PRS without proper authority. However, negotiating no-cost, stand-by plans to be enacted upon NDMS activation may be warranted, when authorized by appropriate contracting officials. Stand-by no-cost contracts may be useful to meet pre-event planning requirements (see Appendix 1 to Annex H).

### PRS ACTIVATION AND OPERATIONAL EXPENSES

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

The FCC Director, or the designated fiscal authority, will collect bills for appropriate charges for those services incurred by the FCC during PRS 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 PRS should be supported by the Mission Assignment or Sub-Tasking (See FEMA mission-assignment-billing-reimbursement-checklist at <https://www.fema.gov/mission-assignment-billing-reimbursement-checklist>).

Additional guidance on what is reimbursable is in Title 44 Code of Federal Regulations (44CFR), 206.8 - Reimbursement of Other Federal Agencies at <https://www.gpo.gov/fdsys/pkg/CFR-2011-title44-vol1/pdf/CFR-2011-title44-vol1-sec206-8.pdf>

FEMA forms that can assist in documentation of expenses can be found at <https://www.fema.gov/forms> (suggested forms are 90-123 to 90-127).

FCCs may coordinate, through their chains of command, a request for HHS direct support (e.g., DMATs or U.S. Public Health Service (PHS)) for PRS operations. However, FCC coordinators should refrain from relying on HHS assets as a primary source of PRT personnel. DMATs are subject to deployment by HHS. The HHS Secretary's Operation Center (SOC) manages DMAT operations. If the FCC needs DMAT, or PHS assistance, they must forward a request, through agency channels, to HHS. As in all requests for outside assistance, VA and DoD must be able to show the need for the request.

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.

Civil service personnel costs are also eligible for reimbursement under some conditions. Regular shifts worked by personnel at a PRS instead of the normal duty station are generally not eligible for reimbursement. However, overtime, weekends and holiday expenses may be eligible for reimbursement.

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.

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 PRS, are generally eligible for reimbursement, so long as they can be justified as necessary. Documentation is critical.

Discharged patients and non-medical attendants (e.g., accompanying family members) who have been discharged will be the responsibility of the Service Access Team (SAT).

Payments for direct services from the Salvation Army, Red Cross, or other Non-Governmental Organization (NGO) 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.

For further guidance on Definitive care reimbursement, see Health & Human Services (HHS) Partner MOA for Definitive Care.

## **BASIC PROVISIONS OF FINANCIAL CLAIMS PROCESSING**

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.

NDMS partner 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.

NDMS will be payer of last resort to any other existing medical coverage, except Medicaid, which by law is payer of last resort. Compensation for NDMS-related claims will be reimbursed at rates, in accordance with the Definitive Medical Care MOA.

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

Any claims presented for processing must identify the disaster/contingency associated.

## **RESPONSIBILITIES FOR FINANCIAL CLAIMS PROCESSING**

The FCC Director or the FCC Coordinator:

- Provide HHS/ASPR with contact information to NDMS partner medical facilities in order to facilitate medical claims processing.
- Provide patient validation data to HHS.
- FCC Coordinator will serve as a Liaison between the FCC Director and/or the appropriate financial authority and the NDMS member facilities and partners for DoD FCC and MTF reimbursement procedures, refer to Appendix 2, Annex H.

NDMS partner facilities:

- Will be required to identify patients' primary and secondary third party payers and submit billing for patient care services to the patient's identified third party payer(s) for reimbursement.
- Submit Affidavit of Non-insurance for uninsured patients and submit associated final bills for payment directly to the appropriate HHS/ASPR Fiscal Intermediary.
- All protected health information should be safeguarded in accordance with the Health Insurance Portability and Accountability Act of 1996, (HIPAA).

Claims:

- **Medical Care of NDMS Patients**

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

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

TRICARE will directly reimburse NDMS partner medical facilities, physicians and other care providers for healthcare services provided to patients who are beneficiaries of the Military Healthcare System (MHS) in accordance with the

payment rules stated in Title 32 to the Code of Federal Regulations (32 CFR), Part 199. Final bills for payment are submitted by NDMS partner medical facilities, physicians and other care providers to the appropriate TRICARE Managed Care Support Contractor for the patient's command.

- **Claims for Transportation of Civilians**

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

- **Claims for Transportation of Military Beneficiaries**

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

## PATIENT VALIDATION AND TRACKING DATA COLLECTION

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

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

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



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

An example is provided as to how an FCC can track costs associated with a contingency: The below reflects how FCC Columbia tracked all incremental costs associated with their operations.

**HURRICANE MARIA 2017 "FCC Columbia"**

MISSION ASSIGNMENT 4339DR-PR-DOD-21	Budget	\$750,000.00	Thru 21 OCT	\$328,959.65	Remaining	\$421,040.35		
<b>ORGANIZATION</b>								
<b>SC FORESTRY COMMISSION IMT</b>	23-Sep-17	24-Sep-17	25-Sep-17	26-Sep-17	27-Sep-17	28-Sep-17	29-Sep-17	30-Sep-17
Salaries	\$1,820.00	\$10,500.00	\$9,750.00	\$10,000.00	\$10,000.00	\$10,000.00	\$10,000.00	\$10,000.00
Equipment & Supplies	\$405.00	\$253.00	\$150.00	\$150.00	\$150.00	\$150.00	\$150.00	\$150.00
Mileage	\$403.85	\$1,955.75	\$1,950.00	\$1,000.00	\$1,000.00	\$1,000.00	\$1,000.00	\$1,000.00
Lodging	\$300.00	\$775.00	\$750.00	\$750.00	\$750.00	\$750.00	\$750.00	\$750.00
Meals Not Provided by the Salvation Army	\$0.00	\$45.00	\$0.00	\$50.00	\$50.00	\$50.00	\$50.00	\$50.00
<b>Subtotal</b>	<b>\$2,928.85</b>	<b>\$13,528.75</b>	<b>\$12,600.00</b>	<b>\$11,950.00</b>	<b>\$11,950.00</b>	<b>\$11,950.00</b>	<b>\$11,950.00</b>	<b>\$11,950.00</b>
<b>AMBULANCE SERVICES</b>	23-Sep-17	24-Sep-17	25-Sep-17	26-Sep-17	27-Sep-17	28-Sep-17	29-Sep-17	30-Sep-17
Personnel	\$0.00	\$500.00	\$0.00	\$500.00	\$500.00	\$500.00	\$500.00	\$500.00
Trip Charge	\$0.00	\$2,500.00	\$0.00	\$2,500.00	\$2,500.00	\$2,500.00	\$2,500.00	\$2,500.00
<i>*For purposes or reporting this spreadsheet condenses Ambulance Services into one category. It may eventually contain multiple agencies if demand requires*</i>								
<b>Subtotal</b>	<b>\$0.00</b>	<b>\$3,000.00</b>	<b>\$0.00</b>	<b>\$3,000.00</b>	<b>\$3,000.00</b>	<b>\$3,000.00</b>	<b>\$3,000.00</b>	<b>\$3,000.00</b>
<b>COLUMBIA FIRE DEPARTMENT</b>	23-Sep-17	24-Sep-17	25-Sep-17	26-Sep-17	27-Sep-17	28-Sep-17	29-Sep-17	30-Sep-17
Salaries	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Equipment & Supplies	\$100.00	\$100.00	\$100.00	\$100.00	\$100.00	\$100.00	\$100.00	\$100.00
<b>Subtotal</b>	<b>\$100.00</b>	<b>\$100.00</b>	<b>\$100.00</b>	<b>\$100.00</b>	<b>\$100.00</b>	<b>\$100.00</b>	<b>\$100.00</b>	<b>\$100.00</b>
<b>SPARTANBURG REGIONAL HERT</b>	23-Sep-17	24-Sep-17	25-Sep-17	26-Sep-17	27-Sep-17	28-Sep-17	29-Sep-17	30-Sep-17
Salaries	\$0.00	\$9,500.00	\$9,500.00	\$9,500.00	\$9,500.00	\$9,500.00	\$9,500.00	\$9,500.00
Equipment & Supplies (HVAC)	\$250.00	\$250.00	\$250.00	\$250.00	\$250.00	\$675.00	\$675.00	\$675.00
Mileage	\$520.00	\$82.00	\$81.00	\$174.00	\$176.00	\$176.00	\$176.00	\$176.00
Lodging	\$856.00	\$856.00	\$856.00	\$856.00	\$856.00	\$856.00	\$856.00	\$856.00
Meals Not Provided by the Salvation Army	\$50.00	\$50.00	\$50.00	\$50.00	\$50.00	\$50.00	\$50.00	\$50.00
<b>Subtotal</b>	<b>\$1,676.00</b>	<b>\$10,738.00</b>	<b>\$10,737.00</b>	<b>\$10,830.00</b>	<b>\$10,832.00</b>	<b>\$11,257.00</b>	<b>\$11,257.00</b>	<b>\$11,257.00</b>
<b>SC AERONAUTICS COMMISSION</b>	23-Sep-17	24-Sep-17	25-Sep-17	26-Sep-17	27-Sep-17	28-Sep-17	29-Sep-17	30-Sep-17
Additional Salary Costs	\$974.22	\$1,688.32	\$1,453.04	\$1,700.35	\$2,172.31	\$2,172.31	\$1,750.50	\$1,225.00
<b>Subtotal</b>	<b>\$974.22</b>	<b>\$1,688.32</b>	<b>\$1,453.04</b>	<b>\$1,700.35</b>	<b>\$2,172.31</b>	<b>\$2,172.31</b>	<b>\$1,750.50</b>	<b>\$1,225.00</b>
<b>THE SALVATION ARMY</b>	23-Sep-17	24-Sep-17	25-Sep-17	26-Sep-17	27-Sep-17	28-Sep-17	29-Sep-17	30-Sep-17
Lunch	\$661.25	\$661.25	\$661.25	\$661.25	\$661.25	\$661.25	\$661.25	\$661.25
Dinner	\$454.25	\$454.25	\$454.25	\$454.25	\$454.25	\$454.25	\$454.25	\$454.25
<b>Subtotal</b>	<b>\$1,115.50</b>	<b>\$1,115.50</b>	<b>\$1,115.50</b>	<b>\$1,115.50</b>	<b>\$1,115.50</b>	<b>\$1,115.50</b>	<b>\$1,115.50</b>	<b>\$1,115.50</b>
<b>Subtotal</b>	<b>\$88,807.60</b>	<b>\$18,000.00</b>	<b>\$800.00</b>	<b>\$78,584.00</b>	<b>\$13,136.05</b>	<b>\$8,924.00</b>		<b>\$208,251.65</b>

## MILITARY PATIENT CASE MANAGEMENT

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

## 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 PRS to NDMS medical facility.		
Transportation Costs (not associated with patient transport)	Costs to transport the patient reception team to the PRS		
Costs associated with housing and feeding the patient reception team	Per diem for hotel, meals and incidentals while at the PRS		
Facility usage	Rental, including electricity, water, security		
Office supplies			
Furniture rental			
Equipment rental	Items such as computers, faxes		
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 Organization (NGO)		



## APPENDIX 1 TO ANNEX G – GAO NO-COST CONTRACTS FREQUENTLY ASKED QUESTIONS

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

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

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

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

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

In this situation, the agency could use a traditional contract in which it pays the contractor to provide lunch at no cost to the attendees, or it could use a no-cost contract where the attendees (or possibly their employers) would bear the cost.

In B-308968, Nov. 27, 2007, GAO cautioned that in structuring a no-cost contract there are other considerations beyond compliance with fiscal laws that an agency should take

into account so that the effectiveness of the conference is not compromised, including, for example, who may approve and sign such contracts, the ultimate cost to the government as a whole, and possible conflicts of interest.

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

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

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

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

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

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

Statutory requirements for competition, such as the Competition in Contracting Act (CICA), apply to procurements by federal agencies for property or services. 10 U.S.C. § 2303; 41 U.S.C. § 253. Thus, as a threshold matter, to be subject to these requirements, the agency must be acquiring property or services. Determining whether competition requirements apply to a particular procurement for a no-cost contract for property or services will depend on the agency involved.

CICA does not apply to no-cost contracts of military agencies, see 10 U.S.C. § 2303; *Century 21—AAIM Realty, Inc.*, B-246760, Apr. 3, 1992, 92-1 CPD ¶ 345; *Gino Morena Enterprises*, B-224235, Feb. 5, 1987, 87-1 CPD ¶ 121, but it does apply to no-cost contracts of civilian agencies. See 41 U.S.C. § 253; *Gourmet Distributors*, B-259083, Mar. 6, 1995, 95-1 CPD ¶ 130.

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

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

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

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

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

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

## APPENDIX 2 TO ANNEX G- FCC REIMBURSEMENT

Event Reimbursement: Reimbursement should be sought for any support provided under the Economy Act, Stafford Act or Immediate Response. Under the Economy and Stafford Acts, only the Secretary of Defense has the authority to waive reimbursement. Below are some examples listing reimbursable and non-reimbursable costs (this is not an all-inclusive list).

Economy Act (Under this law full reimbursement is required)

- Reserve forces pay and allowances are reimbursable (Title 10)
- Guard forces, under title 32, pay and allowances are reimbursable
- Federal civil service overtime pay is reimbursable
- Temp civil service hired specifically to support the DSCA event are reimbursable
- Service contracts specifically in support of the DSCA event are reimbursable
- Active Duty pay and allowances are reimbursable
- Federal civil service pay is reimbursable

Stafford Act (allows incremental reimbursement)

- Reserve forces pay and allowances are reimbursable (Title 10)
- Guard forces, under title 32, pay and allowances are reimbursable
- Federal civil service overtime pay is reimbursable
- Temp civil service hired specifically to support the DSCA event are reimbursable
- Service contracts specifically in support of the DSCA event are reimbursable
- Active Duty pay and allowances are NOT reimbursable
- Federal civil service pay is NOT reimbursable

Immediate response (normally local community)

- If an agreement exists, reimbursement goes to the US Treasury
- If no agreement exists, reimbursement not guaranteed

Organizational process flow: (Describes follow-on chart) (pg. 82)

Primary Agency

- Requests DoD support utilizing an RFA (Request for Assistance)
- Coordinates with DoD for support cost estimate
- Issues a reimbursable order that is the basis for DoD to issue reimbursable budget authority (RBA)

DoD

- Assigns DoD assets
- Issues EXORD with specific funding instructions
- Activates scalable Financial Management Augmentation Team (FMAT), if required

ARNORTH/G8 (or FMAT, if established)

- Receives reimbursable order from PA (Primary Agency)



- Receives cost estimates from tasked units
- Issues RBA to units via a Defense Support of Civil Authority Reimbursable Authority Document (DRAD)
- Tracks and reports RBA execution
- Coordinates with DCO for more RBA from PA if needed
- Processes closure certificates through the DCO (Defense Coordinating Officer)

#### Supporting Organizations' Budget Offices

- IMMEDIATELY contacts FMAT/ARNORTH/G8 (ARC) (ARNORTH Reimbursement Cell) to request RBA upon deployment notification IAW the USNORTHCOM EXORD.
- Receives and loads RBA into accounting system
- Tracks event cost expenditures through ESP, APC or JON coding (Emergency and Special Program Code, Account Processing Code, Job Order Number)
- Provides RBA execution reports to FMAT/ARNORTH/G8
- Requests additional RBA through ARNORTH/G8
- Processes reimbursement billing through DFAS and PA
- Closes DRAD through FMAT/ARNORTH/G8 after unit returns and final billing completed

A billing package to FEMA consists of:

FEMA Mission Assignment (Prescribed Mission Assignment (PSMA))

FEMA Mission Reimbursement Request Transmittal form

SF1080

DSCA Reimbursable Authorization Document (DRAD)

Billing Template

Supporting Documentation (receipts from incurred expenses and incremental costs))

#### DCO

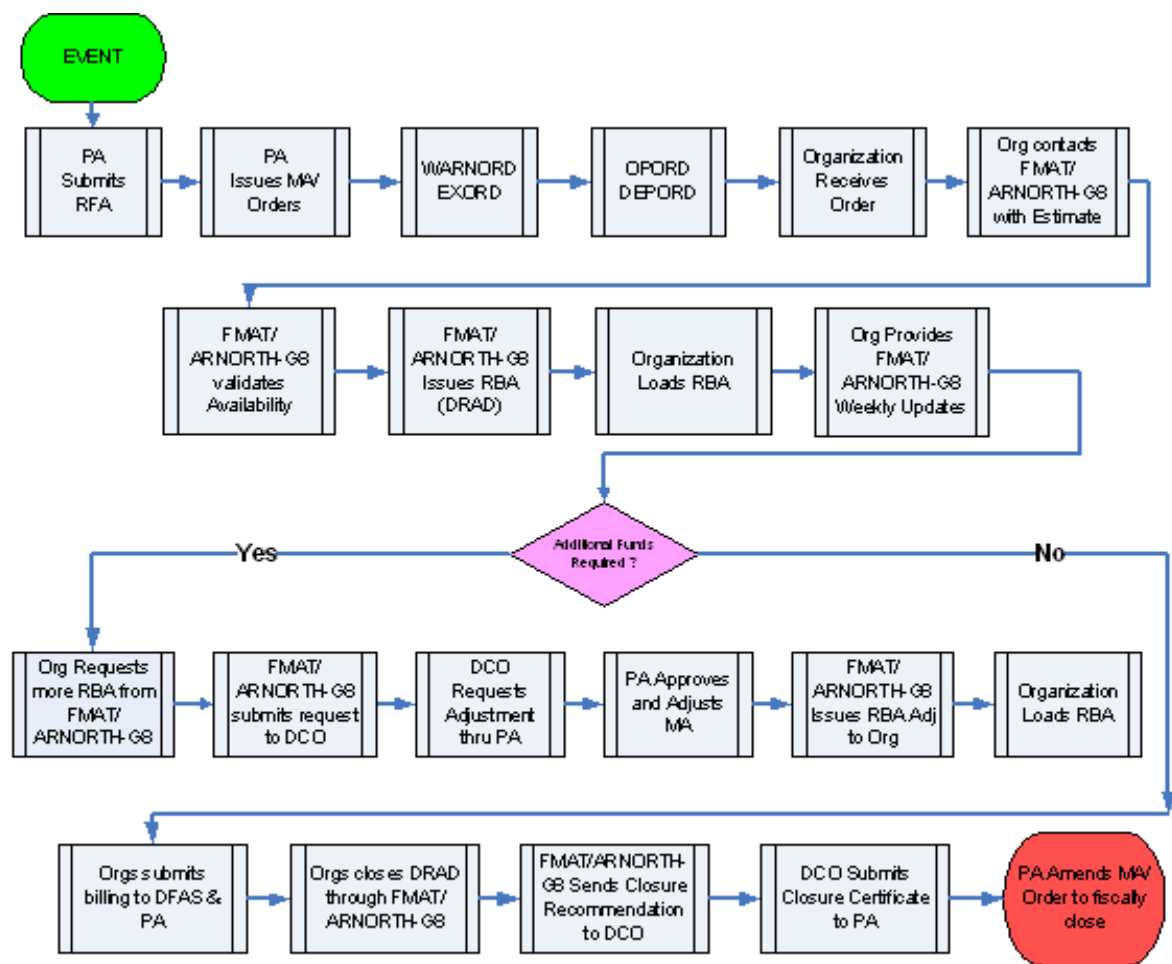
Coordinates on the initial MA/RFA and cost estimate

Coordinates for any required increases to MA/RFA. DoD Reimbursable Rates reference tables:

Current locations to search for reimbursable rates for DoD personnel and equipment are varied. Below is a list of some of the more commonly used reimbursement tables to help with initial estimates units should provide when tasked

Army reimbursement rates are listed at <https://www.asafm.army.mil/offices/CE/Rates.aspx> for the following categories.

- Equipment and vehicles



- Tracks and reports funding execution of tasked Units
- Recommends MA/RFA closure at billing completion

Standard DoD reimbursement rates are listed at:

<http://comptroller.defense.gov/financialmanagement/reports/rates2017.aspx> for the following categories.

- Fixed wing aircraft & crew tables ( Non-TRANSCOM) are listed at Tab F (found within link)
- Rotary wing aircraft & crew tables are listed at Tab H (found within link)
- Military personnel rates are listed at Tab K (found within link)

U.S. Transportation Command (TRANSCOM) aircraft and crew reimbursement rate tables differ and must be researched through the TRANSCOM website at:

<http://www.ustranscom.mil/dbw/rates.cfm>

Naval reimbursement rates for steaming hours, divers, personnel and equipment should be addressed to the specific fleet forces providing the support.

### Useful DSCA Web sites

- DoD Defense Support of Civil Authorities Automated Support System (DDASS)

<https://ddass.erd.c.dren.mil/DSCA/DDASS/DDASS.jsp>

- NORAD and USNORTHCOM Current Operations and Exercise Execution Portal  
<https://portal.noradnorthcom.mil/functions/operations/opex/SitePages/Home.aspx>
- Defense Support of Civil Authorities Directive  
<http://www.dtic.mil/whs/directives/corres/pdf/302518p.pdf>
- NORAD and USNORTHCOM/J8 DSCA-FMAT Document Portal

RBA Estimate Template

Reimbursable Authority Estimate		
<input type="checkbox"/>		
Organization Name	EXORD/DEPORD Number:	
Organization Address:	Issuer:	
Incident Name: PA/MA #:	Date/Time/Group:	
Requesting Financial POC:	Financial POC Email:	
Comm Phone #:	Comm Fax #:	
DSN Phone #:	DSN Fax #:	
<b>Estimated Requirements</b>		
	<b>Dollar Amounts</b>	
<i>Civilian Pay (Overtime)</i>		Notes/Define Other:
<i>Per Diem/Travel</i>		
<i>Transportation</i>		
<i>Fuel</i>		
<i>Flying/Steaming Hours</i>		
<i>Contracts</i>		
<i>Supplies</i>		
<i>Other-</i>		
<i>Other-</i>		
<i>Other-</i>		
<i>Other-</i>		
<b>Total Required:</b>		
Comments:		
<b>ARNORTH POC Information</b>		
ARC POC:	Date Received:	

SF1080

Standard Form 1080 Revised April 1982 Department of the Treasury TFRM 2-2600 1080-109		VOUCHER NO.  SCHEDULE NO.			
<b>VOUCHER FOR TRANSFERS                  BETWEEN APPROPRIATIONS AND/OR FUNDS</b>					
Department, establishment, bureau, or office receiving funds		BILL NO.			
Department, establishment, bureau, or office charged		PAID BY			
ORDER NO.	DATE OF DELIVERY	ARTICLE OR SERVICES	QUAN-TITY	UNIT PRICE	AMOUNT
				COST PER	DOLLARS AND CENTS
					0.00
					0.00
					0.00
				TOTAL	0.00
Remittance in payment hereof should be sent to -					

FEMA Transmittal Form

DEPARTMENT OF HOMELAND SECURITY  
 Federal Emergency Management Agency  
**MISSION ASSIGNMENT REIMBURSEMENT REQUEST TRANSMITTAL FORM**

Section I: Agency Submission	
Agency: <input style="width:90%;" type="text"/>	Current Bill Amount: <input style="width:90%;" type="text"/>
Address: <input style="width:90%;" type="text"/>	Fiscal POC: <input style="width:90%;" type="text"/>
Agency Location Code: <input style="width:90%;" type="text"/>	Phone Number: <input style="width:90%;" type="text"/>
Agency Bill Number: <input style="width:90%;" type="text"/>	POC E-mail Address: <input style="width:90%;" type="text"/>
Mission Assignment Number: <input style="width:90%;" type="text"/>	
Mission Description: (Statement of Work)	
<input style="width:100%; height:100%;" type="text"/>	
Please indicate bill type: <input type="checkbox"/> Partial Bill <input type="checkbox"/> Re-submitted Bill <input type="checkbox"/> Final Bill (No further obligations pending)	
NOTE: Expenditures claimed have been reviewed and are relevant to the mission assigned. Costs are reasonable, supported by source documents maintained by this agency, and are not funded by another source. (Include applicable signatures)	
_____ Primary Agency Project/Program Administrator	_____ Date
_____ Phone Number	

2 page form available at: <https://www.fema.gov/mission-assignment-billing-reimbursement-checklist>

### Billing Package

The billing package must be sent to FEMA by accountable mail or commercial equivalent (e.g., FEDEX) or by e-mail concurrently must send all completed reimbursement documents to ARNORTH G8 FMAT/ARC POC.

#### REGULAR MAIL:

FEMA FINANCE CENTER  
PO BOX 9001  
WINCHESTER, VA 22604

#### EXPRESS MAIL:

FEMA FINANCE CENTER  
188 BROOKE ROAD  
WINCHESTER, VA 22603

EMAIL: [FEMA-Disaster-Federal-Agencies-Payment@fema.dhs.gov](mailto:FEMA-Disaster-Federal-Agencies-Payment@fema.dhs.gov)

Approximately 3 days after sending the billing package to FEMA, the SF1080 should also be sent to the unit's servicing Defense Finance and Account Service (DFAS) office for IPAC Processing.

## ANNEX H: LOGISTICAL SUPPORT

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

### 1. Responsibilities

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

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

The FCC Director will be responsible for consolidating the administrative cost and expenditures for all logistical support during activation. This would include PRS 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 PRS. Future reimbursements will be dependent upon this process.

### 2. Assumptions

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

### 3. Concept

There are two general areas of logistics: Non-medical logistics and medical logistics. Non-medical logistics are those supplies and equipment needed for staging the NDMS patients. Medical logistics refers to the supplies and equipment required for patient care at the patient reception area of the FCC.

Both logistical areas impose several requirements for support. The initial operation should be supported from supplies that are positioned and are available for immediate response. Both medical and non-medical supplies are required and must be replenished as needed. The FCC personnel at the local PRS site will be initially totally dependent on its own patient support resources. Additional logistics support items can be purchased once the mission assignment has been approved. The additional supplies that are used to support the FCC after its activation will need to be documented and tracked for later reimbursement authorized by the MA.

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

- Space large enough for the supplies and ideally the space will be environmentally controlled.
- Shelter with consideration of power, lighting, and a plan to fuel support equipment such as power generators.
- Food and shelter should consider the different cultures of potential NDMS patients (the elderly, children, religious groups, etc.).
- Some arriving patient's clothing may not be suitable for weather conditions at the PRS. 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, inclement weather gear, personal protective equipment, and ICS vests.
- Sanitation requirements for personnel hygiene and toilets, not only for the FCC staff, but the need for increased use as NDMS patients and additional support personnel arriving to support the FCC.
- Hazardous medical waste, such blood products, sharps, pathological, and other waste that is considered including hazardous material.
- Weapons/contraband management. Patients may arrive at the PRS with contraband. Procedures to address should be considered.
- Items include office supplies, automation and computer support equipment. Also consider using equipment that the FCC uses on a regular basis to ensure software updates and compatibility with other automation systems, such as printers, that are supporting the FCC.
- The FCC logistical plan and its implementation may require additional transportation and drivers beyond the FCC capability to support. This would include vehicle and civilian ambulance assets. Plan for adding more space for vehicles, personnel and patients during a surge and what plan for additional logistics would be required to support the increase.

**Medical Logistics planning considerations:**

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

**FCC Caches**

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

<b>Item</b>	<b>NSN or Part Number (PN)</b>	<b>Qty</b>	<b>Potential Source</b>
Litter, Folding, Rigid Pole 91.6" Nominal, Adjustable Handles 90 - 94.4", Aluminum Pole, Polypropylene Cover.	6530-01-380-7309 or PN: 100049	35	Arizona Industries for the Blind 3013 W. Lincoln Street Phoenix, AZ 85009-5704
Litter, Oversized, 90" x 31" x 6" [Folded 45"x9"x7"].	6530-01-552-7708 or PN: 60-0023	15	North America Rescue, Inc. 35 Tedwell Court Greer, SC 29650-4791
Carrier, Litter, Wheeled, attendant Operated	6530-01-220- 7186 Or PN: PSC-HE	10	Rapid Rescue Products 5717 Sellger Drive Norfolk, VA 23502
Support, Litter, Folding, lightweight, 31.5" High	6530-00-660-34	50	ISO Group 770 Technology Drive West Melbourne, FL 32904
Strap, Litter, Webbing, Patient Securing	6530-00-784-4205 or PN: 101037	100	Arizona Industries for the Blind 3013 W. Lincoln Street Phoenix, AZ 85009-5704



Mattress, Litter	6530-01-548- 0262	50	
Blanket, Bed, Wool, 66" x 90", Shrink Resistant, 4 lb. Nominal, or Blanket, Bed, Cotton Thermal Weave White 66" x 90"	7210-00-715-7985 or 7210-00-139-5779 or PN: 2446690	100	Phoenix Textile Corp. 21 Commerce Drive O'Fallon, MO 63366- 4431
Sheet, Bed, Disposable 96" x 60", 100 per package	7210-00-144-6082	1 pkg	
Pillow, Pneumatic, 16.5" x 13"	7210-00-299-8520	50	
Pillowcase, Non-woven Cloth, 31.25-31.75" x 20.25-20.75", Disposable, 10 per package	6532-01-531-7257	5 pkg	
Back Rest, Litter Non- Adjustable, Aluminum / Cotton Duck	6530-00-299-8353	10	
Rod, Intravenous Irrigation Container, Adjustable 18" - 43" High	6530-00-792-6000	25	
Plug, Ear, Noise Protection, Vinyl Foam, 400 pair per package	6515-00-137-6345	2 pkg	GSA Global Supply
Goggles, Sun Wind Dust, Single-Aperture	8465-01-328-8268	50	Stemaco Products Inc. 2211 Ogden Road Rock Hill, SC 29730
Gloves		50	
Belts, Light Reflective	GFLR041 301	50	Sayre Enterprises, Inc.
Cot, Folding 2 per carton	7105-00-935-422	10 ctn	
Moulage Kits	PN: 27-1501 or 27-1502	1	Training For Life via GSA
Tables, Folding 6'x2'		6	
Chairs, Folding, 4 per carton		7 ctn	
Vests, ICS as required		37	TACTRON, INC
Board, Dry erase		3	
Bullhorn		1	
Trailer, 18'	KD7X1 8WT2	1	Haulmark via GSA
<b>Total</b>			

## ANNEX I: COMMUNICATIONS

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

### 1. RECOMMENDED EQUIPMENT AND FREQUENCY OF TESTING

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

Type of Equipment	Quantities	Maintenance Frequency
Laptop computers with internet access (cellular modem access and alpha paging software)	2	As needed
Printer	1	As needed
Scanner/Fax machine	1	As needed
Satellite phone with auxiliary antenna	2	Monthly
Cellular phone with backup batteries	2	As needed
Local Fire EMS Radio with charger and extra battery	2	As needed
Weather radio with battery backup	1	Weekly
JPATS Scanner	2	Quarterly
Pager	2	As needed
Shared Resources (SHARES) HF radio program	1	Monthly
Government Emergency Telecommunications Service (GETS) Card	1	Monthly
Hospital Emergency Administration Radio (HEAR) (as required)	1	Monthly
Locked cargo boxes with wheels or luggage carriers (to transport and store equipment)	As needed	N/A

The following should be considered:

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

## 2. TRAINING

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

### EXERCISING

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

## 3. INFORMATION SYSTEMS

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

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

from DHS, and other local, state, Tribal, territorial and federal departments/agencies/organizations (<https://www.llis.dhs.gov>)

## ANNEX J: 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 PRS under management of this FCC could be among the next to receive patients.

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

**ACTIVATION:** This status implies that FCC reimbursement for all patient reception activities is authorized. It signifies that patients are to be regulated, or have been regulated to a PRS 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 PRS?
- 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 partner medical facilities?
- How many patients have been received?
  - What types of acuities?
  - Litter or ambulatory?
  - Which NDMS partner medical facilities?

**DEACTIVATION:** Once the FCC has been deactivated, the FCC may be called upon to provide historical information. To be clear, there are only two types of activity an FCC may be called upon to be in; either Alert or Activated. There are no partial activations.

- How many and what categories of patients were received at the PRS?
- How many patients are still in NDMS partner medical facilities? Which medical facilities?
- How many patients were discharged from NDMS partner medical facilities?
- What equipment/supplies were used and require reimbursement?
- What was the cost to the facility for reduction of staff in order to stand up and operate the patient reception team? Did the facility reduce clinic hours, cancel surgeries, etc.?
- Of the medical facilities asking for reimbursement, did they receive it in a timely manner?
- What discharge planning information facilitation is required between the NDMS medical facility's case managers and HHS?
- Have you collected after action report items from the FCC and the NDMS partner medical facilities (e.g., medical facility satisfaction, lack of resources, etc.)?
- FCCs are also required to have captured all their costs and expenses and process according to the process outlined in Appendix 2 to Annex H

## ANNEX K: COORDINATE PUBLIC AFFAIRS

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

### RESPONSIBILITIES

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

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

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

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

### Operations

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

PA Tasks during FCC active operations:

- Prepare all informational materials for the media. This should include information about participating agencies supporting the FCC operation.
- Establish a designated area for PA activities.
- Perform media escort activities to control media access to acquire footage and interview of FCC personnel and/or patients.
- Attend FCC staff meetings, when possible, to maintain situational awareness.
- Assume the responsibility for responding to media and community queries.
- Coordinate with spokespersons from FEMA, State, and local agencies when conducting press conferences, writing media releases and informing key leaders of the FCC operations.
- Serve as point of contact for Hometown News Releases (DD Form 2266).

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

## RESOURCES FOR MORE INFORMATION

- The **Defense Information School** units of instruction created for public access and presented for informational purposes only can be found at the Web address listed below. These units cover a wide variety of public affairs disciplines. However, reading these units does not constitute an enrollment into any course offered by the Defense Information School.
- FEMA's **National Preparedness Directorate** (NPD) has developed an online Course Catalog that provides searchable, integrated information on courses provided or managed by FEMA's Center for Domestic Preparedness (CDP), Emergency Management Institute (EMI), and National Training and Education Division (NTED).
- **FEMA Emergency Management Institute (EMI)**  
<https://training.fema.gov/emicourses/> courses available are as follows:
- **Advanced Professional Series (APS)**
  - Basic Public Information Officers Course
- **External Affairs-State/Local/Federal Resident Courses**
  - Advanced Public Information Officers Course Master Public Information Officer
- **State/Local/Tribal Field-Delivered Courses**
  - Public Information Officer Awareness Training Basic Public Information Officers Course
  - Joint Information System/Center Planning for Tribal, State, and Local Public Information Officers
- **Independent Study Courses**
  - Public Information Officer Awareness
  - National Incident Management System Public Information Systems
- **Incident Command System Resident Courses**
  - NIMS ICS All-Hazards Public Information Officer Course
  - NIMS ICS All-Hazards Public Information Officer Train-the-Trainer
- **Integrated Emergency Management Resident Courses**
  - Advanced Public Information Officers Course



## ANNEX L: GLOSSARY OF TERMS AND ACRONYMS

### 1. TERMS:

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

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

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

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

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

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

**Available Beds:** Unoccupied hospital patient beds including supporting space, equipment, medical material, ancillary and support services and staff to operate under contingency circumstances, vacant as of 2400 hours previous bed report day, to which patients can be regulated. Transient patient beds, bassinets, incubators, and labor and recovery beds are excluded.

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

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

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

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

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

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

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

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

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

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

**Emergency Support Function (ESF):** ESF is an effective way to bundle and manage resources to deliver core capabilities. The Federal ESFs bring together the capabilities of Federal departments and agencies and other national-level assets. ESFs are not based on the capabilities of a single department or agency, and the functions for which they are responsible cannot be accomplished by any single department or agency.

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

**EXORD:** A military order issued to military units or DoD FCCs.

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

**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 PRSs.

**Global Patient Movement Requirements Center (GPMRC):** The joint activity reporting directly to the Commander, US Transportation Command, the DoD single manager for the strategic and continental United States regulation and movement of uniformed services and other authorized patients. The 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 (TPMRC). The GPMRC coordinates with supporting resource providers to identify available assets and communicates transport to bed plans to the appropriate transportation agency for execution.

**Ham radio:** The word "Ham" as applied to 1908 was the station CALL of the first amateur wireless station operated by some amateurs of the Harvard Radio Club. They were ALBERT S. HYMAN, BOB ALMY and POOGIE MURRAY.

**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. ICS is used by all levels of government—federal, state, Tribal, territorial and local—as well as by many private-sector and

nongovernmental organizations. ICS is also applicable across disciplines. It is normally structured to facilitate activities in five major functional areas: command, operations, planning, logistics, and finance and administration. ICS online resource center: <http://training.fema.gov/EMIWeb/IS/ICSResource/index.htm>

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

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

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

**Medical Regulating:** Medical regulating is a casualty management system designed to coordinate the movement of patients from site of injury or onset of disease through successive roles of medical care to an appropriate MTF. (DoD Joint Publication 4-02, Health Service Support, [http://www.dtic.mil/doctrine/new\\_pubs/j\\_p4\\_02.pdf](http://www.dtic.mil/doctrine/new_pubs/j_p4_02.pdf))

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

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

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

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

**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.

**NDMS partner medical facilities:** Medical facilities are those providers and institutions approved by HHS to receive reimbursement for care provided as outline in the Definitive Medical Care Memorandum of Agreement. The federal departments (DoD, HHS, VA, and DHS) that are signatories to the NDMS Federal Partners Memorandum of Agreement.

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

**National Disaster Medical System Steering Committee:** A committee, established by the FCC, consisting of local medical facility, medical, public health, public safety, emergency management and emergency medical services officials, representatives of voluntary organizations, and elected officials organized in an NDMS PRS 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 provide the template for the management of incidents, while the NRF provides the structure and mechanisms for national-level policy for incident management.

**National Response Framework (NRF):** The guide for U.S. response to all types of disasters and emergencies. It is built on scalable, flexible, and adaptable concepts identified in the National Incident Management System to align key roles and responsibilities across the United States.

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

generally defined as those providing negative airflow and respiratory isolation.

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

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

**Patient Reception Area (PRA):** A geographic locale containing one or more airfields, bus stations, or airheads; adequate patient staging facilities; and adequate local patient transport assets to support patient reception and transport to local voluntary, pre-identified, non-federal, acute care medical facilities capable of providing definitive care for victims of a domestic disaster, emergency, or military contingency. Generally, these medical facilities should be within a reasonable distance for patient transportation given the local road network and predominate traffic conditions (generally within a 75 mile radius of the managing FCC).

**Patient Reception Site (PRS):** Patient Reception Site": the location where patient reception operations are conducted, Patient care, regulating, etc. PRS is commonly used when referring to the reception site

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

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

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

**Patient Movement Coordination Cell (PMCTF):** A cell that coordinates and integrates NDMS operational planning, alerts, activations, and de-activations in order to establish and maintain an NDMS patient movement common operating picture for HHS and the interagency partners. The PMCTF will determine which FCCs are to be alerted and eventually activated. The PMCTF is composed of a representative(s) from the Offices of the ASD(HA) and ASD(HD&GS); HHS; VA; DHS; USNORTHCOM; USPACOM; USTRANSCOM; the Military Services; and the DHA, as required. The PMCTF also includes NDMS patient movement partners (e.g., interagency partners, state health departments, FEMA Regional Emergency Coordinators).

**Prepare to Deploy Order (PTDO):** In the case of DoD FCCs, the Chairman, Joint Chiefs of Staff standing EXORD delegates the authority to USNORTHCOM to place DoD FCCs on Prepare to Deploy Order (PTDO) for up to seven days. PTDO

is equivalent to Alert for the FCC. When needed, USNORTHCOM will issue a Modification Order (MOD) to the EXORD, which would include placing forces on PTDO.

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

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

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

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

## 2. ACRONYMS

AE	Aeromedical Evacuation
AES	Aeromedical Evacuation Squadron
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&GS)	Assistant Secretary of Defense (Homeland Defense & Global Security)
ASPR	Assistant Secretary for Preparedness and Response (HHS)
CAPT	Captain (U.S. Navy or Public Health Service)
CC	Critical Care (bed reporting category)
CCP	Casualty Collection Point
CEO	Chief Executive Officer
COI	Community of Interest
CONOPS	Concept of Operation
CONUS	Continental United States
CS	Civil Support
CSU	Clearing Staging Unit
DCO	Defense Coordinating Officer
DFO	Disaster Field Office
DEM	Division of Emergency Management
DHS	Department of Homeland Security
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Operational Response Team
DoD	Department of Defense
DRG	Diagnosis Related Group
DSCA	Defense Support to Civil Authorities
DVA	Department of Veterans Affairs
EMG	Emergency Management Group
EMS	Emergency Medical Services
EPC	Emergency Planning Committee
ERPSS	En-Route Patient Staging System
ESF	Emergency Support Function



ESF #1	Emergency Support Function #1 – Transportation
ESF #6	Emergency Support Function #6 – Mass Care
ESF #8	Emergency Support Function #8 – Health and Medical Services
EXORD	Execute (or Execution) Order
FCC	Federal Coordinating Center
FCO	Federal Coordinating Officer
FEMA	Federal Emergency Management Agency
FRS	Family Radio System
FY	Fiscal Year
GETS	Government Emergency Telecommunications Service
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
IRCT	Incident Response Coordination Team
JCS	Joint Chiefs of Staff
JDOMS	Joint Director of Military Support
JFO	Joint Field Office
JLFCC	Joint Land Forces Component Command
JPATS	Joint Patient Assessment and Tracking System
JPMT	Joint Patient Movement Team
JPRT	Joint Patient Reporting Team

LEPC	Local Emergency Planning Committee
LFA	Lead Federal Agency
LLIS	Lessons Learned Information System
MA	Mission Assignment
MAC T	Mobile Acute Care Team
MARS	Military Affiliate Radio System
MC	Pediatrics (bed reporting category)
MHS	Military Health System
MM/SS	Medical/Surgical (bed reporting category)
MMRS	Metropolitan Medical Response System
MOA	Memorandum of Agreement
MOD	Modification Order
MOU	Memorandum of Understanding
MP	Psychiatry (bed reporting category)
MSC	Military Sealift Command
MST	Management Support Team
MTF	Military Medical Treatment Facility
NDMS	National Disaster Medical System
NECC	National Emergency Coordination Center
NLE	National Level Exercise
NMCC	National Military Command Center
NPU	Negative Pressure Isolation Unit
NOK	Next of Kin
NRCC	National Response Coordination Center
NRF	National Response Framework
NVRT	National Veterinary Response Team
OASD/HA	Office of the Assistant Secretary of Defense, Health Affairs
OEM	Office of Emergency Management

OPLAN	Operations Plan
OPORD	Operations Order
OSC	Operations Support Center
PA	Public Affairs
POC	Point of Contact
PICU	Pediatric ICU
PIO	Public Information Officers
PMCTF	Patient Movement Coordination Cell
PMI	Patient Movement Items
PMITS	PMI Tracking System
PMR	Patient Movement Request
PRA	Patient Reception Area
PRS	Patient Reception Site
PRC	Primary Reception Center
PRS	Patient Reception Site
PRT	Patient Reception Team
PTDO	Prepare to Deploy Order
RACES	Radio Amateur Communications for Emergency Services
REC	Regional Emergency Coordinator
REP	Regional Evacuation Point
RRCC	Regional Response Coordination Center
SAT	Service Access Team
SBN	Burns (bed reporting category)
SLTT	State, Local, Tribal, and Territorial
SOC	Secretary's Operations Center (HHS)
TACC	Tanker Airlift Control Center
TRAC2ES	TRANSCOM Regulating And Command and Control Evacuation System

USARNORTH	United States Army North
USC	United States Code
USD	Under Secretary of Defense
USH/VA	Under Secretary for Health, Department of Veterans Affairs
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 M: POINT OF CONTACT LIST

### 1. ARMY MEDCOM:

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

### 2. AIR FORCE:

HAF/SG3XO

Main office number: 703-697-9075

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

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

### 3. NAVY: BUMED MOC

**NMOC EMAIL:**

**[USN.NCR.BUMEDFCHVA.LIST.MOC@MAIL.MIL](mailto:USN.NCR.BUMEDFCHVA.LIST.MOC@MAIL.MIL)**

**NMOC PHONE: 703-681-4870;**

**BUMED COMMAND DUTY OFFICER: (202) 714-0131**

### 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](mailto:NOC.SWO@dhs.gov)

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

### 6. HHS SOC

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

SOC 24 hour number 202-619-7800

NDMS: 1-800-872-6367

### 7. VA:

VHA Office of Emergency Management Duty Officer VHA/OEM at 304-264-4800, and if that number is not answered, to the VHA/OEM Watch Desk at 202-461-0268 or 202-461-0269'

## ANNEX N: REFERENCES LIST

### 1. REFERENCES:

- a. Federal Emergency Management Agency, "The National Response Framework (NRF)," Second Edition, May 2013
- b. Robert T. Stafford Disaster Relief and Assistance Act, 42 U.S.C. 5121 et seq; CFR 44 part 206
- c. United States Code, Title 42
- d. United States Code, Title 31, Section 1535
- e. Public Law 97-174, VA and DoD Health Resources Sharing and Emergency Operations Act (4 May 1982)
- f. Public Law 107-188, Public Health Security and Bioterrorism Preparedness and Response Act of 2002
- g. MOA, National Disaster Medical System (24 October 2005); currently under revision
- h. 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)
- i. DoD Directive 3025.18, "Defense Support of Civil Authorities (DSCA)," December 29, 2010, as amended incorporating Change 1, 21 September 2012
- j. DoD Directive 5136.01, Assistant Secretary of Defense for Health Affairs (30 September 2013)
- k. DoD Instruction 3020.47, "DoD Participation in the National Exercise Program (NEP)," January 29, 2009
- l. DoD Instruction 6000.11, Patient Movement (4 May 2012)
- m. DoD Directive 6010.22, National Disaster Medical System (NDMS) (14 April 2016)
- n. DoD Manual 8910.01, Volume 1, "DoD Information Collections Manual: Procedures for DoD Internal Information Collections," 30 June, 2014
- o. HSPD 5 Homeland Security Presidential Directive 5 Management of Domestic Incidents, February 2003
- p. HSPD 8 Homeland Security Presidential Directive 8 National Preparedness, December 2003
- q. HSPD 21 National Strategy for Public Health and Medical Preparedness October 2007

- r. Homeland Security Exercise and Evaluation Program (HSEEP) Vol. I-III, April 2013
- s. FY 2013 Overview: Homeland Security Grant Program (HSGP) State Homeland Security Program
- t. Post-Katrina Emergency Management Reform Act (PKEMRA) (4 October 2006)
- u. Sandy Recovery Improvement Act (29 January 2013)
- v. Air Force Instruction 44-153, Disaster Mental Health Response & Combat And Operational Stress Control (29 MAY 2014)

## 2. WEBSITES:

- a. Army Knowledge Online (AKO): <https://www.us.Army.mil/>
- b. Defense Information School Public Affairs Training: [http://www.dinfos.osd.mil/dinfosweb/adl/learn/ContentModuleMenu\\_public.asp?courseTPI=PAOQC-ADL-NR](http://www.dinfos.osd.mil/dinfosweb/adl/learn/ContentModuleMenu_public.asp?courseTPI=PAOQC-ADL-NR)
- c. Defense Medical Readiness Training Institute: <http://www.dmrta.army.mil/>
- d. Defense Threat Reduction Agency: <http://www.dtra.mil/>
- e. Department of Defense Issuances: <http://www.dtic.mil/whs/directives/>
- f. Department of Health and Humans Services: <http://www.hhs.gov/>
- g. Department of Homeland Security State Contacts and Grant Award information at <http://ipv6.dhs.gov/xgot/grants/> .
- h. Department of Veterans Affairs: <http://www.va.gov/>
- i. Department of Veterans Affairs Office of Emergency Management (OEM) (internal website): <https://VAww.visn5.portal.va.gov/sites/ro/emshg/default.aspx>
- j. Department of Veterans Affairs Office of Emergency Management (OEM) (external website): <https://VAww.visn5.portal.va.gov/sites/ro/emshg/external/default.aspx>
- k. FEMA Lessons Learned Information System (LLIS): <https://www.llis.dhs.gov>
- l. FEMA National Exercise Program: <http://www.Fema.gov/national-exercise-program>
- m. FEMA Training Website: <http://training.fema.gov/IS/>
- n. HHS ASPR NDMS: <http://www.hhs.gov/aspr/oepo/ndms/index.html>
- o. Homeland Security Information Network: <https://auth.dhs.gov/oam/hsinlogin>
- p. Joint Patient Assessment and Tracking System Logon:

- For training module, <https://teams2.hhs.gov/PETSDev/protected/home.do>
  - For real-world operations, <https://asprwebapps.hhs.gov/jpats/protected/home.do;jsessionid=F012C26D5B82630BB19CC5B625E51A39>
- q. National Response Framework Resource Center: <http://www.fema.gov/emergency/nrf/>
- r. TRANSCOM Regulating Command & Control Evacuation System (TRAC2ES): <https://www.trac2es.ustranscom.mil/>
- s. USNORTHERN Command: <http://www.northcom.mil/>
- t. USARNORTH: <http://www.arnorth.army.mil/>

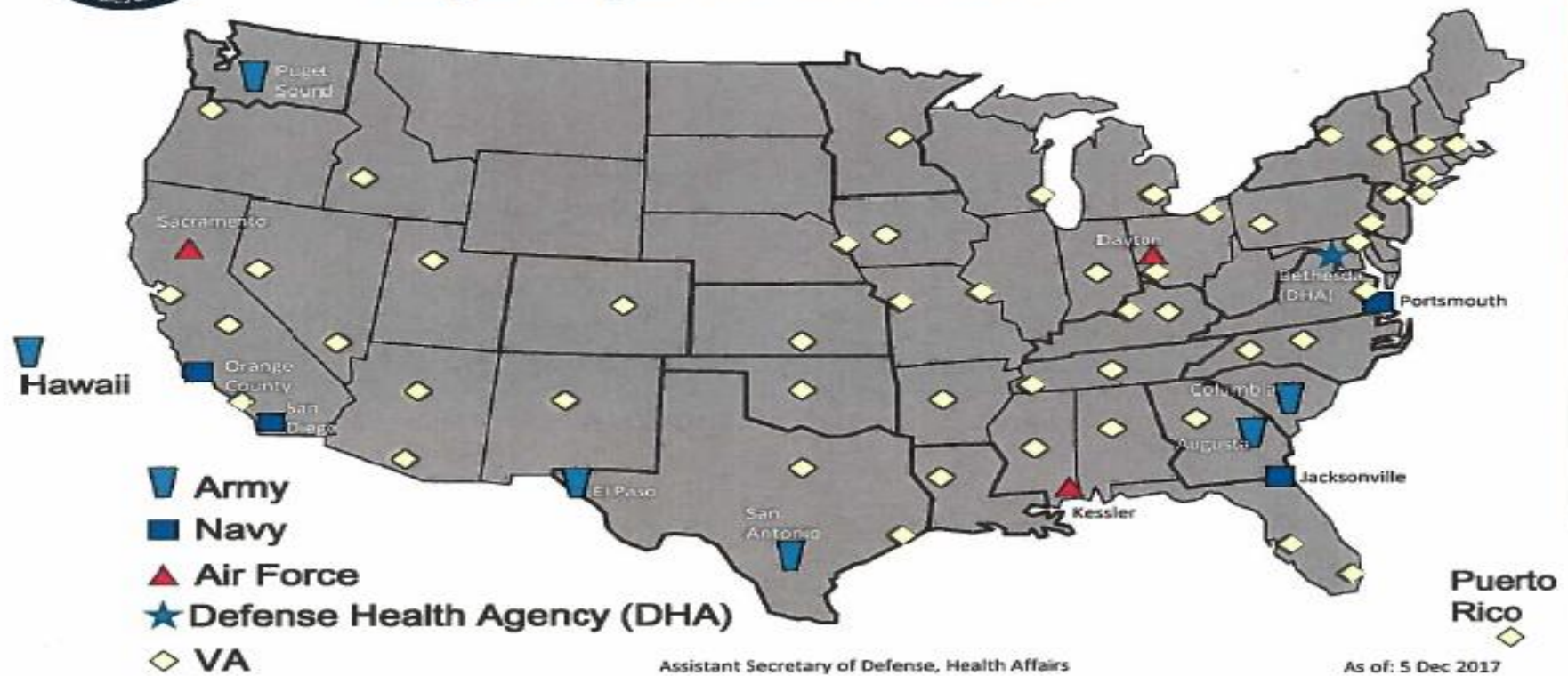


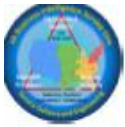
### ANNEX O: MAP OF CURRENT FCCS



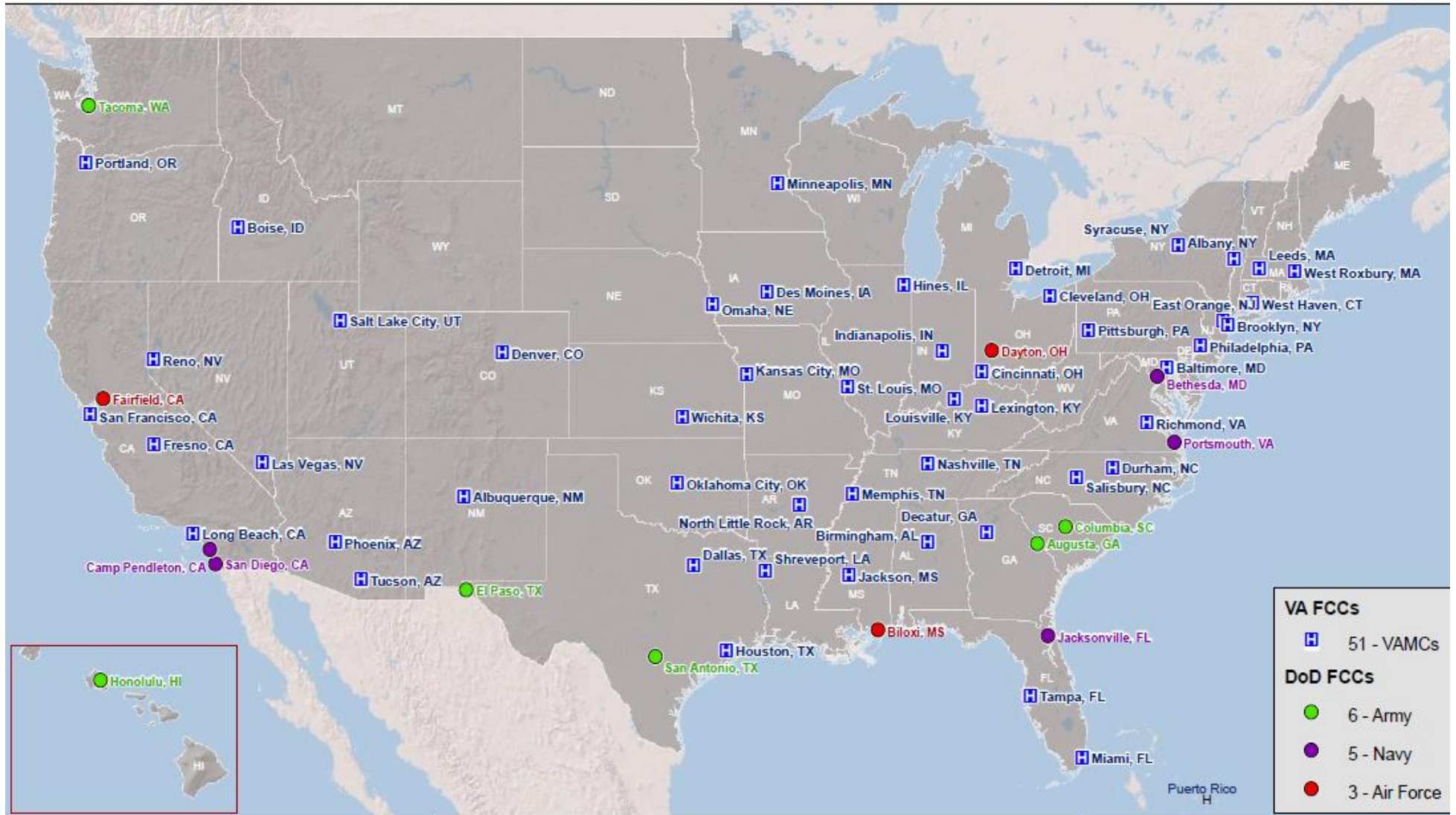
## Federal Coordinating Centers

VA = 51 DoD = 14  
(Army = 6; Navy = 4; Air Force = 3; DHA = 1)





# National Disaster Medical System - Federal Coordinating Centers



## ANNEX P: FCC PRS SELF-ASSESSMENT

**PRS Location / Area of Responsibility:** \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

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

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

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

**FCC Director's Review:**

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\_\_\_\_\_

**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 PRS? \_\_\_\_\_
2. Does the FCC manager more than one PRS?  Yes  No  Unknown
3. If the FCC manages more than one PRS, are sufficient personnel dedicated to manage operations at each PRS?  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. TPMRC-A, GPMRC, Regional Emergency Coordinator, Defense Coordinator Officer, national Operations Center, HHS SOC  Yes  No  Unknown
  - b. Local NDMS Steering Committee
    - i. Does the FCC (Director/Coordinator) maintain the NDMS Steering Committee?  Yes  No  Unknown
    - ii. Current membership?  Yes  No  Unknown
    - iii. Scheduled meetings with minutes?  Yes  No  Unknown
10. Have tracking mechanisms been established to account for expense incurred to support FCC staff training, exercised, equipping, and operations?  Yes  No  Unknown

11. Have tracking mechanisms been established to account for expenses incurred to support local patient reception and distribution operations?  Yes  No  Unknown
12. Are lines of authority, roles and responsibilities for the FCC staff, the Patient Reception Team(s), and other local authorities, companies, and agencies documented?  Yes  No  Unknown
13. Are FCC message control measures and required notifications adequately established?  Yes  No  Unknown
14. Have TRAC2ES accounts been established and maintained for sufficient numbers of FCC staff personnel?  Yes  No  Unknown
15. Have JPATS accounts been established and maintained for sufficient numbers of FCC staff personnel?  Yes  No  Unknown
16. Have contacts been established with TRICARE Regional Offices or with the nearest military treatment facility?  Yes  No  Unknown
17. Have sufficient resources available to support augmenting teams (i.e., JPATS, SATs, PMITs)?  Yes  No  Unknown
18. Is sufficient support provided by a local NDMS Steering Committee?  Yes  No  Unknown
19. Have procedures been established to guide media relations?  Yes  No  Unknown
20. Is accurate FCC contact information (such as the FCC Area Coordinator, 24/7 FCC phone numbers, and addresses) maintained in TRAC2ES?  Yes  No  Unknown
21. Are there sufficient primary and alternate means of communications maintained among the FCC, Patient Reception Team(s), NDMS facilities, and other local POCs?  Yes  No  Unknown
22. Has a PRS plan been developed?  Yes  No  Unknown
23. Has a PRS plan been reviewed/updated on annual basis?  Yes  No  Unknown
24. Has the PRS plan been integrated into community emergency preparedness plans?  Yes  No  Unknown

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

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**Comments:**

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

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**What is the “Plan of Action” to remedy all UNKNOWN answers?**

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## II. PATIENT RECEPTION AND DISTRIBUTION

1. Does the PRS plan address the following areas:

- a. Patient Reception Team(s) information, plans and procedures?  Yes  No  Unknown
- b. Contact information for Patient Reception Team(s)?  Yes  No  Unknown
- c. Plans and procedures for recall and mustering of Patient Reception Team(s)?  Yes  No  Unknown
- d. Identification of local ambulance resources, inventories, capabilities, points of contact, phone numbers, written agreements or contractual requirements (if any)?  Yes  No  Unknown
- e. Identification of local bus or taxi resources, inventories, capabilities, points of contacts, phone numbers, written agreements, or contractual requirements (if any)?  Yes  No  Unknown
- f. Identification of equipment and supplies to support patient care (such as litters, blankets, bandages, etc.)?  Yes  No  Unknown
- g. Patient Reception Team(s) plans, processes and procedures for unloading patients?  Yes  No  Unknown
- h. 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
- i. Resource to support the Patient Reception Team(s): Meals, Water, Bathing and Toilet Facilities, Sleeping Arrangements, Team-Member transportation?  Yes  No  Unknown
- j. Night and/or weekend operations?  Yes  No  Unknown
- k. Inclement weather contingencies?  Yes  No  Unknown
- l. Processes and procedures for patient identification and tracking within the PRS?  Yes  No  Unknown
- m. Record keeping within the PRS?  Yes  No  Unknown

2. What commercial or military airfields support the PRS?
  - a. Primary Airfield:
  - b. Secondary Airfield:
  - c. Tertiary Airfield:
  
3. Are these primary airfields accurately reflected in TRAC2ES? facilities/personnel (if applicable)
  
4. Have primary and alternative airfield authorities been coordinated with regarding the following:
 

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

a. Identification of key points of contact/contact information	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
b. Designated patient unloading and staging area(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
c. Any security issues/ access to patient unloading and staging area(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
d. Potential terminal closures or other operational constraints	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
e. Patient unloading equipment storage, access and use	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
f. Coordination with terminal medical	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown



Yes  No  Unknown

Yes  No  Unknown

6. Have procedures been outlined to coordinate patient follow-on moves and/or return of patients to destinations outside the PRS by either the SAT or PRS?

(NOTE: The SAT has developed checklists and documents to support the process for case management, discharge, and patient return. (Go to {url} for access to toolbox.)

Yes  No  Unknown

7. Are guidelines in place to help to estimate the “THROUGHPUT” (the number of NDMS patients that can be received, off-loaded, staged, triaged, transported, and admitted to the destination NDMS facility within a 24-hour period)?

Yes  No  Unknown

8. Has the local community been consulted on normal daily community ambulance use, to base ambulance availability estimates for calculating “THROUGHPUT”?

Yes  No  Unknown

9. Has the estimated “THROUGHPUT” been tested in an exercise within the past three years?

Yes  No  Unknown

10. Have the factors that limit the sustainability of this PRS’s THROUGHPUT been identified and mitigated to the extent possible?

Yes  No  Unknown

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 the PRS?

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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 remedy all UNKNOWN answers?**

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**III. DEFINITIVE MEDICAL CARE**

1. Have all local appropriate facilities within a reasonable distance for patient transportation given

the local road network and

predominate traffic conditions (generally within a 50 mile radius of the managing FCC) been contacted and invited to join the NDMS within the past five years?

Yes  No  Unknown

2. Are signed Memorandums of Agreement (MOAs) maintained for all participating NDMS facilities?

\_\_\_\_\_

Yes  No  Unknown

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

4. Has a PRS plan been developed and coordinated with all participating NDMS facilities?

5. Have the following been considered by participating NDMS facilities:

Yes  No  Unknown

a. In-service training on expansion of inpatient capacity to support NDMS?

Yes  No  Unknown

b. Cancellation of elective surgeries in order to make additional beds available?

Yes  No  Unknown

c. Inpatient discharge protocols to create additional beds?

Yes  No  Unknown

d. Facility plans for expansion?

Yes  No  Unknown

e. Expanded staff availability?

Yes  No  Unknown

f. Calculated loss of clinical/support staff due to Reserve Mobility Status Activation and/or other federal, state, Tribal, territorial or local obligations?

Yes  No  Unknown

6. Do participating NDMS facilities understand the role of the SAT, if applicable?

Yes  No  Unknown

7. Do participating NDMS facilities know how to contact the nearest military treatment facility(s)?

Yes  No  Unknown

8. Are contingency plans in place to coordinate food, lodging and transport for NDMS patients requiring outpatient services?

Yes  No  Unknown

9. Are contingency plans in place to coordinate food, lodging and transport for NDMS non-medical attendants and/or family members?

10. Are local information packets available for distribution to NDMS patients,

Yes  No  Unknown

non-medical attendants and/or family members?  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 the PRS?

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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 PRS?  Yes  No  Unknown
2. Are FCC PRS training and exercise objectives articulated in the exercise plan and/or calendar?  Yes  No  Unknown
3. Did the FCC formulate a training and exercise budget request in the past year and submit to appropriate authorities?  Yes  No  Unknown
4. Did the FCC provide an orientation to the PRS plan to all representatives of the NDMS partner facilities within the past year?  Yes  No  Unknown
5. Did the FCC provide an orientation to the PRS plan representatives of local emergency management agencies, EMS agencies, police, and fire services within the past year?  Yes  No  Unknown
6. Have NDMS facilities participated in 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 PRS-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 PRS-related event in the past year? \_\_\_\_\_
9. Did the FCC ensure that individuals designated to augment the FCC staff received detailed education and training on their specific duties within the past year?  Yes  No  Unknown
10. Have sufficient numbers of FCC personnel received sufficient TRAC2ES training to accomplish their FCC duties?  Yes  No  Unknown
11. Have sufficient numbers of FCC personnel received sufficient JPATS training to accomplish their FCC duties?  Yes  No  Unknown

12. Have sufficient numbers of FCC

personnel received training with any specialized communications equipment?

13. Did the FCC conduct group training exercises or drills within the past year to ensure they preparedness of teams (e.g., the Patient Reception Team)?

Yes  No  Unknown

14. Did the FCC's PRS team participate in a full-scale NDMS patient reception exercise in this PRS at least once in the past three years?

Yes  No  Unknown

15. Has a PRS plan been subject of a detailed table-top exercise?

Yes  No  Unknown

16. Are training events documented?

17. Are deficiencies and lessons learned during exercises tracked and review for closure?

Yes  No  Unknown

Yes  No  Unknown

Yes  No  Unknown

**Comments:**

**What is the "Plan of Action" to remedy all NO answers?**

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

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## ANNEX Q: EXERCISE EVALUATION GUIDE

### INTRODUCTION:

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

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

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

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

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

### NDMS PATIENT RECEPTION OPERATIONS TARGET

#### CAPABILITIES NDMS Federal Coordinating Center (FCC)

##### Command Center Management

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



## EXERCISE OBJECTIVE 1: ESTABLISH AND MAINTAIN A NDMS FCC COMMAND CENTER ORGANIZATION IN RESPONSE TO A NDMS ALERT AND ACTIVATION.

### PERFORMANCE TASKS AND MEASURES/METRICS:

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

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

#### Critical Tasks

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

#### Activity: Gather and Provide Information

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

#### Critical Tasks

1	Collect, analyze, and disseminate situation information and intelligence.
---	---------------------------------------------------------------------------

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

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

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

#### **Critical Tasks**

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

## NDMS PATIENT TRIAGE, STAGING AND TRANSPORTATION

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

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

PERFORMANCE TASKS AND MEASURES/METRICS:

### Activity: Implement NDMS Patient Reception Procedures

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

#### Critical Tasks

1	Coordinates triage, interim patient care capabilities, and transportation.
2	Establish and organize triage, patient holding areas, and transportation areas.
3	Ensures appropriate support resources are in place.
4	Ensures patient tracking and accountability procedures are in place.
5	Ensures currency of NDMS medical facility bed availability report.
6	Proper litter lifting and carrying techniques are reviewed prior to aircraft arrival.
7	Upon aircraft arrival, receive patient manifest and briefing from the Medical Crew Director.
8	MCD directs patient off-loading.
9	Process patients through triage to appropriate holding areas.
10	Provide necessary and appropriate patient assessment / treatment while waiting transport
11	Regulate patients to an appropriate receiving NDMS facility.
12	Initiate patient tracking procedures.
13	Notify receiving NDMS facilities of patient's enroute.
14	Conduct debriefing of patient reception operations following conclusion of each event.

## JOINT PATIENT ASSESSMENT TRACKING SYSTEM INTEGRATION

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

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

### PERFORMANCE TASKS AND MEASURES/METRICS:

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

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

#### Critical Tasks

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

## NDMS FACILITY OPERATIONS

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

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

PERFORMANCE TASKS AND MEASURES/METRICS:

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

Definition: Upon receiving NDMS alert and/or activation notification, identify patient reception capacity and establish the capability.

#### Critical Tasks

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

#### Attachments:

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

## NDMS PATIENT RECEPTION “FULL SCALE” EXERCISE

### NDMS FCC COMMAND CENTER EVALUATION & ANALYSIS FORM

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

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

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

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

#### Critical Tasks

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

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

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

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

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

**Critical Tasks**

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

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

**Activity Analysis / Observations****Strengths:**

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**Areas for Improvement:**

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**Additional Comments:**



**Activity: Gather and Provide Information**

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

**Critical Tasks**

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

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

**Activity Analysis / Observations****Strengths:**

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**Areas for Improvement:**

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

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

**Critical Tasks**

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

Performance Measures	Metric
Time in which NDMS medical facility bed availability report is completed.	Indicate time from when the bed availability report was requested to when the final report is received
Time in which operational capabilities assessment is completed.	Indicate time from when the Command Center become Operational to when the Operational capabilities assessment was completed
Patient reception expense tracking procedures in place.	Continuous
Reimbursement procedures in place for expenses incurred by external support organizations.	Continuous

**Activity Analysis / Observations****Strengths:**

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**Areas for Improvement:**

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**Additional Comments:**

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## NDMS PATIENT RECEPTION “FULL SCALE” EXERCISE

### NDMS Patient Reception Site Evaluation & Analysis Form

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

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

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

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

#### **Critical Tasks**

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

Performance Measures	Metric	Yes	No	Partial
Time in which patient reception site incident command staff is identified and incident operations established.	Indicate time required to establish incident command operations.			
Safety analysis conducted.	Yes / No			
Reception Site Commander conducts a command staff meeting / situation briefing at	Yes / No			

the start of each operational period.				
Patient reception team members receive an operational brief and safety briefing at the start of each operational period.	Yes / No			

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

**Activity: Conduct Resource Management**

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

**Critical Tasks**

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

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

**Activity Analysis / Observations****Strengths:**

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**Areas for Improvement:**

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**Additional Comments:**

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

**Activity: Implement NDMS Patient Reception Procedures**

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

**Critical Tasks**

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

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



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

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

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

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

#### Critical Tasks

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

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

#### Activity Analysis / Observations

##### Strengths:

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##### Areas for Improvement:

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**Additional Comments:**

## NDMS PATIENT RECEPTION “FULL SCALE” EXERCISE

### NDMS Medical Facility Evaluation & Analysis Form

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

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

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

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

#### **Critical Tasks**

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

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

#### **Activity Analysis / Observations**

##### **Strengths:**

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##### **Areas for Improvement:**

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##### **Additional Comments:**

# NDMS PATIENT RECEPTION “FULL SCALE” EXERCISE

## EXERCISE PARTICIPANT FEEDBACK FORM

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

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

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

Player     Facilitator     Observer     Evaluator

### Part I: Recommendations and Corrective Actions

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

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

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

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

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## Part II: Assessment of Exercise Design and Conduct

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

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

## Part III: Participant Feedback

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

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## ANNEX R: MISSION ASSIGNMENT EXAMPLE

FEDERAL EMERGENCY MANAGEMENT AGENCY <b>MISSION ASSIGNMENT (MA)</b>	See reverse side for Paperwork Burden Disclosure Notice	O.M.B. NO. 3067-0278 Expires November 30, 2007
<b>I. TRACKING INFORMATION (FEMA Use Only)</b>		<b>EXAMPLE</b>
State: TX (Texas) Incident: 2008082602-Hurricane Gustav		Action Request #: 1509-107153
Program Code/Event #: 3290EM-TX: HURRICANE GUSTAV		Date/Time Rec'd: 08/31/2008 00:38
<b>II. ASSISTANCE REQUESTED</b>		<input type="checkbox"/> See Attached
Assistance Requested: Request USFS pre-position appropriate USFS DOI/USFS personnel in support of response operations for 3290EM-Hurricane Gustav.		
Quantity: 1 (Each)	Date/Time Required: 08/31/2008	Internal Control #:
Delivery Location: USFS, Dallas Office, Dallas, TX 00000		
Initiator/Requestor Name: Michael Murphy	24-hour Ph #s: (940) 898-5108	Date: 08/31/2008
POC Name: BREWER, MARSHA C	24-hour Ph #s: (940) 898-5149	Date: 08/31/2008
* State Approving Official (Required for DFA and TA):		Date:
<b>III. INITIAL FEDERAL COORDINATION (Operations Section)</b>		
Action to:	Date/Time:	Priority:
<input checked="" type="checkbox"/> ESF #: 4 <input type="checkbox"/> Other:	08/31/2008 00:04	<input type="checkbox"/> 1 Lifesaving <input type="checkbox"/> 2 Life sustaining <input checked="" type="checkbox"/> 3 High <input type="checkbox"/> 4 Medium <input type="checkbox"/> 5 Normal
<b>IV. DESCRIPTION (Assigned Agency Action Officer)</b>		<input type="checkbox"/> See Attached
<i>Mission Statement: Your agency is responsible for submitting a Mission Assignment Monthly Progress Report to FEMA to include cost data when Mission Assignments take more than 60 days to complete, including billing. The Mission Assignment Monthly Progress Report can be accessed and submitted on-line at <a href="http://www.fema.gov/government/business.shm">http://www.fema.gov/government/business.shm</a>. The new ALC number can also be accessed at the web address.</i>		
As directed by and in coordination with FEMA, USFS will provide appropriate USFS DOI/USFS personnel, pre-position Incident Management Teams, base camps management, and saw crews for clearing roadways, etc. in support of Hurricane Gustav response. This activation may include overtime and administrative costs. Equipment purchases are not authorized under this Mission Assignment. Additionally, ESF 4 is providing the IOF/JFO with resource unit leaders and ESF4s. Personnel to be pre-positioned will be located in Dallas, Austin, or other locations as determined by FEMA. Pre-positioning is necessary due to time it takes to mobilize personnel.		
Assigned Agency: USFS (U.S. FOREST SERVICE)	Projected Start Date: 08/31/2008	Projected End Date: 09/10/2008
<input checked="" type="checkbox"/> New or <input type="checkbox"/> Amendment to MA #:	Total Cost Estimate: \$600,000.00	
Assigned Agency POC Name: MICHAEL MURPHY ESF4 LEAD	Phone and fax #s: (940) 898-5108	
<b>V. COORDINATION (FEMA Use Only)</b>		
Type of MA: Federal Operation Support State Cost Share (0%)	Commodity/Activity Category: Protective Measures	
State Cost Share Percent: 0.0%	State Cost Share Amount: \$0.00	
Fund Citation: 2008-06-3290EM-9064-XXXX-2501-D	Appropriation code: 70X0702	
Mission Assignment Coordinator (Preparer): DEBRA SESSNER	Date: 08/31/2008	
** FEMA Project Officer/Branch Chief (Program Approval): MARSHA BREWER	Date: 08/31/2008	
** Comptroller/Funds Control (Funds Review): GWILLIAM, STEVEN R.	Date: 08/31/2008	
<b>VI. APPROVAL</b>		
* State Approving Official (Required for DFA and TA):		Date:
** Federal Approving Official (Required for all): M FAIRLEY		Date: 08/31/2008
<b>VII. OBLIGATION (FEMA Use Only)</b>		
Mission Assignment #: 3290EM-TX-USFS-01	Amt. This Action: \$600,000.00	Date/Time Obligated: 08/31/2008
Amendment #: 00	Cumulative Amt. \$600,000.00	Initials: IFMIS
* Signature required for Direct Federal Assistance and Technical Assistance Mission Assignments. ** Signature required for all Mission Assignments.		

FEMA Form 90-129, Oct 02

REPLACES ALL PREVIOUS EDITIONS