U.S. Department of Health & Human Services

ASPR Administration for Strategic Preparedness & Response

Office of the Assistant Secretary for Preparedness & Response

Federal Coordinating Center Guide
March 2024

Federal Coordinating Center Guide

Table of Contents

Executive Summary

Federal Coordinating Centers (FCC) are a vital capability of the National Disaster Medical System (NDMS). Federal Patient Movement employ FCCs in support of natural disasters, homeland defense, and DoD large scale contingency operations. Additionally, FCCs provide the NDMS a capability to receive, track, and move patients as they move through the Definitive Care program. FCCs are owned, resourced, and operated by both the Veterans Health Administration and Department of Defense, which adds to the complexity of their operations. The Department of Health and Human Services, through the Administration for Strategic Preparedness and Response is the Lead Federal Agency for NDMS, which adds more complexity to the operating environment. The NDMS FCC Guide is intended to provide clarity and standardization to FCC Operations where possible. The FCC Guide is designed specifically for FCC Directors and FCC Coordinators but may be useful to any person involved in supporting FCC Operations. The FCC Guide will specify, where appropriate, how an FCC is to be operated, resourced, activated, and deactivated. It will also outline training and reporting requirements, and recommendations for engaging with NDMS civilian. The FCC Guide is intended to be prescriptive in nature and is not to be considered a replacement for agency or service policies, but the guide should assist agencies and services as they build more comprehensive operating procedures and policies. The FCC Guide is presented to the agencies responsible for executing the critical FCC mission with the objective of clarifying FCC operating requirements and serving as a reference for interagency policy development.

Andrew McBrearty
Director, Federal Patient Movement

Introduction

This NDMS FCC guide is designed as a reference to build, sustain, manage, and operate an FCC within a local jurisdiction. The guide is designed to standardize FCC operations across the Departments of Defense (DoD) and Veterans Affairs (VA) to the extent possible, while acknowledging agencies and services have unique capabilities and limitations that impact FCC operations. Each agency is responsible for providing additional guidance to address their unique requirements and processes.

The mission of a Federal Coordinating Center (FCC) is to receive, assess, stage, track, and transport patients, affected by a disaster or national emergency, to a participating National Disaster Medical System (NDMS) medical facility capable of providing the required definitive care. NDMS health care facilities may also receive military patients should the DoD Military Health System (MHS) and the VA be overwhelmed during a military emergency.

An FCC is defined as a DoD or VA federal patient movement capability 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). PRAs are comprised of NDMS participating health care facilities which are facilities with a signed Health Care Facility/Partner Memorandum of Agreement for Definitive Medical Care. Participating health care facilities are to be located within a reasonable distance for patient transportation given the local conditions that impact the timeliness of patient transport. The FCC director, at their discretion, may add healthcare facilities with specialty capability (i.e., children's hospital, burn, spine, Level I Trauma, etc.) to their network. FCC Directors will use their best judgment and agency guidance to determine 'reasonable distance' when admitting any facility to their network.

Assumptions

Assumptions are information that is assumed to be true and necessary to enable FCC sustainment and operations planning. If one of the following assumptions are proven to be untrue the FCC Director and/or Coordinator will have to apply mitigating measures. The following are the NDMS FCC Guide assumptions:

- FCC Coordinators and Directors are trained and/or familiar with basic FCC Operations, the NDMS, the National Response Framework, and the federal tasking authorities.
- FCCs are assigned the appropriate manpower to conduct operations as determined by their respective agency.
- FCCs are funded, by their agency, to allow for sustainment operations.
- Upon activation each FCC will have appropriate and sufficient funding available for all scenarios (i.e., Stafford Act, repatriation and/or military contingency).
- Medical and non-medical logistical support is available, and methods of re-supply and transport are maintained through organic agency resources or contractor provided support.
- Each PRA has appropriate infrastructure to support operations.

FCC Operational Overview

NDMS Support

NDMS is comprised of three federal emergency public health capabilities which are a critical component of Emergency Support Function #8, Medical and Public Health. The four capabilities which comprise NDMS are Response Operations, Definitive Care, Fatality Management and Federal Patient Movement. FCCs enable federal patient movement within the NDMS.

Federal patient movement is typically required to support one of the following missions:

- Patient Evacuation in Support of Mass Evacuation/Stafford Act Event - This mission involves supporting a state request and consists of moving both inpatients and outpatients from healthcare facilities and evacuation locations.
- Emergency Repatriation/Noncombatant Evacuation Operations – This mission is a Department of State function and NDMS provides support through the Administration for Children and Families (ACF). This mission may include moving inpatients returning from overseas medical facilities and additional patients from the Emergency Repatriation Centers.
- Active-Duty Patient Distribution – This mission supports USTRANSCOMS CONUS Patient Distribution Plan and NORTHCOMS Integrated CONUS Medical Operations Plan. This mission consists of distributing service members from the theater of operations to:
    1. DoD Medical Treatment Facility
    2. VA Healthcare Facility
    3. NDMS Partner Healthcare Facility.

NDMS Authorities

The authority and funding for NDMS typically comes from the three statutes listed below:

- **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.
- **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 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.
- **The Economy Act:** Authorizes agencies to enter into agreements to obtain supplies or services from another agency. In the event an overseas conflict generates more

casualties than the DoD and VA Health Systems can care for, DoD is able to request and fund the activation of NDMS to care for injured Active-Duty personnel.

FCC Tasking Process

For impending patient movement requirements, the HHS Emergency Incident Support Team (IST) convenes the ESF #8 Patient Movement Coordination Group (PMCG). The PMCG is composed of representatives from all the NDMS partners. The PMCG coordinates and integrates NDMS operational planning, alerts, activations, and de-activations to establish and maintain an NDMS patient movement common operating picture for HHS and the NDMS partners. The PMCG will determine the frequency for contingency bed reporting requirements, which will typically be every 24 hours during patient movement activities.

When FCCs are required, the PMCG will determine which FCCs are to be activated. The decision to activate FCCs is a collective decision by the PMCG and done with full consultation with the Region Emergency Coordinators (REC), FCC Director, and involved states. This includes coordination of aircraft arrival timeframes with the activated FCCs.

Upon official alert/activation of the FCC, HHS may deploy Joint Patient Assessment and Tracking System (JPATs) Teams and Case Management Teams (CMT).

Mission Assignment

Upon federal, state, local, tribal, or territorial (FSLTT) request for NDMS patient movement and definitive care, a mission assignment (MA) is generated by FEMA to HHS. FEMA accepts the request from the State, after validation from the regional Federal Health Coordinating Official (FHCO) and tasks ESF #8, where HHS is the lead and coordinating federal agency. In a non-Stafford Act event, HHS generates a request for assistance (RFA) for the appropriate agencies to support activation and movement. 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 an RFA. MAs 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.

For DoD, the MA goes to NORTHCOM or PACOM (as appropriate). Since the DoD FCCs are on the Standing Joint Chiefs of Staff DSCA (Defense Support of Civil Authorities) 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) to be prepared in time to receive patients. The MA describes the assistance requested, statement of work, duration, and estimated costs. The following paragraphs describe how the DoD and the VA coordinate and accept official NDMS taskings from HHS.

For the VA the 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 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.

Interagency Agreement

In the event a federal agency requires NDMS patient movement and definitive care to fulfill its mandated mission (e.g., DoD requirement to conduct active-duty patient redistribution), in accordance with the Economy Act, that agency can enter into an agreement with HHS to pay for NDMS support. Under the Economy and Stafford Acts, only the Secretary of Defense has the authority to waive reimbursement. Regarding VA funding, they initially pay for costs of the patient reception site (PRS) operations, before being reimbursed by DoD via the Economy Act.

FCC Operational Status

Advisory

This status implies that a credible threat exists and a requirement for federal patient movement is possible. This status does not authorize reimbursement of FCC and/or PRS expenses. The primary focus of this status is to gain situational awareness of an FCCs capability to receive patients.

During this phase FCC Directors/Coordinators should:

- As directed by their agency or the PMCG validate preliminary FCC readiness status with key Stakeholders.
- Provide preliminary FCC Readiness Report information to their agency, PMCG, and/or HHS ASPR.
- As directed by their agency or PMCG conduct Bed Reporting and update TRAC2ES.
- Upon notification of advisory status provide updates to the key Stakeholders.

Alert

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 typically does not authorize reimbursement of FCC and/or PRS expenses incurred preparing for possible reception of patients. FCCs will have at least 24-hour notice of patient arrival.

During this phase FCC Directors/Coordinators should:

- Validate the Advisory status with higher headquarters
- Ensure contracting officials for both VAMC & VISN are notified of potential unplanned obligations
- Notify all patient reception partners of the FCC Advisory status in accordance with local plans
- Notify NDMS health care facilities of the Alert status and bed reporting requirements
- Conduct periodic bed reporting in accordance with agency instructions
- Validate access to TRAC2ES

- Validate/update the PRS' throughput in TRAC2ES
- Consider mobilizing required equipment at the PRS (This decision is situation dependent and should not incur costs and/or disrupt normal operations at the PRS)

Alert

This status is characterized by pre-incident awareness and FCC preparedness to potentially receive patients. Alert occurs when there is an elevated or credible threat, HHS/ASPR may conduct activities to ready and position FCC resources.

Activation

Upon activation of FCC the FCC Director is responsible for covering all costs associated with patient reception activities. The FCC must immediately start tracking all costs associated for reimbursement purposes. Activation status provides a reimbursement capability for all reasonable patient reception activities. It signifies patients are to be regulated or have been regulated to a PRS under management of this FCC. Coordination between PMCG and the FCC Coordinator will determine the earliest possible arrival time.

The FCC's mission dependent operational hours must be communicated to the FCC Branch Director, and state/local partners. FCCs are expected to have a 24/7 operational capability. However, this is based on many items such as throughput, resource availability, and PRS hours of operation (e.g., airfield hours).

In this phase responsibilities of the FCC Director/Coordinator include:

- Validate the "Activation" status with HHS and/or PMCG
- Activate the FCC Operations Plan
- Account for any potential unplanned obligations – track and report obligations in accordance with agency guidance
- Notify all patient reception partners of the FCC Activation in accordance with local plans
- Mobilize and set-up required equipment and supplies at the PRS
- Notify NDMS health care facilities of the Activation status, and bed reporting requirements
- Coordinate with their PMCG representative to ensure NDMS support teams (CMT, JPATS, PMI) have contact and physical location information for arrival and integration
- Establish communications with TRANSCOM Liaison through already established agency/service lines of communications.
- Conduct periodic TRAC2ES bed and throughput reporting in accordance with PMCG instructions (e.g., daily)
- Ensure ground transportation assets are mobilized to transport patients based on patient arrival information
- Provide regular updates of patient movement information to NDMS health care facilities
- Initiate and maintain aircraft logs which include but not limited to; date, arrival time, tail number, aircraft type, Aerial Port of Embarkation (APOE), and number of patients

- Provide Operation Summary (OPSUM) Reports as required, ensuring Health Insurance Portability and Accountability Act (HIPAA) compliance
- Capture after action review (AAR) items

FCC Operations & Patient Movement to the FCC and NDMS Health Care Facility

TPMRC-A regulates NDMS patients to an FCC based upon bed availability reporting and coordination with the FCC. In turn, the FCC matches each NDMS patient with a bed in an NDMS health care facility that has the necessary health service support capabilities.

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

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 annexes that are included in this FCC Guide identify specific requirements to execute the FCC mission.

FCC Deactivation

When it is determined that a PRS is no longer required or able to receive patients, it will be deactivated. The PMCG, through appropriate agency/service representative, will notify the FCC of deactivation of their PRS.

The FCC will still have on-going responsibilities related to demobilization, billing, Case Management Team coordination, reimbursement, resupply, and after-action reviews.

Annex A: Federal Coordinating Center (FCC) Director and FCC Coordinator Responsibilities

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

Plan

Approves the FCC Operations Plan which details functions associated with reception, assessment, staging, transportation, and hospitalization of arriving patients, to include non-medical attendants. Provides direction to the FCC Coordinator.

Train and Assess

- Ensure the development, exercise, and evaluation of local FCC/PRS plans
- Ensure a full-scale exercise (FSE) at least once every two years (DoD) and three years (VA) that tests the FCC/PRS plan of the FCC and the supporting partners
- Conduct an annual exercise to test selected tasks of the FCC/PRS plan
- Ensure that FCC and PRS staff receives appropriate training in FCC operations (as determined by the owning agency/service)
- Conduct an After-Action Review/Report (AAR) at the conclusion of the FCC FSE
- Ensure FCC Operational Readiness as directed by owning agency/service
- The FCC Director will designate personnel to perform PA duties, to include media relations, community relations, sharing of FCC information, and providing PA training for the FCC.

Operate

- Activate local FCC/PRS plans as indicated in activation notifications
- Ensure that bed availability reporting is accomplished as directed
- Upon activation ensures reception, sorting, staging, transportation, and hospitalization of arriving patients occurs efficiently
- Ensures immediate needs are met at the PRS for non-medical attendants and service animals as required
- Provide administrative support for patient control and proper patient accounting
- Assist federal patient movement teams as needed to ensure accurate patient tracking data
- Maintain 100% patient accountability in JPATS. Ensure patient information is updated in patient tracking systems at the local, state, and federal level as dictated by local policy
- Collect and document all costs incurred and expenditures for the FCC operation. Ancillary services, such as ambulance transport, will be documented and request for reimbursement submitted
- Ensures the tracking patients, non-medical attendants (NMA), and service/companion animals received at the PRS.

- Ensure payment of all incurred expenses prior to submission for reimbursement per agency direction

FCC Coordinator Roles and Responsibilities:

Plan

- Identify and recruit local non-federal hospitals for NDMS enrollment and participation
- Coordinate with designated facility staff to support PRS requirements to include personnel and equipment
- 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
- 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, health care coalitions, medical societies, public safety, police and fire services, and local Medical Reserve Corps)
- Provide HHS/ASPR with contact information to NDMS hospitals to facilitate medical claims processing
- Manage/coordinate FCC communication procedures, processes, and equipment to support local patient reception and distribution operations
- Identify local emergency services communications or tracking systems and ensure integration into the FCC operations
- Facilitate the development of a Public Awareness/Affairs Plan to publicize FCC events and local partnerships
- Ensure support contracts for ancillary services (such as porta-toilets and food service) are drafted, coordinated, validated, and reviewed annually
- Assist federal patient movement teams as needed to ensure accurate patient tracking data
- Conduct patient accountability and destination tracking and ensure information is updated in patient movement tracking systems as dictated by local policy

Train and Assess

- Develop, update, and issue guidance and planning documents, in coordination with facility and community partners on supporting efforts
- Plan, develop, and execute training, a discussions-based event (drill or tabletop exercise) or a focused operations-based functional exercise in accordance with agency/service policy
- Plan and execute a multi-agency full-scale exercise in accordance with service/agency policy. Develop an exercise plan and exercise evaluation guidance documents as part of a deliberate planning process
- Provide annual orientation on the roles and responsibilities of those organizations and individuals as described in the FCC Operational Plan--Examples include:
    - NDMS partner health care facilities (through the NDMS Steering Committee)
    - State and local health associations
    - EMS
    - Emergency management agencies
    - Hospital councils

    - Public safety
    - Police and fire services
    - Medical Reserve Corps (MRC)
- Ensure the FCC maintains active TRAC2ES and Joint Patient Assessment Tracking System accounts (This includes training individuals on JPATS)
- Train the FCC staff and other individuals designated in the FCC Operations Plan to maintain proficiency. Some elements may require "Just-in-Time" training
- Educate local NDMS partner facilities on the NDMS hospital bed reporting requirements.
- Participates in nationwide NDMS and ad hoc local bed reporting exercises
- Conduct FCC Self-Assessment annually utilizing Annex P. Notify higher headquarters within 24-48 hours if the FCC mission capability has changed significantly
- Update and gain FCC Director certification of Operational Readiness Reports as directed

Operate

- Collect bed availability data from each NDMS facility and accomplish TRAC2ES reporting as required
- Ensure communications and liaison are established with the Theater Patient Movement Requirements Center-America (TPMRC-A) for the receipt of regulating decisions, evacuation mission information and patient medical data, as applicable
- Provide PMCG agency/service representative with primary and alternate points of contact to ensure 24- hour availability, as needed
- Notify the FCC Director, the Patient Reception Team (PRT), local EMS coordinators, all affected health care facilities, higher headquarters, and all other applicable agencies and individuals when FCC alert status has been received
- Assist federal patient movement teams as needed to ensure accurate patient tracking data is recorded and maintained
- Arrange transportation to move patients from reception sites onward to local participating NDMS partner health care facilities
- Until the JPATS teams arrive at the FCC, the FCC is responsible for all data entry into the JPATS system If available, deployed JPATS Team will be responsible for entering patient tracking data into the JPATS system
- Ensure patient accountability and destination is updated in patient movement tracking systems at the local and State levels as dictated by local policy
- Provide liaison assistance to the HHS Case Management Team for case management, repatriation, and definitive care reimbursement
- Ensure expenditures for support services are being accounted for and reported through appropriate channels

Annex B: Facilitate and Maintain NDMS Health Care Facility Enrollment and Community Support

Purpose:

The purpose of this annex is to assist the FCC in recruiting and maintaining the support of healthcare facilities in PRAs.

Responsibilities

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

Procedures

The FCC enrollment effort should target local general acute care inpatient health care facilities, although other bedded health care facilities should be considered, especially if they express a desire to participate or possess key specialty beds. In general, NDMS participating health care facilities should be within a reasonable distance for patient transportation given the local road network and relevant traffic conditions. Health care 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 Health Care Facility/Partner Memorandum of Agreement (MOA) for Definitive Medical Care. The MOA must be signed by the participating NDMS medical facility, and the FCC Director as the local representative of the NDMS.

As part of the MOA, participating health care facilities agree to participate in NDMS training and exercises. Various accrediting bodies require health care facilities offering emergency services or are community-designated disaster receiving stations conduct at least one patient influx exercise per year.

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 health care facilities for NDMS enrollment and participation. This includes drafting an information package to provide to prospective enrolling health care facilities, including an introductory letter from the FCC Director, a copy of the FCC Guide, and a NDMS Health Care Facility/Partner Memorandum of Agreement (MOA) for Definitive Medical Care ready for signature.

The FCC Coordinator 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.

The FCC Coordinator should collaborate with local, regional, and state emergency services agencies, hospitals, Health Care Coalitions (HCC), long term care, and public health services. This collaboration should also include public safety officials, 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.

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:

- Health care 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

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 several 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

An established committee, consisting of local medical facility, medical, public health, public safety, emergency management and emergency medical services officials, ESF #6 representatives, representatives of voluntary organizations, and elected officials organized in an NDMS PRA to assist in the development 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.

Health Care Coalitions (HCC)

Groups of individual healthcare and response organizations – such as hospitals, EMS providers, emergency management organizations, public health agencies, and more – working in a defined geographic location to prepare for and respond to disasters and emergencies.

Local hospital council/State hospitals (not already in an HCC)

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.

Radiation Injury Treatment Network (RITN)

The Radiation Injury Treatment Network® (RITN) provides a national response to a casualty incident resulting in marrow-toxic injuries. Irradiated casualties are expected to be decontaminated, stabilized, and assessed prior to their arrival at RITN medical centers.

The National Disaster Medical System will oversee the distribution of patients to FCCs which have participating RITN hospitals. FCCs will then coordinate with local public health and NDMS health care facilities to distribute patients to the appropriate hospital. After a casualty incident, formal transport of patients to distant RITN centers is expected to be delayed by at least 96 hours.

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.

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

Annex C: NDMS Health Care Facility Bed Availability

Purpose

The purpose of this annex is to assist the FCC in collecting and reporting medical facility bed availability and throughput using the TRANSCOM Regulating Command and Control System (TRAC2ES). Management of TRAC2ES is the responsibility of US Transportation Command, located at Scott Air Force Base, Illinois.

Definitions

Available Beds

NDMS partner health care facilities will report the number of licensed 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 HHS.

Bed Report

The capacity (the number of patients by bed type a facility can accommodate at a given point in time) for NDMS facilities within a PRA (exercise or real time) to receive, admit, and treat patients evacuated because of NDMS operations. When activated, the PMCG 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 accurate bed capacity and capability.

NDMS Bed Reporting Schedule – FCCs will update TRAC2ES as required per HHS/ASPR Memorandum.

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 the APOE to the FCC. During this process TRANSCOM matches NDMS patients to designated FCCs based upon bed availability reporting. In turn, the FCC matches each NDMS patient with a bed in a NDMS Health Care Facility that has the necessary health service support capabilities.

Throughput

The maximum number of patients that can be received at the NDMS PRS, off-loaded, staged, assessed, 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.

Responsibilities

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

- 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
- Notifies NDMS partner health care facilities to report available beds in the categories listed above, per state and local procedures
- Reports FCC bed availability totals into TRAC2ES, per instructions

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. Both figures (bed availability and throughput) are important to TRANSCOM ability to plan effectively. Factors that should be considered and effect throughput include:

- Type, quantity and availability of ground transport resources and critical care equipment.
- Patient reception team staffing
- Medical facility surge capability may vary by facility. Patient processing time and available resources may limit the number of patients a facility can accept in a short timeframe, regardless of available beds
- Airfield operations, to include hours of operation, ramp/hanger availability, aircraft servicing, and access control
- Ground operations intervals – Many key details need to be considered when factoring for sustained operations:
    - Deplaning time
    - Transportation time to move patients to participating health care facilities
    - Reset time for next arriving flight
    - Personnel sustainability factors.
- Duration it takes for transportation assets to return to FCC and be prepared to move additional patients
- Airport and Runway constraints

Annex D: FCC Operations Plan Development

Purpose

The purpose of this annex is to assist FCC Directors and Coordinators in developing and maintaining a comprehensive plan for their Patient Reception Area.

Responsibilities

The FCC Director is responsible to ensure the development, exercise, and evaluation of the local FCC operations plan. Normally, this is accomplished by the FCC Coordinator in conjunction with the local NDMS Steering Committee which includes the local partners necessary to accomplish the requirements.

Plan Development.

The development of an FCC Operations Plan is critical to the viability of the NDMS. The key to success is the thoroughness and effectiveness of local planning. Each local PRA community is unique. The degree of sophistication of community disaster planning and the availability of resources that can be incorporated into the FCC plan will vary widely. Each FCC plan must be tailored to its community. The FCC Plan should include specific information for each Patient Reception Site (PRS). 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 can be used as a basis for the FCC 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 Plan.

The FCC Operations Plan should consist of the following sections:

Concept of Operations

- Provide a concise mission statement
- Define the Patient Reception Area for the FCC
- Describe the roles and responsibilities of principle agencies, teams, and individuals
- Identify all applicable references, including the National Response Framework as well as all applicable local and state disaster plans
- Identify applicable state and local governmental and non-governmental bodies, including local EMS agencies
- Identify primary and alternate Patient Reception Sites (PRS) (e.g., airfields, railheads, bus terminals, and any other place patients will be received at and distributed from)
- Identify local resources for transporting patients
- Identify all NDMS facilities to which patients will be distributed. Reference the Memorandum of Agreement the FCC has with the NDMS Health Care Facilities

FCC Advisory/Activation

- Define who is responsible to put the FCC on ADVISORY or ACTIVATION status (reference comment on page 6 above – Alert vs Advisory status) after a valid Mission Assignment/Sub-Tasking has been received
- Describe the processes for notifying the FCC staff
- Describe the processes for notifying all applicable State, local governmental and non-governmental bodies, and EMS agencies
- Describe the processes for procuring resources for transporting patients
- Describe the processes for notifying NDMS facilities
- Describe the process for notifying primary and alternate facilities where patients will be received and then distributed
- Post all recall rosters and POC contact lists in this portion of the plan; describe the process to keep this information current

FCC Operations

- Describe FCC staff roles, responsibilities, and shift schedules
- Describe FCC internal communications (logs, reports, etc.)
- Describe “Access Control” to the PRS
- Bed Availability Reporting (See also Annex C)
- Provide definitions of terms, including the list of medical categories
- Describe the processes for collecting initial and recurring bed reports, including “throughput”
- Describe the bed reporting procedure into TRAC2ES; describe how to establish an account; list persons who have accounts

Medical Regulating and Patient Evacuation to the FCC/PRS

- Describe the role of the TPMRC-A
- Describe the processes and procedures for coordinating patient movement missions between TPMRC-A and the FCC

Patient Reception and Staging

Describe the patient reception site(s). Patients arriving from disaster sites will generally be received at a single patient 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 assess 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.

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.

Medical equipment/supply requirements and staging.

This should include PMI handling, cleaning, and return.

Transportation

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 health care 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 health care 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)

Describe the roles, processes, and procedures for managing and tracking the use of local transport resources. Tracking will include using Incident Command Standard (ICS) Forms for tracking resources. (ICS Form 218, Support Vehicle/Equipment Inventory)

Identify primary and alternate routes from the patient reception site(s) to local health care facilities. Ensure advance coordination with local law enforcement agencies is made if traffic control and additional security are needed

Patient Administration and Tracking

The FCC Director has overall responsibility for tracking patients, non-medical attendants (NMA), and service/companion animals received at the PRS. It is important to note that JPATS teams and Case Management Teams will be deployed to FCCs that are receiving patients. However, FCCs must be prepared to conduct patient, NMA, and animal tracking in the event the JPATS and/or CMT teams are unavailable.

The FCC Coordinator is responsible to ensure the FCC tracks patient movement as requested by local and federal agencies. The primary method utilized by NDMS is the Joint Patient Assessment and Tracking System (JPATS). However, the FCC must develop a back-up tracking system to ensure accountability is maintained should the JPATS system become unavailable.

During any FCC activation, JPATS and CMT Teams should always be activated (one JPAT and one CMT team at each FCC). The JPATS cases (laptops, phones, chargers) should be sent to the FCC as soon as it is Alerted to ensure it is on-hand.

Patient registration information required in JPATS:

- 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

Patient tracking entries requirements

- Inbound to the PRS
- Arrival at the PRS
- Transfer to the NDMS facility
- Status at arrival to the NDMS facility
- Movement within the NDMS
- Discharge from the NDMS
- *In the case of military patients, the owning service will track their patient status through the point the military patient is returned to the responsible Service.

Coordinate with the JPATS Teams and CMT Teams, if assigned.

Describe the roles and responsibilities of GPMRC Liaisons and Military Patient Administration Team (MPAT), and USTRANSCOM Joint Patient Movement Enablers (JPME) if available.

Identify contact information for each participating NDMS medical facility for normal operating hours and after regular working hours.

Describe the roles and responsibilities of each participating NDMS medical facility. The medical staff of that facility will accomplish the patients' day-to-day medical management and care. The NDMS facility will provide medical care using its own procedures and forms. The NDMS medical facility should provide patient information to the Case Management Team daily (e.g., case management).

Ensure the following information is included in a back-up/paper tracking system adopted by the FCC (See Appendix 4 of Annex D for examples):

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

The FCC Plan should describe the roles, processes, and procedures for tracking patients and non-medical attendants at the PRS:

- Incoming
- Registration
- Updates
- Transfers

Non-Medical Attendants: Family member(s) or other person(s) who are transported via federal (or federally contracted) assets to accompany and support an NDMS patient.

Weapons

Plans should include a safe location, within the respective PRA, 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 and Controlled Substance

Narcotics/Controlled medications transported with patients stay with patients. Local procedures for handling narcotics/controlled medications will be followed.

Mortuary Affairs

Plans should be developed in coordination with the SLTT medical examiner or coroner for patients that expire enroute. 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, with prior approval from next of kin. The Case Management Team will notify next of kin and coordinating return with the Medical Examiner.

Family Assistance Branch

The purpose of the Family Assistance Branch is to provide mental health support and counseling to patients, non-medical attendants, staff, and volunteers. This branch may include mental health professionals from the VA, Red Cross, and faith-based organizations.

Additionally, the Family Assistance Branch will work with the families to address their behavioral health needs and other general support requirements. They will also work with the HHS Case Management Team in assisting a family to locate their loved one or friend through the hospital's patient tracking program (working with the FCC Coordinator)

Pets and Service Animal Planning Guidance

It is likely that some service animals may accompany the patients. Therefore, coordinate with local/county/state animal services to make provisions for care, holding, and feeding.

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 collect/maintain service animals' identification card, medical treatment/immunization records or other written documentation (if available).

Appendix 1 to Annex D: Patient Reception Operations

The FCC Director implements the FCC Operations Plan as required by the specific activation notification. This may include, at full activation, alerting all member health care facilities and all elements of the local patient reception and ground transport agencies. The FCC Director may find it advisable to initiate local bed reporting in anticipation of receiving bed reporting instructions from GPMRC.

The FCC Coordinator should ensure that the FCC Director, the PRT, local EMS coordinators, all affected health care facilities, higher headquarters, installation commanders, and all other applicable agencies and individuals are notified when patients are regulated to the FCC/PRS. Depending on the information received from GPMRC/TPMRC-A, the FCC may elect to begin the process of assigning patients to specific local health care facilities prior to the arrival of the patients. The FCC Coordinator ensures reception, assessment, 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 health care facilities. Accordingly, this implies close coordination between the FCC Incident Management Team and local NDMS Health Care facilities.

Aeromedical Patient Reception Operations (DoD)

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

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

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

- Thumbs- up = “Go”
- Crossed arms = “Stop —don’t come on board the aircraft”
- 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. If you see a thumbs up, things are good to go. 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 but heavier patients require a 4-person carry. It is 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 like 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 must 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 health care facilities.

Aeromedical Patient Reception Operations (Air Ambulance)

The reception of a patient via an air ambulance is less complex and FCC staffing can be adjusted as needed. In most cases the ambulance will be allowed onto the flight-line. The flight medical crew will coordinate patient hand-off directly with the ground ambulance crew to include medical records and medical equipment. It is still important to document the patient’s and non-medical attendant’s information on the tracking sheet to subsequently update JPATS.

Appendix 2 to Annex D: Medical Regulating

Medical regulating is the coordination and control of moving patients to participating NDMS health care 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 movement, locating available beds, and coordinating the transportation means for movement. Careful control of patient movement to appropriate health care facilities is necessary to:

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

The following factors influence the scheduling of patient movement

- Patient's medical condition (stabilized to withstand transport)
- Availability of transport 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:

Theater Patient Movement Requirements Center Americas (TPMRC-A): The TPMRC-A 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 TPMRC-A 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.

Aeromedical Evacuation System (AES): A system that provides:

- Control of patient movement by air transport
- Specialized medical aircrew, medical crew augmentees, and specialty medical attendants and equipment for inflight medical care
- Facilities on or in the vicinity of airports and air bases for the limited medical care of in-transit patients entering, enroute, or leaving the system

*Note: Reception of patients per FEMA national ambulance contract aircraft has different planning factors than reception of DoD aircraft. FEMA contract aircraft are normally for patients with higher acuity and can hold only 1-2 patients.

Medical Regulating Process: The TPMRC monitors patient evacuation requests and passes requirements to the Aeromedical Evacuation Liaison Team (AELT). At the same time, they pass airlift requirements to the Aeromedical Evacuation Control Team (AECT) seeking an aircraft to perform the evacuation mission. The AELT requests the TPMRC/AECT to move patients. Included in the request are the Originating Medical Facility (OMF) and the destination airfields. In the case of NDMS, these airfields are those associated with the activated FCCs.

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 to meet the evacuation requirements.

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

Appendix 3 to Annex D: Patient Movement Items (PMI) Management

Purpose:

This Appendix describes the processes to procure, track and return PMI.

PMI must be returned promptly from a medical facility to prevent an equipment shortage in the disaster area. Once patient care is transferred to a medical facility or other such provider, it is critical that the PMI equipment be returned to the closest PMI cell. The FCC Coordinator should designate and train individuals on recycling PMI back to the PMI Cell. Health care facilities will decontaminate and clean PMI equipment IAW local infection control guidelines.

The FCC Coordinator will designate a location for collecting PMI from the PRS. Health care facilities recycling PMI should contact HQ AMC/SGXM COM 1-877-286-1931. Questions regarding recycling PMI should be directed to the HQ, AMC.

Annex E: Training and Exercises

Purpose

The purpose of this Annex is to provide planners, emergency managers, 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 state and local authorities in planning for the reception of patients of a disasters or national emergency.

As with any planning effort, the development of the FCC 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.

Training

Training provides 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 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 Plan to the FCC NDMS Steering Committee.

The following is a recommended list of courses FCC Directors and Coordinator's should complete:

- DMRTI FCC Course
- HSS JPATS Training
- OEM FCC Orientation Training

Exercises

FCCs should conduct full scale patient reception exercises every three years, at a minimum. 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 Plan. Exercises should test the following operations:

- Patient reception
- Off-loading
- Assess and staging at selected patient reception site
- Patient assignment to participating NDMS Health Care Facility
- Transportation of patients (may be simulated)
- Patient tracking (to include paper, JPATS and, if applicable, local tracking system)
- Management of Non-Medical Attendants
- Communications
- Unified Command

Patient symptoms/conditions should be tailored based on the exercise scenario. 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.

Identify key issues and lessons learned by utilizing this guide and local plans and policy for creating After Action Reports.

Considerations

The following items may incur costs:

- Hangar or other shelter
- Ambulances:
- Consider 10 or 15 ambulances
- Consider 1 bus
- Command/Control:
- Local jurisdiction may contribute their command/control vehicle(s) and communications equipment to participate in the exercise.
- Exercise control may be provided by local FCC staff, or by other personnel to be brought in.
- Personnel: Potential overtime costs
- Clinical PRT personnel
- PRT support personnel
- “Patients” (35) and Non-Medical Attendants
- Fire Department.
- Security
- Social Services
- Animal Control
- Food: Will be provided by owning agency/service (Coordinate 6 weeks out – contact FCC/Operations Program Manager)
- Toilets: Consider portable units, if required.

Training and Exercise Funding

FCCs must request exercise and training funds from their respective agency and/or service. Each agency and/or service is responsible for adequately funding an FCC's training and exercise program. FCCs should consider developing exercise opportunities through collaboration with the community. Should funding be reduced or not available the exercise planning team should modify the exercise based on available funding.

Annex F: Financial Management

Purpose

The purpose of this annex is to provide additional guidance regarding the funding and reimbursement process for training, equipping, and operating FCCs.

FCC Alert Expenses

Alert Costs

Generally, there is no funding available for alert activities (such as rental charges to set up in a hangar, procurement of equipment, staffing). 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.

FCC Activation and Operational Expenses

The mission assignment (MA), sub-tasking, or interagency agreement will specifically stipulate funding scope and authority (e.g., whether from DoD or HHS).

The FCC Director, or the designated fiscal authority, will collect claims/bills for appropriate charges for those services incurred by the FCC during PRS operations. Bills for goods and services incurred by FCCs will be paid by the FCC Director and forwarded up through the agency's/service's respective financial process. See Appendix 1 to Annex G.

*Important: The FCC Director must ensure all obligations are approved ahead of time per fiscal/contracting protocols. Past real-world activations have resulted in Unauthorized Obligations.

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 Reimburse Other Federal Agencies

Civilian personnel costs are eligible for reimbursement under some conditions. For example, if a city fire department provided personnel to assist with assessment, 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 daily as they incur.

Civil Service personnel costs are 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 are 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 operational 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. Documentation is critical.

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

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

Basic Provisions of Financial Claims Processing of Definitive Care

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 health care facilities identify if 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.

Compensation for NDMS-related claims will be reimbursed at rates, in accordance with the NDMS Health Care Facility/Partner Memorandum of Agreement for Definitive Medical Care.

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

Responsibilities for Financial Claims Processing

The FCC Director:

Is responsible for consolidating the administrative cost and expenditures for all personnel and logistical support during activation. This would include PRS staffing, 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 Site.

Shall maintain a process to capture, track, and validate all expenditures for supplies, equipment, and services associated with the PRS.

Pay all invoices associated with PRS operations prior to submitting for reimbursement.

The FCC Coordinator will:

Provide the HHS Case Management Team with locations of NDMS patients to facilitate medical claims processing.

Provide patient validation data to the HHS Case Management Team. This information should include all documentation for patient and non-medical attendant assignment. Additionally, all patient and non-medical attendant information must be updated in JPATS.

NDMS Health Care Facilities and Partners will:

Submit Affidavit of Non-insurance for uninsured patients and submit associated final bills for payment directly to the appropriate HHS/ASPR Fiscal Intermediary.

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

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

Claims for Transportation of Civilians

The FCC Director will ensure payment of transportation is made prior to submitting for reimbursement. Costs for transporting NDMS patients to receiving medical facilities will be authorized according to the Mission Assignment or Sub-Tasking which allows for all FCC operational activity expenses.

Patient Validation and Tracking Data

A paper method process should be established to track and document patient and non-medical attendants. These documents can be used to update TRAC2ES and JPATS in the event of system failures.

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

Annex G: Logistical Support

Purpose

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

Logistics Section Chief Responsibilities

On request, procures and delivers initial supplies and equipment to the NDMS Patient Reception Site (PRS).

Coordinates food, water, and refreshments for patients and non-medical attendants.

In coordination with the FCC Incident Command, determine if FCC personnel can be released to get food on their own and/or have nearby access for food and refreshments.

Ensures adequate number of restrooms to include ADA accessible are available.

Supports future resupply efforts in support of continued FCC operations with onsite personnel.

Obtains additional logistical support vehicles and drivers, if/when requested.

Periodically, inspects and maintains supplies and equipment, and any automation support equipment.

Continually maintains and inventories caches of materiel to support FCC operations.

Ensure an adequate amount of paratransit vehicles are available.

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 and non-medical attendants. Medical logistics refers to the supplies and equipment required for patient care at the PRS.

Both logistical types 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 must be replenished as needed.

Equipment and supplies that are used to support the FCC/PRS must be documented and tracked for payment and reimbursement.

Non-Medical Logistics planning considerations

- Space for services, supplies and equipment, ideally environmentally controlled.
- Water, food, and refreshments for staff, patients, and non-medical attendants will be required. Consideration should be given to dietary requirements (elderly, children, religious groups, vegan, etc.)

- Some patient's arriving may not be wearing clothing suitable for weather conditions at the PRS. This may require coats, blankets, or patient gowns as well as the need for collecting and sending the items with the patients
- PRT requirements such as inclement weather gear, personal protective equipment, and ICS vests
- Sanitation requirements for personnel hygiene and toilets, not only for the PRS staff, but the need for increased use as NDMS patients and additional support personnel arrive to support the PRS
- Hazardous medical waste, such blood products, sharps, pathological, and other waste that is considered hazardous material
- Weapons/contraband management (Security Forces/Police). Patients may arrive at the PRS with contraband. Procedures to address should be considered
- Office supplies and computer support equipment to include printers
- Transportation requirements for both VAMC and community partners

Medical Logistics planning considerations

- Medical supplies and pharmaceuticals. The PRS should have enough supplies on hand to match the FCC's throughput.
- There needs to be an Advanced Life Support (ALS) capability at the PRS.

FCC Caches

The following equipment and supplies are designed to support patient reception operations, and are recommended for consideration:

Patient Reception Equipment Inventory

Items	Quantity Required	Vendor	GSA #	Mfr. Part #	Cost
Board, Dry erase	3	GSA Advantage	GS-02F-0099T	BVCMA0312170MV	194.34
Bullhorn	1	GSA Advantage	GS-03F-005CA	THUN1200	169.27
Chairs, Folding	40	GSA Advantage	GS-28F-028AA	1210	761.60
Litters	50	GSA Advantage	GS-07F-0188Y	60-0001	16450.00
Over Sized Litters	10	GSA Advantage	GS-07F-067CA	60-0023	7183.80
Litter Straps (3/litter)	180	GSA Advantage	GS-07F-188AA	SK-957	8208.00
Litters, Wheeled with Case	20	North American Rescue	60-00631	60-0063	42054.60
OSL Litter Stands (3/set)	10	GSA Advantage	GS-07F-067CA	60-0029	2196.40

Litter Stands (2/set)	20	GSA Advantage	GS-07F-0188Y	60-014	3220.00
Back Rest, Litter	10	GSA Advantage	GS-07F-067CA	60-0027	1037.70
OSL Back Rest	10	GSA Advantage	GS-07F-067CA	60-0024	1078.00
Folding Cot	10	ArmyProperty.com		7105-00-935-0422	1199.50
Tables, Folding (72”x30”)	10	GSA Global Supply	7110-01-671-6415	7110-01-671-6415	1533.60
8 pc ICS Vest Kit	1	GSA Advantage.	GS-07F-0100W	DMS-05301	533.11
Reflective Safety Belt	30	GSA Global Supply	FMRA9-3012509Y	FMRA9-3012509Y	810.00
Litter IV Pole	20	GSA Advantage	GS-07F-067CA	60-0008	685.00
Spine Board	2	GSA Advantage	GS-07F-0100W	JSA-365-SEV44	282.40
Leather Gloves (Medium)	15	GSA Advantage	GS-02F-0221W	MCSCRW3215L	102.45
Leather Gloves (Large)	20	GSA Advantage	GS-02F-0221W	MCSCRW3215L	136.60
Pack N Pop Traffic Cones 5 per case	5 cases	GSA Advantage	GS-07F-0100W	05-501-05	1139.90
Anchor Ring Recessed Pkg. 6	2 pkg.	GSA Advantage	GS-21F-033BA	4HXF3	70.68
Tie-Down Strap Ratchet	6	GSA Advantage	GS-21F-0015X	2VKP6	190.08
Wheelchair	2	GSA Advantage	V797D-70060	T420RFAP	808.08
Bariatric Wheelchair	2	GSA Advantage	V797D-50420	926L	1778.90
				TOTAL	94105.41

Annex H: Communications

Purpose

The purpose of this annex is to assist the FCC in establishing and managing communication equipment and protocols in support of patient reception operations. The FCC coordinator should ensure communication networks are compatible, integrated, and redundant (backup) with local and State agencies as applicable. The PRS should have access to, and personnel trained on the Joint Patient Assessment and Tracking System and local/State systems patient tracking systems as applicable.

Recommended Equipment and Frequency of Testing

The table below illustrates various 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.

Communication Equipment

Type of Equipment	Quantities
Laptop computers with internet access	
Printer	
Scanner/Fax machine	
Satellite phone with auxiliary antenna	
Cellular phone with charger	
Local Fire EMS Radio with charger and extra battery	
JPATS Scanner	
Handheld Radios	
Locked cargo boxes with wheels or luggage carriers (to transport and store equipment)	As needed

The following should be considered:

- Prepare for contingencies. For example, expect to have periods of intermittent or no connectivity where you need to resort to tracking and documenting on paper (e.g., FCC Tracking Form; TRANSCOM Regulating and Command and Control Evacuation System (TRAC2ES) Up-loadable Contingency Spreadsheet (TUCS) and JPATS reports).
- It is critically important to maintain and update your equipment, including software, and

most importantly to know how to use it. Best practices include utilizing computers, radios, phones, and accessories identified for use by FCCs on a frequent basis to ensure familiarity with the systems and maintain appropriate software updates.
- Since TRAC2ES and JPATS are web-based systems, internet access is needed. Ensure internet access is available and established at the PRS.

NOTE: National security and emergency preparedness (NS/EP) personnel need to transmit critical messages to coordinate emergency operations even when traditional means of communicating via landlines and cellphones are damaged or destroyed. The Shared Resources (SHARES) High Frequency (HF) Radio Program, administered by the Department of Homeland Security's (DHS) National Coordinating Center for Communications (NCC), provides an additional means for users with a NS/EP mission to communicate when landline and cellular communications are unavailable. The SHARES program should be explored by FCCs to find Auxiliary Communication (AUXCOMM) volunteers to augment conventional communication methods.

Training

The FCC Coordinator should be familiar with how to set up equipment, operation of equipment, use of JPATS, and troubleshooting. Equipment manuals and maintenance/testing schedules should be readily available.

Exercising

FCC communications and information systems (e.g., JPATS) should be incorporated and evaluated as part of FCC exercises.

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://trac2es.transport.mil/
- TRANSCOM Regulating and Command and Control Evacuation System (TRAC2ES) Exercise: https://exercise-trac2es.transport.mil/
- JPATS 2.0 (Training): https://teams2.hhs.gov/PETSDev/protected/home.do For JPATS field support (e.g., helpdesk), contact NDMSHelpDesk@hhs.gov.

Annex I: Information Requirements

Purpose

To prepare the FCC to report relevant information in a timely manner to partners and various agencies. The agency will coordinate with the FCC Director on reporting requirements and timelines. The following is a listing of information requirements FCCs may have to answer during each phase of operations. Also see Appendix 1 to Annex J for the Operations Summary Report template.

Advisory

- 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.
- 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/regional considerations, etc.)
- What is the FCC throughput
- How much time is required if the FCC is notified of Activation before it will be able to receive patients
- Current NDMS bed availability within PRA

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
- What was the actual time the FCC received the first patients
- How many patients have been regulated and/or have arrived at the PRS
- How many and what category of patients have been transported to which NDMS health care facilities
- How many non-medical attendants arrived, where are they staying, etc...
- How many of each bed category does the FCC have remaining? (Keep this count throughout the operation)

Deactivation

When it is determined that a PRS is no longer required or able to receive patients, it will be deactivated. The agency and/or PMCG will notify the FCC of deactivation of their PRS. The FCC will still have on-going responsibilities related to demobilization, billing, Case Management Team coordination, reimbursement, resupply, and after-action reviews.

- How many and what categories of patients were received at the PRS
- How many patients are still in NDMS partner medical facilities and which medical facilities
- How many patients were discharged from NDMS partner medical facilities
- What equipment/supplies were used and require reimbursement?

- 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, communications, etc.)

Critical Information Requirements (CIRs)

During any phase of FCC operations if one of the following occurs it must be reported to the HHS SOC through the NDMS Desk. CIRs may be updated at the beginning and during a response.

- Injury/illness/death of deployed ASPR personnel
- Local weather advisory indicating development of potentially damaging weather system, environmental conditions
- Any current or unanticipated (unplanned) evacuations from assigned sites; movement to alternate locations
- Unplanned incident impacting ability to respond such as a worker safety issues
- Transportation issues that will cause significant detriment to the movement of HHS personnel or assets in the accomplishment of mission
- Sustained loss of communication at mission sites
- Any threat of violence or attack, violent protest, civil unrest, or large demonstration near FCC operations
- Suspicious person, package, material/substance, or vehicle; law enforcement investigation in proximity to FCC operations
- ASPR teams have completed operations and have started "site breakdown"
- Local Significant degradation or inundation of local EMS services, healthcare systems, or infrastructure (within incident)
- Decrease in capability due to loss, malfunction, or reduction of team equipment and/or supplies
- Unusual/unexpected outbreak, contagious disease, widespread illness, or disease/injury patterns at incident sites
- Breaking news highly critical of HHS operations; activity or action that may discredit USG operations or garner unwanted public attention
- Unanticipated change in support/deployment timelines
- Unusually high number of patients (significant deviation from typical baseline at site)

Annex J: 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 will designate personnel to perform PA duties, to include media relations, community relations, sharing of FCC information, and providing PA training for the FCC.

The Public Affairs Officer (PAO) report directly to the FCC Incident Commander/Director and provides PA support staff to the FCC. The goals of the PAO are:

- Provide timely and accurate FCC operations information to local and state partners, media, VA, and other inter-agencies as required
- Prepare staff and key personnel for speaking engagements with the media
- PA personnel must 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
- 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

FEMA Emergency Management Institute (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 K: Health of System Report

Purpose

The Health of the System Report (HOSR) gives an overall assessment of the current capability of the system that is comprised of an FCC and the applicable PRC(s). The program managers at the Agency/Service level are responsible for providing the HOSR but it will require information gathering and review from the FCC Directors and Coordinators.

The report will utilize already existing manning, personnel and equipment standards established by the owning agency/service of the FCC. The purpose of using agency/service standards and not a single standard across all FCCs, is this allows each agency/service to account for their FCCs unique mission (including missions outside the FCC role) and manpower utilization policies. It also acknowledges the agency/service are best positioned to understand the unique context required to determine an FCCs operational capability.

The report will have three categories and each category will have unique reporting requirements and mechanisms. The report will consist of the following sections.

The Agency/Service level FCC program managers will dictate how the report will be collected and submitted by the FCCs. Agency/Service Program Managers will forward their HOSR to HHS ASPR NLT the 15th of each month. A synopsis of the collected reports will be presented at the Senior Leader Council on Patient Movement which will give an assessment of the health of the National FCC System.

FCC Available Resources

This section will measure the percentage of resources available at a single point in time and within a 24-hour period. The report will measure the % of available personnel, % of fully trained personnel and % of resources.

Personnel Availability (PA)

This category will be presented as a percentage. The denominator will be the agency or service derived requirements. The numerator will be total number of personnel assigned against the agency/service derived requirements.

PA = Assigned Personnel / Required Personnel

FCC Throughput Capacity

Throughput will be expressed as a number and should reflect the estimated number of patients, by bed category, that an FCC can coordinate from APOD to a definitive care facility, within a 24-hour period. The FCC coordinator, when calculating this number, should consider all the relevant factors for their FCC. FCCs should consider their ability to receive DoD aircraft or contract aircraft, availability of transport assets, and distance to definitive care and number of facilities with a signed MOA.

FCCs can also provide amplifying comments that add context, to their throughput estimate, about short-term and timely mitigating efforts that will increase FCC throughput.

State Resource Availability

This category should be a narrative statement on the constraints of critical state/local assets. This statement should include the availability of airports, ambulances (BLS and ACLS), airlift and other state/local resources that enable FCC operations.

Annex L: Glossary of Terms and Acronyms

Purpose

This annex provides a relatively comprehensive list of the numerous terms and acronyms utilized with the National Disaster Medical System.

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.

Aerial Port of Debarkation (APOD): This is the airport location within a PRA where NDMS patients are received via various types of aircraft.

Aerial Port of Embarkation (APOE): The airport location within a disaster area identified as the collection and dispersal point for NDMS patients being sent to APODs.

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 authorize reimbursement* of FCC and/or PRS expenses incurred preparing for possible reception of patients unless specified in the Mission Assignment Task Order.

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. Transient patient beds, bassinets, incubators, and labor and recovery beds are excluded.

Bed Report (Available Beds): A medical facility's capacity to receive, admit, and treat patients from a contingency, or the submission of a FCCs 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.

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 personnel, coming together and training as a unit.

Dual-Use Vehicles (DUV): Vehicles operated by numerous VA Medical Centers nation-wide. Large and small versions of the DUVs can be modified for ambulatory, wheelchair, and/or litter patients.

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.

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.

FCC Coordinator: An individual assigned by VHA OEM or DoD MTF Commander to assist the FCC Director in the coordination and management of FCC requirements.

FCC Director: The Medical Center Director responsible for the management of an FCC.

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.

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.

Incident Support Team (IST): 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.

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).

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.

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 90-1 29, 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, FEMA generates a mission assignment.

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.

National Disaster Medical System (NDMS): A federally coordinated initiative that augments the nation's emergency medical response capability. NDMS supplements state and local emergency resources during disaster emergencies. It is a partnership with Department of Homeland Security, Department of Health and Human Services, Department of Defense, and Department of Veterans Affairs.

NDMS Health Care Facility/Partner Memorandum of Agreement (MoA) for Definitive Medical Care: 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.

NDMS Health Care Facilities: Medical facilities that have signed the NDMS Health Care Facility/Partner Memorandum of Agreement (MoA) for Definitive Medical Care.

NDMS 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 NDMS while indicating roles and responsibilities for the partners. It also includes the standard memorandum of agreement between the NDMS and participating medical facilities.

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

National Incident Management System (NIMS): The National Incident Management System (NIMS) provides a systematic, proactive approach to guide departments and agencies at all levels of government, nongovernmental organizations, and the private sector to work seamlessly to prevent, protect against, respond to, recover from, and mitigate the effects of incidents, regardless of cause, size, location, or complexity, in order to reduce the loss of life and property and harm to the environment. NIMS works hand in hand with the National Response Framework (NRF). NIMS 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 (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.

Non-Medical Attendants (NMA): A non-medical person who escorts the patient to assist in daily life skills until the patient is admitted to the destination medical health care 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 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): The location where patient reception operations are conducted, patient care, regulating, etc. (PRS is synonymous with APOD when referring to air transport)

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 Group (PMCG): A multi-agency group that coordinates and integrates NDMS operational planning, alerts, activations, and de-activations to establish and maintain an NDMS patient movement common operating picture for HHS and the interagency partners. The PMCG will determine which FCCs are to be alerted and eventually activated. The PMCG 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 PMCG also includes NDMS patient movement partners (e.g., interagency partners, state health departments, FEMA Regional Emergency Coordinators).

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.

USTRANSCOM Patient Movement Requirements Center (TPMRC): Responsible for theater-wide PM and coordinates with MTFs to identify en-route care to the proper medical treatment facilities. The TPMRC communicates patient transport to the theater Service transportation component or other agencies responsible for executing the mission. All three TPMRCs maintain global oversight, implement policy, and standardization for the regulation, clinical standards, and safe movement of uniformed services and other authorized, or designated patients.

Throughput: The maximum number of patients that can be received at the NDMS patient reception area, off-loaded, staged, assessed, 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.

US Army North (USARNORTH): 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 to protect the American people and our way of life.

Acronyms

AE	Aeromedical Evacuation
AES	Aeromedical Evacuation Squadron
AMC	Air Mobility Command
APOD	Aerial Port of Debarkation
APOE	Aerial Port of Embarkation
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)
CC	Critical Care (bed reporting category)
CCP	Casualty Collection Point
CONOPS	Concept of Operation
CONUS	Continental United States
CS	Civil Support
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
DSCA	Defense Support to Civil Authorities
DUV	Dual-Use Vehicles
EMS	Emergency Medical Services
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
FY	Fiscal Year
GETS	Government Emergency Telecommunications Service
GPMRC	Global Patient Movement Requirements Center
HAZMAT	Hazardous Materials
HF	High Frequency
HHS	Department of Health and Human Services
HSEEP	Homeland Security Exercise and Evaluation Program
IAW	In accordance with
IST	Incident Support Team
JDOMS	Joint Director of Military Support
JFO	Joint Field Office
JPATS	Joint Patient Assessment and Tracking System

LEPC	Local Emergency Planning Committee
LFA	Lead Federal Agency
MA	Mission Assignment
MAC T	Mobile Acute Care Team
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
MOU	Memorandum of Understanding
MP	Psychiatry (bed reporting category)
MSC	Military Sealift Command
MST	Management Support Team
MTF	Military Treatment Facility
NDMS	National Disaster Medical System
NLE	National Level Exercise
NPU	Negative Pressure Isolation Unit
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
PA	Public Affairs
POC	Point of Contact

PICU	Pediatric ICU (bed reporting category)
PIO	Public Information Officers
PMCC	Patient Movement Coordination Cell
PMCG	Patient Movement Coordination Group
PMI	Patient Movement Items
PMITS	PMI Tracking System
PMR	Patient Movement Request
PRA	Patient Reception Area
PRC	Primary Receiving Center
PRS	Patient Reception Site
PRT	Patient Reception Team
RACES	Radio Amateur Communications for Emergency Services
REC	Regional Emergency Coordinator
RRCC	Regional Response Coordination Center
CMT	Case Management Team
SBN	Burns (bed reporting category)
SLTT	State, Local, Tribal, and Territorial
SOC	Secretary's Operations Center (HHS)
TACC	Tanker Airlift Control Center
TPMRC-A	Theater Patient Movement Requirements Center-Americas
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: Points of Contact List

Army MEDCOM: 24-hour OPSCENTER21: EOC.OPNS@amedd.army.mil 703-681-8052

Air Force: HAF/SG3XO Main 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.

Navy: BUMED MOC NMOC Email: usn.ncr.bumedfchva.list.moc@mail.mil
NMOC PHONE: 703-681-4870; BUMED Command Duty Officer: (202) 714-0131.

TPMRC-A: 24-hour OPs Desk (618) 229-4200.

National Operations Center (NOC): Department of Homeland Security
Watch Desk general communication: NOC.SWO@dhs.gov
Sensitive communications: communicationsNOC.SWO.Restricted@dhs.gov

Health and Human Services Secretary's Operations Center (SOC): hhs.soc@hhs.gov, SOC 24-hour number 202-619-7800; NDMS: 1-800-872-6367.

Veterans Health Administration: VHA Office of Emergency Management Watch Desk at 202-461 (missing complete phone number)