PRC Plan Development

Block Objective:

At the end of this block of instruction participants should be able to complete the development of a comprehensive PRC plan.

1

Greetings from the Pentagon

2


NOTICE-PUBLIC BAR
OUR PUBLIC BAR IS PRESENTLY
NOT OPEN BECAUSE IT IS
CLOSED. MANAGER


EXIT
6
FORMERLY EXIT 6
www.StrangeCosmos.com


CAUTION
WATER ON ROAD
DURING
RAIN


dribbleglass.com
Phone out of service?
Give us a call.
PACIFIC BELL
3016
INFINITY


PUPPIES
PUPPIES
PUPPIES
Parking For
Chinese Food Customers


ILLITERATE?
WRITE FOR FREE HELP.
ILLITERACY FOUNDATION
806 MAIN STREET
LAMAR
www.StrangeCosmos.com

GOAL 6 – Joint Medical Contingency/Readiness Capabilities

VA and DoD will collaborate to ensure that plans and readiness capabilities adequately support DoD combatant command contingency requirements.

This collaboration will include the following planning, training, and exercise activities:

- Joint planning to ensure VA support of DoD contingency requirements;
- Collaborative training and exercise activities to enhance joint contingency plans; and,
- Improvement of joint readiness capabilities.

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Service Level Guidance

The HEC Contingency Planning Working Group will develop Departmental plans to support the revised VA/DoD MOA and Contingency Plan and ensure that all VA and DoD Primary Receiving Centers (PRCs) complete local plans to support the VA/DoD MOA and Contingency Plan by April 1, 2009.

Publish DoD Instruction, "Department of Defense and Department of Veterans Affairs Responsibilities Regarding VA Furnishing Health Care Services to Members of the Armed Forces During a War or National Emergency and Joint Contingency Plan/Readiness Programs." Estimated Completion Date: October 31, 2008

Military Departments and VHA provide Service level program implementation guidance to support the VA/DoD Contingency Plan by February 28, 2009.

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Objective 6.2

OBJECTIVE 6.2
Collaborate on training and exercise activities that support the VA/DoD Contingency Plan.

STRATEGY 6.2 (b)
The HEC Contingency Planning Working Group/Exercise sub-group will review the Chairman of the Joint Chiefs of Staff Exercise Program to ensure that joint tasks (e.g. patient movement within the continental United States) are included in at least one National Level Exercise annually.

STRATEGY 6.2 (c)
The HEC Contingency Planning Working Group will facilitate one tactical joint patient movement/reception or disaster response exercise at each VA and DoD PRC every three years beginning in October 2009.

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What Makes Up a Good Plan……

- Simple
- Flexible
- Sets the stage by laying out the situation
- Based on facts and valid assumptions
- Defines the mission and how it will be accomplished
- Provides organization
- Provides for coordination
- Identifies existing resources and gaps
- Identifies personnel, materiel, and resources required to execute the plan
- Provides for Command, Control, and Communication
- Is coordinated and synchronized
  - All elements fit together
  - Control measures are completely and understandable
  - Mutual support requirements are identified and provided for

Planning Consideration

- Off-loading of patients
- Immediate evaluation and triage of patients
- Staging of litter and ambulatory patients prior to transport to local medical facilities
- Coordination and communications with
  - GPMRC
  - Airport authorities
  - Emergency medical services (EMS) provider
  - City emergency planners
  - Other agencies and organizations as appropriate
- Site access
- Adequate staffing
- Security
- Environmental control (heat, water, light)
- Latrines
- Provision of food and drink
- Command and Control

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Planning Outline

1. Situation
   - Facts
   - Assumption
   - Limitation
2. Mission
3. Execution
   - Concept of the operations
   - Tasks
4. Logistics and Administration
5. Command, Control, Communications

PRC Plan Development

Overview

Why have a Primary Receiving Center Plan?

Moffett Federal Airfield – Routine AE missions

San Diego VAMC - Secondary Support Center – plan to receive patients via ground transportation

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PRC Plan Development

Overview

Why have a Primary Receiving Center Plan?

PRCs need a plan because if we are ever activated the number and severity of the injured will exceed the capacity of routine plans

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PRC Plan Development

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PRC Plan Development

Overview

Aeromedical Evacuation

- *Evacuation of injured personnel using fixed wing aircraft for rapid transport of casualties to medical treatment facilities where definitive care can be rendered*
- *The aeromedical environment creates unique stresses on the injured patient*

Emergency War Surgery - 2004

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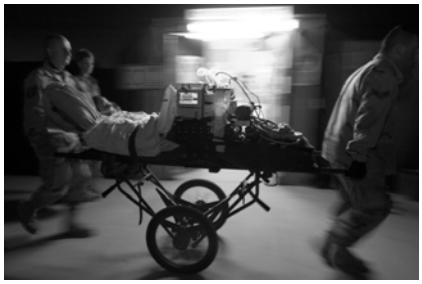
PRC Plan Development



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PRC Plan Development

Overview

There is one incontrovertible truth about aeromedical evacuation

- *It pertains to ever single Primary Receiving Center…*
- *It pertains to every single patient reception area and airfield…*
- *It pertains to every single aeromedical mission and flight…*

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PRC Plan Development

Overview

The one incontrovertible truth about aeromedical evacuation is ….

- *Every single patient that is taken off the aircraft at your airfield …will be one that was loaded onto the plane at the other end*

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PRC Plan Development

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PRC Plan Development

Overview

From the one incontrovertible truth about aeromedical evacuation ….

We will not fully understand how to plan for our incoming patients … without understanding the selection criteria and loading process that DoD uses for aeromedical flights

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PRC Plan Development

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PRC Plan Development

Medical Issues Related to AE

Medical Considerations

Patient stabilized for the anticipated mode and duration of travel

Patient's airway and breathing is adequate for movement

Patient's IV lines, drainage devices, and tubes fully secured

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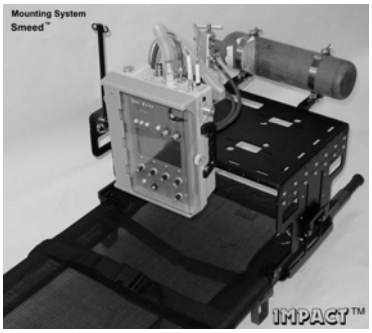
PRC Plan Development

Medical Issues Related to AE



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PRC Plan Development

Medical Issues Related to AE

Medical Considerations - continued

- *Foley catheters-nasogastric tubes allowed to drain*
- *Patient covered - woolen and aluminized blanket*
- *3 litter straps required - secure patient to litter*
- *Personal effects - medical records accompany patient*

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PRC Plan Development

Medical Issues Related to AE

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PRC Plan Development

Medical Issues Related to AE

Aviation Environment - Considerations Prior to Transport

- *Wounds for delayed primary closure*
  - *Should not routinely re-dress wounds*
  - *Inspect if patient develops fever or sepsis*
- *Casts must be bivalved*
  - *Allow for tissue expansion and access*
  - *Document neurovascular checks during flight*

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PRC Plan Development

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PRC Plan Development

Medical Issues Related to AE

Aviation Environment - Considerations Prior to Transport

- *Decreased Barometric Pressure*
- *Consider a Cabin Altitude Restriction (CAR) for the following:*
  - *Penetrating eye injuries with intraocular air*
  - *Free air in any body cavity*
  - *Severe pulmonary disease*

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PRC Plan Development

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PRC Plan Development

Medical Issues Related to AE

- *Aviation Environment - Considerations Prior to Transport*
  - *Decreased Partial Pressure of Oxygen*
  - *Neurosurgical Patients*
    - *Hypoxia may worsen neurological injury*
    - *Ventilator meets oxygen demand at altitude*
  - *Gravitational Stress*
    - *Traumatic brain injury patients*
    - *Increase intracranial pressure - takeoff or landing*
    - *Head forward on takeoff, head rearward on landing*

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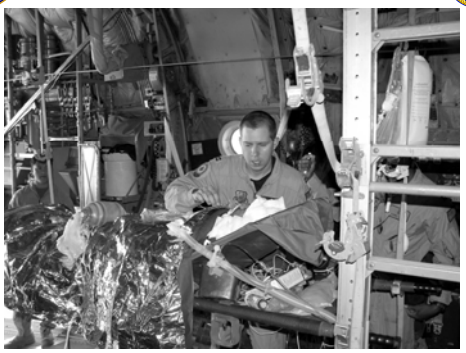
PRC Plan Development



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PRC Plan Development

Medical Issues Related to AE

Aviation Environment - Considerations Prior to Transport

- *Thermal Stress*
- *Noise*
  - *Problems with communication*
  - *Provide hearing protection*
  - *Audible medical equipment alarms are useless*
- *Decreased Humidity*
  - *Low cabin humidity at altitude*
  - *Evaporative losses will increase*
  - *Patients will require additional fluids*

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PRC Plan Development

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PRC Plan Development

Medical Issues Related to AE

CCATT - Critical Care Air Transport Teams

- *A four-person burn transport team*
- *required inhalation injury and/or severe burns*
- *Determine patient movement items (PMI)*
  - *Ventilators*
  - *Pulse oximeters*
  - *All items cleared for in-flight use*

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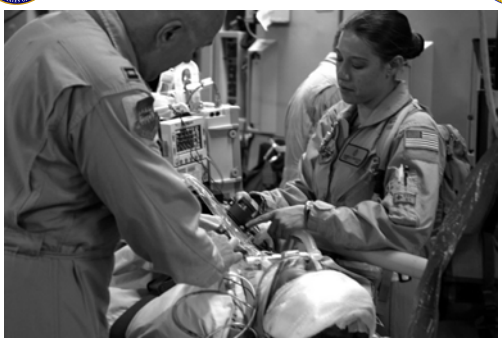
PRC Plan Development



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PRC Plan Development

Mission

Department of Defense with VA backup - principal health care for the Armed Forces during an armed conflict

Commander of the United States (U.S.) Northern Command will coordinate military medical operations

Primary Receiving Centers throughout the United States

PRC develop plans to accomplish this mission

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PRC Plan Development

Mission

Patients could arrive within 24 hours of activation

May be direct from wartime theater to PRC

May be from other CONUS medical facilities

Patients needs come first

Keep in touch in case the 24 hour window collapses

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PRC Plan Development

Plan Format

Nothing is specified regarding a Primary Receiving Center Plan format

If a local policy applies, follow the local guidance

If no local guidance pertains, here is a suggested outline following the sequence of development, activation, and mission conduct

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PRC Plan Development

Mission

Active duty patients will be placed into medical facilities that can best meet the following criteria:

- *Deliver the most appropriate medical care*
- *Nearest to home or unit of record*
- *Seamless transition - military to veteran*

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PRC Plan Development

Mission

During a time of military conflict or national emergency, Primary Receiving Centers will provide the maximum number of staffed beds possible to active duty military patients

Beds in Primary Receiving Center facilities reported as available to the DOD GPMRC may be fully utilized by DOD patients

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PRC Plan Development

Mission

Determine Medical Capacity and Capability

- *Primary Receiving Centers measure medical capacity and capability in terms of available beds*
- *Each Primary Receiving Center will conduct an initial bed estimation assessment to determine how many beds can be made available to DoD in an emergency*

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PRC Plan Development

Mission

Primary Receiving Centers use the following categories of medical care to identify the nature of a patient's illness or injury when determining the capability and capacity of their medical facility.

The five contingency categories (as well as their TRAC2ES codes in parentheses) are:

1. *Critical Care (CC)*
2. *Medical and Surgery (MM-SS)*
3. *Psychiatry (MP)*
4. *Burns (SBN)*
5. *Pediatrics (MC)*

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PRC Plan Development

Mission

Available Beds

- *Those beds to which patients can immediately be transported*
- *They must be set up and ready for all aspects for the care of a patient*
- *Include space, equipment, material, support services and staff*

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PRC Plan Development

Mission

Primary Receiving Centers

- *Determine how many beds can be made available to DoD patients*
- *Report beds that are immediately available*
  - *Empty, fully staffed beds*
- *Not beds that can be made available by sending patients*

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PRC Plan Development

Develop Course of Action

Primary Receiving Centers Plans

- *Receive patients and transport to definitive medical care*
- *Focus on aero-medical evacuation in DoD aircraft*
- *Primary airfield located within the Patient Reception Area*
- *Airfield assigned by DoD - listed in TRAC2ES*
- *Alternate means of patient transport - alternate plans developed*
- *Establish and exercise primary airfield oriented mission*

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PRC Plan Development

Develop Course of Action

Primary Receiving Center Mission Elements

- *Conditions - existing programs - procedures vary by location*
- *Primary Receiving Centers makes best use of local resources*
- *Local working group personnel who understand care within the area*

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PRC Plan Development

Develop Course of Action

Primary Receiving Center Mission Elements

- *Plans - substantially different across country*
- *Some common mission elements*
  - *Should be addressed in most PRC plans*
- *Management of each mission element*

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PRC Plan Development

Plan in Detail

Primary Receiving Centers - Common Mission Elements

1) Notification, confirmation, and acknowledgement of mission orders

- *Alert, activation, or orders - via chain of command*
- *Local confirmation and authentication policies*
- *Specific conditions under which the order is issued*
- *Acknowledgement confirms PRC ready and able to receive patients*
  - *In the numbers and categories reported on bed report*
  - *Consistent with the throughput*
- *If the PRC cannot function at this level the throughput must be officially adjusted through GPMRC prior to the commencement of air operations*
- *Contact any state, county, and city agencies - coordination*

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PRC Plan Development

Plan in Detail

Primary Receiving Centers - Common Mission Elements

2) Receipt of information about inbound patients

- *Specific information - each sortie regulated to PRA*
- *Information should include at a minimum:*
  - *Number and category of each patient*
  - *Means of conveyance: air, ground, or rail*
  - *Airfield location, bus station address or rail station*
- *Compare list of patients - available beds*
  - *Notify GPMRC of any contra-indications*

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PRC Plan Development

Plan in Detail

Primary Receiving Centers - Common Mission Elements

3) Mobilize Patient Reception Team & Transportation Assets

- *Activate their task organized Patient Reception Teams*
- *PRTs deployed with time phased assessments based on:*
  - *Expected time of arrival of the patients*
  - *Staging and setup time estimates*
  - *Other rate limiting processes*

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PRC Plan Development

Plan in Detail

Primary Receiving Centers - Common Mission Elements

3) Mobilization of Patient Reception Team and Transportation Assets

- *PRTs skill sets - quantities consistent with the scale of the mission:*
  - *Medical personnel - interface with flight crew and assess patients*
  - *Administrative - record pertinent information about each patient*
  - *Logistical support-anything the PRT needs*
  - *Lifting teams-strong health personnel*
    - *Plan for 4 person lifts-some may require 6 or 8*
    - *Factor fatigue based on prevailing conditions*

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PRC Plan Development

Plan in Detail

Receiving Centers - Common Mission Elements

3) Mobilization of Patient Reception Team & Transportation Assets

- *Primary Receiving Centers*
  - *Arrange transportation to medical center*
  - *Based on available assets*
- *Including the following depending on your locality:*
  - *County EMS Ambulances*
  - *Contract Ambulances*
  - *Organic vehicles from within your organization*
    - *Ambuses*
    - *DVA vans*
  - *Other Local support such as Transportation Authority Buses*

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PRC Plan Development

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PRC Plan Development

Plan in Detail

Primary Receiving Centers - Common Mission Elements

4) Receive Patients at Point of Embarkation

- *Aircraft or other means of conveyance*
- *PRT Medical personnel meet Medical Crew Director*
- *Medical briefing - Updates PRC medical personnel*
  - *Current condition of the patients*
  - *Exigent circumstances that developed in transport*
- *Patients prioritized for movement based on medical necessity*

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PRC Plan Development

Plan in Detail

Primary Receiving Centers - Common Mission Elements

5) Assess Patient Condition

- *PRC medical personnel assess the patients*
- *Contra-indications for further transport must be addressed*

6) Transport Patients to PRC Medical Center

- *Stabilization or other treatments are undertaken*
- *Suitable transportation means employed for each patient*

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PRC Plan Development

Plan in Detail

Primary Receiving Centers - Common Mission Elements

7) Receive Patients at PRC Medical Center

- *Existing hospital plans for an influx of patients*
- *Implement influx of patients plans*
- *Commence admission of patients at specific estimated time*

8) Admit Patients

- *Any necessary elements beyond hospital admission plans*

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PRC Plan Development

Plan in Detail

Primary Receiving Centers - Common Mission Elements

9) Treat Patients

- *Same high standard for all patients*
- *Altered standards of care - decision made by the senior clinician*
- *Communicated to the chief of staff at the receiving hospital*

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PRC Plan Development

Plan in Detail

Primary Receiving Centers - Common Mission Elements

10) Information Management and Record Keeping

- *Management of information to external authorities*
- *Designated Public Information Officer (PIO)*
- *Record keeping procedures - Beyond normal record keeping*

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PRC Plan Development

Plan in Detail

Primary Receiving Centers - Common Mission Elements

11) Release of Patient to Next Phase

- *Eventual discharge and release of the patients*
- *Outcomes that may need to be considered:*
  - *Back to unit*
  - *Transport to home*
  - *Discharge to civilian sector*
  - *Possible death of patient*

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PRC Plan Development

Plan in Detail

Primary Receiving Centers - Common Mission Elements

12) Special Considerations

- *Night Operation*
- *Inclement weather*
- *Communications*
  - *Reach back to PRC hospital*
  - *Communications with GPMRC*
  - *Communications with local EMS*

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PRC Plan Development

Local Memorandum of Agreement Development

- *Definition of a Memorandum of Agreement*
- *Legal review*
- *Location specific*

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PRC Plan Development

Contractual Development

Definition of a contract

Who are the parties that want to make the contract?

- *Managing Agency*
- *Management of the Location*

67

PRC Plan Development

Contractual Agreement

If you have a PRC committee

If you don't have a PRC committee

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PRC Plan Development

Contractual Relationship

Salesmanship

Education

Finances

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PRC Plan Development

Coordination with Local Authorities

Know who they are

Meet with them

Maintain contact information

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CHAPTER 6
Primary Response Groups
(Casualty Reception Plans)

Long Beach FCC - National Disaster Medical System - Operations Plan
May 2008

I. INTRODUCTION:

A. **Purpose**: The purpose of this plan is to describe the operational elements of the National Disaster Medical System (NDMS) at the Long Beach Federal Coordinating Center (FCC). The policies, coordinating structures, and general responsibilities of local, state, and federal participating agencies and officials are addressed in this plan.

B. **Scope**: The local operational area of this plan consists of 42 NDMS participating hospitals located in the Los Angeles County Metropolitan area.

II. POLICY:

A. **National**: NDMS is primarily designed to fulfill three system objectives, Medical Assistance to communities with Disaster Medical Assistance Teams (DMAT), Evacuation of Patients utilizing the DoD aero-medical evacuation system, and definitive inpatient care in a network of private medical facilities across the nation, along with other disaster services.

1. System Activation Criteria:

a. NDMS purpose is to supplement and assist in catastrophic incidents that overwhelm local and state medical resources. In the event of a domestic emergency, the National Response Framework (NRF), our nation's emergency response system, is activated along with the National Disaster Medical System (NDMS), which is a component of Emergency Support Function (ESF) #8, Health and Medical Services, of the National Response Framework.

b. The system could be activated in the event of a conventional overseas military conflict involving American forces whenever the federal hospital system (VA and DoD medical facilities) are overwhelmed by casualties returning to the United States for treatment.

2. The National Disaster Medical System (NDMS) activation:

a. Domestic Emergencies:

(l) The Secretary Department of Health and Human Services has the authority to activate NDMS for domestic emergency situations, normally on the request of the affected state.

(2) Reimbursement for medical care provided to civilian casualties during domestic emergencies will be provided by the Department of Health and Human Services.

b. Military Contingencies:

(1) The Secretary of Defense (DoD) has the authority to activate NDMS for military contingency operations.

(2) Reimbursement for medical care provided to DoD casualties during overseas conflict would be provided by the Department of Defense (DoD) through the TriCare contractor.

B. **Regional**: Once NDMS has been activated, the operational functions/activities fall under the Regional Response Plan (RRP) and Emergency Support Function (ESF) #8 at the FEMA Disaster Field office (DFO) which is supporting the regional response to a specific state.

1. All components of NDMS may be activated under a regional response scenario.

2. DHHS-PHS Regional Health Administrator is responsible for coordinating all regional health and medical response activities. The Department of Veterans Affairs (VA) is a major support agency to ESF #8, Health and Medical Services.

3. NDMS activation for domestic disasters may be either regional or involve only selected sections of the region.

4. NDMS activation for military contingencies may be regional or by selected facilities based on specialty beds required.

C. **Local**: The Governor, State Emergency Management Agency Director, or State Public Health Director may request activation of NDMS to supplement local and state medical care capabilities.

1. If a major disaster should occur in the Los Angeles area, resulting in a large number of casualties and/or reduction in functional medical facilities, NDMS could be activated to provide assistance. Whenever medical facilities are not usable due to structural damage, lack of utilities or unavailability of staff for duty, care for existing and new trauma patients must still be provided. Care can be at temporary medical care sites or at airfield locations if patients are to be evacuated to other communities.

a. The mass increase in demand for services would result in depletion of medical supplies and equipment locally.

b. Disruptions in the communications and transportation systems must be anticipated and could complicate response operations.

c. Activation of the NDMS system will provide medical assistance teams for triaging and stabilizing victims, an evacuation system to move casualties to unaffected areas, and a large concentration of hospital beds to provide definitive care.

d. Casualty evacuation will be coordinated by the Global Patient Movement Requirement Center (GPMRC) and the U.S. Transportation Command at Scott AFB, IL.

2. Upon activation of the Long Beach NDMS FCC, the Long Beach Airport or Los Alamitos AAF will be the point of entry for disaster victims destined for hospitals in the area. GPMRC will assign casualties to the area and individual hospital beds within the area will be assigned by the NDMS FCC. All patient assignments to hospital beds in the NDMS area will be coordinated between the NDMS Federal Coordinating Center and participating NDMS hospitals.

III. RESPONSIBILITY:

A. **National Disaster Medical System Joint Management Team (JMT)**:

1. The JMT will become operational whenever NDMS is activated and serve as the coordination center to Regional ESF #8 personnel responsible for coordinating medical functions at the Disaster Field Office (DFO) of affected State(s).

2. The NDMS JMT will be staffed by PHS, DoD, FEMA, and VA personnel from the greater Washington area upon system activation.

3. The NDMS JMT coordinates medical resource and logistics support on a national or international level to meet emergency needs of the affected disaster area, in coordination with ESF #8 personnel at the DFO.

B. **VHA / Emergency Management Strategic Healthcare Group (EMSHG)**:

1. Serves as the Department of Veterans Affairs (VA) representative to the National Disaster Medical System (NDMS) Directorate, Policy Management, and Development Groups.

2. Is the Department's point of contact with the Department of Homeland Security, Health and Human Services (DHHS), and Public Health Service (PHS) representatives upon system activation.

3. Coordinates the deployment of VA personnel to assist in operations of the NDMS JMT and other functions based on departmental taskings.

4. Responsible for activation of VHA NDMS FCCs.

5. Coordinates assistance requests from VHA Network(s) with other VA Headquarters officials.

C. **VHA Networks**:

1. Has overall operational management oversight for VHA NDMS FCCs.

2. Coordinates flow of information between VHA NDMS FCCs, EMSHG/Emergency Operations Center, and other federal regional entities.

3. Responsible for providing emergency assistance to VAMCs to meet operational tasking assignments.

D. **NDMS Federal Coordinating Center (FCC)**: NDMS FCCs will be activated by their respective department/agencies upon request by the Secretary of Homeland Security for domestic emergencies, the Secretary of Defense for military contingency operations, or the President of the United States. NDMS FCCs are coordinated by either DoD or VA medical facilities across the country.

1. In the case of activation for military casualties, Department of Defense and Department of Veterans Affairs medical facilities will receive patients first and after they are saturated, patients will be regulated to private sector NDMS hospitals.

2. In the case of activation for civilian disaster casualties, private sector NDMS hospitals will receive patients first, and after they are saturated, the patients will be sent to VA and/or DoD medical facilities.

E. **The Department of Veterans Affairs Medical Center, Long Beach,** has been designated as the NDMS FCC for the Los Angeles Metropolitan Area. The NDMS FCC is also responsible for:

1. Developing and maintaining an NDMS Operations Plan for the Los Angeles Metropolitan Area.

2. Maintaining high level contacts with all NDMS participating hospitals and support agencies, including annual revalidation of MOUs or support agreements.

3. Coordinate activities to conduct NDMS exercises to test and update area Operations Plans as required by community medical facilities to meet JCAHO external drill requirements.

F. **Participating hospitals and support agencies** will support the National Disaster Medical System as outlined in this plan and as mutually agreed upon by the NDMS Federal Coordinating Center (VAMC Long Beach). These facilities/agencies will:

1. Be responsible for designating an individual through their organization as NDMS Coordinators/Liaison (Point of Contact is Theodore A. Gegoux, NDMS Area Emergency Manager, Emergency Management Strategic Healthcare Group (EMSHG).

2. NDMS hospitals will maintain a current listing of key officials' phone numbers (both day and night).

3. Provide information/operational reports as necessary to update data files, and report operational asset availability for actual events or system exercise tests.

4. Will, to the extent possible, support an annual exercise of the local NDMS Operations Plan.

IV. SITUATION ASSUMPTIONS:

A. **Long Beach NDMS FCC activation**:

1. Incoming casualties will have received sufficient medical treatment to stabilize their conditions to allow transport, but still require acute care. Some patients' conditions may have deteriorated to a more critical state during flight. If so, this information may be relayed by the aircraft to the reception team or the NDMS FCC EOC to assure appropriate medical arrangements upon arrival. Receipt of victims from disasters in other states:

a. Sufficient licensed ambulances and crews exist in the State of California to ensure that local jurisdictions should not be without essential emergency medical services (EMS) for the duration of the transport operations.

b. Advance notice of the arrival of casualties would be given.

c. Patients will be evacuated from disaster sites by military aircraft and movement of all patients will be under the direction of the GPMRC, Scott Air Force Base, Illinois, from the evacuation point to the reception point.

d. GPMRC will only regulate to the Long Beach FCC patients in the bed categories and numbers for which the availability of treatment capacity has been reported.

e. Some patients' conditions will deteriorate during flight.

f. Medical and administrative support personnel will be available at the patient reception area at Los Alamitos AAF or Long Beach Airport to receive patients and attend them until they are transported to participating hospitals.

g. Necessary medical supplies and equipment will be on hand at the receiving area to meet routine and emergency care needs.

h. The Long Beach NDMS FCC will regulate patients within the local area to Los Angeles Metropolitan Area NDMS member hospitals.

i. The Long Beach NDMS FCC will provide instructions for patient disposition whenever patients are to be released from area NDMS hospitals.

2. Physicians, nurses, and ancillary support personnel will be available in NDMS participating hospitals to provide treatment to patients in the numbers and categories committed by those hospitals.

3. At least 12 to 48 hours notice will normally be provided prior to arrival of patients in the Los Angeles area. Naturally, if a disaster occurred in the immediate area, casualty flow could be immediate.

4. Medical supplies, pharmaceuticals, and equipment will be readily available in the Los Angeles area to support anticipated hospital requirements.

5. Transportation will be available to provide prompt movement of patients to designated NDMS hospitals from the reception area by local ambulance companies. Ambulance services and FD EMS will provide the bulk of the transports.

B. **Military Contingency Operations**:

1. In time of a military contingency operations overseas, resulting in military casualties, patients will be stabilized prior to aeromedical evacuation to the Continental United States (CONUS).

2. In time of DoD contingency operations, Federal (VA and DoD) medical facilities and personnel will be available to care for incoming casualties.

3. Aeromedical evacuation patients will be moved by the Air Mobility Command (AMC) or Civil Reserve Air Fleet (CRAF) to CONUS. Their movement will be under the auspices of the Global Patient Movement Requirement Center (GPMRC) located at Scott AFB, Illinois.

4. Participating NDMS hospitals will take all necessary actions to accept incoming casualties, based upon bed availability and security risks at the time of NDMS activation.

5. Hospitals may, upon activation of the NDMS system and on actual requests for reporting available beds, offer more or less than the number of beds listed in the NDMS Memorandum of Understanding (MOU).

6. All incoming flights carrying military patients will arrive at one of the CONUS hub airports from the overseas theater of operations and patients will then be moved to NDMS reception area.

V. CONCEPT OF OPERATION:

A. **General**:

1. For disaster in California:

a. The request for NDMS services would originate from the California Emergency Management Service Authority (EMSA) to the Federal Emergency Management Agency (FEMA) in coordination with the State Department of Health Director.

b. Local authorities will operate casualty collection points (CCPs), predetermined emergency treatment centers, which will feed into State operated regional evacuation points (REPs). The casualties would be transferred into the NDMS evacuation system at the REP.

c. Transport of patients to the REP will be the responsibility of the local jurisdiction with mutual aid from the County, State, and Federal governments as required.

d. GPMRC and the NDMS Federal Coordinating Centers will begin initial stand-by notification nationwide. When the number of patients and nature of their injuries from the disaster area is known, GPMRC will begin indicating patient distribution to the NDMS Federal Coordinating Centers over the DoD Computer system. Patients will be assigned to one of the thirteen NDMS bed categories.

2. For disaster outside California:

a. California's participation in NDMS operations will originate with a request from the NDMS Emergency Management Strategic Healthcare Group (EMSHG) at the VA Medical Center in Long Beach, California to the State Emergency Operations Center (SEOC) and the Los Angeles County Emergency Operations Center (LCEOC).

b. All receipt of casualties at the Long Beach Airport or Los Alamitos AAF will be managed by the patient reception team from the VA Medical Center at VA Long Beach.

c. Civilian casualties will be off-loaded, triaged, held and/or dispatched to designated areas immediately following aircraft arrival. Staging areas for ambulances will be coordinated with Million Air Operations at the Long Beach Airport.

B. **Coordination and Control**:

The NDMS FCC Emergency Operating Center will:

1. Establish a NDMS FCC Emergency Operations Center at the Spinal Cord Building Dining Room, VAMC Long Beach and assume responsibility for coordinating all management activities related to the program. Maintain communications with Forward Command Post at Casualty Reception or Regional Evacuation Points.

2. Notify key VA and community personnel using established alert notification systems.

3. Notify key VA and community personnel using California Emergency Management Authority officials, through the SEOC.

4. Establish a coordination and communication center to obtain bed status reports from participating area NDMS hospitals.

5. Notify all community agencies on the NDMS Resource List of stand by or activation status.

6. Communicate bed availability to GPMRC.

7. Review daily bed counts and determine regulating decision for arriving patients to NDMS member hospitals based on bed availability commitment.

8. Coordinate the operation of a local area patient locator system.

9. Provide NDMS member hospitals and supporting agencies with instructions for submission of claim for reimbursement for patient care.

10. Responsible for coordinating all casualty reception functions at point of arrival Long Beach Airport or Los Alamitos AAF.

C. **Alert Notification**:

1. Stand-by Alert: Upon notification of NDMS system alert from Department of Veterans Affairs or National Disaster Medical System officials, NDMS Area Emergency Manager, EMSHG, VAMC Long Beach will alert area participants of primary events, and ensure participants understand no casualties have been regulated to the Los Angeles area at present.

a. The Department of Veterans Affairs Medical Center Long Beach will:

(1) Establish an NDMS FCC Emergency Operations Center, under the leadership of the Medical Center Director, and assume responsibility for coordinating all program actions.

(2) Advise all Metropolitan Los Angeles Area support agencies and participating hospitals as to the status of the operation.

(3) Request NDMS member hospitals report bed availability in the five GPMRC contingency bed categories, as soon as possible.

(4) Contact the American Red Cross to alert them of the need for support of NDMS in patient locator services, reception area functions, and assistance in providing with food and/or shelter for emergency workers.

(5) Communicate bed availability to GPMRC (Scott Air Force Base).

(6) Maintain a viable public information program.

(7) Maintain the NDMS Operations Plan on a current basis and make distribution of any changes to the plan.

b. The State of California and Los Angeles Metropolitan (private, public, and volunteer) Agencies will:

(1) Establish open channel of communications with NDMS FCC EOC at the VAMC Long Beach.

(2) Notify members of reception and transportation teams of alert status.

(3) Prepare to activate the State/County Emergency Operations Center.

(4) Availability of community resources to support NDMS operations is reported to NDMS FCC EOC, VAMC Long Beach.

c. Los Angles Area NDMS hospitals will:

(1) Evaluate bed availability and report available beds in the five GPMRC contingency categories to the VAMC Long Beach as soon as possible.

(2) Prepare to activate individual facility disaster plans to receive casualties from an external disaster.

(3) Determine facility availability of personnel, equipment/supplies, and blood supply.

2. Activation of System: The local area has been notified that casualties will be arriving within 12-48 hours.

a. Preparation: Contact key area participants with aircraft estimated time of arrival (ETA).

(1) Notify County EMA and EMS.

(2) Notify California Emergency Medical Service Authority (EMSA).

(3) Notify NDMS Hospitals.

(4) Notify local NDMS support agencies.

b. Execution:

(1) When aircraft departs disaster staging area or military CONUS hub, GPMRC will contact NDMS FCC EOC, Long Beach VAMC with ETA and patient case mix information.

(2) Two (2) hours prior to ETA of patients the NDMS Area Emergency Manager, Emergency Management Strategic Healthcare Group (EMSHG) will:

(a) Coordinate establishment of patient reception area, on-site command post, and on-site communications system.

(b) Administrative Support staff will report to the reception site and set up patient assignment, bed availability board and patient tracking center.

(c) Set up a Public Information Center at a designated location near the airport patient sorting/holding area and at NDMS FCC EOC, VAMC Long Beach.

(d) Designate holding area for ambulances, other transport vehicles, crowds, and press/media.

(e) Ensure all assets are at the reception airport 60 minutes prior to ETA of patients (ambulances, buses, emergency aircraft, and support staff) are in place and ready to receive casualties.

(3) Los Angeles County agencies primary and support responsibilities:

(a) The Los Angeles and Long Beach Police Department is primarily responsible for traffic control, crowd control, security, and escort (if required) of public transportation sources moving patients to hospitals.

(b) Department of Defense will provide support as requested to transport supplies and patients, and to provide administrative support for military casualties.

(4) Arrival of Aircraft:

(a) The flight crew will direct unloading of patients and bring them to the loading ramp of the aircraft.

(b) Patients will be triage, sorted, assigned to hospitals, and prepared for transport by the patient reception team.

(c) The Patient Reception Team Leader will coordinate assignment of appropriate transportation and dispatch of patients from reception area.

(d) The Patient Reception Team Leader will advise County EOC and NDMS FCC EOC, VAMC Long Beach of scene status. He/She will maintain close contact with the Transportation Officer and report each ambulance departure and destination. He/She will keep the Transportation Officer informed of the number and type of vehicles available for patient transport from community assets.

(5) Patients Arrive at NDMS Hospitals:

(a) Information on arriving patients will be provided by facsimile to NDMS FCC EOC, VAMC Long Beach after an attending physician has evaluated the patient.

(b) Bed availability status by GPMRC five contingency categories is to be provided by email or telephone at (562) 826-5875 or FAX to NDMS FCC EOC at (562) 826-5722 every 24 hours. At the time of any significant changes in the status of individual patients, a report should also be submitted to the NDMS FCC EOC.

3. Stand Down: When the regulation of casualties to the local NDMS area is halted, the NDMS FCC EOC, VAMC Long Beach through the REDDINET, and Los Angeles County EOC will announce that, "The NDMS System will now stand down." Patients already admitted would remain in their hospitals until time of discharge, transfer to another facility, or return to duty for military patients. Routine military airlift missions may be a possible method of returning domestic patients to their area of origin after completion of hospital care.

D. **Public Affairs**: Effective media coordination is imperative to the success of local area operations and procurement of private and public community support for NDMS programs.

1. Information and Public Relations: The VA Medical Center Director and the NDMS Area Emergency Manager are responsible for ensuring public communication is coordinated, accurately and appropriately. The VA Medical Center Public Affairs Officer is directly responsible for establishing, coordinating, and supervising media activities and provides appropriate information for news releases about NDMS reception area activities.

a. An effective information and public relations program will gain community understanding and support by familiarizing the public with the concept of the National Disaster Medical System; assist through an internal information program in each participating medical facility to ensure that personnel understand exercise and actual activation objectives and activities of NDMS and; demonstrate through exercises the value of the NDMS mission and help ensure the system's integrity.

b. NDMS public relations/information should:

(1) Provide the public and participating agencies with full factual information on the operation and participating agencies with full and factual information on NDMS operations.

(2) Provide public affairs guidance and assistance to health care and related executives involved in NDMS.

(3) Coordinate with the media personnel (newspaper, television, and radio).

2. An NDMS Press Information Office will be maintained at the VA Medial Center. All inquiries of a general or sensitive nature will be referred to the Medical Center Public Affairs Officer.

a. Information about local response, number of casualties received, and other general information will be made available in press releases.

b. The Long Beach and Los Angles Chapters of the American Red Cross will establish and maintain a disaster welfare inquiry system, updating it regularly through the NDMS FCC EOC and participating NDMS hospitals. Information on military or civilian disaster victims may also be forwarded to a national database where family members may call to inquire about conditions and locations of family members. Press conferences will be held on a daily basis or as necessary.

3. Public Affairs personnel of NDMS participating hospitals and support agencies should feel free to discuss their organization's involvement in NDMS operations with the VAMC Long Beach Public

Affairs Officer. Each agency is responsible for coordination of press activities at their respective locations. Each NDMS hospital's public affairs office should:

a. Adopt initial press releases from VAMC Long Beach Public Affairs Officer (either actual or exercise) for their own use.

b. Provide public affairs support from their facility for NDMS activities at their location.

c. Fully publicize activities of NDMS for an exercise or in support of actual war/disaster operations.

4. A joint public information function will be established at the casualty reception point to manage media inquiries and coordinate media coverage of reception activities. This function will be staffed by a pre-designated public affairs representative from NDMS member organizations.

E. **Patient Administration**:

1. Patient Transfer/Discharges:

a. Transfer of all NDMS patients will be coordinated and approved by the NDMS FCC EOC, VAMC Long Beach prior to accomplishment with the exception of emergency transfers to preserve life.

(1) All transfers will be by ground transportation unless local air management is approved by the NDMS FCC EOC, VAMC Long Beach.

(2) Whenever possible pre-arranged local area contract ambulance service will be utilized to move NDMS patients between member hospitals.

b. Discharge planning procedures for NDMS patients:

(1) On the day prior to a scheduled discharge, by no later than 2:00 p.m., hospitals will identify to the NDMS FCC EOC, VAMC Long Beach, (562)) 826-8000 or (562) 826-5875, all patients scheduled for discharge.

(2) The NDMS FCC EOC, VAMC Long Beach will establish a tentative patient pickup schedule for all member hospitals.

(3) Member hospitals will arrange to discharge all patients at a pre-established time once daily.

(4) The NDMS FCC EOC, VAMC Long Beach will arrange for group pickup of NDMS patients each day, making adjustment to the tentative "patient pickup schedule" to eliminate facilities without patients to be discharged.

(5) NDMS FCC EOC VAMC Long Beach will coordinate with other government and volunteer agencies to arrange for temporary housing, feeding, and transportation to home location for discharged NDMS patients.

2. Patient tracking and change of status procedures:

a. Patient tracking involves the following steps:

(1) The use of local area triage tag that contains patient’s name, sex, ID number, age, and race should be attached to each patient. The DD Form 602, Aeromedical Evacuation

Tag, contains the patient's previous medical treatment record and the home city. In the absence of a patient's name, the triage tag number becomes the key-tracking tool for that person. All non-identified patients arriving in an NDMS area should have been identified as John Doe (male) #XXX or Jane Doe (female) #XXX at the REP. (NOTE: All participating radio communications between entities will be oriented to using triage tag/NDMS ID numbers rather than patient names.)

(2) Patient movement records at the reception point will include the triage tag number/NDMS number, patient's name, severity category (critical, serious, minor, etc.), the destination hospital, and/or the destination city.

(3) Deceased persons will be processed with the assistance of the Los Angeles County Medical Examiner's Office. The Medical Examiner's office will assist with the identification of fatalities, and will also assist with coordination of victim information with the Red Cross after notification to next of kin has been made. Notification to next of kin may also be performed by Law Enforcement Chaplains, other officials, or hospital Chaplains upon request.

(4) The NDMS Federal Coordinating Center will be responsible for coordinating collection of computerized patient information on all NDMS patients. The information database will include all active and discharged NDMS patients, as well as those that have expired enroute, at the reception area or at area hospitals.

b. Patient Change of Status Reports will be submitted by member hospitals to the NDMS FCC EOC, VAMC Long Beach whenever an NDMS patient's condition changes.

(1) Patients' condition will be functionally grouped into the following severity classes:

(a) Good

(b) Fair

(c) Seriously Ill

(d) Very Seriously Ill

(e) Critical

(2) Patients with incapacitating illness or injuries will also be identified.

(3) Death notification will be accomplished by the healthcare agency providing care to the appropriate community officials and the NDMS FCC EOC, VAMC Long Beach.

3. Resource Cost Tracking, Patient Billing, and Reimbursement Procedures:

a. All costs associated with NDMS operations will be monitored and appropriate bills submitted for reimbursement through the NDMS FCC, VAMC Long Beach.

(1) Bills may include transportation and logistical costs to established patient reception areas.

(2) Costs for ALS and BLS patient transportation.

(3) Costs for movement of patients by transit authority or school system buses, etc.

b. Reimbursement for services rendered by NDMS hospitals and other providers of services will be paid on the basis of allowable Medicare plus 10%.

(1) A single bill is not acceptable for all NDMS patients assigned to member hospitals. Separate bills and documentation for physician fees, hospitalization, medications, transportation services, etc., should be submitted by the participating hospital/organization/provider for each patient received under the NDMS activation.

(2) A copy of a hospital narrative summary and other medical documents pertaining to a specific patients' treatment, medications administered and/or services provided may be requested, in addition to a detailed bill by the financial intermediary or the NDMS FCC, VAMC Long Beach.

c. Bills will be forwarded to:

(1) For civilian casualties:

Through the Security Department of Health and Human Services

(2) For active duty military casualties:

Through TriCare.

4. Safeguarding Patients' Valuables: Patients arriving from a combat zone or civilian disaster area are expected to have only minimal personal valuables such as cash, jewelry and articles of a similar nature. For the few patients who arrive with valuables, NDMS member hospitals are responsible for ensuring patients are given the opportunity to have personal valuables safeguarded. Returning personal valuables to patients is in accordance with the policies of the medical treatment facility where the patient is hospitalized.

5. Medical Records and Release of Information:

a. (1) Inpatient, outpatient, and dental records are prepared, maintained, and retired in accordance with the policies and procedures in effect for NDMS member hospitals at the time of NDMS activation.

(2) NDMS member hospital administrators, however, should supplement this guidance to reduce administrative workloads to the greatest degree possible.

(3) A hospital summary on NDMS patients will be submitted to the NDMS Area Emergency Manager, EMSHG, after the patient is discharged for inclusion of information in an area data file.

b. Safeguarding and releasing medical information: Information in the health record is personal to the individual and must be properly safeguarded. Information is released from the health record at the written request of patients or their legal representatives in compliance with laws regarding the maintenance, use, and release of information. Exception is NDMS patient information will be provided to the NDMS FCC, VAMC Long Beach on request.

6. Military Patient Administration Teams (MPAT):

a. The Department of Defense may send an MPAT whenever military patients are hospitalized under NDMS, a military team will be assigned to the area to assist the NDMS FCC since military patients have needs that are particular to their status as members of the Armed Forces. Military Personnel Assistance Teams (MPAT) responsibilities include pay and allowances, uniforms, personnel actions, discipline, and return to active duty or separation from service.

b. Designated military installations will deploy an MPAT consisting of assorted specialists to the NDMS area to act as liaisons to handle military personnel needs. Areas in which the MPAT might be involved include:

(1) Maintenance of a roster of military patients at each local hospital.

(2) Handling pay and allowances.

(3) Uniforms.

(4) Processing personnel actions.

(5) Disciplinary actions.

(6) Maintaining updates on prognosis, projected dates of discharge, anticipated medical needs, and assignment upon discharge.

(7) Discharge and assistance following discharge.

c. In order to return military personnel to duty as expeditiously as possible, planning must include procedures to:

(1) Maintain constant accountability for military casualties.

(2) Provide necessary personnel and financial assistance.

(3) Be compatible with current personnel/casualty reporting systems (e.g., Seriously Ill, Very Seriously Ill, etc.).

(4) Reissue uniforms and equipment to discharged patients in preparation of reassignment to duty. Those patients whose injuries preclude their return to active duty must be afforded efficient processing for disability retirement/separation through medical evaluation or physical evaluation board procedures.

d. The MPAT is evolving as the method of accomplishing military patient administration.

(1) MPAT is to be utilized for military contingencies only.

(2) A comparable group does not exist for peacetime disasters. This need will be met by local agencies working closely with the NDMS FCC.

(3) Ideally, MPAT operations should integrate into the NDMS plan and existing hospital operations. The ability to either return casualties to duty or process them out of the service is an MPAT function in cooperation with the VA Medical Center Long Beach.

(4) Close coordination by an MPAT in accurate accounting of military patients (admission, transfer, and discharge), close coordination of medical personnel, finance and transportation are essential for successful implementation of NDMS in the Los Angeles Metropolitan Area.

VI. EXERCISE AND EVALUATION:

A. **Exercise Types**: NDMS exercises will be generally categorized by the degree of complexity and realism into three exercise types: basic, intermediate, and advanced. Determination of exercise types will be by agreement of all NDMS participants. At lease one NDMS exercise will be conducted annually.

1. Basic Exercise: The basic exercise is principally a teaching medium to familiarize key players with the NDMS operations Plan. It is designed primarily, but not exclusively, for use the first time the system is exercised. As such, it is conducted in an informal walk through manner, all players thoroughly briefed in advanced about the entire process from beginning to end. Participants should be from middle and upper management levels and have basic responsibilities for future NDMS operations and exercises.

a. The table top exercise should be structured to familiarize key personnel with as many elements of the NDMS Operations Plan as possible and as a minimum it should focus
attention on:

(1) Establishing command, control, and communications. A more defined communication exercise can be used to test communications channels before a full-blown NDMS basic exercise.

(2) Practicing alert and notification processes.

(3) Assessing the requirements of an emergency operations center.

(4) Providing a basis for establishing transportation requirements and capabilities.

(5) Assessing requirements associated with patient reception, sorting, and transport to NDMS hospitals.

(6) Developing an understanding of the process required to report bed availability by specialty category and other information as desired.

(7) Developing relationships with press and other news media representatives to serve as a basis for establishing a positive public information program that will project a positive image for NDMS and NDMS participants.

b. The table top exercise does not involve movement of simulated patients, vehicles, or supplies. Because it lacks the intensity and realism needed to effectively evaluate the efficiency of the NDMS Operations Plan, the basic exercise does not meet JCAHO standards for an external emergency exercise.

2. Functional Exercises: The functional exercise is a more rigorous event, which involves all of the functions of the basic exercise plus the following:

a. The functional exercise differs from the basic in that, upon alert, required staff members will be expected to assemble and report to their respective operating locations; some transportation assets would actually be utilized to move simulated patient; individual patients may be simulated by paper tags, moulage volunteers, or a combination of both.

(1) Assembly of designated personnel at key locations.

(2) Staffing and operation of the Emergency Operations Center and of the patient reception/sorting facility.

(3) Movement of patient transportation assets.

(4) Submission of patient data reports, and compilation of admission and disposition papers.

(5) Simulated patients.

b. The patient reception and sorting area will be staffed and operated to the level necessary to permit an evaluation of this vital element of NDMS. Though equipment need not be set up in the patient reception facility, the staff is expected to simulate activities to be performed at this location, such as: receiving patients, sorting patients, transporting them to a holding area, assigning patients to various participating hospitals by diagnosis and specialty bed availability reports, and actually moving simulated patients or tags to designated hospitals.

c. The intermediate exercise is intended as a training device and also should evaluate most of the operating elements of the NDMS operations Plan.

3. A full-scale exercise : The full-scale exercise is the most sophisticated of the exercise types. It is designed to closely simulate the realism of an actual disaster. In this type of exercise a broad group of players staff all elements of NDMS and respond in as realistic a manner as possible. To enhance realism, patients are moulaged and cycled into the patient reception area where they are sorted, attended for emergency needs, and actually delivered to participating hospitals in available transportation. Hospital bed status reports, admission and discharge reports, and other data are actually passed between activities. Even though it is the most demanding and potentially costly of the three types of exercises described, it will be the most valuable in terms of, personnel training and as a tool to evaluate performance and planning.

B. **Exercise Planning**: Without advance planning the integration of Federal and community resources and civilian hospital support will be disorganized and may unnecessarily disrupt many normal community functions. A voluntary collaborative planning effort will alleviate disruption and will be of significant benefit to both federal and civilian health care systems. In order to effectively carry out an NDMS exercise some timing targets should be met before an exercise is conducted.

1. Exercise Timing: Prior to exercise:

a. The NDMS Operations Plan should be completely coordinated.

b. Key personnel should, along with their subordinates, be familiar enough to respond to the plan.

c. Consensus should be reached by the local NDMS Steering Committee and key personnel that they are ready for an exercise.

2. Exercise Planning: Good planning is extremely important to success. The following steps should be taken:

a. Set objectives.

b. Select participants; determine who will be coordinators, evaluators, and support personnel.

c. Develop exercise play material:

(1) A scenario or narrative description of circumstances.

(2) A master sequence of events or list (MSEL) of chronological major activities within timing elements.

(3) Play generality or prepared simulated events, usually in message format, to stimulate action.

d. Arrange logistical and financial support for the exercise.

e. Arrange evaluation; determine corrective action and lessons learned or the value of the exercise. Part of the planning includes evaluation, checklist, and scheduling of critique.

f. Pre-planning and coordinate planning activities: Involves insuring that details are done in support of the exercise. A list of tasks must be prepared, tasks assigned, and follow-up made to ensure that each task is complete.

VII. REFERENCES:

A. Public Law 93-288, amended, Robert T. Stafford Disaster Relief and Emergency Assistance Act.

B. National Response Framework – January 2008
http://www.fema.gov/emergency/nrf/

C. National Incident Management System – December 2007
http://www.fema.gov/emergency/nims/index.shtm

D. Public Law 97-174 VA/DoD Contingency Plan as implemented by VHA Directive 1095.007 and VHA Handbook 0320.1

E. **Guidance Documents**:

1. NDMS Federal Coordinating Center Guide

2. NDMS Exercise Guide

/s/ 1-3-2008
Ronald Norby Date
Director, VAMC Long Beach
NDMS Federal Coordinating Center

/s/ 1-3-2008
Theodore A. Gegoux Date
Network 22, AEM

Long Beach VA Federal Coordinating Center (FCC) and Primary Receiving Center (PRC)

Patient Reception Area Functional Operations Plan OPLAN

January 2008

Applicability: This plan applies to both FCC and PRC Operations.

1) Receive Notification
Official notice that the NDMS or VA / DoD Contingency system has been activated and that the Long Beach VA needs to commence reception operations will be delivered to the medical center leadership. At that time the Director will be notified as to which airfield will be utilized. This plan assumes the use of Los Alamitos AAF.

2) Alert Personnel
Utilize cascade recall system to notify staff that reception operations will commence per instructions in the activation order.

3) Activate the EOC
At a time to be determined by the Director, or designated representative, have the Emergency Operations Center staffed and operating. The following is the minimum staff needed at the EOC – use HICS model as always:

a) Incident Commander – Director

b) Liaison Officer – Area Emergency Manager – Ted Gegoux

c) Clinical Operations Chief – Assigned by Chief of Staff or Director, should be MD. Responsible to assess patient's needs and to select treatment locations. Physician of record for acceptance of the patients at the airport and for direct admit to local area NDMS hospitals or the VA facility.

d) Nursing Unit Leader – Assigned by Chief of Staff or Director, should be experienced senior nurse to assist in the placement decision making.

e) Patient Tracking Officer – Assigned by Chief of Staff or Director, should be someone with day to day admit and referral experience. Responsible to coordinate the location and admission of patients transported to local area NDMS hospitals or the VA facility.

f) Finance Section Chief – Assigned by Chief of Staff or Director, should be someone with day to day experience with patient third party billing. Responsible to facilitate all Tricare and Department of Defense reimbursement for treatment and transportation of patients. Also accounts for related and ancillary expenses and facilitates recoupment of these costs.

g) Psychological Support Unit Leader – Assigned by Chief of Staff or Director, should be as a minimum an experienced Social Worker with critical incident stress training. Responsible to provide counseling and other services as needed.

h) Situation-Status (Sit-Stat) Unit Leader – Assigned by Chief of Staff or Director, should be an experienced administrator. Responsible to maintain an accurate status of available beds and services at local area NDMS hospitals and within the VA.

i) Labor Pool Unit Leader – Human Resources. Responsible to field a twenty (22) person labor pool to assist with reception reception operations. Eighteen (18) personnel to act as litter bearers with the Patient Reception Team. Four (4) additional persons to assist at the EOC.

j) Public/Patient Information Officer – Responsible to coordinate with the American Red Cross and the Uniformed Services regarding patient information. Prepares press releases as required. Controls press access to information.

k) Logistics Section Chief – Facilities Management – Responsible to coordinate all logistical requirements associated with airport operations as well as patient reception and transportation.

l) Transportation Unit Leader – Responsible to locate and coordinate ambulance and other ground transportation as needed to move the patients from the airport to their place of treatment.

m) Materials Supply Unit Leader – Responsible to locate and obtain all needed materials and supplies to support the patient reception activities.

n) Communications Unit Leader – Information Resources Management – Responsible to ensure that communications between the Patient Reception Team are functional and redundant.

Supplemental Staff Needed for FCC Operations

o) Patient Reception Team Leader – Responsible to meet the airplane and coordinate the patient reception with the flight crew. Receives patients condition and status from the Medical Crew Director (MCD). Coordinates with the Clinic Operations Chief to ensure that patients needs and treatment location are compatible.

p) Patient Reception Team Members – Minimum of two (2) RNs. Responsible to assist the Patient Reception Team Leader in assess the patients. Directs the litter bearers as to which patient to move first and what ambulance is to be used. Assesses patient needs against available Basic Life Support and Advanced Life Support ambulances and directs the loading of the ambulances.

Litter bearer team should include a minimum of 18 people; this provides two alternates.

q) VA Police Chief - Responsible to coordinate with local law enforcement at the airport to ensure that operations proceed safely and smoothly.

4) Make Community Notifications

The Director will designate individuals to ensure that the following community activities are called in the following order:

a) Los Alamitos Army Airfield

Phone Numbers
Flight Data / Operations 562-795-2571
Security Dispatch (24 hours) (Bldg 57) 562-795-2100

Airport / FBO Information
KSLI LOS ALAMITOS AAF LOS ALAMITOS, CA Time Zone: PT
Lat: N 3347.4 Long: W 11803.1 Elev: 35 Var: -14
Longest Runway: 8000 Ground: 126.95 Tower: 123.85

b) Long Beach Airport Security (24 hours) 562-570-2640
Notify them that patient reception activities have been activated and report the time that a military plane carrying patients will be arriving. They will automatically inform the Long Beach Police Department.

c) Long Beach Fire EMS (24 hours) 562-591-7631 or EMS Dispatch – 562-436-8211
Notify them that patient reception activities have been activated and report the time that a military plane carrying patients will be arriving. They will report the number of available LBFD EMS ambulances available. Record the number of both ALS and BLS ambulances.

e) VA Police Chief will notify Cal State University LB as needed. The Public Affairs Officer will notify the American Red Cross.

f) Office of Emergency Services California (OES)562-795-2900

5) Arrange for Ambulances
The Transportation Unit Leader will locate and identify one (1) ambulance for every two (2) patients on the plane manifest. Ambulance acquisition will be coordinated with LBFD EMS to ensure that local EMS activities are not compromised. They will annotate whether the ambulances are ALS or BLS and report those numbers to the Clinical Operations Chief.
Ambulances will be obtained from VA contract service providers or the following agencies in this order:

a) LA County Medical Alert Center - EMS – 323-869-0578
b) LBFD EMS Dispatch – 562-436-8211 or Business Office - 562-591-7631
c) Schaffer Ambulance Company – 800-582-2258
d) American Medical Response (AMR) Ambulance – 562-808-2100
e) Bowers Ambulance Company – 562-599-3006

6) Coordinate with Los Alamitos Army Airfield
The Logistics Section Chief will coordinate any and all requirements with Los Alamitos Army Airfield. Los Alamitos Army Airfield will need to know the type of aircraft, i.e. C-17 or C-130, and the time of arrival. Los Alamitos Army Airfield will notify the Logistics Section Chief where the airplane will be parked, where to stage the ambulances, and what part of Los Alamitos Army Airfield will be available to the Patient Reception team. Los Alamitos Army Airfield may be able to provide restrooms, and occasional access to telephones for the Patient Reception Team to use while waiting for the airplane.

7) Assemble Patient Reception Team
The Patient Reception Team Leader along with the Labor Pool Unit Leader will assemble the team. As a minimum, two RN nurses will be identified and 24 litter bearers. All team members should be willing and able to carry patients on a litter. The team should be notified that sights and sounds associated with airport operations will be experienced and

that their patients may be traumatically injured. Team members should bring gloves

The Psychological Support Unit Leader should be available to assist in team member assessment and counseling as needed.

8) Assess the Arriving Patients Based on the Manifest
The Clinical Operations Chief, Psychological Support Unit Leader, and the Patient Reception Team Leader, assisted by the Nursing Unit Leader and other individuals, will compare the patients medical needs, based on the flight manifest, against the available treatment at the local area NDMS hospitals or VA facility. Preliminary selections for treatment locations will be recorded and the selections will be discussed with the EOC staff. Special attention must be paid to any psychiatric patients identified on the manifest.

9) Notify the Local Area NDMS Hospitals
The Patient Tracking Officer will notify the NDMS hospitals of the patient's condition and arrival time to ensure that the NDMS hospital can accept the patient with the condition as stated in the manifest. If the NDMS hospital states that they cannot accept such a patient, the Clinical Operations Chief will be notified immediately.

10) Deploy Patient Reception Team
The Patient Reception Team Leader will obtain a copy of the annotated and verified manifest to take to the Los Alamitos Army Airfield. The Patient Reception Team Leader will obtain suitable transportation for the team from the Transportation Unit Leader. This would normally be several station wagons supplied from the VA Motor Pool. Also effective communications devices need to be coordinated with the Communications Unit Leader. At a minimum, the team needs to have at least one cellular phone and a dedicated number at the EOC to call the Clinical Operations Chief and the Nursing Unit Leader. The Team will deploy to the Los Alamitos Army Airfield terminal at a time determined by the Team Leader and the FCC Director based on the arrival time of the airplane and other planning considerations.

11) Evaluate Patients at the Airport
Once the airplane arrives, the Patient Reception Team will board the airplane and make contact with the Medical Crew Director (MCD). The Medical Crew Director will advise the Team Leader as to the severity and changes to the patient's condition. The Team Leader will ensure that the most serious patients receive first priority for transport. Any emergent conditions that necessitate a change in treatment location will be accomplished without delay. The FCC will be notify of these changes as

soon as possible with a mind to accurate treating of the patient's condition and location.

The Team leader assisted by the RNs will compare the patient's condition and needs against the treatment location from the preliminary selection process. If the needs of the patient match the selected treatment location's capabilities, the litter bearers will be directed to carry the patient to where the ambulance drivers can load the patient in to the ambulance. It is expected that most ambulances will transport two patients and that very few patients, less than 10%, might require ALS type ambulances. The RNs need to be mindful of whether the patient needs an ALS or BLS type of ambulance. The RNs must also ensure that each ambulance driver knows where to take each patient. Special attention must be paid to any psychiatric patients identified on the manifest due to the potential for self injury and flight risk.

12) Transport Patients

Litter bearers will, at the direct of an RN or the Team Leader, will move the patients to a position that the ambulance driver can access. In the case of a C-17 or C-130 with the back ramp lowered to within 2 feet of the ground, the patients can be placed at the end of the ramp and the ambulance drivers can load the patients right off the ramp and onto the EMS gurney and into the ambulance. The ambulances will be staged as close to the airplane as flight operations will allow. This will facilitate and minimize handling of the patients.
All aeromedical equipment must remain on the airplane.

13) Track Patients Health and Admit Status

The Patient Tracking Officer will maintain a current listing of each patient's location and condition. The Patient Tracking officer is the single point of contact for EOC staff as to the patient's status. The PIO and the entire EOC will assist in keeping the information current by notifying the Patient Tracking Officer of any changes. The Clinical Operations Chief will determine what if any rounds need to be done in order to ensure that each patient is being treated appropriately.

14) Track Expenses & Get Bills Paid

The Finance Section Chief will ensure that all expenses are recorded and that a mechanism is identified and used to recoup expenses. The Liaison Officer will assist with identifying processes for reimbursement.

15) Keep Uniformed Services Informed

The Public Information Officer will ensure that the uniformed services have the information that they need regarding their patient's. Also, the PIO will ensure that only appropriate information is released to the press. All external inquiries will be directed to the PIO or Director.

Primary Receiving Center Plans - Outline

Reference:

VHA HANDBOOK 0320.04

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420
December 26, 2007

DEPARTMENT OF VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE CONTINGENCY PLAN

0320.04 – lists the contents that should be contained in each PRC Plan. Here they are:

(1) Concept of Operations,

(2) System Activation,

(3) Alerting SSCs,

(4) Bed Availability Reporting,

(5) Patient Reception,

(6) Patient Administration and Tracking,

(7) Communications,

(8) Transportation,

(9) PMI,

(10) Personnel Administration,

(11) Exercises and Evaluations, and

(12) Public Relations and Media Information.