

## Patient Movement Appendix

### References:

1. HHS Medical Surge Capacity and Capability, September 2007
2. ESF8 Patient Movement CONOPS Feb 2011
3. AMR/FEMA/HHS Ground Ambulance & Paratransit Utilization Guide, May 2013
4. EMS Scope of Practice, Protocols, Reciprocity, and Medical Control and Direction for AMR/FEMA Federal EMS Deployments, Aug 2013
5. National EMS Core Content, National Highway Traffic Safety Administration, 2010
6. Guidelines for Evacuation of Individuals with Disabilities, May 2013

### Assumptions

- Patients are evacuated only when the health and medical resources available within an affected disaster area are inadequate to provide care or shelter the patients in place.
1. **Purpose:** This appendix will provide a concept of operations, assign tasks, and provide guidance to ensure effective patient movement operations. The base appendix will lay out the general construct for patient movement. Individual tabs will address specific procedures for executing patient movement operations.
  2. **Situation:** During an incident, the first step in addressing medical surge is to implement a system that can effectively manage the medical and health response. The Medical Surge Capacity and Capability (MSCC) Management System guides the development of public health and medical response. **Patient Movement operates in support of the MSCC.** A patient's health does not improve with movement. The MSCC is designed to only move the patient as far as is necessary to provide adequate care. The MSCC Management System describes a framework of coordination and integration across six tiers of response:

- Tier 1 – Single Healthcare Organization
- Tier 2 – Multiple Facilities/Coalition Response
- Tier 3 – Jurisdictional Response
- Tier 4 – State Response/Intrastate
- Tier 5 – Interstate Regional Response
- Tier 6 – Federal support to State and Locals

The Federal Patient Movement capabilities are designed to primarily support a state executing Tier 4-6 medical surge operations.

- a) **General Capabilities:** Federal Patient Movement Capabilities are designed to augment local and state patient movement efforts and can be used in a variety of ways. The FEMA EMS Contract and Department of Defense (DoD) are the two primary sources for these capabilities. Federal patient movement capabilities include:
  - Ground Ambulances (Advanced and Basic Life Support) (FEMA and DoD)
  - Paratransit Vehicles (FEMA)
  - Rotary Wing Air Ambulances (FEMA and DoD)

- Fixed Wing Air Ambulances (FEMA and DoD)

In a catastrophic response where the FEMA EMS Contract and DoD are inadequate, other non-traditional means may be employed to move patients. Such means could include buses, trains and commercial aircraft.

- b) FEMA EMS Contract:** The purpose of these contracts are to supplement state response to any event when federally provided medical transportation and support capabilities are needed with fully stocked ground ambulances, air ambulances, and para-transit vehicles to include any medical support personnel necessary to operate and support these resources. The air assets can also be used to augment the National Disaster Medical System (NDMS) patient movement system.

There are four national zones. Each zone is capable of providing

- 300 Ground Ambulances (max. 70% ALS & 30% BLS)
- 3500 Paratransit Seats (max. 25% wheelchair capable)
- 25 Air Assets (helicopter & fixed wing)(See attach 11 & 12)

The contract requires a 24 hour response for the initial zone. More than one zone can be activated but the response time for the additional zones will be based on the contractor's best effort. The contractor will not draw ambulances from affected or adjacent states.

The requesting state must provide reciprocity. Medical oversight of the EMS technicians is also required. The scope of practice for the AMR/FEMA Contract is the *National EMS Scope of Practice Model*. Please see EMS Scope of Practice, Protocols, Reciprocity, and Medical Control and Direction for AMR/FEMA Federal EMS Deployments (Attach 4 and 9) for more specifics on reciprocity and scope of practice.

- c) Department of Defense:** DoD patient movement assets include:
- All terrain HUMVEE style BLS ground ambulances
  - Dedicated Rotary Wing MEDEVAC Air Ambulances
  - Fixed wing aircraft that can be configured for patient movement with enroute care
  - General purpose vehicles, helicopters and aircraft to move of low acuity patients
- d) National Disaster Medical System (NDMS):** NDMS is a partnership between HHS, DoD, FEMA and VA. The NDMS provides Medical Response, Patient Evacuation and Definitive Care capabilities in response to an incident.

Patient Evacuation component of the NDMS uses DoD or FEMA EMS Contract aircraft. Patients are flown from airfields in the affected area to preidentified reception sites call Federal Coordinating Centers (FCC).

FCCs are maintained by the VA or DoD and provide the Definitive Care Component of the NDMS. FCCs enroll civilian hospitals into agreeing to make beds available during an incident. There are over 1600 hospitals in the NDMS network. FCCs also establish agreements with airports and EMS providers to provide patient reception and distribution of patient into the local NDMS hospital network.

The Patient Evacuation component of the NDMS is a system. The system's components include:

- Established methods for identifying and reporting patients for movement
- The deployment of patient staging capabilities at outbound airfields
- Preidentified reception sites (FCCs)
- Network of hospitals with available beds
- Air transport with enroute care
- Patient tracking systems
- Repatriation of patients

For NDMS planning purposes:

- DoD can deploy up to four staging facilities each capable of processing 140 patients per day for a total of 560 patients per day.
- Critical patients are limited to only 20% of total. Half of the critical can be vented.
- DoD needs 36hrs from the time of notice until the first load of patients are moved.
- FEMA/AMR aircraft are almost all ALS level transport
- FEMA/AMR can provide 25 aircraft within 24hrs of notice and up to an additional 75 aircraft with response times based on the contractor's best effort.
- FEMA/AMR's range is 200 miles for rotary and 250 for fixed wing ambulances
- FEMA/AMR does not stage their patients. They transfer them directly from the ground ambulance to the aircraft which requires a higher level of coordination.

3. **Mission:** Federal patient movement capabilities can support local and state responders in a number of functional areas. The functional areas can be broadly sorted into two categories:

Support to Local EMS/Paratransit requirements within the affected area via ambulance, paratransit vehicles and rotary wing air ambulances which includes:

- Movement from point of origin to first receiver (911 augmentation)
- Movement between facilities
- Movement to medical special needs shelters
- Movement to evacuation points

Evacuation of Patients out of the affected area via ambulance, paratransit, rotary and fixed wing:

- Evacuation of Hospitalized Patients
- Evacuation of Special Medical Needs Patients

**a) Utilization of Ground Resources:**

Effective use of medical transportation requires an understanding of the different types of available resources as well as category limitations based on patient's medical condition and mobility. These limitations will determine whether individuals can be safely transported by ground ambulance (stretcher), paratransit vehicle or general population conveyance, e.g. buses.

Triaging of patients for movement during a large-scale evacuation refers to the process of assessing a patient and determining the most appropriate method of transporting the patient based on the available transportation assets. For ground transportation, patients should be initially triaged into these five major categories:

- Patients needing Advanced Life Support (ALS) Ground Ambulance
- Patients needing Basic Life Support (BLS) Ground Ambulance
- Patients needing Bariatric ALS Ground Ambulance
- Passengers needing Paratransit transportation
- Passengers needing Conventional Transportation

Individuals require recurring professional medical care, special equipment and/or continual medical surveillance should be transported by ambulance. The patient's condition is such that use of any other method of transportation is contraindicated...and transportation other than ambulance could not be used without endangering the individual's health. These evacuees require an ambulance and should not be transported via paratransit or conventional transport vehicles. (Attach 5)

Persons requiring paratransit transport have pre-existing conditions that make it unsafe for them to travel by standard fixed route public conveyance but are not disabled or ill enough to require transport by ambulance stretcher. They may require some medical surveillance from their own caregiver and/or special assistance. They may originate from an institution such as a hospital or nursing home or a non-institutionalized setting such as a residential dwelling. They are individuals whose age, mobility, functional and/or medical disability make them particularly vulnerable and at risk in disaster situations. Passengers who cannot sit safely in a standard vehicle seat or wheelchair should be transported by stretcher in an ambulance. (Attach 5)

Requests for ambulance and paratransit support should specify how many of each category is required. FEMA Ambulance and Paratransit Disaster Transportation Request Form (attach 10) can help facilitate this process.

Ground movement of patients should be limited to less than 200 miles or 6 hours. Movements in excess of these limits should consider air transport as an option.

Please refer to the AMR/FEMA/HHS Ground Ambulance & Paratransit Utilization Guide (Attach 1) for more specific details on patient and vehicle categories.

**b) Utilization of Air Resources:**

Generally speaking, movement of patients by ground is preferred. Air movement is considered when ground is no longer practical due to unavailability of care in the immediate area.

**4. Execution**

**a) Roles and Responsibilities**

**Local/Regional Government**

- Provide overall command and control of local emergency response
- Identify shortfalls in local capabilities, conduct community emergency medical services (EMS) operations, evacuate medically fragile patients from their homes, and submit resource requests for shortfalls.
- Establish primary and alternate evacuation routes and provide traffic control
- Identify support required to maintain 911 EMS response system capable of triage, treatment, and transport.
- Provide Medical Oversight of EMS technicians
- Provide wheelchair vans, passenger vans, and drivers for transport of low acuity patients
- Establish forward staging area for ambulances and paratransit vehicles.
- Coordinate the dispatch of federally provided ambulances and paratransit vehicles

**Local Hospitals/Nursing Homes/Skilled Nursing Facilities**

- Implement facility emergency management plans
- Make the decision to evacuate staff and patients or to shelter-in-place (SIP)
- Request evacuation assistance from County Emergency Management (EM)
- Submit Patient Movement Request Forms (Attach 13)
- Manage the loading and unloading of patients being evacuated from/to their facility
- Notify County EM of the numbers and types of patients who require evacuation

**State Government**

- Declare State of Emergency
- Request Federal Emergency/Disaster Declaration

- Submit Action Request Form (ARF) to FEMA for EF/ESF 8 support requirements
- Issue Executive Order or like documents providing reciprocity for out of state licensed medical providers to practice in the affected State
- Identify ambulance and paratransit vehicle check in and staging location
- Identify and make available airfields for patient evacuation operations.

### **State Health and Medical**

- Coordinates State EF/ESF-8 activities to include medical surge, patient sheltering, EMS support and patient evacuation
- Notify HHS Regional Emergency Coordinator of possible requests for federal assistance to include EMS/Paratransit support and patient evacuation.
- Submits Action Request Forms and FEMA Transportation Request Form (Attach 10) for Federal assistance
- Aggregate local requests for patient evacuation. Prioritize and submit patient movement requests (attach 13) to federal patient movement representative.
- Coordinate the transport of patients from hospitals to evacuation points.
- Coordinate nursing home evacuations with hospital and EMS providers
- Utilize Health Information Network to communicate critical information related to evacuation operations to hospitals and skilled nursing facilities
- Ensure Medical Oversight of out of state EMS technicians

### **Federal**

#### **Department of Health and Human Services (HHS)**

- Federal ESF-8 lead with oversight of all ESF-8 activities
- Assist State in defining federal support requirement and drafting Action Request Forms and FEMA's Transportation Request Form
- Coordinate with FEMA, DoD and VA on generating Mission Assignments in support of State's request for assistance
- Activate NDMS Patient Movement Coordination Cell (PMCC), composed FEMA, DoD, VA, and HHS, to perform required Headquarter actions in support of NDMS patient evacuation
- Provide strike team to support DoD staging facilities at outbound airfields
- Provide Pharmacist and controlled medications in support of FEMA contract ground ambulances
- Provide HHS Flight Surgeon to review patient conditions from Patient Movement Request forms and identify any contraindications for flight

- In coordination with FEMA, monitor utilization of FEMA EMS Contract resources and coordination demobilization as appropriate (Attach 6, 7 & 8)

#### **Federal Emergency Management Agency (FEMA)**

- Provide overall incident coordination, provision of funds and issuance of Mission Assignments and Task Orders
- Issue Task Order for ground ambulance, paratransit and air ambulance support from the National EMS Contract
- Deploy COTR to ambulance staging location to conduct check in procedures
- In coordination with HHS, monitor utilization of deployed contract resources and recommend demobilization as appropriate
- Provide logistics support as appropriate

#### **FEMA National EMS Contractor**

- Provide ambulances, paratransit vehicles and air ambulances as directed
- Provide coordination teams and LNOs to state and locals
- Provide dispatch capability as requested
- Provide utilization reports to HHS and FEMA (Attach 6, 7 & 8)

#### **Department of Defense (DoD)**

- Provide ground and rotary wing ambulances as mission assigned
- As directed by the PMCC, alert, activate and operate DoD NDMS FCCs (Army, Navy, Air Force)
- Deploy all equipment and personnel packages required to evacuate NDMS patients

#### **Department of Veterans Affairs (VA)**

- As directed by the PMCC, alert, activate and operate VA NDMS FCCs

### **5. Coordination and Communication**

#### **a) Coordination**

- FEMA provides overall coordination between federal agencies
- HHS, as ESF8, is the lead federal agency for health and medical
- DoD and VA support HHS as ESF8
- FEMA is the Contracting Officer Representative for the National EMS Contract and will issue a Task Order (40-1) in response to a state's request for support.

- Ground ambulances and paratransit vehicles from the National EMS Contract are given over for local control and dispatch

#### **b) Communication**

- Ambulances from the National EMS Contract deploy with Land Mobile Radio (UHF, VHF, 700/800 MHz) (Attach 3)
- National EMS Contract command and control elements deploy with Satellite Communication, Secure Telephone, Secure Network and internet access (Attach 3)
- HHS utilizes Joint Patient Assessment & Tracking System (JPATS) to track patients evacuated via the NDMS
- Once resources are deployed under the National EMS Contract, the contractor provides utilization reports to HHS and FEMA.

### **6. Administration and Support**

#### **a) Logistics**

- Federal Patient Movement Resources' logistical support will be provided by the federal government so as not to put additional burden on the locals.
- Locals will need to identify forward ambulance and paratransit staging locations
- The EMS Contractor can be self-sufficient on fuel until a federal fuel resource can be established. The contractor will provide themselves with communication and maintenance support.
- Except for controlled substances, the EMS contractor shall be responsible for stocking and/or resupplying ambulances and paratransit vehicles (Attach 2). HHS will supply the Contractor with controlled substances.
- Space will be required for the EMS Contractor's Forward Operations Team
- The State and locals will need to identify airfields for DoD to conduct patient evacuation operations. DoD requires:
  - 5000' x 80' minimum for runway
  - Parking spaces for two aircraft
  - Recommended building of opportunity for staging of patients is:
    - 12000 sq ft
    - Within 100 feet of aircraft parking
    - 72" door
    - Power
    - Potable water and restroom access
    - Ambulance Access



- If no building, space adjacent to parking for tents
- DoD will require space in the State EOC or Health EOC for their Joint Patient Movement Team responsible for coordinating NDMS patient evacuation

**Tabs**

1. Operating Procedures for Use of National EMS Contract (To be developed)
2. Operating Procedures for NDMS Patient Evacuation (To be developed)

**Attachments:**

1. AMR/FEMA/HHS Ground Ambulance & Paratransit Utilization Guide
2. Equipment for Ambulances in Federal Disaster Response
3. Disaster Response Communications Capabilities
4. National EMS Core Content
5. Guidelines for Evacuation of Individuals with Disabilities
6. Operational Summary Report ICS 220-Air Ambulance
7. Operational Summary Report ICS 220-Ground Ambulance
8. Operational Summary Report - ICS 220-Paratransit
9. EMS Scope of Practice, Protocols, Reciprocity, and Medical Control and Direction for AMR/FEMA Federal EMS Deployments
10. FEMA Transportation Request Form
11. Typed Resource Definition for Fixed Wing Air Ambulances
12. Typed Resource Definitions for Rotary Wing Air Ambulances
13. Patient Movement Request Form