

CALIFORNIA PATIENT MOVEMENT PLAN

November 2018





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CALIFORNIA PATIENT MOVEMENT PLAN

November 2018

Dear Emergency Management Partner:

The **California Patient Movement Plan** culminates nearly two and a half years of work by the California Emergency Medical Services Authority (EMSA) in close coordination with the California Department of Public Health (CDPH), the California Governor's Office of Emergency Services (Cal OES), and local, regional, state and federal response partners.

This plan applies whenever local Emergency Medical Services (EMS) systems require regional, state or federal assistance to manage the patient movement needs created by the incident, including triage, treatment, stabilization, transportation to definitive care, tracking and repopulation, in addition to the evacuation of existing healthcare facilities as needed.

This plan addresses a primary responsibility of the California Public Health and Medical Emergency Function (CA-ESF 8), patient movement. The lead agency for CA-ESF 8 is the California Health and Human Services Agency, which has designated EMSA and CDPH as co-lead agencies for CA-ESF 8 development and implementation. This plan directly supports the top Operational Priorities established by the State of California Emergency Plan, i.e., *Save Lives* and *Protect Human Health and Safety*.

This plan should become familiar to all public and private entities within California's Public Health and Medical System in addition to the many response partners, including emergency management, fire, law and transportation, whose contributions would be essential to the success of patient movement activities.

The publication of this plan represents a major step; our challenge now is to educate, train, exercise and refine the plan elements such that the plan's contents become well-understood and practiced, and therefore immediately applicable, should a disaster occur in California that requires extraordinary patient movement.

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PREFACE

This **California Patient Movement Plan** was developed by the California Emergency Medical Services Authority (EMSA) in collaboration with local Emergency Medical Services agencies (LEMSAs), California Department of Public Health (CDPH), California Governor's Office of Emergency Services (Cal OES), and local, regional, state and federal stakeholders involved in the medical and health response to disasters in California. The stakeholder workgroup met over a two-year period to develop this plan. Key aspects of the plan were evaluated in a tabletop exercise (TTX) at the conclusion of the development period and findings from the TTX were used to further refine the plan.

Patient movement is a component of California's Public Health and Medical Emergency Support Function 8 (CA-ESF 8). The California Health and Human Services Agency (CHHS) is the lead state agency for the development and implementation of CA-ESF 8 and has designated EMSA, as the lead state department for disaster medical services, and CDPH, as the lead state department for public health and environmental health, as the co-lead departments responsible for operationalizing and maintaining CA-ESF 8. The U.S. Department of Health and Human Services (HHS) is the lead agency for the federal Emergency Services Function 8 (ESF 8), and coordinates patient movement support among federal agencies.

The California Patient Movement Plan is a major step forward in developing the capability to execute large-scale patient movement within and beyond California's borders. We hope this plan encourages the many private and public organizations involved in patient movement to focus on the following, and, where appropriate, synchronize with local, regional and state planning:

- **Capability Assessment and Development** – Assess and develop capabilities within your organization/jurisdiction to support effective patient movement
- **Planning** – Conduct planning within your organization to carry out the actions described in the plan
- **Training** – Develop and conduct training that increases staff competency and readiness to take action
- **Risk Mitigation** – Identify potential hazards that could lead to the need to move patients and implement strategies to minimize the impact of those hazards

Future Direction: During the two-year development of this plan, a number of operational gaps were identified (maintained as a separate document), many of which were resolved. The unresolved gaps were beyond the scope of the current project and will require subsequent work to resolve. Despite these gaps, the enclosed plan has tremendous value for the coordination and execution of statewide patient movement. Every person who may play a role in local, regional or statewide patient movement during a disaster should become familiar with this plan. Additionally, LEMSAs should evaluate opportunities to implement policies, protocols and procedures that provide for continuity of care and an effective operational interface between local and state-level patient movement plans.



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PLAN ORGANIZATION – PLEASE READ FIRST

The **California Patient Movement Plan** is organized into six major sections as follows:

Section	Title	Description
I	Introduction	Provides a basic overview of patient movement for California.
II	System Description	Describes the main components of the Public Health and Medical System ¹ that would be involved in large-scale patient movement, including local, regional, state and federal resources.
III	Concept of Operations	Describes the state’s strategic approach to patient movement and how the system components would respond and coordinate activities to benefit those who may require patient movement.
IV	Figures	All figures referenced in the plan narrative are grouped together for easy access.
V	Forms	All forms referenced in the plan narrative are grouped together for easy access. Note that convenient, pdf-fillable versions of all forms will be available once this plan is finalized.
VI	Appendices	All relevant supporting material is contained in the appendices, including glossary, authorities, and a “Quick Reference Guide” that identifies potential resources that are likely to be available from the California National Guard and federal agencies, including US Health and Human Services and Department of Defense, as of the writing of this plan.

¹ For a more detailed description of California’s Public Health and Medical System, refer to the *California Public Health and Medical Emergency Operations Manual (EOM)*



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I. INTRODUCTION

A. EXECUTIVE SUMMARY

Under day-to-day conditions, California’s emergency medical services (EMS) systems successfully handle emergency medical calls through a network of private ground and air ambulance providers and public safety response agencies. However, a disaster of sufficient magnitude could overwhelm EMS system capacity in local jurisdictions – particularly, a no-notice event such as a large-magnitude earthquake.

The **California Patient Movement Plan** is activated whenever local EMS systems require regional, state or federal assistance to manage the patient movement needs created by the incident, including triage, treatment, stabilization, transportation to definitive care, tracking and repatriation, in addition to the evacuation of existing healthcare facilities as needed. For the purposes of this plan, the term “patient” is used in the broadest possible context, and includes any person who requires medical treatment, medical care, management by trained medical personnel or the use of specialized resources, including transportation (See also Table 1).

This plan describes the essential coordination functions within the medical and health system that support patient movement, along with the stepwise escalation of resource requests if assistance is needed. At the level of the operational area (county and included jurisdictions), the Medical and Health Operational Area Coordination (MHOAC) Program is responsible for collecting and communicating relevant situational information and resource needs related to patient movement. While this plan describes the information necessary to support local jurisdictions if additional patient movement resources are needed beyond those resources under local control, the manner in which this is accomplished remains at the discretion of the local jurisdiction (similar to the approach used by the *California Public Health and Medical Emergency Operations Manual*).

In addition to local resources that may be mobilized through the medical and health mutual aid system, Cal OES may mission resource task state agencies, including the California National Guard, to assist local response activities. In a situation that requires large-scale patient movement beyond California’s immediate capabilities, California may elect to request one or both of the following federal resources: (1) Activation of the Federal Emergency Management Agency’s (FEMA) **National EMS Contract** and (2) Activation of the **National Disaster Medical System** (NDMS) coordinated through the U.S. Department of Health and Human Services (HHS) as the lead agency for federal ESF 8. The National EMS Contract provides staffed ground and air ambulances along with



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paratransit transportation assets, and if needed, additional EMS responders. The NDMS system can support the movement of patients within the state, e.g., from north to south or vice versa, or out of state to federal coordinating center (FCCs), which arrange for definitive care at NDMS-participating destination hospitals.

To assist local planning, forms have been created that allow healthcare facilities to communicate their patient movement needs to their respective Medical and Health Operational Area Coordinator (MHOAC) Program, in addition to forms that facilitate the ability of MHOAC Programs to advance requests to the regional or state levels.

In addition to providing a concept of operations and supporting operational tools, the plan recommends the incorporation of clinical subject matter expertise relative to the management, movement, and existing systems of care for special classes of patients, e.g., neonates.

In summary, this plan establishes a common framework for regional, state and federal response in support of local jurisdictions when a disaster creates the need for assistance with patient movement within and, if necessary, beyond California's borders.

B. OVERVIEW

California's healthcare system includes a complex array of interconnected private and public service providers. Components of this healthcare system function near capacity on a daily basis to manage 11,000 emergency medical calls per day via 9-1-1 (statewide) and provide acute and chronic medical care to a wide variety of patients and residents. In addition to healthcare facilities such as hospitals and skilled nursing facilities, California also has a multitude of congregate care facilities that provide care to residents with chronic medical conditions, disabilities or access and functional needs. In many ways, schools (especially specialized schools but to some extent even regular schools) are congregate care sites that provide care for children with medical conditions, disabilities and access and functional needs. Lastly, many Californians with chronic medical conditions, special healthcare needs or major disabilities are managed in the home environment by family members or home healthcare agencies. A large-scale disaster that interrupts their ability to receive adequate care may lead to the need for patient movement.

In a worst-case scenario for California, a major earthquake in a populated region will likely produce scores of casualties while simultaneously disrupting the ability of the existing healthcare system to continue to provide service. A major earthquake is likely to cause structural damage to buildings, including hospitals and other healthcare facilities, prompting the need to evacuate patients to safety. If access to critical resources such as



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power and water remain interrupted for days, additional healthcare facilities will be faced with evacuation. Backup generators may sustain essential operations for a short time, assuming fuel remains available, but the lack of potable water and other supply shortages are likely to become escalating challenges.

This plan creates a framework for patient movement when a disaster creates the need for patient movement beyond the existing capabilities of California's EMS systems. This plan may be activated whenever local EMS systems require regional, state or federal assistance to manage the patient movement needs created by the incident, including triage, treatment, stabilization, transportation to definitive care, tracking and repatriation, in addition to the evacuation of existing healthcare facilities as needed.

Under typical day-to-day conditions, California's Emergency Medical Services (EMS) systems successfully handle a large volume of emergency medical calls. This daily activity occurs through a network of private ground and air ambulance companies and public safety response agencies. The Emergency Medical Services Authority (EMSA) oversees EMS system planning and implementation for the state's Local EMS Agencies (LEMSAs), which currently consist of 33 single and multi-county organizations. Each LEMSA is expected to meet certain planning goals, including the development of a multi-casualty incident (MCI) plan and trauma plan. However, a large-scale disaster, including an incident that qualifies as catastrophic, may overwhelm the response capabilities of local EMS systems, in which case requests for assistance are expected. Depending on the scope and severity of the incident, it may be necessary to augment local response capabilities with regional, state, interstate or federal resources.

A principle of California's Standardized Emergency Management System (SEMS) is that requested resources should come from the closest available source, particularly in the case of life-saving and life-sustaining resources such as EMS personnel and patient transport vehicles and aircraft. Delays could lead to unnecessary morbidity and mortality.

California is divided into 58 operational areas (following county borders) and six Cal OES mutual aid regions (see map on page 95). California's Health and Medical System has specialized coordination programs that operate at the level of the operational area (MHOAC Programs) and mutual aid region (*Regional Disaster Medical Health Coordination Programs* or RDMHC Programs). Each mutual aid region has an associated Regional Disaster Medical Health Specialist (RDMHS) who coordinates operational activities in their region. Furthermore, Cal OES operates Regional Emergency Operations Centers (REOCs) in each of the three Cal OES Administrative Regions.

Decisions regarding patient movement, e.g., whether to evacuate or shelter-in-place, will depend on circumstances and available options. If request(s) for emergency assistance



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from an operational area can be met within the mutual aid region, the principles contained in the *California Public Health and Medical Emergency Operations Manual (EOM)* and this plan will be followed. If an incident is deemed *catastrophic* by the California Governor's Office of Emergency Services (Cal OES) and large-scale patient movement is anticipated within or beyond the state's borders, this plan will automatically activate.

Patient movement resources will first be sought in unaffected areas of the region and state, and will include EMSA-affiliated **Ambulance Strike Teams** (consisting of 5 ambulances of like capability and a Team Leader in a separate vehicle, supported by a Disaster Medical Services Unit or DMSU²). There are 41 EMSA-affiliated ASTs in California, along with an additional number of unaffiliated ASTs and single-resource ambulances that may also deploy to provide emergency assistance. In addition to private ambulance providers, local fire districts have EMS response assets that are significant to California's disaster medical response capabilities.

California will mobilize all available EMS personnel and transport vehicles from unaffected areas to support the impacted jurisdictions, with the understanding that public safety in the unaffected areas will continue to require EMS resources.

If state officials determine that the incident is of such magnitude that assistance beyond California's mutual aid resources is required or anticipated, then senior officials from EMSA and CDPH will confer with Cal OES regarding the need to acquire additional patient movement resources. Cal OES may mission resource task state agencies, including the California National Guard (CNG), to assist local response activities. In turn, the CNG can augment response by preparing Emergency Management Assistance Compact (EMAC) requests, submitted through Cal OES, to National Guard forces in neighboring states.

In a situation that requires large-scale patient movement beyond California's immediate capabilities, including National Guard support from other states provided via EMAC, California is likely to request federal emergency assistance that may lead to activation of the FEMA **National EMS Contract** and/or the **National Disaster Medical System (NDMS)**.

It is California's preference to transport patients within the state whenever possible, unless doing so presents an unacceptable risk to the patient when compared to the potential benefit. If a disaster occurs in Northern California, it is expected that Central and Southern California can provide a significant number of available hospital beds,

² A Disaster Medical Services Unit (DMSU) is an EMSA-provided vehicle that enables enhanced communication ability, medical supplies and provisions for AST personnel. Deployed ASTs will require re-supply after approximately 72 hours.



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particularly if hospitals decompress to accommodate the incoming medical surge. If a disaster occurs in Southern California, then Northern and Central California should be able to provide hospital beds to support the affected SoCal region.

The National EMS Contract includes ground and air ambulances, paratransit transportation vehicles, and additional EMS personnel if needed. Once the National EMS Contract is requested and approved, assets are expected to arrive in California within 24 hours of the National EMS Contract holder receiving its Task Order from FEMA. The National EMS Contractor establishes a base camp and handles the logistics for their contracted assets, although the use and control of these resources becomes the responsibility of the requesting jurisdiction. Resources provided by the National EMS Contract can be used as the requesting jurisdictions see fit.

NDMS relies on the assets of federal agencies to evacuate patients to definitive care locations, e.g., hospitals, through a series of Federal Coordinating Centers (FCCs) located throughout the U.S. The NDMS system transports patients via military aircraft. In order to enter the NDMS system, basic demographic and clinical information on the patient must be received by military authorities in advance in order to clear the patient for flight. This information is reviewed by a flight surgeon to determine that the patient is an appropriate candidate for aeromedical evacuation and provided to logistical enablers that schedule military aircraft and crews. The advance patient information is also used to locate an appropriate hospital bed for the patient. For these reasons, it is important that federal authorities receive patient information before patients are transported to the NDMS staging areas called Aerial Ports of Embarkation (APOEs). This necessity illustrates why it is important that hospitals and others that may need to evacuate patients into the NDMS system become familiar with the patient information that is required to be provided.

Patients moved within the NDMS system are flown to an FCC that arranges for patient transportation to an NDMS-participating hospital where the patient receives definitive care. The NDMS system also returns the patients to their home of origin through the efforts of HHS. California currently has six FCC locations.

The NDMS system is better suited for lower acuity patients due to military restrictions on aeromedical evacuation (see page 149). Higher acuity patients may be better served by California-based private ground or air ambulance resources that are capable of providing Advanced Life Support (ALS), Critical Care Transport (CCT), or Specialty Care Transport (SCT) for certain populations like neonates who require critical care. The National EMS Contract is capable of providing between 5 to 10 CCT ground ambulances per zone in addition to advanced care air transport.



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Significant coordination activity will be required for large scale patient movement, either within California's borders or beyond, that is unlike any activity routinely conducted in California. First, the impacted jurisdiction or operational area must be able to assess and communicate its need for assistance with patient movement and provide information regarding staging locations for incoming ground (and possibly air) resources. These activities, and others related to patient movement, are the responsibility of the MHOAC Program and the local emergency management agency. The manner in which the MHOAC Program meets these functional responsibilities is not prescribed; one option is to consider the formation of a **Patient Movement Function** within the LEMSA's DOC or within the Medical Health Branch of the operational area's EOC. More information on the components of a Patient Movement Function can be found on pages 70 and 103.

If needed to support the affected operational areas, the RDMHC Programs in the affected mutual aid region(s) should establish a **Regional Patient Movement Coordination Function** that serves as the logistical coordination point for patient movement within the affected region(s). Depending on the severity of impact and the number of staff needed, it may be necessary to import RDMHC Program staff from other mutual aid regions to assist the impacted Regional Patient Movement Coordination Function.

At the state level, the **Medical and Health Coordination Center (MHCC)** serves as the joint EOC for CDPH, EMSA and the Department of Health Care Services (DHCS), in addition to functioning as the CA-ESF 8 Coordination Center. The MHCC will coordinate the collection of Health and Medical Situation Reports and Resource Requests from affected jurisdictions and serve as a communication hub between RDMHC Programs and CA-ESF 8. When necessary, the MHCC should establish a **Patient Movement Function** within the Operations Section that coordinates the collection of situational information and resource requests involving patient movement. The Patient Movement Function within the MHCC provides coordination of patient movement activities in many cases, acting in support of the coordination activities going on at the affected operational areas and mutual aid region.

When incidents create a large need for patient movement, such as a catastrophic incident, a group of federal patient movement representatives called the **Joint Patient Movement Advisor Team (JPMAT)**³ will be sent to California. The JPMAT is likely to locate at the "center of gravity", most likely at the MHCC, or possibly the State Operations Center (SOC)/Initial Operating Facility (IOF)/Joint Field Office (JFO),

³ Joint Patient Movement Advisor Team (JPMAT) represents the federal agencies involved in providing patient movement assistance to a requesting state (e.g., HHS, DoD, VA, etc.) If the National EMS Contract has been activated, the JPMAT will also include a coordinating representative from the National EMS Contractor. The JPMAT is likely to be located at the MHCC or SOC/IOF/JFO.



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particularly if an HHS **Incident Response Coordination Team (IRCT)** is activated for ESF 8. When the JPMAT is activated, the MHCC Patient Movement Function will coordinate state-level information with the JPMAT.

To summarize, once the NDMS system is activated, the necessary patient information for those who require NDMS transport should be collected at the field level (e.g., at the healthcare facility or casualty collection point), then communicated to the MHOAC Program (or the OA EOC's **Patient Movement Function**), who communicates it to the RDMHC Program (or **Regional Patient Movement Coordination Function**), who communicates it to the **Patient Movement Function** at the MHCC. Forms have been developed that are Word and Adobe PDF fillable for use at every level (see Forms package beginning on page 106).

If the federal **Joint Patient Movement Advisor Team (JPMAT)** has been activated at the MHCC or SOC/IOF/JFO, the information should be sent to the JPMAT, who send the data to military transportation authorities. If the JPMAT is not activated, the MHCC should send this information to the ESF 8 Coordinator (or Regional Emergency Coordinator for Region IX HHS) for forwarding to the proper enabling authorities.

It is also recommended that the primary coordination points for patient movement, particularly at the regional and state levels, include clinical subject matter experts that are knowledgeable about the management, movement, and existing systems of care for special classes of patients (e.g., neonates). Neonatal intensive care is provided at a limited number of hospitals in a regional system of care, and during a disaster, it would be particularly important to have access to clinical subject matter experts who are familiar with the capabilities and capacities of these specialized facilities.

C. PURPOSE

The purpose of this plan is to create a framework for patient movement, including concept of operations, when a disaster creates the need for patient movement beyond the capabilities of California's EMS systems. This plan applies whenever local EMS systems require regional, state or federal assistance to manage the patient movement needs created by the incident, including triage, treatment, stabilization, transportation to definitive care, tracking and repatriation, in addition to the evacuation of existing healthcare facilities as needed.

D. SCOPE

This plan describes the organization of California's EMS systems; process for requesting and acquiring assistance with patient movement; roles and responsibilities assigned to key coordination functions within the Health and Medical System, including the Medical



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and Health Operational Area Coordination (MHOAC) Program, Regional Disaster Medical and Health Coordination (RDMHC) Program, and CA-ESF 8 lead agencies, i.e., EMSA and CDPH. The plan addresses the involvement of the California National Guard and federal partners involved in providing assistance with patient movement, including U.S. Health and Human Services (HHS), FEMA, the Department of Defense (DoD) and Veterans Affairs (VA).

E. DEFINITIONS

Table 1. Definitions of key terms used in this plan.

Definition	
Patient	<p>For the purposes of this plan, the term patient will broadly include persons who:</p> <ul style="list-style-type: none"> • are receiving in-patient medical care at a licensed healthcare facility; • are newly injured or ill due to the incident; • live in the community (e.g., congregate care facilities), and have a medical condition that requires medical care and/or transportation; • live in the community and have chronic medical conditions, or disabilities that are successfully managed using resources that may be unavailable during a disaster.
Patient Movement	<p>The term Patient Movement will include all aspects of patient movement due to a disaster. The initial point of entry may be:</p> <ul style="list-style-type: none"> • In the field at the initial point of contact; • Temporary congregation or staging areas (e.g., casualty collection points, field treatment sites, alternate care sites of all types, or temporary shelters); • Licensed healthcare facilities (e.g., hospitals or skilled nursing facilities); • Congregate care facilities <p>Patient movement may also be necessary for those that live in the community who have chronic medical conditions, disabilities, or access and functional needs that are successfully managed using resources that may be unavailable during a disaster.</p>
5 Essential Functions of Patient Movement	<ol style="list-style-type: none"> 1) Patient Evacuation 2) Regulation (Coordination of Transport Resources and Destinations) 3) En Route Medical Care 4) Patient Tracking 5) Repopulation (Return of Patient to Originating Location)
Patient Evacuation	<p>Patient Evacuation refers to the evacuation of patients from a healthcare facility to a place of safety or the evacuation of patients from</p>



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Definition	
	an impacted area to staging locations or destination healthcare facilities in other regions/states.
Medical Regulation	Medical Regulation is a two-part process: 1) arranging the most appropriate transportation vehicle/staff for the patient’s needs; and 2) identifying an appropriate receiving location.
En Route Medical Care	En Route Medical Care is the provision of medical care during the transportation process, including intermediate locations such as patient congregation or staging areas, prior to arrival at a destination facility that can provide definitive care.
Patient Tracking	Patient Tracking is the ability to follow a patient’s path from the point-of-origin to final destination. Patient tracking typically includes demographic information that allows the patient to be uniquely identified along with key information regarding health status, which may be updated at waypoints. California’s EMS systems use a variety of patient tracking systems that work well for intra-EMS system tracking. For large scale patient movement that anticipates patient movement to outlying areas or states, a unified patient tracking system that is compliant with federal requirements is necessary.
Repatriation (Return of Patient to Originating Location)	Repatriation is the return of the patient to his/her originating location. (Note: This may otherwise be referred to as “repopulation”.)

F. GENERAL ASSUMPTIONS

- The **Standardized Emergency Management System (SEMS)** will be used to manage the response to emergencies in California.
- **EMSA** is the lead state department for disaster medical response and is the co-lead with **CDPH** for the California Public Health and Medical Emergency Function (CA-ESF 8).
- In each of California’s 58 operational areas, a **Medical Health Operational Coordinator (MHOAC)** oversees a comprehensive **MHOAC Program** that addresses the 17 functions identified in California Health and Safety Code (HSC) 1797.153. During the response phase of emergencies, the MHOAC Program is the principle coordination point for medical and health response activities and resource



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coordination within the operational area in cooperation with the local emergency management agency.

- Medical and Health Mutual Aid as referred to in this plan often involves private and public EMS resources that will require reimbursement
- In each of California's six mutual aid regions, a **Regional Disaster Medical Health Coordinator (RDMHC)** is appointed to oversee a comprehensive **RDMHC Program** that encompasses the operational areas in the mutual aid region (HSC 1797.152). Each RDMHC Program is supported by a **Regional Disaster Medical Health Specialist (RDMHS)** who provides operational coordination between the region's operational areas and state agencies.
- Under Health and Safety Code (HSC) Division 2.5 (Emergency Medical Services), an **"EMS system"** consists of personnel, facilities and equipment for the effective and coordinated delivery of medical care services under emergency conditions in a specific area. A **"local EMS agency"** is the agency, department, or office having primary responsibility for administration of emergency medical services in a county. Each county may develop an EMS program and may designate a local EMS agency which shall be the county health department, an agency established and operated by the county, an entity with which the county contracts for the purposes of local EMS administration, or a joint powers agency created for the administration of EMS by agreement between counties or cities and counties. (HSC 1797.200)
- EMSA develops implementation guidelines for EMS systems which include disaster response for use by a local EMS agency when constructing their EMS plan. (HSC 1797.103)
- In cooperation with Cal OES, EMSA will respond to any medical disaster by mobilizing and coordinating EMS mutual aid resources. CDPH oversees the licensing and certification of healthcare facilities and will assist with the response related to healthcare facilities, public health and environmental health. CDPH, EMSA and the Department of Health Care Services (DHCS) jointly operate the CA-ESF 8 Coordination Center in Sacramento called the Medical and Health Coordination Center.
- Federal agencies will respond to emergencies in accordance with the National Response Framework (NRF) and the National Incident Management System (NIMS).
- The statutory authority for federal ESF 8 support for patient movement is found in the Public Health Service Act (42 USC 248j) and various intra-agency agreements.



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The lead agency for federal ESF 8 is the U.S. Department of Health and Human Services through the Office of the Assistant Secretary for Preparedness and Response. *The Movement of Medical Evacuees (2011)* provides the Concept of Operations for federal response activities involving patient movement during disasters.

G. PATIENT MOVEMENT PLANNING ASSUMPTIONS

- During mass casualty incidents (MCIs), healthcare facilities, EMS systems and local jurisdictions will follow existing MCI response plans in accordance with the policies, protocols and procedures established by the LEMSA.
- The Medical and Health Operational Area Coordinator (MHOAC) Program is the functional point of contact for all health and medical response activities in the affected operational area and works closely with the local emergency management agency and/or EOC. The development of local MHOAC plans should include a patient movement component and how operational area processes will integrate with this statewide plan.
- The Regional Disaster Medical and Health Coordination (RDMHC) Program is the functional point of contact for all health and medical response activities in each mutual aid region and works closely with regional Cal OES representatives.
- Initially, patients will be distributed pursuant to policies, protocols and procedures established by the LEMSA. At some point in an escalating event, specialty care destinations may exceed patient reception capacity and the triage and transport scheme will change. Based upon the dynamics of the incident, patients may be sent to more appropriate destinations that are not necessarily the closest facility.
- It may be necessary to establish casualty collection points in the affected areas if the capacity of healthcare facilities is exceeded, or if the capacity of EMS transport is exceeded.
- A patient's health generally does not improve with movement. Patient movement may expose patients to additional risks associated with exacerbation of their medical condition, transportation accidents, or delays en route due to weather, accidents, or secondary events subsequent to the original event (e.g., aftershocks, flooding, power/communications system failures).
- Patients may be moved via ground and air ambulance through direct facility-to-facility transfer. However, competing transport resource requests may quickly overwhelm available resources during large incidents. Additionally, resources



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utilized for day-to-day patient transportation may be re-tasked based upon incident resource management priorities. Local patient movement plans, policies, procedures, ordinances and written agreements should include clear expectations for the prioritized utilization of transport resources during large incidents/events.

- Patient movement support may be requested through the health and medical mutual aid system if local capabilities are exceeded within the operational area.
- Mutual aid may be used to move patients to surrounding operational areas and throughout the region.
- Medical and Health Mutual Aid as referred to in this plan often involves private and public EMS resources that will require reimbursement.
- In larger, more severe incidents, patients may need to be moved out of the operational area/region due to lack of capacity or specialized medical capabilities. State assistance may be requested to facilitate patient movement. Medical and health mutual aid resources include EMSA-affiliated Ambulance Strike Teams (ASTs), unaffiliated ASTs, and single resource ambulances from private ambulance providers and the fire service.
- Intra-state evacuations will be the first option for patient movement if possible, unless doing so presents an unacceptable risk to the patient when compared to the potential benefit.
- In the case of a major or catastrophic incident resulting in a large number of casualties (or need to evacuate healthcare facilities), local and regional capacities may be exceeded. Given the state's size and the considerable number of healthcare facilities in both northern and southern California population centers, it is feasible that patients could be moved to receiving healthcare facilities in the unaffected regions of the state.
- Ideally, evacuated patients should be kept as close to their original location as possible.
- To the extent that it does not adversely impact patient care and safety, patients evacuated from a healthcare facility that belongs to a larger healthcare system should preferentially remain within that system.
- Healthcare facilities in the affected areas may choose to decompress current inpatients/residents to accommodate the surge of casualties. Local systems that employ this option should have processes, protocols and procedures in place as part of their patient movement plan.



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- Pediatric medical transportation capability is limited, and pediatric bed capacity and medical care is distributed regionally. This may require children to be transported further away (including out of state) earlier in a catastrophic event. Further pre-planning will be required to address both neonatal and pediatric patient movement issues. Local/Regional Healthcare Coalitions may be a resource to pre-identify pediatric populations and resources to treat and transport pediatric patients.
- Large scale pediatric Intensive Care Unit (ICU) and neonatal ICU evacuation associated with hospital evacuation of an operational area in a catastrophic earthquake scenario will require out-of-area mutual aid, including assistance from out-of-state pediatric regional centers.
- Pediatric traumatic injury projections associated with a catastrophic earthquake are estimated to affect 2,890 children within the Greater Bay Area Region.⁴
- Availability of EMS assets may be limited during disasters due to competing operational commitments.
- All evacuations are subject to weather conditions and safety considerations.
- Any potentially contaminated patient must be decontaminated before transport.
- Ideally, patients should be stabilized prior to being transported. The capability to effectively stabilize all patients prior to transport may vary based upon medical capabilities, available resources and impending threats to the patient(s) (e.g., emergency evacuations).
- During the patient movement process all efforts are directed toward maintaining continuity of patient care across the entire continuum of care.
- Whenever possible, it is optimal to transport medical attendants, parent/guardians and service animals with their corresponding patients.
- It is anticipated that during patient movement, children may become separated from their parents or guardians and unaccompanied minors will require reunification.
- California's EMS systems use a variety of patient tracking systems, including paper-based and electronic systems. Because these systems are not integrated across the

⁴ Pediatric Emergency Disaster Support Software (PEDSS) Children's LA using Kidsdata.org Region II children population estimates.



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state, there is potential for a greater margin of error and inconsistent tracking in a regional or statewide incident. For this reason, CA-ESF 8 recommends the adoption of a unified tracking system that would accommodate the movement of large numbers of patients to destinations beyond the operational area, region or state boundaries. The proposed California Unified Patient Tracking System (CUPTS) (see page 74) should be used by any location, whether a healthcare facility or field casualty collection point, if patients may be moved beyond the boundaries of the local EMS system.

- The state should use all available local and state resources, including the California National Guard, prior to requesting federal support for patient movement.
- Absent a Presidential declaration of a major disaster or emergency, there is no federal reimbursement available for costs associated with state or local patient movement activities.
- With a Presidential declaration of a major disaster or emergency and a state request that federal patient movement occur, federal assets can provide both intrastate and interstate patient movement support.
- Military aircraft are designed to transport military personnel, not the full range of patients/residents encountered in civilian healthcare. Planners should be particularly cognizant of these restrictions so alternative patient movement strategies for these populations can be identified before disaster strikes, e.g., the movement of pediatric patients. A full list of contraindications to military airlift is contained in the plan on page 148.
- The staging of federal resources should be coordinated between local, state and federal officials.

H. CATASTROPHIC PLANNING ASSUMPTIONS

California, led by Cal OES, has been engaged in catastrophic planning with FEMA to enhance the state's preparedness for a catastrophic incident. This purpose of this joint planning activity is to better prepare both state and federal response agencies to coordinate their resources and activities so that help is effectively and quickly provided to affected jurisdictions. Cal OES and FEMA have developed California specific plans that apply to a San Francisco Bay Area earthquake, a Southern California earthquake, and a Cascadia Subduction Zone (Northern California) earthquake and tsunami. These plans are based on scenarios that are examples of the catastrophic incidents that could befall California.



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Cal OES, in collaboration with FEMA, will determine if an incident impacting California qualifies as catastrophic. If it is so determined, then state and federal partners will establish, as quickly as possible, a joint state-federal EOC (transitioning from the State Operations Center (SOC) to an Initial Operating Facility (IOF) to a Joint Field Office (JFO)). Under a catastrophic scenario, the functions of the Cal OES Regional Emergency Operations Center (REOC) in the affected Cal OES Administrative Region will be managed by personnel located at the joint state-federal EOC. Regional Cal OES staff and federal representatives will also be embedded in the affected operational area EOCs.

Using the **San Francisco Bay Area Earthquake Plan** (2016) as an example, major impacts from catastrophic events include:

- Casualties
 - 21,000 - 82,000 Emergency Department (ED) visits
 - 720 - 2,900 new patients requiring inpatient care
 - 120 - 560 new patients requiring ICU-level care
 - 38,000 - 140,000 persons requiring outpatient medical care
 - 23,000 - 28,000 patients with acute mental health needs
- Medical Infrastructure
 - 25 - 50% of EDs across the Bay Area will be non-functioning
 - Up to 90% of EDs in heavy shake zones will be non-functioning
 - 19 - 41 hospitals will require full or partial evacuation (4,600 - 11,000 patients)
 - Up to 50% of long term care facilities (LTCs) across the Bay Area will require evacuation, accounting for 150 facilities and a total of 26,000 skilled nursing or intermediate-level care residents; up to 90% of LTCs in heavy shake zones will be non-functioning
 - 60% of the mental health capacity across the Bay Area will be non-functioning; 90% will be non-functioning in heavy shake zones
- The remaining functioning parts of the emergency medical system (ambulances, EMTs, dispatch systems, emergency departments) will be unable to manage the surge of patients for several days or even weeks
- Calls for EMS transports in support of 9-1-1 requests and healthcare facility evacuations will far exceed the Bay Area's EMS capacity
- The majority of pediatric regional centers are located on or near major fault zones
- Loss of utilities, supply chains, and services may drive the evacuation of structurally sound hospitals and LTC facilities
- Mutual aid will be fully engaged but insufficient to deal with medical surge, healthcare facility evacuations, and loss of medical infrastructure



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- Patients will need to be evacuated outside of the Bay Area Mutual Aid Region II
- Damage to the transportation infrastructure, including airports and seaports, will impede EMS response and evacuation efforts
- EF 9 (Search and Rescue) and EF 6 (Mass Care) will require medical support.
- Health and medical responders from the state, Department of Defense (DoD), and the U.S. Department of Health and Human Services (HHS) will number over 5,000 and require unified command, coordination, and logistical support in order to be effectively employed
- Monitoring the environment and health of people in temporary shelters and responder base camps will be required

Using the **Southern California Catastrophic Earthquake Plan (2010)** as an example, major impacts include:

- 53,000 injuries
- Hospital capacity will be reduced by an estimated 30%, and as much as 75% in specific OAs. An estimated 13,000 hospital beds are lost
- For the remaining hospitals to continue operation, they will immediately need water, fuel, pharmaceuticals and personnel
- Shortages will exist in hospital equipment, including beds and prescription medications affecting patient care
- Damage to the transportation infrastructure, including airports and seaports, will impede EMS response and evacuation efforts
- Initially, 40% of patients with special medical needs will require immediate assistance with an additional 40% requiring care within 72 hours and the remaining 20% of the population requiring care within the first week
- Many roads, highways, and bridges will be impassable in the first few days after the earthquake due to damage and debris on the roads, hampering patient movement



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II. SYSTEM DESCRIPTION

A. EMS SYSTEMS

In California, EMS systems are organized on a county or regional basis. As of 2017, there are 33 local EMS agencies (LEMSAs) that serve as the lead agency responsible for local EMS system planning, implementation and evaluation in one or more California counties. See page 94 for a map detailing California’s Local EMS Agencies.

B. EMS ROLES DURING DISASTERS

All EMS systems in California are required to include *disaster medical response* in their EMS plans, described in EMSA Guidelines (Publication #101) as:

“The local EMS system must be capable of expanding its standard operations to meet the needs created by multi-casualty incident (MCI) and medical disasters, including integration of out-of-area resources.”

In addition to maintaining day-to-day operations to support community needs, the primary EMS activities during disaster response include:

- Triage, treat and transport patients from the field to a receiving hospital or intermediate destination if a receiving hospital is unavailable or inaccessible
- Support the evacuation of patients from hospitals and other healthcare facilities
- Establish and staff casualty collection points, field treatment sites, alternate care sites, or other temporary patient care locations

C. PUBLIC HEALTH AND MEDICAL SYSTEM COORDINATION

California’s Public Health and Medical Response System relies upon specific coordination programs that support public health and medical activities, including health and medical mutual aid, while integrating into the existing emergency management structure. These coordination programs, including the **Medical Health Operational Area Coordination (MHOAC) Program** and **Regional Disaster Medical and Health Coordination (RDMHC) Program**, are essential to effective and coordinated response. The table below summarizes the primary coordinating entities within the Public Health and Medical System at each SEMS level, the primary EOCs that support health and medical emergency response, and the respective location of patient movement coordination activities.



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Table 2. Entities with health and medical response roles at each SEMS level.

SEMS LEVEL	ENTITY WITH PUBLIC HEALTH AND MEDICAL ROLE
State	<p>State agencies with a public health and medical response role, including but not limited to:</p> <ul style="list-style-type: none"> • Emergency Medical Services Authority (EMSA) • California Department of Public Health (CDPH) • California Department of Health Care Services (DHCS) • California National Guard (CNG) • California Department of Managed Health Care (DMHC) • California Governor’s Office of Emergency Services (Cal OES) <p>State-level emergency operation centers may include:</p> <ul style="list-style-type: none"> • Medical and Health Coordination Center (MHCC) – Joint EOC for CDPH, EMSA and DHCS and CA-ESF 8 Coordination Center. • State Operations Center (SOC) – Manages overall state response activities; Cal OES may request CA-ESF 8 Coordinator position and/or state agency representatives. • Initial Operating Facility (IOF) – If Cal OES assesses that an incident is of such magnitude that it will require significant federal support, in consultation with FEMA, the decision may be made to establish an Initial Operating Facility (IOF) that will co-locate state and federal response operations. The IOF will serve as the state-federal coordination center for the incident. The SOC may initially serve as the IOF or it may be established at a nearby location. • Joint Field Office (JFO) – Under a catastrophic scenario that requires the combination of state and federal resources, the IOF will transition to a Joint Field Office (JFO) within 5-10 days. The JFO will serve as the state-federal coordination center for the incident. <p>State-level patient movement coordination: <i>Patient Movement Function</i> within the Operations Section of the MHCC (CA-ESF 8 Coordination Center)</p>



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<p>Region</p>	<p>Regional programs with a public health and medical response role:</p> <ul style="list-style-type: none"> • Regional Disaster Medical and Health Coordination (RDMHC) Program, which includes the RDMHS. The RDMHC Program is established in each of the six mutual aid regions. • Cal OES Regional Duty Officer Program. <p>Regional emergency operation centers may include:</p> <ul style="list-style-type: none"> • Regional Emergency Operations Centers (REOCs) operated by Cal OES: <ul style="list-style-type: none"> ○ Inland REOC ○ Coastal REOC ○ Southern REOC <p>Note that in the case of a catastrophic scenario, Cal OES may not open the REOC in the affected region. The functions of that REOC will be absorbed into the joint state-federal Initial Operating Facility (IOF) transitioning to the Joint Field Office (JFO), in addition to the EOCs in the affected operational areas.</p> <p>A representative from the RDMHC Program, i.e., the RDMHS, should be considered the primary contact if the Medical and Health (or CA-ESF 8) Branch is activated in a REOC.</p> <p>Regional patient movement coordination: A <i>Regional Patient Movement Coordination Function</i> should be established by the affected RDMHC Program(s). The location of the <i>Regional Patient Movement Coordination Function</i> may be the REOC (if open) or another facility (e.g., LEMSA DOC).</p>
<p>Operational Area</p>	<p>OA programs with a public health and medical response role:</p> <ul style="list-style-type: none"> • Medical Health Operational Area Coordination (MHOAC) Program • Local OES <p>OA emergency operation centers may include:</p> <ul style="list-style-type: none"> • OA EOC <p>Note that a representative from the MHOAC Program should be considered the primary contact if the Medical and Health (or CA-ESF 8) Branch is activated in the OA's EOC.</p> <p>OA patient movement coordination: A <i>Patient Movement Function</i> should be established by the affected MHOAC Program at a location such as the OA EOC or LEMSA/LHD DOC.</p>
<p>Local</p>	<p>Local government agencies with a public health and medical response role include, but are not limited to:</p> <ul style="list-style-type: none"> • Local Emergency Medical Services Agency (LEMSA) • Local Health Department (LHD) • Local Environmental Health Department (EHD) • Local Behavioral/Mental Health Department



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	Local emergency operation centers may include: <ul style="list-style-type: none"> Local Government DOCs and EOCs
Field	Healthcare facilities, EMS providers, paratransit providers, etc.

1. MHOAC Program

The MHOAC Program is responsible for the coordination of patient distribution and medical evaluation within each operational area (OA), and therefore becomes the OA’s point-of-contact for patient movement within or beyond the OA. The MHOAC Program is responsible for situation reporting and resource requests involving the health and medical system, in addition to coordinating the use of incoming resources.

The MHOAC Program is based on the functional activities described in Health and Safety Code §1797.153. Within each operational area, the Health and Safety Code authorizes the county health officer and local emergency medical services administrator to jointly act as the MHOAC or appoint another individual to fulfill the responsibilities.

The Health and Safety Code directs the appointed MHOAC as follows: “The MHOAC shall recommend to the operational area Coordinator of the Office of Emergency Services a medical and health disaster plan for the provision of medical and health mutual aid within the operational area.” Furthermore, the medical and health disaster plan shall include preparedness, response, recovery and mitigation functions in accordance with the State Emergency Plan, as established under Sections 8559 and 8560 of the Government Code as follows:

- 1) Assessment of immediate medical needs
- 2) Coordination of disaster medical and health resources
- 3) Coordination of patient distribution and medical evaluation
- 4) Coordination with inpatient and emergency care providers
- 5) Coordination of out-of-hospital medical care providers
- 6) Coordination and integration with fire agency personnel, resources, and emergency fire pre-hospital medical services
- 7) Coordination of providers of non-fire based pre-hospital emergency medical services
- 8) Coordination of the establishment of temporary field treatment sites
- 9) Health surveillance and epidemiological analyses of community health status
- 10) Assurance of food safety
- 11) Management of exposure to hazardous agents
- 12) Provision or coordination of mental health services
- 13) Provision of medical and health public information protective action



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recommendations

- 14) Provision or coordination of vector control services
- 15) Assurance of drinking water safety
- 16) Assurance of the safe management of liquid, solid, and hazardous wastes
- 17) Investigation and control of communicable disease

The MHOAC Program should involve all of the major organizations and agencies involved in the 17 functions identified above.

In order to accomplish the 17 functions specified in statute, a comprehensive MHOAC Program will:

- Maintain a 24 hour-per-day, 365 day-per-year single point of contact for the MHOAC Program and provide contact information to the RDMHC Program who provides this information to CDPH and EMSA
- Ensure that contact information is readily available to Public Health and Medical System participants within the operational area
- Provide trained backup personnel capacity during emergencies
- Provide situational reports in accordance with the processes identified in this plan
- Maintain a directory of public health, environmental health, and EMS resources, including equipment, supplies, personnel and facilities within the operational area
- Coordinate the identification, acquisition and delivery of health and medical mutual aid and scarce resource allocation
- Utilize resource requesting and management procedures in accordance with the processes identified in this plan
- Support the Medical and Health Branch of the operational area EOC if activated

In accordance with the preparedness, response, recovery and mitigation functions outlined in Health and Safety Code §1797.153, the MHOAC Program in each operational area is encouraged to develop policies and procedures that apply uniformly throughout the operational area so that basic operational processes involving the Public Health and Medical System (e.g., situation reporting and resource requesting), are well understood and practiced. This will enhance coordination between the operational area and successive SEMS levels so that situational awareness is maintained and resources can be provided as efficiently as possible if requested.

If an incident overwhelms the ability of the local EMS system to provide EMS services, including patient movement, then it may be necessary to activate a **Patient Movement**



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Function within the LEMSA or LHD Department Operations Center (DOC) or the operational area's EOC. The Patient Movement Function expands the capabilities of the MHOAC Program to assess the patient movement needs created by the disaster, adequacy of existing EMS resources including operational day-to-day agreements, and need for emergency assistance.

2. RDMHC/RDMHS Program

The Regional Disaster Medical Health Coordination (RDMHC) Program is responsible for the coordination of patient distribution and medical evaluation within the mutual aid region, and therefore becomes the mutual aid region's point-of-contact for patient movement and evacuation within or beyond the mutual aid region. The RDMHC Program coordinates mutual aid within each mutual aid region. See Figure 2 on page 95 for a map of California's mutual aid regions.

The RDMHC is an appointed position in each of the six mutual aid regions established by Health and Safety Code §1797.152. The RDMHC coordinates disaster information and medical and health mutual aid and assistance within the mutual aid region or in support of other affected mutual aid region(s). The RDMHC may be a county health officer, county coordinator of emergency services, local emergency medical services administrator, or local emergency medical services medical director. Appointees are nominated by a plurality of the votes of local health officers in the mutual aid region and jointly appointed by the Directors of CDPH and EMSA.

The Regional Disaster Medical and Health Specialist (RDMHS) is the key operational staff person placed in each mutual aid region who directly supports regional preparedness, response, mitigation and recovery activities. In addition to receiving support from the employing LEMSA, the RDMHS in each region is also supported by the RDMHSs in other mutual aid regions, along with EMSA and CDPH staff at the state level.

The support of activated Medical and Health Branches at REOCs is coordinated by RDMHC Programs, CDPH and EMSA.

In order to accomplish the functions specified in statute, a comprehensive RDMHC Program will:

- Maintain a 24 hour-per-day, 365 day-per-year single point-of-contact for the RDMHC Program and provide contact information to the MHOAC Programs within the mutual aid region, CDPH and EMSA
- Provide the 24 hour-per-day, 365 day-per-year single point of contact information for the MHOAC Programs in the mutual aid region to CDPH and EMSA



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- Provide trained backup personnel capacity during emergencies
- Coordinate with MHOAC Programs in the mutual aid region to ensure that all 17 MHOAC Program functions are met
- Ensure that situational information is provided in accordance with the processes identified in this plan
- Coordinate with MHOAC Programs in the mutual aid region to maintain directories of public health, environmental health, and EMS resources, including equipment, supplies, personnel and facilities, within each operational area
- Coordinate the identification, acquisition and delivery of health and medical mutual aid and assistance to affected operational areas within the mutual aid region, or if necessary, to affected operational areas in other mutual aid regions
- Utilize resource requesting and management procedures in accordance with the processes identified in this plan
- Coordinate with CDPH and EMSA to support the Medical and Health Branch of the REOC, if activated

If the local EMS systems within a region or regions are not able to meet the patient movement needs created by the incident, it may be necessary to activate a **Regional Patient Movement Coordination Function** under the direction of the impacted RDMHC Program(s). The size of the Regional Patient Movement Coordination Function is scalable; if the functions identified in Figure 9 on page 103 could be handled by one person, it may be the RDMHS with assistance. However, in a larger scale event, a larger structure may be necessary (see Figure 10 on page 104). The Regional Patient Movement Coordination Function serves as a logistical support function that operates at the regional level, leveraging the knowledge of EMS systems and healthcare facilities in the affected regions. The Regional Patient Movement Coordination Function expands the capabilities of the RDMHC Programs relative to the assessment of patient movement needs created by the disaster, adequacy of existing EMS resources including operational day-to-day agreements, and need for emergency assistance from beyond the affected regions

The Regional Patient Movement Coordination Function may be located at the REOC for the Cal OES Administrative Region, or if it is not available for this activity, an alternate location.

A Liaison from the federal Joint Patient Movement Advisor Team (JPMAT) or Joint Patient Movement Coordination Team (JPMCT) could be requested by California to



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augment the RDMHC Program if a Regional Patient Movement Coordination Function is activated.

3. EMSA and CDPH

EMSA functions as the lead state department for disaster medical response and CDPH functions as the lead state department for public health and environmental health response. In addition to conducting program activities in accordance with statutory and regulatory authorities, CDPH and EMSA actively conduct operations to support California's public health and medical response during unusual events and emergencies.

EMSA and CDPH operate Duty Officer Programs on a 24 hour-per-day, 365 day-per-year basis. The EMSA and CDPH Duty Officer Programs receive notifications from internal and external sources regarding emerging public health, environmental health and medical events, and notify appropriate state level programs and local partners to increase awareness when a threat is approaching or imminent. When unusual events occur that require additional coordination and communication, the CDPH and/or EMSA Duty Officer Programs notify management, internal programs, local partners, and other state agencies in accordance with established policies and procedures. When incidents require further coordination, CDPH, EMSA and the DHCS activate the Medical and Health Coordination Center (MHCC) to coordinate information and resources in support of California's public health and medical response.

Primary health and medical (CA-ESF 8) support will occur at the MHCC, including situation assessment in the affected operational areas and mutual aid regions, monitoring anticipated resource needs and receiving resource requests, and providing resources and assistance at the discretion of department management or when mission resource tasked by Cal OES. The MHCC, as the CA-ESF 8 Coordination Center, should function as the "center of gravity" for patient movement within the state's emergency management system, although this capability requires further development, along with regional coordination.

Because CA-ESF 8 maintains a health and medical mutual aid system that includes the MHOAC Program, RDMHC Program and EMSA/CDPH, resource requests involving EMS resources are most efficiently handled via that system. This information should be simultaneously shared with appropriate emergency management agency representatives.

Cal OES is likely to request a CA-ESF 8 Coordinator and/or Agency Representatives from EMSA and CDPH for most SOC activations. This would certainly be the case for a catastrophic scenario, and EMSA and CDPH staff would initially be dispatched to the SOC,



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transitioning to the combined state-federal Initial Operating Facility (IOF) and ultimately the Joint Field Office (JFO).

If it is anticipated that federal resources will be needed in the event of a catastrophic scenario or whenever incoming EMS resource requests significantly exceed available state resources, EMSA and CDPH will support the development of federal resource requests for submission to federal authorities by Cal OES. In coordination with federal ESF 8, EMSA and CDPH will provide expertise on the necessary documentation required to activate the FEMA National EMS Contract and/or NDMS as required.

The EMSA Duty Officer Program, in coordination with the CDPH Duty Officer Program, functions as the state level point-of-contact for activities involving patient movement and evacuation. In a disaster that generates significant patient movement needs, the MHCC will serve as a CA-ESF 8 Coordination Center and activate a **Patient Movement Function** within Operations. In addition, CA-ESF 8 will send a representative to the SOC/IOF/JFO for coordination purposes.

D. INTEGRATED HEALTH SYSTEMS

California has several large integrated health systems which cover multiple jurisdictions and/or regions. Local planning efforts should be coordinated with the planning efforts of these systems for medical disaster response to ensure the highest level of integration. These systems should consider they might be vulnerable if they build their plans based on a linear surge capacity model. Specifically, the transportation assets these systems rely upon for day-to-day operations may not be available during catastrophic events; these assets will likely be under the control of the Local EMS Agency (LEMSA). It is strongly recommended that LEMSA and IHS planning efforts be *robust, integrated and compatible*.

Special planning considerations involving IHS may be appropriate. While requests for resources (e.g., personnel, supplies and transportation) will need to follow the pathways outlined in the Public Health and Medical Emergency Operations Manual (EOM), that is, directed to and coordinated by the Medical Health Operational Area Coordinator (MHOAC) Program, the capacities of an IHS might be leveraged to take pressure off local response demands. Consider that an IHS will likely have resources not directly impacted by the event. This provides an opportunity, i.e., capacity, to receive patients, reducing the effort needed by the MHOAC and/or RDMHS Programs to find patient destinations. This is of course mutually beneficial in that the IHS is able to keep patients “in plan”. It also reduces the complexity and effort associated with the repatriation of these patients once the event has been mitigated.



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It is reasonable to expect that an IHS will have the best information on its members/patients and thus will be in the best position to prioritize those persons who must be moved. However, the IHS may find it necessary to prioritize and re-prioritize based on asset scarcity. In other words, there can be no expectation of transportation asset availability except possibly those directly and wholly owned by the IHS. In a catastrophic event, which is the basis for this plan, an IHS could possibly be competing with resources it otherwise would have regular access to. Planning by IHS organizations needs to sufficiently address scenarios of scarce resources.

As mentioned, an IHS can be valuable to the local jurisdiction in that it might provide available capacity via its facilities in unimpacted areas. The IHS can also provide value in terms of information, not only on its members/patients, but also on a broader system or region wide basis. Information can be collected from its various facilities and then centralized to provide a broad, cohesive picture of health and medical needs. Catastrophic events will force entities, public and private, to work collaboratively and in ways atypical in day to day scenarios. By recognizing the value of IHS, local jurisdictions can potentially tap into resources not otherwise anticipated.

E. PATIENT MOVEMENT RESOURCES WITHIN CALIFORNIA

1. Local Private and Public

A robust capability exists for response to large scale patient movement with the private and public air and ground EMS resources currently in cities and counties throughout the state. Local jurisdictions can be called upon in accordance with SEMS to provide resources when areas of the state are overwhelmed by disaster. Local EMS can provide resources to the extent that they have additional resources beyond those needed to operate their day-to-day EMS systems as determined by the respective LEMSA. It is difficult to estimate what this contribution might be given the existing need for 9-1-1 emergency service in all communities and limited surplus inventory (EMS systems in California are generally a combination of public and private partners). It is likely that some larger EMS systems could provide ambulances as Ambulance Strike Teams or single resources. In addition, non-standard patient movement resources such as buses, trains, boats, commercial aircraft and paratransit vehicles may be used.

Table 3. Statewide EMS resources (as of the date of this plan)

RESOURCE	QUANTITY
Emergency Medical Technicians (EMTs)	61,826



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RESOURCE	QUANTITY
Advanced EMTs	115
Paramedics	22,747
ALS and BLS Ground Ambulances	3,600
Air Ambulances	74
Affiliated Ambulance Strike Teams	41

2. EMSA and CDPH

EMSA and CDPH maintain and/or support specialized resources to assist local emergency response when requested. During emergency system activations, all resources, including state and federal assets, should be requested in accordance with SEMS using the health and medical resource requesting process identified in this plan and the California Public Health and Medical Emergency Operations Manual (EOM). Ambulance Strike Teams and Disaster Health Care Volunteers are local resources that are part of programs that have been developed by EMSA. EMSA, therefore, can be effective in providing support and coordination for locals and these specialized resources during events when large numbers are required for response. The following table lists the resources coordinated by EMSA that relate to patient movement:

Table 4. Resources coordinated by EMSA relevant to patient movement.

RESOURCE	DESCRIPTION
Ambulance Strike Teams (AST)	Modeled after the FIREScope Engine Strike Team concept, an Ambulance Strike Team (AST) consists of 5 ambulances of like capability (ALS or BLS), a Strike Team Leader (ASTL) in a separate vehicle, with common communications among all members of the AST, and equipped for 72 hours initial self-sufficiency. There are 41 affiliated ASTs throughout the state. These are teams whose providers have been issued a Disaster Medical Support Unit (DMSU) which can serve as the vehicle for the ASTL. Affiliated AST providers have signed agreements with EMSA to provide an AST upon request when available. There are also unaffiliated ASTs organized at the local level which are not under contract with EMSA, however they may be utilized in the same fashion as affiliated ASTs. AST Program Guide, EMSA Publication #215.



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RESOURCE	DESCRIPTION
<p>California Medical Assistance Team (CAL-MAT)</p>	<p>California Medical Assistance Teams (CAL-MATs) are teams (5 to 50 members) of medical professionals such as physicians, nurses, pharmacists, medical specialists and support staff, who are capable of responding to disasters and emergencies anywhere in the state within 12 hours of activation. CAL-MATs can operate in a variety of settings (Triage, Field treatment Sites, Medical Shelters, Fire Line Base Camps, etc.), and support a variety of missions such as Medication Dispensing, Mass Vaccinations, Nursing Care, acute emergency care, etc. CAL-MATs are completely self-sufficient for up to 72 hours. There are three CAL-MAT caches and six CAL-MAT support vehicle trucks maintained to support the CAL-MAT program. CAL-MATs are a state-controlled asset and must be requested through the Standardized Emergency Management System (SEMS).</p>
<p>Mission Support Teams (MST)</p>	<p>Mission Support Teams (MSTs) provide logistical support for deployed EMSA mobile medical assets (e.g., CAL-MATs), and also provide coordination between the requesting local jurisdiction, deployed asset(s), and the state. Coordinated by EMSA, MSTs may be staffed by personnel recruited by EMSA through the CAL-MAT Program, and like CAL-MAT, the size and composition of the Team is scalable and mission-dependent. There are three MST caches and three MST support vehicles maintained to support the MST program.</p>
<p>Disaster Healthcare Volunteers (DHV)</p>	<p>The Disaster Healthcare Volunteer (DHV) Program is California’s model of the Emergency System for Advance Registration of Volunteer Healthcare Professionals (ESAR-VHP). It is a statewide program operated and administered by EMSA in coordination with Operational Areas to recruit, register, credential, track, identify, deploy, and maintain currently licensed volunteer healthcare professionals, including Medical Reserve Corps members for response to emergencies, disasters, and terrorist incidents in California.</p>

3. California National Guard (CNG)

The California National Guard (CNG) is a state and federal asset. During emergencies, CNG capabilities are resourced by the state in a state status, commonly emergency state active duty (ESAD). The Governor, through Cal OES, may request CNG capabilities through a mission resource tasking (MRT) to support civilian patient movement operations during an emergency. CNG is task organized under the command and control of the Governor, exercised through the state’s adjutant general. In addition, the CNG may be requested to accomplish federal activities, while remaining under the control of the Governor under Title 32 (T32) status. Under T32, CNG forces remain under the authority of the Governor and are funded by the federal government. Finally, CNG may



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be placed in federal active duty status, referred to as Title 10 status. In this case, the forces are under the authority of the President as Commander in Chief. It may be beneficial for the CNG Joint Operations Center and MHCC to exchange liaisons to facilitate patient movement.

4. California ESF-1 (Transportation)

In California, the Transportation Emergency Function (CA-ESF 1) is led by the California Transportation Agency who has delegated operational authority to the California Department of Transportation (Caltrans) and the California Highway Patrol (CHP). If in-state paratransit transportation resources are needed for disaster patient movement, resource requests should be routed through CalTrans (CA-ESF 1) for coordination among local jurisdictions.

F. EMAC AGREEMENTS

The State of California has no pre-established Emergency Management Assistance Compact (EMAC) agreements with ambulance providers outside of California. EMAC resources may be requested by Cal OES and are also utilized by the CNG to request patient movement resources from the National Guard forces in neighboring states.

G. FEDERAL PATIENT MOVEMENT OVERVIEW

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

- 1) Support to local EMS response **within** the affected area via ground ambulances, paratransit vehicles and rotary wing aircraft, including:
 - Movement from point of origin to first receiver (9-1-1 augmentation)
 - Movement between healthcare facilities
 - Movement to medical special needs shelters
 - Movement to evacuation points
- 2) Evacuation of patients **out of** the affected area via ground ambulances, paratransit vehicles, rotary and fixed-wing aircraft:
 - Evacuation of hospitalized or injured patients
 - Evacuation of special medical needs patients



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In general, requests for federal assistance should be submitted as a statement of needs and requirements, not a request for a specific type of aircraft, team, or equipment⁵. Federal ESF 8 will work with supporting agencies including DoD to match the resources that can best meet the state's requirements.

Federal capabilities are designed to augment local and state patient movement efforts and can be used in a variety of ways. The National EMS Contract and NDMS are the two primary sources for these capabilities. Federal patient movement capabilities include:

- Ground Ambulances (Advanced and Basic Life Support) (National EMS Contract and DoD)
- Paratransit Vehicles (National EMS Contract)
- Rotary Wing Air Ambulances (National EMS Contract and DoD)
- Fixed Wing Air Ambulances (National EMS Contract and DoD)

The selection of medical transportation options depends on the patient's medical condition and mobility in addition to the types of transportation resources that are available. Medical and safety considerations will determine whether individuals should be transported by ground ambulance (stretcher), paratransit vehicle or general population conveyance (e.g. buses).

Triaging of patients for movement during a large-scale evacuation includes 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 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

⁵ The exception to this guidance is when California requests the National EMS Contract. Under contract to FEMA, a national ambulance company provides EMS assistance during disasters. When requesting the National EMS Contract, the RRF should specifically state the # of ambulances requested by type (ALS, BLS or ALS Bariatric), # of rotary or fixed wing ambulances, # of paratransit seats required and # of additional EMS personnel by type beyond the EMS personnel that accompany the deployed ground and air ambulances.



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Individuals who require 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.

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 are individuals whose age, mobility, functional and/or medical disability make them particularly vulnerable and at risk in disaster situations. They may require some medical surveillance from their own caregiver and/or special assistance.

In the majority of cases, the movement of patients by ground is preferred, although factors such as transit time, urgency of need for definitive medical care, and availability of specialized transport teams may affect this decision. If an earthquake leads to major disruption of transportation corridors, it may be necessary to establish an airway "bridge" from patient evacuation points to areas beyond the impact zone (either a receiving facility or a staging location awaiting further movement).

H. FEDERAL PATIENT MOVEMENT CAPABILITIES

There are three principle ways to access federal patient movement support:

- 1) National EMS Contract (Contract between FEMA and American Medical Response)
- 2) National Disaster Medical System (NDMS)
- 3) Defense Support of Civil Authorities (DSCA)

1. National EMS Contract

Under a FEMA initiative, a large ambulance provider holds a national contract to provide an array of ground ambulance, air ambulance, paratransit services and EMS personnel to supplement the federal and military response to a disaster or public health emergency. Nationwide, there are four zones under the National EMS contract.

The maximum deployment for a single zone of the National EMS Contract includes:

- 300 ground ambulances (max. 70% ALS and 30% BLS)
- 5-10 CCT ground ambulances
- 25 air assets (helicopter & fixed wing)
- Sufficient paratransit vehicles to transport 3,500 people (not 3,500 vehicles); max. 25% wheelchair capable



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- Non-ambulance EMS personnel (max. 150 fixed location EMTs and Paramedics)
- Communications Support Teams and Operations Support Teams

For planning purposes:

- The National EMS Contractor's aircraft are almost all ALS level transport
- The National EMS Contractor 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
- ASPR may choose to stage EMS resources prior to an order from state EMSA in anticipation of activating the FEMA EMS contract.
- The National EMS Contract's aircraft range is 200 miles for rotary and 250 for fixed wing ambulances
- The National EMS Contractor does not stage their patients. They transfer them directly from the ground ambulance to the aircraft which requires a higher level of coordination

The contracted services provided in the agreement include:

- Patient triage, treatment and transport
- On-scene medical standby
- Transport and re-distribution of patients to free up receiving hospital bed space
- Provide staffing for shelters
- Provide staffing for hospital EDs
- Provide staffing to medical shelters
- Set up mobile medical clinics
- Provide immunizations
- Tactical management functions
- Oversight and management of federal EMS and paratransit services

In order for resources to be deployed under the National EMS Contract, certain conditions must be met⁶. Assuming the state requests the National EMS Contract within

⁶ The requirements to activate the National EMS Contract include: **1)** A completed **Resource Request Form (RRF) for the National EMS Contract**, submitted by the State of California (Cal OES) to FEMA, that includes the following information: a) identify the mission (description of requested assistance), b) the number and type of resources needed, and c) delivery locations. **2)** Reciprocity must be granted to all EMS providers responding



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6 hours of event occurrence (E+6 hrs), and assuming FEMA requires 6 hours to review the request and supporting documentation and issue the Task Order to THE NATIONAL EMS CONTRACTOR (E+12 hrs), the initial National EMS Contract resources will start moving within approximately 6 hours of receiving the Task Order (E+18 hrs). Following this timeline, all of the requested resources from a single zone should arrive at the specified destinations within E+36 hrs (or 24 hrs after receiving the Task Order). See Figure 3 on page 96 to see the anticipated timeline for National EMS Contract resources.

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. If the National EMS Contract is requested under the Stafford Act, FEMA coordinates the assistance. Under the Stafford Act, the federal/state cost share is 75%/25%. If the National EMS Contract is requested for non-Stafford Act incidents, the federal response may be coordinated by HHS consistent with its authorities, including coordination of patient movement, patient care, providing pharmaceuticals to include the distribution and delivery of medical countermeasures, equipment and supplies.

Ground Ambulance Vehicle Types

Basic Life Support (BLS) Ground Ambulance – Vehicle is licensed as a BLS ambulance in accordance with state and local laws and must be staffed by BLS personnel in accordance with state and local laws (e.g., attendant must be minimally certified as an Emergency Medical Technician) (EMT or EMT-B).

Advanced Life Support (ALS) Ground Ambulance - Vehicle is licensed as an ALS ambulance in accordance with state and local laws. Ambulance must be staffed by ALS personnel in accordance with state and local laws (e.g., attendant must be minimally certified as a Paramedic).

Bariatric ALS Ground Ambulance – In addition to meeting the requirements of an ALS Ground Ambulance, the bariatric ambulance has been designed to transport patients whose physical weight would exceed the ability of most ground ambulances to transport

pursuant to the Federal EMS Contract; this reciprocity must be affirmed by signature of the appropriate legal authority via the **EMS Reciprocity Authorization. 3)** A completed **Transportation Request Form** (see Form 3) that provides detailed information regarding the specific number and types of assets requested (i.e., provides greater detail to support the RRF, including delivery locations). All materials submitted to FEMA should be simultaneously submitted to the ESF 8 Coordinator (HHS Region IX REC). In addition, whenever the National EMS Contract is requested, it is recommended that HHS support be requested to provide LNOs to monitor the contract and pharmacists to distribute pharmacy cache medications to ambulances at check-in or re-supply. **4)** **RRF for HHS Support to the National EMS Contract.**



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safely. The Bariatric ALS Ground Ambulance stretcher must be rated to carry at least 700 lbs and must be either 29" wide or compatible with a stretcher converting bariatric board to meet the width criteria. Also, one of the following commercial stretcher-loading devices must be installed:

- A winch and ramp system configured in such a way that two responders can easily and safely load and unload a bariatric patient into the ambulance, or
- The stretcher must be equipped with a hydraulic or mechanical system that allows for unassisted raising and lowering of a patient weighing up to 700 lbs.

ALS Med-Evac Bus - The ALS Med-Evac Bus must be capable of transporting at least four (4) ALS stretcher-patients at one time. Staffing is to be determined by the ambulance provider but must include enough EMT-Paramedics (or other approved ALS providers) to simultaneously treat four (4) ALS patients and be available 24 hours per day. The ALS provider-to-patient ratio must be no less than 1:4. The ALS equipment on the bus must meet or exceed that of a licensed ALS ground ambulance, and the quantity of equipment and supplies must be proportionate to the number of patients being transported.

Paratransit Vehicle Types

The following types of paratransit vehicles are available under the National EMS Contract. An ADA Accessible Vehicle is a vehicle that includes a lift (side or rear mounted) for getting passengers who cannot climb steps onto a vehicle, specific locations for securing the wheelchair to prevent it from sliding, and other features to ease travel for passengers with disabilities.



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Table 4. Paratransit Vehicle Types

VEHICLE TYPE	NAME	ADA ACCESSIBLE	SEATING CAPACITY
Type 1	Minivan	No	3-10 regular seats
Type 2a	Full-size Passenger Van	No	8-15 regular seats
Type 2b	Midibus, Minibus or Shuttle Bus	No	
Type 3	Coach Bus, Full-Size Bus, Transit Bus	No	44-75 regular seats
Type 4a	Minivan	Yes	1 wheelchair, 1-5 regular seats
Type 4b	Full-size Passenger Van	Yes	1-2 wheelchairs, 2-15 regular seats
Type 5	Midibus, Minibus or Shuttle Bus	Yes	1-3 wheelchairs, 8-30 regular seats
Type 6	Coach Bus, Full-Size Bus, Transit Bus	Yes	1-3 wheelchairs, 35-70 regular seats

Paratransit passengers should be matched to the most appropriate mode of ground transportation required for their specific condition:

- **Paratransit vehicles types 1, 2a, 2b, 3** - Passengers can ambulate with or without assistance and have the ability to sit in a taxi, van, or bus without requiring a high level of assistance or equipment (other than self-administered personal portable oxygen supply).
- **Paratransit vehicles types 4a, 4b, 5, 6** - Passengers are either ambulatory with assistance or wheelchair-bound and require a mechanical lift to get into a vehicle and can safely sit upright in a vehicle seat or in a wheelchair which can be secured. No other special medical equipment is required (other than self-administered personal portable oxygen supply). To safely utilize paratransit lifts, wheelchairs cannot exceed 30 inches in width nor 48 inches in length measured two inches above the ground and cannot weigh more than 600 pounds when occupied.
- The passengers and caregivers must be ready to depart when the transportation arrives.
- Passengers are allowed to bring a minimal amount (2 bags) of personal baggage onto response vehicles.



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2. National Disaster Medical System (NDMS)

NDMS is a federal system that provides three distinct capabilities in response to a disaster: Medical Response, Patient Evacuation and Definitive Care. This plan focuses on the Patient Evacuation component. NDMS is a partnership among four federal agencies: U.S. Health and Human Services (HHS), which serves as the lead coordination agency; Department of Defense (DoD); Federal Emergency Management Agency (FEMA) and the Department of Veteran Affairs (VA). These federal agencies have signed an MOU establishing their roles and responsibilities relative to NDMS.

The Patient Evacuation component of NDMS relies on DoD or FEMA EMS contract aircraft. Patients are flown from airfields in the affected area to pre-identified reception sites called Patient Reception Areas (PRAs) coordinated by the Federal Coordinating Centers (FCCs) within NDMS.

FCCs are maintained by the VA or DoD and provide the Definitive Care Component of the NDMS. FCCs enroll civilian hospitals that agree 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 patients into the local NDMS hospital network.

The Patient Evacuation component of NDMS includes:

- Established methods for identifying and reporting information on patients who require federal movement
- The deployment of patient staging capabilities at outbound airfields (Aerial Ports of Embarkation)
- Pre-identified reception sites at FCCs
- Network of hospitals with available beds categorized by the following types:
 - Medical/Surgical
 - Psychiatric
 - Burn
 - Pediatric
 - Critical
- Air transport with en-route care
- Patient tracking systems
- Return of patients



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For NDMS planning purposes:

- DoD can deploy up to four patient staging facilities, each capable of processing 140 patients per day for a maximum of 560 patients per day
- DoD can transport a maximum of 20% critical care patients, i.e., 20% of the total number of patients on board. This equates to 3 ventilated patients or 6 non-ventilated patients or a mixture.
- DoD requires 48-72 hours following receipt of a formal mission assignment to begin moving patients.
- DoD does not currently have the capability to move acutely ill or injured infants or children; limitations are associated with pediatric training and equipment, etc.

See Figures 4 through 7 for figures relevant to the process, timeline and throughput capacity for patient movement. See Figure 4 on page 97 for a diagram showing the planning factors, timeline and maximum patient throughput associated with the NDMS process. See Figure 5 on page 98 for an overview of the NDMS movement steps. Figure 6 illustrates the movement of patients from the field to a receiving facility (page 99), and Figures 7 and 8 show the escalation of information and resource requests through the SEMS system (pages 100, 102).

The NDMS system primarily uses DoD aircraft and procedures to move civilian patients. Although the military's primary mission is to care for military personnel, it provides this service as a necessary component of NDMS.

It is crucial that local and state civilian authorities understand DoD's requirements for patient movement and take these planning considerations into account. The organization that manages patient movement using DoD assets is the *Theater Patient Movement Requirements Center for the Americas* (TPMRC-A) located at Scott Air Force Base in Illinois. The TPMRC-A provides medical regulating services, including patient clearance for flight; identification and scheduling of appropriate airframes and in-flight medical crews; and identification of appropriate receiving beds through the destination FCC. The TPMRC-A communicates patient movement requirements to the many entities that execute the aeromedical evacuation mission.

DoD uses a specialized system for the regulation of aeromedical evacuation called the U.S. Transportation Command (TRANSCOM) Regulating and Command and Control Evacuation System, or TRAC2ES. TRAC2ES is a military system that is not available to civilian authorities. Thus, whenever civilian patients are moved by the military, the information required by TRAC2ES must be obtained by another means and entered into TRAC2ES by enabling military authorities.



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Recognizing the civilian need, a civilian version of TRAC2ES was developed called the **Joint Patient Assessment and Tracking System** or JPATS. Information entered into JPATS can be exported into TRAC2ES. JPATS is a federally developed system that is available to all states; California is considering the adoption of JPATS at some point in the future, but until this occurs, an alternative process for collecting patient information that can be imported into JPATS (and ultimately, TRAC2ES) must be utilized. An Excel spreadsheet has been developed that serves as the data collection tool used by California at this time (See **Form 4** on page 114). Information required by federal agencies to transport patients). NDMS will use a file transport and export routine to provide the Excel data collected by California's Form 4 into TRAC2ES.

In order for the TPMRC-A to conduct its regulating activities, it is essential that the TPMRC-A receive specific information on each patient prior to the initiation of movement. The patient information should be entered as soon as it is recognized that the patient requires federal movement (e.g., at the originating healthcare facility or casualty collection point). Once this information is collected at the field level, it should be communicated to the federal **Joint Patient Movement Advisor Team (JPMAT)** which may be stationed at the MHCC or with the IRCT at the SOC/IOF/JFO. The JPMAT serves as a liaison to the TPMRC-A.

The table that follows shows the information that must be collected on each patient prior to entry into the military aeromedical evacuation system:



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Table 5. Required Information for Federal Patient Movement

Required Information for Federal Patient Movement			
Use Form 4 (Excel Spreadsheet) on page 114			
	Data	Description	Length
1	CA Tracking #	3 characters designating county of origin; M/F/U for sex; last 4 digits of Triage Tag # (8 characters total)	500 characters total
2	First Name	Self-explanatory	25 characters
3	Last Name	Self-explanatory	25 characters
4	Sex	M, F or U	1 character
5	Date of Birth	mm/dd/yyyy	See format
6	Unaccompanied Minor	Yes or No	1 character: Y = Yes N = No
7	CCATT	Is a Critical Care Air Transport Team (CCATT) necessary for en route medical care for this patient? Yes or No.	1 character: Y = Yes N = No
8	Healthcare facility or casualty collection point	Identify the location from which the patient originates	Up to 100 characters
9	Patient Type	Identify the “type” of patient according to the categories at right. For example, a “Federal Non-Medical” would refer to federal transport of an attendant or family member.	Single number: 1 = Federal Patient 2 = State & Local Patient 3 = Federal Non-Medical 4 = State & Local Non-Medical
10	Health Status	Identify the “health status” according to available categories	Single number: 1 = Critical 2 = Priority 3 = Routine 4 = Deceased 5 = N/A
11	Bed Type	Destination bed type using NDMS bed categories	Single number: 1 = Medical/Surgical 2 = Psychiatric 3 = Burns 4 = Pediatric 5 = Critical



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Required Information for Federal Patient Movement Use Form 4 (Excel Spreadsheet) on page 114			
			6 = Unknown
12	Injury Nature	Provide the most important medical information for each patient, including chief complaint, allergies, current meds, etc.	Up to 2000 characters

When federal assistance with patient movement is needed, it is generally preferred to submit the request as a statement of needs and requirements rather than request a specific type of aircraft, team or equipment. Federal ESF 8 will work with supporting agencies including DoD to match the resources that can best meet the state’s requirements. However, it is also important for CA-ESF 8 stakeholders to understand the role of certain specific federal assets. First, this encourages the state to recognize the necessary capability the asset provides; if the state can provide that capability, then the federal asset may not be needed. However, if the state does not have the specific capability provided by the federal asset and the system depends on this capability, it should be made clear to the ESF 8 Coordinating Agency (HHS) and this need should be clearly articulated in the resource requesting process.

The following pages list components of the military’s aeromedical evacuation system utilized in NDMS patient movement. As an example, the Joint Patient Movement Coordination Team (JPMCT) is a team that can be deployed to healthcare facilities or casualty collection points to collect the information that the military aeromedical evacuation system needs to clear patients for transport by NDMS. If the local authorities or the state can collect this information, JPMCTs may not be needed or requested. But if the capability is lacking, the need for military JPMCT should be made clear in the state’s request.

The components listed below are a subset of the patient movement resources and capabilities provided by CNG and federal agencies, including DoD. A more complete listing of the components can be found in Appendix E.

Joint Patient Movement Coordination Team (JPMCT)– CNG or DoD Asset

Civilian authorities may request assistance with collecting the necessary patient information required for clearance into the federal aeromedical evacuation system. **Joint Patient Movement Coordination Team (JPMCT)**, staged at the evacuating healthcare facility or casualty collection point, can collect the necessary patient information that allows patients to be cleared for flight by a DoD flight surgeon. Once patients are cleared for flight, they are either prepared for flight at the evacuating location or transported to



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the Disaster Aeromedical Staging Facility (DASF). DASFs are located on the flight line and require a minimum of two hours to prepare the patients for flight.

However, it is important that evacuating healthcare facilities and other field casualty collection points recognize that JPMCT teams may not be available at the time they are needed (due to military deployment, etc.). Therefore, it is essential that field-level healthcare facilities or casualty collection points understand that a certain amount of information must be communicated on each patient that may be transported by military means (e.g., using the National Disaster Medical System). It is the responsibility of the healthcare facility or casualty collection point to collect that information, which is described later in this plan. See Form 4 on page 114. Note that DoD may decline to transfer patients under certain conditions (see page 148).

Disaster Aeromedical Staging Facility (DASF) – DoD Asset

Civilian authorities may request a **Disaster Aeromedical Staging Facility (DASF)** that provides aeromedical staging/holding of low acuity patients at a single Aerial Port of Embarkation (APOE). The DASF requires a 12,000 square foot building of opportunity and base life support functions (food, water, billeting). Typically consisting of 63 military personnel, DASFs are equipped and staffed to administratively process patients, provide limited care, and transport patients to aircraft.

Patients should be pre-cleared for entry into the aeromedical evacuation system before being transported to the DASF. Patients should arrive at the APOE no less than 2 hours before flight and patient holding time should not exceed 6 hours.

Patients should be transported to the APOE with the medications, supplies and equipment necessary. Only approved attendants and documented service animals will be transported.

Note that the number of DASFs needed corresponds to the number of APOEs activated on a 1:1 ratio.

Mobile Acute Care Team (MAC-T) – HHS Asset

Civilian authorities may request a **Mobile Acute Care Team (MAC-T)**, which is a HHS resource of 15-20 people, including critical care physicians, nurse practitioners, physician assistants, registered nurses, pharmacists, and respiratory therapists that are members of existing Disaster Medical Assistance Teams (DMATs). The MAC-T provides life-sustaining clinical interventions (e.g., mechanical ventilation, hemodynamic support, key pharmacologic therapies), resuscitative and additional stabilizing measures).



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When deployed in support of a DASf, a MAC-T can stabilize and maintain up to 12 critical care patients. A MAC-T is capable of operating for a 24-hour period and will typically be deployed for up to 72 hours in support of the aeromedical evacuation mission or for up to 14 days in support of a definitive care facility.

A DASf with MAC-T is an 86-person temporary federal staging facility with limited critical care staging capability. The facility is combined with a **Joint Patient Assessment and Tracking System (JPATS)** team (provided by HHS) and litter bearers⁷. These assets optimally operate out of existing buildings of opportunity in association with the DASf.

A DASf with MAC-T is equipped and staffed with patient care and support personnel for a throughput planning factor of 140 patients in a 24-hour period with a maximum 1 to 2 hour patient hold time. Twenty percent (20%) of the 140 patients are anticipated to be critical care patients (i.e., 28 patients).

NDMS can support two (2) APOEs with the combination of DASf and MAC-T capabilities.

Critical Care Air Transport Team (CCATT) – DoD Asset

The **Critical Care Air Transport Team (CCATT)** is a DoD medical team that provides care to critical patients during aeromedical evacuation operations. This asset is not requested by civilian authorities; the military makes this determination based on the patient information provided by Form 4. The TPMRC-A will determine if a CCATT is required and which patients will be transported under the care of a CCATT.

The 3-person CCATT includes a CCATT trained physician, nurse and respiratory technician and is used for patients requiring aggressive fluid resuscitation, ventilator management, or cardiovascular management.

Any of the following will require CCATT assignment for the patient:

- 1) At high risk for clinical decompensation
- 2) Requiring mechanical ventilation
- 3) High risk for deteriorating respiratory status
- 4) Requiring invasive hemodynamic monitoring (arterial line and/or central venous pressure)
- 5) Requiring ongoing active resuscitation and/or lab monitoring
- 6) Requiring aggressive in-flight fluid/ blood product administration
- 7) Requiring vasopressor support
- 8) Requiring invasive intracranial pressure monitoring (bolt and/or ventriculostomy)

⁷ The State of California is expected to provide 16 litter bearers at each DASf.



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- 9) Requiring cardiac pacing
- 10) Unstable spine fracture that requires transport on a vacuum spine board
- 11) Undergone a vascular reconstruction and is at high risk for clot or hemorrhage
- 12) Unstable angina, unstable arrhythmia, or recent MI, with risk too high for single medical attendant.

The following, in and of themselves, do not require automatic CCATT use:

- 1) Chest tube
- 2) Epidurals with level below T10
- 3) Regional pain blocks
- 4) Patient in ICU (Consider Medical Attendant)
- 5) Cardiac monitor (Consider Medical Attendant)
- 6) Blood or FFP use (Consider Medical Attendant)

Endotracheal intubation is difficult in flight; if intubation is being considered then it should be accomplished before the patient movement begins. Patients should not be extubated less than four hours before a flight.

Each CCATT can support three (3) critical care/ventilator-dependent patients or six (6) critical care/non-ventilated patients.

NDMS can support two (2) APOEs with the combination of DASF and CCATT capabilities.

To summarize, NDMS can sustain a maximum of four (4) Aerial Ports of Embarkation (APOEs). Two (2) APOEs can utilize DASFs with MAC-T capabilities and two (2) APOEs can use DASFs with CCATT capabilities. All patients should be entered into the aeromedical evacuation system prior to transport to the APOEs so they can be clinically and administratively cleared for flight; i.e., Form 4 information is needed as soon as possible.

Joint Patient Movement Advisor Team (JPMAT)

The **Joint Patient Movement Advisor Team (JPMAT)** is a 4-person federal team that should be stationed at the “center of gravity” for patient movement. This may be the MHCC or the SOC/IOF/JFO. This federal resource will be automatically deployed if the federal aeromedical evacuation system is activated. The JPMAT receives the Form 4 information collected at healthcare facilities and casualty collection points on patients. This information is used by the military to clear patients for flight; identify appropriate beds through the receiving FCC; and regulate aircraft and flight/medical crews. A CA-ESF 8 liaison should be stationed with the JPMAT if it is located at the SOC/IOF/JFO.



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Federal Coordinating Center (FCC) – DoD or VA Asset

A Federal Coordinating Center (FCC) is associated with a patient reception area (PRA) for patients being evacuated. All FCCs are run by either the VA or DoD. The state does not normally determine which FCCs will be activated (this is a federal decision), although California has requested that patients be preferentially moved to FCCs within the State of California.

FCCs will be alerted via a Warning Order when ESF 8 patient movement is anticipated. They will be activated with the Execution Order when the FCC is expected to receive patients. As the FCC receives patients, they will triage patients and select an appropriate receiving NDMS facility. The FCC, in coordination with the receiving NDMS facility, will arrange transportation to that facility. The distribution of patients will be tracked using HHS's **Joint Patient Assessment and Tracking System (JPATS)**.

HHS will deploy a JPATS Team to the FCC to facilitate patient tracking while patients are actively being processed through the receiving FCC. (Note: If the FCC has the inherent capability to use JPATS without assistance, the JPATS team will not be deployed and the FCC will track the patients.) The FCC will remain operational as long as there are patients scheduled to be processed through their FCC from the disaster location. The HHS Service Access Team (SAT) will be responsible for tracking the patients once they are distributed to the NDMS facilities.

NDMS Hospital

Using the NDMS Definitive Care Memorandum of Agreement (MOA), FCCs recruit hospitals to become "NDMS Hospitals". These facilities agree to accept ESF 8 patients and assume the care of the patients until one of the following occurs:

- 1) The medically indicated treatment has been completed (maximum 30 days) resulting in discharge.
- 2) The exhaustion of the Diagnostic Related Group (DRG) payment schedule as defined by the Centers for Medicare and Medicaid Services
- 3) Voluntary refusal of care
- 4) Patient discharge

The NDMS hospital will have patient advocates and case managers that follow NDMS patients during their stay in the facility. Once the patient is ready for discharge, the hospital will look to HHS for direction and support of the patient's post-discharge care.



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Service Access Team (SAT) – HHS Asset

Service Access Teams (SATs) facilitate patient tracking, accountability, assistance for non-medical attendants, and the return of patients. This asset is automatically deployed when patients are moved by NDMS.

A SAT consists of individuals from the U.S. Public Health Service (USPHS). The 10-person SAT is designed to be a stand-alone team. The SAT can be deployed within thirty-six (36) hours of notification. Initially, the SAT's operating location is the FCC. SAT personnel deploy with a Patient Tracking Kit or stand-alone Electronic Medical Record (EMR) kit that includes basic communications capability.

Re-deployment or demobilization of the SAT will occur when all patients are returned to their home of record. It may be appropriate to demobilize portions of the team as the number of patients requiring return or Repatriation decreases.

The SAT is responsible for:

- Tracking and monitoring patient status from the time they are admitted to an NDMS hospital
- Updating JPATS as the status of the patient changes
- Providing information to family members regarding the status of the evacuated patients, or medically fragile individuals to ease fear or distress over the condition or whereabouts of their family member
- Interfacing directly with patients and their families, medical and human services case managers at the sending and receiving location(s), and any designated vendor(s) selected to effect movement of patients
- Coordinating lodging and human services needs for all discharged patients until transportation to their final destination can be facilitated. Lodging and needed human services for non-medical attendants (e.g., family members) and/or service animals (as necessary) will be secured by the SAT.

The SAT facilitates the movement of federal ESF 8 evacuees to their homes/communities or to another final destination that may be utilized in catastrophic or large-scale events. Once the patient is ready for discharge, the SAT will begin to coordinate the return of patients and accompanying non-medical attendants evacuated by federal ESF 8. These individuals will be allowed to return when:

- they are well enough to travel,
- the evacuated state has declared that it is safe to return, and/or
- there is an appropriate receiving facility.



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

3. Defense Support of Civil Authorities

Defense support of civil authorities (DSCA) is provided by federal military forces, DoD civilians, DoD contract personnel, DoD component assets, and National Guard (NG) forces (when the Secretary of Defense, in coordination with the governors of the affected states, elects and requests to use those forces in Title 32, United States Code, status or when federalized) in response to requests for assistance from civil authorities for domestic emergencies, law enforcement support, and other domestic activities, or from qualifying entities for special events.

DSCA may be provided in response to requests from state or local officials through the State Coordinating Officer (SCO) to the Federal Coordinating Officer (FCO). The FCO coordinates DoD support through the defense coordinating officer (DCO) in the Joint Field Office (JFO).

Examples of DoD patient movement assets include fixed wing aircraft that can be configured for patient movement with en route care, dedicated rotary wing MEDEVAC Air Ambulances, and other conveyance vehicles. If requested, the Defense Coordinating Officer (DCO) will send an Aviation Emergency Preparedness Liaison Officer (EPLO) to the Cal OES Air Coordination Group.

III. CONCEPT OF OPERATIONS

A. CALIFORNIA'S OPERATIONAL PRIORITIES

The **State of California Emergency Plan** (2009) establishes four Operational Priorities that govern response strategies for the state and its political subdivisions:

1	Save Lives	The preservation of life is the top priority of emergency managers and first responders and takes precedence over all other considerations.
2	Protect Health and Safety	Measures should be taken to mitigate the emergency's impact on public health and safety.
3	Protect Property	All feasible efforts must be made to protect public and private property and resources, including critical



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		infrastructure, from damage during and after an emergency.
4	Preserve the Environment	All possible efforts must be made to preserve California’s environment and protect it from damage during an emergency.

During a disaster, patient movement efforts will focus on the top two operational priorities.

1	Save Lives	<ul style="list-style-type: none"> Utilize available EMS resources to save the maximum number of lives possible. Utilize available resources to triage, treat and transport injured/ill persons to receiving hospitals. If receiving hospitals are unavailable or unreachable, consider transporting patients to alternate destinations for temporary care until definitive care locations become available and accessible. Establish and staff casualty collection points, field treatment sites or other temporary patient care locations.
2	Protect Health and Safety	<ul style="list-style-type: none"> Provide continuing EMS service via 9-1-1 system Provide support to healthcare facilities (e.g., to assist evacuation, decompress census, assist with ED overflow, etc.) Assess and request resources to meet unmet resource needs.

B. HEALTH AND MEDICAL INCIDENT LEVELS

The California Public Health and Medical Emergency Operations Manual (EOM) describes three Health and Medical Incident Levels based on the need for health and/or medical resources to effectively manage the incident. This plan applies to Level 1 and 2 incidents whenever local EMS systems require regional, state and/or federal assistance to manage the patient movement needs created by the incident.



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Table 6. Health and Medical Incident Levels

Level 1	Requires resources or distribution of patients beyond the mutual aid region. May include resources from other mutual aid regions, state or federal resources.
Level 2	Requires resources from operational areas within the mutual aid region beyond existing agreements (including day-to-day agreements, memoranda of understanding or other emergency assistance agreements) and may include the need for distribution of patients to other operational areas.
Level 3	Requires resources or distribution of patients within the affected operational area only or as available from other operational areas through existing agreements (including day-to-day agreements, memoranda of understanding or other emergency assistance agreements).

1. Level 1 Incident

During a Level 1 Health and Medical Incident, the need for health and/or medical resources exceeds the response capabilities of the affected operational area and associated mutual aid region. This determination is made from an assessment of health and medical resources relative to current and expected demands. As with Level 2 Health and Medical Incidents, requests for health and medical resources are coordinated by the MHOAC Program(s) within the affected operational area(s), working in conjunction with the RDMHC Program(s), as detailed in the EOM.

A Level 1 Health and Medical Incident should lead to activation of DOCs/EOCs within the operational area, mutual aid region, and state.

2. Level 2 Incident

A Level 2 Health and Medical Incident requires health and/or medical resources from other operational areas within the mutual aid region beyond those available through existing agreements and may include the need for distribution of patients to other operational areas. During a Level 2 Health and Medical Incident, resource requests should be coordinated by the MHOAC Program of the affected operational area as detailed in the California Public Health and Medical Emergency Operations Manual (EOM). A Level 2 Health and Medical Incident will typically require assistance from the RDMHC Program within the mutual aid region and may require emergency system



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activation, including activation of DOCs or EOCs within the operational area and mutual aid region.

3. Level 3 Incident

A Level 3 Health and Medical Incident will typically require using available health and/or medical resources from within the affected operational area or by accessing resources from other operational areas through existing agreements (including day-to-day agreements, memoranda of understanding, or other emergency assistance agreements). The MHOAC Program should be notified of Level 1 Health and Medical Incidents, including the need for accessing resources through existing agreements, and assist in accordance with local policies and procedures.

C. PATIENT MOVEMENT OVERVIEW

This plan may be activated whenever local EMS systems require regional, state or federal assistance to manage the patient movement needs created by the incident, including triage, treatment, stabilization and transportation to definitive care, in addition to the evacuation of existing healthcare facilities. The plan may be activated for Level 1 or 2 Health and Medical incidents that generate significant patient movement needs, although circumstances will always dictate the need to activate the plan.

During a Level 1 or 2 Health and Medical Incident that produces a need for assistance with patient movement, the nearest in-state resources will immediately be deployed consistent with California's health and medical mutual aid system. These resources include EMSA-affiliated Ambulance Strike Teams (ASTs), non-affiliated ASTs and single resource ambulances, private air ambulance providers and some non – standard resources that may include buses, trains, trucks, commercial aircraft and paratransit vehicles.

Another important source of patient movement support is provided by the California National Guard (CNG), although their available resources vary depending on state and federal deployment activities. If mission-resourced by Cal OES, it is likely that CNG may provide both patient movement and patient holding capabilities to aid civilian authorities. In addition, CNG is skilled at preparing EMAC requests for National Guard forces in other states who can provide additional patient movement support.

Since the full magnitude of the event's impact may not be apparent at the time a resource request is made, it is important that resource requests related to patient movement contain sufficient information so that if federal assistance is needed, the required information is in hand.



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The following forms have been created to request assistance with patient movement. All forms can be found in Section V of this plan (page 106). Forms 1, 2 and 3 are available as Word and pdf-fillable versions; Form 4 is available as an Excel spreadsheet.

Name of Form	Completed By	Purpose
Form 1. Resource Request Form used by Healthcare Facilities or Field Sites	Field level entities, e.g., healthcare facilities or casualty collection points	Form 1 is used to collect information from field entities on the need for 1) patient transportation, 2) patient placement or 3) both. It is provided to the MHOAC Program. See page 108.
Form 2. Resource Request Form used by MHOAC Programs	MHOAC Program	Form 2 aggregates information across the OA on the need for patient transportation resources and delivery locations for incoming transportation resources; also, the number and types of destination hospital beds needed (if any). Form 2 is provided to the RDMHC Program and communicated as an “FYI” to EMSA/CDPH Duty Officers and the local emergency management agency. See page 110.
Form 3. Resource Request Form used by the State to request assistance from other CA regions or federal agencies	RDMHC Program or CA-ESF 8	If intra-regional resources are inadequate to meet the demand, Form 3 provides the information required to request assistance from other California regions, or if necessary, federal assistance such as the FEMA National EMS Contract or NDMS. Form 3 is provided to the MHCC if generated by the RDMHC Program (or Regional Patient Coordination Function) or to Cal OES if generated by the MHCC. If specific federal resources are needed, e.g., the National EMS Contract or NDMS, CA-ESF 8 should submit Form 3 to Cal OES and provide the pre-scripted RRFs and other necessary documentation to Cal OES for submission to FEMA. (Note that CA-ESF 8 should share copies of any requests with the ESF 8 Coordinator or Regional Emergency Coordinator for Region IX HHS.) See page 112.
Form 4. Information required by federal agencies to transport patients using NDMS	Field level entities, e.g., healthcare facilities or casualty collection points	Form 4 information is required from field level entities in order to move patients using military aeromedical evacuation. This form data is used to clear patients for flight; determine the number and types of aircraft and crews needed; schedule flights; etc. See page 114.



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Because EMS systems in unaffected areas of the state must continue to render services to the communities served, there will be limitations on the amount of in-state medical mutual aid that can assist impacted operational areas. If the amount of in-state mutual aid and state agency support (e.g., CNG patient movement and holding capacity) is insufficient to meet the patient movement needs of the incident, then the state will look to federal assistance.

The following forms are pre-scripted examples of the standard Federal Resource Request Form (RRF) that the State of California would use to request federal patient movement resources. On behalf of CA-ESF 8, EMSA would coordinate with CDPH and the ESF 8 Coordinator (or Regional Emergency Coordinator for Region IX HHS) to develop these forms and would submit the forms to Cal OES, together with other required documentation collected from the affected components of the Health and Medical System (MHOAC and RDMHC Programs). Once approved, Cal OES would submit the required forms to FEMA.

Name of Form	Completed By	Purpose
Federal Resource Request Form (RRF) #1	CA-ESF 8 (EMSA)	This is a pre-scripted RRF to request the <i>National EMS Contract</i> . It is prepared by CA-ESF 8 (EMSA) and submitted to Cal OES. See page 116.
Federal Resource Request Form (RRF) #2	CA-ESF 8 (EMSA)	This is a pre-scripted RRF to request <i>HHS support to the National EMS Contract</i> . It includes pharmacists that re-supply the responding ambulances and LNOs to assist in managing the contract. It is prepared by CA-ESF 8 (EMSA) and submitted to Cal OES. See page 117.
Federal Resource Request Form (RRF) #3	CA-ESF 8 (EMSA)	This is a pre-scripted RRF to request the <i>National Disaster Medical System</i> . It is prepared by CA-ESF 8 (EMSA) and submitted to Cal OES. See page 118.

D. SITUATION ASSESSMENT

A critical factor that will enable the Medical and Health System to save lives and protect health and safety is an accurate assessment of the incident’s impact, and in particular, the anticipated need for assistance with patient movement.

In accordance with local policies and procedures, field level public health and medical entities affected by the disaster (e.g., hospitals, ambulance providers, skilled nursing facilities, etc.) should provide relevant information as soon as possible to the MHOAC Program for inclusion in the initial **Flash Report** or **Medical and Health Situation Report**. The Situation Report should be provided by the MHOAC Program to the 1) OA



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emergency management agency (or OA EOC), 2) RDMHC Program and 3) CDPH/EMSA Duty Officer Programs (or MHCC if activated) within 2 hours of incident occurrence and updated as needed, but no less than once per operational period. The Medical and Health Situation Report provides the foundation for supporting Medical and Health Resource Requests and should always include information about the anticipated or actual need for assistance. The flash report may be sent out by the MHOAC or RDMHS to the same recipients serving as an early warning, providing situational awareness about the severity of the event.

Coordination with Response Partners

Following a major disaster, it is likely that debris, congested traffic and other obstacles may serve as impediments to the ingress and egress of ground ambulances, and airspace restrictions could hamper air ambulance operations. It is critical that EMS responders anticipate and accommodate these challenges, preferably by integrating closely with public safety and transportation authorities. At the state level a CA-ESF 8 representative coordinates with Caltrans and CHP regarding ground transportation routes and with the Air Coordination Group located at the SOC regarding air transportation. In addition, it may be necessary that CA-ESF 8 send a representative to the Fuel Task Force to coordinate fuel for responding ambulances. Lastly, CA-ESF 8 may want to exchange representatives with a CNG liaison since both the MHCC and CNG's Joint Operations Center may be activated in support of patient movement

Communications is always known to be problematic in major disasters because a variety of communication options exist among incoming assets. It is important that a common, interoperable Communications Plan be developed and applied so that communication among responding and coordinating entities can proceed without interruption.

E. EMERGENCY ASSISTANCE

To summarize the SEMS process to request assistance with patient movement:

Patient movement requests originate in the field (e.g., healthcare facilities, casualty collection points, etc.) → MHOAC Program (or Patient Movement Function in LEMSA/LHD DOC or OA EOC if activated) → RDMHC Program (or Regional Patient Movement Coordination Function if activated) → CA-ESF 8 (EMSA and CDPH Duty Officer Programs or Patient Movement Function in MHCC if activated). At each SEMS level, the corresponding emergency management agency is also notified.

See Figures 6, 7 and 8 on pages 99-102 for diagrams depicting the flow of patients, information and resource requests associated with patient movement.



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When assistance is required with patient movement at the field level, **Form 1**⁸ should be completed by the responsible authority for the healthcare facility or the casualty collection point (see page 108). Form 1 information should be sent to the MHOAC Program. Form 1 provides information on the number of patients that require specific types of EMS transportation (e.g., ALS, BLS, bariatric ALS, paratransit, etc.) along with special classes of patients (e.g., neonates that may need specialty hospital bed types).

The MHOAC Program should notify the RDMHC Program and the local emergency management agency so both are aware of the activities underway relative to patient movement (although no action is required), in addition to ensuring that state and local regulatory authorities are informed. If the MHOAC Program can satisfy the need using resources within the OA or through existing agreements, there is no need to escalate.

If the MHOAC Program cannot meet the need utilizing OA resources and existing day-to-day agreements, then the MHOAC Program should forward all Form 1s received, **Form 2**⁹ (which summarizes Form 1 information regarding EMS resources) and the standard **Medical and Health Resource Request** (refer to the *California Public Health and Medical Emergency Operations Manual*) (see page 110 for Form 2). Both forms should be forwarded to the RDMHC Program (or the Regional Patient Movement Coordination Function if activated) with a copy to the local emergency management agency. The MHOAC Program should inform the local emergency management agency as an “FYI”; i.e., no other action is required as the RDMHC Program (or Regional Patient Movement Coordination Function) searches for the resources within the region.

If the RDMHC Program (or Regional Patient Movement Coordination Function) can meet the patient movement needs of the affected OAs with resources from the surrounding OAs in the region, there is no need to escalate.

However, if it is anticipated that assistance may be required from beyond the mutual aid region, then the MHOAC Program should collect both **Form 1** and **Form 4**¹⁰ from each evacuating healthcare facility or casualty collection point. The collection of Form 4 data requires the use of the **California Unified Patient Tracking System (CUPTS)**, anticipating that patients may be transported greater distances (making tracking more challenging). Form 4 also collects the necessary information should the situation evolve so that federal assistance with patient movement is necessary, either within California or beyond the state’s borders.

If the patient movement needs cannot be met by the RDMHC Program (or Regional Patient Coordination Function) within the region, then it will be necessary to look to

⁸ Form 1 is the Resource Request Form used by Healthcare Facilities or Field Sites

⁹ Form 2 is the Resource Request Form used by MHOAC Programs.

¹⁰ Form 4 is the Information required by federal agencies to transport patients using NDMS.



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other regions of the state for the needed resources. EMSA and CDPH will coordinate with RDMHC Programs in the unaffected regions of the state to locate needed resources. Potential resources include EMSA-affiliated and non-affiliated ASTs, single resource ambulances, CAL-MATs, MSTs, and DHV resources.

If EMSA-affiliated Ambulance Strike Teams (ASTs) are needed, EMSA should be immediately notified to facilitate deployment of the needed ASTs (through the EMSA Duty Officer Program or the Patient Movement Function in the MHCC if activated). In addition, a resource request for the ASTs should be entered into Cal EOC by either the RDMHC Program, or if necessary, the regional Cal OES representative. This allows Cal OES to mission resource task EMSA and depending on the scope of the incident, may facilitate reimbursement. Cal OES may also mission resource task CNG to assist with patient movement and holding (staging).

If CA-ESF 8 determines that federal assistance with patient movement is necessary, then CA-ESF 8 agencies, i.e., EMSA and CDPH, should collaborate with the lead agency for federal ESF 8, i.e., HHS, in framing the requests for federal assistance. Because EMSA, CDPH and HHS have familiarity with the types of federal patient movement assistance that are available, they are well positioned to prepare and submit the necessary resource requests to Cal OES. In addition, certain types of federal resources (e.g., the National EMS Contract and NDMS) require additional information beyond the standard Resource Request Form (RRF).

If State officials wishes to request a zone of the **National EMS Contract**, four items must be provided: 1) RRF requesting one zone of the National EMS Contract; 2) **Form 3**¹¹ (which contains specific information on the types of EMS resources needed and destination locations) (see page 112 for Form 3); 3) a Reciprocity Authorization signed by authorized official(s) allowing out-of-state EMS personnel to practice in California; and lastly 4) an RRF requesting HHS support for the National EMS Contract (primarily pharmacists to re-supply the ambulances and Liaison Officers to assess utilization and advise state officials).

If State officials wishes to request assistance from the **National Disaster Medical System** (NDMS), either for transport within California or beyond California's borders, then an RRF requesting NDMS should be submitted to Cal OES.

¹¹ Form 3 provides information on the types of EMS transport vehicles needed, the # of paratransit seats needed, and the # of any additional EMS personnel needed beyond those assigned to ground or air ambulances.



F. INCIDENT PRIORITIZATION AND ALLOCATION OF SCARCE RESOURCES

California's over-arching mutual aid system, established by the *California Disaster and Civil Defense Master Mutual Aid Agreement (MMAA)*, requires all signatories to render available mutual aid without expectation of reimbursement during a declared State of Emergency. However, the MMAA also states that it shall not supplant existing agreements providing for the exchange or furnishing of services and facilities on a reimbursable, exchange or other basis. Certain disciplines have created discipline-specific mutual aid systems to more effectively identify and coordinate the provision of mutual aid resources, including the health and medical system. The EOM includes a description of the health and medical mutual aid system and the coordination processes to deliver mutual aid.

Consistent with SEMS, requests for assistance will be advanced through normal SEMS channels in a progressive fashion. The key coordination points in the medical and health system include the MHOAC Program at the operational area level, the RDMHC Program at the regional level, and EMSA and CDPH Duty Officer Programs (or MHCC if activated) at the state level.

In a major disaster, requests for resources are likely to exceed resource availability. The task of **prioritizing requests and allocating scarce resources** should be supported by the application of Multi-Agency Coordination Group (MAC) processes relative to resources available within the state. FIREScope has developed MAC Group procedures for the California fire service (*MACS Group Procedures Guide*, FIREScope, 2011), including specific procedures to "allocate critical resources based on incident priorities". Cal OES has published the *California Statewide Multi-Agency Coordination System Guide* to further support the development of discipline-specific MAC Group processes [http://www.caloes.ca.gov/PlanningPreparednessSite/Documents/10%20California%20Statewide%20Multi-Agency%20Coordination%20System\(CSMACS\)%20Guide%202-13-13.pdf](http://www.caloes.ca.gov/PlanningPreparednessSite/Documents/10%20California%20Statewide%20Multi-Agency%20Coordination%20System(CSMACS)%20Guide%202-13-13.pdf)). However, it is important to note that both the FIREScope and Cal OES MAC Group publications use "Incident Priority Rating Procedures" that are relevant to fire, not health and medical matters.

Regarding resources owned by the State of California (including the mission resource tasking of state agencies), decisions regarding the allocation of those resources will be made by the senior state officials who have, or have been delegated, the authority to make such decisions. Cal OES, representing the Governor, is likely to form a MAC Group that includes affected jurisdictional authorities and CA-ESF 8 subject matter experts (e.g.,



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EMSA and CDPH Directors or their delegates) who are capable of informing the decision-making process.

If out-of-state resources are requested by the State of California, the allocation of these incoming resources will again be decided by senior state officials who have, or have been delegated, the authority to make such decisions. As before, Cal OES is likely to form a MAC Group that includes the affected jurisdictional authorities and state CA-ESF 8 subject matter experts (e.g., EMSA and CDPH Directors or their delegates) who are capable of informing the decision-making process.

Lastly, under a catastrophic response scenario that leads to a unified state-federal command structure, the allocation of scarce resources will be determined by the Unified Coordination Group (UCG) operating at the IOF/JFO. In this case, a responsibility of the UCG is to serve as a senior-level MAC Group since incoming resources will be under California or federal control. As previously stated, it is likely the UCG will seek the input of CA-ESF 8 subject matter experts (e.g., EMSA and CDPH Directors or their delegates) and affected jurisdictional authorities who are capable of informing the decision-making process.

G. PATIENT MOVEMENT COORDINATING ENTITIES

Depending on the magnitude and scope of the incident, it may be necessary to quickly activate **Patient Movement Coordinating Entities** that manage patient movement activities for the operational area, region and state.

1. Operational Area

At the operational area level, the responsibility for patient movement coordination falls to the **MHOAC Program**. The MHOAC Program may be able to manage smaller incidents with existing staff. However, larger events may require the activation of a DOC at the LEMSA or LHD, or the activation of the OA EOC including a Medical and Health Branch.

Local policies and procedures will determine the manner in which the operational area coordinates patient movement activities when the demand exceeds routine or MCI incidents. It may be desirable to establish a Patient Movement Function within the Operations section of the LEMSA/LHD DOC or OA EOC.

Regardless of how the operational area wishes to organize to accomplish these activities, the following should be addressed:

- Maintain communication with healthcare facilities and casualty collection points regarding the need to move patients



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- Assure a coordinated structure, ideally a single point or center, to support the management of patient transportation resources, including mutual aid
- Provide technical assistance to healthcare facilities and casualty collection points regarding evacuation vs. shelter-in-place and the availability/schedule of incoming resources
- Poll for EMS transportation resources and/or available beds in the OA and coordinate demand with availability
- Collect information on field requests for assistance with patient movement
- Track the progress of healthcare facilities that are evacuating using their own or contracted resources
- Summarize situational information and any unfilled resource requests and share with the RDMHC Program and copy the local emergency management agency and EMSA/CDPH Duty Officers (or MHCC if activated)

2. Region

Should the OA be unable to meet a jurisdiction's patient movement needs, the MHOAC Program will request assistance from the region. At the regional level, this responsibility falls to the **RDMHC Program**. The RDMHC Program, supported by the RDMHS, may be able to manage smaller incidents with existing staff. However, larger events may require the activation of a DOC at the LEMSA or LHD, and finally, the activation of the OA's EOC, including a Medical and Health Branch.

If the local EMS systems within a region or neighboring regions are unable to meet the patient movement needs created by the incident, then it may be necessary to activate a **Regional Patient Movement Coordination Function** under the direction of the impacted RDMHC Program(s). The Regional Patient Movement Coordination Function serves as a logistical support function that operates at the regional level, leveraging the knowledge of EMS systems and healthcare facilities in the affected regions. The Regional Patient Movement Coordination Function expands the capabilities of the RDMHC Programs relative to the assessment of patient movement needs created by the disaster; adequacy of existing EMS resources including operational day-to-day agreements; and need for emergency assistance from beyond the affected regions.

The size of the Regional Patient Movement Coordination Function is scalable and dependent on the size and scope of the incident; it could be as small as a single person who can handle the essential regional coordination functions or may expand to a 20+ person operation for a catastrophic incident. See pages 103 and 104 for examples of small and large configurations.



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It may be prudent for neighboring RDMHC Programs to collaborate and pool resources to effectively support the personnel and facility requirements associated with patient movement coordination. For example, it may be useful for RDMHC Programs to operationalize two Regional Patient Movement Coordination Functions, one in northern California and the other in southern California.

The RDMHC Program, or Regional Patient Movement Coordination Function, should coordinate all activities in the affected region(s) related to patient movement, such as but not limited to:

- Maintain communication with the affected MHOAC Programs (or Patient Movement Functions in activated DOC/EOCs) regarding patient movement
- Gather situational information and communicate any unfilled resource requests to CA-ESF 8 (EMSA and CDPH Duty Officer Programs or MHCC if activated), also share this information with the regional Cal OES representative
- Ensure MHOAC Programs are tracking the progress of healthcare facilities that are evacuating using their own or contracted resources and reporting this information to the RDMHC Program
- Poll for EMS transport resources and/or available beds in the affected regions and coordinate demand with availability
- Notify affected MHOAC Programs of state's ability to provide emergency assistance, including incoming federal resources

3. State (CA-ESF 8)

Should the region be unable to meet the needs of the MHOAC Programs with regard to patient movement, the RDMHC Program will request assistance from the state. The **EMSA and CDPH Duty Officer Programs** may be able to support smaller incidents; however, larger events will require the activation of the **Medical and Health Coordination Center** (which serves as a joint EOC for CDPH, EMSA and DHCS and the CA-ESF 8 Coordination Center).

As soon as it becomes clear that patient movement activities will require it, a **Patient Movement Function** should be established under the Operations Section at the MHCC. See page 103. The Patient Movement Function should coordinate all of the activities related to patient movement at the state level, including:

- Receive and summarize incoming situational information on patient movement activities and needs
- Receive and summarize unmet resource requests for patient movement assistance



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- Support the activated Regional Patient Movement Coordination Function, including communication with other regions of the state regarding available resources (through the respective RDMHC Programs)
- Conduct statewide bed polling
- Coordinate statewide patient tracking
- Continue to inform affected RDMHC Program(s) or the activated Regional Patient Movement Coordination Function of state and federal activities related to patient movement, including the anticipated availability of incoming resources
- Collaborate with HHS to develop federal resource requests that are delivered to Cal OES for submission to FEMA
- Coordinate with CA-ESF 8 Liaison to the federal Joint Patient Movement Advisor Team (JPMAT) if activated at the SOC/IOF/JFO
- Coordinate state-level MAC Group activities related to patient movement
- Provide technical expertise on patient movement

At the OA, regional and state CA-ESF 8 levels, the following functional areas must be supported (at a minimum) by the Regional Patient Movement Coordination Function and the Patient Movement Function in the MHCC, respectively:

Patient Transportation

The Patient Transportation Unit is comprised of EMS liaisons who can validate and coordinate patient transportation requests. This includes identifying the closest and most appropriate transport resources and working with EMS staging to deploy the correct resources.

Bed Availability Polling

The Bed Availability Polling Unit is responsible for collecting information on the available types of hospital beds at California healthcare facilities. This unit may also have to coordinate with other state agencies (e.g., California Department of Social Services, California Department of Developmental Services, California Department of State Hospitals, and the California Department of Health Care Services) to match patient evacuation needs with available resources.

Patient Destinations

The Patient Destinations Unit is comprised of medical specialists with proficiency in hospital and medical diagnosis. Those individuals coordinate the placement of patients



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into appropriate hospital beds at suitable facilities. A component of this unit should include specialists with knowledge of CMS requirements.

Patient Tracking Unit

The Patient Tracking Unit is responsible for tracking patients that are moved due to the incident. In a large-scale incident, the California Unified Patient Tracking System (CUPTS) is a tool that could be used.



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Coordinating Entities / Response Functions for Patient Movement

SEMS/NIMS Level	Coordinating Entity for Patient Movement	Lead Planning and Operational Agency	Primary Response Functions
Field	healthcare facilities and casualty collection points	Emergency Manager in Charge	<ul style="list-style-type: none"> • If assistance with patient movement is needed, complete Forms 1 and 4 and submit to the MHOAC Program (or Patient Movement Function, if activated, at the LEMSA/LHD DOC or Op Area EOC). • Submit Health and Medical Situational Reports as soon as possible to the MHOAC Program; maintain communication on current status.
Operational Area	Patient Movement Function at LEMSA/LHD DOC or Op Area EOC	MHOAC Program	<ul style="list-style-type: none"> • Receive patient movement requests from field entities and EMS systems (e.g., healthcare facilities, casualty collection points, etc.). The specific information required includes Form 1 and Form 4. If more than one facility submits Form 1, aggregate multiple requests into Form 2 which summarizes the total EMS need for the OA and identifies delivery locations for incoming assets. • Submit patient movement requests (Forms 1, 2 and 4) to the RDMHC Program (or Regional Patient Movement Coordination Function if activated). Notify the local emergency management agency of the resource requests with the acknowledgement that the RDMHC Program is working on fulfilling the request within the region (i.e., no action is needed by the local emergency management agency at this time). • Submit overall health and medical situational information as soon as possible to the RDMHC Program, local emergency management agency and the EMSA/CDPH Duty Officers or MHCC if activated. A Flash Report is acceptable within the first 2 hours; this should be followed by a Health and Medical Situation Report. • Work with the local emergency management agency to establish reception points (staging areas) for incoming patient movement resources. • Work with the local emergency management agency to establish appropriate staging locations (airports, railheads, other locations) for evacuating patients if needed. • If resource requests exceed available resources, facilitate MAC Group decision process to allocate resources within the Op Area.



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SEMS/NIMS Level	Coordinating Entity for Patient Movement	Lead Planning and Operational Agency	Primary Response Functions
Region	Regional Patient Movement Coordination Function	RDMHC Program(s)	<ul style="list-style-type: none"> • Receive patient movement requests from MHOAC Programs (or Patient Movement Function in LEMSA/LHD DOC or Op Area EOC(s)) • Determine if the patient movement requests can be accommodated within the affected region(s). • If needed resources are available within the affected region(s), match available resources to resource requests and communicate information to impacted MHOAC Programs (or Patient Movement Function in the DOC/EOC(s)) and the regional representative for Cal OES. • If regional resources are inadequate, communicate unmet resource needs to the Patient Movement Function in the MHCC and the regional representative for Cal OES. • Communicate information received from the MHCC on resources available from other CA regions, state agencies, or federal resources with respect to resource availability, arrival schedules, etc. to the affected MHOAC Programs (or Patient Movement Function in the DOC/EOC(s)) and the regional representative for Cal OES. • Coordinate the distribution of incoming resources. • Aggregate data from affected OAs and submit Forms 3 and 4 to the MHCC



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SEMS/NIMS Level	Coordinating Entity for Patient Movement	Lead Planning and Operational Agency	Primary Response Functions
State (CA-ESF 8)	Patient Movement Function in Operations Section of MHCC (CA-ESF 8 Coordination Center)	EMSA and CDPH	<ul style="list-style-type: none"> • Receive patient movement requests from Regional Patient Movement Coordination Function • Assess ability of unaffected regions to provide emergency assistance • Receive and aggregate CA-ESF 8 situational information from the affected MHOAC Programs and involved state agencies (e.g., Licensing and Certification Division of CDPH, Office of Statewide Health Planning and Development [OSHPD], Cal OES, etc.) • Communicate information received from federal regulating authorities on resource availability, arrival schedules, etc. to the CA-ESF 8 representative assigned to the JPMAT and Cal OES • Coordinate with other regions to identify available resources to meet demands
State (Cal OES)	SOC	Cal OES	<ul style="list-style-type: none"> • Receive Forms 3 and 4 along with pre-scripted RRFs if needed resources cannot be found by health and medical coordination system • Review, approve and submit forms to necessary federal agencies for assistance
Federal	Joint Patient Movement Advisor Team (JPMAT)	HHS (includes DoD, FEMA, VA, National EMS Contractor)	<ul style="list-style-type: none"> • Receive patient movement requests from field (through CA-ESF 8 SEMS channels) • If the volume of requests exceeds resource availability, ask senior state CA-ESF 8 officials to prioritize patient movement requests (this is a state responsibility) • Send prioritized patient movement requests to the federal patient movement regulating authorities (e.g., military TPMRC-A) • Communicate information received from federal authorities on resource availability, arrival schedules, etc. to the CA-ESF 8 representative assigned to the JPMAT. The CA-ESF 8 representative will communicate this information to the Patient Movement Function at the MHCC and Cal OES.



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H. PATIENT TRACKING

Large scale patient movement requires accurate patient tracking. Patients may enter the system at a number of entry points and their final destination may not be known at the time they enter the patient movement process. Patients may be initially transported to casualty collection points or field treatment sites, including staging venues, and enter the National Disaster Medical System. The potential use of multiple resources and the possibility of inter-state movement makes accurate patient tracking essential.

A patient tracking system could be as simple as a written documentation process (pen and paper) or a technology-based tracking system. Because California's 58 counties do not use the same system, a unifying approach for large scale patient movement that is used on a day-to-day basis throughout the state is not readily available. Therefore, a simple system is needed that can be easily applied if and when a major disaster occurs that requires the transport of many patients beyond that EMS systems boundaries. Ideally, the use of this system should be exercised during MCI exercises.

A California Unified Patient Tracking System (CUPTS) should be used when incidents require the movement of patients beyond the EMS system's established tracking system, i.e., large scale patient movement beyond typical MCI incidents, under the assumption that patient destinations may be beyond the normal anticipated locations.

When federal ESF 8 partners are moving patients, the Joint Patient Assessment and Tracking System (JPATS) will be used to maintain visibility of the patients transported by the federal system.

If the FEMA National EMS Contract is utilized for patient transportation, the state should continue to use CUPTS.

1. California Unified Patient Tracking System (CUPTS)

When local EMS systems experience a disaster that produces a large number of casualties that require regional, state and/or federal assistance to manage the patient movement needs created by the incident, it is recognized that a patient tracking system that functions statewide is essential.

The **California Unified Patient Tracking System (CUPTS)** is a simple, non-technology based solution that can be readily adopted, although it should become familiar through use in drills and exercises. It is presented here as an untested concept. For it to become useful in a large-scale disaster, it will need to be taught and practiced.



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To use CUPTS, each patient who requires movement is assigned a simple code that consists of 3 components:

County of Origin	Use 3 letter FIRESCOPE code for the operational area (See Forms section for listing of codes)
Sex	M, F or U
Last 4 digits of Triage Tag Number (or last 4 digits of SSN if no Triage Tag)	XXXX

Unless it is known that the patient will remain within the originating EMS system’s boundaries, all patients should be identified with a California Unified Patient Tracking (CUPTS) number written with felt pen on visible skin (e.g., back of hand, forearm, etc.). The 8-character number consists of 3 alpha characters that designate the originating operational area (using the FIRESCOPE system of geographic identifiers): M/F/U for sex; and the last 4 numbers of Triage Tag number, or as a secondary option, the last 4 digits of the social security number.

Example CUPTS Numbers: XAL-M-1234, XLA-F-4321, XSA-U-1122

The CUPTS number is tracked along with the patient’s first and last name, unless the name is unobtainable due to the patient’s age, non-communicative status or some other reason.

If practical, it may be helpful to take a photo to accompany the CUPTS number to facilitate identification at a later point.

It is the responsibility of the transporting entity to assign and report CUPTS information to the Patient Movement Function at the DOC/EOC. Ideally, CUPTS information should be provided in an Excel format, although any format will be accepted.

When the DOC/EOC receive CUPTS information, it should be shared with the Regional Patient Movement Coordination Function and/or Patient Movement Function at the MHCC.

I. RESPONSE ACTIONS

The specific response actions below identify activities undertaken by agencies/entities when patient transportation and destinations are needed which exceed the capabilities of the EMS system, including the use of day-to-day agreements (i.e., a Level 1 or 2 Health and Medical Incident per the California Public Health and Medical Emergency Operations Manual (EOM)).



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Affected Field-Level Entities (e.g., ambulance providers, healthcare facilities)

- Notify the LEMSA and other local and state agencies in accordance with statutory and regulatory requirements and local policies and procedures
- Provide situational information to the appropriate local agency in accordance with local policies and procedures
- Provide resource status information to the appropriate local agency in accordance with local policies and procedures
- If medical and health resources are needed that cannot be obtained through existing agreements, request resources through the MHOAC Program in accordance with local policies and procedures. Local policies and procedures will determine the appropriate contact within the MHOAC Program (e.g., LEMSA). Include required logistical support (“wrap around services”) such as food, lodging and fuel as part of the resource request. If non-medical and health resources are needed, request resources through the appropriate local agency in accordance with local policies and procedures and inform the MHOAC Program
- Implement emergency operations plans as appropriate
- Coordinate with the LEMSA, LHD, MHOAC Program and other agencies in accordance with local policies and procedures

LEMSA

- Notify:
 - Local and state agencies in accordance with statutory and regulatory requirements and local policies and procedures
 - MHOAC Program
 - EMSA Duty Officer Program (either directly or via the MHOAC Program) or MHCC if activated
- Provide situational information to the MHOAC Program in accordance with local policies and procedures
- Monitor the capacity of healthcare facilities to receive patients and communicate operational status to EMS providers
- Coordinate with EMS providers, MHOAC Program, and others regarding pre-hospital triage, patient care, and medical transportation of injured or contaminated patients in accordance with local policies and procedures



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- Coordinate with healthcare systems/facilities that have independent contracts with ambulance providers regarding the best use of these resources
- Coordinate the establishment of casualty collection centers and field treatment sites to care for patients awaiting transportation to medical facilities
- Coordinate the movement and distribution of patients by EMS providers, including evacuation of patients and re-population of healthcare facilities
- Coordinate medical transportation resources coming into or leaving the operational area, including those included in the statewide AST program
- Coordinate with LHD regarding local hospital assessments, capacity reporting, and patient distribution activities
- Ensure that hospital bed availability assessments are completed when requested by CDPH/EMSA, RDMHC Program or MHOAC Program
- Coordinate with EMS dispatch centers and providers to develop a Communications Plan that addresses communications between transportation provider resources and non-traditional sites (e.g., FTS, ACSs, community clinics, etc.)
- Monitor and consider emergency modifications of dispatch policies and protocols to accommodate EMS surge
- If medical and health resource requests cannot be filled within the local government jurisdiction or through existing agreements, request resources through the MHOAC Program in accordance with local policies and procedures. Local policies and procedures will determine the appropriate contact within the MHOAC Program, since MHOAC Program functions are typically shared between the LHD and LEMSA. Include required logistical support (“wrap around services”) such as food, lodging and fuel as part of the resource request. If non-medical and health resources are needed, request resources through the appropriate local agency in accordance with local policies and procedures and inform the MHOAC Program
- Coordinate with affected field-level entities, LHD, MHOAC Program, Incident Command and DOCs/EOCs in accordance with local policies and procedures
- Activate/support the *Patient Movement Function* at DOC as necessary to support patient movement



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LHD

- Notify:
 - Local and state agencies in accordance with statutory and regulatory requirements and local policies and procedures
 - MHOAC Program
 - CDPH Duty Officer Program (either directly or via the MHOAC Program) or MHCC if activated.

- Provide situational information to the MHOAC Program in accordance with local policies and procedures

- If medical and health resource requests cannot be filled within the local government jurisdiction or through existing agreements, request resources through the MHOAC Program in accordance with local policies and procedures. Local policies and procedures will determine the appropriate contact within the MHOAC Program, since MHOAC Program functions are typically shared between the LHD and LEMSA. Include required logistical support (“wrap around services”) such as food, lodging and fuel as part of the resource request. If non-medical and health resources are needed, request resources through the appropriate local agency in accordance with local policies and procedures and inform the MHOAC Program

- Coordinate the activation of government-authorized ACSs in response to a healthcare surge event as needed in accordance with local policies and procedures

- Take steps necessary to protect public health and environmental health, including proclaiming a local health emergency under the authority of the local health officer.

- Coordinate with affected field-level entities, LEMSA, MHOAC Program, Incident Command and DOCs/EOCs in accordance with local policies and procedures

- Activate/support the *Patient Movement Function* at the DOC/EOC as necessary to support patient movement

MHOAC Program

- Notify:
 - RDMHC Program
 - CDPH and/or EMSA Duty Officer Programs or MHCC if activated (either directly or via the RDMHC Program)



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- Emergency management agency for the operational area (or the operational area EOC if activated).
- Collect field-level requests for resources. For patient movement assistance, collect Form 1 and Form 4 from healthcare facilities, casualty collection points, etc.
- Within two hours of incident recognition prepare and submit a Medical and Health Situation Report containing the minimum data elements to the following recipients.
 - RDMHC Program
 - CDPH and EMSA Duty Officer Programs (or MHCC if activated)
 - Emergency management agency for the operational area (or the operational area EOC if activated) and other agencies in accordance with local policies and procedures
- Flash reports may be sent out preceding or between Medical Health Situation Reports, to the same recipients, by the MHOAC or RDMHS serving as an early warning or critical update providing situational awareness about the severity of the event.
- The initial Medical and Health Situation Report may be provided verbally to the RDMHC Program under pressing circumstances and followed up as soon as possible with the written report.
- Provide updated Medical and Health Situation Reports as follows:
 - Once during each operational period at agreed upon times
 - When there are changes in status, prognosis or actions taken
 - In response to state/Regional agency request as communicated by the RDMHC Program
- Coordinate with the affected field-level entities, LHD, EHD, LEMSA, and CDPH and/or EMSA Duty Officer Programs (or MHCC if activated) to share situational information
- Assist the LEMSA as needed with patient distribution and tracking activities
- Assist in coordinating medical transportation resources within the operational area, and health and medical mutual aid resources, including ASTs in accordance with EMSA guidelines
- Coordinate with the RDMHC Program (or Regional Patient Movement Coordination Function if activated) regarding patient receiving facilities and destinations



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- Coordinate with the RDMHC Program (or Regional Patient Movement Coordination Function if activated) to obtain information, policy-level decisions for response activities, and guidance developed by state-level programs and coordinated through the MHCC
- Attempt to fill resource requests within the operational area or by utilizing existing agreements (including day-to-day agreements, memoranda of understanding, or other emergency assistance agreements).
- If requested resources cannot be met within the operational area or through existing agreements, prepare Form 2 and the EOM's Resource Request: Medical and Health that includes the minimum information, including the need for logistical support ("wrap around services") such as food, lodging, and fuel. Submit these forms to the:
 - RDMHC Program (or Regional Patient Movement Coordination Function if activated), which will begin to coordinate the resource acquisition process. Confirm receipt
 - Emergency management agency for the operational area (or operational area EOC if activated). Confirm receipt and entry in CAL EOC or other resource tracking system
- Ensure that situational information is provided to the RDMHC Program (or Regional Patient Movement Coordination Function if activated), emergency management agency for the operational area (or operational area EOC if activated), and CDPH and EMSA Duty Officers (or MHCC if activated) to support the requested resources. A Medical and Health Situation Report should be submitted with the resource request or as soon as possible
- Notify the requestor of the outcome of the request and delivery details if the request is filled
- Activate/support the *Patient Movement Function* at the operational area EOC as necessary to support patient movement
- Support the Medical and Health Branch of the operational area EOC as necessary
- Ensure final patient tracking information is provided to the RDMHC Program (or Regional Patient Movement Coordination Function if activated)

RDMHC Program

- Establish and maintain communications with the MHOAC Program(s) within the mutual aid region, neighboring mutual aid regions, and the state (e.g., EMSA



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and/or CDPH Duty Officer Program or MHCC if activated) to facilitate patient movement and distribution and anticipated resource requests

- Activate the *Regional Patient Movement Coordination Function* if necessary to support region-wide patient movement
- Coordinate with EMSA and CDPH to support the activation of the *Regional Patient Movement Coordination Function*
- If patient transport destinations are required, request that MHOAC Programs in non-affected operational areas within the region poll patient receiving facilities for patient receiving capacity, and provide the results of those assessments to the LEMSA or MHOAC Program in the affected operational area
- Coordinate with MHOAC Programs to identify and establish casualty collection points or field treatment sites to care for patients that are awaiting transportation to medical facilities outside the region and/or identify and establish areas for receiving patients from outside the region
- Notify and coordinate with emergency management agencies in accordance with policies and procedures, including the Cal OES Regional Duty Officer (or REOC if activated)
- Ensure that the MHOAC Program(s) submitted the Medical and Health Situation Report(s) to the CDPH and/or EMSA Duty Officer Programs (or MHCC if activated); if not, submit immediately
- Ensure that the MHOAC Program(s) submitted the Medical and Health Situation Report(s) to the emergency management agency for the operational area (or operational area EOC if activated); if not, submit immediately
- Confirm the Cal OES Regional Duty Officer (or REOC if activated) received the information contained in the Medical and Health Situation Report(s); if not, submit immediately
- If resources are requested, immediately begin the process of filling the resource request by coordinating with unaffected operational areas within the mutual aid region
- If resources are requested that cannot be provided within the mutual aid region, advance the requests to the MHCC for possible fulfillment by other mutual aid regions in California
- Coordinate with the Cal OES Regional Duty Officer (or REOC if activated) to ensure proper tracking and fulfillment of resource request(s)



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- Notify the CDPH and/or EMSA Duty Officers (or MHCC if activated) that a resource request is being processed
- Notify the requesting MHOAC Program, CDPH and/or EMSA Duty Officers (or MHCC if activated), and Cal OES Regional Duty Officer (or REOC if activated) of the outcome of the request and delivery details if the request is filled within the mutual aid region
- Coordinate with the MHCC to ensure that information, policy-level decisions for response activities, and guidance developed by state-level programs are distributed to the MHOAC Program(s).
- Coordinate with CDPH and EMSA to support the Medical and Health Branch of the REOC if activated

EMSA

- EMSA Duty Officer Program: Notify and share information with local and state agencies, including LEMSAs, MHOAC Programs, RDMHC Programs, CDPH and Cal OES. (Note: If the MHCC activates, the activities related to the specific incident will be coordinated through the MHCC.)
- In collaboration with CDPH, collect and analyze situational information via the receipt of *Flash Reports* and *Medical and Health Situation Reports* from affected MHOAC Programs and RDMHC Programs, conference calls with affected stakeholders, etc. Incorporate this information, along with state department activities, into a *CA-ESF 8 (MHCC) Situation Report* that is disseminated to health and medical stakeholders and collaborating state agencies. (Note: This activity is likely to be coordinated by the MHCC if activated.)
- In collaboration with CDPH, collect and validate all resource requests received from the RDMHC Program(s) or Regional Patient Movement Coordination Function. Resource requests for disaster medical assistance should be routed to EMSA for coordination with other RDMHC Programs. Resource requests for public health or environmental health assistance should be routed to CDPH for coordination with other RDMHC Programs. If the requested resources are not readily available in other regions of the state via the Medical and Health Mutual Aid System, EMSA/CDPH will immediately notify Cal OES of the need for state agency mission resource tasking (if appropriate) or federal assistance. (Note: This activity will be coordinated by the MHCC if activated.)

If a resource request originating from an operational area can be filled by the RDMHC Program representing the affected mutual aid region, no further escalation of the resource request is necessary (although the resource request and



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its disposition should be tracked for possible reimbursement and other purposes). If the resource request cannot be filled within the mutual aid region, then it should be elevated to EMSA and/or CDPH for coordination with unaffected RDMHC Programs in other mutual aid regions. If the requested resource(s) cannot be obtained from other mutual aid regions, the resource request(s) are submitted to Cal OES¹² for fulfillment either through state agency mission resource tasking, resources provided by other states through EMAC, or the request and acquisition of federal assistance

- Anytime it is anticipated that the demand for resources will exceed the available supply, even if on a temporary basis, EMSA and CDPH (as co-leads for CA-ESF 8) may convene a **CA-ESF 8 Advisory Task Force on Patient Movement**¹³ to consider and recommend the allocation of scarce resources. CDPH and EMSA will determine the composition of the Advisory Task Force, but at a minimum it should include appropriate and proportional representatives from the jurisdictions requesting resources and any affected state agencies. Ideally, the process utilized by the Advisory Task Force will be transparent and every effort will be made to reach consensus (similar to the model used by FIRESCOPE in MAC Group decisions)

Specifically regarding the allocation of available in-state medical and health mutual aid resources (e.g., Ambulance Strike Teams), allocation decisions will be made by the Advisory Task Force using standard MAC Group processes appropriate for medical and health and coordinated by EMSA and/or CDPH, unless delays are consequential in terms of life-saving or life-sustaining activities, in which case EMSA will make the final determination regarding the allocation of disaster medical resources and CDPH will make the final determination regarding the allocation of public health resources and environmental health resources that fall under CA-ESF 8 (see Health and Safety Code Section 1797.153)

¹² At the time of publication of this plan, Cal OES' policy direction on the use of Cal EOC (Cal OES' emergency management software system) is to refrain from entering medical and health resource requests into Cal EOC unless it is known that Cal OES will need to mission resource task a state agency.

¹³ The CA-ESF 8 Advisory Task Force on Patient Movement is currently a concept that requires operationalization. It should include government officials representing state agencies responsible for health and medical disaster response in California, e.g., CHHS, EMSA, CDPH, and DHCS, in addition to local jurisdictional representatives based on the matter in need of resolution. The purpose of the Task Force is to consider and reach consensus decisions on key matters related to patient movement (e.g., allocation of scarce resources, number of attendants that can accompany evacuating patients, need for federal support, etc). The CA-ESF 8 Advisory Task Force on Patient Movement will be convened at the discretion of the CA-ESF 8 co-lead departments, EMSA and CDPH, and chaired by the current CA-ESF 8 Lead.



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Specifically, regarding the allocation of resources provided through state agency mission resource tasking or federal agencies, every effort will be made to reach consensus among Advisory Task Force members and communicate the consensus recommendation to Cal OES or the UCG. If consensus is not obtainable and/or delays are consequential in terms of life-saving or life-sustaining activities, EMSA and CDPH will make good-faith recommendations to Cal OES or the UCG. (Note: This activity is likely to be coordinated by the MHCC if activated.)

The CA-ESF 8 Advisory Task Force on Patient Movement will also consider and make recommendations on other important issues related to patient movement (e.g., the number of attendants, including family members or caregivers, that can accompany evacuating patients as this will reduce the space on aircraft for litters or patient transport; allocation of scarce resources, and other decisions)

- In collaboration with CDPH, coordinate closely with federal response partners (primarily HHS Region IX) regarding the need for and availability of federal assistance related to patient movement and share this information with Cal OES. (Note: This activity is likely to be coordinated by the MHCC if activated.)
- Support Cal OES by providing information and subject matter expertise regarding patient movement activities and needs, including assistance preparing federal resource requests. (Note: This activity will likely require the presence of appropriate personnel at the SOC/IOF/JFO.)
- Requests for aviation support beyond local capabilities should be copied to the Air Coordination Group at the SOC.

CDPH

- CDPH Duty Officer Program: Notify and share information with local and state agencies, including LHD/EHDs, CDPH Programs including Licensing and Certification, MHOAC Programs, RDMHC Programs, EMSA and Cal OES. (Note: If the MHCC activates, either as the joint EOC for CDPH, EMSA and DHCS, or as a CA-ESF 8 Coordination Center, the activities related to the specific incident will be coordinated through the MHCC.)
- In collaboration with EMSA, collect and analyze situational information via the receipt of *Flash Reports* and *Medical and Health Situation Reports* from affected MHOAC Programs and RDMHC Programs, conference calls with affected stakeholders, etc. Incorporate this information, along with state agency activities, into a *CA-ESF 8 (MHCC) Situation Report* that is disseminated to health and medical stakeholders and collaborating state agencies. (Note: This activity will be coordinated by the MHCC if activated.)



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- In collaboration with EMSA, collect and validate all resource requests received from the RDMHC Program(s) or Regional Patient Movement Coordination Function. Resource requests for disaster medical assistance should be routed to EMSA for coordination with other RDMHC Programs. Resource requests for public health or environmental health assistance should be routed to CDPH for coordination with other RDMHC Programs. If the requested resources are not readily available in other regions of the state via the Medical and Health Mutual Aid System, EMSA/CDPH will immediately notify Cal OES of the need for state agency mission resource tasking (if appropriate) or federal assistance. (Note: This activity will be coordinated by the MHCC if activated.)

If a resource request originating from an operational area can be filled by the RDMHC Program representing the affected mutual aid region, no further escalation of the resource request is necessary (although the resource request and its disposition should be tracked for possible reimbursement and other purposes). If the resource request cannot be filled within the mutual aid region, then it should be elevated to EMSA and/or CDPH for coordination with unaffected RDMHC Programs in other mutual aid regions. If the requested resource(s) cannot be obtained from other mutual aid regions, the resource request(s) are submitted to Cal OES¹⁴ for fulfillment either through state agency mission resource tasking, resources provided by other states through EMAC, or the request and acquisition of federal assistance

- Anytime it is anticipated that the demand for resources will exceed the available supply, even if on a temporary basis, EMSA and CDPH (as co-leads for CA-ESF 8) will convene a **CA-ESF 8 Advisory Task Force on Patient Movement** to consider and recommend the allocation of scarce resources. CDPH and EMSA will determine the composition of the Advisory Task Force, but at a minimum it should include appropriate and proportional representatives from the jurisdictions requesting resources and any affected state agencies. Ideally, the process utilized by the Advisory Task Force will be transparent and every effort will be made to reach consensus (similar to the model used by FIRESCOPE in MAC Group decisions)

Specifically regarding the allocation of available in-state medical and health mutual aid resources (e.g., Ambulance Strike Teams), allocation decisions will be made by the Advisory Task Force using standard MAC Group processes appropriate for medical and health, coordinated by EMSA and/or CDPH, unless delays are consequential in terms of life-saving or life-sustaining activities, in

¹⁴ At the time of publication of this plan, Cal OES's policy direction on the use of Cal EOC (Cal OES's emergency management software system) is to refrain from entering medical and health resource requests into Cal EOC unless it is known that Cal OES may need to mission resource task a state agency.



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which case EMSA will make the final determination regarding the allocation of disaster medical resources and CDPH will make the final determination regarding the allocation of public health resources and environmental health resources that fall under CA-ESF 8 (see Health and Safety Code Section 1797.153)

- Specifically, regarding the allocation of resources provided through state agency mission resource tasking or federal agencies, every effort will be made to reach consensus among Advisory Task Force members and communicate the consensus recommendation to Cal OES or the UCG. If consensus is not obtainable and/or delays are consequential in terms of life-saving or life-sustaining activities, EMSA and CDPH will make good-faith recommendations to Cal OES or the UCG. (Note: This activity is likely to be coordinated by the MHCC if activated.)
- The **CA-ESF 8 Advisory Task Force on Patient Movement** will also consider and make recommendations on important issues related to patient movement (e.g., the number of attendants, including family members or caregivers that can accompany evacuating patients, which will reduce the space on aircraft for litters or patient transport and other decisions)
- In collaboration with EMSA, coordinate closely with federal response partners (primarily HHS Region IX) regarding the need for and availability of federal assistance related to patient movement and share this information with Cal OES. (Note: This activity is likely to be coordinated by the MHCC if activated.)
- Support Cal OES by providing information and subject matter expertise regarding patient movement activities and needs, including assistance preparing federal resource requests. (Note: This activity will likely require the presence of appropriate personnel at the SOC/IOF/JFO.)

Medical and Health Coordination Center (if activated)

The Medical and Health Coordination Center (MHCC) functions as both the EOC for CDPH, EMSA and DHCS and the CA-ESF 8 Coordination Center. The MHCC coordinates the activities of involved state programs, RDMHC Programs, MHOAC Programs, LHD/EHDs, LEMSAs and other medical and health stakeholders. The MHCC will:

- Send an alert through the California Health Alert Network (CAHAN) that the MHCC has activated, including MHCC contact information and hours of operation. (Note that the CDPH Duty Officer Program and/or EMSA Duty Officer Program are the official points-of-contact outside MHCC operational hours.)
- Distribute state-level policy decisions, key information and guidance to the RDMHC Programs, MHOAC Programs, LHD/EHDs and LEMSAs, and support requests for state-level program information



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- Collect, analyze and respond to Flash Reports and Medical and Health Situation Reports and resource requests received from operational areas via MHOAC Programs and regions via RDMHC Programs
- Activate the *Patient Movement Function* within the Operations Section if necessary to support patient movement
- Monitor medical and health requests, determine if state resources are needed, and fill resource requests as necessary
- Prepare the statewide Medical and Health Situation Report and distribute in accordance with policies and procedures
- Coordinate closely with federal response partners (primarily HHS Region IX) regarding the need for and availability of federal assistance related to patient movement and share this information with Cal OES. Draft requests for federal assistance to be approved and submitted by Cal OES through the State Coordinating Officer (SCO)
- Prepare recommendations for the allocation of incoming resources if the demand exceeds the supply based on analysis of situational information via Medical and Health Situation Reports from affected MHOAC Programs and RDMHC Programs, conference calls with affected stakeholders, and the efforts of the CA-ESF 8 Advisory Task Force. Communicate these recommendations to Cal OES and/or the UCG. (Note: this activity may be coordinated at the MHCC.)
- When the MHCC is activated, many of the incident-specific activities described in the preceding sections for EMSA and CDPH will be coordinated by the MHCC

EMSA Duty Officer:

Telephone: *See Duty Officer distribution list*

Email: EMSADutyOfficer@emsa.ca.gov

CDPH Duty Officer:

Telephone: (916) 328-3605

Email: CDPHDutyOfficer@cdph.ca.gov

California State Warning Center:

Telephone: (916) 845-8911

Email: warning.center@oes.ca.gov



J. TIMELINE

The timeline below is an approximation but may be used as a basis for planning.

0-6 hours

- Impacted healthcare facilities activate emergency operations plans; assess facility status and ability to continue operations, including decisions to evacuate or shelter-in-place
- Impacted healthcare facilities communicate their situational status to the MHOAC Program and as otherwise required
- Local EMS system mobilizes to evacuate patients if conditions are unsafe to shelter-in-place
- Activate Patient Movement Function at DOC/EOC
- Regarding all patient movement: Unless it is known that the patient will remain within the originating EMS system's boundaries, all patients should be identified with a California Unified Patient Tracking (CUPTS) number written with felt pen on visible skin (e.g., back of hand, forearm, etc.). The 8-character number consists of 3 alpha characters that designate the originating operational area (using FIREScope system of identifiers); M/F/U for sex; and last 4 numbers of Triage Tag number. More information on this can be found in the Patient Tracking section on page 74
- MHOAC Programs in affected areas submit initial Flash Report or Medical and Health Situation Report to RDMHC Program, local emergency management, and EMSA/CDPH Duty Officer Programs within 2 hours
- Working with the RDMHC/S and LEMSAs, EMSA coordinates the movement of EMSA affiliated Ambulance Strike Teams from outside the impacted areas to the areas of greatest need
- Healthcare facilities outside the impacted area prepare to support surge operations
- Evacuating healthcare facilities may need to deploy their own hospital staff to accompany pediatric, neonatal or perinatal patients to facilitate safe patient movement
- EMSA and CDPH dispatch Agency Representatives to State Operations Center (SOC)
- CDPH Division of Licensing and Certification begins assessment of licensed healthcare facilities and shares information with MHCC
- CDPH and EMSA activate the Medical and Health Coordination Center (CA-ESF 8 coordination center)
- Medical and Health stakeholders are notified via CAHAN



CALIFORNIA PATIENT MOVEMENT PLAN

- Request Situation Reports from affected areas
- Notify unaffected areas to prepare for surge from affected areas
- Notify unaffected areas of the possible need for EMS resources and who to contact
- MHCC received data from Office of Statewide Health Planning and Development (OSHPD) that provides preliminary (unconfirmed) information on seismic impact to healthcare facilities in the shake zone

6-12 hours

- The RDMHC Programs in the affected region(s) will activate a **Regional Patient Movement Coordination Function** which may be located at the Cal OES REOC or another facility. Additional staff to support the Regional Patient Movement Coordination Function may come from LEMSAs, dispatch centers, interfacility transfer centers, etc. Clinical subject matter specialists should assist as needed. Similar Regional Patient Movement Coordination Function(s) may also be established in unaffected regions of the state to coordinate the receipt of patients from the impacted regions
- Estimate the number of patients to be evacuated from facility reports
- Conduct regional polling of available EMS assets and healthcare beds
- If National EMS Contract assets are needed, local jurisdictions should identify staging locations for incoming ambulances. The information needed to request the National EMS Contract includes Form 2 from the affected MHOAC Programs
- The identification of appropriate airfields that satisfy NDMS requirements should occur in the planning stage since military patient movement operations require that certain conditions are met. If NDMS is activated ASPR will coordinate with state and local jurisdictions to identify Aerial Points of Embarkation (APOE) appropriate for patient staging and loading. NDMS requires receipt of Form 4 information to clear patients for aeromedical evacuation
- Establish coordination with Cal OES' Air Coordination Group to avoid duplicating aviation activities
- The MHCC Operations Section will activate a Patient Movement Function to coordinate state-level activities in support of local jurisdiction
- Representatives of healthcare provider associations will be asked to send Agency Liaisons to the MHCC
- CA-ESF 8 (MHCC) will hold conference call with affected stakeholders representing public health, emergency medical services and environmental health to gain further



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insight on incident's impact and anticipated resource needs

- CA-ESF 8 (MHCC) will aggregate incoming medical and health situational information and resource requests, advises Cal OES on the deployment status of ASTs, and determines if additional patient movement assistance is needed from the California National Guard (CNG) (i.e., assistance with patient movement and staging)
- In collaboration with Cal OES and CNG, EMAC requests of additional National Guard forces from neighboring states to assist with patient movement and staging will be pursued
- CA-ESF 8 (MHCC), in collaboration with the HHS Region IX Regional Emergency Coordinator, will make recommendation to Cal OES to request federal patient movement resources, i.e., National EMS Contract and/or National Disaster Medical System
- If needed, CA-ESF 8 will send a Patient Movement Liaison to the Air Coordination Group at Cal OES
- If needed, CA-ESF 8 will send a Patient Movement Liaison to the Fuel Task Force at Cal OES (to support the fuel re-supply needs of first responders)
- If California air ambulance providers are involved in the movement of patients (rotary or fixed wing), this information should be provided to the SOC Air Coordination Group

12-36 hours

- Rotary-wing patient evacuation points should be established in areas where ground evacuation is not possible
- Evacuations directly from hospitals with Helicopter Landing Zones (HLZs) will also be conducted
- LEMSAs direct all incoming EMS mutual aid (with the exception of military assets, which remain under military command). Ambulance and paratransit vehicles may be used for 9-1-1 augmentation, interfacility transfers, healthcare facility evacuation, movement of patients to evacuation points, or movement of patients to medical shelters
- National EMS Contract assets should begin arriving at designated staging areas within 6 hours of receiving their Task Order from FEMA. One full zone of the National EMS Contract (300 ground ambulances, generally a 70%-30% split between ALS and BLS), 3,500 paratransit seats (not 3,500 vehicles) and sufficient EMS personnel to accompany all ambulances will arrive within 24 hours of receiving the Task Order. The National EMS Contractor will establish its own Base Camp(s) and all National EMS Contract assets will fall under local control (LEMSA). (Note, in addition to transportation assistance, local jurisdictions may also request additional EMS



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personnel to aid with other necessary activities (e.g., medical shelters, etc.)

- NDMS patient movement will occur from designated airfields that are capable of sustaining patient staging and military airlift approximately 30 hours after deployment. Local EMS systems (or National EMS Contract ambulances) are responsible for transporting patients to the airfields (Aerial Ports of Embarkation or APOEs). Note: Patients must be cleared by military authorities prior to military travel; this is accomplished by submitting Form 4 data in advance of movement
- California Medical Assistance Teams (CAL-MATs), HHS Disaster Medical Assistance Teams (DMATs), and DoD medical teams will deploy to locations based on allocation of resources. State and federal medical teams will provide support for the following:
 - Field treatment sites/casualty collection points
 - Damaged healthcare facilities
 - Medical operations at rotary-wing patient evacuation points
 - Medical operations at National Disaster Medical System (NDMS) patient evacuation hubs (Note: any airfield serving as an aerial port of embarkation (APOE) for the NDMS system must meet certain requirements. This should be considered during the planning stage)
- CA-ESF 8 sends representative to the SOC/IOF/JFO

36 hours +

- NDMS patient evacuation will continue, with patients sent to FCCs in other major population centers of California or out-of-state FCCs. Per APOE (airfield), NDMS can move 140 patients per day; 4 APOEs can move a maximum of 560 patients per day
- CA-ESF 8 through the MHCC will continue to interface with Cal OES and HHS to support patient movement until response transitions to recovery
- Patients moved by NDMS will be returned to their origin by HHS



SECTION IV. FIGURES

#	Description
1	Map of California's Local EMS Agencies (2018)
2	Map of California's Mutual Aid Regions
3	Planning Factors and Timeline for the National EMS Contract
4	Planning Factors, Timeline and Throughput for the National Disaster Medical System (NDMS)
5	Overview of NDMS Patient Movement
6	Schematic of Patient Movement from the Field to Destination Healthcare Facilities
7	Escalation of Resource Requests for Assistance with Patient Movement
8	Flow of Information and Resource Requests during Emergencies
9	Patient Movement Coordination Structure – Essential Functions
10	Expanded Patient Movement Coordination Structure



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FIGURE 1. MAP OF CALIFORNIA'S LOCAL EMS AGENCIES (2018)





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FIGURE 2. MAP OF CALIFORNIA'S MUTUAL AID REGIONS

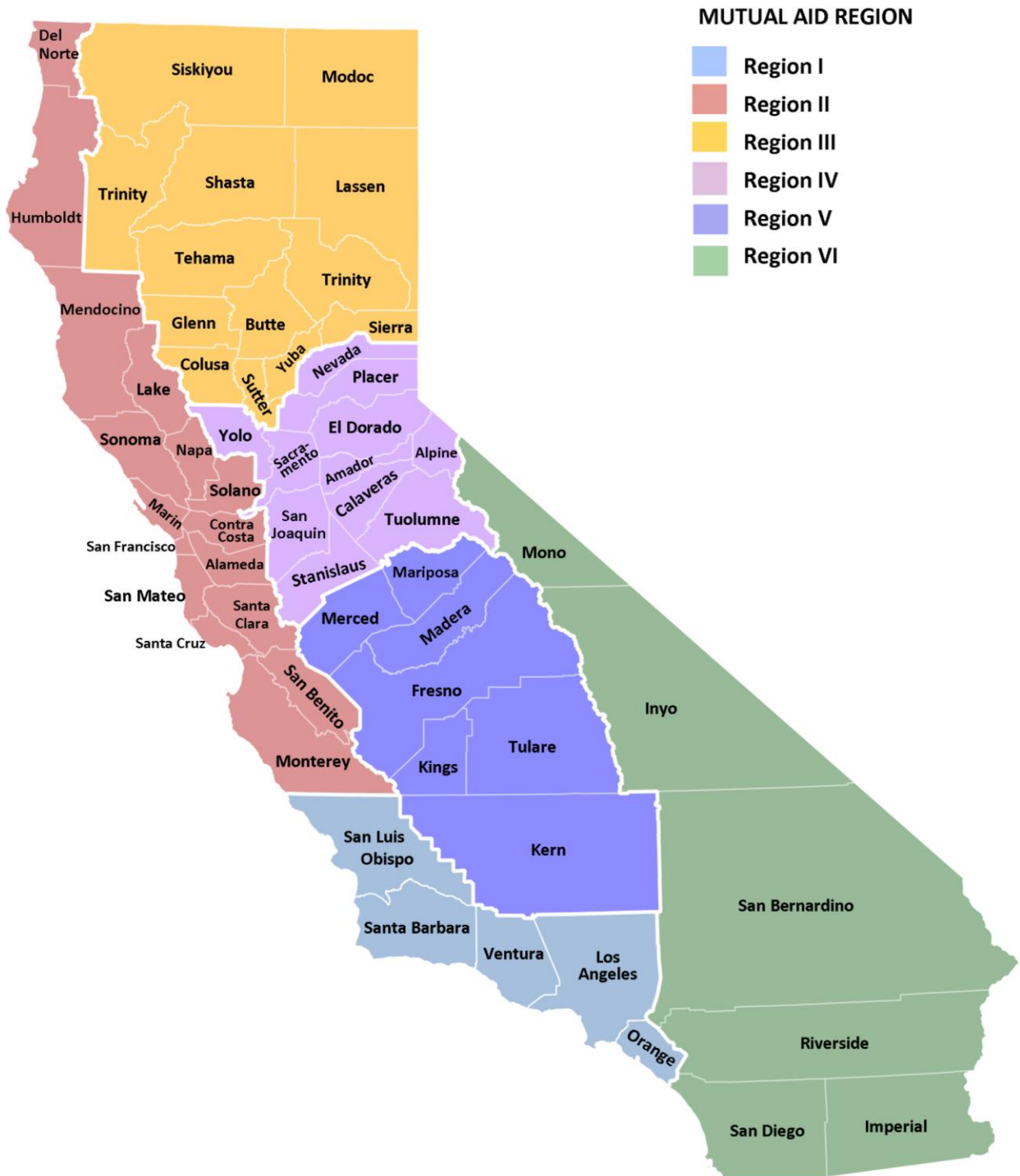
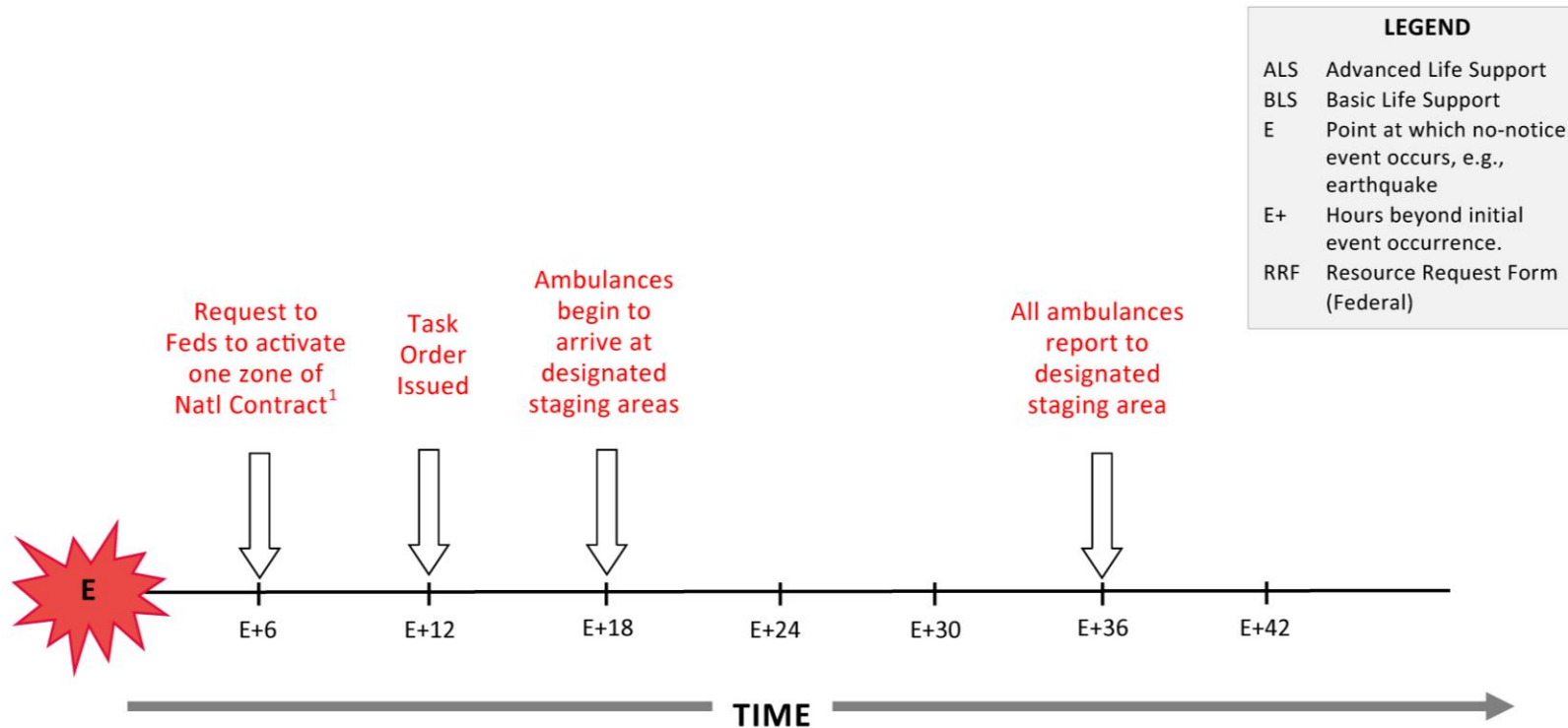




FIGURE 3. PLANNING FACTORS AND TIMELINE FOR THE NATIONAL EMS CONTRACT

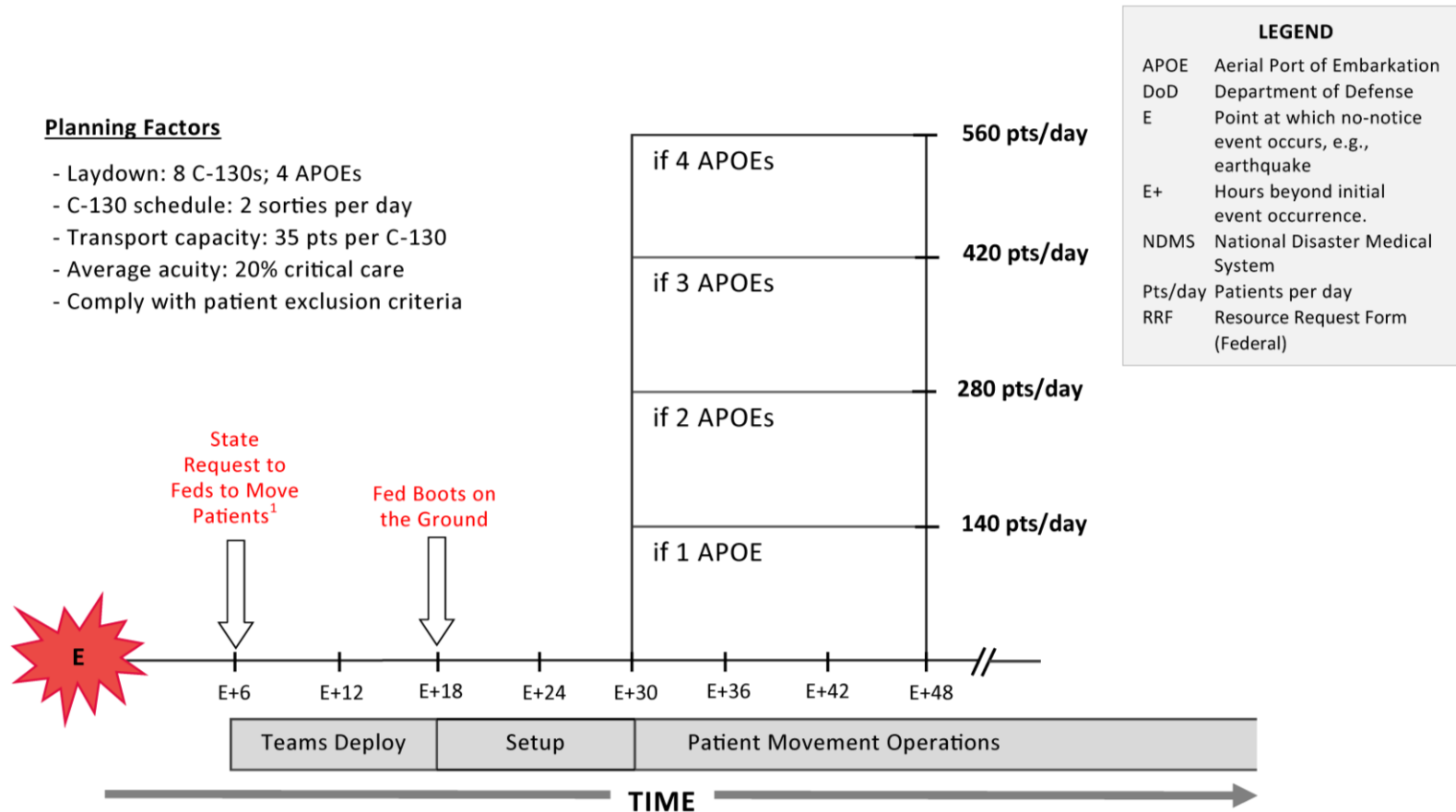


¹ One zone of the National EMS Contract includes up to 300 ground ambulances (typically, a 70%/30% ALS/BLS split unless otherwise specified); up to 25 air ambulances (rotary and fixed wing); and up to 3,500 paratransit seats (not 3,500 paratransit vehicle s). The State request for EMS support via the National EMS Contract should include the federal Resource Request Form (RRF); Letter of Reciprocity signed by authorized official(s); and Form 3 that communicates EMS asset types and delivery locations.



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FIGURE 4. PLANNING FACTORS, TIMELINE AND THROUGHPUT FOR THE NATIONAL DISASTER MEDICAL SYSTEM (NDMS)

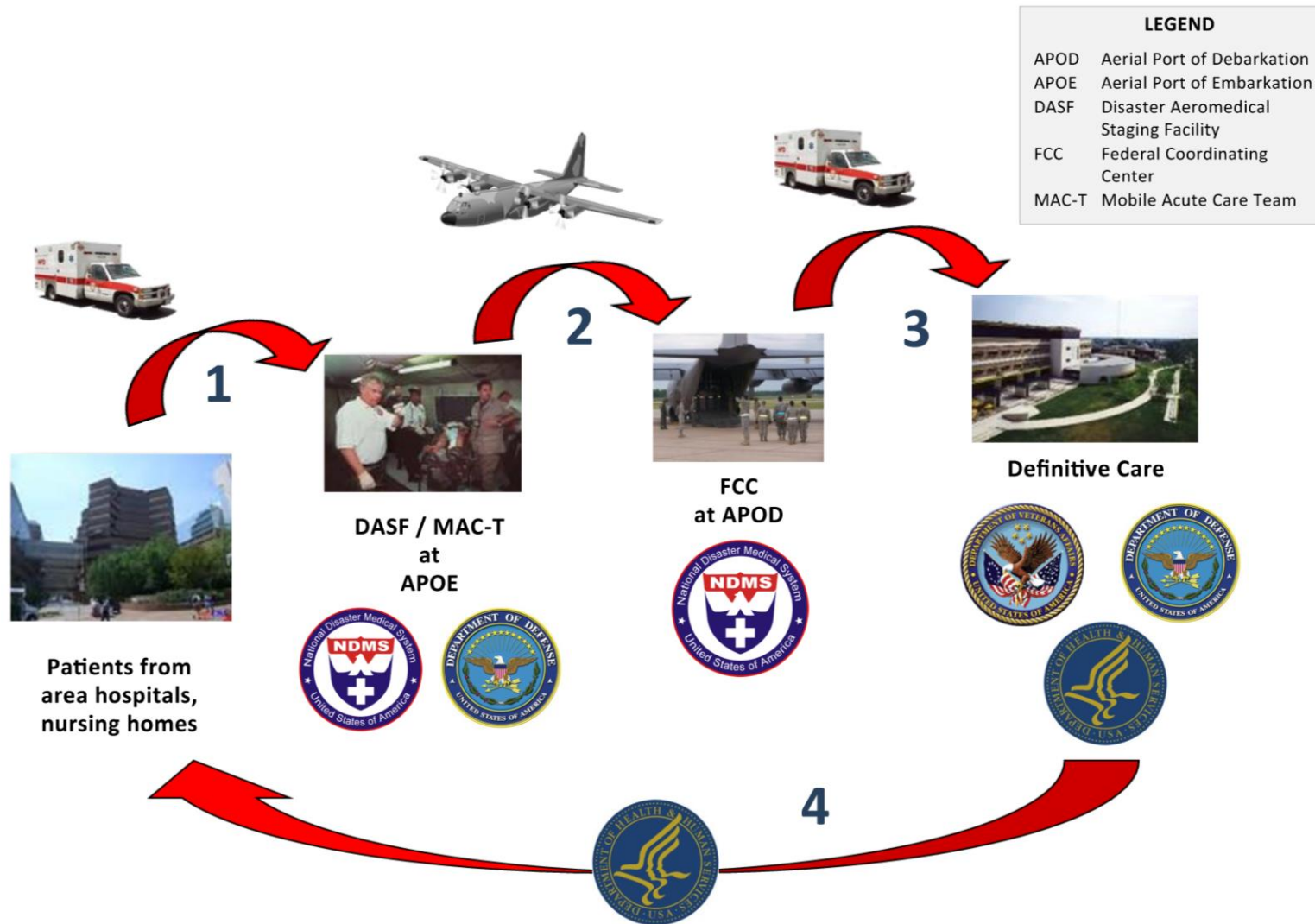


¹ The State request to move patients should include the **Resource Request Form** (RRF) and, as soon as possible, **Form 4** for all patients who require federal movement using NDMS or DoD assets.



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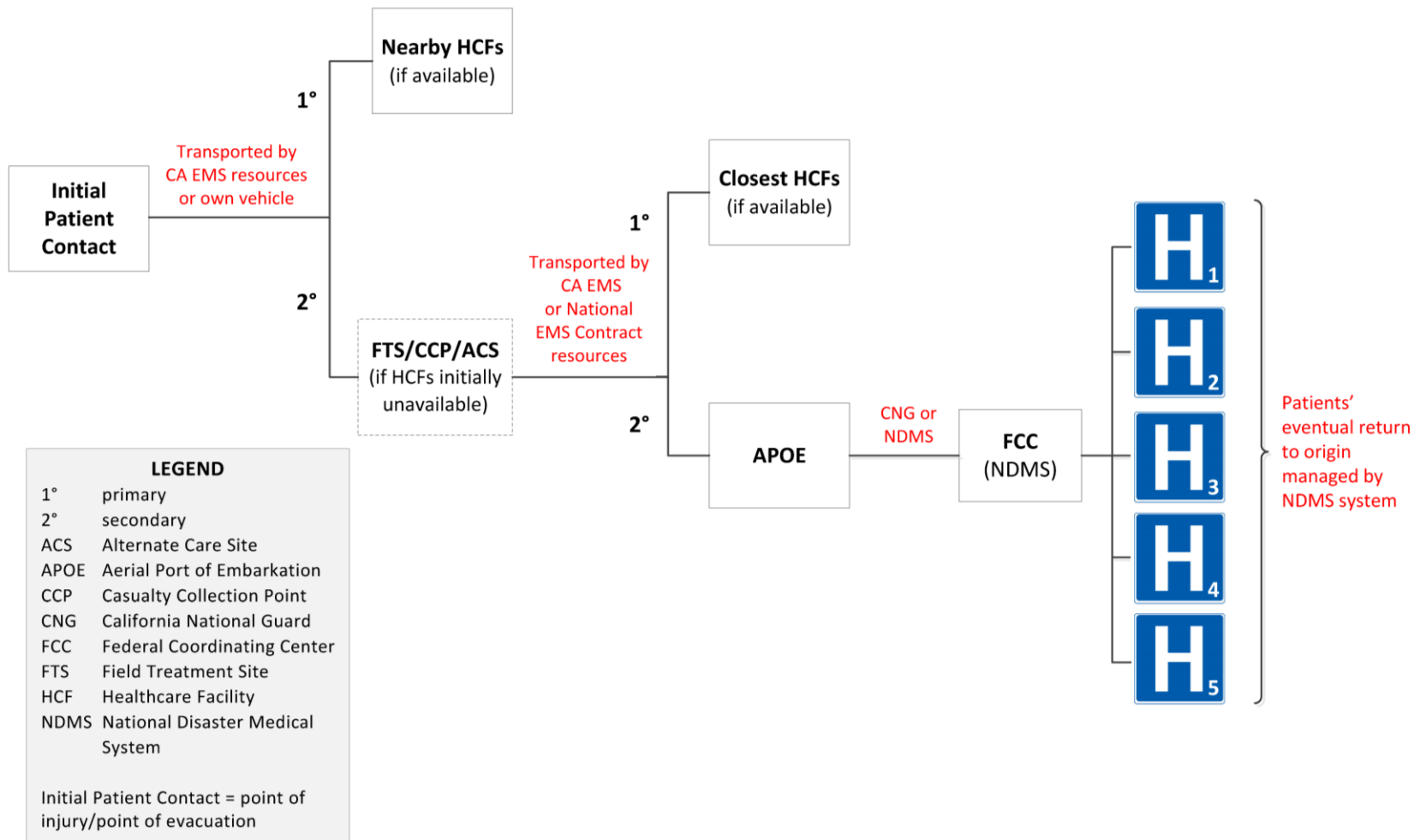
FIGURE 5. OVERVIEW OF NDMS PATIENT MOVEMENT





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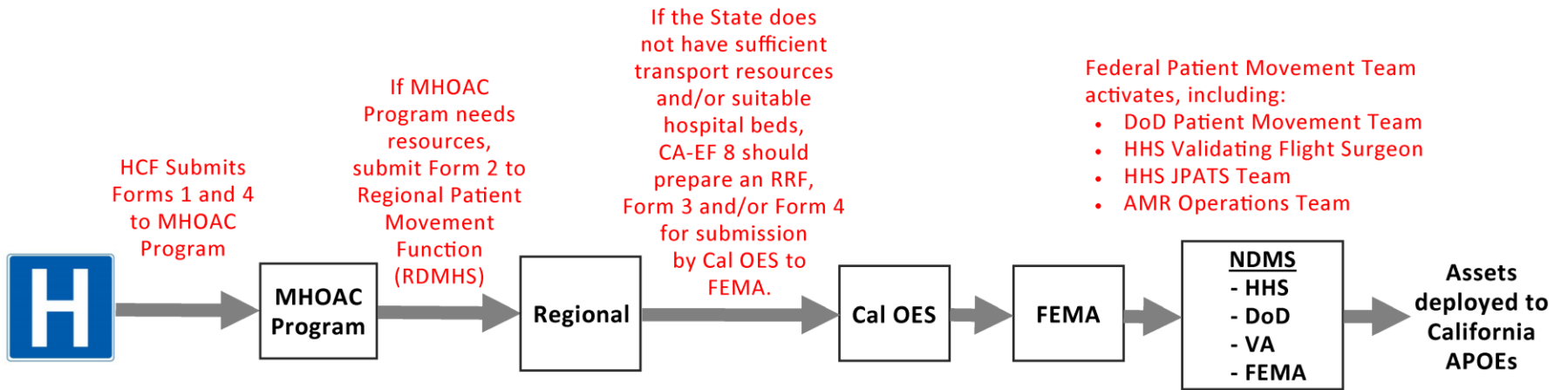
FIGURE 6. PATIENT MOVEMENT FROM THE FIELD TO DESTINATION HEALTHCARE FACILITIES





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FIGURE 7. ESCALATION OF RESOURCE REQUESTS FOR ASSISTANCE WITH PATIENT MOVEMENT



LEGEND			
AMR	American Medical Response	MHOAC	Medical and Health Operational Area Coordination Program
APOE	Aerial Port of Embarkation	NDMS	National Disaster Medical System
Cal OES	California Governor’s Office of Emergency Services	RDMHS	Regional Disaster Medical Health Specialist
DoD	Department of Defense	RRF	Resource Request Form (Federal)
FEMA	Federal Emergency Management Agency	VA	Veterans Administration
HCF	Healthcare Facility		
HHS	U.S. Department of Health and Human Services		
JPATS	Joint Patient Assessment and Tracking System		



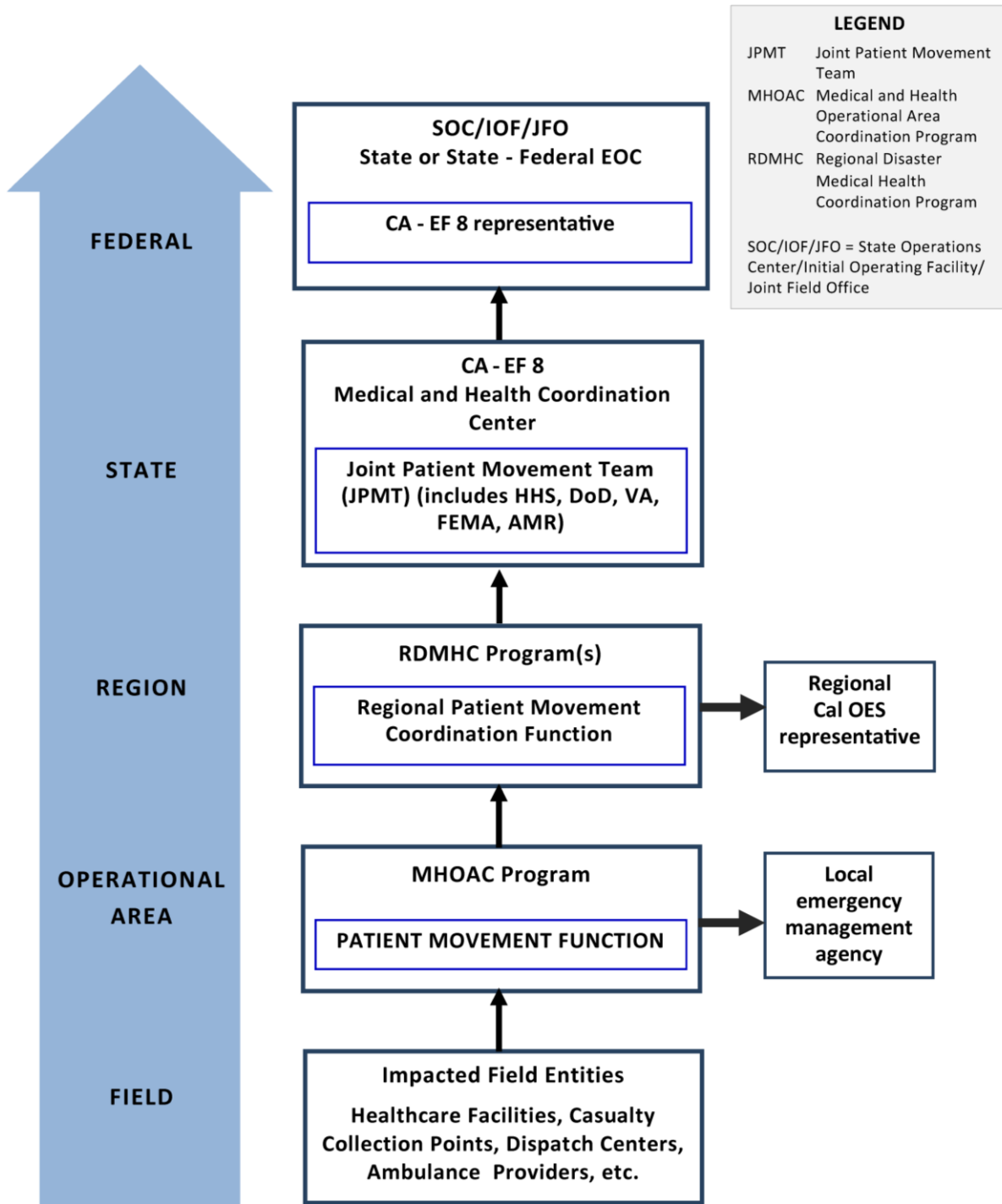
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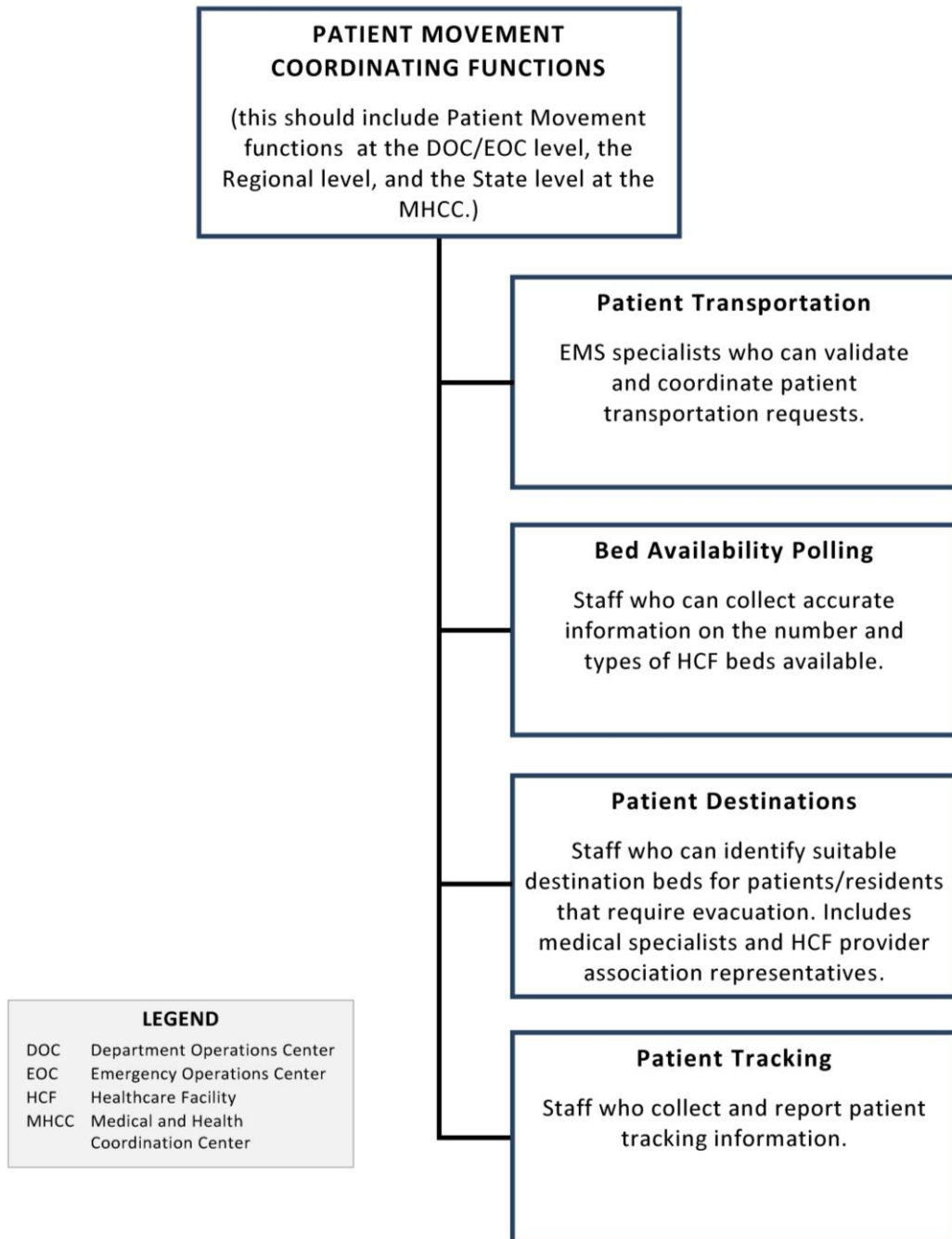
FIGURE 8. FLOW OF INFORMATION AND RESOURCE REQUESTS DURING EMERGENCIES





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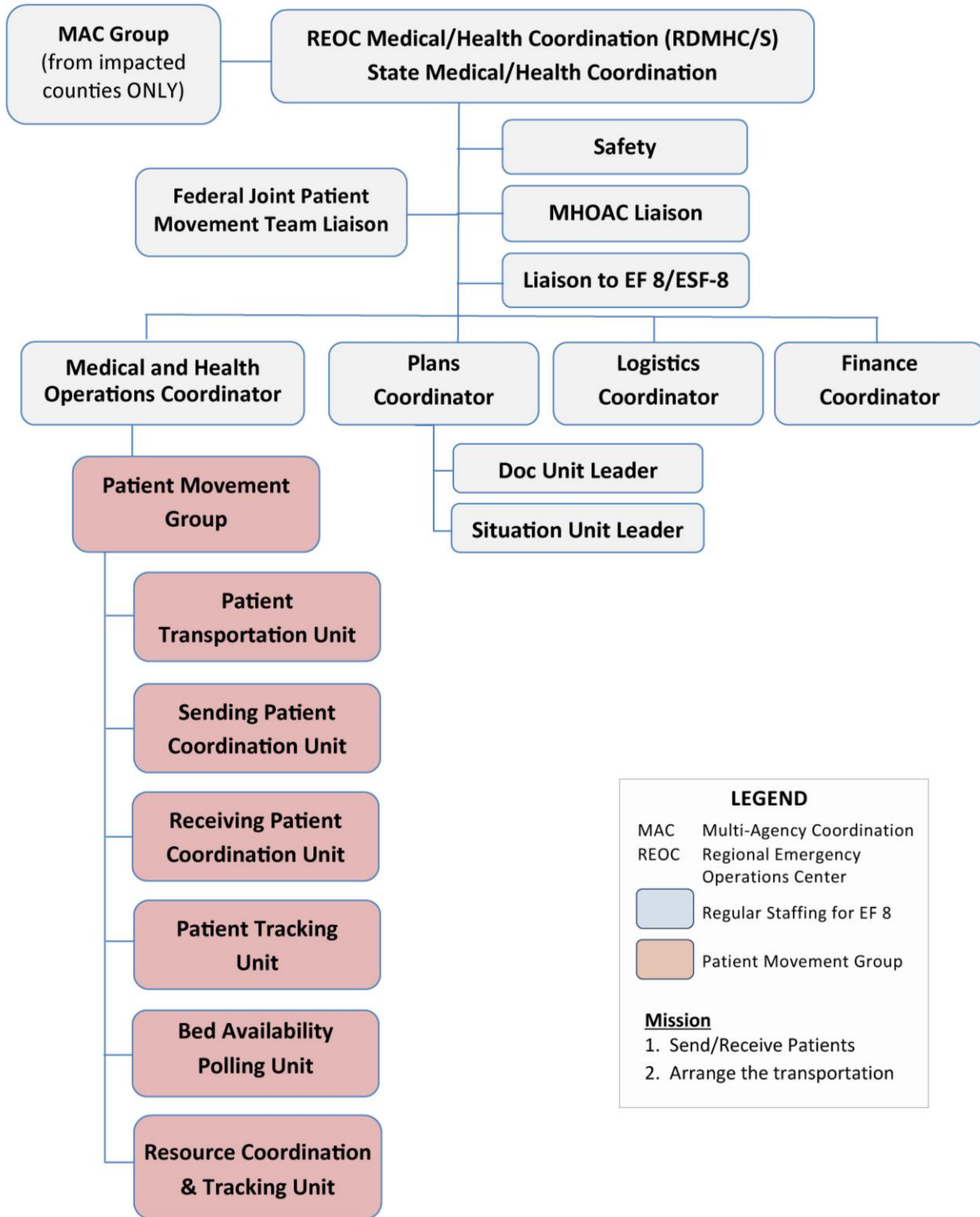
FIGURE 9. PATIENT MOVEMENT COORDINATION STRUCTURE – ESSENTIAL FUNCTIONS





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FIGURE 10. EXPANDED PATIENT MOVEMENT COORDINATION STRUCTURE





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SECTION V. PATIENT MOVEMENT FORMS

#	Form
1	Resource Request Form used by Healthcare Facilities or Field Sites (goes to MHOAC Program)
2	Resource Request Form used by MHOAC Programs (goes to RDMHC Program)
3	Resource Request Form used by CA-ESF 8 to request federal assistance (goes to Cal OES for submission to FEMA)
4	Information required by federal agencies to transport patients using NDMS (includes listing of 3-character county identifiers to assist with patient tracking)
5	Pre-scripted federal Resource Request Form #1 (RRF) for the National EMS Contract (form is submitted by Cal OES to FEMA)
6	Pre-scripted federal Resource Request Form #2 (RRF) for HHS support to the National EMS Contract (form is submitted by Cal OES to FEMA)
7	Pre-scripted federal Resource Request Form #3 (RRF) for the National Disaster Medical System (form is submitted by Cal OES to FEMA)



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FORM 1. RESOURCE REQUEST FORM USED BY HEALTHCARE FACILITIES OR FIELD SITES

Instructions: Healthcare Facility should submit completed form to MHOAC Program.

Healthcare Facility Name	
Facility Type (Hospital, SNF, etc.)	
Address	
City	
County	
POC Name	
POC Phone #	
POC Email	
24 Hour POC (Name/Contact #)	

CHECK THE TYPE OF SUPPORT NEEDED:

Patient Transportation ONLY (complete Section A)

Patient Placement ONLY (complete Section B)

Both Patient Transport & Placement (complete Sections A and B)

Section A – Patient Transport		
GROUND AMBULANCE Patient Types	# of Patients/Passengers	
# of stretcher patients needing ALS		
# of stretcher patients needing BLS		
# of bariatric patients (pt. weighs > 400lbs., extra wide stretcher). All bariatric units are ALS.		
PARATRANSIT Passenger Types		
# of passengers that are ambulatory, do not require assistance and can ride in a van or bus		
# of passengers that are “ambulatory-with-assistance” that can ride in a van or bus with assistance but do not require a wheelchair or stretcher		
# of non-ambulatory passengers that may need a wheelchair but do not require stretcher		
# of caregivers that will be provided to accompany paratransit passengers		
AIR AMBULANCE Patient Types (adult/child and neonatal)	ADULT and CHILD	NEONATE
# of patients requiring transportation by helicopter air ambulance		
# of patients requiring transportation by fixed-wing air ambulance		

Form 1. Resource Request Form used by HCFs or Field Sites

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Form 1. Resource Request Form used by HCFs or Field Sites (cont.)

Section B – Bed Types Needed		
Patient Type	Bed Type	#
<u>Adult:</u>	Med/Surgical	<input type="checkbox"/>
	OB/LND	<input type="checkbox"/>
	Psychiatric	<input type="checkbox"/>
	Critical: Burn	<input type="checkbox"/>
	Critical: ICU	<input type="checkbox"/>
	Critical: CCU	<input type="checkbox"/>
	Critical: Trauma	<input type="checkbox"/>
<u>Pediatric:</u>	Ped Med/Surgical	<input type="checkbox"/>
	PICU	<input type="checkbox"/>
	NICU	<input type="checkbox"/>



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FORM 2. RESOURCE REQUEST FORM USED BY MHOAC PROGRAMS

Instructions: MHOAC Program should submit completed form to RDMHC Program.

Name of Requesting Operational Area	Date	Time (24 hr. format)
Name of person making request (First/Last)	Title of person making request	
Telephone contact numbers (office, cell, fax, other)	Email address	
24-hour POC (Name)	24-hour POC contact numbers	
Location Type <input type="checkbox"/> Evacuating Hospital <input type="checkbox"/> Field Treatment Site <input type="checkbox"/> Evacuating SNF <input type="checkbox"/> Casualty Collection Point	Location Address	

Section 1. Patient Transport		
GROUND AMBULANCE Patient Types	# of Patients/Passengers	
# of stretcher patients needing ALS		
# of stretcher patients needing BLS		
# of bariatric patients (pt. weighs > 400lbs., extra wide stretcher). All bariatric units are ALS.		
PARATRANSIT Passenger Types		
# of passengers that are ambulatory, do not require assistance and can ride in a van or bus		
# of passengers that are "ambulatory-with-assistance" that can ride in a van or bus with assistance but do not require a wheelchair or stretcher		
# of non-ambulatory passengers that may need a wheelchair but do not require stretcher		
# of caregivers that will be provided to accompany paratransit passengers		
AIR AMBULANCE Patient Types (adult/child and neonatal)	ADULT and CHILD	NEONATE
# of patients requiring transportation by helicopter air ambulance		
# of patients requiring transportation by fixed-wing air ambulance		
Additional EMS Personnel Not Assigned to Requested AMR Ambulance Crews		
EMT-Basic / EMT (additional EMTs who are not assigned to ambulances)		
EMT-Paramedic / Paramedic (additional Paramedics who are not assigned to ambulances)		
EMS Communications Support Team Member		
EMS Field Operations Team Member / EMS Incident Management Team Member (IMT)		

Form 2. Resource Request Form used by MHOAC Programs

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Form 2. Resource Request Form used by MHOAC Programs (cont.)

Section 2. EMS Delivery Location													
Delivery Point-of-Contact (Name):					24 Hour Phone #:					Secondary Contact #:			
DELIVERY LOCATION					AMBULANCES					PERSONNEL			
County	Site Name	Address	City	Zip	ALS Ground	BLS Ground	Bari Ground	Fixed Wing	Rotary Wing	EMT Basic	EMT-P	EMS Comms	EMS Field Ops
Section 3. Bed Types Needed													
Patient Type	Bed Type	#											
<u>Adult:</u>	Med/Surgical	<input type="checkbox"/>											
	OB/L&D	<input type="checkbox"/>											
	Psychiatric	<input type="checkbox"/>											
	Critical: Burn	<input type="checkbox"/>											
	Critical: ICU	<input type="checkbox"/>											
	Critical: CCU	<input type="checkbox"/>											
<u>Pediatric:</u>	Critical: Trauma	<input type="checkbox"/>											
	Ped Med/Surgical	<input type="checkbox"/>											
	PICU	<input type="checkbox"/>											
	NICU	<input type="checkbox"/>											



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FORM 3. RESOURCE REQUEST FORM USED BY CA-ESF 8 TO REQUEST FEDERAL ASSISTANCE

Instructions: CA-EF 8 should submit completed form to Cal OES and federal HHS.

Name of Requesting Operational Area	Date	Time (24 hr. format)
Name of person making request (First/Last)	Title of person making request	
Telephone contact numbers (office, cell, fax, other)	Email address	
24-hour POC (Name)	24-hour POC contact numbers	

Patient Transport		
GROUND AMBULANCE Patient Types	# of Patients/Passengers	
# of stretcher patients needing ALS		
# of stretcher patients needing BLS		
# of bariatric patients (pt. weighs > 400lbs., extra wide stretcher). All bariatric units are ALS.		
PARATRANSIT Passenger Types		
# of passengers that are ambulatory, do not require assistance and can ride in a van or bus		
# of passengers that are "ambulatory-with-assistance" that can ride in a van or bus with assistance but do not require a wheelchair or stretcher		
# of non-ambulatory passengers that may need a wheelchair but do not require stretcher		
# of caregivers that will be provided to accompany paratransit passengers		
AIR AMBULANCE Patient Types (adult/child and neonatal)	ADULT and CHILD	NEONATE
# of patients requiring transportation by helicopter air ambulance		
# of patients requiring transportation by fixed-wing air ambulance		
Additional EMS Personnel Not Assigned to Requested AMR Ambulance Crews		
EMT-Basic / EMT (additional EMTs who are not assigned to ambulances)		
EMT-Paramedic / Paramedic (additional Paramedics who are not assigned to ambulances)		
EMS Communications Support Team Member		
EMS Field Operations Team Member / EMS Incident Management Team Member (IMT)		



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Form 3. Resource Request Form used by CA-EF 8 to request federal assistance (cont.)

EMS DELIVERY LOCATIONS													
Delivery Point-of-Contact (Name):					24 Hour Phone #:					Secondary Contact #:			
DELIVERY LOCATION					AMBULANCES					PERSONNEL			
County	Site Name	Address	City	Zip	ALS Ground	BLS Ground	Bari Ground	Fixed Wing	Rotary Wing	EMT Basic	EMT-P	EMS Comms	EMS Field Ops

Form 3. Resource Request Form used by CA-EF 8 to request federal assistance

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FORM 4. INFORMATION REQUIRED BY FEDERAL AGENCIES TO TRANSPORT PATIENTS USING NDMS

CA Tracking # ²	First Name	Last Name	Sex	Date of Birth	Unaccompanied Minor	CCATT	HCF or CCP	Patient Type	Health Status	Bed Type	Injury Nature

¹ **Form 4. Information required by federal agencies to transport patients using NDMS (includes listing of 3-character county identifiers to assist with patient tracking)** includes information required by federal agencies to conduct civilian patient movement. This information should be collected and submitted to the MHOAC Program as soon as it is recognized that federal airlift assistance is required. This information is used by federal authorities to clinically and administratively clear patients for federal movement and deploy the most appropriate means of transportation, including medical crews, for staging patients and movement to receiving healthcare facilities. This information should be entered as indicated via Excel spreadsheet. The structure of this Excel spreadsheet should not be altered; doing so will delay entry of data into the required patient regulating software system.

Submit the information to the MHOAC Program or to the Patient Movement Group if activated at the LEMSA or LHD DOC or Operational Area EOC.

² The **California Tracking #** includes 3 alpha characters corresponding to the Operational Area³ from which the patient originates; M/F/U for sex; and the last 4 digits of the Triage Tag #. Example: XSAF1234 (**XSA** corresponds to Sacramento County, **F** corresponds to Female, and **1234** are the last 4 digits of the Triage Tag).

³ See the 3-character Operational Area Identifiers provided on the following sheet.



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Operational Area Identifiers³

REGION I	
ID	Operational Area (County)
XLA	Los Angeles, Area "A"
XLB	Los Angeles, Area "B"
XLC	Los Angeles, Area "C"
XLD	Los Angeles, Area "D"
XLE	Los Angeles, Area "E"
XLF	Los Angeles, Area "F"
XLG	Los Angeles, Area "G"
XOR	Orange
XSL	San Luis Obispo
XSB	Santa Barbara
XVE	Ventura

REGION II	
ID	Operational Area (County)
NORTH	
XDN	Del Norte
XHU	Humboldt
XLK	Lake
XMR	Marin
XME	Mendocino
XNA	Napa
XSO	Solano
XSN	Sonoma
SOUTH	
XAL	Alameda
XCC	Contra Costa
XMY	Monterey
XBE	San Benito
XSF	San Francisco
XSM	San Mateo
XSC	Santa Clara
XCZ	Santa Cruz

REGION III	
ID	Operational Area (County)
XBU	Butte
XCO	Colusa
XGL	Glenn
XLS	Lassen
XMO	Modoc
XPU	Plumas
XSH	Shasta
XSI	Sierra
XSK	Siskiyou
XSU	Sutter
XTE	Tehama
XTR	Trinity
XYU	Yuba

REGION IV	
ID	Operational Area (County)
XAP	Alpine
XAM	Amador
XCA	Calaveras
XED	El Dorado
XNE	Nevada
XPL	Placer
XSA	Sacramento
XSJ	San Joaquin
XST	Stanislaus
XTB	Tahoe Basin Area
XTO	Tuolumne
XYO	Yolo

REGION V	
ID	Operational Area (County)
XFR	Fresno
XKE	Kern
XKI	Kings
XMA	Madera
XMP	Mariposa
XMD	Merced
XTU	Tulare

REGION VI	
ID	Operational Area (County)
XIM	Imperial
XIN	Inyo
XMN	Mono
XRI	Riverside
XBO	San Bernardino
XSD	San Diego



CALIFORNIA PATIENT MOVEMENT PLAN

PRE-SCRIPTED FEDERAL RESOURCE REQUEST FORM #1 (RRF) FOR THE NATIONAL EMS CONTRACT

DEPARTMENT OF HOMELAND SECURITY
Federal Emergency Management Agency
RESOURCE REQUEST FORM (RRF)

O.M.B. No. 1660-0002
Expires May 31, 2017

CA-ESF 8 #1

PAPERWORK BURDEN DISCLOSURE NOTICE			
Public reporting burden for this form is estimated to average 20 minutes per response. The burden estimate includes the time for reviewing instructions, searching existing data sources, gathering and maintaining the needed data, and completing and submitting this form. This collection of information is required to obtain or retain benefits. You are not required to respond to this collection of information unless it displays a valid OMB control number. Send comments regarding the accuracy of the burden estimate and any suggestions for reducing this burden to: Information Collections Management, Department of Homeland Security, Federal Emergency Management Agency, 500 C Street, SW, Washington, DC 20472-3100, Paperwork Reduction Project (1660-0047). NOTE: Do not send your completed form to this address.			
I. REQUESTING ASSISTANCE (To be completed by Requestor)			
1. Requestor's Name (Please print)	2. Title	3. Phone No.	
4. Requestor's Organization	5. Fax No.	6. E-Mail Address	
II. REQUESTING ASSISTANCE (To be completed by Requestor)			
The State of California is requesting activation of _____ [list transportation resources - # ambulances, # paratransit seats, and/or # aircraft] from the National EMS Contract for _____ [length of time] to support the evacuation/transportation of _____ [describe movement] and/or requesting activation of _____ [#] EMTs from the National EMS Contract to support _____ [location of support] for _____ [length of time]. Note the required Transportation Request Form and Letter of Reciprocity are attached.			
2. Quantity See Attached Transportation Request Form	3. Priority <input type="checkbox"/> Lifesaving <input type="checkbox"/> Life Sustaining <input type="checkbox"/> Normal <input type="checkbox"/> High	4. Date and Time Needed	
5. Delivery Site Location See attached Transportation Request Form for Delivery Site Locations.	6. Site Point of Contact (POC)		
	7. 24 Hour Phone No.	8. Fax No.	
9. State Approving Official Signature			10. Date and Time
III. SOURCING THE REQUEST - REVIEW/COORDINATION (Operations Section Only)			
1. <input type="checkbox"/> OPS Review by: _____ <input type="checkbox"/> LOG Review by: _____ <input type="checkbox"/> Other Coordination: _____ <input type="checkbox"/> Other Coordination: _____ <input type="checkbox"/> Other Coordination: _____	2. Source: <input type="checkbox"/> Donations <input type="checkbox"/> Other (Explain) _____ <input type="checkbox"/> Requisitions <input type="checkbox"/> Procurement <input type="checkbox"/> Interagency Agreement <input type="checkbox"/> Mission Assignment	3. Assigned to: ESF/OFA: _____ RSF/OFA: _____ Other: _____ Date/Time: _____	
4. Immediate Action Required <input type="checkbox"/> Yes <input type="checkbox"/> No			
IV. STATEMENT OF WORK (Operations Section Only)			
1. OFA Action Officer	2. 24 Hour Phone #	3. Fax #	
4. FEMA Project Manager	5. 24 Hour Phone #	6. Fax #	
7. Statement of Work <input type="checkbox"/> See Attached Activate one zone of the National EMS Contract as directed and coordinated with the State of California and FEMA. Resource mix requested is as follows: _____ or resource mix is detailed in the attached Transportation Request Form. State Cost Share is _____ %.			
8. Estimated Completion Date			9. Estimated Cost
V. ACTION TAKEN (Operations Section Only)			
<input type="checkbox"/> Accepted <input type="checkbox"/> Rejected <input type="checkbox"/> Requestor Notified			
Reason / Disposition			



CALIFORNIA PATIENT MOVEMENT PLAN

PRE-SCRIPTED FEDERAL RESOURCE REQUEST FORM #2 (RRF) FOR HHS SUPPORT TO THE NATIONAL EMS CONTRACT

DEPARTMENT OF HOMELAND SECURITY
Federal Emergency Management Agency
RESOURCE REQUEST FORM (RRF)

O.M.B. No. 1660-0002
Expires May 31, 2017

CA-ESF 8 #2

PAPERWORK BURDEN DISCLOSURE NOTICE			
Public reporting burden for this form is estimated to average 20 minutes per response. The burden estimate includes the time for reviewing instructions, searching existing data sources, gathering and maintaining the needed data, and completing and submitting this form. This collection of information is required to obtain or retain benefits. You are not required to respond to this collection of information unless it displays a valid OMB control number. Send comments regarding the accuracy of the burden estimate and any suggestions for reducing this burden to: Information Collections Management, Department of Homeland Security, Federal Emergency Management Agency, 500 C Street, SW, Washington, DC 20472-3100, Paperwork Reduction Project (1660-0047). NOTE: Do not send your completed form to this address.			
I. REQUESTING ASSISTANCE (To be completed by Requestor)			
1. Requestor's Name (Please print)	2. Title	3. Phone No.	
4. Requestor's Organization	5. Fax No.	6. E-Mail Address	
II. REQUESTING ASSISTANCE (To be completed by Requestor)			
1. Description of Requested Assistance: The Department of Health and Human Services (HHS) will provide technical advice and support for the California State activation of the National EMS Contract in response to _____ [name of event].			
2. Quantity	3. Priority	<input type="checkbox"/> Lifesaving <input type="checkbox"/> Life Sustaining <input type="checkbox"/> Normal	4. Date and Time Needed
		<input type="checkbox"/> High	
5. Delivery Site Location		6. Site Point of Contact (POC)	
		7. 24 Hour Phone No.	8. Fax No.
9. State Approving Official Signature			10. Date and Time
III. SOURCING THE REQUEST - REVIEW/COORDINATION (Operations Section Only)			
1. <input type="checkbox"/> OPS Review by: _____ <input type="checkbox"/> LOG Review by: _____ <input type="checkbox"/> Other Coordination: _____ <input type="checkbox"/> Other Coordination: _____ <input type="checkbox"/> Other Coordination: _____		2. Source: <input type="checkbox"/> Donations <input type="checkbox"/> Other (Explain) <input type="checkbox"/> Requisitions <input type="checkbox"/> Procurement <input type="checkbox"/> Interagency Agreement <input type="checkbox"/> Mission Assignment	
3. Assigned to: ESF/OFA: _____ RSF/OFA: _____ Other: _____ Date/Time: _____			
4. Immediate Action Required <input type="checkbox"/> Yes <input type="checkbox"/> No			
IV. STATEMENT OF WORK (Operations Section Only)			
1. OFA Action Officer		2. 24 Hour Phone #	3. Fax #
4. FEMA Project Manager		5. 24 Hour Phone #	6. Fax #
7. Description			<input type="checkbox"/> See Attached
At the direction of, and in coordination with FEMA, HHS will provide the appropriate number of Pharmacists and LNOs for the state activation of the National EMS Contract. The LNOs will be technically knowledgeable of the Federal Acquisition Regulation. The Primary and Alternate CORs responsible for the National EMS Contract are from FEMA Headquarters. HHS will provide oversight of deployed resources and ensure adequate resupply with a pharmacy cache. This will occur at any staging area designated by the State. Equipment purchases are not authorized under this Mission Assignment.			
8. Estimated Completion Date		9. Estimated Cost	
V. ACTION TAKEN (Operations Section Only)			
<input type="checkbox"/> Accepted <input type="checkbox"/> Rejected <input type="checkbox"/> Requestor Notified			
Reason / Disposition			



CALIFORNIA PATIENT MOVEMENT PLAN

PRE-SCRIPTED FEDERAL RESOURCE REQUEST FORM #3 (RRF) FOR THE NATIONAL DISASTER MEDICAL SYSTEM

DEPARTMENT OF HOMELAND SECURITY
Federal Emergency Management Agency
RESOURCE REQUEST FORM (RRF)

O.M.B. No. 1660-0002
Expires May 31, 2017

CA-ESF 8 #3

PAPERWORK BURDEN DISCLOSURE NOTICE			
Public reporting burden for this form is estimated to average 20 minutes per response. The burden estimate includes the time for reviewing instructions, searching existing data sources, gathering and maintaining the needed data, and completing and submitting this form. This collection of information is required to obtain or retain benefits. You are not required to respond to this collection of information unless it displays a valid OMB control number. Send comments regarding the accuracy of the burden estimate and any suggestions for reducing this burden to: Information Collections Management, Department of Homeland Security, Federal Emergency Management Agency, 500 C Street, SW, Washington, DC 20472-3100, Paperwork Reduction Project (1660-0047). NOTE: Do not send your completed form to this address.			
I. REQUESTING ASSISTANCE (To be completed by Requestor)			
1. Requestor's Name (Please print)	2. Title	3. Phone No.	
4. Requestor's Organization	5. Fax No.	6. E-Mail Address	
II. REQUESTING ASSISTANCE (To be completed by Requestor)			
1. Description of Requested Assistance: The State of California requests federal assistance from the National Disaster Medical System (NDMS) to provide medical care to California residents and visitors impacted by _____ [name of incident].			
2. Quantity	3. Priority	<input type="checkbox"/> Lifesaving <input type="checkbox"/> Life Sustaining <input type="checkbox"/> Normal <input type="checkbox"/> High	4. Date and Time Needed
5. Delivery Site Location		6. Site Point of Contact (POC)	
		7. 24 Hour Phone No.	8. Fax No.
9. State Approving Official Signature			10. Date and Time
III. SOURCING THE REQUEST - REVIEW/COORDINATION (Operations Section Only)			
1. <input type="checkbox"/> OPS Review by: _____ <input type="checkbox"/> LOG Review by: _____ <input type="checkbox"/> Other Coordination: _____ <input type="checkbox"/> Other Coordination: _____ <input type="checkbox"/> Other Coordination: _____		2. Source: <input type="checkbox"/> Donations <input type="checkbox"/> Other (Explain) _____ <input type="checkbox"/> Requisitions <input type="checkbox"/> Procurement <input type="checkbox"/> Interagency Agreement <input type="checkbox"/> Mission Assignment	
3. Assigned to: ESF/OFA: _____ RSF/OFA: _____ Other: _____ Date/Time: _____		4. Immediate Action Required <input type="checkbox"/> Yes <input type="checkbox"/> No	
IV. STATEMENT OF WORK (Operations Section Only)			
1. OFA Action Officer	2. 24 Hour Phone #	3. Fax #	
4. FEMA Project Manager	5. 24 Hour Phone #	6. Fax #	
7. Statement of Work			<input type="checkbox"/> See Attached
As requested by California and in coordination with FEMA, HHS will deploy National Disaster Medical Assistance (NDMS) medical response capabilities, including Disaster Medical Assistance Team (DMAT), International Medical Surgical Response Team (IMSuRT) and/or Medical Acute Care Response Team (MAC-T), all of which provide medical surge support to augment State and local medical response resources. Staging locations for requested resources are provided on the sheet attached to this RRF.			
8. Estimated Completion Date		9. Estimated Cost	
V. ACTION TAKEN (Operations Section Only)			
<input type="checkbox"/> Accepted <input type="checkbox"/> Rejected <input type="checkbox"/> Requestor Notified			
Reason / Disposition			



CALIFORNIA PATIENT MOVEMENT PLAN

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SECTION VI. APPENDICES



CALIFORNIA PATIENT MOVEMENT PLAN

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CALIFORNIA PATIENT MOVEMENT PLAN

A. ACRONYMS

ACG	Air Coordination Group
ACS	Alternate Care Site
AE or A/E	Aeromedical Evacuation
AES	Aeromedical Evacuation System
ALS	Advanced Life Support
APOD	Aerial Port (or Point) of Debarkation
APOE	Aerial Port (or Point) of Embarkation
AST	Ambulance Strike Team
BLS	Basic Life Support
CA ANG	California Air National Guard
CA ARNG	California Army National Guard
CAHAN	California Health Alert Network
CA-ESF 8	California – Emergency Function 8
CAL-MAT	California Medical Assistance Team
CCATT	Critical Care Air Transport Team
CCP	Casualty Collection Point
CCR	Continuity of Care Record
CCT	Critical Care Transport
CDPH	California Department of Public Health
CDSS	California Department of Social Services
Cal OES	California Governor’s Office of Emergency Services
CHHS	California Health and Human Services Agency
CA-ESF 8	California Public Health and Medical Emergency Function 8
CMD	California Military Department
CMS	Centers for Medicare and Medicaid Services
CNG	California National Guard
CONOPS	Concept of Operations
CUPTS	California Unified Patient Tracking System
DASF	Disaster Aeromedical Staging Facility
DCO	Defense Coordinating Officer
DCSA	Defense Support of Civil Authorities
DHCS	California Department of Health Care Services



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DHS	Department of Homeland Security
DHV	Disaster Healthcare Volunteers
DMAT	Disaster Medical Assistance Team
DMSU	Disaster Medical Support Unit
DOC	Department (or Agency) Operations Center
DoD	Department of Defense
DRG	Diagnostic Related Group
ED	Emergency Department
EHD	Environmental Health Department
EMAC	Emergency Management Assistance Compact
EMR	Electronic Medical Record
EMSA	Emergency Medical Services Authority
EMT	Emergency Medical Technician
EMT-P	Paramedic Emergency Medical Technician
EOC	Emergency Operations Center
EOM	California Public Health and Medical Emergency Operations Manual
EPLO	Emergency Preparedness Liaison Officer
EPSU	Emergency Services Pharmaceutical Unit
ESF	Emergency Support Function
ESF 8	Public Health and Medical Services Emergency Support Function
FCC	Federal Coordinating Center
FCO	Federal Coordinating Officer
FEMA	Federal Emergency Management Agency
FIRESCOPE	Firefighting Resources of California Organized for Potential Emergencies
FTS	Field Treatment Site
HAVBED	Hospital Available Beds for Emergencies and Disasters
HCF	Healthcare Facility
HHS	U.S. Department of Health and Human Services
ICF	Intermediate Care Facility
IMSuRT	International Medical Surgical Response Team
IOF	Initial Operating Facility
IRCT	Incident Response Coordination Team
JFO	Joint Field Office



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JPATS	Joint Patient Assessment and Tracking System
JPMCT	Joint Patient Movement Coordination Team
JPMAT	Joint Patient Movement Advisor Team
HCF	Healthcare Facility
HLZ	Helicopter Landing Zone
LEMSA	Local Emergency Medical Services Agency
LHD	Local Health Department
MA	Mission Assignment (federal term)
MAC Group	Multi-Agency Coordination Group
MAC-T	Mobile Acute Care Team
MCI	Multi-Casualty Incident
MHCC	Medical and Health Coordination Center (CA-ESF 8 Coordination Center)
MHOAC	Medical and Health Operational Area Coordination Program
MMAA	California Disaster and Civil Defense Master Mutual Aid Agreement
MRC	Medical Reserve Corps
MRT	Mission Resource Tasking (State of CA term)
MST	Mission Support Team
NDMS	National Disaster Medical System
NICU	Neonatal Intensive Care Unit
NIMS	National Incident Management System
NRF	National Response Framework
OA	Operational Area
OB/LND	Obstetrics and labor and delivery
OSHPD	Office of State Health Planning and Development
PRA	Patient Reception Area
RDMHC	Regional Disaster Medical Health Coordination Program
RDMHS	Regional Disaster Medical Health Specialist
REOC	Regional Emergency Operations Center
RRF	Resource Request Form
SAD	State Active Duty
SAT	Service Access Team
SCO	State Coordinating Officer
SCT	Specialty Care Transport



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SEMS	Standardized Emergency Management System
SEP	State of California Emergency Plan
SIP	Shelter-in-Place
SOC	State Operations Center
START	Simple Triage and Rapid Treatment
TPMRC-A	Theater Patient Movement Requirements Center for the Americas
UCG	Unified Coordination Group
USAF	United States Air Force
USPHS	United States Public Health Service
USTRANSCOM	United States Transportation Command
VA	Veterans Administration



B. GLOSSARY

Aeromedical Evacuation (AE): The movement of patients under medical supervision to and between medical treatment facilities by air transportation.

Joint Patient Movement Coordination Team (JPMCT): An JPMCT is a 4-person team that establishes the initial bridge to the Aeromedical Evacuation System to facilitate patient movement. The JPMCT is composed of a Flight Nurse, Medical Service Corps, and two communications personnel. The JPMCT provides a direct communication link and immediate coordination between the user and the Aeromedical Evacuation System.

Aerial Port (Point) of Embarkation (APOE): The geographic point from which patients depart. Patients are loaded onto aircraft at an APOE and proceed to an Aerial Port (Point) of Debarkation.

Aerial Port (Point) of Debarkation (APOD): The geographic point at which transported patients are discharged.

Ambulance Strike Team (AST): Ambulance Strike Teams are positioned throughout the state to support local EMS response. There are both pre-affiliated and unaffiliated ASTs in California. Forty-one (41) **affiliated** ASTs are under contract to EMSA and consist of 5 ambulances of like type (ALS or BLS) and 1 Disaster Medical Support Unit (DMSU) that provides enhanced communication ability and supplies to support field deployment, including medical supplies and provisions for AST personnel. **Unaffiliated** ASTs that consist of ambulances of like type may be organized at the local level and are not under contract with EMSA although they may respond to requests from EMSA in times of need.

Bed Polling: The process of querying hospitals and other licensed healthcare facilities for available beds based on bed type. Different systems poll for different bed categories (e.g., HAVBED, NDMS, etc.)

Cal EOC: The Internet-based information management system maintained by the California Governor's Office of Emergency Services.

California Disaster and Civil Defense Master Mutual Aid Agreement (MMAA): An agreement entered into by and between the State of California, its various departments and agencies and the various political subdivisions, municipal corporations and public agencies of the State of California to assist each other by providing resources during an emergency. Mutual Aid occurs when two or more parties agree to furnish resources and facilities and to render services to each other in response to any type of disaster or emergency.

California Emergency Support Function (CA-ESF): The CA-ESFs represent a grouping of state agencies, departments and other stakeholders with similar functional activities/responsibilities



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whose responsibilities lend to improving the state's ability to collaboratively prepare for, effectively mitigate, cohesively respond to and rapidly recover from any emergency. CA-ESFs unify a broad-spectrum of stakeholders with various capabilities, resources and authorities to improve collaboration and coordination within a particular discipline.

California Emergency Function 8 (CA-ESF8): CA-ESF8, Public Health and Medical, coordinates public health and medical activities and services statewide in support of local jurisdiction resource needs for preparedness, response and recovery from emergencies and disasters. The California Health and Human Services Agency is the lead agency for CA-ESF8, and has tasked EMSA and CDPH with operationalizing the development and implementation of CA-ESF 8.

California Emergency Services Act (ESA): An act within the California Government Code to ensure that preparations within the State will be adequate to deal with natural, man-made, or war caused emergencies which result in conditions of disaster or in extreme peril to life, property and the natural resources of the State and generally to protect the health and safety and preserve the lives and property of the people of the State.

California Governor's Office of Emergency Services (Cal OES): Cal OES is responsible the coordination of overall state agency response to major disasters in support of local government. Cal OES is responsible for assuring the state's readiness to respond to and recover from all hazards – natural, manmade, war-caused emergencies and disasters – and for assisting local governments in their emergency preparedness, response, recovery and hazard mitigation efforts.

California Department of Public Health (CDPH): The California Department of Public Health is dedicated to optimizing the health and well-being of the people in California and is the lead state department for coordinating state-level support for public health and/or environmental health incidents.

California Medical Assistance Teams (CAL-MATs): California Medical Assistance Teams (CAL-MATs) are all-hazard scalable teams (5-50 members) of medical professionals such as physicians, nurses, pharmacists, medical specialists and support staff who are capable of responding to disasters and emergencies anywhere in the state within 12 hours. CAL-MATs are completely self-sufficient for up to 72 hours. There are three CAL-MAT caches and six CAL-MAT support vehicle trucks maintained to support the CAL-MAT program.

California Public Health and Medical Emergency Operations Manual (EOM): The purpose of the EOM is to establish a common operational framework that strengthens the ability of the public health and medical system to rapidly and effectively respond to emergencies. The EOM focuses on standardized operational processes that support coordinated statewide response, including communication and information management (alerts and notifications, situation reporting, horizontal and vertical information sharing) and resource management (requesting process, standardized request forms), etc.



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

Casualty Collection Point (CCP): A patient collection point. It is generally near the incident site and initiates the discovery, triage and flow of patients to definitive care facilities.

Command and Control: The exercise of authority and direction by a properly designated commander over assigned and attached forces in the accomplishment of the mission.

Critical Care: Patients who require sophisticated intervention to restore or maintain life processes to their dynamic equilibrium. This involves the requirement to provide continuous care and monitoring using specialized facilities, equipment and personnel.

Critical Care Air Transport Teams (CCATT): Air transport teams providing specialized care, in conjunction with AE crews, to evacuate critical patients requiring advanced care during transportation. The CCATT typically consists of a critical care intensivist, a critical care nurse and a respiratory therapist.

Defense Coordinating Officer (DCO): Serves as the U.S. Department of Defense (DoD) single point of contact for the UCG at the JFO. The DCO processes requirements for military support and mission assignments as required for activated emergency support functions.

Definitive Medical Care: The medical treatment provided upon admission to an NDMS hospital or treatment facility.

Department Operations Center (DOC): An Emergency Operations Center specific to a single department or agency. The focus is on internal agency incident management and response. DOCs are usually linked to, and in most cases, are physically represented within, a combined agency EOC through authorized representatives for the department or agency.

Disaster: A sudden calamitous event bringing great damage loss or destruction. See Major Disaster.

Disaster Healthcare Volunteers (DHV): DHV is a secure, web-based system that registers and credentials health professionals who may wish to volunteer during a disaster, including doctors, nurses, paramedics, pharmacists, dentists, mental health practitioners, etc. DHV may be locally accessed by all 58 counties and 40 Medical Reserve Corps Units to support a variety of local needs, including augmenting medical staff at healthcare facilities or supporting mass vaccination clinics. EMSA administers the system, coordinates statewide recruitment efforts and ongoing training opportunities. DHV is California's Emergency System for the Advance Registration of Volunteer Health Professionals.

Disaster Medical Assistance Team (DMAT): A group of professional and para-professional medical personnel organized to provide rapid-response medical care or casualty decontamination during a terrorist attack, natural disaster, or other incident in the United States. DMAT members, resourced



CALIFORNIA PATIENT MOVEMENT PLAN

by the NDMS, are individuals who have volunteered to be intermittent NDMS federal employees of HHS.

CA-ESF 8 Task Force on Patient Movement: The CA-ESF 8 Advisory Task Force on Patient Movement will include the government officials representing state agencies responsible for health and medical disaster response in California (e.g., CHHS, EMSA, CDPH, and DHCS), in addition to local jurisdictional representatives based on the matter in need of resolution. The purpose of the Task Force is to consider and reach consensus decisions on key matters related to patient movement (e.g., allocation of scarce resources, number of attendants that can accompany evacuating patients, need for federal support, etc). The CA-ESF 8 Advisory Task Force on Patient Movement will be convened at the discretion of the CA-ESF 8 co-lead departments, EMSA and CDPH, and chaired by the current CA-ESF 8 Lead.

Emergency: Any incident, whether natural or manmade, that requires responsive action to protect life or property. Under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, an emergency means any occasion or instance for which, in the determination of the President, federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States.

Emergency Assistance Agreements: Written or oral agreements between and among public and private agencies and organizations that provide a mechanism to quickly obtain emergency assistance in the form of personnel, equipment, materials, and other associated services. The primary objective is to facilitate the rapid, short-term deployment of emergency support prior to, during, and/or after an incident. Such agreements often describe the circumstances, conditions, limitations, and provisions for reimbursement of costs related to the provision of assistance. Sometimes called day-to-day agreements, such arrangements may supplement resources whenever demand exceeds the available supply of the needed resource. Pre-established emergency assistance agreements are distinct from “mutual aid” provided under the California Civil Defense Master Mutual Aid Agreement

Emergency Management Assistance Compact (EMAC): A congressionally ratified organization that provides form and structure to interstate mutual aid. Through EMAC, a disaster-affected state can request and receive assistance from other member states quickly and efficiently, resolving two key issues upfront: liability and reimbursement.

Emergency Medical Services Authority (EMSA): EMSA is the lead department for coordinating disaster medical services in California. It is responsible for coordinating the delivery of disaster medical resources to local governments in support of their disaster medical response. This includes the acquisition of personnel and medical supplies and materials from unaffected regions of the state to meet the needs of affected counties.



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Emergency Operations Center (EOC): The physical location at which the coordination of information and resources to support incident management (on-scene operations) activities normally takes place. An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOCs may be organized by major functional disciplines (e.g., fire, law enforcement, and medical services), by jurisdiction (e.g., Federal, State, regional, tribal, city, county), or some combination thereof.

Emergency Operations Plan (EOP): The ongoing plan maintained by various jurisdictional levels for responding to a wide variety of potential hazards.

Emergency Support Function (ESF): The federal ESFs bring together the capabilities of federal departments and agencies and other national-level assets. Federal ESFs are groups of organizations that work together to deliver core capabilities and support an effective response.

ESF #8 Patient: Any individual processed through an FCC during an evacuation using federal resources. HHS is responsible for the return of all ESF #8 patients to their home of record.

Evacuee: A person evacuated from a place of danger, a disaster area, etc., to somewhere safe, out of harm's way. A medical evacuee is a subset of all evacuees.

Federal Coordinating Center (FCC): A facility located in a metropolitan area of the United States, or Puerto Rico, responsible for day-to-day coordination of planning and operations in one or more assigned geographic NDMS Patient Reception Areas (PRA). FCCs are normally affiliated with DoD or VA.

Federal Coordinating Officer (FCO): Appointed by the FEMA Director, represents the President of the United States, as provided by Section 303 of the Stafford Act, for the purpose of coordinating the administration of federal response/relief activities in a declared emergency or disaster area.

Emergency System Activation: When an operational area activates any aspect of its Medical and Health Disaster Plan or when an incident leads to activation of Department Operations Centers (DOCs) and/or Emergency Operation Centers (EOCs).

Evacuation: Organized, phased, and supervised withdrawal, dispersal, or removal of civilians from dangerous or potentially dangerous areas, and their reception and care in safe areas.

Firefighting Resources of California Organized for Potential Emergencies (FIRESCOPE): FIRESCOPE was originally developed to improve the capability of firefighting agencies in southern California in allocating and managing fire suppression resources. The current mission of FIRESCOPE is to provide recommendations and technical assistance to Cal OES to provide a statewide program for California that unifies federal, state and local fire agencies into a single fire response system.



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Theater Patient Movement Regulating Center for the Americas (TPMRC-A): The TPMRC-A regulates civilian patient movement within the continental United States when DoD is functioning in support of civil authorities.

Incident Response Coordination Team (IRCT): The IRCT represents federal ESF 8 and performs liaison and leadership functions required of ESF 8. Approximately 30 IRCT members include Operations, Logistics, Planning, Administration/Finance, and Information Chiefs and staffers.

Joint Field Office (JFO): A temporary facility established to provide a central point for federal, state, local, and tribal executives with responsibility for incident oversight, direction, and/or assistance to effectively coordinate protection, prevention, preparedness, response, and recovery actions. The state and FEMA establish a JFO in a forward location within 72 hours.

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

Joint Patient Movement Advisor Team (JPMAT): The Joint Patient Movement Advisor Team (JPMAT) represents the federal agencies involved in providing patient movement assistance to a requesting state (e.g., HHS, DoD, VA, etc). If the National EMS Contract has been activated, the JPMAT will also include a coordinating representative from the National EMS Contractor. The JPMAT is likely to be located at the SOC/IOF/JFO in close proximity to the Incident Response Coordination Team (IRCT).

Local Emergency Medical Services Agency (LEMSA): The agency that has primary responsibility for administration of emergency medical services in a county or multiple counties, including disaster medical preparedness and response.

Local Environmental Health Department (EHD): The department or office that has primary responsibility for administration of environmental health services in a county or counties.

Local Government: A county, municipality, city, town, township, local public authority, school district, special district, intrastate district, council of governments (regardless of whether the council of governments is incorporated as a non-profit corporation under State law), regional or interstate government entity, or agency or instrumentality of a local government; an Indian tribe or authorized tribal entity.

Local Health Department (LHD): The department that has primary responsibility for administration of public health services in a county or city.

Local Health Officer (LHO): City and county health officers are authorized by the Health and Safety Code to take any preventive measure necessary to protect and preserve the public health from any public health hazard during a local emergency or State of Emergency within their jurisdiction. Preventive measures include abatement, correction, removal, or any other protective steps which may be taken against any public health hazard that is caused by a disaster and affects public health.



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Major Disaster: Any natural catastrophe (including any hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought) or, regardless of cause, any fire, flood, or explosion in any part of the United States that, in the determination of the President, causes damage of sufficient severity and magnitude to warrant major disaster assistance under the Stafford Act to supplement the efforts and available resources of states, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby.

Mass Casualty: A large number of casualties produced in a relatively short period of time, usually as the result of a single incident such as a military aircraft accident, hurricane, flood, earthquake, or armed attack that exceeds local logistical support capabilities.

Medical and Health Coordination Center (MHCC): The Medical and Health Coordination Center (MHCC) serves two functions: 1) it is the Emergency Operations Center (EOC) shared by the California Department of Public Health (CDPH), California Emergency Medical Services Authority (EMSA) and the Department of Health Care Services (DHCS); and 2) it is the Coordination Center for state level Public Health and Medical (CA-ESF 8) activities involving other departments within the California Health and Human Services Agency (CHHS) and any other CA-ESF 8 stakeholders with an incident-specific public health and medical role.

Medical Health Operational Area Coordination (MHOAC) Program: A functional designation within the operational area normally fulfilled by the county health officer and local EMS agency administrator (or designee), responsible for the development of a medical and health disaster plan and coordination of situational information and mutual aid during emergencies. The MHOAC Program is comprised of the personnel, facilities and supporting entities that fulfill the functions of the MHOAC role as directed by the designated MHOAC. (CDPH Emergency Operations Response Plan 2013).

Medical Regulation: The actions and coordination necessary to arrange for the movement of patients through the echelons of care. This process matches patients with a medical treatment facility that has the necessary healthcare support capabilities and ensures that bed space is available.

Medical Reserve Corps: The Medical Reserve Corps (MRC) is a national network of volunteers, organized locally to improve the health and safety of their communities. The MRC network comprises volunteers located throughout the United States and its territories. MRC volunteers include medical and public health professionals, as well as other community members without healthcare backgrounds. MRC units engage these volunteers to strengthen public health, improve emergency response capabilities and build community resiliency. They prepare for and respond to natural disasters, such as wildfires, hurricanes, tornados, blizzards, and floods, as well as other emergencies affecting public health, such as disease outbreaks. They frequently contribute to community health activities that promote healthy habits



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Medical Treatment Facility (MTF): A facility established for the purpose of furnishing medical and/or dental care to eligible individuals. (DoD)

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

Mission Assignment (MA): DHS/FEMA uses the mission assignment as a work order to direct completion by a federal agency of a specified task pursuant to a Stafford Act declaration. DHS/FEMA may issue mission assignments to other federal agencies to: 1) address a state's request for federal assistance to meet unmet emergency needs; or 2) support overall federal operations pursuant to, or in anticipation of, a Stafford Act declaration.

Mission Support Team (MSTs): MSTs provide logistical support to deployed mobile medical assets maintained by EMSA, (e.g., California Medical Assistance Teams, Ambulance Strike Teams, etc.), and also provide coordination between the requesting local jurisdiction and the deployed asset(s). Coordinated by EMSA, MSTs may consist of State, local government, and/or private sector personnel. The size of the MST is determined by the medical mission.

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

Multi-Agency Coordination System (MAC System): A MAC System that provides the architecture to support coordination for incident prioritization, critical resource allocation, communications systems integration, and information coordination. A MAC System includes facilities, equipment, personnel, procedures, and communications. Two of the most commonly used elements are EOCs and MAC Groups, which assist agencies and organizations responding to an incident. MAC Groups typically consist of administrators/executives, or their appointed representatives, who are authorized to commit agency resources and funds.

Mutual Aid Region: A mutual aid region is a subdivision of the state established to assist in the coordination of mutual aid and other emergency operations within a geographical area of the state, consisting of two or more operational areas. There are six mutual aid regions in California.

National EMS Contract: FEMA's plan to provide a comprehensive EMS response to federally declared disasters. This contract provides a full array of ground ambulance, air ambulance and para-



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transit services to supplement the federal and military response to a disaster, act of terrorism or other public health emergency. (FCC Guide)

National Disaster Medical System: is the section of HHS responsible for managing Federal government's medical response to major emergencies and disasters. NDMS's Federal partners include the Federal Emergency Management Agency (FEMA), Department of Defense (DoD), and the Department of Veterans Affairs (VA). NDMS also interfaces with state and local Departments of Health, as well as private hospitals. NDMS has three major components: Medical Response, Patient Evacuation, and Definitive Medical Care. (HHS/ASPR)

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

Operational Area (OA): An intermediate level of the State of California emergency organization, consisting of a county and all political subdivisions within the geographical boundaries of the county.

Paratransit Transportation: As defined and required by the Americans with Disabilities Act (ADA), refers to comparable alternate transportation services for people with disabilities who are unable to use traditional transportation systems. Paratransit transportation is typically "demand responsive" vs. "fixed route". A fixed route transportation system is one that operates along a prescribed route according to a fixed schedule. Fixed route systems typically include city bus systems, commuter and over-the-road bus systems, subways, light rail systems, and intercity rail transportation.

Patient: A sick, injured, or wounded person who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement or protection of health or lessening of illness, disability or pain.

Patient Movement: The process of moving sick, injured, or wounded persons from a dangerous area due to the threat or occurrence of a natural or man-made incident to a safer area to obtain needed medical and/or dental care.

Patient Movement Items: A select set of DoD-approved medical equipment and durable supplies required to support a patient during evacuation. Examples include ventilators, litters, patient monitors, and pulse oximeters.

Patient Reception Area: A geographic locale containing one or more airfields, bus stations, or airheads; adequate patient staging facilities; and adequate local patient transport assets to support patient reception and transport to local voluntary, pre-identified, non-federal, acute care medical facilities capable of providing definitive care for victims of a domestic disaster, emergency, or military contingency. Generally, these medical facilities should be within 50 mile radius.



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Patient Tracking: The ability to know, at any given time, the location of a patient from the time the patient is first encountered by an emergency responder at an emergency event to arrival at a facility, whether the facility is a hospital, shelter or morgue.

Public Health and Medical System: An inter-connected system of public and private entities whose activities and responsibilities involve public health; environmental health; and medical services, including emergency medical services. The participants in the Public Health and Medical System include those involved in the delivery of healthcare in addition to those involved in the protection and promotion of public health and environmental health. Examples include but are not limited to healthcare facilities such as hospitals, skilled nursing facilities, and community clinics; Indian health services; local health departments; local emergency medical services agencies; local environmental health departments; ambulance providers; public health laboratories; public water systems; hazardous materials responders; dispatch centers; and many other entities/organizations that conduct daily activities and/or emergency response activities relevant to public health, environmental health and medical services. (EOM 2011)

Regional Disaster Medical and Health Coordinator (RDMHC) Program: A comprehensive program under the direction of the Regional Disaster Medical and Health Coordinator that supports information flow and resource management during unusual events and emergencies. This program includes the Regional Disaster Medical and Health Specialist. (EOM 2011)

Regional Emergency Operations Center (REOC): Facilities found at State Cal OES Administrative Regions. REOCs provide centralized coordination of resources among operational areas within their respective regions, and between the operational areas and the state level.

Robert T. Stafford Disaster Relief and Emergency Assistance Act, PL 100-707: The Stafford Act establishes the programs and processes for the federal government to provide disaster and emergency assistance to states, local governments, tribal nations, individuals, and qualified private nonprofit organizations. The provisions of the Act cover all hazards, including natural disasters and terrorist events. Relevant provisions of the Act also include a process for Governors to request federal disaster and emergency assistance from the President.

Service Animals: Any guide dog, signal dog, or other animal individually trained to provide assistance to an individual with a disability. If they meet this definition, animals are considered service animals under the ADA regardless of whether they have been licensed or certified by a state or local government.

Special Medical Needs: are those individuals, typically living in the community outside of a medical setting or environment, who need support to maintain an adequate level of health and independence during times of emergency. Included under this category are individuals who before, during, and after an emergency are medically dependent on uninterrupted electricity for therapies,



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require continual or intermittent medical care/support from a healthcare professional, or are not self-sufficient with the loss of adequate support form caregivers.

Stabilized: A term used to describe a patient's condition as a result of the medical interventions used to ensure a patient immediate survivability. These interventions include splinting fractures, controlling hemorrhage, treating shock, and securing the airway. In contrast, a "stable" patient does not require immediate medical intervention.

Stable Patient: A patient for whom no inflight medical intervention is expected but the potential for medical intervention exists.

Standardized Emergency Management System (SEMS): A system required by California Government Code for managing response to multi-agency and multi-jurisdictional emergencies in California. SEMS consists of five organizational levels, which are activated as necessary: field response, local government, operational area, region and state.

State Coordinating Officer (SCO): Represents the state and is appointed to manage state activities related to disaster. The SCO is the state's principal point-of-contact with the federal government. Additionally, the SCO is responsible for coordinating the timely delivery of state disaster assistance resources and programs to the affected local governments, individual victims, and the private sector. The SCO works closely with the Federal Coordinating Officer to identify emergency response requirements for the state.

State Operations Center (SOC): The SOC is operated by the California Governor's Office of Emergency Services. It is responsible for the centralized coordination of State resources in support of the three Cal OES Administrative Regions (REOCs). It is also responsible for providing updated situation reports to the Governor and legislature.

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

Unified Coordination Group (UCG): The structure that executes unified command and leads incident activities at the field level in order to achieve unity of effort. Its purpose is to establish and achieve shared objectives. The UCG is comprised of senior leaders representing state and federal interests, and in certain circumstances tribal governments, local jurisdictions, or the private sector. The FCO is responsible for establishing the UCG.



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C. AUTHORITIES

State of California

- 1) California Government Code
 - a. California Emergency Services Act including the Standardized Emergency Management System (SEMS; GC 8607)
 - b. California Disaster Assistance Act
 - c. California Disaster and Civil Defense Master Mutual Aid Agreement
- 2) California Code of Regulations
 - a. Title 18, Division 2.5, Emergency Medical Services
 - b. Title 19, Section 2401, Standardized Emergency Medical System
 - c. Title 22, Division 5 and 6, Licensing and Certification
 - d. Title 22, Division 9, Prehospital Emergency Medical Services
- 3) SEMS Guidelines, 2006
- 4) SEMS Approved Course of Instruction (ACI), 2003
- 5) State of California Emergency Plan (SEP), 2009

U.S. Government

- 1) National Response Framework (NRF), 2008
- 2) Catastrophic Incident Annex to the NRF (NRF-CIA), 2008
- 3) National Incident Management System (NIMS), 2008
- 4) US HHS Concept of Operations for Response (Draft), 2008
- 5) FEMA/HHS Ground Ambulance and Paratransit Utilization Guide, 2013
- 6) US HHS Medical Movement of Evacuees (Draft), 2011
- 7) National Disaster Medical System Concept of Operations (Draft), 2009
- 8) Joint Patient Assessment Tracking System (JPATS) Strike Team ConOps (Draft), 2011
- 9) Public Health Services Act, including Section 319 (provides the legal authority for responding to public health emergencies, including the declaration of a public health emergency (PHE)).
- 10) Social Security Act (certain sections, e.g., section 1135), authorize the Secretary of HHS to temporarily modify or waiver certain Medicare, Medicaid, CHIP and HIPAA requirements when the Secretary has declared a public health emergency and the



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President has declared an emergency or major disaster under the Stafford Act or National Emergencies Act).

- 11) Food, Drug and Cosmetic Act (under certain conditions, authorizes the Secretary of HHS to declare an emergency justifying emergency use authorization (EUA) of unapproved drugs, devices, or biological products; or emergency use authorization of approved drugs, devices or biological products for an unapproved use).
- 12) National Emergencies Act
- 13) Robert T. Stafford Disaster Relief and Emergency Assistance Act



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D. PATIENT CARE FACILITY TYPES

The following table lists the facility types licensed by the State of California through the California Department of Public Health (CDPH) and California Department of Social Services (CDSS). The approximate number of facilities is identified if known.

CDPH and CDSS Licensed Patient Care Facility Types

Facility Type	Licensed By	Description
General Acute Care Hospital	CDPH	General acute care hospital means a hospital, licensed by CDPH, having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff which provides 24- hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services patients.
Acute Psychiatric Hospital	CDPH	Acute psychiatric hospital means a hospital having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff which provides 24-hour inpatient care for mentally disordered, incompetent or other patients referred to in Division 5 (commencing with section 5000) or Division 6 (commencing with section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy and dietary services. An acute psychiatric hospital shall not include separate buildings which are used exclusively to house personnel or provide activities not related to hospital patients
Hospice	CDPH	Provides care to terminally ill individuals (may be facility based or provided through a home health agency)
Intermediate Care Facility	CDPH	Provides skilled nursing and supportive care to patients with developmental disabilities who do not require continuous nursing care.
Intermediate Care Facility – Developmentally Disabled	CDPH	Intermediate care facility for the developmentally disabled is a health facility which provides care and support services to developmentally disabled clients whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services.



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Facility Type	Licensed By	Description
Intermediate Care Facility – DD/Nursing	CDPH	Intermediate care facility for the developmentally disabled – nursing is a health facility with a capacity of 4 to 15 beds that provides 24-hours personal care, developmental services, and nursing supervision for developmentally disabled person who have intermittent recurring needs for skilled nursing care but have been certified by a physician and surgeon as not requiring continuous skilled nursing care. The facility serves medically fragile person who have developmental disabilities or demonstrate significant developmental delay that may lead to a developmental disability if not treated.
Intermediate Care Facility – DD/ Habilitative	CDPH	Intermediate care facility for the developmentally disabled habilitative is a health facility with a capacity of 4 to 15 beds which provides 24-hours personal care, habilitation, developmental, and supportive health services to 15 or fewer developmentally disabled person with intermittent recurring needs for nursing services, but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care.
Congregate Living Health Facility	CDPH	Congregate living health facility is a residential home with a capacity of no more than 12 beds (except those operated by a city or county which may have a capacity of 59 beds), that provides inpatient care, including the following basic services: medical supervision, 24-hour skilled nursing and supportive care, pharmacy, dietary, social, recreational, and at least one type of the following services: services for persons who are mentally alert, physically disabled persons, who may be ventilator dependent; services for persons who have a diagnosis of terminal illness, a diagnosis of a life threatening illness, or both; services for persons who are catastrophically and severely disabled. The primary need of congregate living health facility residents shall be for availability of skilled nursing care on a recurring, intermittent, extended, or continuous basis. This care is generally less intense than that provided in general acute care hospitals but more intense than that provided in skilled nursing facilities.
Skilled Nursing Facility	CDPH	Skilled nursing facility is a health facility or a distinct part of a hospital which provides continuous skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. A skilled nursing facility provides 24-hours inpatient care and, as a minimum, includes physician, skilled nursing, dietary, pharmaceutical services and an activity program.



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Facility Type	Licensed By	Description
Pediatric Day Health and Respite Care Facility	CDPH	Pediatric Day health and respite care facility is a facility which provides an organized program of therapeutic social and day health activities and services and limited 24-hours inpatient respite care to medically fragile children 21 years of age or younger including terminally ill and technology dependent children.
Adult Residential Facilities – Special Health Needs	CDSS	A residential home that provides 24-hour services for up to five adults with developmental disabilities who have special healthcare and intensive support needs and who would otherwise need to reside in an institution.
Adult Residential Facilities	CDSS	Adult Residential Facilities (ARF) are facilities of any capacity that provide 24-hour non-medical care for adults ages 18 through 59, who are unable to provide for their own daily needs. Adults may be physically handicapped, developmentally disabled, and/or mentally disabled.
Adult Residential Facilities – Chronically Ill	CDSS	A facility that provides care and supervision to adults who have a terminal illness, Acquired Immune Deficiency Syndrome (AIDS) or the Human Immunodeficiency Virus.
Adult Residential Facilities – Chronically Ill	CDSS	A facility that provides care and supervision to adults who have a terminal illness, Acquired Immune Deficiency Syndrome (AIDS) or the Human Immunodeficiency Virus.
California Children’s Services Approved Hospitals	CCS	A facility that is approved to provide specialized care for neonates and children as part of the state California Children’s Services Program. Each facility is listed at http://www.dhcs.ca.gov/services/ccs/scc/Pages/SCCName.aspx . Hospitals with PICU and NICUs are subject to approval under CCS. Hospitals that are approved at the tertiary level offer full service pediatric and neonatal specialty care. http://www.dhcs.ca.gov/services/ccs/Documents/Tertiary.pdf



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E. EXPECTATIONS OF LOCAL AND STATE AUTHORITIES IF REQUESTING FEDERAL ASSISTANCE

Local Government

- Declare Local Emergency.
- Provide overall command and control of local emergency response.
- Conduct local EMS operations; when warranted, evacuate medically fragile patients from healthcare facilities and other locations including homes; identify shortfalls in local capabilities; and submit resource requests for shortfalls through the MHOAC Program. The MHOAC Program works closely with the local emergency management agency on health and medical matters.
- Establish primary and alternate evacuation routes and provide traffic control.
- Provide security for EMS if warranted.
- Identify support required to maintain 9-1-1 EMS response system capable of triage, treatment, and transport.
- Provide medical oversight of EMS personnel, including personnel provided by the National EMS contract.
- Provide wheelchair vans, passenger vans, and drivers for transport of low acuity patients/residents.
- Establish forward staging area(s) for ambulances and paratransit vehicles.
- Identify airfields that can be used for patient movement.
- Coordinate the dispatch of federally-provided ground and air ambulances and paratransit vehicles to local hospitals, skilled nursing facilities and other patient congregation sites. The resources from the National EMS Contract remain under local control; military assistance with aeromedical evacuation does not fall under local control.
- Implement facility emergency management plans; support decisions to evacuate patients and staff or shelter-in-place (SIP) based on conditions imposed by the incident and the availability of resources.
- Manage the loading and unloading of patients being evacuated from/to healthcare facilities.
- Notify the MHOAC Program of the numbers and types of patients who require evacuation.



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State Government

- Declare State of Emergency.
- Request Federal Emergency/Major Disaster Declaration.
- If needed, submit the **Resource Request Form** (RRF) provided by CA-ESF 8 to Cal OES for submission to FEMA for federal assistance with patient movement, along with other required documentation.
- If the state requests the National EMS Contract, the request must be accompanied by a **Letter of Reciprocity** signed by the California official(s) authorized to do so. Alternatively, the Governor of the State of California may issue an Executive Order temporarily authorizing a single state official to sign the required Letter of Reciprocity.
- Identify and make available airfields for patient evacuation operations.
- Identify and make available staging locations for incoming EMS resources.

CA-ESF 8 (Co-Leads are EMSA and CDPH)

- Coordinate support to CA-ESF 8 activities, including medical surge, sheltering-in-place, EMS support and patient evacuation.
- Notify Cal OES of identified shortfalls and possible requests for assistance with patient evacuation.
- Notify and coordinate with the HHS Region IX Regional Emergency Coordinator (REC) of possible needs for federal assistance with patient evacuation and movement.
- At the regional level, support the Regional Patient Movement Coordination Function in aggregating operational area requests for patient movement. If adequate resources are not available within the region, advance the unmet resource requests to the state-level Patient Movement Function (located at the MHCC).
- Utilize the California Health Information Network (CAHAN) to communicate critical (non-PHI) information regarding patient/resident evacuation and movement as necessary.
- At the state level, aggregate regional requests for patient movement within the MHCC's Patient Movement Function. Share this information with the Joint Patient Movement Advisor Team if activated at the SOC/IOF/JFO.
- Submit appropriate **Resource Request Forms** and other required documentation for federal patient movement assistance to Cal OES for submission to FEMA; share RRFs with the ESF 8 Coordinator (HHS Region IX REC).
- Identify ambulance and paratransit vehicle check-in and staging locations.
- Coordinate the transport of patients and residents from hospitals and other healthcare facilities to evacuation points.



F. QUICK REFERENCE GUIDE TO CNG AND FEDERAL RESOURCES

The purpose of this section is to describe, for planning purposes, the resources that may be available through the California Military Department (CMD) and federal agencies, including the Department of Defense (DoD), to assist with patient movement during a disaster. It is important to note that the military support of civilian response to disasters is predicated on the availability of resources not otherwise assigned to supporting combat and homeland defense missions.

California Military Department

The California Military Department (CMD) consists of the California Air National Guard (CA ANG), California Army National Guard (CA ARNG) (together, CNG) and California State Military Reserve (CSMR).

CNG operates across both state and federal responses, leveraging State Active Duty (SAD), Full-Time National Guard Duty (Title 32) and Active Duty (Title 10). When the Governor mobilizes the CNG, the forces are typically in Emergency State Active Duty (ESAD) status. They remain under the command and control of the Governor, exercised through the state's adjutant general, and are funded by the state. ESAD forces conduct all state missions in accordance with the needs of the state and within the guidelines of state laws and statutes.

In addition, the CSMR is an all-volunteer militia force under the CMD that provides reserve personnel to both the CA ARNG and the CA ANG. Its members are typically employed within the State of California. It is not subject to be called, ordered or assigned as any element of the federal armed forces. Its mission is to provide units organized, equipped and trained in the protection of life or property and the preservation of peace, order and public safety under competent orders of state authorities.

The following CNG and Federal Patient Movement Resources document is intended to be used as a quick reference guide for California local, operational area, regional and state health and medical emergency managers in the planning and response to events requiring the movement of patients utilizing state (CNG) or federal disaster response resources.

Federal Agencies

The principal federal agencies that may have a role in patient movement during a disaster include U.S. Health and Human Services (HHS), FEMA, Veterans Affairs (VA), Homeland Security (DHS), and the Department of Defense (DoD).



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Purpose of this Section

The resources described on the following pages represent the resources most likely to be supplied to the state to assist with the patient movement needs created by a disaster. Again, these resources may be unavailable at the time of request if they are deployed elsewhere or needed for higher priority missions in the U.S. or overseas. The following pages:

- Describes the resource, resource owner and capabilities
- Quantifies the number of resources likely to be deployed in a disaster
- Identifies “through-put” capabilities for specific resources where applicable
- Identifies the resources/support that the local jurisdiction(s) requesting assistance and/or the state are expected to provide in order to receive and employ the CNG/federal resources (e.g., facilities, personnel, equipment)
- Identifies the specific information that must be provided to the federal teams to support patient movement using federal assets
- Identifies the limitations or exclusions regarding patient categories/types that cannot be transported via the CNG/federal asset

Contraindications for Federal Aeromedical Evacuation

The following are standard contraindications to aeromedical evacuation by federal authorities, including DoD. This standard list includes conditions likely to worsen with air transport/altitude or cannot be successfully managed during flight due to resource limitations. This list of contraindications could be subject to change based on the patient movement requirements produced by the incident and should be verified prior to patient movement.



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Standard Contraindications for Federal Aeromedical Evacuation	
Any medical condition not stabilized	Pneumocephalus
Pregnancy > 34 weeks	Seizure within last 2 weeks
Hemorrhaging (Hgb < 8.5)	New onset cardiac dysrhythmia
Post-op < 72 hours	Unbivalved orthopedic cast
Acute Coronary Syndrome	Communicable disease
Post procedure < 7 Days: Open Heart Surgery	Respiratory isolation including possible TB
Post procedure < 7 Days: Craniotomy	Agitation or other behavior distracting to flight
Post procedure < 7 Days: Spinal Surgery	Agitation or other behavior distracting to flight
Untreated pneumothorax	Decompression sickness
Neonates/young pediatric patients	Psychologically unstable

In addition, federal aeromedical evacuation resources have limited capacity for burn and bariatric patients.



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Name of Resource	JOINT PATIENT MOVEMENT COORDINATION TEAM (JPMCT)
Owner	California Air National Guard (may be requested by local jurisdictions)
Mission/Capability	<ul style="list-style-type: none"> • A 4 to 6 person communication/coordination team that deploys to healthcare facilities or other sites to assist with patient preparation for movement and facilitate coordination with the AE system. • An JPMCT generally consists of 1 or 2 Medical Service Corps officers, flight nurse and radio operator, although this composition may vary. • A required component of AE process is clinical determination that the patient’s medical condition will not be exacerbated during flight (determined by the flight surgeon). • Note: The CNG JPMCTs may be activated in support of federal patient movement activities.
Maximum # Available	Two (2) JPMCTs (from Cal Guard; located at the Channel Islands)
Request Guidance	<p><u>California should specifically request this assistance in the resource request and should include the number and location of healthcare facilities or CCPs that require JPMCT support for the aeromedical evacuation of patients.</u></p> <p>Example of language used to request resource if CNG JPMCT is request as a state resource: <i>“Healthcare facilities (specify names) and/or other casualty collection points (specify locations) need assistance in collecting and entering the information required by state military authorities to validate patients for flight and match and schedule patients on appropriate airframes and crews. Cal Guard Aeromedical Evacuation Liaison Teams (JPMCTs) embedded with healthcare facilities or casualty collection points will assist in providing this capability.”</i></p>
Local/State Responsibilities	<ul style="list-style-type: none"> • Within a requesting OA, local jurisdictional authorities (MHOAC Program) should prioritize the healthcare facilities or CCPs that need receive JPMCT assistance if the need exceeds availability. • If multiple OAs have cumulative needs that exceed available resources, state authorities may need to prioritize the assignment of JPMCTs.



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Name of Resource	JOINT PATIENT MOVEMENT COORDINATION TEAM (JPMCT)
Owner	California Air National Guard (may be requested by local jurisdictions)
Status (State or Federal)	<ul style="list-style-type: none"> • If patient movement begins as an intra-state (non-federal) mission, Cal OES will mission resource task CA ANG through Mission resource tasking. • Federally-assisted patient movement using Air Force assets requires full coordination through the TPMRC-A at US TRANSCOM. Once it is known that patients will enter the NDMS system, Form 4 (Information required by federal agencies to transport patients using NDMS) should be collected at each healthcare facility (HCF) or casualty collection point (CCP) and sent to the Joint Patient Movement Advisor Team (JPMAT) at the state EOC/CA-ESF 8. The JPMAT forwards the information to the TPMRC-A. The TPMRC-A builds the movement request in TRAC2ES and passes the request to the military component that will match aircraft and crew to mission (the TACC). Once this is accomplished, the completed mission information is sent back to the TPMRC-A who builds the mission in TRAC2ES and forwards it to the state EOC/CA-ESF 8 and the receiving FCC.)
Through-Put	N/A
Patient Tracking	JPATS only if part of federal mission.
Exclusions/Limitations	See <i>“Standard Contraindications to Federal Aeromedical Evacuation”</i> . CNG/DoD-excluded patient types should be directed to private ground or air ambulances when necessary (e.g., neonates).



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Name of Resource	MEDICAL COMPANY (ROTARY WING AIR AMBULANCE)
Owner	California Air National Guard (may be requested by local jurisdictions)
Mission/Capability	<p>To provide rotary wing aeromedical evacuation.</p> <ul style="list-style-type: none"> • 12 to 15 UH-60 Blackhawk Helicopters • 76 personnel • Each aircraft can transport 6 litter or 7 ambulatory patients (or combination thereof) • 4 Forward Support MEDEVAC Teams (3 x UH-60 each) can deploy as individual teams or as group • Rapid movement of critical medical personnel or equipment/supplies to meet requirements of mass casualties, reinforcement/reconstitution or emergency situations • Movement of patients from treatment facilities (healthcare facilities, casualty collection points, etc.) to aeromedical staging facilities, railheads, hospital ships, seaport (i.e., this resource can create an “air bridge” to the unaffected periphery).
Maximum # Available	12 to 15 UH-60 Blackhawk Helicopters
Throughput	6 litter or 7 ambulatory patients per mission
Status (State or Federal)	<ul style="list-style-type: none"> • May be requested as a state asset; or may be rolled under DoD when NDMS is activated. • If patient movement begins as an intra-state (non-federal) mission, Cal OES will mission resource task CA ANG through Mission Resource Tasking (MRT) • Federally assisted patient movement using Air Force assets requires full coordination through US TRANSCOM.
Request Guidance	<p><u>Local jurisdictions should specifically request this assistance in the resource request if this assistance is needed (unless the resource is rolled under NDMS).</u></p> <p>Example of language used to request resource: <i>“Healthcare facilities (specify names) and/or other casualty collection points (specify locations) need assistance in collecting and entering the information required to patients entering the military aeromedical evacuation system. Aeromedical Evacuation Liaison Teams (JPMCTs) embedded with healthcare facilities or casualty collection points will assist in providing this capability.”</i></p>



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	MEDICAL COMPANY (ROTARY WING AIR AMBULANCE)
Owner	California Air National Guard (may be requested by local jurisdictions)
Local/State Responsibilities	<ul style="list-style-type: none"> • State (CA-ESF 8) may need to prioritize the locations that are served by this asset. • State (CA-ESF 8) should identify in documentation the following: <ul style="list-style-type: none"> ○ Number and location of healthcare facilities that require aeromedical evacuation of patients (Form 1) ○ Number of patients that require evacuation by JPATS categories (Form 4. Information required by federal agencies to transport patients using NDMS) ○ Number of family members or attendants to be transported with each patient (Form 4) • Pre-identify helipads or landing zone (LZ) and coordinate with Cal OES to have CA ANG inspect/certify helipad for military aeromedical evacuation operations <ul style="list-style-type: none"> ○ Requires 30+ meters in diameter ○ Free of obstacles ○ No more than 15-degree slope
Patient Tracking	JPATS only if part of federal mission
Exclusions/Limitations	For DoD transport, see “ <i>Standard Contraindications to Federal Aeromedical evacuation</i> ”. DoD-excluded patient types should be directed to private ground or air ambulances when necessary (e.g., neonates).



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	NATIONAL EMS CONTRACT
Owner	FEMA
Mission/Capability	<ul style="list-style-type: none"> • The National EMS Contract provides comprehensive EMS resources and services to support the ability of local jurisdictions to manage EMS activities, including patient movement. These contract resources may be used for: <ul style="list-style-type: none"> ○ Patient movement from point of origin to first receiver ○ Patient movement between facilities ○ Patient movement to evacuation points, including APOEs ○ Support of local 9-1-1 service ○ EMS support of field treatment sites/casualty collection points • The FEMA National EMS Contractor provides their own base camp and supplies, including fuel. The Scope of Practice for out-of-state contract EMS resources is the <i>National EMS Scope of Practice Model</i>.
Request Guidance	<ul style="list-style-type: none"> • 300 Ground Ambulances from a single zone (max. 70% ALS, 30% BLS) • 3,500 Paratransit Seats (max. 25% wheelchair capable) • 25 fixed wing/rotary wing aircraft • Up to an additional 150 EMT/paramedics (not attached to ambulances) • Communications Support Team in case existing infrastructure fails <p>(Note that Bariatric ALS ambulances must have a stretcher rated to carry at least 700 lb. and must be at least 29" wide or compatible with a stretcher-converting bariatric board. It must also include a commercial stretcher loading device.)</p>
Maximum # Available	<ul style="list-style-type: none"> • 300 Ground Ambulances from a single zone (max. 70% ALS, 30% BLS) • 3,500 Paratransit Seats (max. 25% wheelchair capable) • 25 fixed wing/rotary wing aircraft • Up to an additional 150 EMT/paramedics (not attached to ambulances) • Communications Support Team in case existing infrastructure fails <p>(Note that Bariatric ALS ambulances must have a stretcher rated to carry at least 700 lb. and must be at least 29" wide or compatible with a stretcher-converting bariatric board. It must also include a commercial stretcher loading device.)</p>



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	NATIONAL EMS CONTRACT
Owner	FEMA
Name of Resource	NATIONAL EMS CONTRACT
Owner	FEMA
Local/State Responsibilities	<ul style="list-style-type: none"> • The National EMS Contract must be requested by the State of California. The request package should include the following: <ol style="list-style-type: none"> 1) RRF (see recommended script provided by HHS), 2) Letter of Reciprocity signed by authorizing official, 3) Provision of medical oversight, and 4) Federal EMS Support Request Form (see the <i>FEMA/HHS Ground Ambulance and Paratransit Resource Utilization Guide</i>) • Note that the Federal EMS Support Request Form asks for the number of patients and passengers that need transportation according to the following 5 categories: <ol style="list-style-type: none"> 1) Patients that need ALS Ground Ambulance 2) Patients that need BLS Ground Ambulance 3) Patients that need Bariatric ALS Ground Ambulance 4) Passengers that need Paratransit transportation 5) Passengers that need Conventional transportation • Forward ambulance and paratransit staging locations must be identified by local jurisdictions and communicated to the state EOC/CA-ESF 8. • Space will need to be provided to the National EMS Contractor’s Forward Operations Team (at state EOC or CA-ESF 8)
Through-Put	Initial ambulances should arrive within 24 hours of approved Task Order.
Patient Tracking	The National EMS Contractor uses its own patient tracking system.
Exclusions/Limitations	<ul style="list-style-type: none"> • In general, ground transportation is applicable for patient movement up to 200 miles or six hours in duration. • Patients needing movement beyond 200 miles should be considered for air transportation.



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	NATIONAL DISASTER MEDICAL SYSTEM (NDMS)
Owner	Combined federal effort by HHS, DoD, VA and FEMA
Capability	<ul style="list-style-type: none"> • In response to a Stafford Act incident, NDMS provides the following capabilities: 1) Medical Response, 2) Patient Evacuation and 3) Definitive Care. • The Patient Evacuation component of NDMS uses DoD or FEMA EMS Contract aircraft. Patients are flown from airfields in the affected area to pre-identified reception sites call Federal Coordinating Centers (FCCs). A FCC may be affiliated with a Patient Reception Area (PRA). • The Patient Evacuation component of NDMS includes: <ul style="list-style-type: none"> ○ Established methods for identifying and reporting patients for movement; ○ The deployment of patient staging capabilities at outbound airfields; ○ Pre-identified reception sites (FCCs); ○ Network of hospitals with available beds; ○ Air transport with en route care; ○ Patient tracking system; and ○ Return of patients to place of origin • FCCs maintained by the VA or DoD coordinate the Definitive Care component of NDMS. FCCs recruit and enroll civilian hospitals that agree to make beds available during an incident. There are over 1,600 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.
Local/State Responsibilities	<ul style="list-style-type: none"> • State must demonstrate all available local and state resources are being utilized and there is still a need; • State must demonstrate that all EMAC agreements have been initiated and there is still a need; • State will request federal patient movement assistance through the Federal Coordinating Official (FCO); • State must determine if they want to utilize the FEMA National EMS Contract and/or the federal patient movement system including NDMS.



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	NATIONAL DISASTER MEDICAL SYSTEM (NDMS)
Owner	Combined federal effort by HHS, DoD, VA and FEMA
	<p>Once the steps above have been taken, the State should identify in its resource request documentation¹⁵, to the best of its ability, the following:</p> <ul style="list-style-type: none"> • Approximate total number of patients to be moved • Number and location of healthcare facilities (healthcare facilities) or casualty collection points (CCPs) from which patients will be transported • Approximate number of patients by JPATS category to be transported • Approximate number of family or personal care attendants to be transported with patients¹⁶ <p>NDMS will make the determination regarding the types and numbers of NDMS resources to initially activate, deploy and sustain the mission requirements as defined by the state.</p>
Activation and Deployment of Federal Patient Movement Resources	<p>Part 1: Identify patients that require federal movement in order to generate mission assignments (Strategic Lift).</p> <ol style="list-style-type: none"> 1) healthcare facilities or CCPs submit Form 4. Information required by federal agencies to transport patients using NDMS through SEMS channels (HCF/CCP → MHOAC Program → RDMHC Program → CA-ESF 8 → Federal JPMAT at state EOC). 2) Depending on the hospital location, DoD or the National EMS Contractor take the mission. 3) The National EMS Contractor assigns missions from the National EMS Contractor’s Forward Operating Team at the state EOC. 4) JPMAT passes Form 4 data to TPMRC-A for DoD mission assignment. 5) Mission information flows back JPMAT and CA-ESF 8. 6) Aircraft are staged out of area. 7) Aircraft begin moving patients according to mission schedule.

¹⁵ The documentation needed to request the NDMS includes a Cal OES-approved **Resource Request Form (RRF)** and an associated JPATS-compliant **Form 4. Information required by federal agencies to transport patients using NDMS**.

¹⁶ In the initial stages of the incident, local and state health officials may not be able to accurately quantify the resources needed; however, an estimate of the magnitude (numbers) will enable NDMS to begin to alert, activate and mobilize resources. Adjustments to those numbers can be refined as situational awareness improves.



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	NATIONAL DISASTER MEDICAL SYSTEM (NDMS)
Owner	Combined federal effort by HHS, DoD, VA and FEMA
	<p>Part 2 : Federal Air Patient Movement (physical movement of patients)</p> <ol style="list-style-type: none"> 1) Mission information passed to Hospital and EMS Dispatch. 2) Patient staging assets are stood up at DoD or civilian airfields. 3) Aircraft begin flying to designated airfields. 4) Based on Mission information, ambulances are dispatched to hospitals. 5) Patients are transported to airfields (2 hrs in advance for DoD or 30 minutes in advance for National EMS Contractor aircraft). 6) Patients are loaded on aircraft and flown to receiving FCCs. 7) Patients are transported to NDMS receiving hospitals.
Throughput	<p><u>DoD</u></p> <ul style="list-style-type: none"> • Commence patient movement within 36 hrs of notification • Evacuate 140 patients/day per airfield at a maximum of four (4) airfields (maximum of 560 pts per day) <p><u>National EMS Contractor</u></p> <ul style="list-style-type: none"> • Commence within 24 hrs of notification • Rotary and Fixed Wing Civilian Air Ambulances (ALS) throughput dependent on # of resources
Patient Tracking	JPATS and TRAC2ES
Exclusions/Limitations	For DoD transport, see “ <i>Standard Contraindications to Federal Aeromedical evacuation</i> ”. DoD-excluded patient types should be directed to private ground or air ambulances when necessary (e.g., neonates).



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	NDMS-PARTICIPATING HEALTHCARE FACILITIES
Owner	Various (a component of NDMS)
Capability	<ul style="list-style-type: none"> • Based on the <i>NDMS Definitive Care Memorandum of Agreement</i>, FCCs recruit healthcare facilities (e.g., hospitals, nursing homes) to participate in the NDMS system. These facilities agree to accept NDMS patients and assume the care of the patients until one of the following occurs: <ul style="list-style-type: none"> ○ The medically indicated treatment has been completed (maximum 30 days) resulting in discharge. ○ The Diagnostic Related Group (DRG) payment schedule as defined by the Centers for Medicare and Medicaid Services (CMS) is exhausted. ○ The patient voluntarily refuses care. ○ Patient is discharged. • Each NDMS hospital has patient advocates and case managers to follow the patient during the patient’s stay in the facility. Once the patient is ready for discharge, the hospital will look to HHS for direction and support for the patient post-discharge. (See Service Access Team)
Maximum Number Available	Up to 1600 hospital beds nationwide
Local/State Responsibilities	<ul style="list-style-type: none"> • Provide JPATS information for all patients using the federal patient movement system (either via JPATS or Patient Movement Request spreadsheet). • The state does not request FCC activation in its federal resource request; FCCs are activated based on internal NDMS procedures to support federal patient movement mission assignments.
Throughput	N/A
Patient Tracking	JPATS
Exclusions/Limitations	For DoD transport, see <i>“Standard Contraindications to Federal Aeromedical evacuation”</i> . DoD-excluded patient types should be directed to the National EMS Contractor’s airlift when necessary (e.g., neonates).



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	JOINT PATIENT MOVEMENT ADVISOR TEAM (JPMAT)
Owner	DoD (a component of NDMS)
Mission/Capability	<ul style="list-style-type: none"> • The Joint Patient Movement Advisor Team (JPMAT) is a 4-person team whose mission is to provide medical regulating support during a civil operation. The JPMAT is usually located at the state EOC (or CA-ESF 8 Coordination Center) and provides guidance on the types of patients DoD can or cannot move. For example, DoD policy currently does not permit the movement of the following types of civilian patients: NICU, PICU and unstable psychiatric patients (leaving the option of ground transportation or private air transportation). • The JPMAT will also inform DoD of any special patient requirements that could impact the mission, e.g., a patient with methicillin-resistant staphylococcus aureus.
Resource Guidance	<u>The state does not have to specifically request this resource in the RRF; it is a component of NDMS.</u>
Maximum # Available	N/A
Through-Put	N/A
Local/State Responsibilities	<ul style="list-style-type: none"> • The state is expected to communicate expectations to local jurisdictions that adequate patient documentation is required for DoD to accept the responsibility for patients during federal patient movement. The required documentation includes the data in Form 4 (Information required by federal agencies to transport patients using NDMS) and medical records including diagnosis, allergies, medications, treatments, medications and emergency family contacts. • Space in the state EOC (or CA-ESF 8 Coordination Center) to accommodate 4-person JPMAT during federal patient movement activity. The JPMAT receives information from healthcare facilities and CCPs on patients who may need federal patient movement and transmits that information to the TPMRC-A for validation, air frame and air crew scheduling and coordination.
Patient Tracking	JPATS
Exclusions/Limitations	For DoD transport, see <i>“Standard Contraindications to Federal Aeromedical evacuation”</i> . DoD-excluded patient types should be directed to private ground or air ambulances when necessary (e.g., neonates).



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	FEDERAL COORDINATING CENTERS (FCCs)
Owner	DoD and VA (a component of NDMS)
Capability	<ul style="list-style-type: none"> • FCCs are run by either the VA or DoD and coordinate the Definitive Care component of NDMS. • FCCs will validate the severity of the received patient’s condition and select an appropriate receiving NDMS facility. The FCC, in coordination with the receiving NDMS facility, will arrange patient transportation to the facility. The distribution of patients will be tracked using HHS’s Joint Patient Assessment and Tracking System (JPATS). • There are over 1,600 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.
Local/State Responsibilities	Provide JPATS information for all patients using the federal patient movement system. Submission of the Form 4. Information required by federal agencies to transport patients using NDMS spreadsheet that includes JPATS data elements is acceptable.
Maximum Number Available	6 FCCs in CA; 2 FCCs in AZ; 1 FCC in AZ Up to 1,600 hospital beds nationwide.
Patient Tracking	JPATS
Exclusions/Limitations	For DoD transport, see “ <i>Standard Contraindications to Federal Aeromedical evacuation</i> ”. DoD-excluded patient types should be directed to the National EMS Contractor’s airlift when necessary (e.g., neonates).



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	JOINT PATIENT MOVEMENT COORDINATION TEAM (JPMCT)
Owner	DoD (optional component of NDMS – may be requested by state)
Mission/Capability	<ul style="list-style-type: none"> • A 4 to 6 person communication/coordination team that deploys to healthcare facilities or other sites to assist with patient preparation for federal movement and coordinate with the AE system • JPMCTs coordinate requests with the AE system and facilitate the validation of patients for flight. A component of the validation process is clinical determination that the patient’s medical condition will not be exacerbated during flight and that the patient can be directed to an appropriate destination HCF. • An JPMCT generally consists of 2 Medical Service Corps officers, a flight nurse and 3 radio operators, although this composition may vary.
Maximum # Available	16 to 20 JPMCTs
Request Guidance	<p><u>California should specifically request this assistance in the RRF and should specify the number and location of healthcare facilities that require JPMCT support for the aeromedical evacuation of patients.</u></p> <p>Example of language used to request resource: <i>“Healthcare facilities (specify names) and/or other casualty collection points (specify locations) need assistance in collecting and entering the information necessary to enter the military aeromedical evacuation system. Aeromedical Evacuation Liaison Teams (JPMCTs) embedded with healthcare facilities or casualty collection points will assist in providing this capability.”</i></p>
Local/State Responsibilities	<ul style="list-style-type: none"> • California authorities may need to prioritize the healthcare facilities that are assigned JPMCTs if the requests exceed JPMCT availability. • (Note: Once it is known that patients will enter the NDMS system, Form 4 (Information required by federal agencies to transport patients using NDMS) information should be collected at each healthcare facility (HCF) or casualty collection point (CCP) and sent to the Joint Patient Movement Advisor Team (JPMAT) at the state EOC/CA-ESF 8. The JPMAT forwards the information to the TPMRC-A at Scott AFB. The TPMRC-A builds the movement request in TRAC2ES and passes the request to the military component that will match aircraft and crew to mission (the TACC). Once this is accomplished, the completed mission information is sent back to the TPMRC-A who builds the mission in TRAC2ES and forwards it to the state EOC/CA-ESF 8 and the receiving FCC.)



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	JOINT PATIENT MOVEMENT COORDINATION TEAM (JPMCT)
Owner	DoD (optional component of NDMS – may be requested by state)
Through-Put	N/A
Patient Tracking	JPATS
Exclusions/Limitations	For DoD transport, see “ <i>Standard Contraindications to Federal Aeromedical evacuation</i> ”. DoD-excluded patient types should be directed to private ground or air ambulances when necessary (e.g., neonates).



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	DISASTER AEROMEDICAL STAGING FACILITY (DASF)
Owner	DoD (optional component of NDMS – may be requested by state)
Mission/Capability	<ul style="list-style-type: none"> • DASFs are rapidly deployable assets that provide patient staging for aeromedical evacuation (AE) operations; typically 63 military personnel. • DASFs are equipped and staffed to provide care for patients, transport to aircraft, and administratively process patients. • DASFs typically deploy within 24 hours of mission assignment. • DASFs operate at Aerial Port of Embarkation (APOE) for patient movement using federal assets. • An APOE may have multiple DASFs based on airport capacity, space and availability. • Patient holding times at a DASF: not less than 2 hours or more than 6 hours. • HHS may provide advanced medical care capability to a DASF through the addition of a Mobile Acute Care Team (MAC-T). • DoD may provide advanced medical care capability to a DASF through the addition of a Critical Care Air Transport Team (CCATT). • Only documented service animals will be transported <p><u>DASF Equipment:</u></p> <ul style="list-style-type: none"> • Requires five (5) C-17s to move DASF to desired APOE location • 40 short tons of cargo • Contingency Response Forces with forklift • Critical care equipment cache • Medical staging equipment and supplies, including PPE
Request Guidance	California should request the number of DASFs it needs to service the APOEs designated by the state, i.e., one DASF per APOE.
Maximum # Available	Four (4) DASFs (Note: Two (2) DASFs will be accompanied by a HHS MAC-T to provide advanced medical care; the other two (2) DASFs will have four (4) CCATTs per location) to provide advanced medical care.



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	DISASTER AEROMEDICAL STAGING FACILITY (DASF)
Owner	DoD (optional component of NDMS – may be requested by state)
Through-Put	<ul style="list-style-type: none"> • Each DASF can evacuate up to 140 patients per location per 24-hour period. Note that DASF through-put capacity is related to aircraft capacity, which depends on the type of patients being moved. An average number of patients per aircraft is 35. • Through-put is also dependent on litter bearers provided by the state.
Local/State Responsibilities	<ul style="list-style-type: none"> • Transport patients to from field to the DASF at the APOE • Patients arriving at the DASF should arrive with 3 days of medications, necessary medical equipment/supplies and essential medical records. • Patients cleared for federal movement should arrive at the DASF no less than two hours before transport, or more than 6 hours before transport. • State must provide the following support to each DASF: <ul style="list-style-type: none"> ○ Provide a building of opportunity (12,000 sq. ft.) ○ Provide base life support functions (food, water, billeting) ○ Provide food and water for patients and volunteers ○ Provide at least 16 litter bearers • Provide space at state EOC for 4-6 personnel (called the Joint Patient Movement Advisor Team) to work with senior state medical officials and hospitals to ensure that the required Form 4 (Information required by federal agencies to transport patients using NDMS) data are transmitted to and received by US TRANSCOM. Once validated, the JPMAT works with the state EOC and hospitals to ensure patients arrive at the DASF at proper times. • If scarce resources necessitate prioritization, senior state medical officials will provide that input to the federal Joint Patient Movement Advisor Team located at the state EOC.
Patient Tracking	JPATS
Exclusions/Limitations	For DoD transport, see “ <i>Standard Contraindications to Federal Aeromedical evacuation</i> ”. DoD-excluded patient types should be directed to private ground or air ambulances when necessary (e.g., neonates).



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	MOBILE ACUTE CARE TEAM (MAC-T)
Owner	HHS (Optional component of NDMS)
Capability	<ul style="list-style-type: none"> • The purpose of a MAC-T is to provide stabilizing care for higher acuity, critical care patients, including preparation for flight, at the DASF. • Mobile Acute Care Teams (MAC-Ts) are composed of 15-20 DMAT members (including critical care physicians, nurse practitioners, physician assistants, registered nurses, pharmacists and respiratory therapists). • A MAC-T is under the direction and administrative control of the federal ESF 8 Incident Response Coordination Team (IRCT). • The average time for a MAC-T to respond is 12-18 hours. A DASF with MAC-T can be minimally operational within one (1) hour of arrival at an APOE, given appropriate state/local support. If a building of opportunity is not provided and tents are required, an increase of 2-4 hours set up time would be required to obtain full operational capacity at any APOE, pending availability of equipment and transportation assets. • A MAC-T is capable of operating for a 24-hour period and may be deployed for up to 72 hours. • Operations are supported for 72 hours before resupply is needed.
Request Guidance	CA-ESF 8 should consult with ESF 8 Coordinator (Region IX REC) regarding the need to request of MAC-Ts. Critical care support can be provided at DASFs by either MAC-Ts (an HHS resource) or CCATTs (a DoD resource).
Maximum # Available	Two (2) MAC-Ts
Through-Put	<ul style="list-style-type: none"> • In support of the DASF, a MAC-T can stabilize and maintain the following (assuming a 1-2 hour patient hold time): <ul style="list-style-type: none"> ○ Twelve (12) ventilator-dependent/high acuity patients or ○ 24 non-ventilated, lower acuity patients, or ○ A combination of the above • The maximum capacity of a MAC-T is 140 pts in a 24-hour period with a maximum 1-2 hour hold time (assuming 20% or 28 pts are critical).
Local/State Responsibilities	Identify existing buildings of opportunity that the DASF and MAC-T can use for operations.
Patient Tracking	JPATS



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	MOBILE ACUTE CARE TEAM (MAC-T)
Owner	HHS (Optional component of NDMS)
Exclusions/Limitations	For DoD transport, see <i>“Standard Contraindications to Federal Aeromedical evacuation”</i> . DoD-excluded patient types should be directed to private ground or air ambulances when necessary (e.g., neonates).



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	CRITICAL CARE AIR TRANSPORT TEAM (CCATT)
Owner	DoD (optional at discretion of DoD)
Capability	<ul style="list-style-type: none"> • Within NDMS, CCATTs are a rapidly deployable resource that prepare and transport critical patients by aeromedical evacuation. • <u>The state does not request CCATTs.</u> The TPMRC-A will determine if a CCATT is required and which patients will be transported under the care of a CCATT. This is determined based on the required patient information (Form 4) received by the Joint Patient Movement Advisor Team and communicated to the TPMRC-A. • CCATT is utilized as a supplementation package to the primary medical AE crew. • Each CCATT includes 1 critical care physician, 1 critical care nurse and 1 respiratory therapist. • CCATTs maintain/enhance the care provided to critically ill/injured patients who require continuous stabilization and/or advanced care during transport. • Each CCATT can care for 3 ventilated patients or 6 non-ventilated, critical patients or a combination thereof.
Request Guidance	The state does not request CCATTs; this is part of DoD Patient Movement support to NDMS and DoD will decide if CCATTs are required.
Maximum # Available	8 CCATTs (4 CCATTs per APOE at a maximum of 2 APOEs)
Local/State Responsibilities	<p>The State of California does not specifically request this resource but requests for assistance should identify the number of patients at each location that meet the following criteria for CCATT assignment:</p> <ol style="list-style-type: none"> 1) At high risk for clinical decompensation 2) Requires mechanical ventilation 3) High risk for deteriorating respiratory status 4) Requires invasive hemodynamic monitoring (arterial line and/or CVP) 5) Requires ongoing active resuscitation and/or lab monitoring 6) Requires aggressive in-flight fluid/ blood product administration 7) Requires vasopressor support 8) Requires invasive intracranial pressure monitoring (ICP) (bolt and/or ventriculostomy) 9) Requires cardiac pacing



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	CRITICAL CARE AIR TRANSPORT TEAM (CCATT)
Owner	DoD (optional at discretion of DoD)
Local/State Responsibilities	<p>10) Unstable spine fracture that requires transport on an Air Transport Vacuum Spine Board (VSB)</p> <p>11) Undergone a vascular reconstruction and is at high risk for clot or hemorrhage</p> <p>12) Unstable angina, unstable arrhythmia, or recent myocardial infarction, with risk too high for single medical attendant</p> <p>13) Patient considered "high risk" on the AE Cardiac Tool</p> <p>Note that the following conditions do not necessarily require CCATT: Chest tube, epidurals with level below T10, regional blocks, patient in ICU (consider medical attendant), cardiac monitor (consider medical attendant), blood or FFP use (consider medical attendant).</p> <p>Note that endotracheal intubation is difficult in flight; if intubation is being considered, it should be accomplished before patient movement begins. Patients should not be extubated less than 4 hours prior to flight.</p>
Through-Put	Each CCATT can care for a maximum of 3 ventilated patients or 6 critical, non-ventilated patients or a combination thereof.
Patient Tracking	JPATS
Exclusions/Limitations	For DoD transport, see <i>“Standard Contraindications to Federal Aeromedical evacuation”</i> . DoD-excluded patient types should be directed to private ground or air ambulances when necessary (e.g., neonates).



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	DISASTER MEDICAL ASSISTANCE TEAMS (DMATs)
Owner	NDMS
Capability	<ul style="list-style-type: none"> • A DMAT is a group of professional and para-professional medical personnel, supported by a cadre of logistical and administrative staff, that provide medical care during a disaster. • DMATs typically deploy as a 35-member team including physicians, physician assistants, nurses, pharmacists, pharmacy technicians, respiratory therapists, paramedics and emergency medical technicians. Smaller teams may be activated depending on the specific mission. • DMAT responsibilities may include triaging patients, providing medical care under adverse conditions, preparing patients for evacuation and patient reception at staging facilities. • DMATs deploy to disaster sites with sufficient supplies and equipment to sustain themselves for 72-hour period while providing medical care at a fixed or temporary medical care site. • For patient movement, DMATS may be used at APOEs, DASFs, or other locations. • Note that DMAT members may be selected for inclusion in MAC-Ts.
Maximum Number Available	3-4 DMATs within 24 hours; additional teams based on need.
Local/State Responsibilities	Identify need and location for requested DMATs.
Throughput	250 patients per day per full DMAT.
Patient Tracking	JPATS
Exclusions/Limitations	For DoD transport, see “ <i>Standard Contraindications to Federal Aeromedical evacuation</i> ”. DoD-excluded patient types should be directed to private ground or air ambulances when necessary (e.g., neonates).



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	FIXED-WING AEROMEDICAL EVACUATION AIRCRAFT
Owner	DoD (a component of NDMS)
Mission/Capability	<ul style="list-style-type: none"> • Transport patients from Aerial Port of Embarkation (APOE) to destination Federal Coordinating Center (FCC) within the NDMS system. • The personnel assigned to a standard AE mission are divided into non-medical and medical components: <ul style="list-style-type: none"> ○ Non-Medical <ul style="list-style-type: none"> ▪ Two pilots typically ▪ One or more loadmasters ▪ Flight engineer ○ Aeromedical evacuation Crew <ul style="list-style-type: none"> ▪ Two or more flight nurses (one is designated Mission Commander) ▪ Three or more EMTs ▪ Critical Care Transport Teams (CCATT) <u>may</u> be included
Request Guidance	<p><u>The state does not specifically request this resource; it is a component of NDMS.</u></p>
Maximum # Available	<ul style="list-style-type: none"> • Eight (8) C-130's at 4 APOEs • C-130 flight schedule is 2 flights per day • Average acuity: 20% critical care • C-130 patient capacity (35 litters, 0 ambulatory, PTLOX, unimproved runway) • C-17 patient capacity (35 litters, 54 ambulatory, onboard O2, unimproved runway) • KC-135 patient capacity (15 litters, 8 ambulatory, PTLOX, improved runway) • 767 requires refit (87 litters, 40 ambulatory, onboard O2, improved runway) <p>Note that both the KC-135 and 767 are unable to load patients from ground level and therefore need additional equipment for patient loading.</p> <p>Note that CCATT patients may require more space/electricity and decrease the maximum number of litter spaces available; likewise,</p>



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	FIXED-WING AEROMEDICAL EVACUATION AIRCRAFT
Owner	DoD (a component of NDMS)
	additional ambulatory patients may be added when fewer litter spaces are used.
Local/State Responsibilities	<ul style="list-style-type: none"> • State must transport patients from originating locations to APOE. • State must identify airfields that meet DoD requirements, including: <ul style="list-style-type: none"> ○ 5000 ft. x 80 ft. minimum for runway ○ Parking spaces for two (2) aircraft ○ Recommended building-of-opportunity for staging patients: <ul style="list-style-type: none"> ▪ 12,000 sq. ft. building of opportunity ▪ Within 100 ft. of aircraft parking ▪ 72" door ▪ Power ▪ Potable water and restroom access ▪ Ambulance access ▪ If no building is available, space should be available for tents adjacent to parking • Form 4 (Information required by federal agencies to transport patients using NDMS) must be generated at originating patient locations (e.g., facility or CCP) in an Excel spreadsheet format; this information should be sent to the Joint Patient Movement Advisor Team (JPMAT) located at the state EOC that will load the information into the medical regulating system and transmit to the TPMRC-A (US TRANSCOM). • Provide space at state EOC for 4-6 personnel (called the Joint Patient Movement Advisor Team) to work with senior state medical officials and hospitals to ensure that the required Form 4 data are collected and transmitted to the TPMRC-A (US TRANSCOM). Once validated, the JPMAT works with the state EOC and hospitals to ensure patients arrive at the DASF at proper times. <i>(Note: This requirement was also noted in DASF section).</i> • If scarce resources necessitate prioritization, senior state officials will provide the necessary guidance to the federal Joint Patient Movement Advisor Team located at the state EOC.
Through-Put	Each APOE can process a maximum of 140 patients/day. Four (4) APOE's can process a maximum of 560 patients/day (4 x 140).



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	FIXED-WING AEROMEDICAL EVACUATION AIRCRAFT
Owner	DoD (a component of NDMS)
Patient Tracking	JPATS
Exclusions/Limitations	For DoD transport, see “ <i>Standard Contraindications to Federal Aeromedical evacuation</i> ”. DoD-excluded patient types should be directed to private ground or air ambulances when necessary (e.g., neonates).



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	MEDICAL COMPANY (ROTARY WING AIR AMBULANCE)
Owner	DoD (optional at discretion of DoD)
Mission/Capability	<ul style="list-style-type: none"> • Rapid movement of critical medical personnel or equipment/supplies to meet requirements of mass casualties, reinforcement/reconstitution or emergency situations. • Move patients between healthcare facilities and aeromedical staging facilities, railheads or seaports.
Request Guidance	<u>This resource is activated based on internal DoD procedures to support patient movement mission assignments.</u>
Maximum # Available	<ul style="list-style-type: none"> • 5 Forward Support MEDEVAC Platoons capable of simultaneously operating in 5 different locations as part of an Aviation Task Force • 109 military personnel per MEDEVAC company • 15 UH-60 Blackhawk Helicopters
Local/State Responsibilities	<ul style="list-style-type: none"> • Pre-identify helipads and coordinate with Cal OES to have DoD inspect/certify helipad for military use • Aircraft heavier than civilian aircraft • Requires 30+ meter diameter landing space • No greater than 15-degree slope • Landing area free of obstacles and clear of potential projectiles created by rotor wash
Through-Put	Each UH-60 Blackhawk can transport 6 litter or 7 ambulatory patients (or combination) with carousel <u>or</u> 3 litter or 4 ambulatory patients (or combination) without carousel.
Patient Tracking	JPATS
Exclusions/Limitations	For DoD transport, see “ <i>Standard Contraindications to Federal Aeromedical evacuation</i> ”. DoD-excluded patient types should be directed to private ground or air ambulances when necessary (e.g., neonates).



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	MEDICAL COMPANY (GROUND AMBULANCE)
Owner	DoD (optional at discretion of DoD)
Mission/Capability	<ul style="list-style-type: none"> • Move patients between healthcare facilities and aeromedical staging facilities, railheads or seaports. • May be more appropriate to use to evacuate patients in lower acuity settings, e.g., nursing homes. • Area evacuation support beyond the capability of area support medical companies. • Emergency movement of medical supplies.
Request Guidance	<p><u>This resource is activated based on internal DoD procedures to support patient movement mission assignments.</u></p>
Maximum # Available	<ul style="list-style-type: none"> • 24 ambulances that can deploy as individual vehicles or as a group. • 65 personnel per Medical Company.
Through-Put	Single lift evacuation of 96 litter patients or 192 ambulatory patients.
Local/State Responsibilities	<p>The state is expected to communicate expectations to local jurisdictions that adequate patient documentation is required for DoD to accept the responsibility for patients during federal patient movement. The required documentation includes the data in Form 4 (Information required by federal agencies to transport patients using NDMS) and medical records including diagnosis, allergies, medications, treatments, medications and emergency family contacts.</p>
Patient Tracking	JPATS
Exclusions/Limitations	<p>For DoD transport, see <i>“Standard Contraindications to Federal Aeromedical evacuation”</i>. DoD-excluded patient types should be directed to private ground or air ambulances when necessary (e.g., neonates).</p>



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	JOINT PATIENT ASSESSMENT AND TRACKING SYSTEM (JPATS)
Owner	NDMS
Capability	<ul style="list-style-type: none"> • JPATS is the official tracking system of NDMS; data entry into JPATS is necessary for federal movement of patients and reimbursement by receiving healthcare facilities. • Two (2) JPATS teams will be deployed at each APOE. • Two (2) JPATS teams will be deployed at each APOD. • JPATS is a web-based application that is available to states at no charge. In addition, NDMS has created an Excel file structure that allows data entry and subsequent import into JPATS. The Excel file is named the Form 4. Information required by federal agencies to transport patients using NDMS. This template should be used by sending facilities and MHOAC Programs to communicate necessary patient information to the Regional Patient Movement Coordination Function and State (CA-ESF 8) Patient Movement Function in the MHCC. • For security purposes, NDMS will password-protect the files that are being sent for import and export (or other secure means of file transport). NDMS will communicate with the appropriate state and local personnel for clear direction and coordination regarding the delivery and receipt of the files.
Maximum Number Available	N/A
Local/State Responsibilities	<ul style="list-style-type: none"> • Provide JPATS information for all patients using the federal patient movement system via JPATS or the Form 4 spreadsheet. • The state does not request FCC activation in its federal resource request; FCCs are activated based on internal NDMS procedures to support federal patient movement mission assignments.
Throughput	N/A
Patient Tracking	JPATS
Exclusions/Limitations	For DoD transport, see <i>“Standard Contraindications to Federal Aeromedical evacuation”</i> . DoD-excluded patient types should be directed to private ground or air ambulances when necessary (e.g., neonates).



CALIFORNIA PATIENT MOVEMENT PLAN



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	TRANSPORTATION COMMAND REGULATING AND COMMAND AND CONTROL EVACUATION SYSTEM (TRAC2ES)
Owner	DoD
Mission/Capability	<p>TRAC2ES is an automated DoD information system that supports global patient movement. It supports:</p> <ul style="list-style-type: none"> • Coordination of DoD patient transportation ground vehicles and aircraft. • Patient movement logistical operations. • Aeromedical clinical decision elements.
Local/State Responsibilities	<ul style="list-style-type: none"> • Minimum data elements are needed for each patient transported by the federal patient movement system. The data elements may be provided via JPATS or an Excel spreadsheet that can be exported to JPATS, which is used to populate TRAC2ES. • The minimum data elements are contained in the Form 4. Information required by federal agencies to transport patients using NDMS, an Excel spreadsheet.
Maximum # Available	76 personnel
Through-Put	N/A – supports maximum NDMS through-put of 560 patients/day
Patient Tracking	JPATS
Exclusions/Limitations	For DoD transport, see “ <i>Standard Contraindications to Federal Aeromedical evacuation</i> ”. DoD-excluded patient types should be directed to private ground or air ambulances when necessary (e.g., neonates).



CALIFORNIA PATIENT MOVEMENT PLAN

Name of Resource	SERVICE ACCESS TEAMS (SATs)
Owner	HHS (a component of NDMS)
Capability	<ul style="list-style-type: none"> • A Service Access Team (SAT) consists of US Public Health Service (USPHS) personnel are responsible for: <ul style="list-style-type: none"> ○ Tracking and monitoring patient status once admitted to an NDMS hospital (this information will be updated into JPATS) ○ Provide information to family members ○ Coordinate lodging and human services needs for all discharged patients until transportation to their final destination can be facilitated. This also includes lodging and human services for non-medical attendants (e.g., family members) and service animals. • Initially, the SAT's operating location will be the receiving Federal Coordinating Center (FCC). SAT personnel will deploy with a Patient Tracking Kit and/or standalone Electronic Medical Record (EMR) kit that includes communications capability. • SATs can be deployed within 36 hrs of activation.
Local/State Responsibilities	N/A. This resource is activated/deployed whenever federal patient movement occurs.
Patient Tracking	JPATS
Exclusions/Limitations	N/A