EMERGENCY SUPPORT FUNCTION 8
PUBLIC HEALTH AND MEDICAL

PATIENT MOVEMENT SUPPORT
STANDARD OPERATING GUIDELINE

Florida Department of Health,
Division of Emergency Preparedness and Community Support
Bureau of Preparedness and Response

December, 2013

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TITLE: State ESF8 Patient Movement Support Standard Operating Guide

DATE: December 2013

I. PURPOSE

The purpose of this Standard Operating Guide (SOG) is to describe the State ESF8's plan to monitor and coordinate resources, in support of the movement of patients in impacted areas where local health and medical systems are overwhelmed and have requested assistance from State ESF8.

II. SITUATION

A. Monitoring and coordinating resources to support care and movement of persons with medical and functional needs in impacted counties is one of State ESF8's 11 core missions as described in Florida's Comprehensive Emergency Management Plan (CEMP) Appendix VIII: ESF8 – Public Health and Medical Services.

In order to fulfill this mission, State ESF8 must be prepared to support facility evacuation or decompression for noticed incidents or events (storm-related pre-landfall or post-impact) or no-notice incidents (tornados, mass casualty incidents, etc.).

Statewide healthcare system monitoring will be conducted and assistance provided when requested by local jurisdictions. This may include coordination and resource support from external partners through the State Emergency Response Team (SERT) or the Emergency Management Assistance Compact (EMAC).

B. If local medical system capacity is exceeded, ESF8 must be prepared to support the following patient movement functions:

1. **Patient coordination** - medical system monitoring and patient placement/destination coordination.
2. **Patient transportation** – the physical movement of patients from one location to another.
3. **Emergency treatment and stabilization** – helping to reconstitute necessary critical services to assure communities have access to appropriate care.
4. **Patient Movement Coordination with State Emergency Response Team Air Operations** – ensures that air movement assets are used effectively.
5. **Large-scale patient movement** – moving a large number of patients from the impact area in bulk.
6. **Patient tracking** – the ability to know, at any given time, the location and the status of a patient from the time of movement to the time of return.
7. **Patient return** – transporting a patient back to their originating medical facility, a step-down facility, or their residence.

C. Florida's Health and Medical System consists of:

1. **300 Licensed Hospitals**[1] (64,694 licensed beds) of which **218 are Acute Care Hospitals**[2]

   a. A **trauma system** consisting of the following centers[3] (see Figure 1 for a map of Florida's Trauma Centers and Acute Care Hospitals)

      - 8 Level I Trauma Centers
      - 13 Level II Trauma Centers
      - 3 Level II/Pediatric Trauma Centers
      - 2 Pediatric Trauma Centers
      - 1 Provisional Level I Trauma Centers
      - 1 Provisional Level II Trauma Centers

   b. **78 Burn Beds**[4]. Of those 78 beds, only 2-10 are available on any given day. Burn patients may be treated in an Intensive Care Unit (ICU) bed, as not all burn patients need to be treated in a designated burn bed. See Reference V, The Southern Region Burn Disaster Plan, for the regional burn disaster plan for the 24 burn centers located in the 11 states comprising the Southern Region of the American Burn Association. Florida's burn beds are located in the following facilities:

      - Tampa General Hospital – 18 beds
      - University of Florida Health Shands Hospital Gainesville – 20 beds
      - Ryder Trauma Center, University of Miami/Jackson Memorial Medical Center – 30 beds
      - Orlando Regional Medical Center -10 beds

2. **682 Nursing Home Facilities** (83,342 beds) – a nursing home is a facility which provides nursing services as defined in part I of chapter 464, F.S. and which is licensed according to this part.

3. **3,035 Assisted Living Facilities** (86,514 licensed beds) - An assisted living facility (ALF) is designed to provide personal care services in the least restrictive and most home-like environment. These facilities can range in size from one resident to several hundred and may offer a wide variety of personal and nursing services designed specifically to meet an individual's personal needs.

[1] Agency for Health Care Administration Active Health Care Provider Report, December 2, 2013
[2] Agency for Health Care Administration Beds and Services List, July, 2013
[3] Bureau of Emergency Medical Oversight, March 29, 2013
[4] American Burn Association (ABA) Burn Care Facility Report – August, 2013

Bed availability data for the aforementioned facilities will be collected through Florida's designated facility status system {currently the Agency for Health Care Administration's (AHCA) Emergency Status System (ESS)}. EMResource is another tool that is used in many counties to monitor bed tracking and situational assessment reporting requirements. EMResource also streamlines communications between medical response teams and healthcare providers by monitoring healthcare assets, emergency department capacity, and behavioral health and dialysis bed status.

Compliance has been low for the self-reporting of facility status information and additional verification of data has been necessary. Multiple systems/sources are being used. The State ESF8 Situation Unit compiles data from multiple sources/systems to maintain state-wide facility status.

4. **Emergency Medical Services (EMS) vehicles and aircraft[5]**

Total # EMS permitted Vehicles and Aircraft	Advanced Life Support (ALS) Transport	ALS non-transport	Basic Life Support (BLS)	Helicopters (rotary-wing)	Airplanes (fixed-wing)
4379	2367	1498	391	55	68*

* Many of these fixed-wing airplanes are private contract only and will not be immediately available.

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[5] Division of Medical Quality Assurance COMPAS DataMart Reporting System – EMS Permitted Vehicles Report, May 30, 2013

Figure 1: Florida's Trauma Centers and Acute Care Hospitals

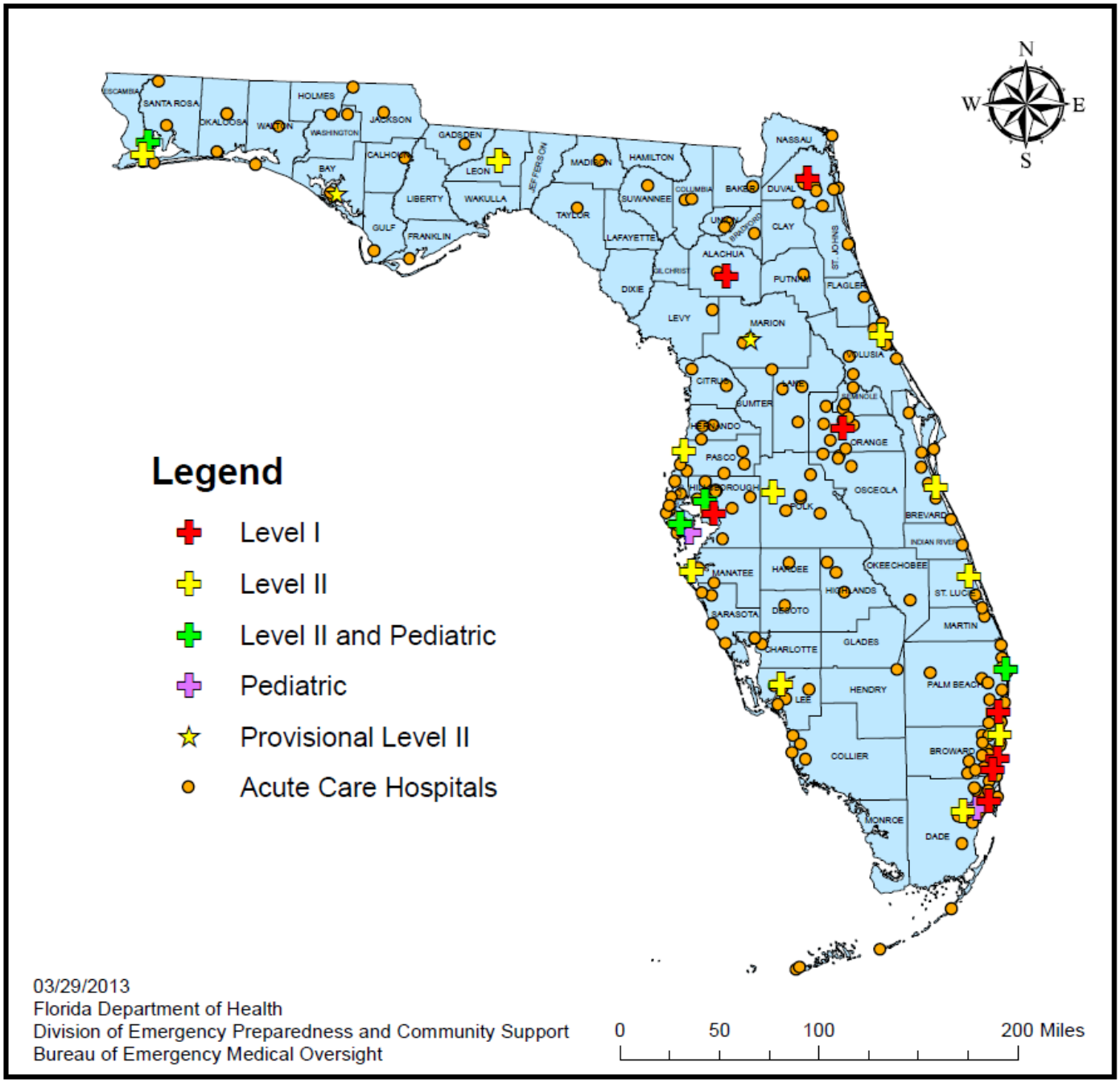
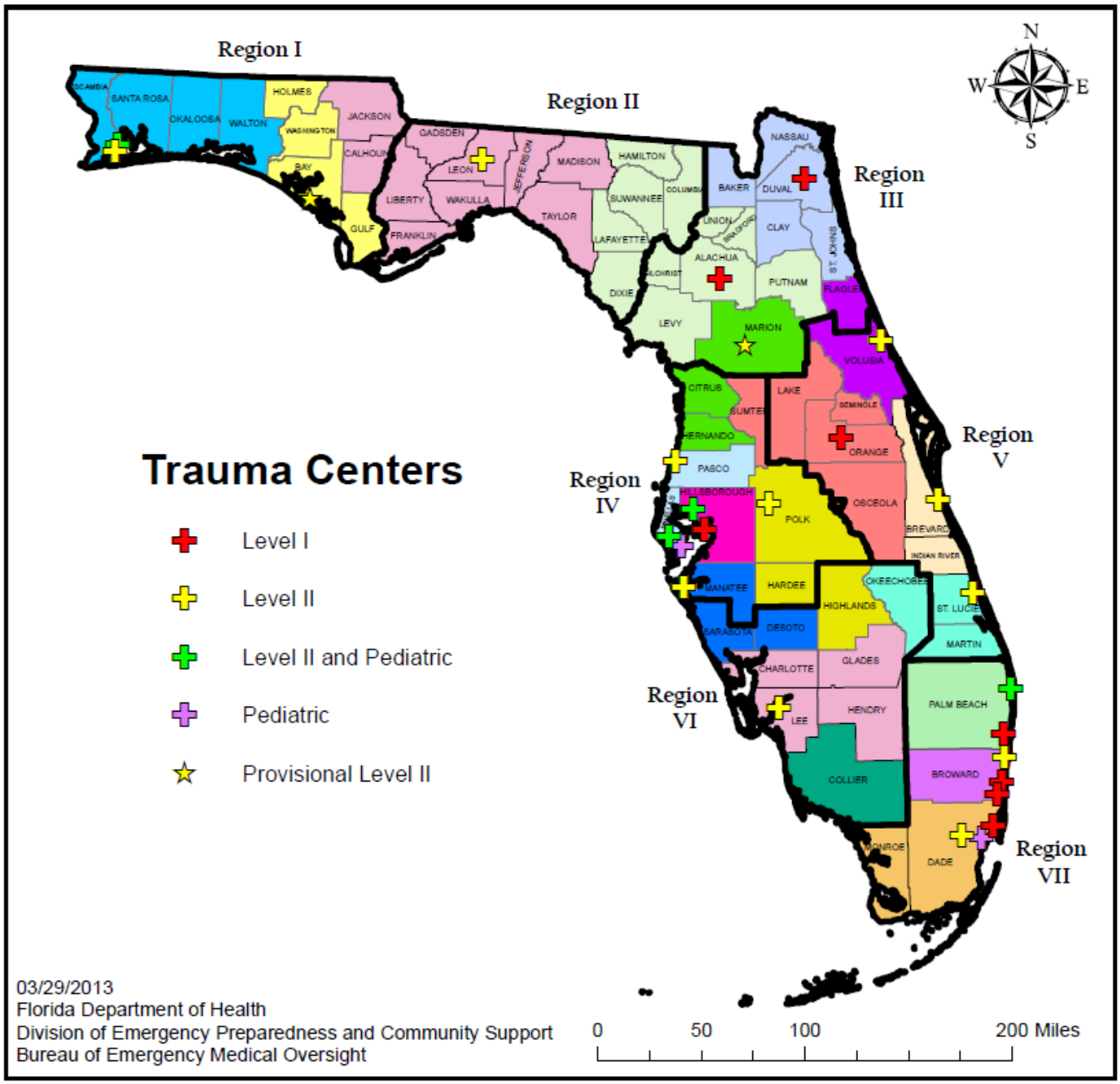


Figure 2: Florida's Trauma Centers by Trauma Service Area and RDSTF



D. Patients may flow through the following locations within local, state and federal systems. See Figure 3 for a graphic depiction of the flow. The red numbers on the diagram correspond with numbers in the text as follows:

1. Processing at and movement of, patients from the point of origin.
   1A. Treat and release – discharged from the scene
   1B. Scene to healthcare facility (initial receiving facility)
   1C. Scene to alternate care site (ACS)

2. Facility Decompression (at facility request) with patients moved from healthcare facilities (initial receiving facilities) to one of the following**:**
   2A. Discharge
   2B. Healthcare facility (initial receiving facility) to healthcare facility (secondary receiving facility) transfers.
   2C. Healthcare facility to Alternate Care Site (ACS)
   2D. Healthcare facility to Aerial Point of Embarkation (APOE)

3. Hold/Care at Alternate Care Site (if operational)
   3A. Treat and release
   3B. ACS to healthcare facility
   3C. Transport from ACS to Aerial Point of Embarkation (APOE)

4. Transport from POE to Aerial Point of Debarkation (APOD) – Patient Reception / Receiving Site

5. Transport from APOD to secondary receiving facility

6. Patient discharge and return

Figure 3: Conceptual Patient Movement Flow

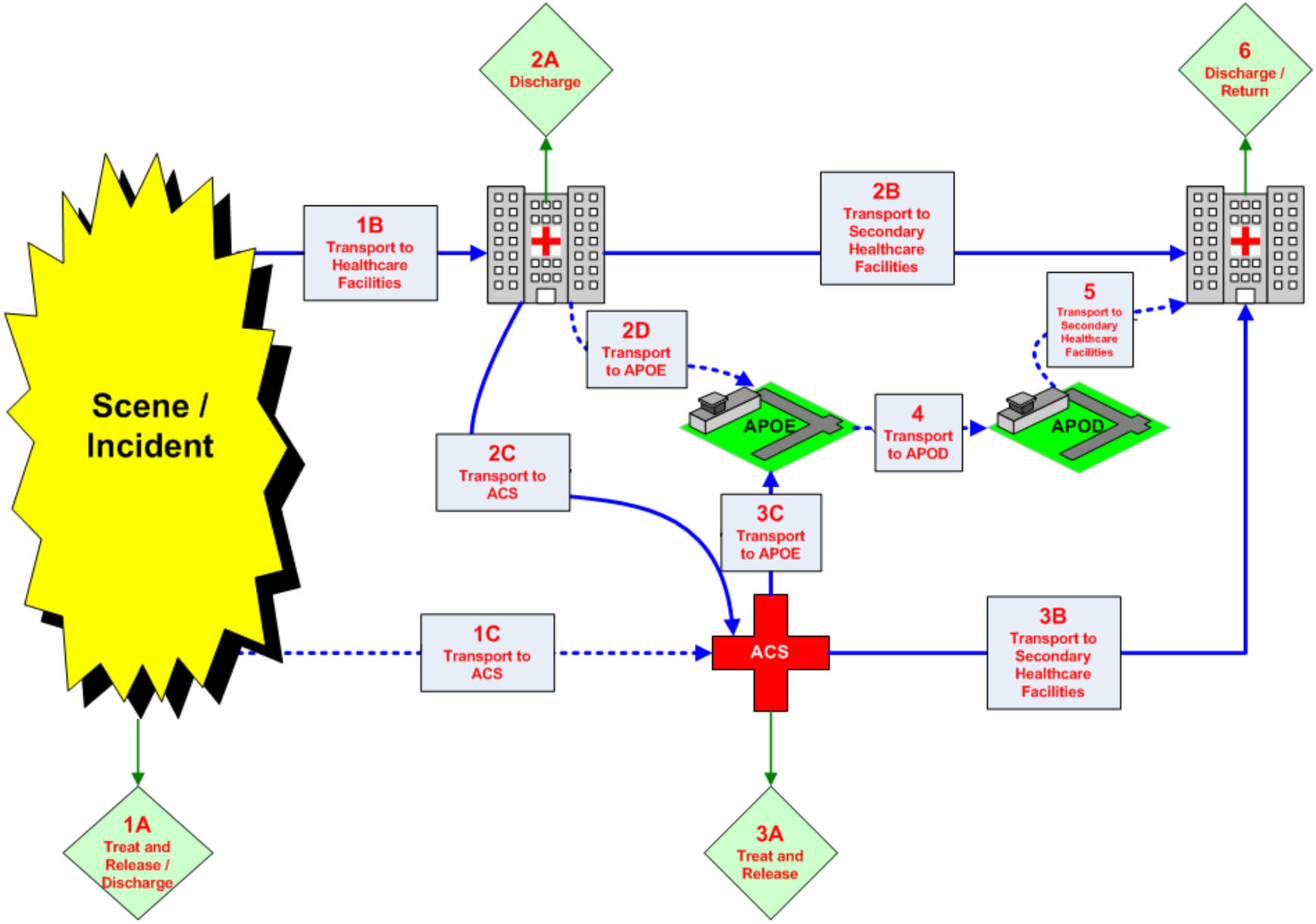


Figure 4: Potential Patient Movement Resource Listing

The following table illustrates potential resources to support each patient movement function.

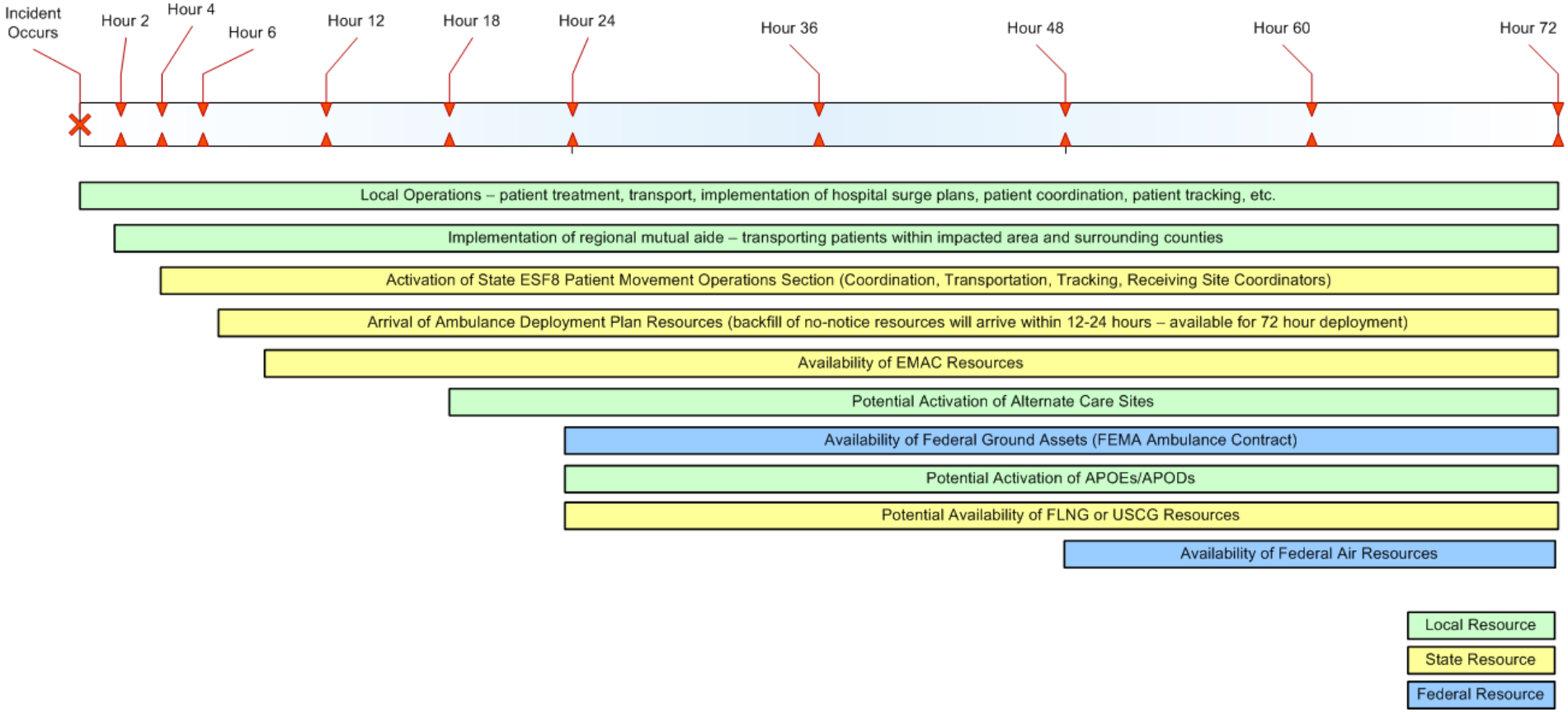
Function / Capability	Potential Resources			
	Local	State	EMAC	Federal
Patient Transportation	• Local response units • Mutual aide resources • Medical Support Unit buses (Jacksonville Fire Rescue, Alachua County Fire Rescue) • Buses (school and mass transit)	• Ambulance Deployment Resources • ESF1 Resources – (non-ambulance resources – buses, etc.) • State Multi-Modal Transportation Contract (private) • Florida National Guard	• AL – 108 bus stretcher conversion kits • MS – 13 bus stretcher conversion kits • NC – 11 Ambuses • TN – 8 bus stretcher conversion kits • Ground/Air ambulances	• FEMA National Ambulance Contract • VA Dual Use Vehicles • NDMS – Patient Movement (DoD aircraft) • USCG (air)
Emergency Treatment and Stabilization	• Hospital employees • Hospital staffing contracts • Medical Reserve Corp • Non-affiliated volunteers	• State Medical Response Teams • Medical Reserve Corps • Nursing contracts	• State Medical Response Teams • Medical Reserve Corps	• DMAT
Patient Coordination	• Local ESF8 • Regional Patient Coordinators	• State ESF8 Patient Coordination Group	• Region IV UPC	• NDMS – Definitive Care • Service Action Teams
Patient Tracking	• EMS provider trip sheets • EM Track (in some counties) • Manual tracking systems	• State ESF8 Patient Tracking Group • EM Track • Manual tracking system	N/A	• JPATS • JPATS Strike Team

Patient Receiving Site (Large Scale Patient Movement)	• APOEs (capability varies by region)
	• APODs (capability varies by region)
		• APOE and APOD support
		  ○ Supplies/Equipment
		  ○ Establishing and managing the health and medical components
			• Reception States/Sites	• FCCs
				• DASF / MASF

Liaisons / Advisors	• Healthcare Coalitions	• State ESF8 Patient Movement Branch • DOH Liaison to HHS IRCT (if IRCT is activated)	• Region IV UPC	• HHS REC • NORTHCOM JRMPO • TRANSCOM • IRCT Liaison (for patient tracking or DMAT data)

Figure 5: No-Notice Resource Availability Timeframes

This graphic depicts the estimated timeframes in which resources would be available to support a no-notice incident/event requiring patient movement.



III. ASSUMPTIONS

A. The term 'patient', for the purposes of this SOG, is defined as an individual who cannot receive adequate health and medical care in the impacted area. This may include individuals who are sick, injured or wounded, and those with special medical needs.

B. During mass casualty incidents, local jurisdictions will follow existing comprehensive emergency management plans, and healthcare facilities existing surge and evacuation plans.

1. Initially, patients will be moved from the scene to the nearest facility. As the nearest facilities reach capacity, patients will be moved to facilities increasingly further away.

    a. Mutual aid may be used to move patients to surrounding counties and throughout the region.
    b. Small numbers of patients may be moved via ground and air ambulance, through direct facility to facility transfer. However, resources may be quickly overwhelmed and these plans may fail during larger or more severe incidents/events. Existing surge on facilities may be a factor (i.e. seasonal flu outbreaks).
    c. Patient movement support may be requested if local capabilities are exceeded.

2. In larger, more severe incidents, patients may need to be moved out of the county/region due to lack of capacity or specialized medical capabilities. State assistance may be requested. Local, regional and state personnel will work to place patients in non-impacted counties/regions. Patient destinations will be pre-determined and additional transportation resources may be requested according to Florida's Ambulance Deployment Plan Standard Operating Procedure to facilitate the movement.

3. In the case of a major or catastrophic incident resulting in a large number of casualties, local, regional, and state capacities may be exceeded and Emergency Management Assistance Compact (EMAC) and Federal assistance may be requested. Large numbers of patients may be sent via ground and air to points of debarkation in non-impacted areas. Although all efforts will be made to pre-determine final destinations for patients prior to arriving at points of debarkation, host communities should be prepared to place patients if needed.

C. Decisions to evacuate, and who to evacuate, are always local decisions.

1. Based on the size, scope, and scale of the event, existing evacuation plans may be rendered invalid or ineffective.

2. Intrastate evacuations will be the first option for patient movement, if possible. The greater and more complex the patient movement, the greater the risk of a poor outcome to the patient.

3. Evacuated patients should be kept as close to their original location as possible.

4. Hospitals may choose to decompress current inpatients to accommodate the surge of casualties.

D. Pediatric capability is limited, including resources to transport pediatric patients. Local/Regional Healthcare Coalitions may be a resource to pre-identify pediatric populations and resources to treat and transport pediatric patients.

E. Availability of EMS assets may be limited during disasters due to competing operational commitments.

F. All evacuations are subject to weather conditions and safety considerations.

G. Any potentially contaminated patient must be decontaminated before transport.

H. Patients will be stabilized prior to movement. Level of stabilization may vary.

I. During the patient movement process, the continuum of care must be maintained.

J. Patients may decompensate during transport.

K. Every attempt to ensure medical caregivers are transported with their corresponding patients should be made.

L. Various tracking systems/processes will be used from the time of injury to time of release. Because these systems are not integrated, there is potential for a greater margin for error, inconsistent tracking, and duplication of services.

M. The state should use all available state and local resources in their planning to include, but should not be limited to Statewide Mutual Aid agreements, Emergency Management Assistance Compacts (EMAC) agreements, and the Florida National Guard prior to requesting federal support for patient movement.

N. 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.

O. 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. See Section 4F for an overview of federal support. Federal patient movement support is expected within 48 hours.

P. Military aircraft are designed to transport average sized soldiers. Due to size constraints, bariatric and pediatric patients may not be appropriate for transport on these aircraft.

Q. Staging of federal resources should be coordinated between state and federal officials. Federal resources should not be deployed without a mission assignment.

IV. OPERATIONS

State ESF8 is prepared to coordinate resources to support the movement of persons with medical and functional needs in impacted areas where local health and medical systems are overwhelmed. The support needed by impacted counties will vary based on local capabilities and the size and severity of the incident/event. Available support is scalable. State ESF8 support can include any or all of the following functions:

A. Patient Coordination (situational assessment and patient placement)
B. Patient Tracking
C. Emergency Treatment and Stabilization
D. Patient Transportation
E. Patient Movement Coordination with SERT Air Operations
F. Large-Scale Patient Movement
G. Patient Return
H. Request and Integration of EMAC Resources
I. Request and Integration of Federal Patient Movement Resources

Upon receipt of a local request, the State ESF8 Patient Movement Branch will be activated. The Patient Movement Branch will be comprised of the following:

A. Patient Coordination Group (medical specialists with hospital and medical diagnosis proficiency)
    - Regional Patient Coordinators have been identified in each region to assist in coordinating patient placement. A Regional Patient Coordinator (RPC) is familiar with the health care system within his or her region or county and serves as a local point of contact for State ESF8. Upon request from State ESF8, an RPC will coordinate the placement of patients in appropriate facilities based on capability and capacity and the patients' acuity and required medical treatment/interventions.
B. Patient Transportation Group (EMS liaisons to coordinate with ESF4&9, FFCA, and FAMA)
C. Patient Movement Onsite Coordinator
D. Patient Tracking Group
E. Branch Tactical Planner

The following section provides an overview of the support available through State ESF8.

For detailed information regarding actions/tasks required to provide the requested support, refer to:
Attachment E, Patient Movement Branch Sequence of Activities
Attachment F, Patient Movement Branch Position Checklists

Figure 6: Patient Movement Operations Section Organizational Chart

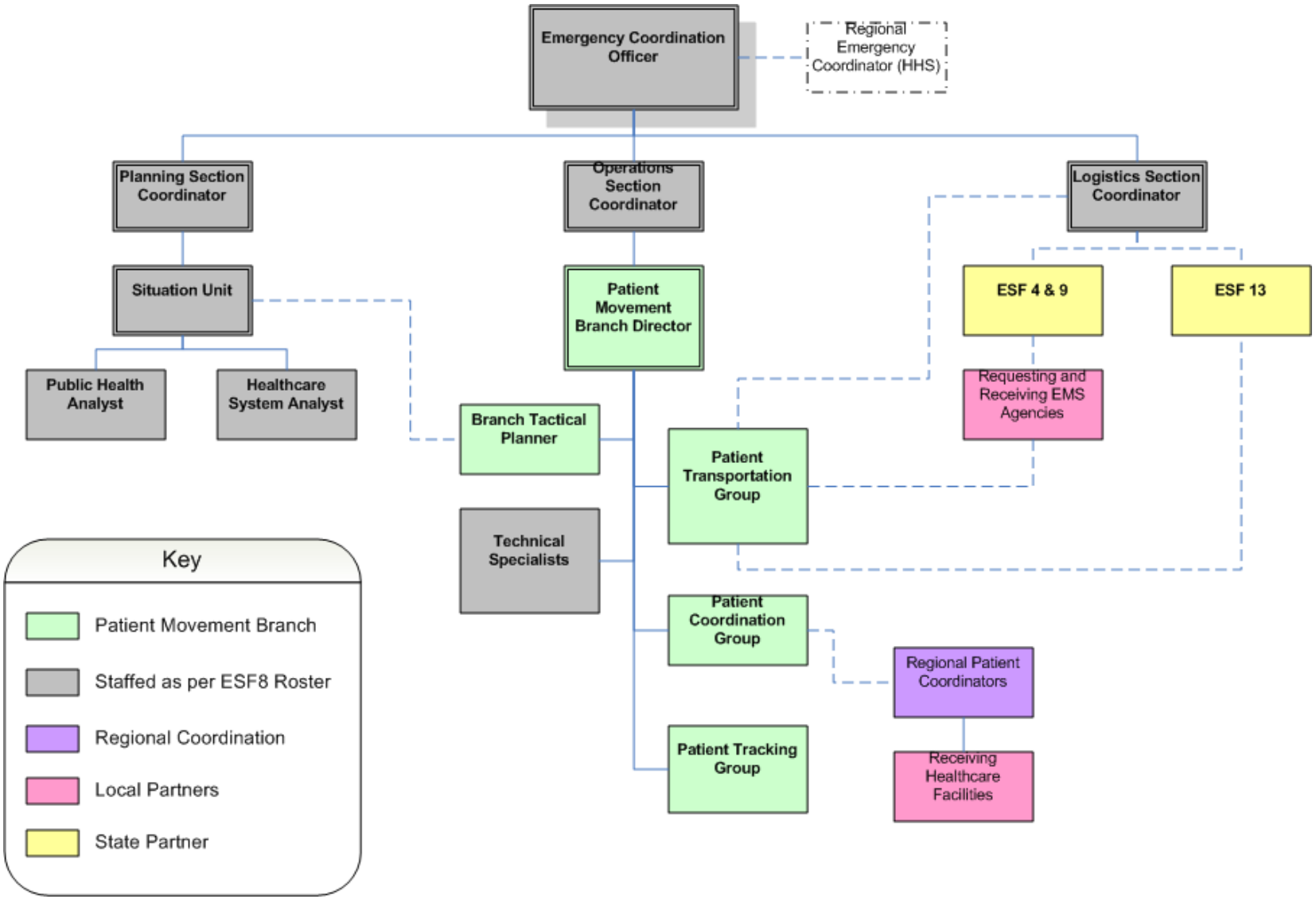
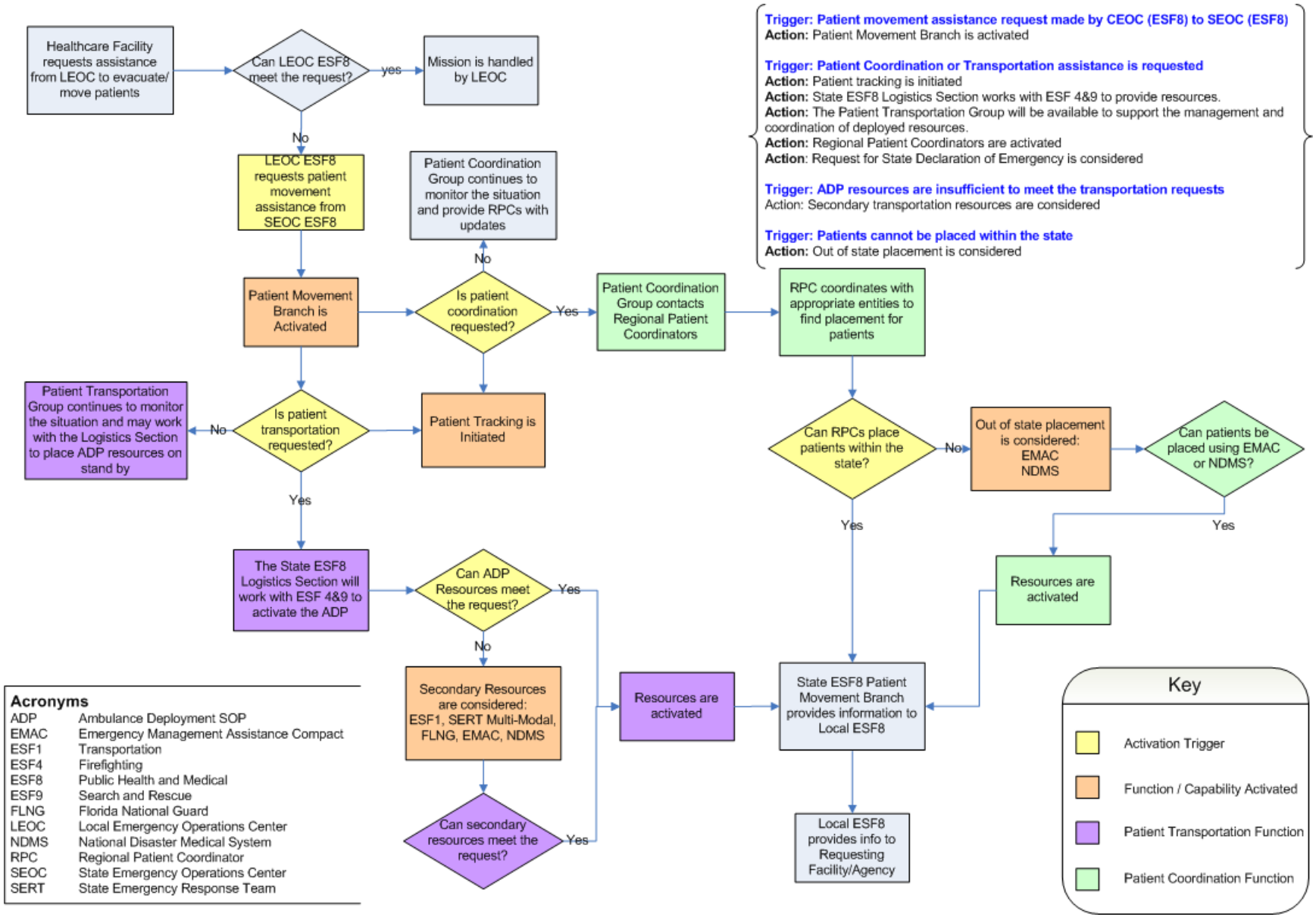


Figure 7: Request and Activation of State ESF8 Patient Movement Branch - Triggers and Potential Actions



A. Patient Coordination (situational assessment and patient placement)

Patient Coordination refers to:

1. Conducting situational assessment (state-wide medical system monitoring)
2. Coordinating the placement of patients in an appropriate facility based on their level of acuity and needs.

Licensed healthcare facilities are required to have pre-established evacuation plans with patient receiving facilities pre-determined. However, these plans may fail during the response for multiple reasons.

1. If a facility determines it is necessary to evacuate or decompress by transferring patients to another facility, assistance can be obtained by making a request to their local emergency operations center (LEOC) through Local ESF8.

2. Local personnel have the best knowledge of available facilities and the capacity and capability to accept patients. Centralized coordination will be required between hospitals, emergency medical services and receiving airports in order to minimize undue surge on any one hospital.

3. If local personnel need assistance in placing patients, they will make a request to the state through their LEOC. See Attachment C, State ESF8 Patient Movement Request Guidance for essential information requirements.

4. Management and coordination of medical evacuees is best coordinated at the local/regional level with support and system-wide monitoring from the state. Although regional coordination is the primary method of operation, State ESF8 is prepared to fully facilitate patient coordination responsibilities when regional infrastructures are not available or capable of doing so.

    a. The State ESF8 Situation Unit (Healthcare System Analysts and Public Health Analysts) will conduct statewide monitoring and reporting of medical system impacts. Reports may include:
        i. Healthcare communications monitoring/current bed availability (capacity and capability)
        ii. Emergency Department capacity and potential through-put
        iii. Healthcare facility status
        iv. Potential for healthcare facility evacuation
        v. Status of the Emergency Medical Services (EMS) system
        vi. Epidemiology and environmental health impacts

    b. Regional Patient Coordinators (RPC) will be provided with situational updates at the onset of an incident/event. Upon receiving an official request from Local ESF8, for patient placement, the Patient Coordination Group will determine which region(s) will receive patients and forward the request to the corresponding Regional Patient Coordinators. Patient tracking will be initiated at this point.

c. The RPC will coordinate with appropriate people in the region to facilitate patient placement and report back to State ESF8.

d. State ESF8 will coordinate patient transportation (if requested) and communicate the patient's destination and transportation information back to the Local ESF8.

B. Patient Tracking

1. Patient tracking is the ability to know, at any given time, the location and status of a patient from the time of first encounter by an emergency responder until his/her release from care. Potential tracking points may include:

   a. Incident scene/Initiating facility
   b. Departures
   c. Transports
   d. Arrivals
   e. Patient discharges

2. Patients moved during local operations may be tracked using a variety of systems, including a web-based application (EM Track), ambulance provider trip sheets, patient registration systems, and manual tracking systems (spreadsheets). It is highly unlikely systematic patient tracking will begin at the incident scene. It is anticipated formal patient tracking will be initiated when the patient is identified for movement.

   a. Although State ESF8 will not be tracking patients moved at the local level, situational awareness and healthcare system monitoring will be maintained through the Situation Unit.

3. State ESF8 is responsible for tracking patients once a local request is made for assistance with patient coordination or transportation. Patients will be tracked until the patient is released, returned, deceased, or as otherwise determined by the Patient Movement Branch Director.

4. Patients should be linked to emergency contacts to assist with family reunification. Guardian information must be collected for pediatric patients being transported

5. The Patient Tracking Group will be responsible for obtaining data from multiple sources and merging it into a single patient tracking system. The following systems may be used:

   a. A tracking process consisting of an Excel Spreadsheet and paper back-up. See Attachment D, State ESF8 Patient Tracking Form.

   b. EM Track is designed to track the location of patients and their conditions as well as other important information.
      i. If the impacted jurisdiction is using EM Track for patient tracking, State ESF8 has the ability to access this information.
      ii. If the impacted jurisdiction is not using EM Track, the system can be used as a web-based database allowing real-time monitoring by multiple users.

6. Where Federal ESF8 partners are engaged in patient movement, and patient tracking is employed, the Joint Patient Assessment and Tracking System (JPATS) will be used to maintain visibility of patients transported using the federal patient movement system. Florida will not have access to JPATS, but will maintain visibility of patients in the federal system through an Incident Response and Coordination Team (IRCT) Liaison.

    a. If the FEMA National Ambulance Contract is utilized for patient transportation, State ESF8 will be responsible for maintaining patient tracking data.

C. Emergency Treatment and Stabilization

State ESF8 is prepared to support the stabilization of the impacted community by helping to reconstitute necessary critical services to help assure populations have access to appropriate levels of care based on patient acuity and to prevent adverse health outcomes as a result of an incident. The following are examples of resources that can be requested to support emergency treatment and stabilization:

1. The **Florida State Medical Response System (SMRS**) provides medical care surge to the survivors of and responders to a Florida disaster, and to support ESF-8 infrastructure and operations at regional and local jurisdictions where and when the public health and medical infrastructure is overwhelmed. The Florida Department of Health SMRS is comprised of the State Medical Response Teams (SMRT), the Florida Advanced Surgical and Transport Team (FAST) and medical caches.

    a. Three 50 bed **Gatekeeper Mobile Medical Systems** (Western Shelter Systems)
    b. **Medical** (supplies and equipment)and **Pharmaceutical Caches**

2. **Mass Casualty Incident (MCI) Support Units (Trailers)** Enclosed trailers with medical supplies and equipment that may be needed in trauma situations for mass casualty incidents. Trailers each have a dedicated prime mover to haul them when needed.

3. **Disaster Behavioral Health Assessment Teams** provide on-scene assessment of the need for behavioral support services to victims, survivors, responders, and the public communities impacted by traumatic events.

4. **State Pharmaceutical Caches**
    a. Chempack nerve agent antidotes supported by the Centers for Disease Control and Prevention (108 containers throughout the state)
        - 73 EMS containers – auto injector (each container can treat 454 patients)
        - 35 hospital containers – bulk medication (each container can treat 1000 patients)
    b. Radiation Packs - Potassium Iodide, Prussian Blue, diethylene triamine pentaacetic acid (DTPA)
    c. Antibiotic (Doxycycline, Ciproflaxin, Amoxicillin) and antiviral (Tamiflu, Relenza) stockpiles

5. **Portable Ventilator Caches –** The Department of Health maintains a cache of 787 portable generators.
   a. 137 portable ventilators are stored in Region 2 (North Florida).
   b. 280 portable ventilators are stored in Region 5 (Central Florida).
   c. 290 portable ventilators are stored in are stored in Region7 (South Florida).
   d. 80 portable ventilators are maintained as part of the SMRT/FAST caches.

D. Patient Transportation

The Florida Ambulance Deployment Standard Operating Procedure (SOP) establishes a mechanism for State ESF8 to marshal and deploy ground and air emergency medical services (EMS) assets during a disaster response. Specific missions for EMS assets may include:

- Augmentation of day to day EMS services
- Patient and medical facility evacuation support
- Patient triage and transport

1. Request for EMS assets to the state must be coordinated through the LEOC and documented in EM Constellation. EM Constellation is a web-based platform adopted by the State of Florida as an information management solution for emergency management. The platform allows county, state, federal and mutual aid entities to use the same operating environment when responding to and recovering from an emergency.

   a. Resources should be requested by asset typed descriptions, and include a capability based description of how the resources will be used as part of the operation.

   b. Missions for EMS assets will be assigned to State ESF8. Once validated, State ESF8 will request EMS resources deployment from State ESFs 4 & 9 or the Florida Air Medical Association (FAMA), depending on the type of resource requested.

2. Ground ambulances, emergency medical technicians (EMTs) and paramedics will be identified, mobilized, deployed and demobilized through the Florida Fire Chiefs Association, State Emergency Response Plan (SERP).

   a. Resources will not be pulled from areas designated as receiving sites if it will impact their ability to transport the received patients.

   b. The Florida Ambulance Deployment SOP can also be activated for receiving sites.

3. Air ambulance resources will be identified, mobilized, deployed and demobilized through the Florida Air Medical Association per the Florida Air Medical Services Disaster Response Plan.

   a. Rotary-wing aircraft
      i. As of April 2013, licensed rotary-wing air ambulances in Florida consist of 55 licensed helicopters.

ii. Due to the dynamics of aero medical transport, it is not practical to pre-alert rotary-wing aero medical assets. This support must be coordinated at the time of the event. When requesting aero medical support, consider the following:
- Pilots are limited (by FAA regulations) to 12 hour flight times.
  - For example, at the incident time, if the requested rotor-wing pilot has been on duty for "x" hours, and the mission time will take him/her past the 12 hour window, that asset will not be available until the vendor arranges for additional pilots.
  - If pilots would be needed beyond the 12 hour shift period, logistics must be arranged. If the operations period is extended over several days, the vendor may be willing to coordinate this.
- Flight range is 150 nautical miles round trip.
- Fuel must be available (FAA approved fuel for medical aircraft) and accessible.
- Maintenance / service must be available, if needed.

b. Fixed wing aircraft
   i. As of March 18, 2013, licensed fixed-wing air ambulances in Florida consist of 68 fixed-wing aircraft licensed for facility to facility transport only. Many of these fixed-wing airplanes may be out-of-service or out-of-state at any given time.

4. Secondary transportation resources may include the following:

   a. **ESF1 (Transportation)** can provide non-ambulance transportation resources, such as buses or para-transit.

   b. The State **Division of Emergency Management** maintains multi-modal transportation contracts that could be utilized depending on the incident/event.

   c. **Florida National Guard (FLNG)** assets are available for request and utilization in accordance with military doctrine. Assets would function in a supporting role. Potential assets include Standard or Medical Evacuation (MEDEVAC) platforms that are staffed and equipped to provide en route care and ground ambulances. Additionally, Non-Standard or Casualty Evacuation (CASEVAC) platforms exist and should be considered during emergency operations for the planning of moving personnel, cargo, and patients that either do not require care en route or when no other option is available. Those assets include utility and cargo vehicles and aircraft. FLNG Providers and Medic(s)/Medical Personnel, when operating autonomously, utilize unit-specific medical protocols, formularies, and medical regulating procedures. When providing transportation/movement support for other providers and patient(s) not in the care of FLNG personnel, those providers will operate under their own unique scope of practice.

      i. **Ground Ambulance Capabilities (45):** Ground evacuation assets provide a bridge/gap capability to local/regional EMS when local roadways are impassable and patient needs/volume do not require aerial evacuation. Ground evacuation assets are robust, yet have size, speed

and clinical capability constraints. Assets may likely be employed in other organic NG evacuation plans for supporting units.

ii. **Air Ambulance Capabilities (6):** HH-60 Black Hawk helicopters are the NG Air Ambulance platform. These helicopters may utilize larger (22,000lb) hospital helipads or coordinate for adjoining landing zones/fields nearby for patient exchange. Aircraft are rescue hoist and forward looking infra-red (FLIR) capable for adverse conditions/isolated patient rescues in denied areas. The best use of the HH-60 is for inter-facility transport of patients between hospitals. This allows local EMS aircraft to service areas/scenes/intersections they are familiar with. Flight crew includes a paramedic as the on board care provider. Unlike civilian EMS aircraft, additional seating is available for additional, highly-skilled (CRNA/PA/Specialist) Provider(s) to provide advanced care. Aircraft have on-board A/C power, O2 generation, and suction. Medical equipment sets include, at a minimum, defibrillation, monitoring, ventilating, and other equipment upon request.

iii. **Non-Standard Ground and Air CASEVAC:** Casualty Evacuation (CASEVAC) ***implies no medical personnel and/or equipment are on board the vehicle to provide en route care.***

- **CASEVAC Ground Assets**: High Mobility Multi-purpose Wheeled Vehicles (HMMWV) through 5 ton trucks. These vehicles have high water / off-road capabilities.

- **CASEVAC Air Assets:**
  - **Chinook (CH-47):** Generally restricted to airport environments or other large operating areas – too heavy / large for all hospital pads. Massive cargo/personnel movement capability with long range and high speed.
  - **Sikorsky (UH-60) Black Hawk:** May utilize larger (22,000lb) hospital helipads. Indicated for medium-lift cargo missions and key medical provider/equipment movement not supported by HH-60M MEDEVAC aircraft; larger internal cargo capacity for delicate/sensitive items not suitable for external/sling load.
  - **UH-72:** Comparable in size to civilian EMS aircraft and may land at virtually any hospital pad. Not equipped for patient movement. Indicated for key personnel/low density provider movement between critical locations.

d. FEMA Region IV states can provide ground and air ambulances, as well as buses through the **Emergency Management Assistance Compact (EMAC).** See Section 3G for additional information.

e. **Federal resources** can be requested to support patient movement (FEMA Ambulance Contract, DoD, NDMS, VA, etc.). See section 4G – Federal ESF8 Patient Movement.

5. When using non-ambulance transportation resources, medical personnel will need to be identified to provide in-transit care. Potential sources for this staffing are:
   a. Skilled Nursing Care Contracts
   b. Medical Reserve Corps
   c. SMRT and FAST Team members

E. Patient Movement Coordination with SERT Air Operations

In a hurricane strike or large-scale emergency / disaster, it is likely that air operations (Air Ops) missions will be initiated involving patient movement. The most likely scenario would be small, specific patient transport or evacuation missions, however, it is conceivable that a more large-scale patient movement process might be initiated. For specific individual or small-scale air transport missions, locally obtained and coordinated resources would be used. These local missions would not require coordination by the SERT Air Ops Branch.

On the other hand, if larger aeromedical transportation or patient evacuation missions are needed, there would be a need for coordination with SERT Air Ops. As such, as part of the ESF8 Patient Movement process, a liaison will need to be assigned from the Patient Movement Branch to coordinate actions with SERT Air Ops.

This individual will be responsible for coordinating missions, attending specially called Air Operations meetings, sharing information, briefing the SERT Air Ops Branch on ESF8 Aeromedical patient transport needs and actions, briefing the Patient Movement Branch on SERT Air Ops status, and other key tasks related to air operations.

When the need for this position becomes evident, it will be the responsibility of the Patient Movement Branch Director to assign an appropriate person to the position. Given the likely heavy workload in such a situation, the individual will likely have to serve more than just the role of SERT Air Operations Liaison with in the Patient Movement Branch.

Tasks for this position include:

- Report to the Patient Movement Branch Director
- Maintain an awareness of local patient movement / transport operations in the impacted area
- Monitor the need for patient movements requiring large-scale Air Operations
- Coordinate air operation patient movement with the SERT Air Ops

F. Large-Scale Patient Movement Operations

In the unlikely event that a large number of patients would need to be moved from an impacted area to another area in bulk, and aeromedical evacuation resources were available, points of embarkation and debarkation may be activated.

1. Aerial Points of Embarkation (APOE) are points of departure defined as designated locations where medical evacuees or patients are routed to and held, awaiting transport out of the area. APOEs would be activated and managed locally.

a. The need for activation of an APOE would only occur after a significant, catastrophic incident, and there would be a state declaration of emergency in place.

b. APOE activation and regional movement of patients would be based on the need to decompress medical facilities.

c. Patients may arrive at an APOE by ground ambulance or para-ambulance or by rotor wing aircraft.

d. An alternate care site (ACS) may also be utilized in conjunction with an APOE. This site would be used to stage patients prior to bringing them to the APOE for loading on aircraft, and would be staffed with basic medical staff.

2. State ESF8 may support local embarkation operations either by supplying personnel, equipment and/or supplies to local entities operating embarkation sites or by establishing and managing the health and medical components of embarkation sites on behalf of local entities

3. Aerial Points of Debarkation (APOD) are defined as designated locations where medical evacuees or patients are received (usually from a APOE) and held awaiting transport to a facility or other place of care, otherwise known as a "Receiving Site."

4. State ESF8 may support local/regional debarkation operations by making all attempts to pre-determine final destinations for patients prior to arriving at receiving sites, and ensuring receiving areas are included in the Executive Order. In the event of a catastrophic incident involving patient numbers that exceed the patient coordination capabilities at the local incident and state level, regions must be prepared to receive and coordinate destinations for patients.

5. NDMS patient movement may include resources to run and operate embarkation sites: Mobile Aeromedical Staging Facility (MASF) and Disaster Aeromedical Staging Facility (DASF) Teams. The requesting state is responsible for determining patient movement requirements. Local/State responsibilities in support of federally managed APOEs consist of the following:

   a. Designating the APOE location (in coordination with Federal and DoD authorities).
      i. Smaller/private airfields are ideal. Typically, there is less air traffic and heavily populated areas can prohibit ambulances from coming and going freely.
      ii. NDMS air transport resources have specific logistics requirements for landing military aircraft, which must be considered when identifying APOEs/APODs.

   b. Base Operating Support
      i. Building of opportunity (12,000 sq. feet), climate control preferred (air conditioning or fans). Must have wide entry and exit doors to allow passage of 4 litter bearers
      ii. Power source

iii. Restrooms for staff/patients
iv. Potable water
v. Rest location for staff
vi. Security
vii. Secure and dry area for supplies

c. Transportation of patients to the APOE.

d. Preparing patients before transport to the APOE
   i. Sending documentation which includes physicians orders:
      - Diagnosis
      - Allergies
      - Medications
      - Treatments
      - Emergency Contact Information
   ii. Providing 24 hour supply of scheduled medications, IV fluids, supplies.
   iii. Starting IVs and airways, if needed
   iv. Administering pain medication or sedation, if needed
   v. Transfusing, if needed

e. Providing 16 litter bearers (for loading patients).

f. Contingency planning for patients brought to the APOE who will not be approved as safe for air transport. For example; combative patients, patients who have decompensated in such a way that air transport is no longer ideal, bariatric patients who will not fit on the aircraft, etc. Ambulances may be stated at APOEs to take patients to alternate locations if necessary.

g. Contingency planning for managing people who self-report to the APOE.

h. Managing / tracking non-medical attendees.

G. Patient Return

If State ESF8 coordinates the movement of patients, the State ESF8 Patient Movement Branch will be responsible for working with facility discharge teams to coordinate patient return. For the purposes of this SOG, “return” can refer to transporting the patient back to the originating medical facility, a step-down facility (e.g., nursing home, rehabilitation facility, or other long-term care facility) or the patient’s residence.

1. The Patient Tracking Group is responsible for tracking and monitoring patient status. When patient tracking indicates a patient has arrived at the receiving facility, the Patient Tracking Group will collect updates regarding the patient’s status and location, at an interval to be determined by the Patient Movement Branch Director. These updates will be documented in the patient tracking system. The Patient Tracking Group will provide receiving facilities with contact information for the State ESF8 Patient Movement Branch (Patient Coordination Group), for questions related to patient return.

2. When a patient is released, he/she may return home via:
   a. Self-transport
   b. Family transport
   c. Arrangements made by the discharging facility
   d. Arrangements made by the originating facility

3. The discharging facility may request assistance from the State ESF8 Patient Movement Branch (Patient Coordination Group) when a patient whose destination or transportation was coordinated by State ESF8 does not have a means to return home. Subject to the availability of appropriations, the State ESF8 Patient Movement Branch will be responsible, financially and physically, for returning these patients home. The discharging facility must coordinate with State ESF8 to be considered for support. Patient return coordinated independent of ESF8, will not be considered for reimbursement.

4. If the State Emergency Response Team (SERT) or ESF6 (Mass Care) has established an internally displaced persons unit, they will assume this role in conjunction with the Department of Children and Families.

H. Emergency Management Assistance Compact (EMAC) Patient Movement Support

When local and state capabilities have been exceeded, patient movement support can be requested through EMAC.

1. The FEMA Region IV ESF8 Unified Planning Coalition (UPC) has worked to pre-identify patient movement resources. If one or more of the pre-identified resources is needed, Florida may make a request directly to one or more of the Region IV states.

   a. The Region IV UPC Patient Movement Concept of Operations, Reference Document N, provides a concept of operations for patient movement during a major disaster or catastrophic event/incident which assigns patient movement responsibilities, provides intrastate and interstate/inter-region patient movement guidance, identifies resources available to support patient triage, tracking, evacuation, staging, transportation, reception, and disposition planning, and defines eligibility for movement within and from the state and/or region.

   b. Potential resources (listed also in Figure 4) include:
      i. Ground/air ambulances
      ii. Buses (converted for patient movement)
      iii. Personnel and teams
      iv. Reception States/Sites

   c. Note: In a hurricane scenario, Region IV pre-landfall resources may be limited, as states will not release their resources until they are certain they will not be impacted by the storm.

2. If additional EMAC support is desired, an “EMAC Broadcast” will be sent to member states identifying the resources/capability needed.

3. In all cases, costs and specific logistics requirements will be negotiated prior to deployment through the EMAC systems by means of a Request for Assistance (REQ- A). The REQ-A is the form used to officially request assistance, offer assistance, and accept assistance between member states.

I. Federal ESF8 Patient Movement Support

1. When local and state capabilities have been exceeded, federal patient movement support may be requested. Federal patient movement support can include any or all of the following 10 functional areas.

    a. Movement of patients from point of origin to first receiver
    b. Hold/care at originating facility
    c. Movement and care to medical special needs shelters
    d. Movement from originating facility to another facility or APOE
    e. Reception, hold, care at APOE or aeromedical marshaling point area
    f. Movement and in-transit medical care from APOE to APOD
    g. Reception, hold, care at APOE area
    h. Movement from reception area to definitive care or healthcare facility
    i. Hold, care at definitive care facility
    j. Movement from healthcare facility to final disposition – home of record

2. The resources outlined in this section are available to support those functional areas. All requests for federal assistance will be made in coordination with the U.S. Department of Health and Human Services (HHS) Regional Emergency Coordinator and with approval from the State Emergency Response Team, using the Action Request Form (ARF).

    a. The State is responsible for determining patient movement requirements and requesting Federal support through the Action Request Form (ARF) / Mission Assignment (MA) process.

    b. As are all federal requests, the request to move patients is initiated by the State Emergency Operations Center. The State will decide the mode of transport for evacuation. The SEOC will forward the request to the Joint Field Office (JFO) when established, and the Regional Response and Coordination Center (RRCC) when not, who will hand the request to the Federal ESF8 Liaison in the JFO.

    c. The State must provide types, numbers and locations of patients who require movement, as well as an estimate of non-medical attendants. Attendants will be limited to those required to support patient care, provide informed consent, or assist with the performance of activities of daily living.

    d. Logistical support and sustainment costs are typically the responsibility of the requestor and should be negotiated in advance.

3. The designated **Regional Emergency Coordinator (REC)**, from the HHS, serves as the central coordinating point between State ESF8 and Federal ESF8 systems. The REC acts as liaison between the State and Federal ESF8 to carryout the

stated objectives. The State requests the deployment of the REC to the State Emergency Operations Center to be co-located with the State ESF8 team when the ESF8 Emergency Coordination Officer (ECO) anticipates a need for federal support.

4. The State can request ambulances from the **Federal National Ambulance Contract.** See Reference T, ESF8 National Ambulance Contract (FEMA Contracted Medical Transport Resources for Patient Evacuation) Concept of Operations and Reference L, Concept of Operations for Utilization of the FEMA Ambulance Contract in Florida during Disaster, for additional information.

    a. For the purpose of the contract; the country is divided into four zones from which the vendor will pull contacted resources. Each zone is required to produce:
        i. 300 Ground Ambulances (typically 70% ALS / 30% BLS)
        ii. 25 Aircraft (mix of rotor wing / fixed wing)
        iii. 3500 Para-transit seats (note: not total number of vehicles)

    b. Resources will be available to respond within 24 hours of activation of the contract.

    c. Resources will not be pulled from the affected state or from neighboring states' committees via EMAC.

    d. The staging of federal resources should be coordinated between state and federal officials. Federal resources should not be deployed without a mission assignment.

    e. If the contract is activated:
        i. The state should initiate a supplemental order to the Governor's Executive Order, allowing the licensed EMS personnel from another state to practice in Florida as a part of the response. This must be in place for EMTs and paramedics to legally provide services in Florida (F.S. 252.36 provides authority).
        ii. States should provide medical direction to the assets deployed by FEMA. If states are unable or unwilling to provide medical direction, HHS will provide a physician to serve in this capacity.
        iii. Resources fall under the tactical control of state/local officials until their assigned tasking is complete.
        iv. The contractor is responsible for logistics support and administrative control of the deployed resources, and will assure lodging, feeding, equipment maintenance, and pharmaceutical resupply.

5. The **National Disaster Medical System (NDMS**) has three operational components. Florida may request activation and support from any or all of the three components to support a patient movement operation. See Attachment C for a full description of these resources, as well as considerations for requesting activation of the Patient Movement and Definitive Care components.

    a. Medical response of personnel, teams and individuals, supplies, and equipment.

i. Disaster Medical Assistance Teams (DMAT)

b. Patient movement from a disaster site to unaffected areas.
   i. Patient evacuation
   ii. Medical regulating
   iii. En-route care
   iv. Patient tracking

c. Definitive medical care at participating hospitals in unaffected areas.
   i. Patient reception
   ii. NDMS hospitals
   iii. Service Access Teams (SAT)

6. **Joint Patient Assessment and Tracking System (JPATS) Strike Teams**

   a. JPATS Strike Team members are NDMS intermittent employees and will require formal activation. A two-person stand-alone team can be deployed within 24 hours of notification by the NDMS Operations Branch.

   b. In most cases, DoD will be provide aeromedical evacuation assets. TRACE2ES is the system used to match the patient with the appropriate airframe, in-flight crew, and destination hospital (patient regulation).

   c. Traditionally, state and local entities requesting JPATS Team support are responsible for providing wrap-around/external services and will negotiate these services and sustainment costs before deployment.

7. **Service Access Teams (SATs)**

   a. If Federal ESF8 moves medical evacuees/patients out, they will be responsible, financially and physically for returning such evacuees/patients to their homes, subject to availability of appropriations.

   b. The SAT Scope of Service is as follows:
      i. Facilitating communication between medical providers, case managers, and coordinators for evacuees who need medical and social services as needed.
      ii. Arranging transportation for evacuees and accompanying non-medical attendees who require assistance in either returning home or transferring to a resettlement locations.
      iii. Ensuring that human services (translation, food, and lodging), transportation, and medical care and supplies are provided for discharged patients and non-medical attendants.

   c. SAT teams require local/state support for logistics and sustainment.

V. AUTHORITIES AND REFERENCES

A. Chap. 252, F.S., Emergency Management
B. Chap. 408, F.S., Facility Status Reporting
C. Chap. 395, F.S., Healthcare Facility Plans
D. Chap. 381, F.S., Public Health
E. Chap. 401, F.S., Emergency Medical Services
F. Florida Comprehensive Emergency Management Plan, Appendix VIII: ESF8 – Public Health and Medical Services, 2012
G. ESF8 Standard Operating Procedures
H. Florida Ambulance Deployment Standard Operating Procedure, February, 2012
I. Concept of Operations for Utilization of the FEMA Ambulance Contract in Florida During Disaster, November 1, 2010
J. State Emergency Response Team (SERT) Air Operations Branch Guide, March 2012
K. Region IV ESF8 Unified Planning Coalition Patient Movement Concept of Operations, April 25, 2008.
L. HHS, Medical Movement of Evacuees ESF#8 Patient Movement Concept of Operations, January 3, 2011
M. Patient Movement Medical Capabilities Smartbook, June 11, 2012
N. HHS Service Action Team Concept of Operations, April 2011
O. HHS Return Movement of Domestic Medical Evacuees Concept of Operations, October 20, 2010
P. HHS Joint Patient Assessment Tracking System (JPATS) Strike Team Concept of Operations, December 15, 2010
Q. ESF8 National Ambulance Contract (FEMA Contracted Medical Transport Resources for Patient Evacuation) Concept of Operations, August 18, 2011
R. Air Mobility Command Aeromedical Evacuation Homeland Support Planning Factors, August 10, 2010
S. The Southern Region Burn Disaster Plan, October 2006

VI. RECORD OF CHANGES AND APPROVAL

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VII. ATTACHMENTS

A. Acronyms
B. Definitions
C. State ESF8 Patient Movement Request Guidance
C1. Patient Movement Request Summary Form
C2. Individual Patient Placement Form
D. State ESF8 Patient Tracking Form
E. Patient Movement Branch Sequence of Activities Matrix
F. State ESF8 Patient Movement Branch Position Checklists
G. State Considerations for Requesting Activation of the Patient Movement and Definitive Care Components of the National Disaster Medical System (NDMS)

Florida's Comprehensive Emergency Management Plan (CEMP)
Appendix VIII: ESF8 – Public Health and Medical Services
Patient Movement Support Standard Operating Guideline

Attachment A: Acronyms

Acronym	Meaning
ACS	Alternate Care Site
AHCA	Agency for Health Care Administration
ALS	Advanced Life Support
APOD	Aerial Point of Debarkation
APOE	Aerial Point of Embarkation
ARF	Action Request Form
BLS	Basic Life Support
CEMP	Comprehensive Emergency Management Plan
DASF	Disaster Aeromedical Staging Facility
DMAT	Disaster Medical Assistance Team
DoD	Department of Defense
ECO	Emergency Coordination Officer
EMAC	Emergency Management Assistance Compact
EMR	Electronic Medical Record
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
ESF	Emergency Support Function
ESF4	Emergency Support Function 4: Firefighting
ESF8	Emergency Support Function 8: Public Health and Medical Services
ESF9	Emergency Support Function 9: Search and Rescue
ESS	Emergency Status System
FAA	Federal Aviation Administration
FAMA	Florida Air Medical Association
FAST	Florida Advanced Surgical and Transport
FEMA	Federal Emergency Management Agency
FFCA	Florida Fire Chief's Association
FCC	Federal Coordinating Center
FLNG	Florida National Guard
HHS	US Department of Health and Human Services
IRCT	Incident Response and Coordination Team
JFO	Joint Field Office
JPATS	Joint Patient Assessment and Tracking System
LEOC	Local Emergency Operations Center
MA	Mission Assignment
MASF	Mobile Aeromedical Staging Facility
NDMS	National Disaster Medical System
PCG	Patient Coordination Group
PMB	Patient Movement Branch
PRA	Patient Reception Area

Acronym	Meaning
PRT	Patient Reception Team
PTG	Patient Transportation Group
PTRG	Patient Tracking Group
RDSTF	Regional Domestic Security Task Force
REC	Regional Emergency Coordinator
RPC	Regional Patient Coordinator
RRCC	Regional Response and Coordination Center
SAT	Service Action Team
SEOC	State Emergency Operations Center
SERP	State Emergency Response Plan
SERT	State Emergency Response Team
SMRT	State Medical Response Team
SOG	Standard Operating Guideline
SOP	Standard Operating Procedure
UPC	Unified Planning Coalition
USCG	United States Coast Guard
VA	Department of Veteran's Affairs

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Attachment B: Definitions

Term	Definition
Acuity	Acuity is a measurement of the intensity of care required for a patient.
Decompression	Facility decompression is the act of discharging patients in preparation for an anticipated or actual surge of incoming patients.
Disaster Medical Assistance Team (DMAT)	A DMAT is a group of professional and para-professional medical personnel (supported by a cadre of logistical and administrative staff) designed to provide medical care during a disaster or other event. DMATs are designed to be a rapid-response element to supplement local medical care until other Federal or contract resources can be mobilized, or the situation is resolved.
EM Constellation	EM Constellation is a web-based platform adopted by the State of Florida as an information management solution for emergency management. The platform allows county, state, federal and mutual aid entities to use the same operating environment when responding to and recovering from an emergency.
EM Resource	EMResource is a proven Communications and Resource Management solution that streamlines communications between medical response teams and healthcare providers by monitoring healthcare assets, emergency department capacity, and behavioral health and dialysis bed status; the product facilitates NDMS and HAvBED reporting and broadcasting.
EM Track	EM Track is a web-based system used to track patients from incident scene through final disposition. EMTrack follows the locations of patients and their condition as well as other important information. EMTrack scanners connect to the EMTrack server and provide a mobile solution to patient/responder tracking.
Emergency Status System (ESS)	ESS is the system that the Agency for Healthcare Administration (AHCA) requires hospitals to use to report bed status during emergencies.
Federal Coordinating Center (FCC)	Florida has three Federal Coordinating Centers strategically located throughout the state. These FCC's are managed by the Department of Veterans Affairs (VA) and the Department of Defense (DoD). The FCC's in Tampa and Miami are VA managed, while the FCC at Naval Air Station Jacksonville is managed by DoD. Responsibilities of the FCC include coordination of definitive medical care in the FCC's assigned area. In doing this, the FCC solicits and organizes community support services, enrolls non-federal local hospitals in the NDMS and when needed coordinates bed availability with the Armed Services Medical Regulating Office (ASMRO) when the evacuation portion of NDMS is mobilized. FCC's also assist local and state authorities with preparation of local NDMS patient reception plans. Additionally, they plan and conduct annual NDMS exercises

Term	Definition
National Disaster Medical System (NDMS)	The National Disaster Medical System is the section of the Department of Health and Human Services responsible for managing the Federal government's medical response to major emergencies and disasters. NDMS has three major components: Medical Response, Patient Evacuation, and Definitive Medical Care.
Patient Coordination Group	The Patient Coordination Group within the State ESF8 Patient Movement Branch, is comprised of medical specialists with hospital and medical diagnosis proficiency, who coordinate the placement of patients in appropriate facilities based on level of acuity and needs.
Patient Movement	Patient movement is the process of moving sick, injured, or wounded persons from one area to another to obtain medical care.
Patient Movement Branch (PMB)	The Patient Movement Branch, located in the State ESF 8 Operations Section, is activated upon receipt of a patient movement support request. Led by a Director, the Branch is comprised of a Patient Coordination Group, Patient Transportation Group, Patient Tracking Group, and Branch Tactical Planner.
Patient Reception Area (PRA)	A Patient Reception Area is 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 hospitals capable of providing definitive care for victims of a domestic disaster, emergency, or military contingency. Generally, these hospitals should be within a 50-mile radius of the PRA..
Patient Reception Team (PRT)	A Patient Reception Team is a multi-function group consisting mainly of clinical staff, but also including appropriate support from medical administration and communications personnel, logistics personnel, and people acting as litter bearers and drivers.
Patient Return	Patient Return is the process of returning a patient, who was moved to another location to receive medical care, to his or her originating medical facility or residence.
Patient Transportation Group	The Patient Transportation Group, within the State ESF 8 Patient Movement Branch, is comprised of Emergency Medical Services liaisons who validate and coordinate patient transportation requests.
Patient Tracking Group	The Patient Tracking Group, within the State ESF 8 Patient Movement Branch, is responsible for tracking patients once a local request is made for assistance with a patient coordination or with transportation. Patients will be tracked until the patients are released, returned, have expired, or as otherwise determined by the Patient Movement Branch Director.
Point of Debarkation	A Point of Debarkation is a designated location where medical evacuees or patients are received (usually from a APOE) and held awaiting transport to facilities or other places of care, otherwise known as "Receiving Sites."
Point of Embarkation	A Point of Embarkation is a designated location where medical evacuees or patients are routed to, and held awaiting transport out of, a point of departure.

Term	Definition
Region IV	FEMA Region IV serves the southeastern states of Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee.
Regional Domestic Security Task Force (RDSTF)	Pursuant to Section 943.0312, Florida Statutes, Florida created seven (7) RDSTFs. The RDSTFs are the foundation of the state's domestic security structure. Each RDSTF consists of local, multi-disciplinary representatives who collectively support preparing for, preventing, protecting against, and recovering from a terrorism event.
Regional Patient Coordinator	A Regional Patient Coordinator (RPC) is familiar with the health care system within his or her region or county and serves as a local point of contact for State ESF 8. Upon request from State ESF 8, an RPC will coordinate the placement of patients in appropriate facilities based on capability and capacity and the patients' acuity and required medical treatment/interventions.

Florida's Comprehensive Emergency Management Plan (CEMP)
Appendix VIII: ESF8 – Public Health and Medical Services
Patient Movement Support Standard Operating Guideline

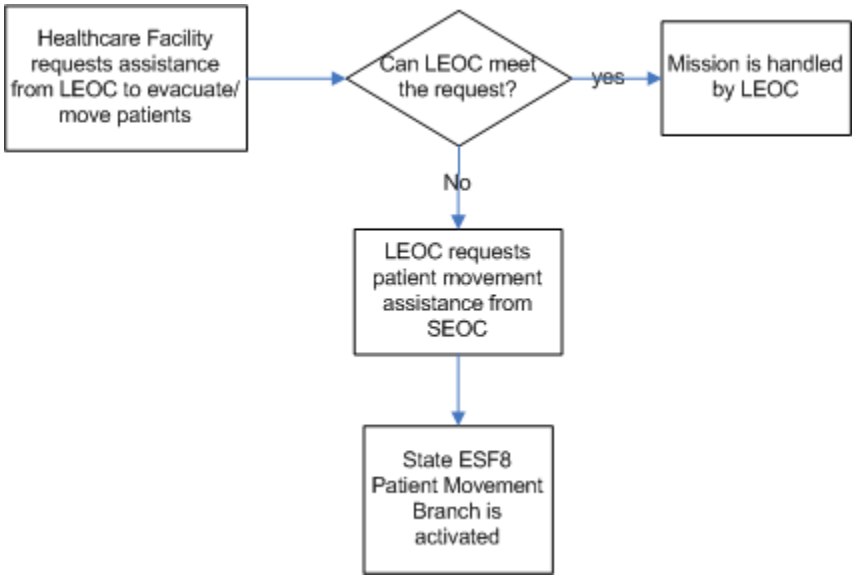
Attachment C: State ESF8 Patient Movement Request Guidance

Purpose:
State ESF8 is prepared to support local jurisdictions with patient placement and transportation when requested to do so. This document outlines the process for requesting patient movement assistance.

Assumptions:

- Local jurisdictions will follow existing comprehensive emergency management plans and healthcare facilities will follow existing surge and evacuation plans.
- Based on the size, scope, and scale of the incident, existing plans may be rendered invalid or ineffective.
- Decisions to move patients and which patients to move, are local decisions.
- Patients will not be transferred until they have been stabilized. The level of stabilization may vary.
- Physician to physician communications should occur to approve the transfer.
- If there is no emergency declaration in effect, and the patient is conscious and capable of making decisions, the patient must consent to the transfer.

Process:
If a health care facility determines it is necessary to move or evacuate patients from their facility and has exhausted its ability to do so, the facility will contact its Local Emergency Operations Center (LEOC). If the LEOC (Local ESF8) is unable to support the request, it will request assistance from the State Emergency Operations Center (SEOC) which will task the request to State ESF8 (Patient Movement Branch).



1. The initial request to the state may be transmitted in a variety of ways, depending on the circumstances of the incident. More than likely, the initial request will contain only general information about the number and type of patients needing to be moved. At a minimum, the request should contain:

    - The type of support being requested (patient transport, patient placement, etc.)
    - The number and status of patients (which can be an estimate)
    - Facility information (from which the patients need to be moved)

    The initial request information can be:

    a. Entered into the **Patient Movement Request Summary Form (Attachment C1)** and attached to the EM Constellation (EMC) mission request; or
    b. Entered directly into the "special instructions" field in EMC.

    The initial request will trigger activation of the State ESF8 Patient Movement Branch and allow the Branch to begin to vet potential receiving facilities and transportation resources. The request may initially be provided by phone or email, but must eventually be entered into EMC to generate a formal mission request.

2. Patient specific information will be needed to facilitate individual patient placement and transport. Local ESF8 will provide the information contained in the **Individual Patient Placement Form (Attachment C2)** to State ESF8. Depending on the incident and the technologies available, this information may be provided in a variety of ways including the following:

    a. The Individual Patient Placement Form (Attachment C2) may be completed, scanned, and emailed to State ESF8. StateESF8.Operations@flhealth.gov
    b. The information listed in the Individual Patient Placement Form can be entered into a spreadsheet and emailed to State ESF8. StateESF8.Operations@flhealth.gov
    c. A Continuity of Care Record (CCR) or other Electronic Medical Record report, containing the information in the Individual Patient Placement Form, can be provided to State ESF8 in lieu of the Individual Patient Placement Form.
    d. The information listed in the Individual Patient Placement Form can be provided verbally to State ESF8.

3. Based on current bed capacity / capability, the State ESF8 Patient Coordination Group will contact targeted Regional Patient Coordinators (RPCs) to initiate coordination with appropriate entities within the region to find placement for patients.

4. When appropriate placement has been determined, Regional Patient Coordinators will provide the following information to State ESF8:

    a. Receiving Hospital's Name and Address
    b. Receiving Physician's Name and Phone Number

5. State ESF8 will coordinate transportation resources (if requested to do so) and provide the following information to the requesting Local ESF8 point of contact:

    a. Receiving hospital's name and address
    b. Accepting physician's name and phone number
    c. Transportation provider name(s) and unit number(s)
    d. Transportation provider's estimated time of arrival at transferring facility or designated staging area.

6. Local ESF8 will provide the patient placement and transportation information to the requesting facility and/or other organizations as appropriate.

7. The requesting facility will ensure patients are prepared for transport. At a minimum, the following documentation should be sent with the patient:

    a. All information on the Individual Patient Placement Form (Attachment C2)
    b. Allergies
    c. Medications
    d. Emergency contact information
    e. Brief clinical summary including recent lab work, tests, treatments, imaging, etc.

Attachment C1: Patient Movement Request Summary Form

The following information, to the extent it is available, should be provided in the initial request. Upon receiving this information, StateESF8 will reach out to RPCs and begin determining potential receiving facilities. Individual patient information will be needed to facilitate patient placement and transport and should be provided as soon as possible. See Attachment C2.

Requestor:			
County			
Local ESF8 Point of Contact			
Phone numbers			
Email address			
Request Type – check the type(s) of support that is needed			
☐ Patient Placement Support	Patients need to be moved to facilities outside of the county. Assistance is needed to identify facilities that have the capability/capacity to accept these patients.		
☐ Patient Transportation Support	In-county transportation resources have been exhausted and assistance is needed to transport patients.		
Patient Summary			
Sending Facility Name			
Sending Facility Address			
Facility Type (hospital, nursing home, assisted living facility, etc.)			
Total Number of Patients Requiring Placement		**Adults**	**Pediatrics**
Patient Numbers by Status	**If known, please provide a breakdown of the total number of patients by status:**		
	Med/Surgical		
	OB/LND		
	Psychiatric		
	Critical Care		
Patient Numbers by Critical Care Specialties	**If known, please provide a breakdown of the critical care patients by specialty:**		
	Cardiac		
	Burn		
	Neurology		
	Ventilator		
Safety Information			
Note any blocked routes, impact areas, etc. that incoming transportation resources would need to know.			

Attachment C2: Individual Patient Placement Form

Part A: Patient Information:					
Name					
Sex		**DOB/Age**		**Weight**	
Health Status / Diagnosis					
Space Type	☐ Standard size stretcher patient ☐ Bariatric stretcher patient ☐ Wheelchair patient ☐ Ambulatory patient				
Special Medical/Equipment Needs	☐ Ventilator dependent ☐ Requires cardiac monitoring ☐ Requires IV pump ☐ Requires isolation precautions ☐ Requires oxygen ☐ Infectious (requires isolation) ☐ Other _____				
Other Special Needs (language barriers, medical attendees, service animals, etc.)					
Part B: Patient Location / Facility Contact Information					
Facility Name		**Facility Type**			
Facility Address					
Patient location within the facility (floor, room, ER, etc.)		**Date/Time patient will be ready for pick up**			
Location transportation unit should report for staging or pick-up					
Transferring Physician's Name		**Transferring Physician's Phone #**			
Part C: Patient Destination Information (to be completed by State ESF8)					
Patient Number		**Mission Number**			
Receiving Hospital Name					
Receiving Hospital Address					
Accepting Physician's Name		**Accepting Physician's Phone #**			
Transportation Provider Name and Unit Number					
Estimated Arrival Time					

Florida's Comprehensive Emergency Management Plan (CEMP)
Appendix VIII: ESF8 – Public Health and Medical Services
Patient Movement Support Standard Operating Guideline

Attachment D: State ESF8 Patient Tracking Form

Patient Identifier	Patient Name	Sex	DOB or Age	Weight	Health Status / Diagnosis	Space Type	Special Medical Needs	Other Special Needs	Emerg Contact Info	Date/Time Patient Ready for Pick Up	Receiving Hospital Name	Transportation Provider Name and Unit Number	ETA at Transferring Facility	Arrival Time at Transferring Facility	Departure Time from Transferring Facility	Arrival at Receiving Facility	Final Disposition / Notes

Notes:
The intent of this tracking form is to maintain visibility of the status of all movement (placement or transport) coordinated by State ESF8
The patient identification number will be linked to the Individual Patient Transfer Form
This document is intended only to display the recommended tracking fields, not to be a functional tracking tool.

Florida's Comprehensive Emergency Management Plan (CEMP)
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Attachment E: Patient Movement Branch Sequence of Response Activities

The following matrix provides a step by step depiction of the activities required to support patient movement requests. The Position Checklists in Attachment F provide description of the tasks that should be completed by each Group in the Patient Movement Branch during any activation of ESF8 involving patient movement missions

Function	Initiating Party	Activity	Responding Party / Response Actions	√
Initiation	Impacted Jurisdiction	An **incident occurs** that requires local medical surge handled by local resources.	Local jurisdiction implements emergency plans to respond to the incident.	
Notification	Impacted Jurisdiction	The State becomes aware of the incident. Notification could come from a variety of sources including: State Watch Office (SWO), Regional Emergency Response Advisor (RERA), Local ESF8, or County Health Department.	Local Emergency Operations Center (LEOC)/Local ESF8 is activated. State Emergency Response Team (SERT) / ESF8 monitor the situation and activate if warranted.	
Initial Assessment	ESF8	The situation is monitored for any potential health/medical issues and potential for patient movement activities. • Estimated number of casualties • Healthcare facility status (surge, diversion, etc.) • Statewide bed availability (EM Resource/ESS) • ED capacities and potential through-put • Potential for facility decompression or evacuation • Status of EMS System (Resource Availability)	Situation Unit – Healthcare System, Public Health, and Emergency Management Analysts begin monitoring and reporting. Patient Movement Branch (PMB) may be placed on alert/stand-by.	
Activation	Impacted Area - LEOC	An incident occurs/escalates and exceeds local capacity. Hospitals may go on diversion status. Mutual aid requests may be made to neighboring counties for EMS augmentation. Requests for state support will be made by the LEOC to the SEOC.	• SEOC receives the request and tasks to ESF8. • EM Constellation mission number is generated. • **PMB is activated.**	
Mission Scrubbing	ESF8 Logistics & PMB Director	Determine what type of support is needed. • Patient transport? Patient placement? • Number of patients needing to be moved and their acuity. • Sending facility information	• Requestor provides general information included on **Patient Movement Summary Form.** • Information is added to EMC mission	

Function	Initiating Party	Activity	Responding Party / Response Actions	√
Initial PMB Actions	PMB Branch Director and Planner	Initial PMB Briefing is conducted. PMB staff are provided with the following: • Situation update / immediate priorities • Assigned work location • Communication procedures, position checklists, forms, etc PMB Director will designate a single point of contact for Local ESF8 and determine if a PMB staff member is needed in the incident area to serve as a liaison between Local ESF8 and State ESF8.	PMB Branch personnel will set-up work spaces and begin assigned tasks. PMB Branch Director will provide Local ESF8 with name and contact information for a single State ESF8 point of contact. If needed, a liaison will be deployed to the incident area.	
Patient Coordination	PCG	1. Obtain and analyze statewide bed availability data. 2. Prioritize receiving regions. 3. Provide Regional Patient Coordinators (RPCs) with an initial situation update.	• Data will be obtained from the Situation Unit. • RPCs will be contacted; those in priority regions will pass situation updates to hospital contacts.	
Patient Transportation	PTG	In coordination with State ESF8 Logistics, provide initial situation updates to the following response partners, notifying them of a potential need for their assistance: • ESF 4&9 for potential activation of the Ambulance Deployment SOP. • FLNG, for the potential need of patient movement support. • ESF 1 (Transportation) for the potential need of non-ambulance ground assets (buses, para-transit, etc.)	Response partners will begin to look at potential resources in preparation for a potential request.	
Patient Coordination and Transport	PCG and PTG	Work with the impacted county to determine specific patient placement and transportation requirements.	Requestor provides specific patient requirements (see **Individual Patient Placement Form**)	
Patient Tracking	PTRG	Initiate manual or electronic patient tracking.	Information collected on Individual Patient Placement Forms will be used to establish patient entries.	
Patient Coordination	PCG	RPCs will be provided with specific patient information and will coordinate patient placement. ***Note: If the incident exceeds state capacity for patient placement, out-of-state placement (through EMAC and NDMS) will be considered.***	• Designated RPCs will work with hospitals to find appropriate placement for patients that need to be moved. • PCG and RPCs will analyze future numbers and acuity level of patients.	

Function	Initiating Party	Activity	Responding Party / Response Actions	√
Patient Coordination	RPC	Determine appropriate patient placement and provide State ESF8 with the following: • Receiving hospitals name and address • Receiving physician's name and phone number	PCG will complete **Individual Patient Placement Form** with information provided by RPCs.	
Patient Coordination and Transport	PCG	Provide PTG with receiving hospitals name and address to be added to the transportation orders.	PTG will relay this information to State ESF8 Logistics.	
Patient Transportation	PTG	Determine appropriate transportation resources needed to meet the request. The Ambulance Deployment SOP (ADP) is the primary method for obtaining resources to support patient transportation. ***Note: If Ambulance Deployment Plan resources cannot meet the request, secondary resources (ESF1, SERT multi-modal contract, FLNG, EMAC, NDMS) will be considered.***	**Primary:** 1. State ESF8 Logistics 2. ESF4&9 and/or FAMA **Secondary:** 3. FLNG 4. ESF1 5. SERT Logistics (contract) 6. FEMA Region IV States (EMAC) 7. FEMA Ambulance Contract 8. NDMS	
Large Scale Patient Movement	PMBD	Determine how ESF8 would support large-scale patient movement operations requiring patients to be moved in bulk. This may include activation of Alternate Care Sites and Aerial Points of Embarkation (APOE)/Debarkation (APOD). ***Note: If NDMS patient movement support is requested, local/state APOE support will be required***. Support would include, establishing a site, base operations, providing litter bearers, tracking non-patient medical attendees, and contingencies for self-reporting patients and those not approved for flight.	Impacted jurisdiction will establish APOE and request support if needed. State ESF8 (in conjunction with Regional Receiving Site Leads) will designate a Receiving Site. Host community will establish APOD and request support if needed.	
Patient Transportation	PTG	Coordinate with the State ESF8 Logistics Section to validate the patient transportation request. 1. Any specialized equipment/staffing needed? 2. Who will resources report to? 3. Will resources deploy to a staging area or directly to a facility? Once they have delivered the initial patient, will they return to staging? If not, who do they report to for the next assignment?	• Once validated, State ESF8 will request EMS resources through State ESF4&9 and/or FAMA. • Ensure each transport unit has a cell phone available for communications with Task Force/Strike Team Leaders, reach-back to medical control, and receiving facilities.	

Function	Initiating Party	Activity	Responding Party / Response Actions	√
		4. Establish the ESF8 Liaison (PTG) to the Ambulance Task Force/Strike Team Leaders (in accordance with the ADP), and determine if an on-scene liaison will also be needed. 5. Estimate turn-around time based on identified receiving facilities.	• If cell phones are not available on each unit, prepare a request to Logistics for a cell phone cache.	
Patient Transportation	ESF 4&9 and/or FAMA	1. Identify and deploy appropriate transportation resources to meet the mission request. 2. Provide the Ambulance Task Force/Strike Team Leaders with the name and contact information for the designated ESF8 Liaison. Request that they report arrival/departure information that should be reported to the ESF8 Liaison. 3. Provide State ESF8 with the following: • Designated Ambulance Task Force/Strike Team Leader names and contact info (for relaying departure/arrival times for patient tracking purposes) • Transportation provider's names and unit numbers • Estimated time of arrival	State ESF8 Logistics will relay the information to the PTG: • Designated Ambulance Task Force/Strike Team Leader names and contact information (for relaying departure/arrival time for patient tracking purposes) • Transportation provider's names and unit number • Estimated time of arrival	
Patient Tracking	PCG and PTG	PCG and PTG will provide patient placement and transportation information to the PTRG.	PTRG will compile and log data in patient tracking system.	
Resource Assignment	PMB	The PMB Director or designee will provide the following information to the requestor (Local ESF8) via email. Email will be followed-up with a confirmation telephone call. • Receiving hospital's name and address • Accepting physician's name and phone number • Transportation provider's names and unit numbers • Estimated time of arrival	Local ESF8 will provide the patient placement and transportation information to the requesting facility and/or other organizations as appropriate.	
Patient Transportation	Assigned Trans. Unit	1. Transportation provider reports to designated staging area to receive assignment. If instructed to do so, transportation providers may report directly to the transferring facility. 2. Upon patient pick-up, the transportation provider will provide the ATF/AST Leader with an estimated time of arrival to the receiving facility 3. Upon arrival at the receiving facility, the transportation provider reports the arrival time to the ATF/AST Leader. 4. Upon completion, provider reports for the next assignment.	Ambulance Strike Team/Task Force Leaders will report departure and arrival times to the PTG for patient tracking purposes.	

Function	Initiating Party	Activity	Responding Party / Response Actions	√
Patient Transportation	PTG	PTG will relay to the PTRG, all departure/arrival times provided by the ATF/AST Leaders.	PTRG will document this information in the patient tracking system.	
Patient Tracking	PTRG	PTRG will ensure the following information is documented in the patient tracking system: • Arrival at transferring facility • Departure from transferring facility • Arrival at receiving facility • Final disposition	Once patients have been transported to a receiving facility, the PTRG will collect patient status updates, at an interval determined by the PMB Director.	
Patient Return	Discharge Teams at Receiving Facilities	The discharging facility may request assistance from the State ESF8 Patient Movement Branch when a patient whose destination or transportation was coordinated by State ESF8 does not have a means to return home. While communicating with facilities to collect patient updates, the PTRG will provide contact information for the PMB/PCG. The discharging facility must coordinate with State ESF8 to be considered for support. Patient return coordinated independent of ESF8, will not be considered for reimbursement.	PCG will field all questions related to patient return. If the discharging facility needs assistance in returning patients, the PCG will coordinate this support with State ESF8 Logistics.	
Mission Completion	PMB	Process will continue until all patients have been placed, transported, tracked and returned.	State ESF8 will demobilize the PMB when all missions have been completed.	

Attachment F: State ESF8 Patient Movement Branch Position Checklists

Upon receipt of a local request, the State ESF8 Patient Movement Branch will be activated. The Patient Movement Branch will be comprised of the following:

A. Patient Coordination Group (medical specialists with hospital and medical diagnosis proficiency)
B. Patient Transportation Group (EMS liaisons to coordinate with ESF4&9, FFCA, and FAMA)
C. Patient Tracking Group
D. Branch Tactical Planner

The following position checklists provide a description of the tasks that should be completed during any activation of ESF8 involving patient movement missions. Not all tasks may apply to every incident and additional tasks may be assigned during an incident.

A. Patient Movement Branch Director
B. Patient Movement Onsite Coordinator
C. Branch Tactical Planner
D. Patient Coordination Group
E. Patient Transportation Group
F. Patient Tracking Group

The Patient Movement Sequence of Action Matrix in Attachment E provides an integrated depiction of the activities required to support patient movement requests.

State ESF8 Patient Movement Branch Director Checklist

Activities to be completed	Complete	N/A
Upon Activation		
1. Receive initial briefing and immediate priorities from Operations Section Coordinator (OSC). Determine what type of patient movement support has been requested.		
2. Activate Patient Movement Branch (PMB) staff.		
3. Establish work location for PMB and request any facility needs through Logistics.		
4. Brief PMB staff on incident status, priorities, reporting timelines, and meeting schedules.		
5. Make assignments to PMB staff.		
6. Designate a single point of contact for Local ESF8 and determine if a PMB staff member is needed in the incident area to serve as a liaison between Local ESF8 and State ESF8. (If possible, PMB Branch Director should serve in this role). Provide Local ESF8 with the name and contact information for the designated State ESF8 point of contact. If it is determined that a liaison is needed on-site, select, direct, and deploy that individual. (Consider the alternate PMB Branch Director or Branch Tactical Planner for this role.)		
7. Ensure Branch Tactical Planner (BTP) obtains healthcare facility status and bed availability data from the Situation Unit.		
8. Ensure Patient Coordination Group (PCG) analyzes bed availability data and prioritizes receiving regions.		
9. Ensure PCG provides Regional Patient Coordinators (RPCs) with initial situation update to include established priorities for receiving regions.		
10. Ensure PTG / State ESF8 Logistics provide initial situation updates to response partners (ESF 1, 4, 9, 13) notifying them of a potential need for their assistance:		
11. Ensure PCG and Patient Transportation Group (PTG) obtain patient placement and transportation requirements.		
12. Ensure Patient Tracking Group (PTRG) has established the patient tracking system.		
13. Ensure PCG is completing is completing Individual Patient Placement Forms.		
14. Ensure PCG is providing RPCs with individual patient placement requirements and collecting patient placement information.		
15. Ensure PTG is coordinating with State ESF8 Logistics to validate patient transportation requests.		
16. The Ambulance Deployment SOP (ADP) is the primary method for obtaining resources to support patient transportation. Assess the need to consider secondary resources (ESF1, SERT multi-modal contract, FLNG, EMAC, NDMS).		
17. Designate a PTG member as the ESF8 Liaison to the deployed Ambulance Task Force/Strike Team Leaders (according to the ADP). Determine if an on-site liaison is needed.		
18. Ensure the PTG is monitoring the transportation request made to ESF4&9 by State ESF8 Logistics. PTG should be ensuring cell phones are available on all transportation units as out-of-area communications will be a challenge.		
19. Provide the requestor (Local ESF8) with request updates (receiving facilities, receiving physicians, transportation resources en route, estimated time of arrival, etc.)		
20. Determine the interval at which the Patient Tracking Group will obtain patient updates from the receiving facilities. Establish reporting requirements and communicate expectations to the Patient Tracking Group.		

Continued on the next page.

State ESF8 Patient Movement Branch Director Checklist (continued)

Activities to be completed	Complete	N/A
Each Operational Period		
1. Sign in/out at the beginning/ending of each shift.		
2. Monitor Patient Movement Branch Mailbox.		
3. Schedule and facilitate Patient Movement Branch briefings.		
4. Continue activities noted in the "Upon Activation" section above until all patients have been placed, transported, and tracked.		
5. Ensure the PTG (ESF8 Liaison) is monitoring (through the Ambulance Task Force/Strike Team Leaders) the • Arrival of transportation units at the transferring facility • Departure of transportation units from the transferring facility • Arrival of transportation units at the receiving facility		
6. Ensure the PTRG is documenting the status of all patient transports and arrivals in the established patient tracking system.		
7. Ensure the PTRG has relayed procedures and contact information to the receiving facilities for assistance in coordinating patient return.		
8. Ensure the PCG is supporting discharging facilities in coordinating patient return when a patient whose destination or transportation was coordinated by State ESF8 does not have a means to return home. "		
9. Prepare ad hoc reports as requested by the OSC.		
10. Provide report to OSC regarding completion of any incident objectives.		
11. Save incident documentation in established incident file on Z drive.		
Upon Demobilization		
1. De-activate Patient Movement Branch personnel		
2. Complete evaluations for direct reports.		
3. Ensure all Patient Movement Branch workspaces have been cleaned-up.		
4. Complete demobilization paperwork		
5. Provide information for after-action report		
6. Assure incident archive includes all: • Patient Movement Request Summaries • Individual Patient Placement Forms • Patient Tracking Forms		

State ESF8 Patient Movement Onsite Coordinator Checklist

Activities to be completed	Complete	N / A
Upon Activation		
1. Report to the Patient Movement Branch Director by phone.		
2. Secure the telephone numbers of LEOC, ESF 8, Patient Movement Branch Director, local health and medical representatives, and other key personnel to facilitate incident communications.		
3. Obtain, in hard copy or digital form, a copy of the *Patient Movement Playbook* in order to reference key patient movement operational guidance during the event.		
4. Receive initial briefing and immediate priorities from the Operations Section Coordinator (OSC), or the Patient Movement Branch Director. Determine what type of patient movement support has been requested.		
5. Respond to site of patient movement operations.		
6. Establish contact with the impacted hospital or requestor for patient movement services and secure a good work location.		
7. Obtain intelligence on the patient movement situation, including the number and types of patients, local transportation resources, and additional resources needed.		
8. Assist in the establishment of reliable communications.		
9. Coordinate with local ESF 8 representatives.		
Each Operational Period		
1. Coordinate with representatives from the Hospital, EMS, Fire, County Health Department, Emergency Management, and other response partners involved in the patient movement operation as well as with the Regional Emergency Response Advisor (RERA).		
2. Work to establish a single point of contact for local ESF 8.		
3. Maintain communication with Patient Movement Branch Director in Tallahassee.		
4. Serve as a Patient Movement liaison between the Patient Movement Unit and local agencies.		
5. Confirm the number of patients to be transported.		
6. Assess the need for and application of State Medical Response System assets.		
7. Coordinate with and provide direction to State Medical Response Team command personnel who have been assigned to the patient movement operation.		
8. Relay “hospitals available” information to local representatives.		
9. Ensure that patient tracking is occurring.		
10. Assess need for air transportation resources and ascertain from local operations the Aerial Port of Embarkation (APOE).		
11. Assess need for Alternate Care Site support.		
12. Coordinate with onsite personnel for implementation of the Ambulance Deployment Plan.		
13. Work with local representatives to ensure a proper staging area has been established for transport resources, including designating routes of ingress and egress for the incoming units.		
14. Assess need for non-ambulance transportation resources, such as buses, for the transport of patients.		
15. Assess need for and application of National Guard resources.		
16. Assess need for patient movement unit assistance, including Patient Coordination Group (PCG), and Patient Tracking Group (PTG) positions.		

Continued on the next page.

Activities to be completed	Complete	N / A
17. Assess need for transportation of any special patients, such as burn, bariatric, etc. and special resources needed.		
18. Determine if transporting resources will need to return to the site for multiple transports.		
19. If an incident becomes a major-scale operation, assess the need for and application of EMAC or Federal resources.		
20. Assess the need for any logistical support that will be needed from the State for patient movement operations.		
Upon Demobilization		
1. De-activate Patient Movement Onsite Coordinator position.		
2. Complete evaluations for direct reports.		
3. Ensure the Patient Movement Onsite Coordinator workspace has been cleaned up.		
4. Complete demobilization paperwork.		
5. Provide information for After Action Report / Improvement Plan.		
6. Ensure incident archive includes all: • Patient Movement Request Summaries • Individual Patient Placement Forms • Patient Tracking Forms		
7. Assist with the demobilization of the patient movement operation.		
8. Be cognizant of the need to assist patients in returning home after discharge from distant hospitals.		

State ESF8 Patient Movement Branch Tactical Planner Checklist

Activities to be completed	Complete	Not Applicable
Upon Activation		
1. Receive initial briefing and immediate priorities from Patient Movement Branch Director (PMBD)		
2. Assist the PMBD in activating Patient Movement Branch (PMB) staff.		
3. Assist PMBD in establishing work location for PMB and request any facility needs through Logistics.		
4. Assist PMBD in preparing initial PMB Briefing.		
5. Establish a Patient Movement folder within the Incident folder (under Operations Section) and load electronic copies of all forms and resources.		
6. Finalize PMB Communications Procedures document and disseminate to PMB and Planning Mailbox.		
7. Establish communications with Situation Unit and obtain the healthcare facility status report including, evacuation reports, healthcare assessment data and electronic self-reporting data. Provide to Patient Coordination Group (PCG).		
Each Operational Period		
1. Sign in/out at the beginning/ending of each shift.		
2. Monitor Patient Movement Branch Mailbox.		
3. Assist the PMBD in preparing for PMB briefings.		
4. Participate in the Patient Movement Branch briefings.		
5. Serve as a liaison between the PMB and the Planning Section.		
6. Prepare ad hoc reports as requested by PMBD or Planning Section Coordinator (PSC).		
7. Participate in Planning Section Meeting.		
8. Document tactical plans for patient movement operations as needed.		
9. Obtain / produce information to support PMB personnel.		
10. Provide report to PMBD regarding completion of any incident objectives.		
11. Save incident documentation in established incident file on z drive.		
Upon Demobilization		
1. Complete demobilization paperwork.		
2. Return any equipment used during activation.		
3. Clean-up work space.		
4. Provide information for after-action report.		
5. Assure incident archive includes all: • Patient Movement Request Summaries • Individual Patient Placement Forms • Patient Tracking Forms		

State ESF8 Patient Coordination Group Checklist

Activities to be completed	Complete	N/A
Upon Activation		
1. Receive initial briefing and immediate priorities from Patient Movement Branch Director (PMBD)		
2. Obtain the healthcare facility status report including, evacuation reports, healthcare assessment data and electronic self-reporting data from the Branch Tactical Planner.		
3. Analyze state-wide bed availability and prioritize potential receiving regions.		
4. Provide Regional Patient Coordinators (RPCs) with an initial situation update to include established priorities for receiving regions. Establish reporting and briefing requirements. Send communications through the ESF8 Patient Movement Branch Mailbox.		
5. Determine specific patient placement requirements and complete Individual Patient Placement Forms.		
6. Provide designated RPCs with individual patient placement requirements.		
7. Collect patient placement information from RPCs. Relay information to: a. Patient Transportation Group, to coordinate corresponding transportation requests b. Patient Tracking Group, to document patient tracking data c. Patient Movement Branch Director, to provide information to the requestor		
Each Operational Period		
1. Sign-in/out at the beginning and ending of each shift.		
2. Monitor ESF8 Patient Movement Branch Mailbox.		
3. Continue activities noted in the “Upon Activation” section above until all patients have been placed.		
4. Continue to analyze state-wide bed availability and healthcare facility status and make adjustments to priorities for receiving regions as needed.		
5. Provide routine situational updates to the RPCs according to the established reporting and briefing requirements.		
6. Support discharging facilities in coordinating patient return when a patient whose destination or transportation was coordinated by State ESF8 does not have a means to return home. “Return” can refer to transporting the patient back their originating medical facility, a step-down facility (e.g., nursing home, rehabilitation facility, or other long-term care facility) or their residence.		
7. Participate in scheduled PMB meetings.		
8. Prepare ad hoc reports as requested by PMB.		
9. Provide report to PMB regarding completion of any incident objectives.		
10. Save incident documentation in established incident file on z drive.		
Upon Demobilization		
1. Provide Regional Patient Coordinators with a close-out notification including instructions for contacting State ESF8 after demobilization.		
2. Complete demobilization paperwork.		
3. Return any equipment used during activation.		
4. Clean-up work space.		
5. Provide information for after-action report.		
6. Assure incident archive includes all any documents developed by Patient Coordination Group		

State ESF8 Patient Transportation Group Checklist

Activities to be completed	Complete	N/A
Upon Activation		
1. Receive initial briefing and immediate priorities from Patient Movement Branch Director (PMB)		
2. In coordination with State ESF8 Logistics, provide initial situation updates to the following response partners, notifying them of a potential need for their assistance: a. ESF 4&9 for potential activation of the Ambulance Deployment SOP. b. FLNG, for the potential need of patient movement support. c. ESF 1 (Transportation) for the potential need of non-ambulance ground assets (buses, para-transit, etc.)		
3. Determine specific patient transportation requirements provided by the requestor.		
4. Coordinate with State ESF8 Logistics Section to clarify and validate the patient transportation requests. Determine the following: a. Any specialized equipment/staffing needed? b. Who will resources report to? c. Will resources deploy to a staging area or directly to a facility? Once they have delivered the initial patient, will they return to staging? If not – who do they report to for the next assignment?		
5. The Ambulance Deployment SOP (ADP) is the primary method for obtaining resources to support patient transportation. Note: If ADP resources cannot meet the request, secondary resources (ESF1, SERT multi-modal contract, FLNG, EMAC, NDMS) will be considered.		
6. Designate a member of the Patient Transportation Group as the ESF8 Liaison to the Ambulance Task Force/Strike Team Leaders (according to the Ambulance Deployment SOP) and determine if an on-site liaison will be needed.		
7. Obtain receiving facility information from the Patient Coordination Group and provide to State ESF8 Logistics to provide to ESF 4&9.		
8. Monitor the transportation request submitted by State ESF8 to ESF 4&9. When ESF4&9 have identified appropriate transportation resources to meet the mission request, obtain the following information: a. Designated Strike Team and Task Force Leaders names and contact information (for relaying departure/arrival times) **Note: Ensure cell phone numbers are available, as out-of area radio communications will be a challenge.** If cell phones are not available on each transport unit, prepare a request to Logistics for a cell phone cache. b. Transportation providers name(s) and unit numbers c. Estimated time of arrival (ETA) at the designated staging area or facilities. Provide ETA to: i. Patient Tracking Group to document in patient tracking system. ii. Patient Movement Branch Director, to provide information to the requestor.		
9. Receive status updates from Strike Team and Task Force Leaders. Provide information to the Patient Tracking Group to document in the patient tracking system.		
Each Operational Period		
1. Sign-in/out at the beginning and ending of each shift.		
2. Monitor ESF8 Patient Movement Branch Mailbox.		
3. Continue activities noted in the “Upon Activation” section above until all patients have been transported and transportation assigned units have returned to home base.		
4. Participate in scheduled PMB meetings.		
5. Prepare ad hoc reports as requested by PMB.		
6. Provide report to PMB regarding completion of any incident objectives.		
7. Save incident documentation in established incident file on z drive.		
Upon Demobilization		
1. Complete demobilization paperwork.		
2. Return any equipment used during activation.		
3. Clean-up work space.		
4. Provide information for after-action report.		
5. Assure incident archive includes all any documents developed by Patient Transportation Group.		

State ESF8 Patient Tracking Group Checklist

Activities to be completed	Complete	N/A
Upon Activation		
1. Receive initial briefing and immediate priorities from Patient Movement Branch Director (PMBD)		
2. Establish electronic or manual patient tracking system for the incident.		
3. Notify Patient Coordination Group and Patient Transportation Group of mechanism used to create individual patient numbers.		
4. Assist the Patient Coordination Group in completing Individual Patient Placement Forms.		
5. Enter data collected from Individual Patient Placement Forms into the patient tracking system.		
6. Collect and compile patient placement and transportation information and document in the patient tracking system.		
7. Work with the Patient Transportation Group to document the following: a. Arrival at transferring facility b. Departure from transferring facility c. Arrival at receiving facility d. Final disposition		
Each Operational Period		
1. Sign-in/out at the beginning and ending of each shift.		
2. Monitor ESF8 Patient Movement Branch Mailbox.		
3. Continue activities noted in the “Upon Activation” section above until all patients have been placed, transported, and tracked.		
4. Collect updates regarding patient’s status and location, at an interval determined by the Patient Movement Branch Director. Document these updates in the patient tracking system.		
5. Provide receiving facilities with contact information for the PMB/Patient Coordination Group for questions related to patient return. The discharging facility must coordinate with State ESF8 to be considered for support. Patient return coordinated independent of ESF8, will not be considered for reimbursement.		
6. Participate in scheduled PMB meetings.		
7. Prepare patient tracking status reports as directed by the PMBD.		
8. Prepare ad hoc reports as requested by PMB.		
9. Provide report to PMB regarding completion of any incident objectives.		
10. Save incident documentation in established incident file on z drive.		
Upon Demobilization		
1. Complete demobilization paperwork.		
2. Return any equipment used during activation.		
3. Clean-up work space.		
4. Provide information for after-action report.		
5. Assure incident archive includes all any documents developed by Patient Tracking Group.		

Attachment G: State Considerations for Requesting Activation of the Patient Movement and Definitive Care Components of the National Disaster Medical System (NDMS)

The National Disaster Medical System (NDMS) has three operational components:

1. Medical response to a disaster area in the form of personnel, teams and individuals, supplies, and equipment.
2. Patient movement from a disaster site to unaffected areas of the nation.
3. Definitive medical care at participating hospitals in unaffected areas.

Florida may request activation of and support from any of the three components during a response to a disaster in Florida. This document provides an overview of each component of NDMS and identifies specific state-level factors that should be considered before requesting NDMS support. All requests for NDMS resources must be requested through an Action Request Form (ARF).

NDMS Personnel, Teams, Supplies and Equipment

The NDMS is a nationwide partnership designed to deliver quality medical care to the victims of, and responders to, a domestic disaster. NDMS provides state-of-the-art medical care under any conditions at a disaster site, in transit from the impacted area, and in participating definitive care facilities. The main NDMS teams consist of the following:

- *Disaster Medical Assistance Team (DMAT)*: DMATs provide primary and acute care, triage of mass casualties, initial resuscitation and stabilization, advanced life support and preparation of sick or injured for evacuation. The basic deployment configuration of a DMAT consists of 35 persons; including physicians, nurses, medical technicians, and ancillary support personnel. They can be mobile within six hours of notification and are capable of arriving at a disaster site within 48 hours. They can sustain operations for 72 hours without external support. DMATs are responsible for establishing an initial (electronic) medical record for each patient, including assigning patient unique identifiers in order to facilitate tracking throughout the NDMS.

- *Disaster Mortuary Operational Response Team (DMORT)*: DMORTs work under the guidance of local authorities by providing technical assistance and personnel to recover, identify, and process deceased victims. Teams are composed of funeral directors, medical examiners, coroners, pathologists, forensic anthropologists, medical records technicians and transcribers, fingerprint specialists, forensic odontologists, dental assistants, x-ray technicians, and other personnel. HHS also maintains several Disaster Portable Morgue Units (DPMU) that can be used by DMORTs to establish a stand-alone morgue operation.

- *National Veterinary Response Team (NVRT)*: NVRT provides assistance in identifying the need for veterinary services following major disasters, emergencies, public health or other events requiring Federal support and in assessing the extent of disruption to animal and public health infrastructures.

- *National Medical Response Team (NMRT)*: NMRTs provide medical care following a nuclear, biological, and/or chemical incident. This team is capable of providing mass casualty decontamination, medical triage, and primary and secondary medical care to

stabilize victims for transportation to tertiary care facilities in a hazardous material environment. The basic deployment configuration of an NMRT consists of 50 personnel.

State Factors to Consider Before Requesting NDMS Personnel, Teams, Supplies, and Equipment

- NDMS teams are managed on a rotating on-call schedule. Teams will be deployed according to that schedule and at the discretion of federal ESF8. The state may not request a specific team for a mission.

- Requests should be made through a capability based mission. The state should describe the need/gap that it is trying to meet with the resource as opposed to requesting a specific resource in the ARF. Federal ESF8, in discussion with the state, will determine the most appropriate resource for the mission.

Patient Movement

In the event that the local medical systems within a disaster area are overwhelmed, there may be a need for a system to move patients out of the disaster area. When this occurs, local authorities may operate Casualty Collection Points (CCPs) that feed into State-operated Embarkation Sites. If State or local authorities determine that resources are inadequate to transport or care for all patients, a request for Federal medical evacuation assistance can be initiated.

Patient movement, within NDMS, includes patient evacuation, medical regulating, en-route care, and patient tracking/in-transit visibility.

The DoD coordinates patient movement for the NDMS in collaboration with other federal ESF8 partners, as required. The DoD US Transportation Command (USTRANSCOM) Defense Distribution Operations Center is the single manager for the movement of NDMS in-patients who require en route medical care, to include accepting requests for movement of NDMS patients out of the disaster area, regulating patients to definitive medical care, tracking patients between disaster area and definitive care reception sites, and coordinating patient transportation.

- Transportation by air may be accomplished through the USTRANSCOM's Air Mobility Command (AMC).

- Patient Regulating: If DoD assets (to include National Guard assets in Title 32 or Title 10 status) are utilized to transport patients by air, they will be tracked by the Global Patient Movement Requirements Center (GPMRC). Evacuation that is performed by DoD is generated by the completion and validation of patient movement requests (PMR), and is coordinated through the GPMRC (intra or inter-state strategic ESF #8 aeromedical evacuation (AE) from aerial port of embarkation (APOE) to aerial port of debarkation (APOD) only). The responsible receiving agency will provide in-transit visibility from the receiving airhead to the destination facility (e.g., National Disaster Medical System (NDMS) hospital). For example, the Federal Coordination Centers (FCC), if activated within NDMS will provide in-transit visibility from the APOD to the destination facility.

- Patient Tracking: The NDMS has developed a national patient tracking system called Joint Patient Assessment and Tracking System (JPATS).

State Factors to Consider Before Requesting NDMS Patient Movement

- NDMS patient movement and definitive care components do not have to be activated simultaneously. NDMS may provide transportation resources and patient tracking support without activating definitive care (i.e. FCC operations and NDMS hospitals).

- NDMS air transportation resources require specific logistics requirement for landing military aircraft and must be considered when identifying embarkation and reception sites.

- NDMS patient movement support does not include processes to run and operate embarkation sites, only the transportation assets. DoD Mobile Aeromedical Staging Facility (MASF) or Disaster Aeromedical Staging Facility (DASF) Team support can be requested.

- NDMS is limited to 20 percent critical care patients per DoD airframe. 10 percent of these patients can be ventilator patients.

- NICU/PICU patients should not be considered for transport on military aircraft.

- If using NDMS transport- DoD flight surgeons will have final determination regarding which patients can be transported. Contingencies need to be considered for any patients who may be denied transport.

- Movement of patients on military aircraft will be tracked using TRACERS.

Definitive Care

Patients moved via NDMS from a disaster area for definitive medical care arrive at a Federal Coordinating Center's (FCC) Patient Reception Area (PRA). The mission of a FCC is to receive, triage, stage, track and transport inpatients, affected by a disaster, to a participating National Disaster Medical System (NDMS) inpatient hospital capable of providing the required definitive care. The PRA generally operates from pre-identified airfield, bus station or railhead Patient Reception Sites (PRS). More information about NDMS FCCs can be found in the current FCC guide.

Definitive Care, according to the NDMS CONOPS, dated July 2009, is defined as:

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

NDMS payment will end when one of the following occurs, whichever comes first: completion of medically indicated treatment (maximum of 30 days); exhaustion of Diagnosis Related Group (DRG) payment schedule; voluntary refusal of care; return home or to point of origin/fiscally comparable location or to destination of choice for patient (whichever costs less). Definitive care is rendered by a nationwide network of voluntarily participating, pre-identified, non-Federal and Federal hospital services. The network includes an ability to track available beds by medical specialty. In a public health emergency, these services provide definitive medical care for victims. In a military health emergency, NDMS non-Federal hospitals provide backup to the available military and VA medical services for military beneficiaries. In the case of DoD and VA hospital services, use in a public health emergency is contingent on availability and appropriate approval. FCCs monitor the status of NDMS patients treated at medical facilities associated with their FCC.

- NDMS Hospitals are reimbursed for the care they provide in accordance with the signed NDMS Memorandum of Agreement.

- HHS is responsible for coordinating the discharge and transportation of patients returning to their point of origin, or other destinations, as authorized. Patients requiring continuing care are returned as soon as appropriate care is available in the area from which they were evacuated and the patient can be transported safely.

<u>State Factors to Consider Before Requesting NDMS Definitive Care</u>

- The NDMS definitive care component requires the activation of an FCC patient reception area in to which patients will be moved. Federal ESF8 determines which FCCs will be activated for an incident, not the state. Therefore Florida patients could be moved to another state or other region.
  - Currently, there are three FCCs designated in Florida

    1. Jacksonville (managed by DoD)
       - PRA – Naval Air Station Jacksonville
       - 18 NDMS partner hospitals

    2. Tampa (managed by VA)
       - PRA – Tampa International Airport
       - 64 NDMS partner hospitals

    3. Miami (managed by VA)
       - PRA – USCG Miami Air Station, Opa Locka
       - 30 NDMS partner hospitals

- Patient Reception Areas accept incoming patients. They do not move outgoing patients. Embarkation is a state/local function (though federal resources may be requested to assist).

- FCC PRA operations depend on the local community (in the city where the PRA is activated) to support PRA operations and assist in placing patients in medical facilities.

- NDMS hospitals are pre-identified and must maintain a signed MOA with HHS to participate as an NDMS definitive care hospital. Additional hospitals may be identified during the incident as necessary.

- Per the NDMS hospital MOA, hospitals will be reimbursed for un-insured patients at 110 percent of Medicare rates for in-patient care provided within the first 30 days. After 30 days Medicaid will be billed.

- Patients moved by NDMS and under NDMS definitive care will be provided transport home by HHS through a Patient Return Contract.

- Service Access Teams will be deployed to support NDMS definitive care operations. Responsibilities include tracking and monitoring patients, providing information to family members, coordinating lodging and human service needs for discharged patients, and facilitating the return of patients to their homes.