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03/20/2014

Office of the Assistant Secretary for Preparedness and Response

Office of Emergency Management

Version: March 2014

NUMBER OEM 2013-04B

FEDERAL MEDICAL STATION (FMS)

CONCEPT OF OPERATIONS (CONOPS)

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FORWARD

The FMS is a significant federal Public Health and Medical Services response capability, yet no implementing concept of operation was published heretofore. This document, after many years in development, provides initial published information that will be of use within the Federal response community and to our many partners including state, local, regional, tribal and territorial authorities.

This CONOPS describes the FMS capabilities and missions, staffing and augmentation, employment, and logistical support requirements.

Office of Emergency Management (OEM) Division of Operations has primary responsibility for this CONOPS. As such, Operations Division bears responsibility to implement and coordinate maintenance of this CONOPS.

I thank all the professionals who have contributed to this document for their commitment in moving it to completion.

Approved:


Don R. Boyce, JD
Deputy Assistant Secretary
Director, Office of Emergency Management

Date



EXECUTIVE SUMMARY

Background

In August 2004, the Department of Health and Human Services (HHS) initiated a project to design, demonstrate and evaluate a deployable medical materiel capability to support medical response requirements of the then-National Response Plan (NRP). The Federal Medical Contingency Station, Type III (FMCS TIII) was the result of this early work.

In late August 2005, the on-hand FMCS TIII prototype units were deployed in response to Hurricane Katrina. HHS/then-Office of Public Health Emergency Preparedness (OPHEP), now the Office of Emergency Management (OEM), and the Centers for Disease Control and Prevention (CDC)/Division of Strategic National Stockpile (DSNS) compiled inputs from after action reports and reviews to refine the FMCS TIII. This resulted in the development of the FMS, the first generation variant of the FMCS prototype.

In April 2006, HHS formally assigned to CDC/DSNS the mission to manage FMS caches as part of the Strategic National Stockpile (SNS) and entered into an interagency agreement for assistance in prototyping the FMS cache. At the time, the goal was to have 20 (250 bed) FMS sets ready for deployment by June 2006.

As requirements for the FMS were evaluated, OPHEP estimated a need to surge nationwide bed capacity by up to 50,000 beds in some disaster scenarios. To help mitigate this shortfall, a target of 120 FMSs (30,000 beds) was programmed for development in 2010. Simultaneously, other efforts were underway at the local and state levels to increase medical and public health preparedness and surge capacity.

The original target of 120 FMS caches was revised downward due to increased preparedness on the parts of state, local, tribal, and territorial (SLTT) jurisdictions. The lower than anticipated FMS deployment history, feedback from SLTT partners regarding FMS space requirements, and evolving missions led to additional requirements modeling and analysis and an HHS Assistant Secretary for Preparedness and Response (ASPR) initiative to increase FMS modularity and flexibility. These analytic efforts were conducted by Biological Advanced Research and Development Authority (BARDA) Modeling and approved by the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) and the ASPR in 2013.

CDC continues the mission to manage the FMS caches, currently including 59 250 bed equipment sets and 15 pharmacy caches. In 2013, the partners developed and tested a concept revision that yielded one complete 50 bed FMS prototype. The ASPR approved the 50-bed concept in late 2013 along with a plan for 10 50-bed FMSs. The smaller capability is anticipated to be available for use in time for the 2014 hurricane season. The goal for 2014 is ten 50-bed FMSs and retaining 32 of the 250-bed FMSs, providing total capacity of 8,500 beds.

Capability Overview

FMS capabilities have been developed and maintained through a partnership between ASPR and the DSNS, and with the collaboration of key partners in the National Response Framework's (NRF) Emergency Support Function – 8 (ESF #8), Public Health and Medical Services. The FMS provides federal low acuity healthcare surge capacity in a deployable and sustainable manner. FMS are early-entry elements that can be forward deployed near affected areas.

An FMS offers health and medical surge capability and capacity for short-term care of patients who require treatment of low acuity or chronic illnesses, injuries, and disease conditions, and of persons with these needs who are displaced by the disaster from their habitual residence and care milieu. They are disaster response capabilities operating in more or less austere environments under conditions that are less than ideal. FMSs are not acute care hospitals, emergency departments, or nursing homes. An FMS cache must be set up in an existing building of opportunity and staffed with health care providers and support personnel.

One or more FMSs can be employed to augment local capability to support health and medical needs of disaster victims and displaced persons from nursing homes, other skilled nursing facilities, and those with low acuity injuries or illnesses who would otherwise remain independent in their homes. The FMS may also be employed to support quarantine requirements.

The FMS CONOPS describes the mobilization, deployment and employment of FMS, defines organizational and operational relationships, and describes the logistical site support required to successfully conduct FMS operations. It provides partners with an overview of the employment and operation of FMS in the context of other federal response structures, specifically those supporting ESFs #8 and #6 (Mass Care, Emergency Assistance, Housing, and Human Services). When the ASPR Emergency Management Group (EMG) deploys an FMS, this CONOPS can be used as an implementation guide to conduct FMS operations. It may also be used as a reference during planning as part of the preparedness phase of operations.

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**United States Department of Health & Human Services
Office of the Assistant Secretary for Preparedness and Response**

Office of Emergency Management

FMS CONOPS

Purpose

The FMS CONOPS:

- Describes FMS capabilities, including personnel, equipment and supplies (including medical and non-medical contents of the FMS cache),
- Defines operational concepts and establishes HHS functional roles, administrative responsibilities and execution authority when deploying FMS to support SLTT disaster and public health emergency requirements,
- Serves as a working guide for FMS capability coordination and management, and the operational deployment and employment of FMS, and
- Identifies preparedness activities such as training FMS staff, verifying suitability of potential FMS sites, and identifying methods to provide wrap-around services.

Scope

The FMS CONOPS describes requirements and coordination activities of agencies supporting and participating in FMS operations. This document applies to all HHS components, especially ASPR, Office of the Assistant Secretary for Health (OASH), OEM and the CDC, that have key roles. Others with significant FMS roles or interests include the Department of Defense (DOD), Veteran's Health Administration (VHA), other Interagency (IA), SLTT, private sector (PS), and non-governmental organization (NGO) partners.

Mission

An FMS provides 24-hour medical care and supervision for those whose medical conditions require ongoing professional care. It provides surge medical or public health capacity in the form of Alternate Care Facilities (ACF), quarantine facilities (see limitations regarding this mission set in Annex B, Appendix B1), short-term casualty collecting points, and low acuity health care facilities to augment local health care systems in an affected area.

Situation

When public health emergencies exceed the capacity and capabilities of State, regional, and local health care resources, temporary patient surge occurs that may trigger a support requirement for federal public health and medical services.

The FMS provides support and resolves health and medical capability gaps in scenarios that lead to significant displacement of the affected area's residents, significant damage to or degradation of the health care system, extensive evacuations of hospitals, skilled nursing facilities, and nursing homes, and/or catastrophic numbers of casualties (based on circumstances in each state or region). Quarantine operations could include support of local healthcare systems near points of debarkation (points of entry to U.S.), and other biological incident response requirements.

Those people with medical needs who do not require an acute care hospital bed represent a unique challenge for planners. National policies about how and where these individuals are best served have evolved considerably in recent years. This evolution has led to the use of varied terms to describe these patients and their needs. This document uses the term "low acuity" to differentiate FMS-appropriate patients from those who require care in a hospital.

Assumptions and Critical Considerations

Assumptions

- The results of large-scale natural or man-made disasters or attacks will likely overwhelm SLTT health and medical resources;
- Local surges in public health and medical requirements will be temporary in duration, lasting not more than 30 days;
- Healthcare system surge capacity will not meet disaster requirements;
- Healthcare resources in the affected area will focus on providing care for the most seriously ill and injured casualties, and will request Federal support to care for less ill or injured casualties and chronically ill displaced persons and their families;
- SLTT jurisdiction partners who request support for requirements consistent with FMS capability will have identified appropriate building(s) of opportunity, and logistical site support (or "wrap around services") to support FMS operations;
- Shelter planners at the local level should be utilizing the Guidance on Planning for Integration of Functional Needs Support Services in General Population Shelters (FEMA, 2010, Reference s) which provides guidance to assist emergency managers and shelter planners in understanding the requirements related to sheltering children and adults with functional support needs in general population shelters. They should also be utilizing the US Department of Justice's (DOJ) ADA Best Practices Tool Kit for

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State and Local Governments, including Chapter 7, Addendum 2: The ADA and Emergency Shelters: Access for All in Emergencies and Disasters (See reference t);

- A deployable healthcare capability with patient holding capability will be needed within the affected area to conduct triage, provide treatment, and hold patients temporarily or transfer them to appropriate definitive care facilities outside the affected area;
- In coordination with SLTT authorities, admission into the FMS of individuals with medical needs, including those who also have access and functional needs, will be based on the judgment of the clinical staff and with individual patients' consent;
- States will request federal ESF #8 support in the forms of full FMS capability, FMS cache (alone), or FMS staff (alone);
- FMS locations will meet all selection criteria or the host jurisdiction will resolve or mitigate gaps in site attributes (See Annex B, Appendix 1, FMS Site Selection Criteria);
- The FMS, when operated by the federal government, will primarily be staffed by a Rapid Deployment Force (RDF) of U.S. Public Health Service (PHS) Commissioned Corps officers, from the Office of the Assistant Secretary for Health, Division of Commissioned Corps Personnel Readiness (DCCPR), with augmentation provided by the National Disaster Medical System (NDMS), the VA and DOD. SLTT and NGO personnel may be co-located with Federal personnel as necessary;
- If staffing an FMS, the DOD senior officer will coordinate directly with the FMS Leader and/or DOD will provide a liaison officer (LNO) to the Incident Response Coordination Team (IRCT) to support coordination as DOD personnel will remain under military command and control;
- Although the FMS is intended to provide care for patients with low acuity conditions, during disasters patients with higher acuity needs will likely be transported to or self-evacuate to an FMS; patients with higher acuity needs who present to/are evacuated to an FMS will be cared for until evacuated to an appropriate facility;
- The HHS Disaster Medical Information Suite (DMIS) Electronic Medical Records (EMR) application will be used at all ASPR-staffed FMSs. The records maintained by this system and application adhere to guidelines, applicable legal authorities, and Executive Orders (EO) governing the routine use of personal and patient related data;
- Paper medical records, used only when the DMIS/EMR is unavailable or unusable, adhere to the same applicable legal authorities and Executive Orders governing the collection, storage, and routine use of personal information;

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- FMS caches will be re-allocated or relocated for higher priority missions, as needed;
- Animal sheltering support will be coordinated with local animal welfare and support organizations and with the U.S. Department of Agriculture (USDA)/ESF #11 (Agriculture and Natural Resources) when applicable.

Critical Considerations

- The FMS is not a stand-alone capability, but is dependent on the host jurisdiction for an appropriate operating site and critical logistical site support. If wrap around services are not pre-planned or available, the FMS cannot fulfill its mission. In response to incidents causing catastrophic damage to infrastructure and services, wrap around services should be provided by an unaffected jurisdiction through Mutual Aid Agreements or the Emergency Management Assistance Compact (EMAC). This logistical support is coordinated through existing service providers and contracted locally or regionally.
- An FMS is not a hospital, hospital ward, or emergency department. The FMS is not designed to provide "total care," surgery, blood bank services, on-site dialysis treatment*, ventilator support, patient regulating, or long-term acute care. Additionally, the FMS can provide only limited pediatric and bariatric services. (**Note: Patients who regularly have peritoneal dialysis in their "home setting," can be dialyzed in the FMS only if they present with the necessary equipment and all related supplies. Otherwise, these patients would be triaged for evacuation to an appropriate facility with access to the materials.*)
- Patients will arrive at an FMS with family members and/or other caregivers who should remain together. Maintaining unity is in the best interest of the patient(s) and supports the staff in caring for the patient(s).
- A Disaster Medical Assistance Team (DMAT) Task Force (TF) should support each Federally staffed FMS. The DMAT TF will support triage, augment the FMS staff, and, as required, provide acute care and adjunctive support. A Mobile Lifesaving Kit (MLK) supports the TF logistically.
- The FMS is not an animal shelter or a veterinary medical treatment facility. A low percentage of FMS patients will present with service animals and companion animals, and service animals must remain with their owners. Companion animals are not required to remain with their owners; however, keeping them as close as possible supports the wellbeing of patients and their families. The IRCT or National Veterinary Response Team (NVRT) will assist in coordinating necessary animal care resources when they are not available near the FMS.
- Once established and occupied, movement and re-establishment of the FMS must include cache rehabilitation and cleaning/decontamination of durable equipment.

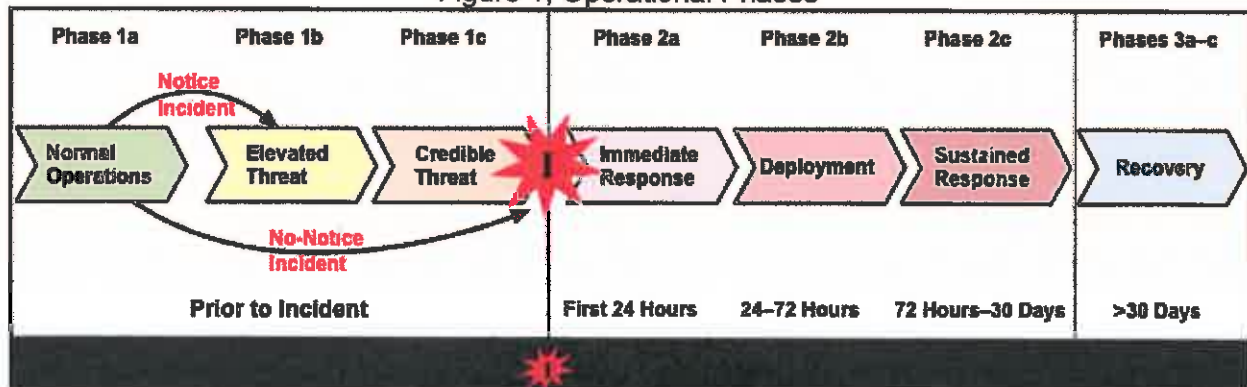
- An FMS may be staffed using a hybrid model (see Annex A, Glossary) consisting of both federal **and** non-federal personnel. Non-Federal personnel may be co-located with Federal personnel if needed. Pre-coordination for FMS support should include discussions regarding potential FMS utilization of displaced staff specialists from evacuated facilities, Medical Reserve Corps personnel, and extenders such as nursing or medical students to enhance non-Federal staffing. Staffing requirements including medical specialties are listed in Annex B, Appendix B4.
- The FMS cache can be deployed independent of staffing if requested by the affected jurisdiction. Caches deployed in this manner will be accompanied by the FMS ST and/or NDMS LRATs to facilitate set up.
- The FMS deployment timeline begins when the DSNS is directed to deploy one or more FMS caches; the time until delivery ranges from 24 to 48 hours (see Appendix B7).

Concept of Operations

Activities by Operational Phase

The frequency, types and duration of incidents vary widely, and OEM must be flexible in employing response resources including FMS. This flexibility is supported by distinct operational phases used in both planning and response execution. OEM utilizes FEMA's three operational phases: **Pre-Incident**, **Response**, and **Recovery** (see Figure 1).

Figure 1, Operational Phases



A. **Pre-Incident.** This phase includes activities related to preparedness and maintaining operational awareness, with emphasis on FMS program coordination, monitoring emerging threats, maintaining personnel readiness through training, and enhancing preparedness through planning, coordination, and integrated collective training. OEM and other ASPR stakeholders should:

1. Review observations, recommendations, and lessons learned from previous response operations and incorporate changes into this CONOPS and other

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relevant policies and guidance within functional areas of responsibility, to increase effectiveness and efficiency of future responses;

2. Convene the FMS Clinical Oversight and Recommendations Working Group (encompassing Pharmaceuticals and Therapeutics (P&T) committee) and review available data and lessons learned to enhance program guidance, support program management, and make recommended changes to cache, staffing models, and administrative policies. Include representatives from interagency partners (VA, DoD), and ensure representatives include those with expertise in gerontology, internal medicine, behavioral health, case management, logistics, nursing, health care administration and pharmacy management.

3. Work to build relationships with SLTT jurisdiction authorities, and with stakeholder public health and emergency management officials. Identify support requirement and provide technical assistance as required. Coordinate preparedness and response activities ensuring all governing and coordination documents related to the FMS, site selection, and logistical site support are periodically reviewed and updated, including contracts (i.e., pre-coordinated or contingency contracts and support arrangements);

4. Monitor readiness indicators including training, credentialing, team composition, and monthly on-call rotation schedules;

5. Maintain FMS equipment and caches through a coordinated, proactive logistics sustainment system that includes monitoring equipment and supply inventories, replacing expended supplies and rotating shelf-life items, ensuring the security, proper storage, and accountability of hazardous and controlled items, and conducting routine equipment testing and repair, as needed;

6. Monitor reports and other communications; participate in conference calls (CONCALLs), video-conferences (VTC's), meetings and other opportunities for coordination; obtain status updates and coordinate actions regarding outstanding issues and unresolved problems; identify and extract relevant information regarding ESF #8 equities; share information with appropriate offices, report status, and obtain guidance;

7. Maintain situational awareness and publish informational reports as needed, according to guidance, policy and SOP;

8. When indications and warnings suggest response may be imminently required, initiate communication with the affected Regional Emergency Coordinator (REC) and identify or confirm the points of contact (POCs) and potential FMS location(s);

9. For incidents with prior notice or warning (such as an evolving influenza pandemic) and events, which are pre-planned,

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- a. Assess need for FMSs and coordinate staging location(s), assess FMS cache status and begin planning for movement operations;
- b. Assess staffing requirements for FMSs, based on anticipated missions/utilization, to include the Public Health Service RDF, the DMAT TF, and any augmentation or enablers required;
- c. Confirm the pre-identified FMS sites' selection criteria have been met (Appendix B1) and coordinate the arrival and set up of FMSs, or deploy a Logistics-led advance team to conduct FMS site assessment;
- d. Publish the ESF #8 Warning Order (WARNORD) and contact necessary personnel by telephone to give preliminary instructions. The WARNORD will identify staging and operational locations, when known;
- e. Identify the FMS Leader(s), report current personnel readiness for FMS staffing, initiate coordination with the DSNS Team Room regarding potential deployment of FMS cache(s), and begin coordination of staging operations (if necessary);

B. Response. This phase includes mobilization and response activities. During this phase ASPR staff will:

1. For no-notice incidents,
 - a. Assess need for FMSs and coordinate staging location(s), if required, assess FMS cache status and begin planning for movement operations;
 - b. Assess staffing requirements for FMSs, based on anticipated missions/utilization, to include the RDF, the DMAT TF, and any augmentation or enablers required;
 - c. Confirm pre-identified FMS sites' selection criteria have been met (Appendix B1) and coordinate the arrival and set up of FMS, OR, deploy an advance team to conduct FMS site assessment;
 - d. Publish the ESF #8 Warning Order (WARNORD) and contact necessary personnel by telephone to give preliminary instructions. The WARNORD will identify staging and operational locations, when known;
 - e. Identify the FMS Leader(s), report current personnel readiness for FMS staffing, initiate coordination with the DSNS Team Room regarding potential deployment of FMS cache(s), and begin coordination of staging operations (if necessary);
2. When authorized and directed, EMG Operations publishes the ESF #8 Execution Order (EXORD) as well as initial schedule for required coordination calls and reporting. The EXORD will provide details regarding travel, mobilization and demobilization processing, staging, and operational locations to the extent known. It directs CDC DSNS to deploy the necessary cache(s), FMS ST, and an LNO to the EMG, and simultaneously directs activation and mobilization of Logistics Response Assistance Teams (LRATs) and staffing capabilities (RDF, NDMS, and/or partner support) for the FMS;
3. Coordinate staging, transport, and deployment operations. The DSNS warehouse and technical support personnel coordinate with their transportation partners

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for deployment of FMS caches. The FMS cache is under the operational control of the DSNS during en route movement until it arrives at the employment location when DSNS transfers tactical control to the Federal Health Official (FHO) or the operational IRCT;

4. Deploy advance elements according to policy and SOP, and conduct reception and mobilization processing of personnel. A REC may act as IRCT Advance Element pending arrival of the designated IRCT Commander to provide Federal asset oversight, management and support;

5. The REC assigned to the affected region communicates with the incident command officials, identifies the site POC's, confirms FMS site selection criteria are met, and coordinates the arrival and integration of FMS resources and other ESF #8 assets. The (up to four person) DSNS FMS ST provides technical assistance to the set-up team in establishing the FMS. The FMS ST will direct the 10-12 person set up team, and will include the FMS Leader or designee (if arrived) in coordinating the physical layout and set up (The FMS ST does not set up the FMS). The 10-12 person set up team of local personnel is one element of the required wrap around services, and they physically unpack and set up the FMS. ASPR Logistics Response Assistance Team (LRAT) members who support FMS ST must deploy simultaneously with the FMS ST. If multiple FMSs are to be employed, the FMS ST will drop off cache(s) and initiate set up in the first location, and when underway will move on to the next site. For this reason a set up team is required for each site, when possible, to meet the timeline for each FMS to be fully operational;

6. Upon arrival, clinical and support staff verify all equipment and supplies are in place and organize their work areas in preparation for receiving patients. If not already completed during mobilization processing, IRCT Operations will brief FMS staff on the operational situation, Safety will conduct a safety briefing, and CMO will brief the clinical staff. The FMS Leader will notify the IRCT (by Spot Report) when the FMS becomes operational and is prepared to admit and provide care for patients. Due to the potential variation among the operating facilities, the FMS Leader, Safety Officer and clinical staff will ensure the FMS layout is acceptable and will facilitate patient flow;

7. A successful FMS deployment requires early and ongoing collaboration between many partners in order to provide healthcare augmentation and conduct operations for an unknown duration in an area affected by a public health emergency or disaster.

8. Maintain and sustain FMS operations as an integrated component of ESF #8 support to SLTT authorities and the Incident Commander;

9. IRCT assumes authority to command and control ESF #8 response operations, supports response elements, and begins planning and preparing for demobilization and recovery.

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10. Management, administrative, and clinical staff may be from one organization or may be pulled from several. Personnel must work together to provide seamless 24-hour patient care and support services. The EMG or IRCT will identify the FMS Leader and administrative support requirements and assign personnel required for federally operated FMSs including those clinically staffed by VA or DOD personnel. DOD staff remains under the command and control of DoD authorities, with a senior representative assigned in support of the FMS Leader. Both DOD and VA have liaison officer positions within the EMG. Federally staffed FMSs operate under the direction and coordination of the IRCT when operational. The FMS is a resource within an ICS structure under the command and control of the IRCT. ICS functions must be assigned to FMS staff members or coordinated by the FMS with the IRCT.

11. FMS Logistics, through the IRCT Logistics Section, will coordinate operational resupply of the FMS cache. The IRCT Logistics Chief, in coordination with FMS Logistics staff will account for all property deployed to their assigned area of responsibility. EMG Logistics will coordinate with prime vendors and/or the DSNS for additional logistics support if necessary.

C. Recovery. This phase includes both demobilization and recovery activities.

1. IRCT includes FMS turnover to the SLTT jurisdiction and/or recovery of cache(s) and equipment in the Demobilization Plan submitted for approval by EMG Operations. On approval of the Plan, EMG Operations will publish a Demobilization Order directing IRCT to place staff and assets into demobilizing status in an orderly fashion according to mission requirements and the Demobilization Plan;

2. Personnel placed in demobilizing status will be processed by EMG for demobilization and released to transportation for return to home/duty station, with the IRCT and Demobilization Processing capabilities the last to depart the area of operations.

Scope of Care

FMS clinical resource capabilities using federal staffing options range from triage to field treatment, stabilizing for transport, maximizing survival, limiting and managing pain and suffering, and referrals to an appropriate hospital facility (the FMS does not have organic patient transport capability; however, this is one element of the required wrap around services). The FMS must have a wide range of capabilities, and the IRCT may be required to augment the staff based on patient needs and mission requirements. The FMS is a deployable surge capability to support the healthcare needs of individuals who live in congregate, supportive settings (e.g., long-term care facilities, hospice facilities, group homes or affected hospitals) who present with physical, mental, and/or behavioral health conditions. Additionally, individuals with previously stable chronic medical, mental or behavioral health conditions that are likely to deteriorate in the post-disaster setting and those under hospice care may be cared for at an FMS. Individuals who prior to a disaster were residing at home with personal assistance services (e.g.,

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home health care, oxygen support) should, when possible, be served in the most integrated setting (a mass care shelter) (See reference s).

A. Triage. Two types of triage decisions are needed to describe FMS patients. Type one is traditional acuity triage to prioritize life and limb-threatening situations, as follows: Immediate (Red, Emergent), Delayed (Yellow, Urgent), and Minimal (Green, Minor). Type two triage includes Medical Resource Needs levels 1-4 as follows: "Level 1" (functionally independent), "Level 2" (occasional functional assistance needed), "Level 3" (frequent nursing assistance required), and "Level 4" (near continuous nursing assistance required). Level 3 patients and their families are the most common FMS patients. Levels 1 and 2 patients are likely best served in a mass care shelter. Level 4 patients have a higher morbidity in makeshift environments, require frequent advanced laboratory and imaging studies, and ideally are transferred to a fixed facility, although some Level 4 patients may be appropriate for an FMS depending on employment circumstances. (See Appendix F: FMS Emergency Triage Tool)

B. The primary function of the FMS is to provide patient care and monitor and treat individuals whose medical conditions may deteriorate in the post-disaster environment, whether staffing is provided by SLTT authorities (using local resources, MRC, or NGO personnel) or federal resources (such as USPHS or NDMS personnel). Individuals requiring imaging (x-rays, CT, MRI, or nuclear medicine), comprehensive labs, and specialty consultation should be triaged for transfer to a definitive health care facility.

C. Medically fragile individuals with conditions that may deteriorate are accommodated and cared for to the fullest extent possible in the FMS as supported by the host jurisdiction's provision of wrap around services. In keeping with section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA), this includes the use of bariatric beds and lifts, standard and bariatric wheelchairs and walkers, pediatric equipment and supplies, and non-verbal communication boards. Staff will coordinate with IRCT Logistics regarding requirements for adjunctive items not available in the FMS cache.

D. At-risk individuals who have access or functional needs and require certain medical services may not be excluded from a mass care shelter. SLTT plans should direct, at a minimum, medical care commonly provided in the home setting (e.g., assistance in wound management, bowel or bladder management, or the administration of medications or use of medical equipment) be available at mass care shelters (see reference s).

E. Missions to support quarantine operations* are anticipated but not always feasible. Exposed individuals requiring quarantine should not generally be placed into a FMS, in order to avoid exposing otherwise healthy but vulnerable patients/residents with Medical Resource Needs (level 1-4). Current residents who require quarantine (i.e., exposed but exhibiting no symptoms) should be kept in a separate area with dedicated and restricted sanitary, dining, and bathing facilities. The ability to safely enforce

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quarantine within a building of opportunity (where the staff may not be able to control the HVAC system, and adequate decontamination of the building and surfaces may not be possible), and the duty to protect the larger, but frail FMS population necessitates decisions be based on the greater good. Potential use of the FMS for quarantine requires additional square footage and specialized environmental conditions to maintain a safe environment for patients and staff. The additional space, environmental, and services requirements must be taken into consideration during site selection and wrap around services planning for this mission set. (**Note: Specialized requirements for quarantine operations depend upon the physical characteristics, quantity and concentration of the identified contaminant or bioaerosol of concern. Every FMS site is inspected prior to occupancy for safety and sanitation efficacy, and the endemic nature of contaminants and bioaerosols or the health status of the population to be served is considered. The environmental health parameters reviewed will, in concert with the health data acquired, identify whether the FMS is a safe and appropriate facility for quarantine services.*)

F. Some patients and residents will present to an FMS with their own medications. The pharmacist will inventory the medications with the patient, document the medications and dosages, and leave them with the patient if the patient is responsible to self-administer medications. When the patient's supply contains controlled substances, however, these will be inventoried and taken to the pharmacy to be secured in a container marked with the patient's name. These items will be secured by the pharmacy as a safety and security measure, and dispensed to the patient by the staff.

G. Veterinary Medical Support Services that cannot be provided by local responders may be required for animals sheltered in conjunction with an FMS. When this is the case treatment may be provided by the veterinarian on the team deployed to augment the FMS assuming they are clinically current. This support should be coordinated with the IRCT Veterinary Medical Branch Director who can coordinate for veterinary medical personnel as well as supplies required from the National Veterinary Response Team (NVRT) cache.

Safety and Security

Safety and security at the FMS is essential. Physical security is coordinated and provided by the host jurisdiction as part of wrap around services. The FMS Safety Officer (if assigned) is responsible for working with IRCT Safety Officer, REC, and the SLTT jurisdiction to ensure that the safety and security measures adequately safeguard FMS patients and other occupants. Maintaining a healthy working environment requires attention to occupational health and environmental conditions, including equipment and work site design, physical environment (temperature, humidity, light, noise, ventilation, and space), duties, psychological factors (personal interactions, work pace, job control) and sometimes, chemical or other environmental exposures. Situations in workplaces that can lead to injury or illness range from physical hazards (such as cords across walkways, leaving supplies or equipment along evacuation routes, leaving low containers open, objects falling from overhead) to task-related (speed or repetition,

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duration, job control, etc.), environmental (chemical or biological sources) or design-related hazards (such as locations of pillars or other structural objects that may limit movement or evacuation). Operating in areas that have been affected by a public health emergency, the nature of the emergency, and the requirement to work in close proximity to large populations in enclosed facilities under austere conditions may also result in illness.

When SLTT physical security must be augmented or prior to it being established, physical security may be provided through federal law enforcement via mutual aid agreements or in coordination with ESF#13. Initially the EMG coordinates security support until the IRCT is in place to coordinate locally and with the Joint Field Office (JFO). A security specialist in the IRCT will provide assessments and direct coordination support of security requirements with ESF #13.

Facility Access Controls. Factors influencing access and movement vary depending upon the type of emergency and local conditions. Controlling the movement of individuals into, throughout, and out of the facility during an emergency is essential to the safety of patients and staff, and to the security of critical supplies, equipment, and information. The SLTT jurisdiction determines the type of access and movement to be allowed by staff, patients, visitors, emergency volunteers, vendors, maintenance and repair workers, utility suppliers, and other individuals when emergency measures are initiated.

Plans must support the establishment of effective physical access controls, including the requirement for formal, documented policies and procedures for limiting physical access to an FMS while ensuring that properly authorized access is allowed.

These controls should include the following implementation features: disaster recovery, emergency mode operation, equipment control (into and out of site), a facility security plan, procedures for verifying access authorization before allowing physical access, maintenance records, need-to-know procedures for personnel access, sign-in for visitors and escort requirements, if any.

Safety. Pre-deployment preparation, training, and access to readily available information, field assessment, and safety equipment are critical to minimizing consequent deaths, injuries, and illnesses, and to promote overall workforce resilience. Once an incident occurs HHS/ESF #8 responders are placed under a time-urgent, dual-cognitive demand: 1) they must attend to the hazards (including attention to self and staff members' safety and health), and 2) they must perform the work necessary to complete response operations. Fire extinguishers and other safety equipment must be provided as required by law or as necessary to maintain patient and worker safety.

A. Individual Safety. All federal employees are under the protection of the Department of Labor (DOL) Occupational Safety and Health Act (OSHA) standards. Additionally, a Risk Assessment and Hazard Analysis are provided for each response, and published by the Chief Medical Officer in HERA format. The HERA identifies both

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physical and behavioral concerns that would preclude a responder from FMS participation, both prior to and during response activities. The HERA is provided to all deploying personnel PRIOR to the response, and covers environmental and physical hazards, as well as medical conditions necessary to ensure a safe deployment. Responder compliance is checked during Mobilization Processing, prior to on-site activities.

B. Work Place Safety. Both a site-specific Safety Analysis and a Response-specific Health and Safety Plan (HASP) protect each FMS and deploying personnel. A Safety Officer is assigned to each FMS location, and is supported by reach-back to safety-related SMEs through the IRCT or EMG Safety Officer (SOFR). The SOFR is briefed on the deployment HASP, which is certified to meet OSHA standards for deployment activities. Both health hazards (illness prevention) and accident/emergency protocols are covered, and a qualified person certifies the HASP. Subsequent to the identification of an approved location for an FMS, the site SOFR identifies site-specific concerns, and develops site-specific safety rules - which provide additional direction to employees during FMS operations. These include evacuation routes and procedures. Safety briefings and messages are provided daily by the FMS SOFR, and location specific concerns are communicated to the site through the SOFR at the IRCT or EMG. Fire safety, personal protective equipment (PPE), safe work locations and sanitation/health issues are covered in the HASP, which, unlike the HERA, is designed to be implemented by a trained/taped SOFR.

C. Patient Safety. The FMS ensures patient safety through a robust system of quality assurance and control protocols, despite the austere environment. All orders/actions/charting and directions are documented either in the EMR or written form. A Patient Safety group is identified which consists of caregivers (medical and nursing staff), infection control practitioners and the FMS SOFR, and this group meets daily while the FMS is operational to review incidents, accidents, medication protocols, and other patient safety issues. Incidents are documented with corrective action plans and change management measured.

The FMS professionals are responsible to maintain the environment of care. The facility is assessed daily by the FMS SOFR and infection control practitioner for physical safety concerns. Protocols are maintained as specified by the American College of Infection Control Practitioners (ACICP). Patients are identified at all times, and medications secured in environmentally controlled locations. Temperatures within the facility are charted to ensure they are within comfort zones as specified by the American Society of Heating Refrigeration and Air Conditioning Engineers (ASHRAE) [Heat/Cold/Humidity], and adequate ventilation (e.g., 4 air exchanges per hour in occupied areas) is maintained for the site. Hot water temperatures at all patient accessible water locations are maintained at < 104F.

The FMS staff develops sanitation schedules; at a minimum, daily cleaning and disinfection, and areas of concern (e.g., quarantine or isolation areas) have specified cleaning agents and schedules identified. Food service areas are separated from other

areas of the FMS, and hand-washing facilities located at all food/toilet/rest areas. All cleaning must be done using hospital grade disinfectants listed/certified by the Environmental Protection Agency (EPA).

Security. Security planning must ensure appropriate physical security and accountability measures are established to protect personnel, real and personal property, and to safeguard sensitive information. Assigned and supporting personnel, patients and other occupants are responsible for maintaining adequate awareness of their surroundings and immediately reporting any suspicious packages or activities and security concerns to the FMS SOFR or FMS Leader. The FMS Leader or his/her designee will coordinate with the IRCT and appropriate law enforcement representatives for detainment and removal of unauthorized personnel, and evaluation and rendering safe, confiscation and removal of potentially hazardous and prohibited items inside the FMS.

A. Physical Security. A physical security system should safeguard against unauthorized access and introduction of contraband, detect actual or attempted unauthorized access, provide security for federal equipment, supplies, and valuables, and be able to activate a response. Response refers to reactions such as the involvement of guards and law enforcement, damage assessments and measures to prevent the failure of other elements of the system. At a minimum, physical security planning will address the following:

- Limiting access and egress to and from the FMS, including the facility and its immediate surroundings;
- Providing security against introduction of weapons by patients or visitors, and means for securing/storing valuables;
- Using a government photo identification to identify staff, patients, and other occupants. High-risk or high-value areas within the facility, such as the pharmacy, nursing stations, and treatment areas must be properly evaluated and secured. Patients must have a wristband that includes the patient's name, date of birth, and allergy status at a minimum; and,
- Security of entry and exit points to the local area and the perimeter (e.g., the city block), when possible and practical.

B. Property Accountability. Accountability of FMS property is essential. Accountability begins prior to mobilization and continues throughout the duration of the response, and is completed by the appropriate party at the cache's point of origin after redeployment. The IRCT Logistics Section Chief is responsible for working with all parties to ensure that accountability measures are properly executed. Detailed procedures will be implemented for accountability and responsibility, including record keeping, transfer of accountability, relief of accountability, property removal permits, and

theft or vandalism reporting. All FMS personnel are responsible for maintaining adequate control of FMS assets and to immediately report any discrepancies and concerns to the FMS Leader or his/her designee.

C. Personnel Accountability. Personnel accountability is one of the most critical information requirements of the EMG and IRCT during response operations. Individual personnel and supervisors bear significant responsibility to check in and out for accountability purposes IAW SOPs and applicable instructions conveyed in orders.

D. Safeguarding Information. Information Access Controls will comply with applicable statutory and related authorities, policies and other governing documents.

E. Amnesty boxes. In coordination with local law enforcement, FMS may provide a means for residents to turn in, without attribution, items such as illicit drugs or weapons upon intake to an FMS. Use of an amnesty box enhances safety and security of the facility.

Risk Analysis. Many HHS/ESF #8 activities and deployments inherently involve variables and unknowns, which may have a substantial impact on team and mission success. These uncertainties require frequent identification, assessment, analysis, and planning to minimize impact. Risks should be assessed based on the likelihood of occurrence and the potential severity of impact. A mitigation plan for each risk should be developed to reduce the likelihood or severity of each negative risk, or conversely, increase the likelihood or maximize the benefit of each positive risk. In addition, team safety or well-being may be compromised. Each team should review their risks and plans on a routine basis, and while deployed, risk assessment and mitigation should occur daily.

Integration and Interoperability

FMS assets must be capable of rapid integration into and interoperability within the community's existing healthcare infrastructure. As such, FMS operations must be deliberate and synchronized for maximum efficiency and effectiveness. From the selection of an FMS site to contracting logistical site support requirements, every effort must be made to rapidly achieve operational capability and effective integration and interoperability. All applicable Federal and SLTT jurisdiction statutory and related authorities, policies and other governing documents will be observed. If they compete, the FMS Leader in coordination with the IRCT, and the State POC should consult with their legal counsel to determine how to proceed.

Integration into an Overall Response Scenario. FMS operations are developed and coordinated to remain flexible and ensure the rapid integration and unity of effort with other ESF #8 and federal response resources, and the local healthcare system. This includes conducting direct and frequent communication among the IRCT, FMS management team, local and other healthcare stakeholders regarding current and anticipated status of response operations and capabilities.

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Multiple Mission Requirements. Multiple FMSs may be deployed in an affected area to accomplish several different missions. FMS support personnel must be familiar with the cache(s) and staffing implications for the various likely missions (for example, hospital decompression, skilled nursing facility evacuation, mental or behavioral health patient holding, etc.).

Caregivers and Family Members. During displacement due to catastrophic incidents, some patients will present to an FMS along with their home healthcare provider or other caregiver(s). Family members will want to remain together, especially if one member has a need for medical care or treatment. These providers and family members are welcome to shelter within the FMS as non-medical attendants to provide care for and support their patient/family member.

Policies on family members residing in the FMS with a patient vary by state, so must be considered and incorporated into FMS planning. For example, in states that do not allow non-patients to remain in the FMS, SLTT authorities should plan to locate an FMS near a general shelter under auspices of SLTT or ESF #6, so family members not requiring or involved in providing care can remain in proximity to their loved ones.

Interoperability with the Local Healthcare Infrastructure. FMS are designed to be scalable and tailored to ensure they are interoperable and capable of adequately augmenting the local healthcare infrastructure's response capabilities.

Partnership Integration and Interoperability to Support FMS Operations. An FMS may be staffed by Federal personnel, non-Federal personnel, or a hybrid of staffing sources. When a hybrid model is used, Federal personnel may be co-located with SLTT personnel and/or other non-Federal personnel. While Federal and non-Federal personnel may need to coordinate in providing care in a hybrid model, personnel remain under the supervision and control of their respective agency or organization.

A. **VA.** The VA may provide clinical and non-clinical staff to augment an existing FMS, or deploy, establish and independently operate an FMS. See Annex C: Department of Veterans Affairs (VA) FMS CONOPS for additional details.

B. **DOD.** Upon approval by the Secretary of Defense and receipt of a validated, funded, and appropriate mission assignment (MA), the DOD may provide clinical staff for an FMS managed by HHS. (Annex D: Department of Defense (DoD) FMS CONOPS, Pending)

C. **National Guard Bureau (NGB).** At the discretion and approval of the individual Governor, the State National Guard (NG) may provide clinical and non-clinical staff to augment an existing FMS, or deploy, establish and independently operate an FMS in either a Title 10 or Title 32 status. Note: NG members serving in a Title 10 status remain under the operational control of the DoD during mobilization, deployment and employment in support of FMS. NG Soldiers serving in a Title 32 or State Active Duty (SAD) status remain under the operational control of the Governor.

D. State Department of Public Health. State and local health agencies may provide FMS staff or augmentation.

E. Non-Governmental Organizations (NGOs) and Private Sector (PS). NGOs and PS partners are comprised of non-profit, voluntary citizens' groups and for-profit businesses, respectively. They perform a variety of service and humanitarian functions, including providing funds, goods, and services such as food service, and may provide staffing for SLTT FMS.

F. Prime Vendors. Utilization of Prime Vendors eliminates the layering of supplies at multiple echelons and shifts inventory, inventory management, transportation, and personnel costs from the Government to commercial firms. Prime Vendor programs take advantage of the experience of commercial vendors, whose profit based business practices demand lean inventories and rapid deliveries. Prime Vendor initiatives allow HHS to achieve significant annual savings and are crucial to maintaining a coordinated, proactive and automated logistics sustainment system that is connected directly to private industry partners, which allows active monitoring and facilitates all logistical site support requirements to ensure there is no degradation in the logistics sustainment operations for the duration of the response.

Concept of Support Responsibilities

A. HHS, Assistant Secretary for Preparedness and Response (ASPR)

1. Direct the development of strategic and programmatic policies and operational and budgetary plans to support preparedness for, response to, and recovery from incidents requiring federal public health and medical support;
2. Maintain oversight of the development and deployment of FMS and related capabilities;
3. Assist with coordination of resources to conduct FMS operations including but not limited to personnel, logistics caches, information technology, communications, medical records, and telemedicine support;
4. Coordinate Prime Vendor support capable of facilitating a coordinated, proactive logistics sustainment system that is connected directly to private industry partners, allows active monitoring, and facilitates all logistics requirements to ensure there is no degradation in logistics sustainment operations for the duration of FMS operations;

B. HHS, Assistant Secretary for Health (ASH)

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1. Serve as a Principal Staff Assistant and advisor to the Secretary for all non-deployed and potentially deployable U.S. Public Health Service (USPHS) Commissioned Corps Officers, and Reserve USPHS Commissioned Corps Officers;
2. Incorporate all policy implications of this CONOPS into OPDIV directives, doctrine and training, as appropriate;
3. Monitor and confirm valid unrestricted licensure status, credentials, and currency of USPHS health and medical providers before assignment to provide patient care;
4. Through the Division of Commissioned Corps Personnel and Readiness (DCCPR), Office of the Surgeon General, provide U.S. Public Health Service (PHS) Commissioned Corps Officers to staff the FMS.
5. Through the OSG/Division of the Civilian Volunteer Medical Reserve Corps (DCVMRC), maintain situational awareness of any Medical Reserve Corps (MRC) unit activities in affected SLTT area.

C. HHS, Office of the Secretary, Office of the General Counsel (OGC)

1. Provide legal counsel to HHS staff and operating divisions on issues related to FMS operations and strategic policy;
2. Coordinate with Offices of General Counsel within ESF #8 partner agencies, as necessary.

D. HHS, Centers for Disease Control and Prevention (CDC) /Division of Strategic National Stockpile (DSNS)

1. Incorporate policy and procedural implications of this CONOPS into OPDIV directives, doctrine and training as appropriate;
2. Provide life-cycle management of FMS caches and deploy them as directed to support federal response operations;
3. Coordinate SNS operations through CDC with EMG;
4. Support FMS Working Group, cache planning, management, pre-staging and readiness reporting, deploy Strike Team(s) (FMS ST) with FMS caches to facilitate FMS installation and operation, provide subject matter expertise (SME), facilitate material and pharmaceutical re-supply (as required), and recover and rehabilitate FMS caches (if necessary) when mission complete. Be prepared to conduct turnover of complete FMS caches to SLTT authorities when authorized.

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E. HHS, ASPR, Office of Emergency Management (OEM)

1. Coordinate and implement strategic policies;
2. Designate an FMS Program Coordinator to facilitate communication and coordination with internal and external partners and to conduct program coordination activities;
3. Develop, coordinate, approve, and implement operational policies including readiness standards to support this CONOPS;
4. Through the Division of Operations, develop and issue amplifying execution guidance for OEM and supporting partners within their various area(s) of responsibility;
5. Through the NDMS and Tactical Programs Divisions,
 - a. Through the National Disaster Medical System Chief Medical Officer (CMO), provide scope of care and medical oversight, monitor and confirm valid unrestricted licensure status, credentials, and currency of NDMS health and medical providers before employees are assigned to provide patient care under the auspices of ESFs #8 or 6;
 - b. Assess needs for, develop and provide curricula for individual training to support safe and effective operation of FMS;
 - c. Coordinate as necessary to ensure FMS operations can support veterinary requirements of patients/residents;
 - d. Develop policies and procedures to support inter-agency training, operating and medically staffing FMS.
6. Through the Regional and International Emergency Coordination Division (RICD), Regional Emergency Coordinators (RECs),
 - a. Serve as the FHO (ESF #8 Lead) in the region during disasters;
 - b. Coordinate with SLTT authorities and regional entities to identify anticipated requirements for FMS support, engage in stakeholder coordination and preparedness to support FMS operations IAW this CONOPS and related planning guidance, and identify jurisdictions' liaison requirements to support FMS operations; The REC or IRCT is responsible to coordinate with Federal and SLTT jurisdiction partners to identify and validate the suitability of the proposed location using the Checklist provided in Annex B, Appendix 2;

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c. Pre-identify gaps, which may necessitate Federal support for medical special needs operations and suitable sites to serve as potential FMS cache locations while considering the recommended FMS operating site(s);

d. Educate the SLTT and regional stakeholders on the mission, requirements, limitations, and logistical site support options needed for a successful FMS operation;

e. Encourage SLTT and regional entities to have pre-coordinated or contingency/ crisis contracts and support arrangements necessary to operate and sustain an FMS;

f. Coordinate with SLTT and OEM Logistics to conduct FMS site survey(s) to ensure the logistical wraparound services are appropriate and to identify any gaps requiring resolution during a response;

g. Assist the SLTT jurisdictions with initiation and submission of the initial Request for Assistance (RFA) identifying ESF#8 requirements. In the absence of a Stafford Act declaration, a jurisdiction may also submit a request for FMS directly to HHS through the RECs;

h. Provide initial coordination with SLTT for deployment and operations of the FMS. If an Incident Response Coordination Team is deployed, the IRCT may assume operational coordination with the SLTT. The IRCT Team Lead reports directly to the FHO and keeps him/her informed of progress, issues, and status. The IRCT provides all coordination and communication with the FMS when the operation is federally staffed and operated. If the State or locality operates a FMS, the personnel operate under that State's or locality's command and control and medical direction.

F. Veterans Administration (VA), and Department of Defense (DOD)

1. Identify the required personnel skill sets/specialties necessary to staff FMS;
2. Develop specific policies and procedures to support training, deployment, operating, and/or medically staffing FMS.

G. State, Local, Tribes and Territories (SLTT)

1. Pre-identify potential FMS operating sites and coordinate site assessments thru HHS/OEM/RICD;
2. When developing the Action Request Form (ARF) to request support consistent with the FMS capability, coordinate with RECs for requests and requirements. Confirm the following are complete and available:

a. Ability to provide at least 12 personnel to physically set up the FMS under the Initial direction of the FMS ST;

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b. Identify Point of Contact for FMS Team;

c. Arrangements for wrap around services.

3. The facility POC, as identified in the initial ARF, be prepared to coordinate with the FMS ST, set-up crew, and the clinical staff team leader (if present), as they physically set-up the FMS IAW the logistical site support previously validated by the State or REC and using the site selection checklist to re-confirm site suitability;

4. The SLTT FMS POC, as designated by the jurisdiction's Department of Health or Emergency Management (or equivalent), establish and communicate coordination and reporting protocols with the RECs, FMS Leader, and any LNOs.

Personnel Resources

The potential variation in missions and patient mix requires the EMG (initially) and IRCT (during operations) to modify or augment staffing, as needed, to support the full spectrum of patient care requirements. The staffing model requires clinical competence and relevance (in skill sets), and supports scalable and modular operations. USPHS Rapid Deployment Force (RDF) Officers typically staff Federally operated FMSs with augmentation by NDMS and PHS specialty teams. VA or DOD personnel, with or without augmentation, may provide federal staffing. SLTT operated FMS may be staffed by State/local Departments of Health. In any of these cases, augmentation may be provided by local or Emergency Management Assistance Compact (EMAC) – interstate mutual aid healthcare resources, Territorial or Tribal, Medical Reserve Corps (MRC), National Guard Bureau (NGB), and federal personnel. While Federal personnel who are co-located with SLTT or other non-Federal personnel may need to coordinate in providing care using the hybrid model, personnel remain under the supervision and control of their respective organizations. All FMS health care providers are required to maintain appropriate certifications and licensure within their disciplines. Healthcare providers who are Federal employees only need to be licensed in a State. Because of the expectation for mixed staffing models in some scenarios, participating personnel must be willing to remain flexible and to participate in just-in-time training opportunities in every phase of the FMS operation. Each FMS has a management team not assigned to perform clinical work. Their function is to coordinate horizontally and vertically to maintain and sustain operations, and they provide, or coordinate with the IRCT for administrative, logistical, and operations management support of the clinical staff.

HHS is capable of staffing eight to ten FMSs with RDF personnel augmented by DMAT TFs and additional clinical personnel. Each mission's size, scope, or duration will determine additional personnel needs and may include requirements for individuals with unique skills (such as pediatric nurses and wound care specialists) or large numbers of individuals with broad-based nursing skills. Staffing includes a minimal management staff, administrative section, and logistics capability but is predominately clinical. See Appendix B4, Minimum Staffing Model, for detail on initial FMS staffing requirements. In the absence of a designated team member, the FMS Leader or clinical operations lead

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will delegate or assume responsibility for unfilled requirements. Personnel requirements must be communicated to the IRCT for approval and resolution.

USPHS Commissioned Corps officers, NDMS personnel, and federal partners typically staff and support deployment of FMS. These federal personnel resources may also support SLTT FMSs. The following paragraphs describe staffing resources in greater detail.

A. Division of Commissioned Corps Personnel and Readiness (DCCPR), Office of the Assistant Secretary for Health. DCCPR coordinates employment of Officers of the U.S. Public Health Service (USPHS) Commissioned Corps in teams or as individual subject matter experts or augmentees. The USPHS Commissioned Corps Officers assigned to HHS teams are on call one out of every five months and usually deploy only during the month they are on call. Deployments do not typically exceed 14 days. Team members are identified and mobilized using tier designations:

- **Tier 1:** Respond within 12 hours; includes the RDF;
- **Tier 2:** Respond within 36 hours; includes the Applied Public Health Team (APHT) and Mental Health Team (MHT); and
- **Tier 3*:** Respond within 72 hours; includes the remainder of PHS Commissioned Corps. **Note: Access to Tier 3 USPHS officers requires the HHS Secretary activate the USPHS Commissioned Corps.*

1. Rapid Deployment Force (RDF): The RDF consists of five pre-identified teams, each with 105 staff representing multiple disciplines. The teams serve on a rotating call basis, with the on-call team capable of deploying within 12-hours of notification. RDF teams provide care at FMSs, and staff Points of Distribution (PODs) and Casualty Collection Points (CCP). The RDF can also conduct community outreach and assessments such as needs assessments, resource identification, advocating, and re-integration, among other functions. Each RDF is able to deploy for 14 days.

2. Applied Public Health Team (APHT): The APHT is composed of professionals in applied public health and can function as a "public health department in a box." An APHT can deploy within 36 hours of notification and provide assistance in public health assessments, environmental health, infrastructure integrity, food safety, vector control, epidemiology, and surveillance. Each APHT is able to deploy for 14 days.

3. Mental Health Team (MHT): The MHTs, with 25 personnel per team, consists of five pre-identified teams that serve on a rotating call basis. The MHT consists of mental and behavioral health professionals who assess stress and suicide risks within the affected population, manage responder stress, and provide therapy, counseling, and crisis intervention. The MHT can deploy within 36-hours of notification and is able to deploy for 14 days.

4. Service Access Teams (SAT): The SAT assesses and monitors ongoing health and human services needs of affected populations and is particularly skilled at serving "at-risk" individuals and populations, defined as people who are unable to plan, advocate/or obtain resources and/or services to meet basic health and safety needs. A SAT team can deploy within 36 hours of notification and is able to deploy for 14 days.

B. NDMS. The NDMS is a federal partnership of HHS with DHS/FEMA, VA, and DOD, that was designed, in part, to deliver quality medical care to the victims of a domestic disaster. NDMS teams are capable of providing medical care under austere conditions at a disaster site and in participating definitive care facilities. NDMS teams include, but are not limited to, the following:

1. Disaster Medical Assistance Team (DMAT) Task Force (TF). HHS has a total of 49 operational DMATs across the U.S., each with health care provider personnel who can be deployed as a team, a tailored TF, or assigned individually to backfill another team. DMATs provide ambulatory 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 includes physicians, nurses, physician extenders, pharmacists, and paramedics along with ancillary support personnel. On call teams can be deployed within 12 hours of notification and arrive at a disaster site within 24-48 hours for a deployment of fourteen days. See DMAT CONOPS (Ref o) for more information about the DMAT cache. A Mobile Lifesaving Kit (MLK) is the logistics support package for a DMAT TF.

Each Federally staffed FMS will typically deploy with a DMAT TF of 12 or 24 personnel. The DMAT TF primarily treats those FMS patients who require a higher level of care, and FMS patients whose conditions deteriorate, until they can be transported by ambulance to definitive care facilities. ESF #8 partners who are staffing FMS but are unable to provide all required specialties/skill sets should coordinate with the EMG to arrange for supplemental staff. (Refer to Annex B, Appendix 4: FMS Staffing Model, for additional information.

2. Logistics Response Assistance Teams (LRAT). ASPR's LRAT members who are DSNS-trained may deploy as a force multiplier with the FMS cache and FMS ST to assist and provide consultation on the adequacy of the building of opportunity and wrap around services.

C. CDC DSNS. When FMS caches are deployed, DSNS will also be required to provide FMS STs (2-4 personnel) to deploy simultaneously to facilitate the set-up and provide technical assistance to meet the timeline for the FMS to be operational. DSNS LNOs may also deploy to the IRCT, the EMG, or other location to provide technical assistance regarding all DSNS capabilities.

D. Federal – SLTT Hybrid Model. SLTT requirements for assistance may include staffing augmentation, full capabilities, or materiel alone. When feasible, prior planning and coordination will facilitate federal response integration with SLTT plans.

Pre-coordination for FMS should include discussions with SLTT jurisdiction partners regarding their potential utilization of displaced staff specialists from evacuated facilities, MRC personnel, and extenders such as nursing or medical students to enhance non-Federal staffing.

E. FEMA Federal Emergency Medical Services Contract. The purpose of the FEMA Federal Emergency Medical Services Contract (also referred to as the National Ambulance Contract or NAC) is to provide multi-functional medical transportation and support resources in support of SLTT requirements. Resources include staffed medical transport capabilities and/or licensed and certified medical personnel. The NAC provides ground, air (both rotary- and fixed-wing), and para-transit evacuation support of seriously ill or injured patients from casualty collection staging areas, affected facilities (hospitals, nursing homes, or other medical treatment/health care facilities), and the FMS, in impacted areas. Patients will be transported to patient reception medical facilities where they can receive the appropriate level of care. The contract is activated to evacuate patients and at-risk populations from an area at significant risk, to provide transport services in a region that has already been affected by a disaster, and to provide medical support personnel (EMTs and paramedics). The FEMA contract is not specifically intended for returning patients back to their point of origin; however, at the request of the state, it may be used for returning patients in the immediate aftermath of a disaster if the healthcare infrastructure is in place and operational.

F. Medical Reserve Corps (MRC). There are 1,000 MRC units nationwide, with over 200,000 volunteers. The mission of the MRC is to engage volunteers to strengthen public health, emergency response and community resiliency. It provides the structure necessary to locally deploy medical and public health personnel in response to an emergency, as it identifies specific, trained, credentialed personnel available and ready to respond to emergencies. The MRC units are community-based and function as a way to locally organize and utilize volunteers who want to donate their time and expertise to prepare for and respond to emergencies and promote healthy living throughout the year. The MRC volunteers supplement existing emergency and public health resources. The MRC volunteers can choose to support communities in need outside their local jurisdiction by including their contact information in state volunteer registries such as the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP). The MRC volunteers include medical and public health professionals such as physicians, nurses, pharmacists, dentists, veterinarians, and epidemiologists. Many community members, including interpreters, chaplains, office workers, legal advisors, and others, can fill key support positions. In addition to emergency response activities, MRC units also help to strengthen public health in their communities and many focus on the priorities of the U.S. Surgeon General (improving health, increasing disease prevention, and eliminating health disparities).

G. VA. Refer to Annex C for details regarding VA staffing of FMS.

H. DOD. Refer to Annex D for details regarding DOD staffing of FMS.

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Certifications and Licensure. All ESF #8 providers are required to maintain valid unrestricted licensure within their disciplines. The ASPR Office of the Chief Medical Officer (CMO) will monitor credentials and currency of NDMS providers, while the Office of the Assistant Secretary for Health performs this function for USPHS officers. Local MRC units (or their housing organizations) perform this function, often using their state ESAR-VHP system, for MRC volunteers.

ESF #8 Partners. Upon receipt of a validated, approved and funded mission assignment (MA) (for Stafford Act deployments), the Approving Authority for each ESF #8 partner (e.g., Secretary of Defense; Secretary of Veterans Affairs; Director, NGB; etc.) will ensure their supporting personnel respond within 24-96 hours of receipt of notification or as agreed during coordination (DoD requests 14 days' notice prior to deployment). The ASPR/OEM will use the MA to activate ESF #8 partner support, issue sub-taskings or coordinate with FEMA to issue partner MAs if necessary, and to coordinate to fill gaps in logistical site support prior to mobilization of ESF #8 assets.

Staff Augmentation. Requests for additional personnel must be routed through IRCT Operations. Ad hoc recruitment of civilians is not permissible. The FMS Leader, in coordination with the IRCT, may leverage other HHS or ESF #8 partner response teams to augment staffing requirements. Conversely, ESF #8 teams may be attached to provide support to other HHS or ESF #8 partner response teams. With the approval of the IRCT, the FMS Leader may coordinate requests to share team members between Federal response teams, if careful attention is given to team assignment to ensure full accountability for each team member. The FMS Leader is responsible to maintain accountability IAW ASPR policies, OEM orders, and IRCT Commander's guidance. Related duties may be delegated as the FMS Leader sees fit based on circumstances.

Logistics

FMS Cache Composition. FMSs are packaged for shipping in modules with both alphabetical and functional packing lists provided with each container. Each module is comprised of multiple sets and kits that are configured, packaged, and labeled for rapid loading and deployment. The modules contain medical and non-medical items to support patients and residents for up to three days of continuous operations.

A. DSNS-Managed FMS Cache

1. Base Support Module (BSM). The BSM contains administration, feeding, pediatric, utility/electrical distribution, facility support, general supply/resupply, and bed sets including bariatric equipment. BSM provides bedding, bedside packs, common support items (tables, chairs, lamps, and fixtures), and personal protective equipment for staff. It also includes items needed for quarantine and durable medical equipment.

2. Treatment Module (TM). The FMS TM contains equipment and materials for medical diagnosis and treatment, including medical/surgical and chronic care items.

3. Pharmacy Module (PM). This module contains FMS Formulary medications. The formulary may be modified with the approval of the Cache Management Working Group (CMWG) at the recommendation of the Clinical Oversight & Recommendations Working Group, and the Pharmacy and Therapeutics (P&T) committee, based upon medical and pharmacologic advances, emerging operational requirements and lessons learned, on an as-needed basis. At a minimum, the formulary should be reviewed and updated annually by a P&T committee.

B. OEM Logistics-Managed FMS Cache

1. Pharmacy Controlled Substance Kit. This kit contains controlled substance Class II through IV drugs, providing up to three days of supply.

2. Lab-Plus Cache. This cache provides limited Point of Care testing capability, both CLIA-waived and non-waived. It includes assays for chemistry/electrolytes, pregnancy, blood gases, cardiac biomarkers, urinalysis, glucose testing, Complete Blood Count and liver function.

3. Communications Cache. The Communications cache contains an EMR Kit, 5 laptops, 5 cell phones, a G2 satellite phone, and a DTR kit.

4. Mobile Lifesaving Kit (MLK). The MLK provides person-portable logistical support for the DMAT TF. It contains materials for early life support interventions for up to two adult patients and one pediatric patient. The kit includes an airway bag (packed and transported without oxygen), a Thomas Pack with ACLS drug bags, a LifePak 12, and a rolling cart with two oxygen D cylinders.

5. Personnel Support Kit (PSK). Contains cots, sleeping bags, lights (flashlights and headlamps), water, and food (in the form of Meals-Ready-to-Eat, MREs). PSKs are intended to support personnel billeting within the FMS facility or a Base Camp environment.

Logistics Framework—Federal Responsibilities. Upon completion of an FMS operation, FMS sets should be signed over to the SLTT/non-federal entity if authorized. If caches remain federally controlled, the DSNS assumes responsibility to recover the durable goods contained within the cache, transport to a decontamination location for decontamination as needed, and return to a storage location for inventory and replenishment of supplies. The DSNS will build new FMS sets to replace those signed over to SLTT, and continue standard life cycle management.

Storage Requirements for FMS Operations. All medical and surgical supplies should be stored in a secure, climate controlled area in close proximity to the patient treatment area. Most pharmaceuticals are labeled with storage temperatures. United States Pharmacopeia (USP) defines the various temperatures as:

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- Controlled room temperature: 59 to 86 degrees Fahrenheit (F) or 15 to 30 degrees Celsius (C).
- Refrigerator: 36 to 46 degrees (F) or 2 to 8 degrees (C).
- Freezer: 32 degrees (F) and lower or 0 degrees (C) and lower.

Pharmaceuticals that are stored at other than USP standard temperatures are considered to be "adulterated" and therefore unsuitable for human use. It is the responsibility of the DSNS to ensure that the cold chain storage is completed from deployment to arrival on scene. It is the responsibility of the IRCT Logistics section to ensure that the cold chain storage is maintained from that point forward.

Resupply / Sustainment. In a deployed setting, resupply and sustainment will be coordinated through IRCT Logistics by the FMS Leader or Logistics Chief. Supply requests generated by the FMS will be reviewed and approved by FMS Logistics Chief. Provided the request is appropriate and available, EMG Logistics will place the order IAW the Logistics CONOPS. EMG Logistics will coordinate with DSNS for additional sustainment support if required.

Host Agency Logistics Site Support and Services. As with other medical disaster response capabilities, FMS is not designed to be self-sufficient. When deployed, the FMS will rely on the host jurisdiction to provide some or all logistics site support and services necessary to sustain operational capability. Host jurisdictions may be responsible for service support management and planning. The SLTT or regional jurisdiction is responsible for identifying sites, providing site managers/coordinators, and within their abilities providing all external service support requirements of the FMS. By exception, the State can request specific external service support from the Federal government (FEMA) as needed. See Appendix B: FMS Requirements Checklist for additional FMS requirements (e.g., square footage, electrical needs, ice, billeting, etc.). The identified building of opportunity should be close as practical to both a supporting hospital and general shelter for ease of transferring patients and sharing resources such as laboratories and diagnostic capabilities. Recommended buildings of opportunity that **may** be suitable for use as an FMS include National Guard armories, gymnasiums, colleges and universities, hotel conference centers, community centers, and climate-controlled warehouses.

Host jurisdiction support must include arrangements such as contingency support contracts that provide services including (but not limited to) (See Appendix B2):

- Electrical power
- Refrigeration
- Waste disposal, including biomedical waste
- Laundry and housekeeping services
- Food service support (patient/resident feeding)
- Potable water and wastewater management
- Transportation
- Fuel
- Medical oxygen

- Latrines, hand washing stations, and showers
- Mortuary support
- Material handling equipment
- Site and facility security

Transportation Support. FMS caches are staged and deployed by the DSNS and ASPR/OEM using commercial transportation. Responders will have rental vehicles or buses. Vehicle support requirements for the FMS must be coordinated through the IRCT. There is no organic transportation in the FMS.

FMS Delivery, Assembly, and Logistical Site Support. For an FMS deployment to be successful, it is critical to have pre-planned logistical site support. FMS equipment and supplies are to be employed in existing buildings of opportunity; rely upon available utilities, and support the clinical practices and procedures of the supported local public health organizations. Appendix A: FMS Site Selection Criteria describes additional area requirements for proposed FMS locations. The DSNS will support FMS cache planning, management, pre-staging and readiness reporting, and deploy FMS ST to facilitate set-up, provide technical materiel subject matter expertise (SME), expedite material and pharmaceutical resupply as required, and conduct turnover with SLTT authorities or recover FMS caches.

A. Delivery and Assembly. The DSNS will provide life-cycle management of FMS caches and deploy them as directed by the EMG. The FMS equipment cache will arrive at the designated site with the FMS ST to facilitate proper set up. The FMS ST will not physically set up the FMS. The FMS ST will coordinate with the host facility POC (as defined by the initial ARF), clinical staff if available (e.g., RDF, NDMS, VA, DOD, NGB, or the State), and will direct and guide the 10-12 person team of volunteers in physically setting up the FMS.

B. Logistical Site Support. The FMS must be housed inside a structurally intact facility that has the appropriate square footage of open space (depending on the FMS beds required), adequate electrical power, heating, air conditioning, ventilation, potable hot and cold water, housekeeping and waste removal services. It requires logistical site support for patients/residents, to include food service and laundry. Staff require, within reasonable proximity, billeting and laundry facilities, and access to meals. Other operational requirements include bathroom and showering facilities, billeting for staff, and contracted support for food, ice, medical oxygen filling, and biomedical waste disposal. The FMS cache is capable of supporting patient care for up to three days without resupply. Note: Staff may be billeted adjacent to or away from the FMS operation, but separate hygiene facilities are required in either case. Patient/resident feeding is part of the wrap around services requirements; however, staff are generally on paid government travel and responsible to obtain their own food and beverages. Staff feeding opportunities must be managed and provided by the FMS Leader and supporting task force or strike team leaders as coordinated with the IRCT.

C. Responder Life Support. When the response environment is austere Logistics deploys Personnel Support Kits (PSKs) for federal responders. PSKs support personnel billeting within the FMS facility or a Base Camp environment. In most cases, when commercial or other SLTT lodging is available, responders are responsible to pay for their food and water IAW the Federal Travel Regulations (FTR). Lodging may be individually paid (using Government Credit Card, GCC) or paid centrally by ASPR Travel or the supporting Federal partner. VA and DoD should identify and coordinate any life support requirements (such as requirements for PSKs) with the EMG in advance of deployment.

Communications, Information Technology, and Reporting

Communications. Communication flow and accurate information are critical to effective decision-making. A standardized framework for communications that is capable of ensuring continuous and uninterrupted communications is critical. It is based on the concepts of interoperability, reliability, scalability, portability, and addresses the need for resiliency and redundancy of communications and information systems. Plain language and common terminology will be used. Codes should not be used, and all communications should be confined to essential messages. Use of acronyms should be limited and clarified for safety. Communications equipment will be issued by the EMG or IRCT Logistics for federally operated FMS. Both equipment and protocols are subject to change based upon technological advances, emerging operational requirements, and lessons learned. Communications systems must be:

- Interoperable—able to communicate within and across agencies and jurisdictions as required;
- Reliable—able to function in the context of any kind of emergency;
- Portable—built on standardized radio technologies, protocols, and frequencies;
- Scalable—suitable for use on a small or large scale as the needs of the incident dictate;
- Resilient—able to perform despite damaged or lost infrastructure; and
- Redundant—able to use alternate communications methods when primary systems go out.

A. Internal Communications. The primary means of internal, interactive voice communications between FMS personnel is portable two-way radios, such as the Motorola handheld units provided by the IRCT. Communications within the FMS is required for staff coordination, support for command and control, and patient tracking.

B. External Communications. The FMS is equipped with 800-MHz portable radios for use if local land and cellular communications are disrupted. The radios may

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also be used to communicate with ambulance transports and support services. Communication with external agencies is critical for support and coordination. External agencies include disaster officials, local healthcare organizations, ambulance services, and service support organizations. Caches include eight basic, non-encrypted walkie-talkie radios with capability for both 9 KHz and 300 GHz operation.

C. Personal Communications Devices. Personal devices may not be used for patient care purposes or in patient care areas. Inside the facility use should be limited to receiving emergency calls only. If necessary to use personal devices within the facility, staff must move to an administrative area away from patients/residents to maintain patient/resident privacy, operational security, and a professional work environment.

D. Information Technology (IT). The FMS requires information technology support that complies with applicable laws and federal regulations during contingency operations. Reportable IT data requirements include, at a minimum:

1. Patient tracking, clinical information, and data storage (electronic medical record);
2. Information for third party reimbursement, when required;
3. Procedures performed;
4. Type of care and treatment provided;
5. Medication regimen and dispensing records;
6. Pharmacy tracking system to facilitate dispensing, quality control and patient tracking;
7. Discharge date and time; and,
8. Medical materiel ordering and management history.

This information technology capability will:

- Be deployed with technical support personnel as an augmentation. FMS does not have organic IT/IM capability;
- Coordinate with other federal assets;
- Use software that will allow it to perform the above listed functions; and
- Have established policies, procedures, training and guidance in place.

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Reporting. Upon achieving initial operating capability (IOC) and throughout the duration of operations, each FMS must provide reports to the IRCT to inform the Common Operating Picture (COP) for the EMG, HHS leadership and ESF#8 partners. In addition to providing operational updates, the reports will be used to identify and support process improvement and lessons learned. Reporting will be in accordance with (IAW) IRCT Field Operations Guide (FOG) (Ref j) or SOPs. Incident Command System (ICS) report forms 209 (status updates) and 214 (personnel accountability) will include details regarding FMS response and recovery activities, at a minimum:

- Number of FMS beds (and cots) occupied;
- Number of FMS beds (and cots) available;
- Number of non-medical attendants (family members or caregivers who are not patients);
- The types of patients being cared for and common disease states encountered;
- Existing or anticipated issues relating to personnel, security, logistics sustainment, or operational capabilities (e.g., personnel, the FMS site or wrap around services, etc.) other than those already identified/submitted for resolution. Refer to the appropriate Section guidance (by functional area) for specific reporting requirements (e.g., Operations, Planning, Administration and Finance, Logistics, Safety, Chief Medical Officer, etc.).

Burn rate reporting will be according to the Logistics CONOPS and SOPs.

Personnel accountability reporting during travel and between unit assignments will be according to existing SOPs, instructions provided in deployment orders, or by the EMG and IRCT.

Training

FMS training is a readiness indicator and is essential for HHS and partner agencies supporting the FMS mission.

The purpose of training is to provide the orientation and procedural information necessary for staff members to effectively operate in the FMS. OEM Division of Tactical Programs, Training, Exercises, and Lessons Learned (TELL) Branch, is responsible for collective training and exercise development. NDMS Program Development Branch (PDB), and OASH, DCCPR provide input to TELL regarding training needs of their respective personnel. Various functional stakeholders provide individual training opportunities for appropriate personnel, to include cross training. Individual and team training may include but are not limited to topics such as:

- FMS standard operating procedures;

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- Scope of care, triage, and treatment modalities;
- Safe patient transfers, bed changes, and other patient management;
- Standard reporting procedures and use of Information Management systems such as Electronic Medical Records (EMR), Joint Patient Application Tracking System (JPATS), Personnel Accountability Resource System (PARS), Resources Management System (RMS), and WebEOC (Web-based Emergency Operations Center);
- Response to requests for information including media queries;
- Patient confidentiality and handling of personally identifiable information (PII);
- Use and safe operation of FMS equipment;
- Infection control and personal protective equipment, to include handling and disposing of waste materials;
- Medico-legal training;
- End of life care for hospice patients in FMS;

When feasible, training and exercises should be integrated and include supporting agencies that may participate in staffing and supporting an FMS.

DSNS conducts training in FMS cache deployment and set-up for LRATs and other personnel when required.

Key Federal Decisions

Authorities. The authority for the FMS capability is the Public Health Service Act, as amended, primarily sections 311, 319F-2, 2811, and 2812 (42 USC sections 243, 247d-6b, 300hh-10 and 300hh-11). Funding for FMS operations may be provided through other laws, such as the Stafford Act (reference x), for incidents in which the President declares a major disaster or emergency. The PHS Act authorities are “all-hazards” (e.g., support any type of public health emergency) although HHS may need to rely on funding from other sources such as the Stafford Act in operating an FMS.

In October 2007, the White House published Homeland Security Presidential Directive 21 (HSPD-21) (reference d) establishing a *National Strategy for Public Health and Medical Preparedness*. HSPD-21 recognized the limitations of our national health and medical systems capabilities to meet surge requirements of catastrophic incidents. It directed capability development or enhancement in four critical components of public health emergency preparedness to prepare for and respond to catastrophic health events. This effort increased capability and capacity to support one critical component of public health preparedness, Mass Casualty Care. HHS further refined the Federal Medical Station (FMS) concept to meet this requirement.

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Authorities for maintenance of Disaster Medical Information System (DMIS) data include, but are not limited to, the Public Health Service Act, primarily section 2812 (42 USC 300hh-11).

Decision Points for Deployment of FMS

Establish the Requirement

- Have SLTT authorities requested federal assistance consistent with the FMS capability?
- Has the President declared an emergency or major disaster in the affected area?
- Has FEMA directed execution of activities IAW the Catastrophic Incident Supplement?

Confirm the Suitability of the Site(s)

- Has the state pre-identified suitable buildings of opportunity?
- Have the RECs or ASPR Logistics assessed and confirmed the site suitability, and documented the existence of or coordination for wrap around services?

Confirm Pre-Deployment Coordination

- Have SLTT authorities provided the name and contact information of their SLTT point of contact as well as the name and contact information for the facility point of contact?
- Have the EMG and DSNS Team Room established communications and initiated coordination of transportation, lodging, and en route requirements for the FMS and enablers (to include but not limited to FMS ST)?
- Have the required FMS ST and/or FMS-trained LRATs been simultaneously alerted for deployment along with an IRCT advance element, at least one FMS-experienced leader from the RDF, and one or more EMG personnel to conduct reception and mobilization functions for first arriving deployers and coordinate installation of the FMS?

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Annex A: Acronyms & Glossary

Acronyms

ACF	Administration for Children and Families
ACLS	Advanced Cardiac Life Support
ADL	Activities of Daily Living
AE	Aeromedical Evacuation
AEM	Area Emergency Manager
ALF	Assisted Living Facility
AMTS	Alternate Medical Treatment Sites
ANG	Air National Guard
ARC	American Red Cross
ARF	Action Request Form
ASPR	Assistant Secretary for Preparedness and Response
C2	Command and Control
CCP	Casualty Collection Point
CDC	Centers for Disease Control and Prevention
CLIA	Clinical Laboratory Improvement Amendments
CMO	Chief Medical Officer
CMS	Centers for Medicaid and Medicare Services
CONCALL	Conference Call
DCCPR	Division of Commissioned Corps Personnel and Readiness
DCE	Defense Coordinating Element
DCO	Defense Coordinating Officer
DCVMRC	Division of the Civilian Volunteer Medical Reserve Corps, OSG
DHS	Department of Homeland Security
DMAT	Disaster Medical Assistance Team
DMIS	Disaster Medical Information System
DMORT	Disaster Mortuary Operational Response Team
DOD	Department of Defense
DOH	Department of Health
DOT	Department of Transportation
DSNS	Division of Strategic National Stockpile
DTR	Digital Two-Way Radio
EMAC	Emergency Management Assistance Compact
EMG	Emergency Management Group
EMR	Electronic Medical Record
EMS	Emergency Management System
EOC	Emergency Operations Center
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Function
EXORD	Execution Order
FAA	Federal Aviation Administration

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FDA	Food and Drug Administration
FCC	Federal Coordinating Center
FEMA	Federal Emergency Management Agency
FMS	Federal Medical Station
FMS ST	Federal Medical Station Strike Team
FOC	Full operating capability
GCC	Government Credit Card
HASP	Health And Safety Plan
HERA	Hazard Evaluation and Risk Assessment
HHS	Health and Human Services, Department of
IA	Individual Assistance
ICS	Incident Command System
IRCT	Incident Response Coordination Team
ITV	In-Transit Visibility
JFO	Joint Field Office
JIC	Joint Information Center
JoCC	Joint Coordination Center
JPATS	Joint Patient Assessment and Tracking System
JRMP	Joint Regional Medical Planner
LMD	Logistics Management Directorate
LNO	Liaison Officer
LRAT	Logistics Response Assistance Team
MA	Mission Assignment
MLK	Mobile Lifesaving Kit
MOA	Memorandum of Agreement
MOD	Modification
MRC	Medical Reserve Corps
MRE	Meals, Ready-to-Eat
MSNS	Medical Special Needs Shelter
MTF	Medical Treatment Facility
NDMS	National Disaster Medical System
NGB	National Guard Bureau
NIH	National Institutes of Health
NIMS	National Incident Management System
NVOAD	National Voluntary Organizations Active in Disaster
NMA	Non-Medical Attendants
NMETS	National Mass Evacuation Tracking System
NRF	National Response Framework
NRCC	National Response Coordination Center
OEM	Office of Emergency Management (formerly the Office of Preparedness and Emergency Operations, OPEO)
OSG	Office of the Surgeon General (of the United States)
OPDIVs	Operating Divisions
PARS	Personnel Accountability Reporting System
PDD	Presidential Disaster Declaration
PHS	Public Health Service (see also USPHS)

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PII	Personally Identifiable Information
POD	Point of Debarkation
PODs	Points of Distribution
POE	Point of Embarkation
PRA	Patient Reception Area
PRT	Patient Reporting Team
PTDO	Prepare to Deploy Order
REC	Regional Emergency Coordinator
RFA	Request for Assistance
RMS	Resource Management System
RRCC	Regional Response Coordination Center
SNF	Skilled Nursing Facility
SLTT	State, Local, Tribal, and Territorial
SOC	Secretary's Operation Center
SOFR	Safety Officer
StaffDivs	Staff Divisions
TELL	Training, Exercises, and Lessons Learned Branch
UCG	Unified Coordination Group
USPHS	United States Public Health Service
VA	Veterans Affairs, Department of
VHA	Veterans Health Administration
VOLAG	Voluntary Agency
VTC	Video-Teleconference
WARNORD	Warning Order
WebEOC	Web Emergency Operations Center

Glossary

Accountability: The maintaining of an accurate tracking and awareness of personnel and resources deploying to, committed at, and demobilizing from an incident or event.

At-risk individuals: Before, during, and after an incident, members of at-risk populations may have additional needs in one or more of the following functional areas: communication, medical care, maintaining independence, supervision, and transportation. In addition to those individuals specifically recognized as at-risk in the Pandemic and All-Hazards Preparedness Act (i.e., children, senior citizens, and pregnant women), individuals who may need additional assistance during a response include those who have disabilities, live in institutionalized settings, are from diverse cultures, have limited English proficiency or are non-English speaking, are transportation disadvantaged, have chronic medical disorders, and have pharmacological dependency.

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Building of opportunity: Existing structure meeting the size and access requirements and having the utilities and services required for operation of a FMS as a surge medical facility.

Cache: A pre-determined complement of tools, equipment, and/or supplies packaged for rapid deployment and stored in a designated location, available for incident use.

Chain of Command: A series of management positions in order of authority.

Command: The act of directing and/or controlling resources by virtue of explicit legal, agency, or delegated authority. For any incident, there is only one Incident Commander. Command of ESF #8 response resources is vested by the EMG Manager (Deputy Assistant Secretary or his designee) in the IRCT upon their reaching full operating capability (FOC). Individual team leaders ("commanders" by position description) are not "in command" during response operations.

Definitive Care: The capabilities for monitoring, diagnosis, and inpatient treatment of illnesses and injuries available at hospitals.

Department of Health and Human Services (HHS): U.S. Cabinet-level department having the lead to respond, or coordinate response, to requirements for federal public health and medical support under the auspices of ESF #8 and other ESFs of the NRF.

Division of Commissioned Corps Personnel and Readiness (DCCPR): Within the Office of the Surgeon General, DCCPR is responsible for maintaining rosters of on call USPHS teams, and ensuring that the USPHS is trained and ready for emergency deployments.

Emergency: Absent a presidentially declared emergency, any incident(s), human-caused or natural, that requires responsive action to protect life or property. Under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, an emergency means any occasion or instance for which, in the determination of the president, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States.

Federal: Of or pertaining to the Federal Government of the United States of America.

Federal Medical Station (FMS): A HHS health care capability that generally provides low acuity health care with the capability to manage mild exacerbations of common chronic diseases for up to 250 patients.

Federal Medical Station Strike Team (FMS ST): A DSNS team of up to four members who deploy simultaneously with the FMS to provide technical assistance to a local installation/set up crew. An FMS ST of two personnel may be augmented by two DSNS-trained LRAT members to extend the capability of DSNS to support multiple FMS deployments or other competing high priority missions.

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Hybrid Model: In the hybrid model for staffing an FMS, multiple staffing sources (e.g., Federal, SLTT, and/or other non-Federal entities) may be co-located to facilitate the operation of an FMS. While such staffing sources may need to coordinate in providing care in a hybrid model, personnel remain under the supervision and control of their respective agency/organization as they carry out their respective agency/organization's mission.

Incident: An unplanned (no-notice or short notice) occurrence, natural or human-caused, which requires an emergency response in order to protect life or property. Incidents can, for example, include major disasters, emergencies, terrorist attacks or threats, wild land and urban fires, floods, hazardous materials spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, tropical storms, war-related disasters, public health and medical emergencies, and other occurrences requiring an emergency response.

Incident Action Plan (IAP) / Incident Coordination Plan (ICP): An oral or written plan containing general objectives reflecting the overall strategy for managing an incident. It may include the identification of operational resources and assignments. It may also include attachments that provide direction and important information for management of the incident during one or more operational periods.

Incident Command System (ICS): A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.

Incident Objectives: Statements of guidance and direction necessary for the selection of appropriate strategies, and the tactical direction of resources. Incident objectives are based on realistic expectations of what can be accomplished when all allocated resources have been effectively deployed. Incident objectives must be achievable and measurable, yet flexible enough to allow for strategic and tactical alternatives.

Integrated setting: The ADA and Section 504 of the Rehabilitation Act require that public entities administer services, programs, and activities in the "most integrated setting" appropriate to the needs of qualified individuals with disabilities. According to Federal regulations, the most integrated setting is one that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible.

Logistics: Providing resources and other services to support incident management.

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Logistics Section: The Section responsible for providing facilities, services, and materials for the incident.

Mobilization: The process and procedures used by all organizations (Federal, State, and local) for activating, assembling, and transporting all resources requested to respond to or support an incident.

National Disaster Medical System (NDMS): A Federally-coordinated system that augments the Nation's medical response capability. See www.phe.gov/preparedness/responders/ndms/Pages/default.aspx.

National Incident Management System (NIMS): A system mandated by HSPD-5 that provides a consistent nationwide approach for HHS, DOD, IA, VA, NGO, PS, and SLTT partners to work effectively and efficiently together to prepare for, respond to, and recover from domestic incidents, regardless of cause, size, or complexity. To provide for interoperability and compatibility among Federal, State, local, and tribal capabilities, the NIMS includes a core set of concepts, principles, and terminology. HSPD-5 identifies these as the ICS; multi-agency coordination systems; training; identification and management of resources (including systems for classifying types of resources); qualification and certification; and the collection, tracking, and reporting of incident information and incident resources.

Non-Governmental Organization (NGO): Private or voluntary citizens' groups organized on a local, national or international level. Task-oriented and driven by people with a common interest, NGOs perform a variety of service and humanitarian functions, bring citizen concerns to Governments, advocate and monitor policies and encourage political participation through provision of information. Some are organized around specific issues, such as human rights, environment or health. They provide analysis and expertise, serve as early warning mechanisms and help monitor and implement international agreements. Their relationship with offices and agencies of the United Nations system differs depending on their goals, their venue and the mandate of a particular institution.

Operating Divisions (OPDIVs): HHS has 11 operating divisions, including eight agencies in the U.S. Public Health Service and three human services agencies, which administer a wide variety of health and human services and conduct life-saving research for the nation. These agencies protect and serve all Americans.
<http://www.hhs.gov/about/foa/index.html>

Operations Section: The Section responsible for all execution of operations; at the incident responsible for tactical operations; as part of the Emergency Management Group responsible for strategic operational coordination and management. Subordinate elements include Branches, Divisions and/or Groups, Task Forces, Strike Teams, Single Resources, and Staging Areas.

Patient Tracking: The ability to know, at any given time, the location and status of a patient from the time the patient is first encountered by an emergency responder at an

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emergency event to arrival at a facility, whether the facility is a hospital, shelter or morgue.

Private Sector (PS): The part of the economy that is not state controlled, and is run by individuals and companies for profit. The private sector encompasses all for-profit businesses that are not owned or operated by the government. Companies and corporations that are government run are part of the public sector, while businesses, charities and other non-public organizations are part of the private sector.

Public Health Emergency: An emergency need for health care services to respond to a disaster, significant outbreak of an infectious disease, bioterrorist attack, or other significant or catastrophic event. A public health emergency may include, but is not limited to, public health emergencies declared by the Secretary of HHS, and/or a declaration of a major disaster or emergency under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act).

Safety Officer (SOFR): A member of the Command Staff responsible for monitoring and assessing safety hazards or unsafe situations, and for developing measures for ensuring personnel safety. The SOFR may have Assistants.

Staff Divisions (StaffDivs): The Office of the Secretary provides leadership through several offices that oversee operations, provide guidance, and ensure that funds are spent wisely and laws are followed fairly.

Wrap Around Services: External support services, such as housekeeping and food services that are not an organic capability within the FMS and must be provided by the local jurisdiction.

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Annex B: FMS Operational Requirements

- Appendix 1: FMS Site Selection Checklist**
- Appendix 2: FMS Wrap Around Services Checklist**
- Appendix 3: Example FMS Layout**
- Appendix 4: Minimum Staffing Model**
- Appendix 5: Modular Design of FMS Cache**
- Appendix 6: FMS Triage Tool**
- Appendix 7: Timeline for Employment of FMS**
- Appendix 8: FMS Cache and Pharmaceutical Formulary**

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Appendix B1: FMS Site Survey Checklist

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**FMS SITE SURVEY CHECKLIST**

HHS REC _____ ASPR REP _____ CDC REP _____

STATE REP _____ Phone Number _____

HHS Region: _____ Site POC _____ Phone Number _____

State: _____ Alt POC _____ Phone Number _____

Address _____

City _____ State _____ Zip _____ County _____

Geo Coordinates: _____

Nearest Hospital #1 _____ Nearest Hospital #1 _____

Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Structure Construction Type: _____

Parking Spaces for Staff _____ Trucks _____ Daily Cost _____

Loading Docks ☐ Yes ☐ No Location _____Entry Doors 48" or greater with no obstructions ☐ Yes ☐ No Location _____Sidewalks ADA Compliant ☐ Yes ☐ No Helipad ☐ Yes ☐ No Location _____

Perimeter Lighting Building _____ Parking Lot _____

Entry Doors Lock and have panic bars for exit from inside ☐ Yes ☐ No

Restrooms (1 / 20 people)

Men _____ ADA Compliant _____ Women _____ ADA Compliant _____

Showers (3 people / hour / 24 hours)

Men _____ ADA Compliant _____ Women _____ ADA Compliant _____

Hot Water (120 degrees - 6 gallon per patient)

Number of Tanks _____ Size of Tanks (Gallons) _____

Flooring

Type _____ Protective Covering Available ☐ Yes ☐ NoPallet Jack permitted on flooring ☐ Yes ☐ No **48****FOR OFFICIAL USE ONLY**

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Bariatric Capable ☐ Yes ☐ No

Staff Billeting

Prearranged on site ☐ Yes ☐ No

Site POC _____

Local Hotels _____ with _____ miles

Pharmacy

Separate Room with locking door/limited access ☐ Yes ☐ No

Refrigerator ☐ Yes ☐ No Size _____

Freezer ☐ Yes ☐ No Size _____

Kitchen Facilities ☐ Yes ☐ No Available for staff ☐ Yes ☐ No

Electrical (40 Amp, 480 volt, 3 phase, 80 Amp Service / 200 Amp, 120/240 volt, 3 phase)

Power coming into facility Volts _____ Amps _____ Phase _____

Number of outlets _____

Back up Generator on site ☐ Yes ☐ No

Operational ☐ Yes ☐ No Type _____ KW _____ Phase _____ Volt _____

Number of outlets dedicated to generator power _____

Fuel on site ☐ Yes ☐ No Amount in Gallons _____ Burn Rate _____ Gallon/Hour

HVAC

Operational in entire facility ☐ Yes ☐ No

Location of Shut Off Valve _____

A. Recommended Facilities.

Recommended existing structures suitable for use as an FMS include, if available: National Guard armories, gymnasiums, civic sports centers, schools, hotel conference rooms, health clubs (only if equipment can be moved/removed), convention centers, and community centers. A factor that makes National Guard armories and schools attractive is the fact that they are generally publicly owned structures, making it easier for emergency coordinators to rapidly secure them in the event of a disaster.

Multi-floor facilities are not suitable if the upper floors are intended for patients or equipment because of the difficulty in moving them up and down stairs. Upper floors may be suitable for other uses. Buildings posted with asbestos abatement warnings are not suitable for use.

Facilities that will resume normal operations shortly after the disaster/emergency and while FMS operations are ongoing should not be planned as primary FMS locations.

B. Building Size Considerations.

Building size is a key factor when selecting an existing structure. The building should be large enough to provide space for the desired number of patient beds. The availability of space will be largely determined by the facility design. The FMS consists of five 50 bed sets. If needed, the FMS configuration allows for expanding capacity by adding modules within a given facility as space permits. The minimum building size to accommodate the full 250 bed capacity of a functional FMS is approximately 40,000 square feet. The total number of beds that are used will be directly influenced by factors such as facility layout, wrap around services issues, patient acuity, and the medical logistics support.

E. Space/Layout Considerations.

While smaller, separate rooms may be useful for some patient care requirements (such as dialysis, wound care, etc.), this layout increases staffing requirements for patient care and supervision.

Square footage as well as the facility layout must be included in the assessment of suitability. Some buildings with apparently adequate space cannot hold the maximum number of beds due to layout constraints.

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Appendix B2: FMS Wrap Around Services Checklist

An FMS requires the following external service support provisions which are not organic to the FMS cache. Many of these services are regularly contracted for by health care facilities as part of their emergency preparedness program (Note: Asterisked items may be contracted by the SLTT or regional jurisdiction):

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FMS WRAP AROUND CHECKLIST



State Primary POC _____ On Site POC _____ Facility Name _____
 _____ Address _____
 _____ City _____ State _____ Zip _____ County _____

Capacity _____ Primary Power Source _____ Restrooms _____
 Helo Pad ☐ Yes ☐ No Alternate/Back Up Power _____ ADA Restrooms _____
 GPS Coordinates _____ Available ☐ Yes ☐ No Showers _____
 _____ Operational ☐ Yes ☐ No ADA Showers _____

Nearest Hospital #1 _____ Nearest Hospital #1 _____

Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Wrap Around Service	Quantity	Organization Name/Location	POC for Service Contract Information	Time Frame In Place By	Status	Comments
Building Requirement						250 Bed = 40K sq ft 100 Beds = 25K sq ft 50 Beds = 15K sq ft
Lease/MOU for use of Facility						On file at:
Staffing						
Security Inside (24 hr)						
Security Outside (24 hr)						
Total Occupants Beds/Staff/Security						
Billeting of Staff						On site Off site list local hotels in comments at end of form
Fire Suppression						System Operational
Secure Room						For Pharmacy
Parking for Staff						

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Parking for trucks						Parking for 4 53' trailers and 24' box truck
Electrical Distribution						Uninterrupted Service for 40+ Outlets
HVAC						Operational for entire facility
Heat						Operational for entire facility
Ventilation						Operational for entire facility
Set up Labor						12- 15 people
Forklift						1 Required to operate on pavement
Pallet Jack						Permitted to operate on floors
Toilet						1/20 people ADA Compliant Recommended
Showers						3 people per hour for 24 hours ADA Compliant Recommended
Hot Water						Heats up to 120 degree - 6 Gallons per patient/caregiver/staff per day
Hand Washing Station						Running Water in sinks Sinks available other than in bathrooms
Meals						4 Meals/Day per Patient/Caregiver Special Diets
Drinking water						15 L per day per Patient/Caregiver
Ice						5 lbs/day per Patient Up to 3100 lbs per day (Therapy Needs)
Oxygen						5 D Cylinders, 50 E Cylinders, 3 M Cylinders
Medical Resupply						
Lab Arrangement with Local Hosptial						To conduct Lab
Lab Arrangement with Local Lab						To conduct Lab
Transportation for Out Patient Services						To transport patients to medical appointments
Waste Removal						Normal day to day waste

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Bio Hazard Waste Removal						Picked up daily
Cleaning Services						Cleaning of common areas, rest rooms and showers
Laundry						Service for 250 set of clothes daily for Patient/Caregivers
Washer/Dryer						5 of each for emergency laundry services
Internet (Wireless Friendly)						No interference or signal shielding
Telephone Service						Number of Lines into Facility - Size (t-1 or t-3)
EMS-ALS Ambulance						1 ALS Unit stationed at facility while operational
Mortuary Services						Arrangements made locally

Additional Comments:

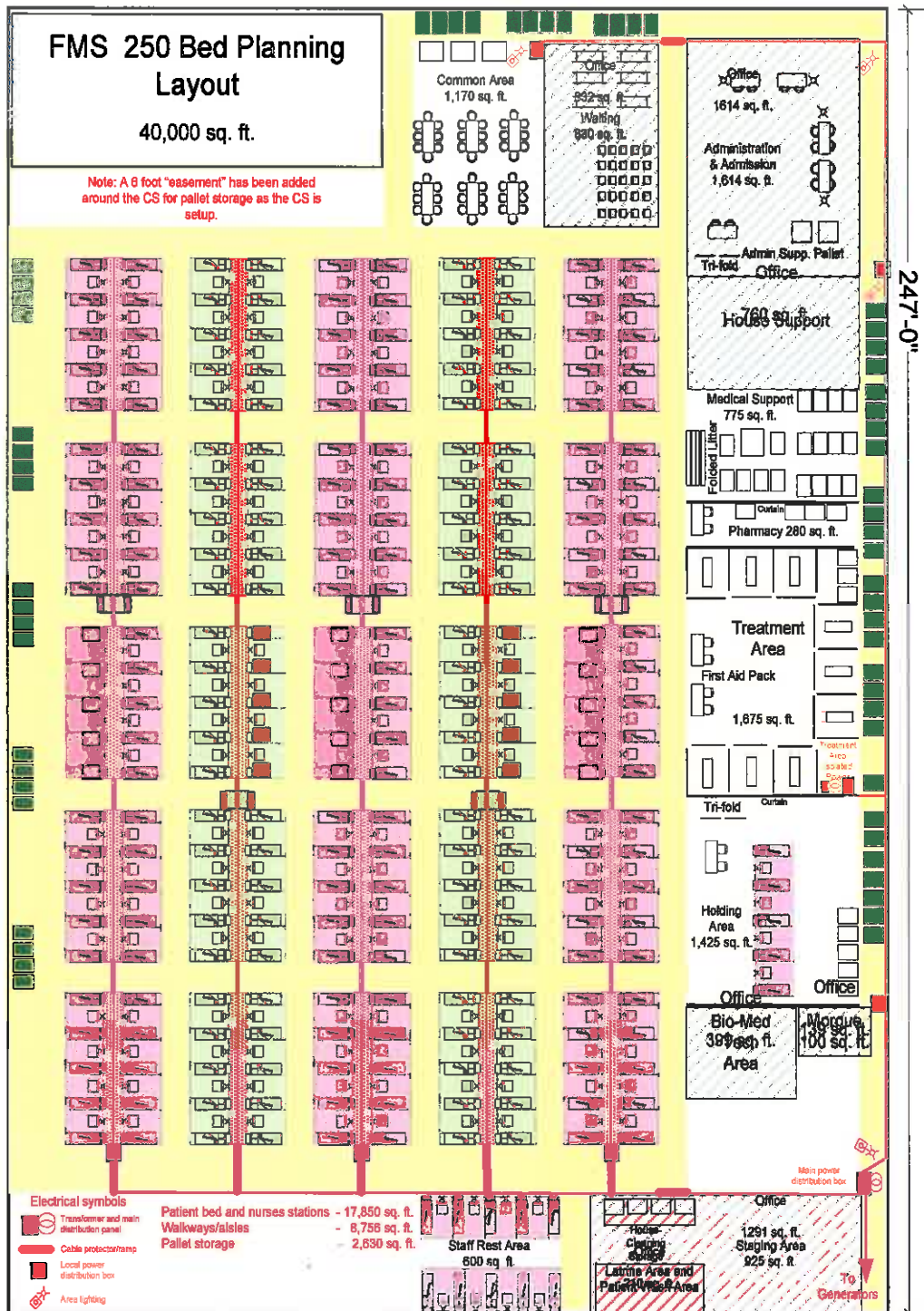
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Appendix B3: Example FMS Layout (250 Beds) - Facility similar to Field House or Convention Center



Note: Consider identifying a small area for infected patients, including designating/setting aside hygiene facilities for these patients.

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Appendix B4: Minimum Initial Staffing Model (250 bed FMS)

*Recommended minimum staffing if not using an RDF as primary staff	
FMS Leader	01
FMS Manager (Assistant)	02 (1:shift)
Safety Officer	01
Admin Assistant	02
Subtotal	06
Logistics/Pharmacy Unit	
Pharmacist	02
Pharmacy Technician	02
LRAT	04
Subtotal	08
Clinical Operations Unit	
Unit Leader (Physician)	01
Nurse Manager	01
Physician	04
Charge Nurse (1:shift)	02
PA and/or NP	04
Dentist	01
RN (including Triage Officers) [Factor at least 45 minutes hands-on/patient/shift/day]	42
LPN (DoD/VA only) [May replace RN if constant RN oversight available]	
EMT-B or P (DoD/VA only) [Not acceptable substitute for skilled nursing coverage]	
Respiratory Therapist* or Technician	2
Occupational Therapist	02
Behavioral Health Provider (Clinical)	02

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Epidemiologist	01
Environmental Health/Sanitarian**	02
Food Safety/Nutritionist	02
Veterinary Officer or Technician (Animal health) (as needed – from NVRT)	
Subtotal	66
Total	80

*Or Medical Provider/Nurse who has respiratory care experience.

**Or Infection Control Nurse Specialist

(Note: Additional and/or specialty staff augmentation based on patient needs and mission will be requested through the IRCT using the Request for Personnel (RFP) function in WebEOC.)

DMAT TF

The DMAT TF is comprised of from 12-24 personnel. The DMAT TF supports FMS operations and patient care, and provides care and treatment of acutely ill FMS patients until they can be transported by ambulance to a more appropriate definitive care setting.

	12 hours	24 hours
Emergency Medicine (EM) Physician	01	02
(EM) Physician Assistant / Nurse Practitioner	01	02
(EM) Nurse	02	04
EMT-P	08	16
<u>TF Total</u>	<u>12</u>	<u>24</u>

*Note: A Mobile Lifesaving Kit (MLK) is the required logistical support for the ECE (See Logistics Annex).

The following augmentation capabilities may be assigned to the IRCT in support of the FMS and other resources, or may be assigned directly to augment the FMS based on mission requirements:

Safety Officer
 Communications/IT
 Mental Health Team
 Applied Public Health Team
 Service Access Team

FMS Positions and Functions

- FMS Leader** is a person qualified to lead, direct, and manage a medical facility, and who is assigned responsibility for the overall operation of the FMS from establishment to demobilization. The FMS Leader is responsible to coordinate

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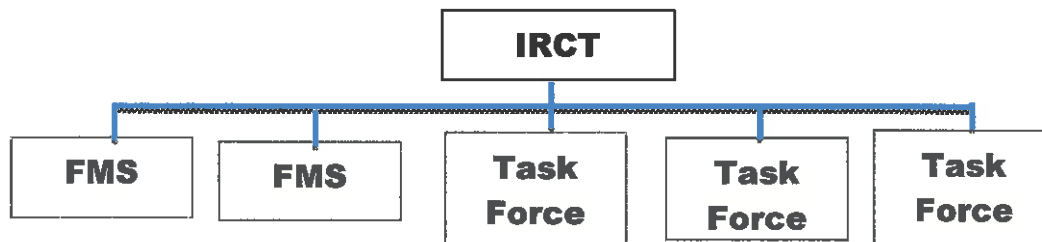
and direct all FMS functions. The FMS Leader reports to the IRCT Commander or the Commander's designee.

- b. **FMS Manager (Assistant Leader)** (if required) provides management support to the Leader as assigned.
- c. **Safety Officer** will monitor conditions and develop measures for assuring the safety of all FMS personnel and patients. The Safety Officer will work with the Preventative Medicine staff to ensure that worker health and safety is maintained. Security is critical to ensuring the safety and well-being of both FMS personnel and patient populations. The Safety Officer is responsible for ensuring that the FMS facility is safe for patients, residents, staff, and visitors, and for notifying the FMS Director of safety concerns. The FMS Leader or Safety Officer may halt operations at any time based upon a safety or security risk. The FMS Leader will immediately notify the IRCT regarding any security risks that jeopardize the well-being of team members, patients, or mission success. Safety Officer reports to the FMS Leader.
- d. The **Logistics Unit** provides support, resources, and other services needed to meet operational objectives. When needed, the Logistics Unit may create Service and Support sections to assist with span of control. Logistics reports to the FMS Leader. It coordinates all clinical, administrative and technical activities related to pharmaceutical and logistics operations. Responsibilities include:
 - Identifying, acquiring, allocating and tracking resources;
 - Planning to manage and use resources;
 - Immediately establishing a warehousing operation upon set-up to maintain accountability of supplies and equipment and determine "burn rate" items to begin ordering;
 - Coordinating FMS re-supply with the IRCT;
 - Requisitioning unique requirements through the IRCT as required;
 - Clinical pharmacy services including therapeutic selection, dose monitoring and adjustment, adverse event assessment, etc.;
 - Coordinating with logistics for potential shortfalls in pharmaceuticals.
 - Preparing and dispensing pharmaceuticals.
- e. The **Clinical Operations Unit**, led by the designated medical officer, conducts medical operations as defined by the IAP, maintains situational awareness, and creates the situation reports. They report to the FMS Leader. Operations Unit is

responsible to manage clinical operations to accomplish the patient care and treatment objectives established by the FMS Leader.

- f. The **Ancillary Services Unit** includes dental, laboratory, occupational therapy and behavioral health/social services. They report to the Clinical Operations Officer. The Ancillary Services Unit responsibilities include:
- Provide laboratory, occupational, physical, and recreational therapy services to patients;
 - Monitor and assess mental health and well-being of patients, and residents; and
 - Provide general behavioral health support to staff.

Figure B4. Example IRCT Resource Organization



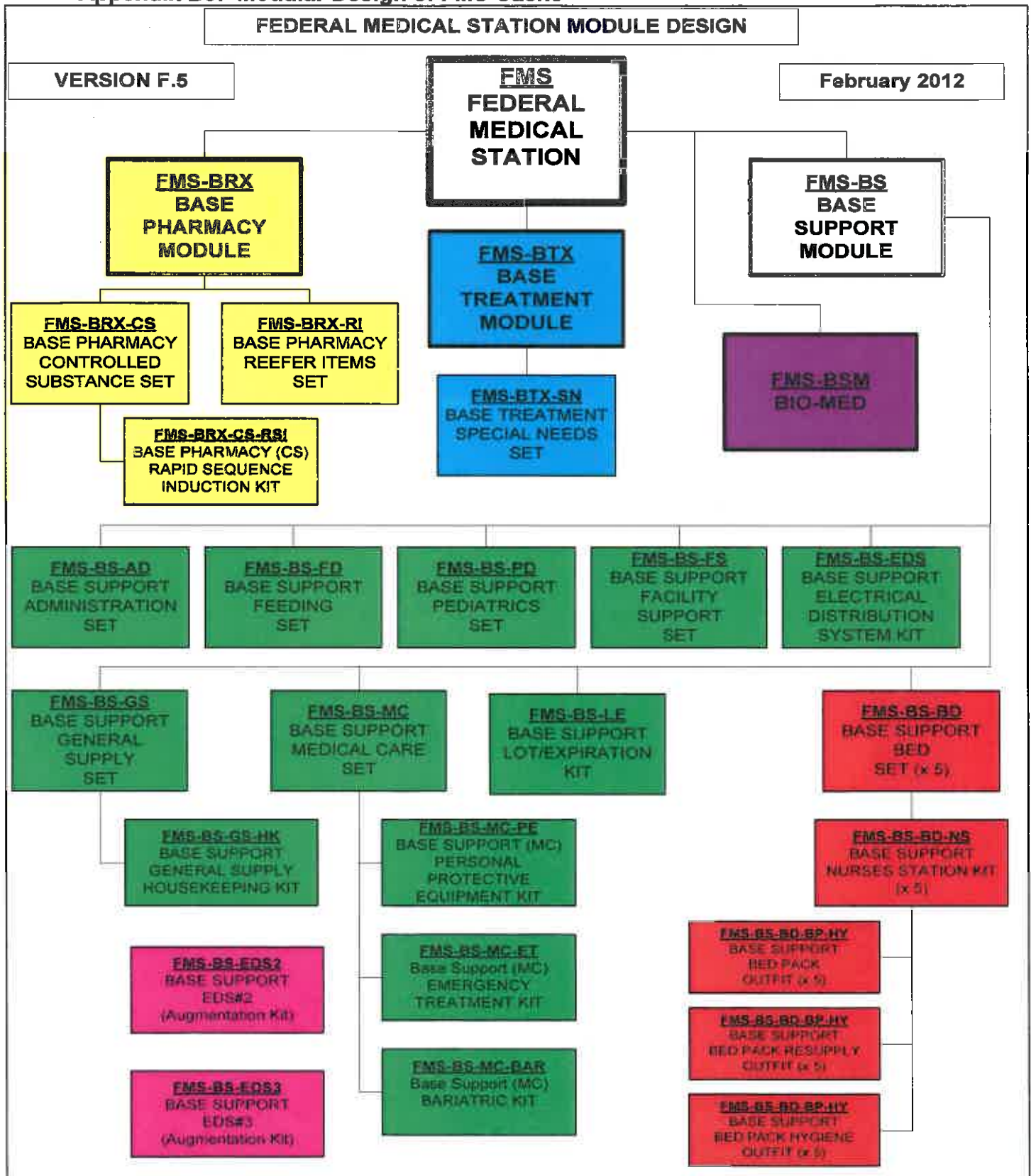
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Appendix B5: Modular Design of FMS Cache



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Appendix B6: FMS Triage Tool

Health and Medical Resource Levels to Assist with Patient Selection

Note: Typically Level 3 is the most common FMS patient.

- Level 1** Person is able to function independently and manage daily living activities with the assistance of a non-medical attendant or companion providing personal assistance services (PAS)
- Level 2** Person with an acute or chronic medical condition who is dependent on others for some assistance in addressing functional needs and maintaining routine living activities (eating, walking, toileting, etc) and is able to consistently express needs, and
- requires little monitoring, and
 - requires minimal or infrequent physical assistance in meeting needs.

Persons identified as Levels 1 or 2 should be considered for placement in a General shelter operated under the auspices of the SLTT jurisdiction or ESF#6. This is based on the concept of "most integrated setting appropriate to needs" federal guidance (reference s).

- Level 3** Person with chronic or acute medical condition(s) who requires regular or frequent medical or nursing assistance such as:
- meeting most of daily functional needs, or
 - medical care, or
 - monitoring by a nurse, or
 - those dependent on equipment requiring uninterrupted electrical power, or who require assistance in use/servicing such equipment, or
 - assistance with medications, or
 - monitoring, supervision related to mental or behavioral health disorders.

Some persons identified as Level 3 may be well served in a mass care shelter IAW the FNSS.

- Level 4** Person with acute and/or chronic medical condition(s) whose health care and medical needs require extensive medical oversight and/or daily professional care such as:
- IV chemotherapy,
 - Extensive wound care,
 - Quarantine,
 - Ventilator management,
 - Peritoneal dialysis or hemodialysis,
 - Life support equipment,

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- Health and medical sequelae to morbid obesity to include requiring substantial assistance for safe transfer or routine movement.

Special Note on Persons with Disabilities: Persons with disabilities (hearing, speech or vision impairment, mobility impaired, cognitive impairment, etc.) may require no assistance in meeting daily functional needs when principles of Universal Access are applied in the routine operations of mass care shelters. When persons with disabilities have medical or health sustainment requirements beyond those met by Universal Access, those requirements will be reflected in the Triage Levels above.

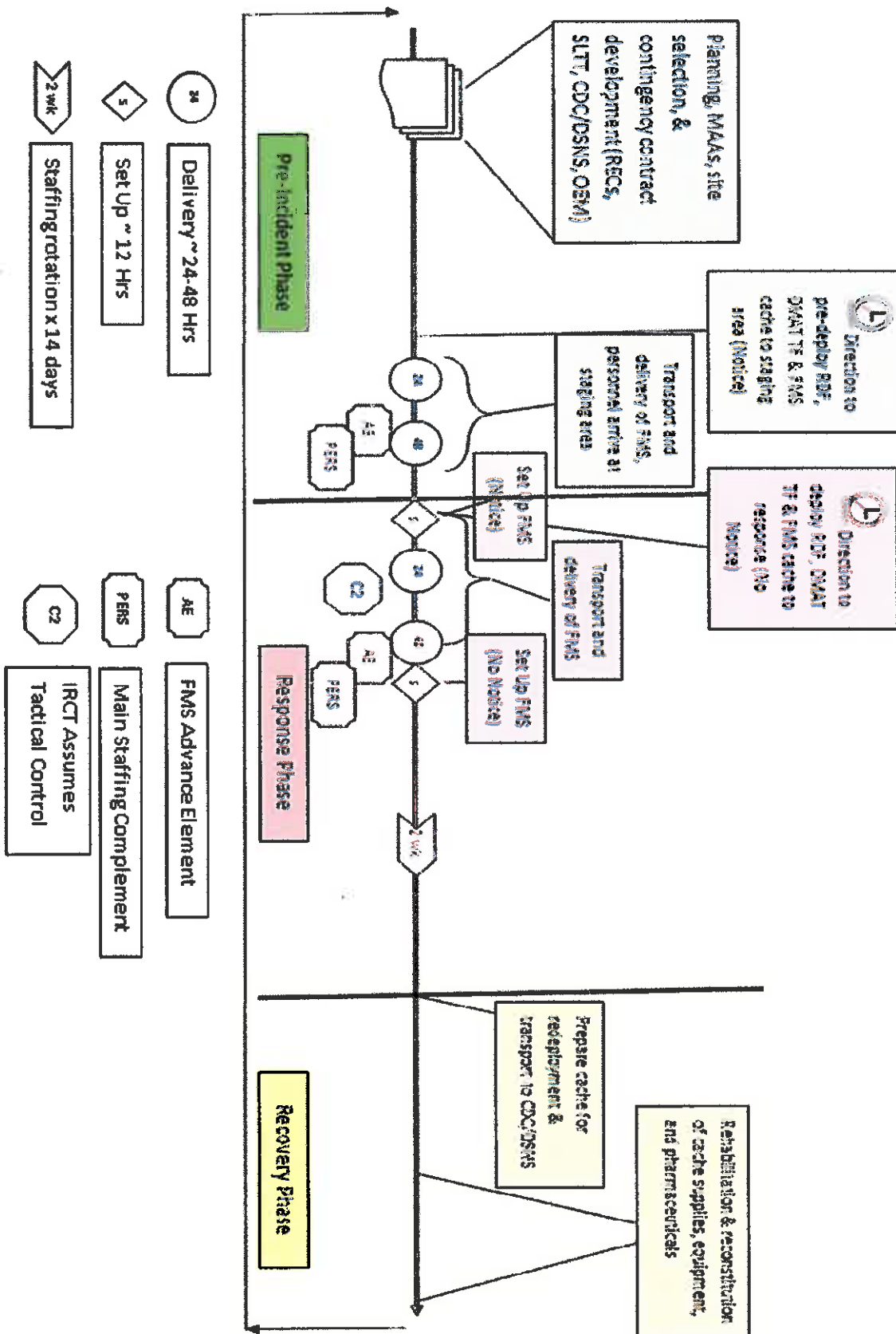
Appendix 7B: FMS Operational Timeline

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Appendix B8: FMS Cache and Pharmaceutical Formulary

Cache formulary lists are viewable online in Responder e-Learn.

NDMS personnel, you can review the FMS and inventory listings in the "all team community" on Responder e-Learn: <https://www.respondere-learn.com>

If you already belong to the community, click the "My Communities" tab in the blue header, click "National Disaster Medical System (NDMS)" option, click "NDMS Team Communities", click "NDMS TEAMS-NDMS Community", these materials are in the "Documents" course menu option (left hand side of page) in the FMS Information folder.

If you do not already belong to the community you will need to search and join it: click the "Search" tab in the blue header, type "NDMS Community" in the NAME field, click the NDMS Teams selection under the ID, then follow the above (see attached tutorial on searching for communities which can also be found under the "Help/Tutorial" tab in the blue header).

If you need assistance please click the "Get Technical Support" tab in the blue header.

DCCPR personnel, you can review the FMS and inventory listings on Responder e-Learn: <https://www.respondere-learn.com>

If you already belong to the community, click the "My Communities" tab in the blue header, click "US Public Health Service (USPHS)" option, click "FMS Information," then click "FMS101-FMS Documents." The materials are in the "Documents" course menu option (left hand side of page under "Outline") in the FMS Information folder.

If you do not already belong to the community you will need to search and join it: click the "Search" tab in the blue header, type "FMS" in the NAME field, click the "FMS101" selection under the ID, then follow the above (see tutorial on searching for communities under the "Help/Tutorial" tab in the blue header).

If you need assistance please click the "Get Technical Support" tab in the blue header.

Annex C: Department of Veterans Affairs (VA) FMS CONOPS

(As of 2012)

Background: The FMS is a deployable healthcare capability established by the U.S. Department of Health and Human Services (HHS) to provide deployable, low acuity healthcare services anywhere in the U.S. The FMS was designed to be staffed by multi-disciplinary U.S. Public Health Service (PHS) teams. During the 2005 and 2008 hurricane seasons, the VA operated FMSs at the request of HHS. The VA's FMSs successfully addressed the healthcare needs of those patients who were displaced from their primary sources of care. In order to enhance VA's ability to support future FMS assignments, VA formed a steering Committee composed of Headquarters and Emergency Management Strategic Health Group (EMSHG) Staff, under the consultancy of key VA Medical Center staff

Purpose: The purpose of this Concept of Operations (CONOPS) is to:

- a. Provide planning considerations and the initial strategy for VA Veterans Health Administration (VHA) support of FMS operations..
- b. Create a national VHA management support structure to facilitate FMS operations.
- c. Establish a framework for the development of Standard Operating Procedures (SOP) for a VA-staffed FMS.

Planning Assumptions: VHA developed this initial CONOPS using the following planning assumptions:

- a. Care of veterans remains VHA's first priority. VHA will support interagency taskings if the support does not impact VHA's quality of healthcare services to veterans.
- b. The FMS will be staffed and equipped to provide low acuity medical care for up to 250 patients. (The total FMS population shall not exceed 250 patients, including care givers and/or family members who may accompany patients.)
- c. Each FMS contains a three-day supply of medical and pharmaceutical supplies to sustain 250 stable patients. HHS will replenish depleted stocks upon request.
- d. The FMS requires 48-96 hours from the time of request to delivery inside the continental U.S. and a 12-hour assembly time.
- e. The length of stay for patients will be based upon individual medical behavioral or social needs. Discharge planning begins upon admission.
- f. Only service animals will be permitted in a VA-staffed FMS.

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- g. Every effort will be made to provide available VA resources in order to operate and/or staff up to two FMS' for one rotation each, or one FMS for two rotations.

FMS Site Selection: VA and HHS will work collaboratively to identify the most practical and appropriate site for a VA-staffed FMS.

- a. FMS-sites will be buildings of opportunity that have been pre-identified by the host State and pre-approved by HHS (e.g., auditorium, warehouse, stadium, hotel or similar facility that provides a large, open space for setup of beds). Sites shall be within one hour drive time of a VA medical center.
- b. VHA will deploy at least two personnel to assess the safety and security of any potential FMS-site that VA personnel may be expected to utilize. The advance survey team should consist of, at a minimum, a Safety Officer and a local Veterans Integrated Service Networks (VISN) Emergency Preparedness Coordinator (EPC). Other members of the advance team may include the FMS Director, Associate Director, Area Emergency Manager (AEM), VA Police Official, and HHS Regional Emergency Coordinator (REC).
- c. The potential FMS site must be a structurally intact facility that has roughly 40,000 square feet of space, electricity, heating, air conditioning, ventilation, and potable water services. Other operational requirements include bathroom and showering facilities, billeting for staff, and contracted support for food, potable water, laundry, ice, medical oxygen filling, and biomedical waste disposal.
- d. VA acceptance of an HHS Mission Assignment (MA) to staff or operate an FMS is predicated on a satisfactory safety assessment of the FMS.

VA Senior Management Teams: VHA will establish field-based VHA Senior Management Teams (SMTs) that are trained, equipped, and prepared to run an FMS.

- a. Upon notification by HHS, and IAW the appropriate HHS funding source, VHA Central Office (10N) will contact SMT members to determine availability to lead FMS operations.
- b. The SMT will be composed of pre-identified VHA personnel representing the following positions:
 - Director
 - Associate Director of Operations
 - Chief of Staff
 - Nurse Executive
 - Police Chief

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- Safety Officer
 - Logistics/Sterile Processing and Distribution Specialist (SPD)
 - M & O Foreman
 - AEM
 - VISN EPC
- c. The SMT Director has the latitude to select and assemble team members who will most effectively work together in a high-stress crisis environment.
- d. SMT personnel deploy to the FMS within 24 hours of notification by VHA CO (10N).
- e. The SMT will determine appropriate FMS personnel composition based on the anticipated mission and environment, and will adjust the staffing model and/or acquire supplemental personnel as needed.
- f. Upon installation of the FMS, the SMT is responsible for accepting the layout, or determining necessary modifications prior to the HHS rike Team's departure.
- g. The Regional Emergency Manager is responsible for coordinating with the SMT Logistics Officer to identify resource shortfalls. Any resources considered essential to the FMS's operating capability shall be reported immediately to the Incident Response Coordination Team (IRCT) VA liaison.

HHS Responsibilities: As mutually agreed upon by HHS and VA, HHS will ensure the following actions are carried out in support of any VA-staffed FMS:

- a. HHS provides the basic FMS-cache(s) and FMS pharmaceutical cache(s), and will conduct the initial setup of the FMS. HHS will make every attempt to ensure that all FMS equipment, supplies, beds and supporting infrastructure will be unpacked, set up and ready for use prior to the arrival of VHA's main body of FMS personnel. If available, VA staff from nearby VA Medical Centers (VAMC) may be asked assist with the unloading and set up.
- b. HHS (and VA if the safety officer and preventative medicine team are VA staff) provides ongoing facility maintenance and sanitation.
- c. The HHS IRCT will be HHS's primary liaison to VHA for logistics and other support.
- d. Maintenance, housekeeping, and other logistical site support necessary for non-medical facility operations will be provided via HHS contract or through other non-VA sources.

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- e. Logistics (medical/non-medical supplies and re-supply) support will be provided by/through HHS. This includes the supporting infrastructure (water, light, heating ventilation and air-conditioning (HVAC), food services, animal care, sanitary facilities, housing, local transportation, computers and phones for deployed staff, and so on). An accountability system will be in place to ensure proper accounting of all assigned and purchased equipment.
- f. HHS will determine the appropriate method for medical record-keeping, and will supply the resources and instructions for capturing and reporting patient data (e.g., hard-copy charts, electronic medical records), including post-deployment records disposition.
- g. HHS will supplement the VA-staffed FMS with the following personnel:
 - **Family Practice / Pediatric Physician**
 - **Pediatric Nurse Practitioner (PNP) or Physician Assistant (PA) with Pediatric experience.**
 - **Security detail***

* VA will provide security personnel if the FMS is located on a VA campus, or upon HHS request.

VA Responsibilities: The initial CONOPS responsibilities for VA operation of FMSs include:

- a. Establish the initial plans and procedures to support FMSs as indicated in approved HHS MA sub-taskings IAW the Financial Management Support Annex of the NRF.
- b. Support the FMS operations using staffing model templates below, as tailored by the VA SMT for each FMS.
- c. Deploy VA personnel for periods of 14 days (to include two travel days and one day of staff overlap).
- d. Coordinate with HHS to develop funding provisions to sustain all potential expenses that VA may incur during the course of FMS operations, such as additional / essential medical and personal protective equipment, supplies, life sustaining needs of VA staff, etc.
- e. VA will maintain necessary documents to meet HHS and/or VA auditing requirements for acquisition of all funding associated with the operations of the FMS, inclusive of activation and shut down.

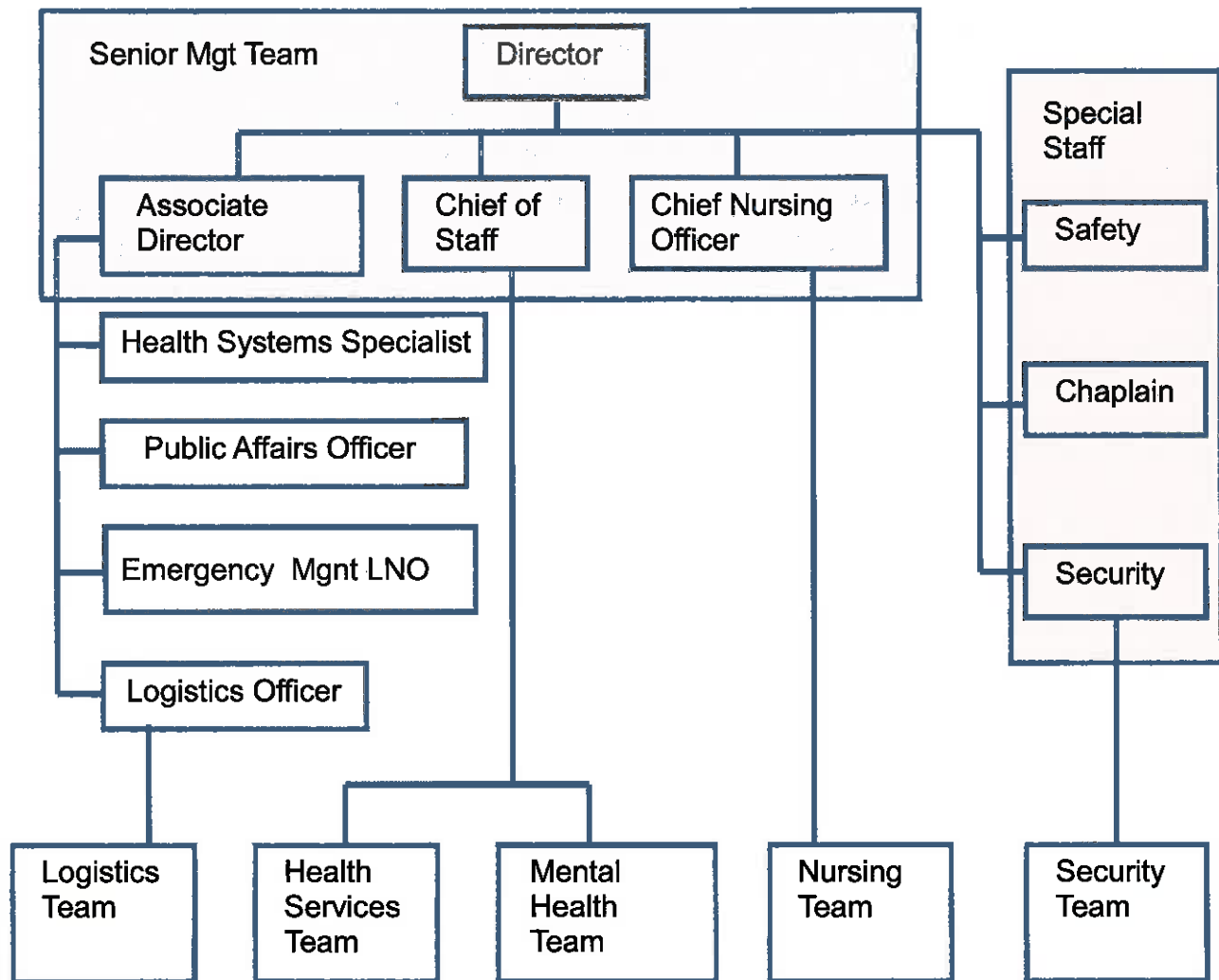
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Organization: VA managed FMSs employ a modified hospital command structure, as outlined below:

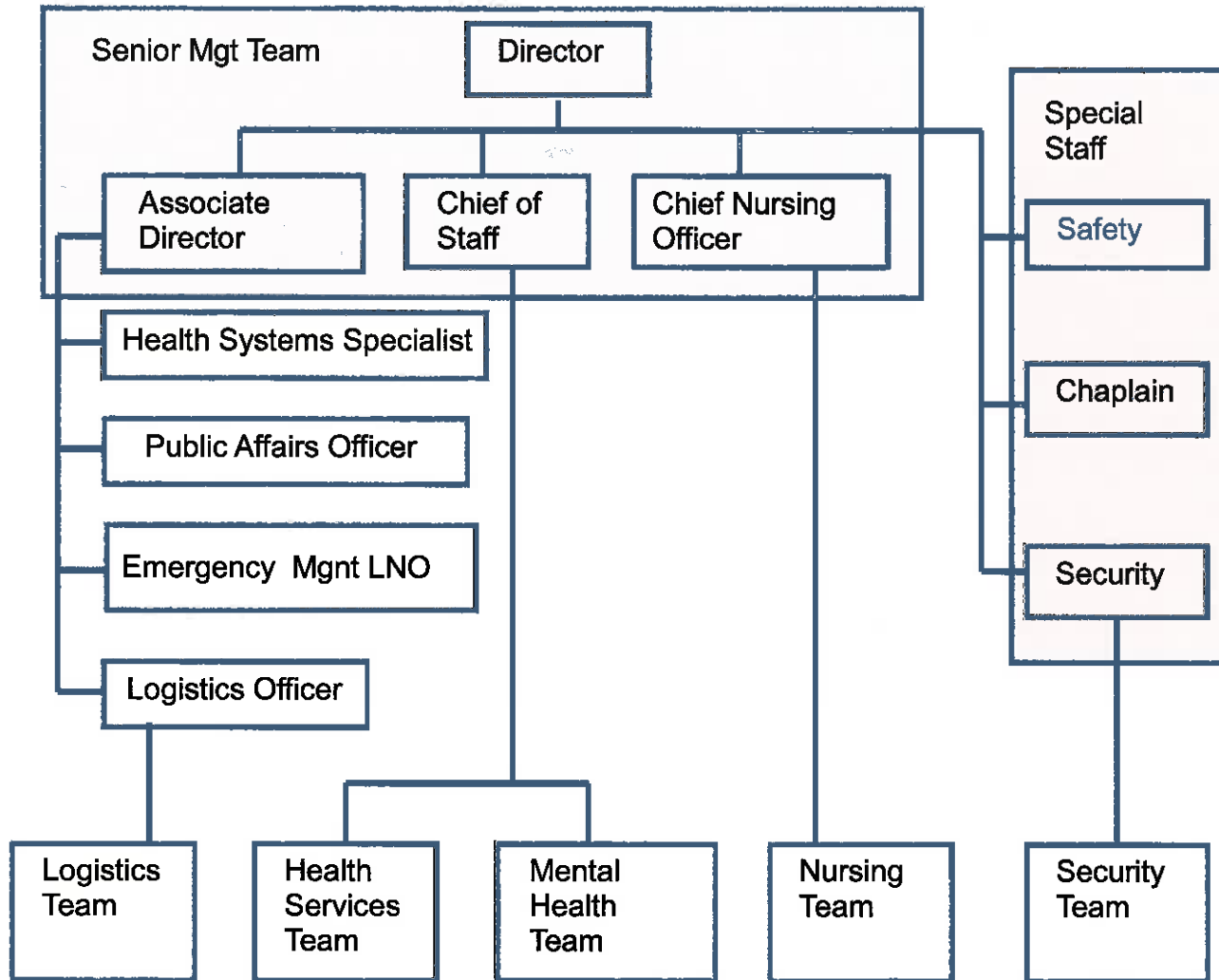


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- a. The FMS will operate under the administrative direction of HHS, IAW the NRF Emergency Support Function #8 (ESF #8). However, the VHA SMT retains operational authority and control over VHA staff supporting an FMS.
- b. VISNs will support VHA FMS operations, to include recruiting a minimum number of personnel to join the Disaster Emergency Medical Personnel System (DEMPS).

Staffing: FMS personnel will generally be identified via the DEMPS database for the essential positions described below. All potential FMS personnel will be requested for deployment through 10N.

- a. EMSHG will provide HHS any funding requirements for the deployment of FMS personnel and Senior Management Team.

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- b. VHA will utilize the Retiree Emergency Reserve Corps from the DEMPS database to backfill for deployed VHA personnel when possible.

FMS Senior Management Team

Reporting Official: Director	
<u>Position/Profession/Job Skill</u>	<u>Number of FTEE</u>
Director	1
Associate Director	2
Chief of Staff	1
Chief Nurse Executive	1
Deputy Chief Nurse Executive	1
Police Chief	1
Area Emergency Manager	1
VISN Emergency Preparedness Coordinator	1
Safety Officer	1
Engineer	1
Logistics/SPD	1
Total	12

FMS Personnel

Logistics	
Reporting official: Logistics Officer/SPD	<u>Number of FTEE</u>
Driver (w/CDL and patient transport experience)	3
SPD/Supply **	-
Supervisor	1
Staff (Including contract specialist)	3
Labor Pool **	4
Telecom Specialist	1
IT Specialist	2
Food Services *	-
Food Service Manager	2
Food Service Worker	5
Environmental Service Supervisor	1
Environmental Service Aide	6
Total	28

Nursing Staff	
Reporting official: Nurse Executive	<u>Number of FTEE</u>
Nurse Manager	2

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RN	20
LPN	30
Nursing Assistant	36
Medical Records Clerk	1
Nurse Practitioner/Physician Assistant	3
Pediatric Nurse Practitioner	1
Infection Control Nurse	1
Total	92

Security	
Reporting Official: VA Police Chief	Number of FTEE
Security detail*	10
Total	10

Health Services	
Reporting Official: Chief of Staff	Number of FTEE
Physician	
Internal Medicine	6
Urgent Care	1
Family Practice/Pediatrician*	2
Psychiatrist	2
Psychologist	1
Dietician	1
Physical Therapy	1
Mental Health Social Worker	2
Pharmacist	5
Pharmacy Tech	3
Respiratory Therapist	4
Recreation Therapist	2
Social Worker	8
Counselor (Vet Center)	1
Total	38

Special Staff	
Reporting Official: Associate Director	Number of FTEE
Health Systems Specialist	1
Secretary	2
Public Affairs Officer (PAO)	1
Liaison (EMSHG)	3
Chaplain	4

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Total	11
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Summary of Staffing

Senior Management Team	12
FMS-personnel	
Logistics	28
Nursing	92
Security	10
Health Services	38
Special Staff	11
<u>Total FMS-personnel Required</u>	<u>202</u> <u>(190 VA, 12 non-VA ***)</u>

* = If available from OSP, VA will provide security personnel if the FMS is located on a VA campus, or if requested by the SMT, or upon HHS request

** = Must have purchasing authority

*** = Includes HHS police detail

Annex D: To be published by DoD

Annex E: References and Related Information of Interest

References

- a The Public Health Service Act, as amended (42 USC Chapter 6A)
- b National Response Framework, 2013
- c Federal Interagency Response Plan – Hurricane, Update 1.0, August 2011
- d Homeland Security Presidential Directive 21, Public Health and Medical Preparedness, October 18, 2007
- e Federal Travel Regulations (41 Code of Federal Regulations, Ch. 300-304)
- f National Health Security Strategy of the United States of America, December 2009
- g FEMA Mass Evacuation Incident Annex
- h National Incident Management System (NIMS)
- i Pandemic and All-Hazards Preparedness Reauthorization Act of 2013
- j IRCT Field Operations Guide, 2011
- k FMS Tasking Memo from ASPR to Centers for Disease Control (CDC) Division of Strategic National Stockpile (DSNS), 2006
- l ASPR Mobilization Processing CONOPS, 2010
- m ASPR/OPEO Logistics CONOPS, September 1, 2012
- n HHS Disaster Behavioral Health CONOPS, December 2011
- o DMAT CONOPS, 2010
- p DMORT CONOPS, 2012
- q NVRT CONOPS, 2011
- r National Ambulance Contract CONOPS, March 2012
- s FEMA Guidance on Planning for Integration of Functional Needs Support Services (FNSS) in General Population Shelters, November 2010
- t Department of Justice, ADA Best Practices Tool Kit for States and Local Governments (DOJ, 2007)
- u Title VI of the Civil Rights Act of 1964 (42 USC 2000d et seq.)
- v Rehabilitation Act of 1973 (29 USC § 794)
- w Executive Order 13527, Medical Countermeasures Following a Biological Attack, December 30, 2009
- x Public Law 93-288, the Robert T. Stafford Disaster Relief and Emergency Assistance Act (as amended)

Other Related Information:

Internal:

Trabert, E., Giovachino, M., Nebelkopf, D., Morgan, D., and Byrne, L. (2006). After action review of Federal Medical Station (FMS) operations during hurricanes Katrina and Rita. The CNA Corporation under contract 233-03-0028 for the Department of Health and Human Services

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(Draft) ASPR Hurricane Isaac After-Action Report, OEM TE&LL

(Draft) ASPR Hurricane Sandy After-Action Report, OEM TE&LL

Final Trip Report, FMS New Orleans, Johnson, Kelly, CTR, GIS

HHS Concept of Operations for Response (Draft)

OEM Disaster Medical Information System Suite (DMISS) Charter (Draft)

External:

Hick, J.L., Hanfling, D., Burstein, J.L., DeAtley, C., Barbisch, D., Bogdan, G.M., Cantrill, S. (2004, September). Health Care Facility and Community Strategies for Patient Care Surge Capacity. *Annals of Emergency Medicine*, 44(3), 253-261.
doi:10.1016/j.annemergmed.2004.04.011

Addison, D. L., Thompson, L. S., Rolon, L., Zhussanbay, K. A., Evans, D., Donahue, R. I., & Stewart, J. (2005, May). Federal Medical Contingency Station Type III-Basic Prototype Evaluation, Vols. I & II. Report CD305T3. LMI Government Consulting: McLean, VA.

OSD Memorandum, "Department of Defense (DoD) Support of DHHS Federal Medical Stations (FMS)," May 26, 2011

VHA HANDBOOK 0320.03, Disaster Emergency Medical Personnel System (DEMPS).

Zusman, E.E., & Marghella, P.D. (2013). Disaster Management in the Era of Lean Healthcare. *Neurosurgery*, 72(2), 11-13

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Annex F: CONOPS Development and Coordination

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OEM, Operations	Ms. Pam Evans, Mr. Ed Siekierski, Mr. DeRamus Smart, Mr. Derrick Jaastad, Mr. Ted Kennedy, and Mr. Marshal Bickert
OEM, Plans	CAPT Scott Lee, Ms. Lauren Toomey, Mr. Tom Leinberger
OEM, Regional and International Coordination	Mr. Andy Stevermer*, CDR Damon Smith, and CDR John Gibbons

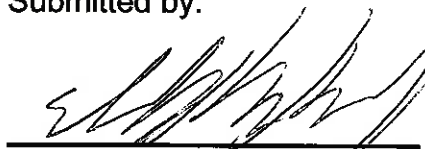
*FMS WG Co-chair

Project Officers: CDR Thomas Janisko, USPHS & Ms. Deborah Knickerbocker, CEM, Response Operations, ASPR Office of Emergency Management

Please forward recommendations for changes to this CONOPS in line in/line out format to the following:

Director, Operations, Office of Emergency Management, ATTN: Response Operations Project Officer, at OS.OSResponseOperations@hhs.gov.

Submitted by:



Ted Kennedy
Director (Acting), Division of Operations

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