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STUDY OF THE PROBLEMS ASSOCIATED WITH RELIANCE ON CIVILIAN MEDICINE (U)

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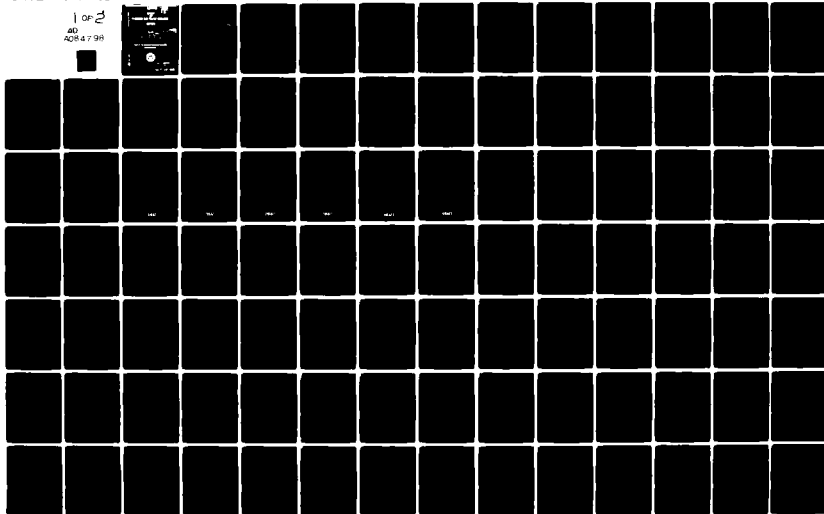
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Prepared for:

Office of Assistant Secretary of Defense
(Health Affairs)

Under Contract Number ¹⁵ MDA-903-78-C-0130 ¹⁰²⁴⁷⁹⁷

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FINAL REPORT

⑥ STUDY OF THE PROBLEMS ASSOCIATED WITH
RELIANCE ON CIVILIAN MEDICAL MANPOWER
AND NON-DOD FACILITIES
DURING PERIODS OF NATIONAL
EMERGENCY, MOBILIZATION, AND WAR.

Volume II.

Volume II

① 11-11 Mo. 77

March 15, 1979

MAXIMUS, INC.
6723 Whittier Avenue, Suite 101
McLean, Virginia 22101

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VOLUME II OF A TWO VOLUME REPORT

(Table of Contents of Both Volumes Included)

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TABLE OF CONTENTS

Volume I

	<u>Page</u>
EXECUTIVE SUMMARY AND RECOMMENDATIONS	ix
I. INTRODUCTION.....	1
A. Background and Purpose of the Study.....	1
B. Major Assumptions.....	2
C. Organization of this Report.....	4
II. CAPABILITIES OF THE CIVILIAN HEALTH SYSTEM....	7
A. Introduction and Overview.....	7
B. Hospitals.....	10
C. Manpower.....	36
D. Logistical Support Systems.....	54
E. Payment Systems.....	60
F. Summary.....	68
III. DEVELOPMENT AND TEST OF THE CIVILIAN-MILITARY CONTINGENCY HOSPITAL SYSTEM (CMCHS) CONCEPT.	72
A. Background and Objectives.....	72
B. Test Organization and Results.....	77
C. Observations and Conclusions.....	104
IV. THE RECOMMENDED CIVILIAN-MILITARY CONTINGENCY HOSPITAL SYSTEM CONFIGURATION.....	107
A. Introduction.....	107
B. CMCHS Beds and Their Locations.....	107

MAXIMUS

TABLE OF CONTENTS (Continued)

Volume I

	<u>Page</u>
C. Manpower Considerations.....	131
D. Organization and Control of the System...	136
E. Concept of Operations.....	147
F. Agreements with Hospitals and Payment Mechanisms.....	155
G. Interagency Coordination.....	159
V. THE AUTHORITY FOR CMCHS.....	161
A. Purpose of Chapter.....	161
B. The Authority Needed to Implement the CMCHS.....	161
C. Planning Authority.....	162
D. Contractual Authority.....	165
E. Related Issues.....	171
F. Resource Allocation.....	178
G. Alternative Authorities.....	182
H. Conclusions.....	187
VI. IMPLEMENTATION PLAN.....	190
A. Introduction.....	190
B. The Task Plan.....	191
C. Schedule and Staffing.....	201
D. Budget Guidelines.....	201
E. Conclusion.....	204
F. Ancillary Studies.....	205

MAXIMUS

TABLE OF CONTENTS (Continued)

Volume II

APPENDICES:

- Appendix A: American Hospital Association Memoranda
- Appendix B: Text of a Draft Scope of Work for a Contract
- Appendix C: Text of a Draft Information Agreement
- Appendix D: The CRAF Program—Allocation in Action
- Appendix E: Draft—Department of Defense Directive
- Appendix F: Operations Manual
- Appendix G: Training Slides for Nifty Nugget Exercise Text

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APPENDIX A

AMERICAN HOSPITAL ASSOCIATION MEMORANDA

OFFICE COMMUNICATION

DATE July 24, 1978
TO Dr. Robert L. White, Maximus, Inc.
FROM Carol A. Lively *CL*
SUBJECT "LAUNDRY LIST" OF POSSIBLE
PROBLEMS AND CONCERNS RAISED

by

AHA STAFF

July 24, 1978

1. Hospitals, MD's etc. will need governmental immunity by tort claims for all patients.
2. Hospitals, MD's etc. will need waiver of subrogation under Federal Tort Claims Act.
3. The need to develop local triage.
4. Need for adequate transportation.
5. Location of air terminals.
6. The question of stock piling field hospitals.
7. Hospitals used as a nucleus for field hospitals.
8. Seasonal fluctuations for capacity.
9. Manpower availability.
10. Medicare reimbursement.
11. All joint commission approved hospitals have disaster preparedness programs which they test twice yearly. It may be very desirable for DOD to request copies of the local plan prior to on site visits to gain some understanding as to how the community resources are involved in the event of simulated disaster and how closely these plans, including transportation of casualties from disaster sites, match what DOD might need should they involve that hospital.

Dr. Robert L. White/2.

12. As a follow-up to 11 DOD may wish to request that the local disaster plan simulate a large air disaster involving their local airport. This would very closely simulate what would occur in the event of a major wartime event. Such a drill would test the very system which would be involved should the real thing occur.
13. Should several hospitals in any urban area sign agreements between themselves and DOD, this might open up the possibilities of effective patient exchange shortly after their initial placement when it is discovered that the burn patient did not get to the right hospital. This could be explored as a real potential problem.
14. When the DOD visits hospitals, they might wish to review the patient records which each hospital uses for disaster admissions. (Many hospitals have a separate and different record which they use for disasters.) Such a review could give insight into any shortcomings which might have to be met in some other way.
15. Many large urban hospitals have heliports to expedite distribution of high risk casualties. DOD may wish to incorporate this information into their plans for each urban area.
16. Some casualties will be suffering from radiation sickness as they would represent casualties that have a survival chance but hospitals may well have to take extreme precautions to safeguard these patients from the civilian population.
17. Management of early lower extremity amputees may require agreement between DOD and the civilian hospitals as to type of operation, positioning, etc.
18. Civilian capacity would not be adequate for fast training to render even minimal services, therefore, the quality of care needs to be addressed.
19. Coordination with division of Emergency Medical Services/HEW is necessary to plug into EMS system. Contact Dr. David Boyd.
20. The necessity of the DOD stock-piling critical drugs, plasma and other supplies on a regional basis so they would be readily available. Further, some arrangements would need to be made for handling any unusual number of fatalities among the patient.

Dr. Robert L. White/3.

21. The possibility of arranging for out-placement of custodial patients at Veterans Administration hospitals to allow for treatment of more critical cases.
22. A reemphasis that relatively few hospitals could make a firm commitment, since they cannot project what their occupancy may be when a DOD crisis occurs. Rather, most hospitals would prefer to give some sort of "letter of intent". Many hospitals might also be reluctant to make firm commitment of capacity, lest it appear to be an acknowledgement of "excess capacity".
23. Need to address the issues of:
 - case mix for aged, rehabilitation, acute care, or long-term care
 - the recognition that all manpower is not alike just as all hospitals are not alike
 - what to do in triage issue in manpower. Plans are now available from all hospitals and should be reviewed.
24. I believe there are few PR implications or considerations to be examined at this point in the development of the study, with the exception of "acceptance" of the proposal by hospitals. When, or if, the plan is finally adopted, however, I envision that there will be a number of considerations which have a public relations dimension. For example, there will be a community relations aspect, in that this program will have to be sold to the communities as well as the hospitals; there will be questions concerning dissemination of information; there will be consideration of incentives for participation, etc. I suggest that the Department of Defense be made aware that these considerations will exist following adoption of the plan.
 - I question the scenario on which this contingency system is based, and its validity. The scenario calls for a limited war abroad, and yet the plan calls for a massive allocation of health facilities. Conflict on the scale that would require this allocation would, to my mind, be bigger than Vietnam and yet, to my knowledge, there was never a plan of this type during the Vietnam era. Is this limited war realistic; should not, in fact, we be talking about a nuclear war when we talk about a conflict of these dimensions? If so, then that obviates the need for this kind of plan.
 - It's a small issue, but if the Department of Defense expects to sell this program to hospitals, they are going to have to clean up their communications about it; the language is too bureaucratic and, therefore, unintelligible. Any communications with hospitals will have to take this into account.

- This plan will need very clear incentives for hospitals (and others) to participate. These incentives will have to go beyond reimbursement of full costs, to include some psychological elements. Hospitals and their communities will have to see this as something bigger than themselves and DOD should work this into the plan if there is going to be acceptance and support.
 - As noted in your memo, consideration should be made about seasonal fluctuations for capacity and the ability of hospitals to "guarantee" beds for DOD use. At this point, I see this as perhaps the major flaw in the program.
 - The suggested "no contract, will negotiate" approach to Group III hospitals appears to me to be unrealistic. If the plan ever went into effect I don't believe that Group III or DOD would have the time to negotiate. I suggest DOD have a limited contract with Group III hospitals.
 - In the presentation it wasn't clear what kind of homework DOD has done with regard to meshing this with countrywide disaster planning or individual hospital disaster planning. I think a review of plans now in effect in different communities and hospitals would ensure a more realistic proposal by DOD. This kind of meshing with existing plans, in addition, might make hospitals look more favorably upon it.
 - I believe that there may be an unwillingness on the part of hospitals to accept the "delegation of authority" which DOD describes as being a part of patient administration, both for cost and paper work reasons. I suggest DOD consider alternatives.
25. Address the issues of skill level of personnel - trauma training that hospitals will have to assume responsibility for.
 26. Coordinating DOD mobilization plan with existing area wide emergency medical services and disaster programs.
 27. Neighboring hospitals share physicians and services.
 28. Increased cost to hospital in terms of deploying additional staff, overtimes, increased supplies, materials, etc. (Hospitals should have a record of cost of providing care during disaster(s)).
 29. Availability of trained personnel to activate, manage and implement the DOD mobilization program.

Dr. Robert L. White/5.

30. Need for test runs.
31. Availability of standards of care, documentation, etc.
32. Bookkeeping and accounting.
33. Available space and equipment.
34. Orientation and training of key staff to DOD mobilization program.
35. Patient and/or public awareness and support of DOD mobilization plan.

CAL:mj

OFFICE COMMUNICATION

DATE July 24, 1978
TO Distribution Below
FROM Carol A. Lively *AL*
SUBJECT Meeting with Department of Defense

Attached is the "laundry list" of problems and pitfalls the Department of Defense (DOD) requested from AHA. This list was compiled from comments sent to me from the various program areas and is in response to our discussion with DOD during the first Pentagon Mobilization Planning Meeting with Dr. Robert L. White and Col. John B. Kelly. As you recall, we agreed to send this list to them and meet with them a second time to discuss any problems or questions they might have as they move to Phase II. The second phase is the implementation and site visit stage to test the survey instrument to ascertain hospitals willingness to participate in the Pentagon mobilization planning activity. The second meeting with DOD has been scheduled on:

August 2, Wednesday
10:30 AM to 12 NOON
Room - 209

Please let me know if you will be attending this meeting.

Again, my appreciation for your help in this project. If you have any questions please do not hesitate to call me on Ext. 640.

CAL/mj

cc: Robert Flanagan
Jeff Seubel
Jay Hedgepeth
Mike Guerdin
Ray Norquist
Julie Menaz
Ed Tuller
Gail Warden

Dan Thomas
Pat Sweeney
Richard Epstein
Nancy Noie
Jim Huoy
Tita Corpuz
Barbara Bloom
Dr. Robert L. White

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APPENDIX B

TEXT OF A DRAFT SCOPE OF WORK FOR A CONTRACT

APPENDIX B

TEXT OF A DRAFT SCOPE OF WORK FOR A CONTRACT

The purpose of this contract between {hospital} and the Department of Defense is to firmly commit {hospital} to the Civilian-Military Contingency Hospital System (CMCHS) and to assure that {hospital} is fully prepared to participate in this emergency system during the period _____ to _____ in return for the compensation stated below.

The Civilian-Military Contingency Hospital System (CMCHS) has been developed to provide the Military Health Services System (MHSS) with additional hospital and medical capability in the event that military casualties generated in a limited war abroad should ever exceed the capability of the MHSS to care for them. This system is being developed as part of a long-range preparedness plan, and nothing in this document should be construed as indicating that this system will be used in the foreseeable future. Rather, this system is part of an effort to prepare for any contingency so that American servicemen can be assured of adequate medical care under all circumstances.

The hospital's duties as a member of this system are twofold: the first level representing peacetime activities and the second emergency or wartime activities.

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Unless otherwise notified or activated, as defined below, {hospital} will in peacetime agree to be listed as an active member of the CMCHS, to maintain at least two staff members in significant administrative positions who are knowledgeable about the purpose and procedures of the CMCHS; to inform all physicians with privileges and staff at the hospital of the meaning, importance, and obligation of CMCHS; to participate in at least one exercise of the CMCHS, if asked to do so, during the period _____ to _____, and to report the hospital's ability to receive military patients to the Military Medical Liaison Officer (MMLO) in accordance with procedures outlined in the CMCHS Operations Manual upon receiving notice of alert from the Secretary of Defense or his appointed representative—a Military Medical Liaison Officer. An alert is defined as notification of an emergency, national emergency, or state of war that requires the potential use of CMCHS.

Further, as an active member of CMCHS {hospital} agrees to provide the Department of Defense the option to use under the conditions of activation described in this document a minimum of ____ surgical, ____ medical, ____ psychiatric and ____ specialized care {type} beds, and physicians and support staff to care for total of ____ military patients for the usual and customary charge associated with the present cases. Compensation for this commitment and for participation in these activities of this paragraph is \$_____ per annum.

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Upon receiving notice of activation, i.e., that the hospital may receive military patients within a specified time period, the hospital administrator will consider the government's option to acquire beds to be exercised and will make every effort to assure that the staff, physicians, supplies, and facilities are available for the prompt treatment of these patients. { Hospital } agrees to use its existing system to assure appropriate care and prompt disposition of military patients. Those minimal administrative procedures described in the Operations Manual will be accomplished.

Payment for treatments and services rendered, while in the state of activation, are to be at the regular and customary rate for any given treatment or service required. Both hospitals and attending physicians are to submit their statements or billings to the MMLO, {address} for processing and payment.

Although the Operations Manual and contract will specify policies, procedures, and standards, the MMLO will be available to answer questions and handle problems if the system is ever activated. The MMLO will obtain local ground transportation. The Chief Officer of the MMLO will be the Contracting Officer's Technical Representative.

Nothing in this contract guarantees that this system will ever be activated or used. However, this contract is independent from and does not preclude or interfere with the treatment

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of military personnel or their dependents in the event of an emergency or under the CHAMPUS program.

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APPENDIX C

TEXT OF A DRAFT INFORMAL AGREEMENT

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APPENDIX C

TEXT OF A DRAFT INFORMAL AGREEMENT

The Civilian-Military Contingency Hospital System (CMCHS) has been developed to provide the Military Health Services System (MHSS) with additional hospital and medical capability in the event that military casualties generated in a limited war abroad should ever exceed the capability of the MHSS to care for them. This system is being developed as part of a long-range preparedness plan, and nothing in this document should be construed as indicating that this system might be used in the foreseeable future. Rather, this system is part of an effort to prepare for any contingency so that American servicemen can be assured of adequate medical care under all circumstances.

This informal agreement is not meant to obligate its signatories. Its purpose rather is to outline the goals and structure of CMCHS, to ascertain the interest of selected hospitals in key areas, and to express the Department's interest in those selected hospitals. Neither party signing this informal agreement will construe this letter as a contract or an obligation. Signing this letter serves to attest to the Department's desire to use {this hospital} in the event of an emergency and expresses {the hospital's} desire to participate in the system if needed and under terms to be fully delineated

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in a contract, signed at the time of need. Each following year on the anniversary of signing this letter, both the Department of Defense and {the participating hospitals} may re-evaluate their participation in this program, and renew or terminate such participation.

Hospitals that are invited to participate in this system have been chosen by DoD planners for a number of reasons, including in part proximity to landing facilities for military patients, range and type of services provided, type of care available, size of staff, and potential bed commitment. In order that DoD planners have a grasp of the system and its potential, each hospital is requested to indicate the number of beds it feels that it could reasonably expect to commit to military patients in an emergency situation without appreciably reducing civilian health care. In this instance ___ beds is the basic commitment that can be made.

The basic functions of the hospital in this system are the same as would be required in any emergency situation. That is, the hospital will be asked to receive and treat as expeditiously as possible a number of military patients in accordance with the hospital's bed commitment. The hospital will be asked to provide physicians and surgeons as appropriate to treat these patients, and to provide the basic nursing and domiciliary care functions as needed.

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Hospital participation will be coordinated by a Military Medical Liaison Office (MMLO). This MMLO will serve a number of functions and will be the hospital's link to the Department of Defense. If this system is activated the hospital will receive such word from the MMLO, and will subsequently report bed availability, military patient census and status, status changes, and other information and questions to this Office. Both hospitals and physicians will submit all statements to the MMLO for payment, charging customary rates and charges. Although the Operations Manual and contract will specify policies, procedures, and standards, the MMLO will be available to answer questions and handle problems if the system is ever activated. The MMLO will obtain local ground transportation. The Chief Officer of the MMLO will be the Contracting Officer's Technical Representative.

The activation of the system will proceed in as orderly a fashion as possible, beginning with the signing of a contract to provide services at such time as the Secretary of Defense judges these services might be needed. However, participating hospitals should take no action to make beds available until specifically notified that military patients may be expected. It is hoped that forty-eight hours warning can be provided, and attempts will be made to phase-in patients in an orderly fashion.

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From time to time this system may be tested, and participating hospitals are urged to join these exercises if asked and if at all possible.

Having read and understood this letter of intent, both signatories agree that there is an interest in participating in this program, and that should the Department of Defense need this system and offer a contract, the signing hospital will consider such contract at the time of offering.

Defense Department

{Hospital}

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APPENDIX D

THE CRAF PROGRAM—ALLOCATION IN ACTION

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APPENDIX D

THE CRAF PROGRAM—ALLOCATION IN ACTION

There are few current examples, outside of the national stockpiles of strategic materials, of active programs that employ the various aspects of allocation, though much planning has been and is being done. The Civil Reserve Air Fleet (CRAF), however, provides an example of how military planning and resource allocation impact on the civilian sector when there is a conflict in the demand for a resource.

The CRAF program was designed to use civilian air carriers to meet the emergency airlift requirements of the Department of Defense. The program is based upon a 1951 Executive Order which was modified in 1962.¹ The basic point of the order was to direct the Secretary of Commerce to develop a national plan to use civilian air carriers in the event of a national emergency, and to allocate such aircraft as would meet the needs of both DoD and the Civil Aeronautics Board. A Memorandum of Understanding was signed in 1963, and remains in force today though the functions of the Department of Commerce were transferred to the Department of Transportation.² The Office of Emergency Transportation now analyzes DoD requirements and, in light of

¹ Executive Order Number 10999 revised the earlier Executive Order Number 10219.

² 49 U.S.C.A. § 1651

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other needs, assigns specific civilian aircraft to DoD. It should be noted that DoT feels that it represents the civilian sector to a great extent, but must make an equitable allocation to all parties.

DoD then negotiates contracts for airlift services with the carriers who have volunteered their aircraft for inclusion in the program. As a general rule, the greater the number of planes offered and accepted, the greater the amount of the airlift contract. Also contained in the contract are clauses providing for the expansion of the amount of services in the event of an emergency. Stage I of an emergency expansion is activated by the Secretary of Defense declaring that an airlift emergency exists and planes in a first grouping, known to both the carrier and DoD, are to be made available on twenty-four hours' notice. Stage II activation requires a statement by the President, and makes a second grouping of aircraft available to DoD. Finally in Stage III certain other aircraft, equipped with government-furnished equipment for communication and navigation, are made available. The carrier agrees to retain control of the aircraft in Stage I, but it is not required to do so in Stages II and III. The services are paid for on a cost-reimbursable basis. Other provisions for operating airfields and ground support have been made. CRAF contracts require that carriers must furnish personnel, equipment, and supplies. Contracts are negotiated on a yearly basis.

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CRAF has not been activated as such since its inception, though the civilian carriers have responded voluntarily to situations requiring at least a Stage I activation. Examples include the Operation Babylift in which orphans were evacuated from Saigon, and the later evacuation of some 117,000 American and local nationals from that same city.

This program is a good demonstration of the system of allocation in both its planning and operational stages. DoD submits its requirements, the airlines indicate the availability of the required aircraft, and Department of Transportation makes the final allocation. Contracts are then drawn up and the system is in place for emergency use.

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APPENDIX E

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DEPARTMENT OF DEFENSE DIRECTIVE

APPENDIX E

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DEPARTMENT OF DEFENSE DIRECTIVE

SUBJECT: Civilian-Military Contingency Hospital System
(CMCHS) Program

I. PURPOSE

Pursuant to the authority vested in the Secretary of Defense, this Directive establishes the Civilian-Military Contingency Hospital System (CMCHS) Program.

II. APPLICABILITY

The provisions of this Directive apply to the Office of the Secretary of Defense, Secretaries of the Military Departments, the Organization of the Joint Chiefs of Staff, and the Defense Agencies (hereinafter referred to collectively as "DoD Components").

III. MISSION

The mission of the CMCHS Program is to enhance the state of military medical preparedness by developing, organizing, negotiating, and managing a system of linked civilian hospitals which are committed to provide hospital beds and medical manpower in time of war or other emergent need.

IV. ORGANIZATION

- A. The Office of the Civilian-Military Contingency Hospital System (OCMCHS) is hereby established as an Office of the Secretary of Defense field activity, under the policy guidance and operational direction of the Assistant Secretary of Defense (Health Affairs). It shall consist of a Director and a subordinate organizational structure as established by the Director.
- B. Military Medical Liaison Offices (MMLO's) will be established in accordance with approved OCMCHS plans and under the authority of the Military Departments. MMLO's will be composed of one or more members of the military services.

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V. RESPONSIBILITIES AND FUNCTIONS

A. The Director, OCMCHS shall:

1. Organize and manage the OCMCHS.
2. Supervise, administer, develop, implement and evaluate policies and procedures required for the CMCHS Program.
3. Formulate, submit, and justify budget requirements for the implementation of CMCHS linkages.
4. Execute the approved CMCHS budget.
5. Provide planning guidance to the Services for the CMCHS Program.
6. Recommend to the ASD(HA) such policies and instructions as may be required for the effective implementation and management of the CMCHS Program.
7. Direct and manage the activities of CMCHS in accordance with (1) operational policies, programs and standards established by the Secretary of Defense and the Joint Chiefs of Staff, and (2) professional, medical, and technical policies of the Military Departments.
8. Organize the structure of and staff the OCMCHS; develop the broad outline of policy and procedures needed to implement the system according to guidelines.
9. Develop the concept of MMLO areas, assist in selecting staff for them, and coordinate MMLO activities and duties with the Services.
10. Train MMLO staffs.
11. Formulate and gain agreement on operating procedures between CMCHS, MMLO's, ASMRO, Military Medical and Personnel Systems, and other organizations as appropriate.
12. Formulate instruments and supervise negotiation of contracts and agreements in accordance with appropriate procurement regulations.

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13. Develop and promulgate criteria and procedures for MMLO review of hospital and physician billings.
14. Propose and develop methods of protecting and retaining staffs at participating hospitals during war.
15. Supervise training and exercise of participating hospitals, including development of training materials and exercises.
16. Develop necessary plans for wartime expansion.
17. When ordered, alert and activate CMCHS.
18. Monitor operation of the activated system.
19. Maintain liaison with the Surgeons General, AHA, AMA, ASMRO, and other appropriate civilian and military organizations.
20. In accordance with existing policies, programs, and standards established by the Office of the Secretary of Defense, the Joint Chiefs of Staff, and the Military Departments, recommend doctrine, policy, procedures, and guidance for issuance of appropriate departmental joint regulations covering CMCHS activities, especially in the areas of patient administration and provide payment procedures necessary for smooth operation of the system.
21. Maintain active liaison with the Military Departments, the U.S. Public Health Service, and the Veterans Administration concerning the needs and activities of the system. Assure timely coordination and integration of all pertinent policies, doctrine, plans, procedures, and requirements.
22. Maintain liaison with the Defense Traffic Management Service and a close reciprocal working liaison with appropriate transportation and other agencies on matters pertaining to transfer of sick and injured to and within the continental United States.
23. Develop and maintain files of data and statistics necessary to support and evaluate the system.

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24. Develop and maintain current continuity of operations plans and mobilization plans for the expansion of CMCHS, in the event such action is indicated.
 25. When deemed appropriate, obtain from the Military Departments an estimation of wartime casualties to be evacuated; anticipated wartime bed availability in medical treatment facilities coming under the cognizance of ASMRO; and, patient transportation capabilities to and within the continental United States so that CMCHS will be up to date in its estimation of potential needs.
 26. Prepare an annual report for the Secretary and the Joint Chiefs of Staff regarding the operations, capabilities, targets, plans, and problems of CMCHS.
- B. The Assistant Secretary of Defense (Health Affairs) shall:
1. Recommend to the Secretary of Defense, policies for the administration of the CMCHS Program.
 2. Provide policy guidance and operational direction to the Director, OCMCHS.
- C. The Secretaries of the Military Departments shall:
1. Review CMCHS Program plans and actions which require the expenditure of service resources.
 2. Formulate, submit, and justify budgets for CMCHS operational requirements.
 3. Operate designated MMLO's.

VI. RELATIONSHIPS

- A. In the performance of his duties, the Director, OCMCHS shall:
1. Coordinate with the concerned elements of the Office of the Secretary of Defense and other DoD Components having related functions in the area of his assigned responsibility.

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2. Exchange information and advice with concerned elements of the Office of the Secretary of Defense and other DoD Components.
 3. Use established facilities in the Office of the Secretary of Defense and other DoD Components insofar as possible, to avoid duplication.
- B. All DoD Components shall coordinate with the Director OCMCHS on matters concerning CMCHS programs.

VII. AUTHORITY

The Director, OCMCHS, is delegated authority to:

- A. Obtain such information, advice, and assistance from DoD Components as he deems necessary consistent with DoD policies and criteria.
- B. Communicate directly with DoD Components and with other government and non-government organizations, as required.

VIII. ADMINISTRATION

- A. The Director, OCMCHS, shall be selected by the ASD(HA).
- B. The OCMCHS shall be authorized such personnel, facilities, funds, and other support as the Secretary of Defense deems necessary.
- C. The Military Departments shall assign personnel to the OCMCHS in accordance with approved authorizations and procedures for assignment to joint duty.
- D. The Deputy Assistant Secretary of Defense (Administration) shall be responsible for providing or negotiating for necessary administrative support for the OCMCHS.

IX. EFFECTIVE DATE

This Directive is effective immediately.

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X. TERMINATION

Unless sooner modified, extended, or vacated, this Directive, Office, and Program are abolished five (5) years from this date.

/s/ _____

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APPENDIX F

OPERATIONS MANUALS

FOR NIFTY NUGGET EXERCISE TEST

- Including:
- MMLO
 - Hospital Administrators
 - EMS Officials

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OPERATIONS MANUAL

MILITARY MEDICAL LIAISON OFFICE

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OPERATIONS MANUAL

FOR

DOD MEDICAL REGION 8

MILITARY LIAISON OFFICE

DURING THE

NIFTY NUGGET EXERCISE

OCTOBER 1978

MAXIMUS, INC.
6723 Whittier Avenue
McLean, Virginia 22101

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TABLE OF CONTENTS

	<u>Page</u>
Ø. INTRODUCTION.....	1
I. ALERT.....	2
II. REPORTING OF CAPABILITIES.....	3
III. ACTIVATION OF THE SYSTEM.....	4
IV. REGULATION.....	5
V. REPORTS ON PATIENTS.....	7
VI. REPORTS FROM YOUR REGION.....	8
VII. SPECIAL EVENTS.....	9
VIII. EVALUATION LOG.....	10
IX. TELEPHONE NUMBERS.....	11

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Ø. INTRODUCTION

During the Nifty Nugget Exercise your office will serve as a Military Liaison Office for a system of civilian hospitals that will be used to treat military patients. Your tasks, which will combine regulation, coordination, and interface roles, will be unique and significant. This interim reliance upon the civilian sector is important and it may well be that this civilian system will require the type of contact and coordination that can be provided only through a regional office.

We will call upon you to perform a number of tasks that you have not previously done at least on this scale. Included among them are patient regulating, routine reporting to ASMRO, serving as a conduit for patient administration information, and coordinating closely with civilian hospitals and Emergency Medical Services units. This manual provides step-by-step instructions for your participation including details on what to do and how to do it for all aspects of this exercise. It does not provide answers to the problems that will arise; you will have to provide them in response to the situations that are presented to you.

We request that you keep a log of events and that you annotate it freely as you proceed with this exercise. This will provide both you and us with a written record of what happened and what factors affected your decision-making.

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I. ALERT

Very early in the exercise the CMCHS will be placed on alert. The purpose of this alert is to start the hospitals' reporting on bed availability to ASMRO. The hospitals have been instructed to provide data by medical, surgical, and psychiatric categories starting the day after notification.

When the system is to be alerted, you will receive a telephone call from ASMRO advising you of the alert. ASMRO should also then indicate the time of day it would like to receive the data on bed availability. It is your task to notify the hospitals, and to request the input of information in time to assimilate it for reporting to ASMRO.

II. REPORTING OF CAPABILITIES

The day following the alert, information should flow to you from the hospitals at the specified time. You may use any system you wish to collect and report this data. The information should then be combined and reported to ASMRO as directed. This report will continue on a daily basis throughout the course of the exercise.

The daily census report format for the hospitals is attached.

III. ACTIVATION

When the casualty flow begins or when it is apparent that the flow will saturate all available military and civilian facilities, ASMRO will receive authority to activate the CMCHS. Subsequently, ASMRO will telephone your office, advising you of the activation and of the probable arrival of patients within 48 hours. It is then your responsibility to advise the participating hospitals of these facts.

IV. REGULATION

When patients are regulated to your region you will be so advised by ASMRO in a telephone conversation. They will tell you how many patients to expect in each of the categories. Your office must then allocate these patients to each participating facility. You will not have details on the patients, and must make the assignment based on the capabilities of the facilities involved in terms of beds available and treatment available.

In order to accomplish this regulation you should call each hospital, and advise them that patients, in the numbers you have determined, have arrived as of that time. If this is the first time that the hospital has received patients, you should advise the participant to open envelope number 1, which will contain the names, diagnoses, and other information on these patients.

Having thus sent the patients to the hospital you should then assume a different role. We must ask you to call the EMS participants and advise them that patients in whatever number are arriving at designated location (you will be advised of this) and that they have two hours to estimate their ability to get to this location and transfer these patients. At the end of the two hours you should call them back, and find out how successfully they felt they could have moved these patients. Also, some concept of the time involved from notification to estimated completion of such an operation is important, and should be requested.

There are certain restrictions that must be imposed in dealing with these facilities. First, patients may be regulated to and the hospitals

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contacted only between 0900 and 1700, Monday through Friday. The hospitals will play only during these hours. Second, we request that a maximum of 25 patients be regulated to any one facility at any one time. The envelopes containing patient information will contain only 25 cases. Should you regulate fewer than that, remind the hospital to disregard any additional names.

Finally, in all Nifty Nugget exercise communications, written or oral, please state at the beginning and at the end of the message that it is a Nifty Nugget exercise communication.

V. REPORTS ON PATIENTS

You will receive various reports and requests from the hospitals in your region.

The form for admissions of patients follows. As you can see it contains the basic data on each admission and a total of patients admitted on that day. The last number should be verified against the number regulated. The other information should be forwarded to the appropriate offices for each case. It is up to your office to identify the appropriate office, through the information itself should not be forwarded, but rather filed in your office for later evaluation. Form number 3, Change in Status/Request for Instruction, may simply need to be filed as described above for report number two, or it may require some action on your part. An example of the latter would be to approve the transfer of a patient from one facility to another or to indicate disposition instructions on a patient ready for duty.

Finally, report number four on disposition will advise you and the services of the disposition of the patients when they left the hospital. This information, again, is theoretically to be passed on to the services, since your office is the sole point of contact between the military and the civilian hospitals.

The purpose in providing this information is to obtain some idea how well the civilian facilities can report even this minimal information, and to obtain some insights into how well a regional office might serve as a conduit for this information.

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VI. REPORTS FROM YOUR REGION

The Region 8 Military Liaison Office will handle all of the types of messages described in Section V of this manual. As a general rule you will transmit to ASMRO only data on bed availability and responses to specific inquiries.

VII. SPECIAL EVENTS

In addition to the events discussed above, the Exercise Control Group may insert some planned or free-play events to add realism, seek status information, or test certain feasibility limits for your participation in an actual system. You are encouraged to treat these special situations as real ones requiring realistic reactions.

VIII. EVALUATION/LOG

We urge your office to maintain a log of events and actions taken, annotated with information about why these actions were taken, that will focus on the use of the civilian sector. It is important that we know how you were stressed, and where there are weaknesses that should be corrected. We will make an appointment to meet with you after this exercise in order to discuss this proposed system, and such a log will be of great assistance in formulating your comments.

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IX. TELEPHONE CONTACTS

Military Liaison Office

Tidewater:

— Naval Hospital Portsmouth, VA	*Lt Daniel *LTJG Hawkins Capt Shuler	} (804) 397-6541, ext. 516
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Philadelphia:

— ASMRO, RM 2D 537 The Pentagon Washington, D.C.	CDR Nelson *LCOL Vervena *Staff	} (202) 695-9119
--	---------------------------------------	------------------

MAXIMUS Staff

Washington

Bob White Ernie Swiger Dave Mastran Howard Miller	} (703) 893-7447
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Tidewater

Ted Conaway	(804) 424-1385
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Philadelphia

(To be determined)

Participants

Tidewater

— Norfolk General Hospital	Mr. David Bernd	(804) 628-3361
	*Mr. Lloyd Wenrick	(804) 628-3551
— Hampton General Hospital	Mrs. Lynne Moore	(804) 727-7554
	*Mrs. Katherine Hallissy	(804) 727-7244
— Riverside Hospital	Mr. Gerald Brink	} (804) 599-2000
	*Mr. Lonnie Byrd	
— Veterans Admin. M.C.	Mrs. Margaret Etheridge	(804) 722-9961
	*Mr. R.J. McDonnel	(804) 722-9961
— Tidewater EMS	*Mr. R.C. Dailey	(804) 461-1331
— Peninsula EMS	*Mrs. Nancy Fary	(804) 642-4416

*Designated player

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Philadelphia

— Hospital of University of Pennsylvania	*Mr. Frank Esposito *Mr. Glenn Chong	(215)662-3642 (215)662-2943
— Pennsylvania Hospital	*Ms. Joanne Moriconi Mr. Gary Aden	(215)829-3957 (215)829-3313
— Thomas Jefferson University Hospital	*Mr. Robert Dotson *Mr. Max Goodman Mr. Cary Leptuck	(215)928-8340 (215)928-6831 (215)928-8351
— Philadelphia Health Management Corporation (EMS)	*Mr. Robert Brand	(215)629-8226
— Southeastern Pa. Emergency Health Services Council, Inc.	*Ms. Saula Poach *Mr. Marc Panepinto	(215)628-4424 (215)628-4424
— Veterans Administration Medical Center	*Mr. David Berg *Ms. Cheryl Korman	(215)382-2400 ext. 203

Other Interested Parties

<u>Department of Defense</u>	Col Kelly Maj Sandidge	(202)695-2640 (202)694-4704
<u>Veterans Administration</u>	Dr. Walsh Ms. Kathy Bauman	(202)389-3210
<u>American Hospital Association</u>	Ms. Carol Lively Mr. Tom Berriman	(312)645-9640 (215)337-0870
<u>Delaware Valley Hospital Council</u>	Ms. Barbara Schoenfeld	(215)735-9695
<u>Naval Hospital, Philadelphia</u>	LCDR Kelner	(215)755-8234

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OPERATIONS MANUAL

FOR HOSPITAL ADMINISTRATORS

MAXIMUS

OPERATIONS MANUAL
FOR
HOSPITAL ADMINISTRATORS
PARTICIPATING IN A TEST
OF
THE PROPOSED
CIVILIAN-MILITARY CONTINGENCY HOSPITAL SYSTEM

October 1978

MAXIMUS, INC.
6723 Whittier Avenue
McLean, Virginia 22101

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TABLE OF CONTENTS

	<u>PAGE</u>
Ø. INTRODUCTION.....	1
I. ALERT.....	2
II. REPORTING AFTER ALERT.....	3
III. ACTIVATION.....	5
IV. ARRIVAL OF PATIENTS.....	6
V. PATIENT ADMINISTRATION.....	8
VI. SPECIAL INQUIRIES/SPECIAL EVENTS.....	15
VII. DAILY EVALUATIONS.....	16
VIII. DIRECTORY OF KEY PERSONS AND TELEPHONE NUMBERS.....	17

0. INTRODUCTION

The proposed Civilian-Military Contingency Hospital System (CMCHS), which will be tested by your hospital this October, is an interim system designed to provide medical care for military patients in the event of a major mobilization which would severely stress the Military Health Services System.

This manual provides step-by-step instructions for your participation, including details on what to do and how to do it, for all aspects of the exercise, including communication with the Military Liaison Office and your own assessment of the impact on your facility. It does not provide the answers; you will have to provide them in response to the situations that are presented to you. We must note that as part of this exercise may stress your hospital. It will be your imagination, insight, and knowledge that will make the difference.

We urge you to keep a log of events and to annotate it as you proceed with this exercise. This will provide both you and us with a written record of what happened and what factors affected your decision-making.

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I. ALERT

The purpose of the alert message is to advise the hospital administrator that the world and/or military situation is deemed serious enough that up-to-date information on bed availability is needed by health planners in the Department of Defense.

The message that the hospital administrator will receive in this exercise will be a telephone call from the Military Liaison Office advising him that the Secretary of Defense has placed the CMCHS on alert and that daily reporting of bed availability by capability (medical-surgical-psychiatric) is requested to begin at once and should continue until advised otherwise.

The hospital administrator's initial action in this exercise should be to alert other key personnel and then to assess the hospital's capabilities as outlined in Section II. This message is simply an alert, and it is not necessary to begin taking exercise actions to increase the number of beds available. Arrival of military patients is not assured under alert conditions.

II. REPORTING OF FACILITY CAPABILITIES

The purpose of reporting facility capabilities is to advise the Military Liaison Office of the numbers of beds (medical-surgical-psychiatric) that are available for use on a given day, as well as to determine any other constraints that would limit a hospital's participation in this program (e.g., shortages of supplies, personnel, or equipment, or local disasters).

The hospital administrator or his designate should begin reporting the census, bed, and status information noted in Report Format #1 to the Military Liaison Office on a daily basis at the time assigned in the alert message. Lacking a more sophisticated communications system, this data will be given orally over the telephone each day from the day following the alert message until the exercise is terminated. A record of these reports should be retained in your file of exercise communications.

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Report Format #1: DAILY CENSUS, BED, AND STATUS REPORT

(As of Date and Time)

FROM: _____
(NAME AND LOCATION OF HOSPITAL)

TO: _____
(MILITARY MEDICAL LIAISON OFFICE)

SUBJECT: DAILY CENSUS, BED, AND STATUS REPORT (CMCHS Report #1)

THIS IS A NIFTY NUGGET EXERCISE COMMUNICATION

1. CENSUS REPORT (of Military Patients)

- a. Previous Census: _____
- b. Admissions : _____
- c. Dispositions : _____
- d. Current Census : _____

2. BED STATUS

a. Open Military Beds

- 1) Medical : _____
- 2) Surgical : _____
- 3) Psychiatric: _____
- TOTAL Open Beds: _____

b. Military Commitment

- 1) Current Military Census: _____
- 2) Open Military Beds : _____
- 3) Occupied by Civilians : _____
- TOTAL Military Commitment : _____

3: PROBLEMS: (List and discuss any problems which circumscribe the ability of your hospital to care for military patients.)

THIS WAS A NIFTY NUGGET EXERCISE COMMUNICATION

III. ACTIVATION

The purpose of the activation message is to advise the hospital administrator that his facility can expect to receive military patients within 24-48 hours, though it is conceivable that patients might well arrive before this message is received. It should be understood that every attempt will be made to phase patients in, but given the usual operations of aeromedical evacuation planes and the problems of redistributing patients from major air heads, fairly large groups of patients may arrive at one time, and the condition of these patients may vary greatly.

Upon receipt of the activation notice, which will be a telephone call from your Military Liaison Office, the hospital administrator should, for purposes of this exercise, examine his patient load with an eye toward assuring that his hospital can make available beds at the level previously committed. Military patients will soon be on the way.

This evaluation of revised bed availability should be reflected in the Census, Bed, and Status Report (Report Format #1) on the day following activation. The hospital administrator should acknowledge his state of of activation in the telephone conversation.

IV. ARRIVAL OF PATIENTS

For this exercise the arrival of patients at your hospital will be accomplished through a series of telephone calls and the opening of numbered envelopes which will contain information on the patients. The process will work as follows:

- The Exercise Control Group, ASMR0, and/or the local Military Liaison Office will decide that casualties are to be sent to your area or facility.
- For purposes of this exercise your local EMS director or his arriving at an airfield or other location.
- At the same time the hospital administrator will be contacted and advised that patients have arrived at his facility. He will be instructed to open a designated envelope which will have names, other personal data, diagnoses, and other information on the imaginary patients.

Two telephone calls are made in this instance so that the exercise continues smoothly. The EMS director is faced with a problem which he must solve in a limited amount of time, but we do not want his problems to interfere with the hospital exercise. Thus, we will assume that the patients arrive at your hospital without undue transportation delay.

This arrival of patients should trigger a number of exercise events at your hospital. First, you should analyze the number of patients to determine whether or not there is space available for them. If not, what alternatives could you use? Second, examining the diagnoses and conditions of these patients, to what extent could you integrate the surgery and treatment needed into your schedule? Would your present staff be sufficient for this load? Given this patient load and especially the

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surgical load, could you obtain sufficient physician assistance? This may entail calling a number of physicians to check on their availability, not only the first time you receive patients, but each subsequent time.

We encourage you to be flexible and innovative in this exercise. This is the first time that this system, or anything like it, has been tested, and your actions and reactions are an essential part of this exercise. Only through your participation can we judge what types of problems may come up and what solutions are available.

Please keep notes or some records of your thoughts, analyses, and answers to problems. They will be of great value in the final evaluation.

V. PATIENT ADMINISTRATION

Patient administration is an essential element of any hospital system, and it usually involves a complicated series of records and forms. In this system, however, the emphasis is upon simplicity and minimal reporting. What follows is a series of guidelines for the disposition of the patients and outlines of the information needed on those occasions when reports on the patients are required.

REPORTS

There are basically only three instances in which it is necessary to report to the Military Liaison Office: upon admission, if there is a change in status or a request for information, and upon final disposition of a patient from your hospital.

A. THE ADMISSION REPORT

This daily report contains the basic data necessary to keep track of military patients. This data should be forwarded once for all military patients, within twenty-four hours of their admission to your hospital.

The information required should be provided as shown in Report Format #2.

This information should be communicated in writing, by messenger, or should be kept for collection and evaluation after the exercise.

B. CHANGE IN PATIENT STATUS/REQUEST FOR INSTRUCTIONS

This report is to be filed only if there is a significant change in the patient's medical status or if there is a required or specific request from or about the patient. Routine status reporting is not required.

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Report Format #2: ADMISSIONS

DATE

FROM: _____
(NAME AND ADDRESS OF HOSPITAL)

TO: _____
(MILITARY LIAISON OFFICE)

SUBJECT: REPORT OF ADMISSIONS (CMCHS Report #2)

THIS IS A NIFTY NUGGET EXERCISE COMMUNICATION

1. The following military patients were admitted this date:

(Repeat for each patient)

- a. Name
- b. Grade
- c. Military Service
- d. Social Security Number
- e. Date of Birth
- f. Diagnosis, primary and secondary
- g. Condition (after initial treatment)
- h. Estimated length of stay

2. TOTAL number of patients admitted this date: _____

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A "significant change in the patient's medical status" means that the patient is placed on or removed from the critical or serious list.

The Military Liaison Office should be notified 48 hours in advance of a patient's:

- availability for return to full duty (request information on military post to which patient should be transferred and travel funds (TR) for each patient);
- need for transfer to a non-local hospital for special care, disability hearings, or other purposes.

There may well be instances in which the physician or the hospital may seek instructions about what to do with a particular patient. That is, he may need particular care, for say burns, which is not readily available, or he may be a potential disability or long-term care case for which guidance may be needed. You may also find that the patient may wish to have his paycheck sent to him, may request leave, or may make some other inquiry. In all of these cases a Report #3 should be made. This information should be communicated to the Military Liaison Office in writing and a written synopsis retained.

The required information should be provided as shown in Report Format #3.

C. DISPOSITION OF PATIENTS

This final type of report advises the Military Liaison Office of what happened to the patients sent to your hospital. This includes a variety of events or conditions, but in particular notifies the contact office of:

Report Format #3: CHANGE IN STATUS/REQUEST FOR INSTRUCTION

DATE

FROM: (NAME AND ADDRESS OF HOSPITAL)

TO: (MILITARY LIAISON OFFICE)

SUBJECT: (NATURE OF REPORT/REQUEST) (CMCHS Report #3)

THIS IS A NIFTY NUGGET EXERCISE COMMUNICATION

1. (Patient Name, Grade, Military Service, SSN)
2. (Nature of Status Change or Information Request)
 - Describe the nature of the change
 - placed on critical list
 - ready for discharge - request destination and TR
 - Describe the problem concerning the patient
 - DX requires transfer to Burn Center
 - Request information or state need of patient
 - Patient requests pay or emergency leave

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- return to duty
- transfer to another hospital
- left without authority
- died
- dead on arrival

This Report #4 should be made within twenty-four hours of the event and in this exercise, by telephone. Please keep a file copy for evaluation after the exercise.

Required disposition information should be provided as outlined in Report Format #4.

Transfer to another local facility may be effected not only to better distribute patients and provide specialized care, but for other specific purposes as outlined below. If transfers involving two or three patients per day from any one hospital are contemplated, it may be assumed that such transfers can be accomplished without advance reference to the Military Liaison Office. However, more local transfers than that number may impact on EMS operations, and the Military Liaison Office should be advised before such transfers take place. The transfer can then be considered accomplished.

It is envisioned that the following general guidelines for patient condition, length of stay, and disposition will prevail, and your operations may be influenced by these considerations:

GUIDELINES FOR PATIENT GROUPS

<u>Patient Group</u>	<u>If on Admission the estimated patient stay to full recovery is</u>	<u>Then your hospital should</u>	<u>After acute care</u>	<u>On discharge</u>
1	< 30 days	hold to full recovery	hold for convalescent period	send to nearest military authority
2	$\geq 30 < 180$ days	hold thru acute phase of care	request instructions from Military Liaison Office	e.g., convalescent leave tr. to MHSS tr. to VA tr. to light care facility
3	≥ 180 days	stabilize & transfer to VA hospital as soon as possible		

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Report Format #4: DISPOSITION

DATE

FROM: _____
(NAME AND ADDRESS OF HOSPITAL)

TO: _____
(MILITARY LIAISON OFFICE)

SUBJECT: DISPOSITION OF MILITARY PATIENTS (CMCHS Report #4)

THIS IS A NIFTY NUGGET EXERCISE COMMUNICATION

1. The following disposition of military patients occurred this date:
(Repeat for each patient disposition)

- a. Name:
- b. Grade:
- c. Military Service:
- d. Social Security Number:
- e. Nature of disposition

- Return to Duty - told to report to _____.
- Transferred to _____ for _____
(another hospital)
- Left without authority - time, circumstances.
- Died - Remains located at _____. (For purposes
of this exercise you may assume the remains were sent to a
local mortician).
- Dead on Arrival - Remains located at _____.
(File this report, rather than Report #2 for DOA's).

2. Total dispositions this report: _____.

THIS WAS A NIFTY NUGGET EXERCISE COMMUNICATION

VI. SPECIAL EVENTS

In addition to the events discussed above, the Exercise Control Group may insert some planned or free-play events to add realism, seek status information, or test certain feasibility limits for your participation in an actual system. You are encouraged to treat these special situations as real ones requiring realistic reactions.

VII. DAILY EVALUATION

As you can see, this exercise will depend in large measure upon your response to events and situations that are thrust upon you. We encourage you to maintain a log of messages sent and received and to annotate this log extensively as you gauge your hospital's ability to perform under these emergency conditions. Ideas and options should be noted, and the more viable ones or the course that is chosen should be noted in particular. This data will be useful to you in answering our questions and in commenting upon this system. It is important that we know how your facility was stressed, where shortfalls in manpower and physicians may come, and where this system should be improved, augmented, or restructured. We draw your attention especially to the considerations that must be made in developing a course of action in stages IV, V, and VI.

Your hospital will be notified by telephone on termination of exercise play.

MAXIMUS staff members will contact you in early November for collection of data and follow-up evaluation.

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VIII. DIRECTORY OF KEY PERSONS AND TELEPHONE NUMBERS

The following list of telephone numbers is provided for your convenience. All calls to Military Liaison Offices and MAXIMUS staff members may be made collect. After identifying yourself initially, please inform the receiving party that this is a NIFTY NUGGET EXERCISE call. You will then be connected with the exercise players, and you should then begin your report. At the end of your message, remind the other party that this was a NIFTY NUGGET EXERCISE message.

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TELEPHONE CONTACTS

Military Liaison Office

Tidewater:

— Naval Hospital

*Lt Daniel
*LTJG Hawkins } (804) 397-6541, ext.516
Capt Shuler }

Philadelphia:

— ASMRO

CDR Nelson
*LCOL Vervena } (202) 695-9119

MAXIMUS Staff

Washington

Bob White
Ernie Swiger } (703) 893-7447
Dave Mastran }
Howard Miller }

Tidewater

Ted Conaway (804) 424-1385

Philadelphia

(To be determined)

Participants

Tidewater

— Norfolk General Hospital

Mr. David Bernd (804) 628-3361
*Mr. Lloyd Wenrick (804) 628-3551

— Hampton General Hospital

Mrs. Lynne Moore (804) 727-7554
*Mrs. Katherine Hallissy (804) 727-7244

— Riverside Hospital

Mr. Gerald Brink (804) 599-2000

— Veterans Admin. M.C.

Ms. Margaret Etheridge (804) 722-9961

— Tidewater EMS

*Mr. R.J. McDonnell (804) 722-9961

— Peninsula EMS

*Mr. R.C. Dailey (804) 461-1331

*Mrs. Nancy Fary (804) 642-4416

*Designated Player

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Philadelphia

— Delaware Valley Hospital Council	Ms. Barbara Schoenfeld(215) 735-9695 Mr. Dwayne Long
— University Hospital of Pennsylvania	Mr. Glenn Chung (215) 662-4000
— Pennsylvania Hospital	Mr. Gary Aden (215) 829-3000
— Jefferson Hospital	Mr. Cary Leptuck(215) 829-8315
— EMS	
— Veterans Administration Hospital	Mr. Joseph Mason(215) 382-2201
— Naval Hospital	LCDR Kelner (215) 755-8234

Other Interested Parties

<u>Department of Defense</u>	Col Kelly (202) 695-2640 Maj Sandidge (202) 694-4704
<u>Veterans Administration</u>	Dr. Walsh Ms. Kathy Bauman (202) 389-3210
<u>American Hospital Association</u>	Ms. Carol Lively(312) 645-9640 Mr. Tom Berriman(215) 337-0870

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PROPOSED FLYER FOR STAFF PHYSICIANS

TO: Physicians at _____

FROM: _____

SUBJECT: Emergency Exercise

This hospital will participate in a large scale emergency exercise during the month of October. This exercise, which is being conducted by the Department of Defense, will involve the simulated treatment of large numbers of military patients at civilian hospitals under emergency conditions. We do not know the exact date or duration of this exercise at this time.

As participants we will be called upon to evaluate how effectively this hospital could treat a large influx of patients on short notice. As a part of this evaluation, we must determine as best we can how we could treat such patients. To this end we will call upon some of you several times during the course of this exercise to determine the extent to which you could treat patients with specific diagnoses. These patients will become a part of your rounds, and they should be viewed as a part of your overall workload. Given these emergency conditions, some types of activity, notably elective surgery, might be curtailed. This should be borne in mind in evaluating your capability.

I must stress that this exercise will not simulate casualties; rather it will focus on our best judgments about what we can and cannot accomplish. Your thoughtful and reasoned cooperation will be most appreciated and valued in this exercise, and we will try not to take too much of your time with this test.

If you have further questions, please feel free to contact me.

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OPERATIONS MANUAL

FOR EMS OFFICIALS

MAXIMUS

OPERATIONS MANUAL

FOR EMS OFFICIALS

PARTICIPATING IN A TEST

OF

THE PROPOSED

CIVILIAN-MILITARY CONTINGENCY HOSPITAL SYSTEM

OCTOBER 1978

MAXIMUS, INC.
6723 Whittier Avenue
McLean, Virginia 22101

TABLE OF CONTENTS

	<u>PAGE</u>
Ø. INTRODUCTION.....	1
I. MESSAGES.....	2
II. RESPONSES.....	3
III. TELEPHONE NUMBERS.....	4

Ø. INTRODUCTION

The proposed Civilian-Military Contingency Hospital System, which will be tested by hospitals in your area this October, is an interim system designed to provide medical care for military patients in the event of a major mobilization which would severely stress the capabilities of the Military Health Services System. This manual provides some background on this system, and instructions about assistance we hope you can provide in this exercise.

The proposed system is just that — proposed. As such, this test will provide valuable information about problems, shortcomings, and strengths of the system. For this reason, we need your active participation and your candid assessment. There will be no patient movement in this exercise and, hopefully, only minor disruptions of your daily routine as problems are presented to you and solutions are sought. Your imagination, insight, and knowledge will be needed to solve these problems that would, if real, stress your resources.

We urge you to keep a log of events, and to annotate it as you proceed with this exercise. This will provide both you and us with a written record of what happened and what factors affected your decision making.

We very much appreciate your participation in this exercise, and encourage you to call us with any comments, suggestions, or questions you have between now and the beginning of the exercise. We look forward to this exercise and hope that it will prove as useful and stimulating to you as it will to us.

I. MESSAGES

The exact date that EMS systems and civilian hospitals will be called into action for this exercise is not known at this time. However, the general flow of events, and your participation in them, can be described.

At some point in October you will receive a telephone call advising you that the contingency system has been alerted. This will require no action on your part in this exercise.

At a later date you will be advised by telephone that the system is being activated. This message means that patients for hospitals in your area may be expected to arrive within 24-48 hours. Though patients will generally arrive at a local airfield, other points of arrival may be used. In this period of activation, you should assess your capabilities, and consider alternative sources of vehicles and crews for transporting patients in all states from critical to ambulatory. It should be noted that a planeload of litter patients may include anywhere from 20-50 persons.

You will be advised of the arrival of patients by a telephone call in which you will be provided with the supposed time and arrival point of a specified number of casualties. Information on the condition of these patients may or may not be available. Generally you will be given a specified amount of time to formulate a plan to move these patients from their arrival point to local hospitals. It should be noted that in most instances the designated hospital for patients will be specified; i.e., of 20 patients, five are to go to hospital X, ten to Y, and five to Z.

There will be no actual movement of patients; vehicles need not be dispatched for this exercise.

II. RESPONSES

The number of patients you are tasked with transporting will probably exceed your established capability. Thus, you will need to find ways to meet this shortfall. This is the heart of the exercise from your viewpoint, and it is a key consideration for the system as a whole.

Given what you know from the telephone call, we need your appraisal of how far your resources could go to move these patients, especially considering that there may be other actual or test civilian emergencies at the same time. What alternatives for transportation are available? To which of them would you have access and which of them would you use? How long do you think it would take to get such patients to the named facilities? Are there other local organizations or insititutions that you could call upon?

All of these questions are important if this system is to be feasible, and your answers to these and other questions are important to the implementation of any such system. We hope you will develop an approach to these issues and probe your potential resources sufficiently (with telephone inquiries) to test the workability of your approach. At the end of the allotted problem-solving time, you will be contacted again for your general assessment of the situation and some first-hand comments on the impact this task would have on your program.

In early November a MAXIMUS staff member will contact you to arrange an interview session in which you may discuss your experiences and express your opinions about this system. Your log book and records will be of value in obtaining a broad picture of the problems faced and solutions proposed.

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III. DIRECTORY OF KEY PERSONS AND TELEPHONE NUMBERS

As indicated above, you will receive a number of telephone messages as part of this exercise. The caller will ask for the exercise player and identify himself to you. He will state at the beginning and at the end of the message that this is a NIFTY NUGGET EXERCISE MESSAGE.

If you have any questions or problems, please feel free to call collect to the appropriate MAXIMUS staff member noted on the attached list of telephone numbers.

TELEPHONE CONTACTS

Military Liaison Office

Tidewater:

— Naval Hospital

*Lt Daniel
*LTJG Hawkins } (804) 397-6541, ext.516
Capt Shuler }

Philadelphia:

— ASMRO

CDR Nelson
*LCOL Vervena } (202) 695-9119

MAXIMUS Staff

Washington

Bob White
Ernie Swiger } (703) 893-7447
Dave Mastran }
Howard Miller }

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Philadelphia

(To be determined)

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*Mr. R.C. Dailey (804) 461-1331

*Mrs. Nancy Fary (804) 642-4416

*Designated Player

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Philadelphia

— Hospital of University of Pennsylvania	*Mr. Frank Esposito *Mr. Glenn Chong	(215)662-3642 (215)662-2943
— Pennsylvania Hospital	*Ms. Joanne Moriconi Mr. Gary Aden	(215)829-3957 (215)829-3313
— Thomas Jefferson University Hospital	*Mr. Robert Dotson *Mr. Max Goodman Mr. Cary Leptuck	(215)928-8340 (215)928-6831 (215)928-8351
— Philadelphia Health Management Corporation (EMS)	*Mr. Robert Brand	(215)629-8226
— Southeastern Pa. Emergency Health Services Council, Inc.	*Ms. Sauna Poach *Mr. Marc Panepinto	(215)628-4424 (215)628-4424
— Veterans Administration Medical Center	*Mr. David Berg	(215)382-2400 ext. 203

Other Interested Parties

<u>Department of Defense</u>	Col Kelly Maj Sandidge	(202)695-2640 (202)694-4704
<u>Veterans Administration</u>	Dr. Walsh Ms. Kathy Bauman }	(202)389-3210
<u>American Hospital Association</u>	Ms. Carol Lively Mr. Tom Berriman	(312)645-9640 (215)337-0870
<u>Delaware Valley Hospital Council</u>	Mrs. Barbara Schoenfeld	(215)735-9695
<u>Naval Hospital, Philadelphia</u>	LCDR Kelner	(215)755-8234

APPENDIX G
TRAINING SLIDES
FOR NIFTY NUGGET EXERCISE TEST

MAXIMUS

A
TRAINING SEMINAR
FOR
HOSPITAL ADMINISTRATORS AND EMS OFFICIALS
PARTICIPATING IN
NIFTY NUGGET EXERCISE TEST
OF THE
CIVILIAN-MILITARY CONTINGENCY HOSPITAL SYSTEM
(CMCHS)
SEPTEMBER 1978

MAXIMUS, INC.
6723 Whittier Avenue
McLean, Virginia 22101

MAXIMUS

PURPOSE OF THIS SEMINAR

- o TO PROVIDE INFORMATION ON:
 - I. PURPOSE AND CONCEPT OF CMCHS
 - II. NIFTY NUGGET EXERCISE OF CMCHS
 - III. TEST EVENTS AND ACTIONS
 - IV. TEST FOLLOWUP AND EVALUATION
- o TO ANSWER YOUR QUESTIONS

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I. CMCHS CONCEPT

A. SCENARIO

B. CMCHS COMPONENTS

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I.A. SCENARIO

- LIMITED WAR ABROAD GENERATES A LARGE NUMBER OF PATIENTS WHICH EXCEEDS THE CAPABILITY OF MILITARY HOSPITALS AT THAT STAGE OF MOBILIZATION
- CIVILIAN HOSPITAL CAPABILITY WILL BE REQUIRED TO CARE FOR THE OVERFLOW

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I. B. COMPONENTS OF A PROPOSED CIVILIAN-MILITARY CONTINGENCY SYSTEM (CMCHS)

1. HOSPITALS
2. MANPOWER
3. LOGISTICAL SUPPORT SYSTEMS
4. PAYMENT

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II. NIFTY NUGGET EXERCISE

A. PURPOSE

B. TEST METHODOLOGY

C. APPROACH

D. ROLE OF HOSPITALS AND EMS

E. SPECIFIC REQUIREMENTS FOR PARTICIPANTS

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II.A. PURPOSE OF NIFTY NUGGET EXERCISE

- JCS MOBILIZATION EXERCISE
- VEHICLE FOR TESTING PARTS OF CMCHS
- TEST WILL INVOLVE NO SIMULATION OF WOUNDED, ONLY MESSAGE TRAFFIC AND EVALUATIONS BY HOSPITAL AND EMS STAFF MEMBERS
- 3-4 HOSPITALS TO PARTICIPATE IN EACH OF TWO AREAS (PHILADELPHIA AND TIDEWATER)
- EMS TO PARTICIPATE

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II. B. EXERCISE METHODOLOGY

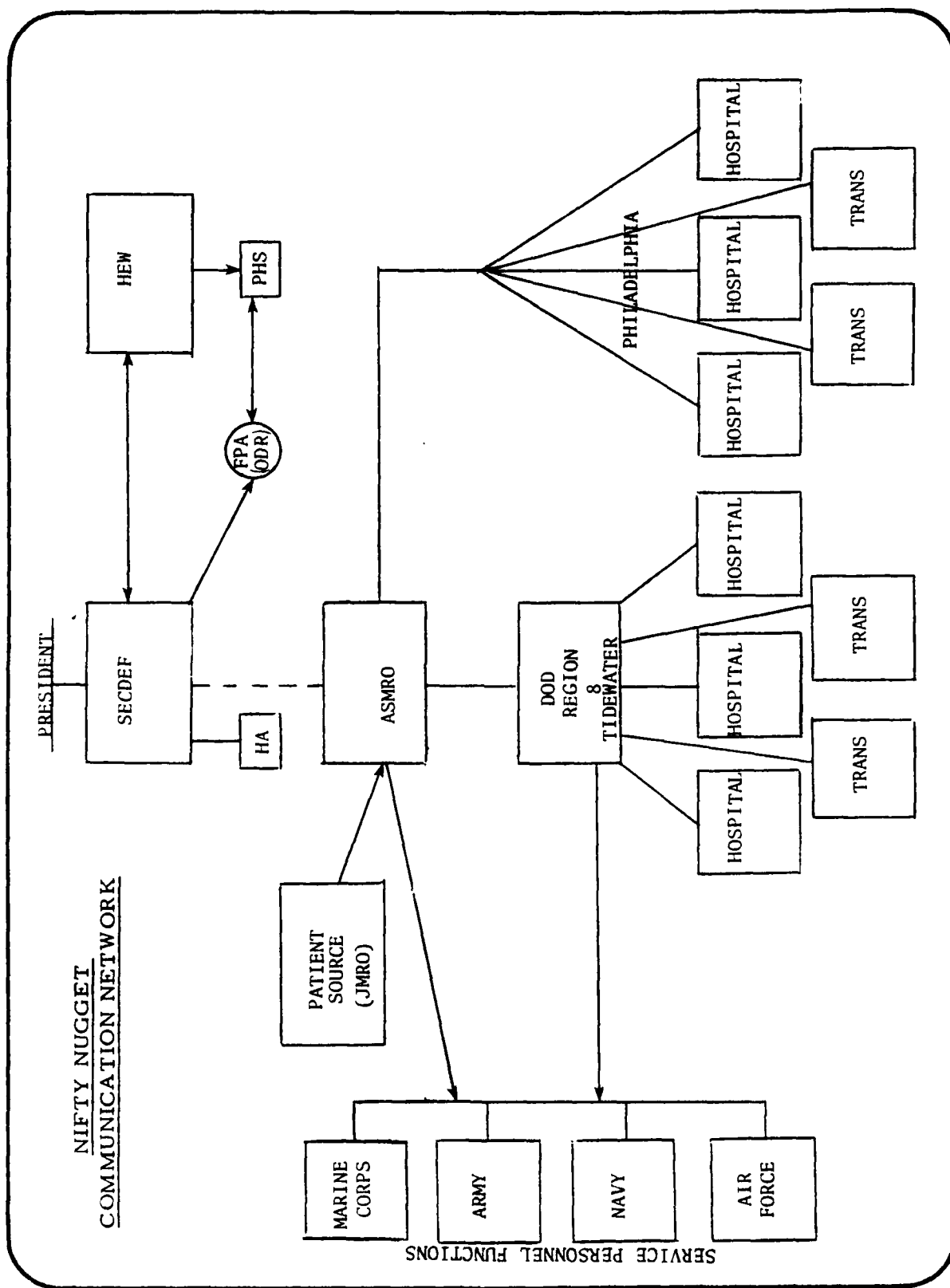
- o COMMUNICATIONS AMONG PARTICIPANTS
- o ENVELOPES WITH DATA AND SITUATIONS
- o ON-GOING ANALYSIS OF HOSPITAL AND EMS OPERATIONS BY LOCAL ADMINISTRATORS

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II.C. APPROACH TO NIFTY NUGGET TEST

<u>WHAT TO TEST</u>	<u>HOW TO TEST</u>	<u>HOW TO EVALUATE</u>
1. Ability of Federal agencies to interact and coordinate • approve allocation • activation of system • response to crisis	1. • Submit Mock allocation request thru channels • Send activation notices • Send urgent requests (as well as regular rpts)	1. • Was allocation approved in a timely fashion? • Did the Government system respond to activation?
2. Ability of command & control systems for CMCHS to function.	2. • Devise message traffic among all players in all modes, i.e., -- activation -- patient dispatch -- patient status reporting -- patient problems & requests	2. • Did the system break down? If so, where and why? • Were "people" or messages lost or misplaced for a time?
3. Ability of hospitals to receive and treat patients.	3. • Advise participating hospital of numbers & types of patients & have hospital analyze the impact on their operations.	3. • Did the hospitals feel that they could accommodate such a surge?

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II.D. THE ROLE OF THE HOSPITAL AND THE EMS

- o TRANSPORT, RECEIVE, AND ADMIT PATIENTS (ON PAPER ONLY)
- o COMMUNICATE CERTAIN PRESCRIBED PATIENT INFORMATION AND MANAGEMENT INFORMATION TO MILITARY OFFICIALS
- o ASSESS AVAILABILITY OF TRANSPORTATION, SURGERY TIME AND CAPACITY, BED SPACE, AND PHYSICIANS GIVEN AN EXERCISE PATIENT LOAD
- o ASSESS THE IMPACT OF THIS PATIENT LOAD ON THE OPERATION OF YOUR FACILITY, EQUIPMENT AND PERSONNEL

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II. E. SPECIFIC REQUIREMENTS FOR PARTICIPANTS

- o PARTICIPATE IN
 - TRAINING SEMINAR
 - THE EXERCISE (5-21 DAYS)
- o ASSIGN PERSONNEL WHO CAN
 - DEVOTE UP TO ONE HOUR PER DAY
 - RECEIVE EXERCISE COMMUNICATIONS
 - RESPOND FOR YOUR ORGANIZATION
- o PROVIDE AFTER EXERCISE EVALUATION OF:
 - PROBLEMS ENCOUNTERED
 - VIABILITY OF CMCHS

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III. TEST EVENTS AND ACTIONS

A. ALERT

B. ACTIVATION

C. ARRIVAL OF PATIENTS

D. PATIENT ADMINISTRATION

E. SPECIAL EVENTS

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F/G 15/3

STUDY OF THE PROBLEMS ASSOCIATED WITH RELIANCE ON CIVILIAN MEDIC--ETC(U)

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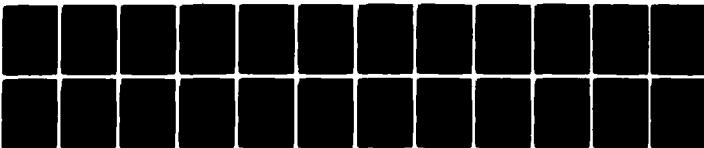
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DATE

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III. A. ALERT

1. MEANING
2. REQUIRED ACTIONS

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III. A. ALERT

I. MEANING

- o WORLD MILITARY SITUATION IS QUESTIONABLE
- o THERE IS NEED FOR INCREASED READINESS
- o DoD NEEDS UP-TO-DATE INFORMATION ABOUT YOUR CONTINGENT ABILITY TO CARE FOR MILITARY PATIENTS

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III.A. ALERT

I. MEANING

- o WORLD MILITARY SITUATION IS QUESTIONABLE
- o THERE IS NEED FOR INCREASED READINESS
- o DoD NEEDS UP-TO-DATE INFORMATION ABOUT YOUR CONTINGENT ABILITY TO CARE FOR MILITARY PATIENTS

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III.A. ALERT

2. REQUIRED ACTIONS

o MILITARY LIAISON OFFICE:

- NOTIFY PARTICIPATING HOSPITALS AND EMS
- RECEIVE DAILY STATUS REPORTS
- NOTIFY ASMRO OF DAILY STATUS

o HOSPITALS

- ASSESS CURRENT CAPABILITY
- COMMENCE DAILY REPORTS (SEE FORMAT #1)

o EMS

- ASSESS CURRENT CAPABILITY

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REPORT FORMAT #1: DAILY CENSUS, BED, AND STATUS REPORT

CONTENT:

FROM:

(NAME AND LOCATION OF HOSPITAL)

(DATE)

TO:

(MILITARY LIAISON OFFICER)

SUBJECT: Daily Census, Bed, and Status Report (CMCHS Report #1)

THIS IS A NIFTY NUGGET EXERCISE COMMUNICATION

1. CENSUS REPORT

(DATE AND TIME)

- a. Previous Census: _____
- b. Admissions : _____
- c. Dispositions : _____
- d. Current Census : _____

2. BED STATUS (NUMBER OF OPEN BEDS)

- a. Medical : _____
- b. Surgical : _____
- c. Psychiatric : _____

3. PROBLEMS (List and discuss any problems which circumscribe the ability of your hospital to care for military patients.)

THIS WAS A NIFTY NUGGET EXERCISE COMMUNICATION

METHOD:

- o TELEPHONE TO MILITARY LIAISON OFFICE/ASMRO
- o DOCUMENT TIME AND CONTENT OF REPORT

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III. B. ACTIVATION

1. MEANING

2. REQUIRED ACTIONS

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III. B. ACTIVATION

1. MEANING:

- CMCHS HOSPITALS WILL BE USED FOR MILITARY PATIENTS
- HOSPITALS COULD RECEIVE SOME MILITARY PATIENTS
WITH 24 to 48 HOURS

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III. B. ACTIVATION

2. REQUIRED ACTIONS

o MILITARY LIAISON OFFICE

- NOTIFY PARTICIPATING HOSPITALS AND EMS
- ENHANCE PLAN FOR REGULATING PATIENTS

o HOSPITALS

- EVALUATE CURRENT ABILITY TO MEET COMMITMENT
- REPORT ENHANCED, ACTUAL, AND POTENTIAL CAPABILITY (REPORT FORMAT #1)

o EMS

- REVIEW CURRENT CAPABILITY TO MOBILIZE VEHICLES AND CREWS ON SHORT NOTICE

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III. C. ARRIVAL OF PATIENTS

1. SOURCE OF PATIENTS
2. ROLE OF MILITARY LIAISON OFFICE
3. ROLE OF EMS
4. ROLE OF HOSPITALS

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III. C. 1. SOURCE OF PATIENTS

- o PATIENTS ARE TO BE CREATED BY THE EXERCISE
CONTROL GROUP AND EXERCISE EVENTS

- o SIMULATED CREATION OF PATIENTS THROUGH:

- TELEPHONE CALLS

- ENVELOPES CONTAINING PATIENT DATA

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III. C. 2. ROLE OF MILITARY LIAISON OFFICE

- o RECEIVE NOTICE OF PATIENTS FROM ASMRO
- o REGULATE PATIENTS TO AVAILABLE LOCAL BEDS
- o NOTIFY EMS OF PATIENT ARRIVAL TIME
- o NOTIFY HOSPITALS OF PATIENT ARRIVAL TIME
- o RECEIVE STATUS AND PATIENT ADMINISTRATIVE REPORTS
- o REPORT TO MILITARY PERSONNEL OFFICES
- o ARRANGE FOR PAY
- o ARRANGE TRAVEL MONEY OR TRANSPORTATION REQUEST

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III. C. 3. EMS ROLE

- o RECEIVE TELEPHONE MESSAGE OF PATIENT ARRIVALS, TO INCLUDE:
 - NUMBER OF PATIENTS
 - POINT AND TIME OF ARRIVAL
 - GENERAL CONDITION
 - DESTINATION (INTENDED HOSPITAL)
- o DETERMINE HOW TO MOVE THESE PATIENTS
- o REPORT AND DOCUMENT:
 - SOLUTIONS
 - OPTIONS
 - PROBLEMS
 - ESTIMATED TIME TO MOVE
 - IDEAS/SUGGESTIONS

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III. C. 4. HOSPITAL ROLE

- o RECEIVE PATIENTS (I. E., OPEN NUMBERED ENVELOP WHEN INSTRUCTED)
- o ASSESS CAPABILITY TO CARE FOR THESE PATIENTS
 - ARE PHYSICIANS AVAILABLE? (PLACE CALLS TO SAMPLE)
 - IS SURGICAL TIME/SPACE AVAILABLE?
 - ARE SUPPLIES AND BLOOD ON HAND OR AVAILABLE?
 - ARE BEDS AVAILABLE?
 - WHAT ACTIONS COULD YOU TAKE TO MEET SHORTFALLS?
- o RECORD
 - SOLUTIONS
 - OPTIONS
 - PROBLEMS
 - IDEAS/SUGGESTIONS

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SAMPLE PATIENT GROUP

<u>NAME</u>	<u>GRADE</u>	<u>SERVICE</u>	<u>SSN</u>	<u>DOB</u>	<u>DX₁</u>	<u>DX₂</u>	<u>CONDITION</u>	<u>PT. GROUP</u>
ABLE	PVT	USMC	1234	58	SURG		SER	2
BAKER	PFC	USA	1235	50	MED			1
CHARLIE	CPL	USA	1236	57	SURG			1
DELTA	SGT	USAF	1237	55	BLIND	PSYCH		3
ECHO	SN	USN	1238	59	AMPUTEE	SURG	CRI	3
FOX TROT	CAPT	USAF	1239	55	SURG	MED		2
GEORGE	PFC	USA	1240	58	PSYCH			1
HECTOR	SGT	USA	1241	45	URI			1
IDA	1st LT	USAF	1242	53	OB			1
JACOBS	BMC	USN	1243	39	SURG	PSYCH	SER	3

SER = SERIOUS
CRI = CRITICAL

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III. D. PATIENT ADMINISTRATION

1. GUIDELINES FOR PATIENT GROUPS
2. ADMISSION REPORTS
3. REPORT OF STATUS CHANGE/REQUEST FOR INSTRUCTIONS
4. DISPOSITION REPORTS

III.D.1. GUIDELINES FOR PATIENT GROUPS

<u>Patient Group</u>	<u>If on Admission the estimated patient stay to full recovery is</u>	<u>Then your hospital should</u>	<u>After acute care</u>	<u>On discharge</u>
1	< 30 days	hold to full recovery	hold for convalescent period	send to nearest military authority
2	≥ 30 < 180 days	hold thru acute phase of care	request instructions from Military Liaison Office	e.g., convalescent leave tr. to MHSS tr. to VA tr. to light care facility
3	≥ 180 days	stabilize & transfer to VA hospital as soon as possible		

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III. D. 2. ADMISSION REPORTS

- WHEN TO REPORT: DAILY DURING EXERCISE (IF THERE ARE ADMISSIONS)
- TO WHOM TO REPORT: MILITARY LIAISON OFFICE
- ON WHOM TO REPORT: ALL ACTIVE DUTY MILITARY PATIENTS ADMITTED TO YOUR HOSPITAL
- WHAT TO REPORT: (SEE REPORT FORMAT #2)

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REPORT FORMAT #2: ADMISSIONS

DATE

FROM: (NAME AND ADDRESS OF HOSPITAL)

TO: (MILITARY LIAISON OFFICE)

SUBJECT: REPORT OF ADMISSIONS (CMCHS REPORT #2)

THIS IS A NIFTY NUGGET EXERCISE COMMUNICATION

1. The following military patients were admitted this date: (Repeat for ea patient)

- a. Name
- b. Grade
- c. Military Service
- d. Social Security Number
- e. Date of Birth
- f. Diagnosis, primary and secondary
- g. Condition
- h. Estimated length of stay

2. TOTAL number of patients admitted this date: _____

THIS WAS A NIFTY NUGGET EXERCISE COMMUNICATION

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III. D. 3. REPORT OF STATUS CHANGE/REQUEST FOR INSTRUCTIONS

- o WHEN TO REPORT:
 - CHANGE IN SERIOUS OR CRITICAL LIST STATUS
 - SPECIAL INSTRUCTIONS ARE REQUIRED
- o TO WHOM TO REPORT: MILITARY LIAISON OFFICE
- o ON WHOM TO REPORT: ANY ACTIVE DUTY MILITARY PATIENT IN YOUR HOSPITAL
- o WHAT TO REPORT: (SEE REPORT FORMAT #3)

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REPORT FORMAT #3:
REPORT OF CHANGE IN STATUS/REQUEST FOR INSTRUCTIONS

DATE

FROM: (NAME AND ADDRESS OF HOSPITAL)

TO: (MILITARY LIAISON OFFICE)

SUBJECT: (NATURE OF REPORT/REQUEST)(CMCHS REPORT #3)

THIS IS A NIFTY NUGGET EXERCISE COMMUNICATION

1. (PATIENT NAME, GRADE, MILITARY SERVICE, SSN)
2. (NATURE OF STATUS CHANGE OR INFORMATION REQUEST)
 - o DESCRIBE THE NATURE OF THE CHANGE
 - o DESCRIBE THE PROBLEM CONCERNING THE PATIENT
 - o REQUEST INFORMATION OR STATE NEED OF PATIENT: e. g.

-- TRANSFER TO ANOTHER FACILITY
-- TRAVEL FUNDS FOR AND DESTINATION OF PATIENTS
READY FOR DUTY WITHIN 48 HOURS

THIS WAS A NIFTY NUGGET EXERCISE COMMUNICATION

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III. D. 4. DISPOSITION REPORTS

- o WHEN TO REPORT: DAILY DURING EXERCISE (IF THERE ARE DISPOSITIONS)
- o TO WHOM TO REPORT: MILITARY LIAISON OFFICE
- o ON WHOM TO REPORT: ALL ACTIVE DUTY MILITARY PATIENTS WHO:
 - WERE RETURNED TO DUTY
 - WERE TRANSFERRED
 - LEFT WITHOUT AUTHORITY
 - DIED (INCLUDING DOA)
- o WHAT TO REPORT: (SEE REPORT FORMAT #4)

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REPORT FORMAT #4: DISPOSITIONS

(DATE)

FROM:

(NAME AND ADDRESS OF HOSPITAL)

TO:

(MILITARY LIAISON OFFICE)

SUBJECT: DISPOSITION OF MILITARY PATIENTS (CMCHS REPORT #4)

THIS IS A NIFTY NUGGET EXERCISE COMMUNICATION

1. The following disposition of military patients occurred this date:
(Repeat for each patient disposition)

- a. Name
- b. Grade
- c. Military Service
- d. Social Security Number
- e. Nature of disposition

- o Return to Duty -- Told to Report to _____.
- o Transferred to another Hspital _____ for _____.
- o Left without Authority -- Time, Circumstances.
- o Died -- Remains located at _____. (For purposes of this exercise you may assume the remains were sent to a local mortician).
- o Dead on Arrival -- Remains located at _____. (File this report rather than Report #1 for DOA's).

2. TOTAL dispositions this report: _____

THIS WAS A NIFTY NUGGET EXERCISE COMMUNICATION

III. E. SPECIAL EVENTS

1. SPECIAL REQUESTS FOR INFORMATION FROM MILITARY
LIAISON OFFICE
2. SPECIAL SITUATIONS MAY BE STRUCTURED TO TEST
IMPACT AND REACTION

IV. TEST EVALUATION

A. AFTER THE TEST

B. DURING THE TEST

C. PROBLEMS AND THEIR SOLUTION

D. CONTACTS AND TELEPHONE NUMBERS

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IV.A. EVALUATION AFTER THE TEST

- o NO-FAULT EXERCISE
- o WE WILL FOLLOW -UP TO
 - INTERVIEW YOU ABOUT THE EXERCISE PLAY
 - REVIEW/GET COPY OF YOUR LOG
- o WE WILL PROVIDE EACH PARTICIPANT A SYNOPSIS OF RESULTS

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IV. B. EVALUATION DURING THE TEST

- o DAILY LOG IS IMPORTANT, NOT ONLY FOR MESSAGES,
BUT OF CONSIDERATIONS AND IDEAS IN DECISION-MAKING
- o IMPORTANT FOR IDEAS ABOUT HOW AND WHEN SYSTEM
COULD BE IMPROVED OR RESTRUCTURED
- o IF INSURMOUNTABLE PROBLEMS ARISE, PLEASE CALL COLLECT

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IV. C. PROBLEMS AND THEIR SOLUTION

- WE INTEND TO STRESS YOUR SYSTEM
- WE HOPE YOU CAN SOLVE THE PROBLEMS
- BUT, DON'T SIT ON A PROBLEM YOU CAN'T SOLVE

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PROBLEMS

- SOLVE IT IF YOU CAN
- SHARE IT IF YOU CAN'T
- DOCUMENT WHATEVER HAPPENS

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TELEPHONE CONTACTS

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*LTJG Hawkins } (804) 397-6541, ext.516
Capt Shuler }

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*Mrs. Nancy Fary (804) 642-4416

*Designated Player

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Philadelphia

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— University Hospital of Pennsylvania	Mr. Glenn Chung (215) 662-4000
— Pennsylvania Hospital	Mr. Gary Aden (215) 829-3000
— Jefferson Hospital	Mr. Cary Leptuck(215) 829-8315
— EMS	
— Veterans Administration Hospital	Mr. Joseph Mason(215) 382-2201
— Naval Hospital	LCDR Kelner (215) 755-8234

Other Interested Parties

<u>Department of Defense</u>	Col Kelly (202) 695-2640 Maj Sandidge (202) 694-4704
<u>Veterans Administration</u>	Dr. Walsh Ms. Kathy Bauman (202) 389-3210
<u>American Hospital Association</u>	Ms. Carol Lively(312) 645-9640 Mr. Tom Berriman(215) 337-0870

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PRESENTING INFORMATION		HOSPITAL ACTIVITIES		CONTROL NO:
<u>PATIENT IDENTIFICATION</u> NAME: _____ GRADE: _____ MILITARY SERVICE: _____ SSN: _____ DOB: _____		<u>ATTENDING PHYSICIAN</u> NAME: _____ TIME CONTACTED: _____ AGREES TO ATTEND: ☐		
<u>ADMISSION DIAGNOSES</u> 1. _____ 2. _____ 3. _____		WARD/ROOM #: _____ SURGERY: _____ (Date and Time)		
<u>PATIENT CATEGORY:</u> _____ <u>CONDITION</u> ☐ SATISFACTORY ☐ SERIOUS ☐ CRITICAL ☐ DEAD ON ARRIVAL		DISPOSITION: _____ ☐ RETURNED TO DUTY ☐ TRANSFERRED TO _____ ☐ LEFT WITHOUT AUTHORITY ☐ DIED - REMAINS SENT TO _____		
NOTES:				