

Evacuating and Receiving Patients in the Midst of a Wildfire

At the end of June 2018, the State of Colorado (CO) experienced the third largest wildfire in state history. Dave McGraw, the Safety and Security Officer of Spanish Peaks Regional Health Center found himself and the facility Incident Command Team having to evacuate more than 100 patients and residents. Karen Bryant, who was serving as the Chief Operating Officer and overseeing the emergency preparedness program at Prowers Medical Center at the time, helped to coordinate a team in their preparation to receive 14 of those residents. This article highlights their experiences and how they applied lessons learned from years of training and past incidents to the success of patient evacuation and return.

John Hick (JH)

ABSTRACT

Let's start off with both of you describing your facilities for our readers.

Dave McGraw (DM)

Spanish Peaks Regional Health Center is located in a rural area of southern Colorado, just west of Walsenburg (population 3000) and 150 miles south of Denver. One of the facilities that makes up this center is a veterans nursing home, with 120 beds (13 devoted to residents with memory care challenges). Our census average is between 100 and 115. On the day we evacuated, it was 91. We are also attached to a 20-bed critical access hospital, the only hospital within 40 miles of our community.

Karen Bryant (KB)

Prowers Medical Center is a critical access hospital, licensed for 25 beds. We also have a 24/7 emergency room, a rural health clinic, and an outpatient specialty clinic where visiting providers treat patients. We are a little over two hours and nearly 110 miles away from Spanish Peaks.

JH

Take us through the period leading up to the evacuation.

DM

It was early during the day on June 28, and our area was already under a total fire restriction. We were made aware of a human-caused fire close to our facility. At first, we activated incident command to ensure situational awareness and take advantage of the time we had. We had five patients with more serious pre-existing respiratory issues, and we arranged to transfer them to other facilities because the air quality was declining. We activated WebEOC to enable us to communicate with staff and keep everyone apprised of the situation.

A group of us were in the parking lot waiting for nightshift staff to make the full transition when a cloud of smoke suddenly settled on top of us. It started to snow ash and visibility went from 10 miles to less than half a mile in one minute. We turned around, went back in, and



reactivated incident command at 9:45 PM. We identified 17 more residents who had to be evacuated and started the process.

JH

This wasn't your first experience with a wildfire, though—were you able to apply any lessons learned from the 2013 incident to this fire? Did anything take you by surprise in 2018?

DM

In 2013, we did not leave the building, but we did learn some lessons that we incorporated into our plans. Because we have a longer-term, predictable population, it is easier for us to have more things prepared in advance. We keep medical record summaries current and, in this case, we were able to print and grab those and match them to every resident prior to evacuation. We also learned the importance of (and challenges associated with) having patients maintain go-bags of pre-identified personal items that would allow them to be comfortable for several days. In 2013, we also realized that the amount of supplies it takes to relocate a resident is larger than we had planned for, so we adjusted and created arrangements with our vendors to divert supply orders to receiving facilities as needed.

We did not have a continuity of operations plan in 2013 either, and we made some mistakes shutting down computers. Now we have a plan for downtime procedures that includes shutting down and reconnecting computers and more effectively preserving vital records.

The biggest surprise was how fast the fire moved. We were never threatened by the actual flames, but the smoke plume that drifted over our facility did so very quickly.

Check out the ASPR TRACIE Healthcare Facility Evacuation / Sheltering Topic Collection and Issue 6: Evacuating Healthcare Facilities for helpful resources and more information.

IJH

Who made the decision to evacuate? Did you work with local emergency management, Emergency Medical Services (EMS), and other hospitals before you evacuated?

Resident/Patient Evacuation Supply Considerations

- Clothes (e.g., pajamas, slippers)
- Portable food/snacks
- Water
- Medications
- Undergarments for incontinence
- Personal care and grooming products (e.g., lotions, specialty cleansing products for sensitive skin, specialty shampoo, toothpaste)
- Small personal effects (e.g., photos, blankets, pillows)

One challenge associated with having these "gobags" prepared in advance for residents is that they take up space (a premium in healthcare facilities). Another is that they must be kept current with seasons, weight gain/loss, treatment changes, and other factors. Items also must be labeled and inventoried to ensure they return with residents. Tracking involves so much more than just the physical location of residents and patients.

-- Dave McGraw



Wildfire smoke approaches the facility. Photo courtesy of Dave McGraw.



DM

Our county Emergency Operations Center (EOC) told us we could decide on a facility basis. At that point we were contacting anyone we could get a hold of and our executive team was contacting their colleagues at other facilities. I used WebEOC as our primary tool to communicate with the EOC. I didn't want to overwhelm them with phone calls—they were working with the town of La Veta and were very busy. We also regularly shared information with local and state health departments and regulatory agencies like the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Veterans Affairs (VA), U.S. Department of Health and Human Services (HHS), and the regional healthcare coalition.

JH

Take us through the actual evacuation—were there staging areas? How did you track patients?

DM

On June 27, the fire started on the west side of the mountain. We could see the smoke, but we hoped it wouldn't be a big deal. On June 28, it was obvious that it would become a long-term event. Our biggest concern was the direction of the smoke. In 2013 the fire was far enough away that you could smell and see it, but it wasn't inundating our facility. This time, the ash was inundating our area and we are charged with taking care of elderly people who can't take in a lot of air without oxygen therapy. At first, we were able to close our dampers and keep residents inside. But once the plume settled over our facility, that changed. We were all having trouble breathing, then we realized smoke was getting in the building. We had doors and windows taped shut-we did everything we could do but we knew we had to get our residents out that night.

All identification and labeling took place in our main lobby, which is on the second floor. We labeled everything that went out with residents, including the residents! Once this process was complete, we moved residents to the first floor where the main staging area for load out took place. We had a checklist we used to confirm details with the drivers and we successfully worked with our partners to move 17 patients between 9:30 PM and 3:00 AM the next day. By 1:10 PM on June 29, we had evacuated all 104 patients and residents.

We really didn't encounter any challenges—we have a regional compact and a licensure agreement between CO and New Mexico (NM) that allows providers to care for patients in both states. We also have a Memorandum of

Residents waiting to evacuate. Photo courtesy of Dave McGraw.



Understanding (MOU) with a nearby community, and they sent a few vehicles down to help with transportation. Most of our receiving facilities also sent buses down and we used some of our own vehicles. Only one resident needed specialized transportation.

JH

Did the critical access hospital maintain operations during the incident?

DM

We evacuated all units but kept the emergency department functioning and kept most outpatient services other than surgery operational. These were needed to support our Level 4 Trauma Emergency Department.

JH

Karen, what was the situation like on your end?

KB

On the evening of June 28, the Chief Executive Officer (CEO) at Spanish Peaks reached out to our CEO to advise him of the situation in Walsenburg and inquired whether our hospital was in a position to receive 17 patients. Our CEO reached out to me and our Chief Clinical Officer, asking for us to activate call trees to determine if we had enough staff to receive that many patients. I was also asked to be on "stand by" to activate our external disaster procedures. The next day, at about 8:40 am, we were in our morning huddles. The Chief Clinical Officer holds her huddle next door to my office. The CEO at Walsenburg had reached out once again asking if we had room for 14 patients. We had 15 beds available at the time, so when we found out about the need to receive 14 patients, we joined her "huddle," invited some other key



representatives, and started brainstorming the process for receipt of patients. One of the bigger issues that I know a lot of other facilities deal with is wheelchairs; they are often missing parts. We had someone conduct a "wheelchair roundup" to ensure we had enough complete wheelchairs for the incoming patients.

Because we are a small rural community, and due to the distance between us, we often must be creative and consider local and regional assets that could be helpful. In our case, we have a MOU with two local agencies to develop alternate care sites in case the patient surge exceeds our capability. We worked directly with city and county agencies (in Lamar, where we are located) and we also have an agreement with the community college wellness center. I knew we had transportation alternatives, so that was helpful.

Everyone was on board right away. Not all the vehicles were accessible (particularly the college vehicles), so we worked out the logistics to make sure the trip was safe for all. Shortly thereafter, we found out that Spanish Peaks had secured the necessary transportation and the patients were on their way, with their own wheelchairs. I called the college and commissioner back to cancel the request for transportation.

Our staff was phenomenal, from providers to registration staff—everyone offered to help.

JH

Were there any surprises related to patient transport or their records/belongings?

DM

We had already practiced and exercised evacuating patients and residents to an alternate care site four miles outside of town. Part of our plan was to use school buses. When the bus showed up, we realized non-ambulatory people could not board those buses. That was a good lesson to learn in an exercise. We had MOUs with transportation companies in Pueblo (50 miles north) and we had five vans.

One thing we did do on the fly for tracking purposes is take pictures of all residents on the vans, then photographed the van's license plate and side placard to ensure we were accurately tracking patients. We also verified with the driver that they were taking their passengers to the correct facility.

JH

What other communications did you share with family members?

DM

We started communicating during the day of the 28th when we were preparing to evacuate. Our social services department put together a small team and began contacting family members. They shared our plan every step of the way. In 2013, we learned that regular communication with family members and residents kept them from being stressed out and overly concerned. Don't be afraid to tell people what your plan is.

Throughout the day and into the late-night hours, we contacted those 14 families and told them which facilities we were taking their loved ones to and let them know approximately what time they could meet them there. We also sent some of our staff to the receiving facilities to ensure patients were familiar with some providers.

∎JH

Karen, were there any issues on your end with records transfer and belongings?

I KB

No, we actually received enough information that allowed us to begin entering patient information into our electronic health records system. They all arrived here with packets as Dave mentioned, and that was helpful. We were able to move four of our existing patients from one side of the wing to another and into an adjacent department so we could keep all the evacuees together to minimize confusion and maximize comfort. We also had a line of staff waiting to greet the evacuees, escort them down the hallways, and get them settled in their rooms. Our staff did a great job-our hospitalist helped complete all assessments when each patient arrived; she was able to work with the staff Dave sent to collect information and provide continuity of care. The communication between CEOs and other staff allowed the transition to be a very smooth one.

∎JH

How many staff were sent?

I KB

We had two to three staff members sent to us per day on a rotating basis.

DM

We also transported some supplies along with staff. We had eight partners in total that took patients from our facility. Karen's facility was the farthest, but we also had another receiving facility in NM, who had sent us



six residents due to a fire earlier that month. Looking outside of your traditional regions and areas when you need a response partner, especially from a rural facility, is important. You must plan for the longer distances as well as for the fire to shift directions.

JH

Karen, did you have to care for any patients in non-traditional ways?

KB

The biggest issue we had that we didn't think about ahead of time was laundry. We do not have on-site laundry services; we contract that out to a local vendor. We struggled with being able to maintain inventory of linens and the quality of our linens had been an issue for a while. Long-term care patients require more linen changes than acute care patients. We had to be resourceful and reach out to our network (BridgeCare) which includes five hospitals—I reached out to a hospital that had a long-term care hospital on site to request help with laundering. I was told if I could figure out transportation, they could help, and we created a MOU. One of their staff members (who lived close to our facility) came by at 6 a.m. every morning, picked up the soiled laundry, took it to his facility where it was laundered during his shift, and brought it back clean throughout the duration of the event.

Prior to creating the MOU, one of our operating room nurses took residents' laundry to the local laundromat three times until we could get a more formal process in place.

JH

Do you require residents and staff to have go-bags?

DM

Residents have a two-day change of clothing, which we found wasn't enough for the whole situation. As far as staff goes, we encourage them and educate them about how to create and maintain go-bags in their cars. We try to model this behavior from a leadership perspective, too.

KB

The training and ongoing exercising is key. One thing that helped us tremendously is we had just completed an evacuation exercise in which Prowers Medical Center was identified as a receiving facility as part of the Southeast Regional Healthcare Coalition. We participated with a neighboring community hospital about 36 miles northwest. Members of the coalition participated, and we learned about developing go-bags and consistent forms throughout the region to make it easier for evacuating and receiving facilities.

Related Resources

- Durable Medical Equipment in Disasters
- Online Course: Wildfire Smoke and Your Patients' Health
- Smoke Sense Study: A Citizen Science Project Using a Mobile App
- The National Center for Disaster Medicine and Public Health Wildfires Webinar
- Wildfire Smoke: Considerations for California's
 Public Health Officials

JH

Were there any acute respiratory issues due to smoke inhalation?

DM

We did not have any patients or residents with any issues. Our cardiovascular department providers regularly tested residents and patients to make sure their oxygen saturation levels were healthy. We did identify two of our staff whose levels had fallen into the mid-80s due to the smoke effects and had to be treated with oxygen and sent to different facilities (their homes were affected by the wildfire smoke, too). We gave all residents, patients, and staff N95 masks almost immediately, and they wore them until we were able to evacuate them.

JH

How many days were you evacuated, and were there challenges associated with reoccupation?

DB

We were partially evacuated for three days and fully evacuated for six, a total of nine days fully or partially evacuated. Reoccupation is never practiced, and it takes a lot of time to plan to reoccupy your facility. Not having any income for nine days also created a large financial hit for staff—we were trying to get back to normal business as quickly as possible.

We met with climatologists who were on the incident management team at least twice a day and they told us we needed to have two consecutive days of good air quality and a weather forecast that suggested continued good air quality.

TRACIE

I JT

Did you have to conduct any special type of cleaning to recertify your facility?

DM

When you evacuate your facility, according to the VA and CMS, if there is no damage to your structure and you haven't made any significant modifications to your floorplans, you do not have to recertify. We did have to perform a lot of smoke cleanup. On the first good air quality day, our environmental service staff (who were amazing) came in, stripped all beds, did all laundry, remade beds, and took down, laundered, and replaced all cubicle curtains. Our janitorial staff extracted all carpeting in the building. Nearly 60 percent of our floors were carpeted at the time.

I JH

Karen, were there any issues with the patients and staff you received or upon their return?

KB

We treated these residents like our other patients. We had no significant issues—we helped them gather their belongings and send them on their way.

There were some issues with visiting staff members. As we mentioned, some staff came with the patients and did not have their own clothing or other supplies. One thing receiving facilities need to keep in mind is if staff aren't coming with per diem money, you need to plan to accommodate their meals and some housing. We worked very closely with local hotels; they were willing to adjust the schedules of their environmental services teams which allowed them to clean rooms between the rotation of medical staff. Our staff also reached out to local restaurants and made arrangements that would allow the restaurant to bill the hospital directly for visiting staff members' meals (as long as they provided proper identification).

Another issue we had to manage was the verification of staff licensure. After we checked that, we had each person complete a confidentiality statement and an emergency contact form. We also maintained communication with Spanish Peaks staff because they were concerned about their team members and patients who were miles away.

DM

The response was phenomenal—the hospital and community supported a hurting facility. The decision to evacuate was taken very seriously by the entire incident command team. We are the largest employer in our community, and we knew there would be an economic impact while we weren't able to provide the healthcare they are used to receiving. I have surveyed our command team several times since then, and without hesitation, each one has stated that we would not have done anything differently.

The other thing I will continue to preach is you have got to exercise and practice your plans. We've been doing evacuation drills for 18 years—long before we were mandated to. Practice moving people—figure out what worked and make changes, then practice it again. We had no injuries and no loss of life, and I attribute that to knowing what our plans were and being very open with our residents and their family members to minimize stress.

In a real event, there will be volunteers that just show up unsolicited because everyone wants to help during a crisis. Be prepared to manage this. Most of these people, supplies, vehicles, and other things may not be needed, but it's important to acknowledge their efforts and concern. This never occurs during an exercise. Also, try to include the press and media with your exercise when appropriate. Command teams and public information officers don't often get to practice during an exercise as exercises tend to end when patients or residents are triaged and relocated. Crowd management is also something that should be considered during an exercise. Are these people the walking wounded who self-presented? Family members? Or are they just curious onlookers? These things happen in a real event and should be exercised.

KB

It is so important to have the partnerships and develop the creative resources—there will always be hiccups. Make sure you're addressing issues identified in your After-Action Reports and incorporating them into your plans.

