

St. Louis Area Regional
Hospital Evacuation and Transportation Plan

# **Signatories**

This regional plan is being endorsed by the following regional committees: (Name), (Name), Co-chair Co-chair Hospital Preparedness Committee Hospital Preparedness Committee (Name) (Name) Chari Chair St. Louis Regional EMS Officers Association STARRS EMS Committee (Name), (Name), Co-chair Co-chair **Emergency Management Committee Emergency Management Committee** 

(Name),

Co-chair

Public Health Committee

(Name),

Co-chair

Public Health Committee

# **Approval and Implementation**

This annex does not supersede any other state, regional, and local emergency plans. It is intended to work with and support individual hospitals, emergency medical services (EMS) agencies, and local jurisdictional evacuation policies, mutual aid agreements, and emergency operations plans.

This plan will be managed and maintained by the Hospital Preparedness Committee. Modifications and changes to the plan are allowed with the consent and approval of the Hospital Preparedness Committee.

# **Record of Changes**

Change Number	Date	Section Changed	Date Posted	Who Posted

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## **Executive Summary**

This plan references hospital and medical facility evacuation procedures and establishes a system to coordinate safe, timely, and efficient evacuation of patients. The plan establishes an organizational structure to facilitate communication and cooperation between the evacuating facilities, the St. Louis Medical Operations Center (SMOC), receiving facilities, alternate care sites, and transportation resources.

This plan provides a framework for hospitals and medical facilities to adopt and streamline the evacuation process for an integrated and operationally ready regional plan. Further, the plan contains information for local emergency medical services providers to quickly gather resources in response to a potential or emergent evacuation of medical facilities within the region, including communications, hospital coordination, and administrative issues.

To activate the Hospital Evacuation and Transportation Plan, hospitals must notify the SMOC Duty Officer, who will contact supporting healthcare organizations and emergency medical services agencies to request their assistance with a potential or actual evacuation.

The plan will provide for rapid response and coordination of any evacuation of an emergent nature. Any protracted incident or long-term evacuation situation may require additional coordination of issues relating to cost reimbursement, EMS stand-by resources, and utilization of private EMS contracts or para-transit providers. This plan focuses on emergencies and disasters requiring immediate response from regional partners and the St. Louis Medical Operations Center, in order to save lives and prevent unnecessary suffering.

# Section 1 Introduction

This plan describes how the healthcare organizations in the region will plan for and respond to an emergent situation requiring evacuation of one or more medical facilities due to internal or external disaster. It provides a framework for planning, notification, and coordination of facility evacuation and transportation to an accepting medical facility or alternate care site.

Forces of nature, unexpected technological disruptions, or manmade disasters have the capability of damaging or rendering unsafe a hospital or medical facility. Whether the disaster is internal or external, a medical facility may be faced with the difficult decision of whether to evacuate. The disaster may involve more than one facility, requiring regional coordination of resources to safely evacuate patients and facilitate resource sharing, coordinate patient placement and transportation, and implement patient tracking.

## 1.1 Purpose

This plan provides guidance in the development of an evacuation plan by offering detailed information, instructions, and procedures that can be engaged in any emergency situation necessitating either a full or partial evacuation of a hospital. Further, it provides a common structure for the integration of hospital and transportation resources when planning for, responding to, and recovering from a hospital evacuation scenario.

## 1.2 Scope

This plan is intended to be used as a guide when one or more hospitals or medical facilities within the region are affected by an internal or external disaster requiring full or partial evacuation.

This plan covers the following St. Louis Area Regional Response System (STARRS) jurisdictions:

- Missouri
  - ✓ Franklin County
  - ✓ Jefferson County
  - ✓ Lincoln County
  - ✓ Perry County
  - ✓ Pike County
  - ✓ St. Charles County
  - ✓ Washington County

- ✓ St. Louis County
- ✓ City of St. Louis
- ✓ St. François County
- ✓ St. Genevieve County
- ✓ Warren County

#### Illinois

- ✓ Madison County
- ✓ Monroe County
- ✓ St. Clair County

#### Hospitals

- ✓ Alton Memorial Hospital
- ✓ Anderson Hospital
- ✓ Barnes-Jewish Hospital
- ✓ Barnes-Jewish St. Peters Hospital
- ✓ Barnes-Jewish West County Hospital
- ✓ Belleville Memorial Hospital
- ✓ CenterPointe Hospital
- ✓ Christian Hospital
- ✓ Des Peres Hospital
- ✓ Gateway Regional Medical Center
- ✓ Hawthorn Children's Psychiatric
- ✓ Mercy Hospital Jefferson
- ✓ Kindred Hospital -St. Louis
- ✓ Kindred Hospital -St. Louis at Mercy
- ✓ Kindred Hospital -St. Louis, St. Anthony's
- ✓ Lincoln County Medical Center
- ✓ Metropolitan St. Louis Psychiatric
- Mercy Rehabilitation Hospital St. Louis
- Mineral Area Regional Medical Center
- ✓ Missouri Baptist Medical Center
- ✓ Northwest HealthCare
- ✓ Parkland Health Center -Bonne Terre
- ✓ Parkland Health Center -Farmington
- ✓ Perry County Memorial Hospital

- ✓ Pike County Memorial Hospital
- ✓ Progress West Hospital
- ✓ Ranken Jordan A Pediatric Specialty Hospital
- ✓ Saint Louis University Hospital
- ✓ Select Specialty Hospital
- ✓ Shriners Hospitals for Children
- ✓ Southeast Missouri Mental Health Center
- ✓ SSM Cardinal Glennon Children's Medical Center
- ✓ SSM DePaul Health Center
- ✓ SSM Rehab
- ✓ SSM St. Joseph Health Center St. Charles
- ✓ SSM St. Joseph Health Center Wentzville
- ✓ SSM St. Clare Health Center-Fenton
- ✓ SSM St. Joseph Hospital West
- ✓ SSM St. Mary's Health Center
- ✓ St. Alexius Hospital
- ✓ St. Anthony's Health Center -Alton
- ✓ St. Anthony's Medical Center
- ✓ St. Elizabeth's Hospital
- ✓ Mercy Hospital Washington
- ✓ Mercy Hospital St. Louis
- ✓ St. Joseph's Hospital -Highland
- ✓ St. Louis Children's Hospital

- ✓ St. Louis Psychiatric Rehabilitation
- ✓ St. Luke's Hospital
- ✓ St. Luke's Rehabilitation Hospital
- ✓ Ste. Genevieve County Memorial Hospital
- ✓ The Rehabilitation Institute of St. Louis

- ✓ Touchette Regional Hospital
- ✓ Veterans Affairs Medical Center
- ✓ Washington County Memorial Hospital

## 1.3 Situation Overview

Fire, structural collapse, extended power outage, dam failures or severe weather-related incidents, including tornadoes, severe thunderstorms, waterway flooding (including flash flooding), severe winter weather (including snow, ice, and extreme cold), drought, heat wave, earthquakes, and wildfires, are all risks that affect the greater St. Louis region's hospitals. All of these hazards may cause direct damage to healthcare facilities or indirectly affect critical services such as water, heating/cooling, medical gases, or electricity, thereby compromising a hospital's ability to function safely and care for patients.

## 1.4 Assumptions

The following characteristics are assumed in order for this plan to be implemented. During an incident, if these assumptions are not evident, then adjustments to this plan are necessary.

## 1.4.1 Regional Coordination Assumptions

- Effective response and recovery requires a coordinated effort among public and private entities. Hospitals and healthcare facilities are critical during an emergency and therefore must be active participants in emergency preparedness efforts, including partnering with emergency management, law enforcement, EMS, fire, and other entities.
- The St. Louis regional response structure promotes inter- and intra-jurisdictional cooperation and coordination, but recognizes the autonomy, operational authority, and unique characteristics of each jurisdiction at the facility, local, regional, and state levels.

### 1.4.2 Planning Assumptions

- This plan is intended to support and enhance the emergency plans and protocols maintained by emergency managers and other first response agencies, healthcare agencies, and nongovernmental organizations in the region. This plan is not intended to supersede or infringe upon any other preceding authorities, plans, or procedures of any jurisdiction, organization, or agency.
- This plan is intended to work with existing regional and State Mutual Aid documents, including the Missouri Systems Concept of Operational Planning for Emergencies (MoSCOPE), other agreements between hospitals and private EMS providers, and municipal agreements among jurisdictions.
- Evacuating hospital has entered into the Missouri Statewide Hospital Mutual Aid Agreement (MAA) as established to coordinate hospitals throughout Missouri and in adjoining states to provide mutual aid to each other as necessary in order to support emergency medical care needs in a medical disaster.
- This plan works in conjunction with the regional coordination and concept of operations described in the STARRS Regional Resource Coordination System Plan and the St. Louis

- Regional Healthcare Coordination Plan and the St. Louis Medical Operations Center (SMOC) Standard Operating Guidelines (SOG).
- Each hospital has an emergency operations plan (EOP) that describes roles and responsibilities and designates personnel to activate and lead evacuation operations.
- Local EMS providers and First Responder Organizations have EOPs that describe roles and responsibilities pertaining to command and control procedures, which are National Incident Management System (NIMS)-compliant.
- Hospitals and other healthcare facilities are responsible for development of an EOP specific to their facility.

### 1.4.3 Operational Assumptions

- Emergencies are managed within the incident command structure as designated by the jurisdictional authority in accordance with the NIMS and the Incident Command System.
- Individual healthcare organizations will need to make an informed decision whether to evacuate and to request assistance from the SMOC.
- Many incidents may involve a pre-hospital care component that may directly affect the availability of EMS resources. Existing private ambulance contracts may be insufficient to serve the needs of all facilities involved. Additionally, resources operated by municipalities conducting 911 emergency operations may be overwhelmed and unable to provide transportation resources sufficient to relocate patients. EMS agencies will responsd to requests for transport to the best of their ability. Hospitals should communicate through EOC/Unified Command and utilize mutual aid and private ambulances to fill resource gaps.
- This plan is not intended to describe or limit medical decisions or to remove or add responsibility regarding the provision of and access to medical care.
- Hospital evacuations will impact all departments within a hospital, including non-clinical departments, requiring a comprehensive approach during planning.

#### 1.4.4 Guiding Principles

The planning process involved utilizing recognized principles to guide the development of the Hospital Evacuation and Transportation Plan. These principles should also be considered when staff members implement the plan and are faced with key decisions. Hospital evacuation principals and guidelines have incorporated materials from federal and best practice documents to ensure these tools are quickly and seamlessly able to integrate into a state or federal response.

- The safety and welfare of medical facility staff, patients, and visitors is the priority during evacuation.
- Evacuation should be considered when other response efforts are not adequate to maintain a safe care environment.
- It is imperative that staff members are provided with procedures that are simple to follow and allow for flexibility in changing environments.

#### **Section 1**

- A certain level of self-sufficiency is required at the unit level to empower decision making should an evacuation be ordered.
- The planning process must include procedures and detailed locations for assembly points, areas identified prior to evacuation while care teams await transportation resources.
- The planning process should include procedures and detailed locations for staging areas to facilitate efficient loading and unloading of transportation assets.

# Section 2 Concept of Operations

The purpose of this section is to detail the overall concept of operations for evacuation of a healthcare facility.

## 2.1 Organizational Structure

Hospital command centers within each healthcare facility will make a decision whether or not evacuation is necessary and prudent.

Each healthcare facility will have its own incident command structure. Hospital Incident Command Centers will direct movement of patients along with staff, needed medical equipment, and supplies within their facilities. They will coordinate directly with the SMOC to provide timely information about the current situation and establish external resource needs.

Simultaneously, the SMOC will notify the Emergency Medical Services Liaison Officer to the SMOC (EMS LNO) to begin obtaining availability of transportation resources and planning for the physical movement of patients from one facility to another.

The SMOC is also responsible for polling participating hospitals and medical facilities for availability of patient beds, utilizing the SMOC standard operating procedure for available bed reporting.

Hospitals and healthcare organizations are responsible for the evacuation of their patients and tracking of those patients during this process. The SMOC will serve as a clearinghouse for information on available beds as well as coordination of transportation resources, operation information, and a centralized patient tracking manifest.

All hospitals and healthcare facilities should have a pre-identified organizational structure or Incident Command System (ICS), which identifies all roles of emergency operation. In addition to those standards ICS organizational charts, hospitals should consider these evacuation specific roles and subsequent responsibilities.

Figure 1
Hospital Incident Command System Evacuation Positions

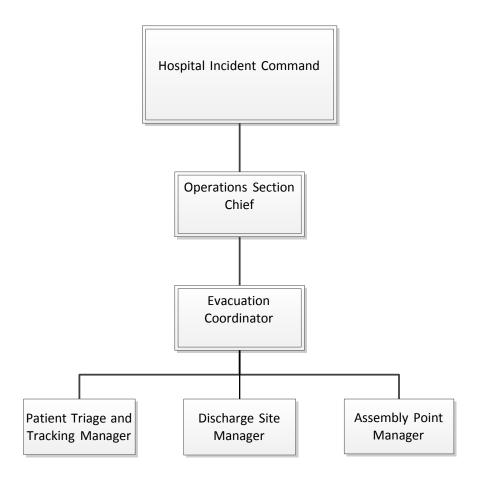


Figure 2 EMS Resource Coordination Group

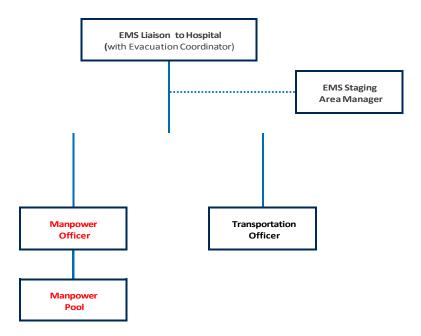
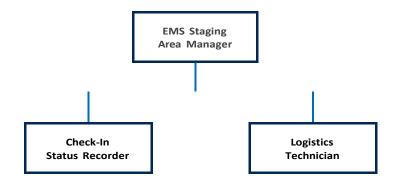


Figure 3 EMS Staging Team



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## 2.1.1 Assembly Points and Discharge Site Locations

Certain pre-identified locations are essential to ensuring a smooth evacuation. These include assembly points and discharge sites.

An assembly point is an area, or areas, designated to allow patient care units to gather, continue basic healthcare, and either await transportation to another medical facility or re-entry to the hospital. These are not comprehensive field hospitals or alternate care sites, but holding areas to provide essential care resources out of harm's way.

Identifying assembly points is the responsibility of each medical facility. Each assembly point should be easily accessible both to evacuating persons and transportation assets, be far enough away from the threat, and be large enough for the number of people and equipment. Ideally, the assembly point will be indoors.

In instances where patients are discharged from the medical facility as a resort to quick evacuation, a discharge site may be set up. A discharge site is an area designated for those being discharged, as opposed to being transferred, to meet their loved ones.

Both assembly points and discharge sites need to employ detailed patient tracking systems, which will be provided to the Triage and Tracking Manager, which will ultimately be submitted to the SMOC for a centralized manifest.

## 2.2 Hospital Evacuation and Transportation Plan Activation

Facility personnel authorized to request activation of the Hospital Evacuation and Transportation Plan will vary depending on the situation and facility, but may include the Chief Executive Officer, the Administrator On-Call, or the Incident Commander if activation of the Hospital Emergency Operations Plan or Hospital Command Center occurs.

A full activation of the Hospital Evacuation and Transportation Plan may not be necessary. A medical facility can issue a "prepare only" order in which staff members begin preparations for evacuation. This may include preparing patients for evacuation, collecting supplies, and activating assembly points and discharge sites. The "prepare only" order provides an opportunity to be ready if the evacuation decision is made, while not physically disrupting the patients' care plans.

#### 2.3 Notification of Evacuation

Upon a decision to evacuate or recognition of a need for assistance with a partial evacuation, the Hospital Incident Commander (or their designee) will contact the St. Louis Medical Operations Center (SMOC) Duty Officer to activate this plan.

Notification of a facility evacuation begins by notifying staff members, patients, and visitors of the impending evacuation. If possible, an automated emergency notification system should be

utilized. Other forms of mass communication, including public address systems, emails, text messages, or other forms of contacting employees may be useful as well.

The evacuating facility Incident Commander (or their designee) should notify the SMOC Duty Officer as soon as the need or potential for an evacuation has been identified. The SMOC Duty Officer on-call will make appropriate notifications, to include SMOC staff, EMS Liaison Officer through Emergency 9-1-1, STARRS staff, and representatives of participating healthcare organizations and stakeholders.

#### 2.4 Levels of Evacuation

Not all situations are the same and therefore may not require the same type of response. The Hospital Evacuation and Transportation Plan may be utilized depending on the level of evacuation required and authorized by facility personnel. The following levels of evacuation have been identified:

- Shelter-in-place
- Horizontal evacuation
- Vertical evacuation
- Total or full evacuation

#### Shelter-in-Place:

This level requires cessation of all routine activities in preparation for an impending threat, such as severe weather. Preparations should be made to mitigate the anticipated threat. Generally, patients, visitors, and staff remain where they are until they receive further instructions. In most cases, the safest place for the patient is in his/her room. Closing doors/windows provides initial protection from fire and smoke. When possible, preparations should also be made to enable immediate evacuation of patients, should evacuation become necessary.

#### Horizontal Evacuation:

This level involves moving patients in immediate danger away from the threat while remaining on the same floor. It typically involves moving patients to an area of refuge in an adjacent smoke/fire zone or, in some cases, at the opposite side of the building. Most evacuations of single departments or patient care units can be done horizontally, which is the fastest option and facilitates the simplest re-entry process. Evacuation of an entire building may be accomplished horizontally if every floor of the evacuating building connects to another building.

#### Vertical Evacuation:

This level refers to the complete evacuation of a specific floor in a building. In general, patients and staff evacuate vertically toward ground level whenever possible to prepare for evacuation outside should it become necessary. For most localized incidents, vertically evacuated patients and staff are sent to an area of refuge elsewhere in the hospital or assembly point, typically at least two floors away from the incident floor.

#### Total or Full Evacuation:

This level involves a complete evacuation of the facility and is used only as a last resort.

### 2.5 Evacuation Timeframes

The following timeframes should be identified when ordering any type of evacuation. A decision guide for Advanced Warning Event Evacuation Decisions is located in Appendix D. A decision guide for events with No Advanced Warning Event Evacuation Decisions is located in Appendix E.

Immediate:	Immediate threat to life safety. Exit the area immediately.
Rapid:	Conditions require evacuation of staff and patients within a few hours (e.g. rising temperature, medical gas disruption).
Gradual:	Conditions worsening over time will require evacuation within several hours/days (e.g. loss of sewer, power failure).
Prepare Only:	Patient movement being planned but not executed upon.

#### 2.6 Patient Prioritization

Any level of evacuation, during any timeframe, will require identifying in what order the patients will be evacuated from the facility. Due to the complexity and ever-changing conditions of disasters, there is no single method or procedure for prioritization. Below are some considerations to use during the decision-making process:

- The priority during time-sensitive evacuations, in which there is an immediate and broad threat to life safety, is the evacuation of as many patients as possible in the most efficient and safe manner. The priorities in these situations may be:
  - Patients in immediate danger
  - Ambulatory patients
  - o Patients on general care units requiring transport assistance
  - Patients on intensive care units
- Patient prioritization may also depend on the number of staff available to assist in evacuation efforts. Prioritization dependent on staff levels may be:
  - o Move first patients able to move with minimal assistance: 1 person to move many (green)
  - o Move next patients requiring one staff member : 1 person to move one patient (yellow)
  - o Move last patients requiring multiple staff to move: >1 person to move one patient (red)
- If evacuation is not immediate but should occur rapidly, a process should be initiated in which entire patient care units are moved sequentially, ensuring unity of different acuity levels are evacuated in parallel to decrease the demand on EMS resources.
- During a gradual evacuation in which assembly points are not in use and patients are transported directly to ambulances, coordination between different units and EMS resources is the priority to ensure patients are not left waiting at the door for a transportation resource.

•	All patients should exit through a centralized and coordinated point (generally referred to as an assembly point or discharge site) to allow for proper documentation, patient tracking, and efficient resource utilization.

# Section 3 Resources, Roles, and Responsibilities

This section describes the resources, roles, and responsibilities that various stakeholders will provide to support the Hospital Evacuation and Transportation Plan.

#### 3.1 Medical Facilities

Each medical facility has the primary responsibility to conduct a risk analysis and plan for potential evacuation scenarios. The medical facility should take necessary steps to mitigate these risks as well as plan for actions required for a potential evacuation. These include but are not limited to identifying evacuation resources (sleds, well lit stairwells, assembly points, etc.), entering into mutual aid agreements with receiving facilities, ensuring access to various types of transportation resources (e.g., ambulances, para-transit, etc.), and coordinating regular exercises and drills to train staff and evaluate plans, as needed.

In addition to these preparedness principals, hospitals' Incident Command System may be fully implemented during an evacuation (including evacuation-specific roles as outlined in concept of operations) and the following roles, responsibilities, and resources should be considered in the hospital-specific evacuation plan.

### 3.1.1 Leadership Roles

Hospital administrative leadership and hospital emergency planners are responsible for completing hazard assessments, developing and testing plans, completing the Pre-Disaster Critical Infrastructure Self-Assessment (Appendix B), reviewing pre-event evacuation considerations (Appendix C), reviewing department-specific responsibilities (Appendix F), and ensuring evacuation-specific roles are developed and trained upon.

## 3.1.2 Evacuation Adjunct Resources

Hospitals and healthcare facilities have a responsibility to ensure patient evacuation resources are readily available in the unlikely event patients would need to be evacuated from their normal patient care areas, including horizontal and vertical movement. These may include charged biomedical devices, portable medical equipment and supplies, and evacuation adjuncts (e.g., evacuation sleds, patient carry adjuncts, etc.).

## 3.1.3 Assembly Points and Discharge Sites

Assembly points should be pre-identified to ensure evacuation is as efficient and safe as possible. These assembly points are the last patient location within the evacuating healthcare facility and are a point for which the healthcare personnel can validate necessary paperwork, medical records, completed memoranda of transfer, and needed medical equipment/medications are available during transport. Likewise, Discharge Sites allow for quick and efficient patient discharge for those being released from the evacuating facility.

## 3.2 EMS and Transportation Resources

Any incident that requires movement of patients from one facility to another will necessitate coordination and efficient utilization of EMS and medical transportation resources. Those resources are varied and are intended for distinct populations of patients. Detailed and deliberate communication of patient transportation requirements is vital to ensure that the right patient gets to the right destination by the most appropriate means available.

### 3.2.1 Types of Transportation Resources

Once notified by Emergency 9-1-1, the Emergency Medical Services (EMS) Liaison to the SMOC will begin to gather availability of medical transportation resources. Based on the anticipated patient load, that may include ambulances (both basic life support and advanced life support units), medical ambulance buses, para-transit vehicles, or rotor wing aeromedical resources. These resources must be carefully matched to their intended patient to ensure appropriate care during transport. As noted earlier in this document, the incident may involve a large population of injured besides the evacuating medical facility or facilities, resources may be scarce, and patients' transport decisions may need to be altered.

#### 3.2.1.1 Aeromedical Assets

In the event that rotor wing aircraft may be required to transfer critical or time-sensitive patients from an affected facility, the EMS Liaison to the SMOC (EMS LNO) will contact the local air medical provider to obtain availability. Additional arrangements may need to be made to stage aircraft offsite (at a nearby airport) and plan for the helipad at the hospital to be used for rapid off-load of air crews or loading of patients.

In this type of situation, additional staging and transportation personnel may be required at the affected facility to ensure good communication between aircraft and the hospital.

If possible, air medical personnel may consider leaving one crew at the hospital to package and transport patients to the helipad and provide a quick patient report during the loading process before returning to the facility to prepare the next patient. This strategy may also minimize the amount of time that the helipad is closed due to aircraft present on the pad.

Local air medical providers may be able to provide additional personnel to assist with these roles.

#### 3.2.1.2 Ambulances

Most hospitals within the region have limited parking available for EMS units to load and unload patients. It is imperative that ingress and egress from the facility is not impeded by parked units, causing delays for other ambulances attempting to transport patients. For this reason, the EMS Liaison to each hospital will work closely with the Evacuation Coordinator from the hospital to ensure that the right resources are requested for each patient. The EMS Transportation Officer assigned to each hospital will maintain constant communications with the EMS Staging Officer offsite, if established to ensure efficient traffic flow at the hospital.

Ambulances should be deployed in Federal Emergency Management Agency typed Ambulance Strike Teams, consisting of five like resources and a Strike Team Leader in a separate vehicle, with common communications. This ensures proper operational oversight of these resources, as well as appropriate span of control.

#### 3.2.1.3 Medical Ambulance Buses

Specially designed medical ambulance buses may be utilized to transport bed-confined patients or other special populations, per the standard operating procedures of the agency. These resources can greatly aid in moving large numbers of patients in a single vehicle.

#### 3.2.1.4 Coach Buses, Para-transit Vehicles, and Alternative Transportation

Alternate transportation is often the most efficient method for the urgent movement and evacuation of large patient volumes in a short period of time. All patient movement modalities should be coordinated as a part of the overall EMS/transportation effort.

Many patients can be transported in a seat position in a coach bus, school bus or para-transit vehicle. Certain patients will be much more comfortable riding upright. When possible, providers from the affected hospital or healthcare facility should accompany these patients during transport to provide support during the movement.

Patients that utilize wheelchairs or electric power chairs would benefit from movement utilizing accessible transportation. It also ensures that these patients are mobile after arrival at the receiving facility or other destination.

The EMS Liaison to the SMOC should maintain a list of transportation resources that include all of the assets listed above.

#### 3.2.1.5 EMS / Medical Resource Staging Area

The EMS Staging Area may be established near the affected area to maintain EMS units in a rapidly deployable status and to be assigned tasks as required by the healthcare facilities. The EMS Staging Officer (and their assigned staff, when needed) will maintain a roster of available units, including their capability and any special equipment on board, to assign the most appropriate resource to each request. They EMS Staging Officer will provide situational awareness to the EMS Liaison at the SMOC regarding numbers and types of available resources in staging, to facilitate additional requests or demobilization, when appropriate.

# 3.2.2 EMS Coordination during Incidents with Multiple Facility Evacuations

The SMOC Duty Officer on-call will convene a SMOC conference call or activate the SMOC to coordinate assignment of resources during an incident where several hospitals or healthcare facilities are involved. The SMOC will delegate hospital resources based on the greatest need as well as the facilities at the greatest risk. The SMOC will provide guidance to the EMS LNO, who will be responsible to assign EMS resources to particular facilities or geographic divisions.

## 3.2.3 Coordination, Communication and Decision Making

Communication between EMS units, the EMS Liaison at the SMOC, and EMS Liaisons at each individual hospital will utilize regional radio frequencies assigned based on the location of the incident. Cell phone communications will serve as a backup communications system during evacuation operations.

EMS units will be instructed, by the EMS Staging Officer, to update the EMS LNO to the SMOC when transporting and arriving at destinations to provide for patient tracking. Additionally, EMS units will be instructed where to return after dropping of patients to ensure proper use of resources.

Decision making on appropriate resources to assign to each patient will be coordinated between the Hospital Evacuation Coordinator and the EMS Liaison at the Hospital. Hospital requests will be sent to the SMOC for resource allocation and assignment and EMS resources will be allocated via the EMS LNO.

## 3.2.4 Emergency Medical Services

Depending on the evacuation time frame, transportation resources may be requested through two different routes. In immediate or rapid evacuation scenarios, the Healthcare Facility or Healthcare Organization may contact the jurisdictional EMS provider, potentially by means of 911 Communications. In these situations, the Senior EMS Provider on scene will be responsible for making appropriate notifications (utilizing the MCI-1 system) to begin alerting and deploying resources to participate in the evacuation.

In some rapid scenarios, but certainly gradual scenarios, the Healthcare Facility or Healthcare Organization may contact the St. Louis Medical Operations Center Duty Officer On-Call directly. EMS resources will be requested through Emergency 9-1-1.

Whether the initial notification is accomplished through a 911 Communications Center or the St. Louis Medical Operations Center, the EMS LNO will receive the call and begin notifying municipal and private providers to request availability or deploy resources, as needed. The EMS LNO will continue to provide situational awareness to the SMOC or the SMOC Duty Officer regarding the status and response of transportation resources.

Depending on the size and scope of the incident, the EMS LNO may also activate other Senior EMS Supervisors or Leadership to serve in the roles of EMS Liaison to Hospitals, EMS Staging Officer, and Transportation Officer. They may also elect to activate EMS personnel to serve as logistical support or manpower for movement of patients within the facility, if requested.

## 3.2.5 Medical Control and Liability

Per the MoSCOPE Agreement, Medical Control will remain per the standard operating procedures of the jurisdiction that operates the EMS Unit. At no time will EMS crews deviate from their standard operating procedures without contacting their agency Medical Director.

#### 3.2.5.1 Medical Liability

Liability of all types remains the responsibility of each participating organization; if a jurisdiction chooses to participate in giving and receiving mutual aid, the organization agrees it will maintain liability over its people and equipment.

To the extent permitted by law and without waiving sovereign immunity, each participating organization will be responsible for any and all claims, demands, suits, actions, damages, and causes for action related to or arising out of or in any way connected with its own actions, and the actions of its personnel in providing mutual aid assistance rendered or performed pursuant to the terms and conditions of the plan.

#### 3.2.5.2 Workers Compensation Coverage

Each participating organization will be responsible for its own actions and those of its employees and volunteers, and is responsible for complying with the Missouri and/or Illinois workers' compensation laws, depending on where the agency is licensed to operate.

#### 3.2.5.3 Vehicle Liability Coverage

Each participating organization will be responsible for its own actions and those of its employees and volunteers, and is responsible for complying with the Missouri and/ or Illinois vehicle financial responsibility laws.

#### 3.2.6 Cost Reimbursement

General responsibility for cost-reimbursement lies with the evacuating hospital. Regardless of aid received for evacuation costs, the hospital is responsible for providing payment to responding EMS agencies.

Any response coordinated through the St. Louis Medical Operations Center is considered regional mutual aid, utilizing the Missouri Systems Concept of Operational Planning for Emergencies (MoSCOPE) agreement, and therefore is not considered a reimbursed response unless an agreement is arranged between the requesting and responding entities prior to the actual response.

Any reimbursement is dependent on accurate supporting documentation. In the event of agreed upon reimbursement between the requesting entity and the responding resource, necessary documentation will include a mutual aid agreement (MAA) and records of any operational costs related to personnel, use of equipment, and travel. Additionally, it is critical to document the request for mutual aid in addition to documenting costs.

Documentation is the sole responsibility of the responding resource. The forms included in the Mutual Aid Forms Packet in the MoSCOPE provide guidelines and tools to properly document costs. Reimbursement claims must be coordinated with the EMS agency and/or emergency management agency of the impacted county.

Reimbursement for services rendered according to this plan shall be in accordance with any local, state, and federal guidelines.

Even without a reimbursement agreement, each responding entity should maintain exactly the same documentation for each deployment for a number of reasons.

First, in the event of a major incident, a "bill" of response costs submitted to the affected jurisdiction can be used by that jurisdiction to reach the minimum threshold of disaster costs necessary for federal aid. The responding organization may then choose to assume or donate those costs in whole or in part to that affected jurisdiction.

Second, in the event of a federal declaration, volunteer mutual aid personnel response hours may be able to be used by the affected jurisdiction to offset the local match portion of the disaster costs, resulting in more federal reimbursement to that impacted location.

Third, documentation of mutual aid costs is utilized for state reporting and data analysis, which may impact any decision on the part of the state to provide financial or logistical support to mutual aid response agencies.

### 3.2.7 Self-Dispatch

MoSCOPE states clearly that self-dispatch will not be allowed under the activation of the State Mutual Aid Plan and the local Incident Commander will be discouraged from utilizing the self-dispatched resources over the resources deployed through the Plan. MoSCOPE (version dated August 29, 2013) further states that:

Those resources deployed through self-dispatch will be communicated to the appropriate State Plan Coordinator and will be subject to removal as part of the State Mutual Aid Plan up-to a period of one (1) year. In addition, self-dispatched units will not be eligible for any logistical support (including but not limited to food, shelter, fuel) or reimbursement. Self-dispatched resources may not be covered for liability and may not be eligible for line of duty injury or death benefits.

#### 3.2.8 Demobilization of EMS Resources

Demobilization of EMS resources shall be conducted as part of the deactivation of requested resources by the Incident Commander, the Hospital Command Center, and the SMOC. Each EMS Strike Team Leader is responsible to ensure that all personnel, equipment, and apparatus are accounted for prior to leaving the incident location.

Prior to leaving the incident each EMS crew shall check-out with the Strike Team Leader and/or the EMS Liaison responsible for that geographic division, whichever is appropriate. The EMS Liaison to the SMOC shall be updated regarding demobilization status, in order to provide real-time situational awareness to the SMOC.

Per the MAA, the EMS Liaison to the SMOC should plan and conduct a post incident debriefing with assigned units when possible.

The operational issues should be presented to the requesting jurisdiction in a timely manner, and the plan issues should be forwarded to the SMOC for integration in to future planning.

## 3.3 Emergency Management Agencies

Evacuation of a medical facility will require a significant push for resources, including transportation assets, medical equipment, medications, and personnel. Requests for and acquisition of additional resources may need to be coordinated through emergency management agencies. Local emergency management agencies are responsible for communicating resources needs up the chain to ensure their arrival. The Missouri State Emergency Management Association and the Illinois Emergency Management Agency are responsible for state-level coordination and acquisition of resources. Should the need for a medical facility evacuation arise, these agencies will primarily be responsible for acquiring resources as identified by the impacted medical facility, the SMOC, and local jurisdictions.

Emergency management agencies will work with Unified Command and the SMOC to coordinate response operations, communications, and the delivery of resource and reimbursement requests.

#### **Section 4**

# **Plan Development and Maintenance**

This section describes the process used to develop the St. Louis Area Regional Response System (STARRS) Hospital Evacuation and Transportation Plan, identifies who is responsible for reviewing and maintaining the plan, and explains how the plan will be reviewed and maintained.

## 4.1 Planning Process

The STARRS Hospital Evacuation and Transportation Plan was developed through funding provided by the U.S. Department of Health and Human Services (HHS). A task force of disaster human services, healthcare, public health, emergency medical services (EMS), and emergency management personnel met to identify information needed to guide medical facilities, including hospitals and EMS, in the coordination of evacuation efforts. The process began with a review of documents previously developed related to evacuation and resource coordination. These documents included:

- Missouri Medical Incident Coordination Team Concept of Operations (CoNops)
- Missouri Systems Concept of Operational Planning for Emergencies
- Current and Ideal Patient Flow
- Missouri Catastrophic Patient Movement Plan
- STARRS Regional Hospital Alternate Care Site Plan
- St. Charles County Environmental Health and Protection Standard Operation Procedures for Emergency Response
- St. Louis Medical Operations Center Standard Operation Guidelines

Following document review, multiple planning meetings were held to identify job aids, information flows, and algorithms needed to guide the evacuation process. Additionally, two surveys were distributed to best understand current evacuation planning efforts undertaken by hospitals and EMS resources in the St. Louis region. Key understandings from those survey results were used in the development of this plan. Following this assessment, the task force developed this plan with the aid of a consultant. The task force developed the plan using the results of the meetings, survey, and document reviews.

### 4.2 Plan Review and Maintenance

The St. Louis Regional Hospital Evacuation and Transportation Plan will be managed and maintained by the STARRS Hospital Preparedness Committee. Each medical facility and EMS resource is responsible for reviewing, updating, and maintaining their individual patient evacuation procedures.

The St. Louis Regional Hospital Evacuation and Transportation Plan should be reviewed annually and after incidents that require plan implementation. Lessons learned from emergencies

and exercises should be incorporated into the plan. Changes in capabilities, procedures, and systems should be incorporated in the plan.

## 4.3 Testing, Training, and Exercises

The development of a comprehensive and ongoing testing, training, and exercise program to inform and educate mass care, medical, public health, and emergency management representatives is essential for effective response and implementation of this plan.

The St. Louis Regional Hospital Evacuation and Transportation Plan will be tested in coordination with the regional Multi-Year Training and Exercise Plan. Responsibility for training personnel on the contents of the plan lies with STARRS, the St. Louis ESF-8 Committee, and each medical facility or EMS agency.

An annual functional exercise will be held to test the plan as well as the coordination and communications capabilities of hospitals and EMS agencies in the region.

# Appendix A Acronyms

ALS Advanced Life Support

EMS Emergency Medical Services

EMS-LNO Emergency Medical Services Liaison Officer to the SMOC

EOP Emergency Operations Plan

HCC Hospital Command Center

HHS Health and Human Services

HICS Hospital Incident Command System

ICS Incident Command System

ICU Intensive Care Unit

MAA Mutual Aid Agreement

MoSCOPE Missouri Systems Concept of Operational Planning for Emergencies

NIMS National Incident Management System

SMOC St. Louis Medical Operations Center

SOP Standard Operating Procedures

STARRS St. Louis Area Regional Response System

TPN Total Parenteral Nutrition

# Appendix B Pre-Disaster Critical Infrastructure Self-Assessment<sup>1</sup>

	Evacuation-Relevant Resources	Implication
City Wat	ter	
	Is water used for heating the hospital? Is water used for cooling? Does the hospital have a well?	Y = more vulnerable Y = more vulnerable N = more vulnerable
	Is there one water line going into the hospital, or also a backup line? Is there a water storage tower/tank on the roof? If the water tower/tank collapsed, would the hospital then be without water (or	Only 1 = more vulnerable Y = more vulnerable to earthquakes (but good backup water source)
	sufficient pressure)? How long can the hospital maintain a safe temperature without city water in summer heat?	Y = more vulnerable Hours = time to evacuation
	How long can the hospital maintain a safe temperature without city water in winter cold?	Hours = time to evacuation
Steam		
	Does the hospital receive steam for heat from a separate steam-generation plant?	Y = more vulnerable
	Is that steam plant on the hospital premises?	N = more vulnerable
	Is there one steam line into the hospital, or also a backup conduit?  How long can the hospital maintain a safe temperature if the steam-generation plant is offline?	Only 1 = more vulnerable Hours = time to evacuation
	Is steam also used to generate electricity? If so, what percentage of electricity would be lost if the steam-generation plant went offline?	Y = more vulnerable >50% = vulnerable
Electrici	ity	
	Does the hospital have a central backup generator? More than 1?	N = more vulnerable N = more vulnerable
	Is there a fuel storage tank on-site with a direct line to the backup generator?  Is the fuel storage tank underground?  In a flood, would the intake be underwater?	N = more vulnerable N = more vulnerable Y = more vulnerable
	How long can essential power be maintained using the current fuel supply?  Does the hospital have smaller or portable generators for floors/sections of the hospital?	Hours = time to evacuation N = more vulnerable
	Can all essential areas of the hospital be powered with these smaller generators?	N = more vulnerable
	Is fuel stored on-site for these smaller generators?  How long can essential power be maintained using the current fuel supply and these smaller generators?	N = more vulnerable Hours = time to evacuation
Natural	Gas	
	Is the boiler or other heating equipment fired by natural gas? Is there one gas line into the hospital, or also a backup line? How long can the hospital maintain a safe temperature if the gas stops?	N = more vulnerable N = more vulnerable Hours = time until evacuation

 $<sup>^{1}</sup>$  U.S. Department of Health and Human Services Agency for Healthcare Research and Quality, *Hospital Evacuation Decision Guide*, 2010.

### Appendix B

Evacuation-Relevant Resources	Implication
Boilers/Chillers	
☐ Does the hospital have backup/redundant boilers?	N = more vulnerable
☐ Does the hospital have backup/redundant chillers?	N = more vulnerable

# Appendix C Pre-Event Evacuation Considerations<sup>2</sup>

Factor	Issues to Consider	Implications			
Event Char	Event Characteristics				
Arrival	<ul> <li>When is the event expected to "hit" the hospital?</li> <li>The metropolitan area?</li> <li>How variable is the time the event is expected to "hit"?</li> </ul>	The amount of time until the event "hits", combined with the anticipated time to evacuate patients, determines how long an evacuation decision can be deferred			
Magnitude	<ul> <li>What is the expected strength of the event?</li> <li>How likely is the event to gain or lose strength before it reaches the hospital? The metropolitan area?</li> </ul>	The magnitude of the event forewarns the potential damage to a facility and utilities, which could cut off the supply of key resources, or otherwise limit the ability to shelter-in-place and care for patients			
Area impac	<ul> <li>How large is the geographic area to be affected by the event?</li> <li>How many vulnerable health care facilities are in this geographic area?</li> </ul>	Competition for resources needed to evacuate patients (especially vehicles) increases when more facilities evacuate simultaneously			
Duration	<ul> <li>How long is the event expected to last?</li> <li>How variable is the expected duration of the event?</li> </ul>	The duration of the event will affect how long hospitals have to shelter-in-place or operate on backup, alternative, or less predictable sources of key resources			
Anticipated	Effect of the Event on Key Resources Needed to Care for	or Patients			
Water sour	<ul> <li>Is the main city water supply in jeopardy? Already non-functional?</li> <li>Is there a backup water supply (well, nearby building with intact water mains?</li> <li>If not, how soon will city water return?</li> </ul>	Water loss of unknown duration (more than 1-2 days) is almost always cause for evacuation			
Heat Sourc	<ul> <li>Is the heat source in jeopardy (steam, water for boilers, etc.)? Already non-functional?</li> <li>Is there a backup (intact nearby building that still has power/heat)?</li> <li>If not, will the building be too cold for patient safety before adequate heat returns?</li> </ul>	Loss of heat, especially during a northern winter, is almost always a cause for evacuation – often within 12 hours			
Electricity	<ul> <li>Is power in jeopardy? Just for the hospital or a wider area?</li> <li>Are backup generators functional? How long can they run without refueling? Is refueling possible (e.g., intake not under water)?</li> <li>Can some sections/wings be shut down to reduce fuel consumption and stretch fuel supplies?</li> </ul>	Loss of electricity endangers ventilated patients, among others, and may affect the sequence in which patients are evacuated			

<sup>-</sup>

 $<sup>^2</sup>$  U.S. Department of Health and Human Services Agency for Healthcare Research and Quality, *Hospital Evacuation Decision Guide*, 2010.

# Appendix D Pre-Event Evacuation Decision Guide<sup>3</sup>

The following is an example of the possible decision flow for hospital leaders, as provided by the U.S. Department of Health and Human Resources. Hospital incident commanders will need to determine the most appropriate decisions for their facility, patients, and staff based upon the incident for which they are responding.

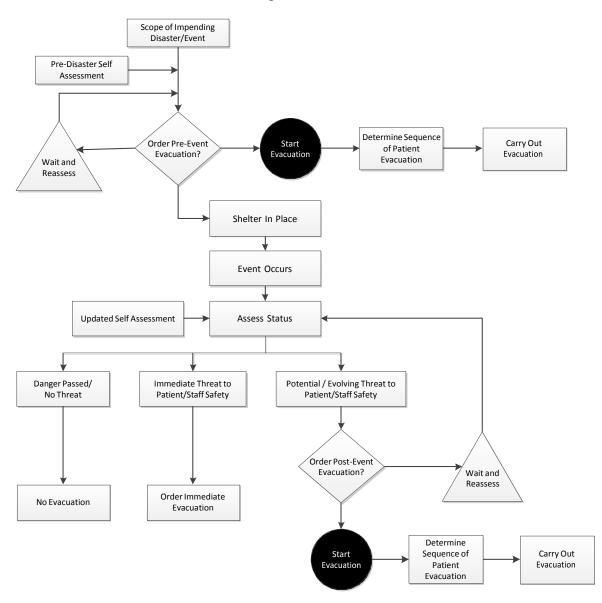


Figure D-1
Advanced Warning Event Evacuation Decisions

<sup>&</sup>lt;sup>3</sup> U.S. Department of Health and Human Services Agency for Healthcare Research and Quality, *Hospital Evacuation Decision Guide*, 2010.

# Appendix E Post-Event Evacuation Decision Guide<sup>4</sup>

The following is an example of the possible decision flow for hospital leaders, as provided by the U.S. Department of Health and Human Resources. Hospital incident commanders will need to determine the most appropriate decisions for their facility, patients, and staff based upon the incident for which they are responding.

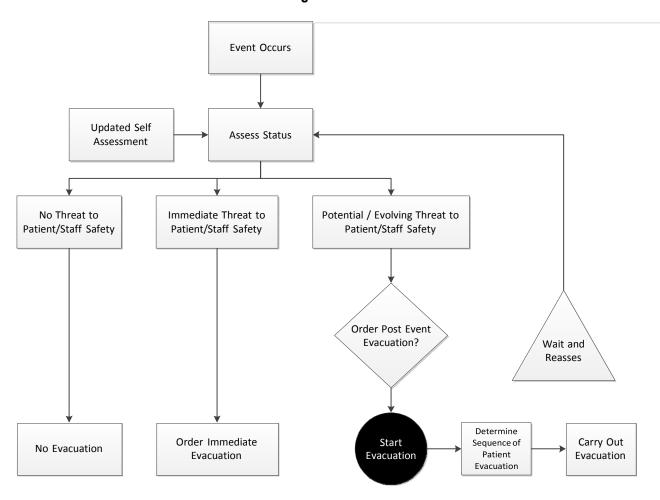


Figure E-1
No Advanced Warning Event Evacuation Decisions

<sup>&</sup>lt;sup>4</sup> U.S. Department of Health and Human Services Agency for Healthcare Research and Quality, *Hospital Evacuation Decision Guide*, 2010.

# Appendix F General Evacuation Responsibilities<sup>5</sup>

The following is a summary of example key *evacuation* responsibilities by department. This table was developed by the Massachusetts Department of Health and is considered a best practice for identifying evacuation responsibilities. Depending on the administrative structure of each hospital, these responsibilities may fit into the department listed or they may be better assumed by another department. For smaller hospitals, many of these responsibilities may need to be combined under one department or Incident Command System function. All of the responsibilities listed are in addition to the general responsibilities that will be otherwise listed in the Hospital Emergency Operations Plan.

Department	Responsibilities	Notes
Admitting	Patient Tracking:	Social Services may also need a list of patents by unit with "next of kin" information, including contact phone numbers.  All patient reception or transfer documents should be forwarded to the St. Louis Medical Operations Center for centralized tracking coordination.
Biomedical Engineering	<ul> <li>Identify all available equipment for internal and external patient transport.</li> <li>Transport appropriate medical equipment to assembly points.</li> <li>Troubleshoot malfunctioning equipment during evacuation.</li> <li>Track any equipment that leaves facility.</li> </ul>	coordination.
Blood Bank	<ul> <li>Inventory available blood products.</li> <li>Identify coolers and other resources available to support blood transport.</li> <li>Transport blood products to assembly points.</li> </ul>	
Facilities Management	<ul> <li>□ Activate emergency systems to commandeer elevator banks.</li> <li>□ Monitor system utilities.</li> <li>□ Assist with assembly points and Discharge Site setup.</li> <li>□ Assist with patient transport as needed.</li> </ul>	
Case Management	<ul><li>Assist with patent Destination Team.</li><li>Identify non-acute care transfers (on unit)</li></ul>	

 $<sup>5\ \</sup>textbf{Massachusetts Department of Public Health}, \textit{Hospital Evacuation Toolkit}, 2010.$ 

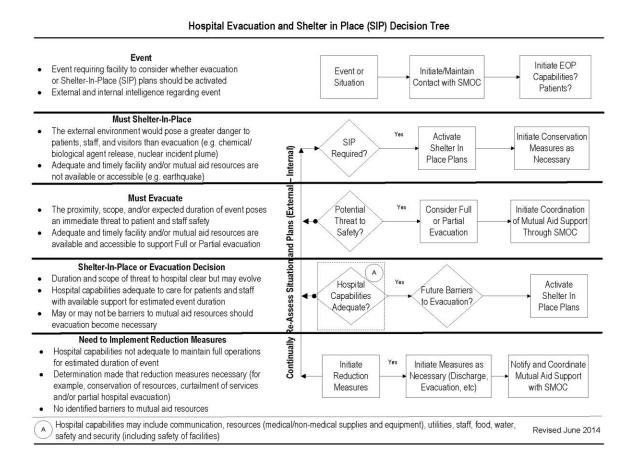
Department	Responsibilities	Notes
	that may be discharged to skilled nursing facilities.  Staff the Discharge Site as needed.  Support Family Assistance Center as needed.	
Emergency Department	<ul> <li>□ Staff emergency resuscitation and stabilization area at the assembly points.</li> <li>□ Respond to injuries/illness during evacuation as requested</li> <li>□ Provide staff to support loading teams</li> </ul>	
Environmental Services	<ul> <li>□ Set up assembly points and Discharge Site.</li> <li>□ Provide staff for patient transport.</li> </ul>	
Food/Nutrition Services	<ul> <li>Transport emergency supplies to assembly points and Discharge site and distribute as needed.</li> </ul>	Includes standard TPN bags
Health Information System	<ul> <li>Retrieve or track medical records before patient transfer to other facility.</li> <li>Assist receiving institutions with obtaining medical record data.</li> </ul>	Or print/email abstracts
Human Resources	<ul> <li>□ Provide Labor Pool resources.</li> <li>□ Assign assembly points Labor Pool representative.</li> <li>□ Track staff who travel to other facilities.</li> <li>□ Monitor emergency challenges to labor agreements.</li> </ul>	Clinical staff may be needed for transport
Interpreter Services	<ul> <li>□ Provide interpreter staff at the assembly points and Discharge Site.</li> <li>□ Assist with the translation in the Family Assistance Center.</li> </ul>	
Materials Management	<ul> <li>Manage patient transport process.</li> <li>Transport medical supplies, linens, other needed items to assembly points,</li> <li>Discharge Site.</li> </ul>	
Pharmacy	<ul> <li>□ Transport medication "cache" and IV fluids to assembly points and dispense as needed.</li> <li>□ Support Discharge Site with needed medications and dispensing as possible.</li> </ul>	
Security	□ Communicate with outside agencies.     □ Lockdown facility and secure roadways.     □ Unlock all stairwell doors.     □ Manage access to/from secure units.     □ Clear evacuation route.     □ Manage routes/checkpoints.     □ Check units after closing (if possible).     □ Support care units and Family Waiting areas at the assembly points.     □ Provide staff to manage ambulance flow.	
Respiratory Therapy	<ul> <li>□ Deploy staff to critical care units for internal and external transport.</li> <li>□ Transport respiratory equipment to</li> </ul>	

# **General Evacuation Responsibilities**

Department	Responsibilities	Notes
	<ul> <li>assembly points.</li> <li>Provide emergency care as needed in the resuscitation and stabilization area at the assembly points.</li> </ul>	
Social Services	☐ Manage family call center.	
	<ul> <li>Manage family support/waiting areas.</li> </ul>	
Telecommunications	<ul> <li>Use overhead paging system to</li> </ul>	
	communicate information as appropriate.	
	<ul> <li>Set up phone bank at assembly points,</li> </ul>	
	discharge site, and family support center.	

# Appendix G Hospital Evacuation and Shelter-in-Place Decision Tree

This flowchart is intended to assist hospital personnel with weighing the risks and benefits of sheltering-in-place compared to vertical/horizontal evacuation. The decision tree was adopted from the California Hospital Association Shelter-In-Place Planning Checklist tool.



# Appendix H<sup>6</sup> Evacuation Tracking Form

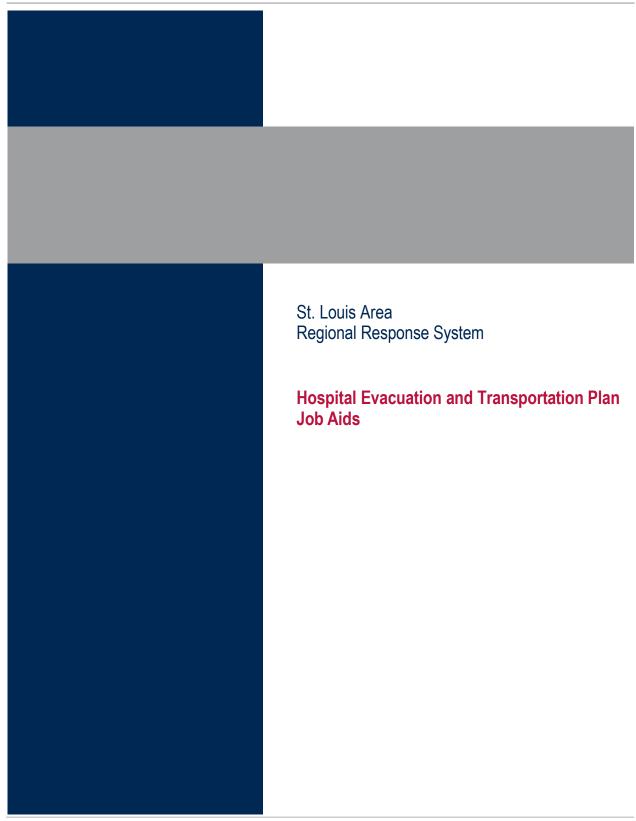
This form should be completed by the evacuating facility (generally finalized at the assembly point). It was developed for use in the Hospital Incident Command System. The following information is the minimum provided when transporting a patient to another care facility. A copy of the medical record and advanced directives should be included, if possible. A copy of this form should be maintained in the Medical Record and by the Patient Tracking Manager.

<sup>6</sup> Hospital Incident Command System. <a href="http://www.calhospitalprepare.org/hics-forms">http://www.calhospitalprepare.org/hics-forms</a>. 2014

### **Appendix H**

HICS-260 – PATIENT EVACUATION TRACKING FORM								
1. Date 2. From (Unit)								
3. Patient Name			4. DOB	5. Medical Record Number		ord Number		
J. Faucht Hame				4. DOB	J. IN.		Old Namber	
6. Diagnosis				7. Admitting Physician				
8. Family Notified	NO NAME:			CONTACT INFORMATION:				
9. Mode of Transport	_	10. Accomp	oanying Equipme	ent (check those that apply)	)			
☐ Hospital Bed		☐ IV Pump	o(s)	☐ Isolette/Warmer		Foley Catheter		
☐ Gurney		* * *		Traction	Traction		☐ Halo-Device	
☐ Wheelchair		☐ Ventilato	or	☐ Monitor		☐ Cranial Bolt/Screw		
☐ Ambulatory		☐ Chest Tu		☐ A-Line/Swan			sseous Device	
Other:		Other:	(-)	Other:		Other		
11. Special Needs			l					
12. Isolation YES	NO TYPE:			REASON:				
13. Evacuating Clinical Loc	ation			14. Arriving Location				
ROOM# TIME				ROOM# TIM	ИΕ			
ID BAND CONFIRMED BY:		☐YES [	□NO	ID BAND CONFIRMED BY:			YES NO	
MEDICAL RECORD SENT		☐YES [	□NO	MEDICAL RECORD RECEIVE	MEDICAL RECORD RECEIVED		YES NO	
BELONGINGS	☐ WITH PATIENT	LEFT IN	N ROOM	BELONGINGS RECEIVED			YES NO	
VALUABLES	☐ WITH PATIENT	LEFT IN	N SAFE	VALUABLES RECEIVED			YES NO	
MEDICATIONS	☐ WITH PATIENT	☐ LEFT C		MEDICATIONS RECEIVED			YES NO	
	PEDS / INFANTS	;			PEDS	/ INFANT	S	
BAG/MASK WITH TUBING SENT		YES [	NO	BAG/MASK /W TUBING RCVD	)		YES NO	
BULB SYRINGE SENT		☐ YES [	NO	BULB SYRINGE RECEIVED			YES NO	
15. Transferring to another	Facility / Location			•		•		
TIME TO STAGING AREA		-	TIME DEPARTING TO	RECEIVING FACILITY				
Destination								
TRANSPORTATION AMBULANCE. # AGENCY				HELICOPTER		OTHE	R	
ID BAND CONFIRMED YES NO BY								
DEPARTURE TIME:								
16. Prepared by  PRINT NAME: SIGNATURE:								
DATE/TIME:				FACILITY:				

# Appendix I Job Aids



Appendix I

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#### MEDICAL FACILITY EVACUATION PERSONNEL

#### Purpose

These job aides have been developed to facilitate training and exercises as well as provide reference material to specific roles during real-world evacuation incidents and are intended to supplement routine job actions and roles as delineated in standard emergency operations plans (EOPs). Staff positions are organized in accordance with the National Incident Management System (NIMS) and the Incident Command System (ICS). One staff member may support multiple positions simultaneously.

### Hospitals

#### **Hospital Command Staff**

The Hospital Incident Commander and Command staff is responsible for the overall planning, response, and recovery from an evacuation incident. Hospital emergency planners and command staff should work to ensure their hospitals plans are integrated with local, regional, and state plans to move effectively coordinate scare resources during these time-sensitive situations.

#### **Evacuation Coordinator**

The Evacuation Coordinator is a unique role specifically designated during a possible or actual hospital evacuation that oversees the evacuation specific operations. While overall hospital operations and patient care activities must be continued during an evacuation scenario, the Evacuation Coordinator ensures that evacuation prioritization and patient movement are conducted in a manner that aligns with Hospital Incident Commander's directive, which may change throughout a significant incident.

#### Patient Triage and Tracking Manager

The Patient Triage and Tracking Manager has a critical role in the efficient and safe evacuation of patients. To prevent hallways, elevators, stairwells, and egress points from becoming congested as well as unnecessary patient movement, this role coordinates the movement priority of patients based upon triage level, impact area priorities, and availability of transport resources, as coordinated with the Assembly Point Manager.

#### Discharge Site Manager

The Discharge Site Manager is responsible to coordinate with the Evacuation Coordinator for the efficient and safety early discharge of patients. This role will require patient pick-up coordination, patient discharge teaching, and prescriptions. This role will require follow-up actions with patients discharged during the evacuation process for reassessment of complete discharge instructions, referral care, and review for readmission needs.

#### **Assembly Point Manager**

The Assembly Point Manager is responsible to coordinate with the Emergency Medical Services Liaison Officer to the SMOC (EMS LNO) and Patient Triage and Tracking Manager for efficient patient movement from the patient care unit to the transportation resource. This critical role ensures patient transfer documentation and necessary medical equipment and supplies are available during transfer as well as ensure that patients are not waiting in egress hallways anticipating transportation resources, which may be scare.

### **Emergency Medical Services**

#### EMS Liaison to the SMOC (EMS LNO)

A Regional Emergency Medical Services (EMS) Director or Senior Supervisor is identified within the region to serve as the Subject Matter Expert to the St. Louis Medical Operations Center (SMOC) for all matters concerning Emergency Medical Treatment and Transportation during a disaster. There may be multiple Regional EMS Directors or Senior Supervisors per MoSCOPE; however, during a response this is a single operational position that may be filled by a single person or a team. Per the SMOC Standard Operating Procedures (SOP), this position is maintained in an on-call status until requested by the SMOC Duty Officer on-call or a local jurisdiction responding to an incident. The primary role of this position is to coordinate EMS resources to assist the SMOC with issues requiring movement of patients and mass casualty.

#### EMS Liaison to the Hospital

A Regional EMS Director or Senior Supervisor is assigned by the EMS LNO (with approval of sponsoring jurisdiction) to provide on-site coordination with Hospital Administration conducting an evacuation. This position is responsible for developing resources needs for the hospital and managing EMS resources assigned to evacuation of that particular facility. This Officer maintains situational awareness and shares information with the EMS LNO to ensure common operating picture across the region.

#### **Emergency Medical Services Transportation Officer**

The EMS Transportation Officer works directly for the EMS Liaison to the Hospital to ensure quick and efficient movement of ambulances and personnel around the hospital property. This position is responsible for marshaling, parking, and accountability of EMS units and crews operating at assigned hospital or healthcare facility.

#### **Emergency Medical Services Staging Area Manager**

If established, the EMS Staging Area will serve as a "forward" marshaling area to provide rapid access to EMS resources for hospitals who are evacuating patients. Staging Area personnel maintain units in high state of readiness and dispatch the most appropriate unit to assist hospitals as requested by EMS Transportation Officers operating at hospitals in the area.

### Air Medical Transportation Officer

Similar to the EMS Transportation Officer, the Air Medical Transportation Officer works with air medical service providers to coordinate drop off of crews and equipment, communication between air crews and pilots, and quick loading/departure of patients from the helipad. The primary responsibility of the Air Medical Transportation Officer is to maintain an "open" helipad as much as possible to ensure availability for rapid movement of patients by rotor wing aircraft.

Appendix I

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#### MEDICAL FACILITY EVACUATION PERSONNEL

# Emergency Medical Services Liaison to the St. Louis Medical Operations Center (SMOC)

**Position:** Emergency Medical Services Liaison to the SMOC (EMS LNO)

**Reports to:** EMS Lead at EOC

**EMS Command** 

**Section:** Operations

Mission: The EMS LNO coordinates and directs all of the operational activities of the EMS units

and personnel during a hospital evacuation in collaboration with the SMOC. The responsibilities of this role include communicating between the SMOC and regional EMS providers, rostering of available EMS units and transportation resources for movement of patients during an incident, communicating with EMS Liaisons at assigned hospitals, maintaining situational awareness of units in EMS Staging, and communicating with EMS Directors/Supervisors from agencies that

provide resources to evacuation.

Pre-deployment Procedures			
	Ensure that all contact numbers for participating agency dispatch centers and leadership are current.		
	Maintain roster of pertinent resources in the area, for rapid activation following a no-notice incident.		
	Review Hospital Evacuation and Transportation Plan.		

Immediate		
Receive assignment and obtain a briefing from the SMOC Duty Officer.		
Gather appropriate information from SMOC Duty Officer or requesting jurisdiction/facility.		
Identify facilities requiring evacuation, appropriate staging areas, and required overhead personnel.		
Contact all participating agencies to request EMS transportation resources and overhead personnel.		
Establish a plan for tracking resource utilization.		
Maintain communications with all tasked and/or deployed units to maintain optimal readiness and safety of responders and patients. Establish routine update interval with overhead personnel to maintain situational awareness and provide common operating picture to SMOC.		

Intermediate
Work closely with the Strike Team Leaders and Overhead Team to complete the operational planning worksheet (ICS Form 215) to ensure proper staffing and equipment levels for the next operational

period.
Continue to monitor the incident and reports from field personnel to address responder safety issues as they arise.
Continue to account for all resources (personnel, equipment, and supplies) that have been deployed to support the incident. Assess resource utilization each operational period to determine when resources can be demobilized or reassigned.
Work closely with the SMOC Operations Section to provide updates on census, facility status, transfers, staffing, demobilization plans, or any other pertinent information that is obtained during the response.
Extended Extended
Coordinate with the EMS Liaisons to Hospitals and the SMOC consolidate evacuation operations or to terminate operations as the incident resolves.
Continue to document critical activities and decisions in the unit log (ICS Form 214). Ensure that all operational teams continue to do the same.
Continue to work with the Medical Support Planning Unit to meet the operational needs of the incident as they plan for the next operational period.
Closing Actions
Complete all documentation, gather documentation from Strike Team Leaders, EMS Liaisons to the Hospitals, Staging Area Managers, and other overhead personnel and forward the documentation to the Planning Unit – Documentation.
Provide a detailed briefing to the SMOC Duty Officer or SMOC Operations Section Chief about any continuing efforts and potential gaps related to evacuation or medical care in the community.
Ensure that overhead personnel and EMS resources are aware of operational changes, including demobilization of all resources. Assist with alternative planning to ensure that the needs of the hospitals are being met.
Demobilization Procedures
Complete appropriate demobilization documentation. Ensure that all financial and administrative documentation has been completed for reimbursement.
Meet with the SMOC Finance/Administration Unit to ensure that the incident documentation file is complete.
Work closely with the Strike Team Leaders to develop a demobilization plan and ensure that all operational units are following the plan.
Maintain communications with all EMS Liaisons, Staging Area Managers, and Strike Team Leaders to ensure that demobilization is occurring and address any issues (such as injuries, claims, equipment shortfalls, and supply or facilities issues).
Debrief all staff to identify lessons learned during the incident.
Upon deactivation, brief the SMOC Operations Section Chief and the SMOC Finance/Administration Section on continuing issues and the status of any open procurement requests and ongoing costs.
Inform the SMOC that the Medical Evacuation Resources have been successfully demobilized.

### **Emergency Medical Services Liaison to Hospital**

**Position: Emergency Medical Services Liaison to Hospital** 

**Reports to:** Emergency Medical Services Liaison to SMOC (EMS LNO)

**Section: Operations** 

Mission: The Emergency Medical Services Liaison to Hospital works closely with Hospital

Evacuation Coordinator and EMS LNO at the SMOC to ascertain resource requirements and conduct efficient, safe, and rapid evacuation of an affected facility. Supervises the EMS Transportation Officer on-site at the assigned hospital to coordinate efficient movement of resources around the hospital

property.

Pre-deployment Procedures
Become familiar with these plans and operational expectations.
Immediate
Receive assignment and obtain a briefing from the EMS LNO to the SMOC.
Review job action sheet for assigned position and review the organizational chart.
Meet with Hospital Evacuation Coordinator to ascertain resource requirements. Forward requests to the EMS LNO to the SMOC for assignment.
Work closely with Transportation Officer assigned to Hospital to ensure efficient traffic and parking plan to minimize delay. Ensure adequate communication with EMS Staging Area Manager, if applicable.
Intermediate
Continue to monitor the evacuation status at assigned facility and reports from field personnel to address responder safety issues as they arise.
Continue to account for all resources (personnel, equipment, and supplies) that have been deployed to support the incident. Assess resource utilization each operational period to determine when resources can be demobilized or reassigned.
Work closely with the EMS LNO to SMOC to provide updates on status, unmet needs, staffing or any other pertinent information that is obtained during the response. Ensure situational awareness pertaining to resource needs/gaps and planning for the next operational period.
Extended Extended
Work with the EMS LNO to the SMOC to demobilize units when evacuation is complete.
Continue to document critical activities and decisions in the unit log (ICS Form 214).

Ensure that all operational teams continue to do the same.

Closing Actions			
	Consolidate documentation from the operational units and ensure the security of PHI.		
	Provide a detailed briefing to the EMS LNO to the SMOC about any issues pertaining to resources or any potential problems in the demobilization process.		
	Meet with Hospital Evacuation Coordinator to ensure all needs are met.		

Demobilization Procedures			
	Complete appropriate demobilization documentation. Ensure that all financial and administrative documentation has been completed for reimbursement.		
	Meet with the EMS Liaison to the SMOC to ensure that the incident documentation file is complete.		
	Maintain communications with all assigned personnel to ensure that demobilization is occurring and address any issues (such as injuries, claims, equipment shortfalls, and supply or facilities issues).		
	Debrief all staff to identify lessons learned during the incident.		

## **Emergency Medical Services Transportation Officer**

**Position:** Emergency Medical Services Transportation Officer

**Reports to:** Emergency Medical Services Liaison to Hospital

**Section:** Operations

Mission: The Transportation Officer is responsible for traffic flow and organized movement

of patients from the Hospital Collection Point to waiting EMS units. Coordinate manpower pool (if deployed) to assist staff with movement of patients inside the hospital. Communicate with EMS Staging Area Manager to ensure efficient

dispatch of resources to complete evacuation safely in a timely fashion.

Pre-deployment Procedures			
	Become familiar with these plans and operational expectations.		
	Immediate		
	Receive assignment and obtain a briefing from the EMS Liaison.		
	Review job action sheet for assigned position and review the organizational chart.		
	Meet with Hospital Evacuation Coordinator and EMS LNO to the Hospital to develop traffic and parking plan for EMS units to minimize congestion and maximize rapid movement of EMS resources, so as not to interfere with other operations, such as discharge and civilian movement.		
	Ensure communications with EMS units, Staging Area Manager, and EMS Liaison to the Hospital.		
	Intermediate		
	Continue to monitor operational area for congestion and improve traffic and parking plan as needed.		
	Provide situational awareness to the EMS Liaison to Hospital regarding any issues or pertinent updates.		
	Extended		
	Work with the EMS LNO to the Hospital to demobilize units when evacuation is complete.		
	Continue to document critical activities and decisions in the unit log (ICS Form 214). Ensure that all operational teams continue to do the same.		
	Monitor staff for signs of fatigue and stress. Rotate personnel as needed.		
Closing Actions			
	Consolidate documentation from the operational units and ensure the security of PHI.		

Provide a detailed briefing to the EMS LNO to the SMOC about any issues pertaining to resources or

any potential problems in the demobilization process.

	Meet with Hospital Evacuation Team Leader and EMS LNO to Hospital to ensure all needs are met.		
Demobilization Procedures			
	Complete appropriate demobilization documentation. Ensure that all financial and administrative documentation has been completed for reimbursement.		
	Meet with the EMS Liaison to the SMOC to ensure that the incident documentation file is complete.		
	Maintain communications with all assigned personnel to ensure that demobilization is occurring and address any issues (such as injuries, claims, equipment shortfalls, and supply or facilities issues).		
	Debrief all staff to identify lessons learned during the incident.		
	Ensure that all equipment and supplies utilized during the incident have been properly accounted for and have been demobilized. All equipment and supplies should be returned to deployable condition. Work closely with hospitals and regional partners to ensure that all equipment was returned in the same condition in which it was issued. Document any discrepancies.		

## **Emergency Medical Services Staging Officer**

**Position:** Emergency Medical Services Staging Officer

**Reports to:** Emergency Medical Services Liaison to the SMOC

**Section:** Operations

Mission: The EMS Staging Officer establishes a marshaling area near the affected healthcare facilities and manages assigned resources to minimize congestion at the

evacuating facilities and provide ready resources as needed.

Maintains accountability of ambulances and Strike Team Leaders awaiting assignment to an evacuation task. Provides situational awareness to the and EMS Liaisons pertaining to available resources and usage.

Pre-deployment Procedures				
	Maintain a cache of equipment required to establish an access controlled staging area, to include marking paint, chalk, signage, cones, flashlights with traffic wands and safety vests.			
	Preplan staging areas at various locations near medical facilities.			
	Immediate			
	Receive assignment and obtain a briefing from the EMS LNO to the SMOC.			
	Review job action sheet for assigned position and review the organizational chart.			
	Instruct EMS units topdate the EMS LNO to the SMOC when transporting and arriving at destinations to provide for patient tracking and where to return after dropping of patients to ensure proper use of resources.			
	Meet with property owner to establish any ground rules or special requests. Ensure that all responders are respectful of property. Forward any concerns to the EMS LNO to the SMOC.			
	Work closely with Transportation Officers assigned to hospital to ensure efficient traffic and parking plan to minimize delay. Ensure adequate communication with all EMS Liaisons and Transport Officers.			
	Intermediate			
	Maintain accountability (electronically if able) of all units in staging to real-time situational awareness for the SMOC and hospitals. Pay special attention to units with special equipment or bariatric units.			
	Establish system to assign tasks to the most appropriate unit.			
	Communicate frequently with the EMS LNO to the SMOC,.			
	Extended			

Work with the EMS LNO to the Hospital to demobilize units when evacuation is complete.

Appendix I

Continue to document critical activities and decisions in the unit log (ICS Form 214).  Ensure that all operational teams continue to do the same.
Monitor staff for signs of fatigue and stress. Rotate personnel as needed.
Closing Actions
Consolidate documentation from the operational units and ensure the security of PHI.
Provide a detailed briefing to the EMS LNO to the SMOC about any issues pertaining to resources or any potential problems in the demobilization process.
Meet with Hospital Evacuation Team Leader and EMS LNO to Hospital to ensure all needs are met.
Demobilization Procedures
Complete appropriate demobilization documentation. Ensure that all financial and administrative documentation has been completed for reimbursement.
Meet with the EMS Liaison to the SMOC to ensure that the incident documentation file is complete.
Maintain communications with all assigned personnel to ensure that demobilization is occurring and address any issues (such as injuries, claims, equipment shortfalls, and supply or facilities issues).
Debrief all staff to identify lessons learned during the incident.
Ensure that all equipment and supplies utilized during the incident have been properly accounted for and have been demobilized. All equipment and supplies should be returned to deployable condition. Work closely with hospitals and regional partners to ensure that all equipment was returned in the same condition in which it was issued. Document any discrepancies.

# **Aeromedical Transportation Officer**

**Position:** Aeromedical Transportation Officer

**Reports to:** Emergency Medical Services Liaison to the Hospital

**Section:** Operations

Mission: The Aeromedical Transportation Officer ensures efficient air medical evacuation

of patients by working with air crews to minimize time that helipad is closed due to transient aircraft parking. Works with EMS LNO to the Hospital to ascertain how many patients require air medical evacuation and how to most effectively

move aircraft to evacuate as quickly and safely as possible.

	Pre-deployment Procedures
	Maintain a list of all air medical resources in the area, including appropriate contact information and pertinent data about the aircraft. Be sure to include information on telephone and radio communications.
	Preplan air medical staging areas at airports or other appropriate locations near medical facilities.
	Immediate
	Receive assignment and obtain a briefing from the EMS LNO to the SMOC.
	Review job action sheet for assigned position and review the organizational chart.
	Ensure security of helipad.
	Establish reliable communications with EMS Liaison to the Hospital and incoming aircraft.
	Interact with pilots and air medical crews to facilitate "hot loading" in order to minimize time that aircraft are sitting on the helipad. Direct pilots to staging area at nearby airport or other appropriate area while crews are preparing patient. Ensure adequate communications with pilot or aircraft to notify when they are needed to return.
	If necessary, utilize air crew members to prepare patients for transport on long spine boards for rapid transfer to aircraft when they arrive on the helipad. Ensure proper patient report is being given to crews taking patient from transfer crews.
	Intermediate
	Maintain accountability (electronically if able) of all units in staging to real-time situational awareness at the SMOC and hospitals. Pay special attention to units with special equipment or bariatric units.
	Establish system to assign tasks to the most appropriate unit.
	Communicate frequently with the EMS LNO to the SMOC, and routinely brief the SMOC on resource status.

**Extended** 

Work with the EMS LNO to the Hospital to demobilize units when evacuation is complete.

Appendix I

Continue to document critical activities and decisions in the unit log (ICS Form 214). Ensure that all operational teams continue to do the same.
Monitor staff for signs of fatigue and stress. Rotate personnel as needed.
Closing Actions
Consolidate documentation from the operational units and ensure the security of PHI.
Provide a detailed briefing to the EMS LNO to the SMOC about any issues pertaining to resources or any potential problems in the demobilization process.
Meet with Hospital Evacuation Team Leader and EMS LNO to Hospital to ensure all needs are met.
Demobilization Procedures
Complete appropriate demobilization documentation. Ensure that all financial and administrative documentation has been completed for reimbursement.
Meet with the EMS Liaison to the SMOC to ensure that the incident documentation file is complete.
Maintain communications with all assigned personnel to ensure that demobilization is occurring and address any issues (such as injuries, claims, equipment shortfalls, and supply or facilities issues).
Debrief all staff to identify lessons learned during the incident.
Ensure that all equipment and supplies utilized during the incident have been properly accounted for and have been demobilized. All equipment and supplies should be returned to deployable condition. Work closely with hospitals and regional partners to ensure that all equipment was returned in the same condition in which it was issued. Document any discrepancies.

# **Hospital Command Staff**

**Position:** Reports to: Hospital Incident

Commander Section: Command

**Mission:** Hospital Command Staff and specifically the Hospital Commander are responsible to ensure the safe and efficient evacuation of patients and staff, which includes **Hospital Command Staff** pre-event assessments, training, and coordination with local, regional, and state emergency management planners.

	Pre-deployment Procedures
	Review threat intensity and likely duration.
	Implement Hospital Emergency Operations Plan and any specific threat impact annex.
	Immediate
	Review any department specific relocations that have occurred and implement hospital ICS.
	Plan for further shelter-in-place and horizontal evacuations and request activation of the St. Louis Regional Hospital Evacuation Plan.
	Ensure damage assessment is being conducted to ensure adequate information for potential evacuation decisions.
	Determine the need for shelter-in-place versus evacuation requires, for each patient care unit.
	Direct cessation of unsafe systems (water, air intake, medical gases, etc.).
	Direct the implementation of access control measures and monitoring, to ensure facility threat reduction.
	Intermediate
	Determine department specific actions necessary (Shelter-in-Place, Horizontal Movement, Vertical Evacuation).
	Notify local Emergency Management Agency and SMOC of facility conditions.
	Review and implement, as needed, mutual aid agreements with hospitals and transportation agencies.
	Extended Extended
	Determine and communicate the scope of evacuation.
	Ensure assembly points and discharge sites are activated and early discharge actions are communicated to physician medical staff.
	Activate and communicate the evacuation order.
·	

Closing Actions	
	Ensure all patient tracking documents are supplied to SMOC.
	Ensure all staff and patients whereabouts are known and documented.
	Ensure facility is secured and access is limited, as appropriate.

Demobilization Procedures	
	Complete appropriate demobilization documentation. Ensure that all financial and administrative documentation has been completed.
	Meet with Command Staff to ensure that the incident documentation file is complete.
	Maintain communications with SMOC and patient receiving facilities.
	Debrief all staff to identify lessons learned during the incident.

#### **Evacuation Coordinator**

**Position:** Evacuation Coordinator

**Reports to:** Operations Section Chief

**Section:** Operations

Mission: The Evacuation Coordinator coordinates the crucial activities of early discharge

and emergent transfer of patient from an evacuating facility. The role requires constant communication with patient care units and management of the span of control, based upon the acuity types and size of the facility. Prioritization and physical patient movement are key activities that must be carried out safely and

efficiently.

**Supervises:** Patient Triage and Tracking Manager and Assembly Point Manager.

Pre-deployment Procedures	
	Have a detailed understanding of hospital mutual aid agreements and transfer requirements.
	Have a detailed understanding of medical units and patient types throughout the facility.
	Immediate
	Conduct detailed briefing for Operations Section Chief and Hospital Incident Commander on the incident urgency, impact areas, and the timeline for patient movement.
	Appoint and brief Patient Triage and Tracking Manager, including providing priority activities.
	Appoint and brief Assembly Point Manager, including providing priority activities.
	Appoint and brief Discharge Site Manager, including providing priority activities.
	Determine the total number of support staff necessary and communicate to the Labor Pool.
	Direct the priority and sequence of patient transfer and discharge.
	Intermediate
	Based upon damage assessment information, determine the effective and safe use of elevators, and assign to units as appropriate.
	Based upon damage assessment information, determine the effective and safe use of specific stairwells, and assign to units as appropriate.
	Begin implementation of staff rotation plan due to the number of staff required for patient evacuation and the exhaustive nature of the activity.

**Extended** 

Work with Operations Section Chief to monitor situation and make adjustments as necessary.

### Appendix I

	Ensure evacuated units are communicated to hospital incident command.
	Serve as hospital liaison to SMOC as patient specific transfer needs change.
Closing Actions	
	Ensure hospital command and SMOC are updated on evacuation status.
	Ensure all staff and patient locations are known and documented.
	Demobilization Procedures
	Complete appropriate demobilization of personnel.
	Provide detailed briefing to Operations Section Chief and hospital command.

### Hospital Patient Triage and Tracking Manager

**Position: Hospital Patient Triage and Tracking Manager Evacuation Coordinator Reports to: Section: Operations** Mission: The Hospital Patient Triage and Tracking Manager is responsible to coordinating the evacuation of patients in an efficient manner ensuring the greatest good for the greatest number of patients and tracking all patient locations, both discharged and transferred. This role ensures all patients are triaged using evacuation triage criteria and are grouped together based upon evacuation priorities. **Pre-deployment Procedures** П Review and understand hospital evacuation procedures. Have a good understanding of medical units and patient types throughout the facility. **Immediate** Ensure tracking supplies and documents are available at assembly points and discharge areas. Assist with triaging patients that require transfer, providing a status of red, yellow or green as outline in hospital evacuation procedures. Ensure triage tags are applied to each transfer patient and reflect the appropriate priority. Intermediate Ensure patients are grouped appropriately in coordination with Assembly Point Manager. П Initiate the early discharge process via the Discharge Site. П Initiate the readiness of Green patients (ambulatory and low acuity patients) to assembly point. Extended Prepare for the movement and transport of Yellow patients (non-ambulatory and non-critical care patients) to assembly point. Prepare for the movement and transport of Red patients (critical care and advanced life support patients) to assembly point. **Closing Actions** Consolidate documentation and all Patient Tracking Documentation.

Provide a detailed briefing to Evacuation Coordinator.

Demobilization Procedures	
	Complete appropriate demobilization documentation.
	Meet with the Evacuation Coordinator to ensure that the incident documentation file is complete.
	Ensure that all equipment and supplies utilized during the incident have been properly accounted for and have been demobilized.

## **Assembly Point Manager**

**Position:** Assembly Point Manager

**Reports to:** Evacuation Coordinator

**Section:** Logistics

Mission: The Assembly Point Manager is responsible for the overall management of patients within the assembly point and the communication, coordination, and effective resource utilization in concert with the EMS LNO to Hospital. The Assembly Point Manager must ensure patients arrive and depart in the most efficient manner through coordination with the Patient Triage and Tracking Manager and the EMS

Liaison to the Hospital, which must be balanced by facility hazards and

transportation resource availability.

Pre-deployment Procedures	
	Understand the concepts and requirements of patient transfer requirements.
	Have a good understanding of medical units and patient types throughout the facility.

Immediate	
	Ensure patient staff, medical supplies, and equipment are available at the assembly point.
	Coordinate with Patient Triage and Tracking Manager regarding patient transfer priorities.
	Coordinate with EMS LNO to Hospital regarding staged EMS/transportation resources to ensure efficient transfers.
	Brief assembly point team members on priorities, incident specific needs, and set briefing frequency.
	Identify team members specifically responsible for: 1) ensuring patient care equipment; 2) ensuring patient medications; 3) ensuring required completed transfer documents; and 4) completed tracking forms are with patients and ready for transfer.
	Ensure each patient leaving for transfer has the appropriate receiving facility documented and communicated with the EMS LNO.

Intermediate	
	Ensure patients are grouped together for loading by acuity and/or destination (e.g. group of patients traveling by bus).
	Determine, in coordination with Labor Pool, a rotation schedule for team members.
	Monitor patients for deterioration in condition.
	Monitor patient medical equipment and supply resources.
	Ensure each patient transferred has a documented HICS Form 260.

Extended		
	Work with the EMS LNO to Hospital to demobilize units when evacuation is complete.	
	Coordinate personnel assignment and orientation as patient throughput increases.	
	Monitor staff for signs of fatigue and stress. Rotate personnel as needed.	
Closing Actions		
	Consolidate documentation from the operational units and ensure the security of PHI.	
	Provide a detailed briefing to the EMS LNO and Evacuation Coordinator.	
	Meet with team members and EMS LNO to Hospital to ensure all needs are met and transfers were carried out as expected.	
	Demobilization Procedures	
	Complete appropriate demobilization documentation.	
	Maintain communications with all assigned personnel to ensure that demobilization is occurring and address any issues (such as injuries, claims, equipment shortfalls, and supply or facilities issues).	
	Ensure that all equipment and supplies utilized during the incident have been properly accounted for and have been demobilized.	

## Discharge Site Manager

**Position:** Discharge Site Manager

**Reports to:** Evacuation Coordinator

**Section:** Logistics

Mission: The Discharge Site Manager is responsible for the overall discharge of patients from

the healthcare facility. The Discharge Site Manager will ensure rapid discharge instructions, teaching and medication. The Discharge Site Manager will coordinate the discharge of patients and pick-up by friends or family and guardian. The speed and level of discharge specificity must be balanced by facility

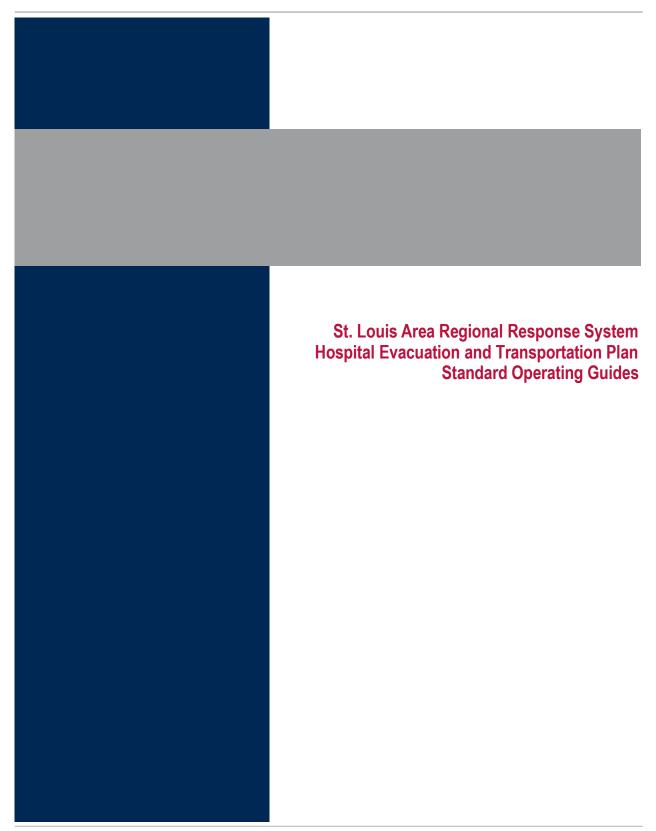
hazards and transportation resource availability.

	nazards and transportation resource availability.				
Pre-deployment Procedures					
	Understand the concepts and requirements of patient discharge requirements.				
	Have a good understanding of medical units and patient types throughout the facility.				
Immediate					
	Ensure patient staff document and transfer equipment is available at the Discharge Site.				
	Coordinate with Patient Triage and Tracking Manager regarding discharge priorities.				
	Coordinate with Security for efficient traffic flow during pick-up				
	Identify team members specifically responsible for: 1) needed discharge equipment; 2) teaching; 3) processing of prescriiptions.				
	Document each patient discharge for census reconciliation.				
	Intermediate				
	Coordinate with social workers and case managers for follow-up checks on each patient.				
	Extended				
	Coordinate personnel assignment and orientation as patient throughput increases.				
	Monitor staff for signs of fatigue and stress. Rotate personnel as needed.				
Closing Actions					
	Consolidate documentation from the operational units and ensure the security of PHI.				
	Provide a detailed briefing to Evacuation Coordinator.				

]	Conduct detailed review of all patient discharge to ensure complete and adequate discharge teaching,
	prescriptions, follow-up care, or need for re-admission.

Demobilization Procedures				
	Complete appropriate demobilization documentation.			
	Maintain communications with all assigned personnel to ensure that demobilization is occurring and address any issues (such as injuries, claims, equipment shortfalls, and supply or facilities issues).			
	Ensure that all equipment and supplies utilized during the incident have been properly accounted for and have been demobilized.			

# Appendix J Standard Operating Guides



# Hospital Evacuation and Transportation Plan Standard Operating Guides

#### 1.0 References

St. Louis Regional Hospital Evacuation and Transportation Plan

### 2.0 Purpose

The purpose of this standard operating guide is to provide specific procedures for notification and activation of the Hospital Evacuation and Transportation Plan as well as the Patient Triage requirements for safe and efficient patient evacuation.

### 3.0 Scope

The following guide will provide recommended actions for notification and activation of the Hospital Evacuation and Transportation Plan in support of a localized or regional incident or in support of any event that results in a request for immediate or rapid evacuation of a hospital or appropriate medical facility. In addition, this guide will provide general triage prioritization guidance.

#### 4.0 Definitions

**Request for Activation:** This is when the St. Louis Medical Operations Center (SMOC) Duty Officer receives a request and mission tasking from a Hospital Command Center (HCC) for Medical Facility Evacuation assistance. The formal request and mission tasking usually occurs after the affected facility has consulted with the SMOC, or has contacted local EMS resources for assistance.

**Activation:** This is the process of establishing evacuation operations and deploying Emergency Medical Services (EMS) Transportation assets and overhead personnel.

**Triage:** For the purposes of evacuation, triage is the process that identifies patients into red, yellow, and green categories to ensure patients are evacuated and tracked in a manner that provides for the greatest good to the greatest number of patients and to help provide for safe and efficient patient transfer.

#### 5.0 Procedures

#### 5.1 Notification

When a hospital or medical treatment facility experiences a situation where conditions require immediate or rapid evacuation of the facility, they will contact the SMOC Duty Officer on-call, and/or contact local 911 Dispatch. The SMOC Duty Officer or 911 Dispatcher will contact the

EMS Liaison to the SMOC (EMS LNO) who is identified on-call. They EMS LNO will begin to roster EMS transportation resources and overhead personnel required to support the evacuation request. The EMS LNO will maintain communication with the SMOC Duty Officer and provide routine updates. The SMOC Duty Officer may elect to activate the SMOC.

#### 5.2 Activation

When the SMOC Duty Officer, the Hospital Incident Commander and the EMS LNO determine that significant resources will be required to facilitate evacuation of one or more facilities, Ambulance Strike Teams, medical ambulance buses, para-transit vehicles, and other appropriate medical transportation platforms will be activated using existing regional and statewide mutual aid agreements.

Once a formal request for evacuation resource activation occurs, the SMOC Duty Officer convenes a conference call with the emergency contacts or liaison officers from the participating healthcare facilities to determine which facilities can accept patients. Simultaneously, the EMS LNO is tracking resources committed to the evacuation and establishing a system of staging and coordinated evacuation using assigned personnel.

#### 5.3 Triage

An evacuating facility is faced with a significant challenge of moving patients in a manner that provides the greatest good for the greatest number of patients. This is generally accomplished by ranking patients into three categories: red, yellow, and green.

Experience clinical personnel will be responsible for patient assessment and triage categorization, which will dictate the priority and method for transfer from the evacuating facility. The triage determination should be left with the patient for all personnel to reference until the patient is loaded onto a transport resource and should be completed prior to beginning patient movement. Triage categories may be updated by the Patient Triage and Tracking Managers, as needed.

Patient clinical assessment and situational needs may supersede triage guidelines; however, general triage principals, which are inversed from those used a mass casualty incident, are as follows:

Evacuation Group	Triage Level	General Patient Descriptions
1st	Green	Patients that require transfer but are ambulatory, require minimal care and assistance from medical personnel. Patients are able to travel in groups with minimal medical personnel (e.g., buses, para-transit, vans).
2 <sup>nd</sup>	Yellow	Patients that requires some assistance due to medical equipment, therapies, isolation, or patient care requirements. These might include non-ambulatory patients, wheel chairs, step-down units, etc.
3rd	Red	Patient that require constant medical supervision or intervention or those in high-risk patient types, including ICU, neonates, elderly, and those with life-saving interventions (e.g., ventilator, medical gas, or vacuum dependent).