



EVACUATION AND
TRANSPORTATION PLAN
GUIDANCE

2022

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1. Introduction

1.1 Evacuation and Need for Planning

Evacuation and transportation of patients, residents, staff, and medical resources from a healthcare facility is a difficult task at best, and has unfortunately been a repeated operation conducted nationally in the past 30 years due mainly to effects caused by large-scale disasters such as hurricanes, wildfires, earthquakes, and other severe weather. Facility fire, rising rivers, levy breach, bomb threat, and a chemical plant explosion have also resulted in healthcare facility evacuations.¹

The challenges of evacuation and transportation of a healthcare facility are complex and nuanced, and any level of evacuation inherently puts patients at risk even in best case scenarios. As such, the decision to evacuate should be made with the utmost care and consideration.² Due diligence in evacuation and transportation planning should help facilitate a sound evacuation if the need arises. This plan was developed with input from BBHCC member plans, as well as State and Federal guiding documents and resources.

This document serves as guidance for the development and updating of evacuation and transportation plans for BBHCC Members. This document does not supersede any applicable laws or statutes, or authorities, plans, or procedures of participating entities.

1.2 The Big Bend Healthcare Coalition

The Big Bend Healthcare Coalition (BBHCC) forms a broad collaborative network of healthcare and support organizations and their respective public and private sector response partners. The goal of the BBHCC is to facilitate integration, collaboration and coordination of healthcare organizations in the Big Bend region for emergency preparedness, response and recovery.

BBHCC has over 100 member organizations from eight counties: Taylor County, Jefferson County, Madison County, Leon County, Wakulla County, Gadsden County, Franklin County, and Gulf County. The BBHCC encompasses a region that is overwhelmingly rural, with Leon County having the largest municipality in the city of Tallahassee, largest population, and largest number of resources. The estimated population of the combined eight counties per the April 1, 2020 to July 1, 2021 census data is 452,814 residents.³

The types of healthcare facilities within the BBHCC include assisted living facilities, nursing homes, clinics, dialysis centers, community health centers, and hospitals. Facilities serve anywhere from less than a dozen patients/residents up to several thousand patients/residents annually.

¹ (Zane, 2010)

² *ibid*

³ (United States Census Bureau, 2022)

The two largest hospitals in the region are Tallahassee Memorial Hospital and Hospital Corporation of America (HCA) Florida Capital Hospital, and are both based in Tallahassee in Leon County. Both hospitals regularly treat patients from surrounding counties, including those in Southern Georgia.

1.3 BBHCC 2022 HVA and JVA Findings

Florida is susceptible to a wide variety of hazards that could potentially disrupt the day-to-day operations of the critical healthcare infrastructure and system. Acute events or targeted attacks could threaten individual or small groups of facilities; hurricanes, severe storms, or wildfires may rend sections of entire counties or regions inoperable for extended periods of time.

Two recent major hurricanes – Hurricane Irma in 2017 and Hurricane Michael in 2018 – have dealt devastating blows to the state of Florida, and their widespread effects did not spare the healthcare system. Their implications for sound evacuation and transportation plans for the full range of healthcare facilities are far-reaching and help inform the need for these guidelines.

Evacuation plans should consider a Hazard Vulnerability Analysis as a key facet of Evacuation planning.⁴ The 2022 BBHCC Hazard Vulnerability Assessment (HVA) and Jurisdictional Risk Assessment (JVA) posit several important findings that may be used when developing Evacuation and Transportation Plans for members within the region. These findings were synthesized from the Public Health Risk Assessment Tool (PHRAT) of each member county, and are summarized in the following table:

Top Risks	Top County Capability Gaps	Top Resource Readiness Gaps
Tropical Cyclones	Volunteer Management	Storm Surge
Storm Surge	Fatality Management	Nuclear Attack
Extreme Heat	Mass Care Coordination	Mass Casualty Incidents
Extreme Cold	Community Preparedness	Wildfires
Flood	Responder Health and Safety	Radiological Incidents – Fixed Facility
	Public Health Lab Testing	
	Emergency Public Information and Warning	
	Medical Surge Capability	

Table 1: 2022 BBHCC HVA & JRA Summary

⁴ (Florida Department of Health, 2011)

BBHCC members have been affected in recent years by hazards such as Hurricane Hermine (2016), Hurricane Irma, Hurricane Michael, wildfires, tornados, and the COVID-19 pandemic.

2. Purpose and Scope

2.1 Federal Guidance

The U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR) leads the country in preparing for, responding to, and recovering from the adverse health effects of emergencies and disasters. This is accomplished by supporting the nation’s ability to withstand adversity, strengthening health and emergency response systems, and enhancing national health security.⁵

ASPR’s Hospital Preparedness Program (HPP) enables the health care delivery system to save lives during emergencies and disaster events that exceed the day-to-day capacity and capability of existing health and emergency response systems. HPP is the only source of federal funding for health care delivery system readiness, intended to improve patient outcomes, minimize the need for federal and supplemental state resources during emergencies, and enable rapid recovery. HPP prepares the health care delivery system to save lives through the development of health care coalitions (HCCs) that incentivize diverse, and often competitive, health care organizations (HCOs), which have differing priorities and objectives, to work together.⁶

Capability 3 set forth by ASPR in the 2017-2022 Health Care Preparedness and Response Capabilities is as follows:

Capability 3: Continuity of Health Care Service Delivery

Health care organizations, with support from the HCC and the state’s/jurisdiction’s ESF-8 lead agency, provide uninterrupted, optimal medical care to all populations in the face of damaged or disabled health care infrastructure. Health care workers are well-trained, well-educated, and well-equipped to care for patients during emergencies. Simultaneous response and recovery operations result in a return to normal or, ideally, improved operations.

2.2 Continuity of Operations

Continuity of Operations (COOP) is the “internal effort of an organization to assure that the capability exists to continue essential functions and services in response to a comprehensive array of potential emergencies or disasters...[it] is an effort to ensure that Primary Mission-Essential Functions (PMEF) continue to be performed during a wide range of emergencies, including localized acts of nature, accidents, and technological or attack-related emergencies.”⁷

A summary of hazard examples for acts of nature, technological, and human-caused are shown in the following table:

⁵ (U.S. Department of Health and Human Services, 2020)

⁶ Ibid.

⁷ (Federal Emergency Management Agency)

Natural	Technological	Human-Caused
Hurricane	Dam Failure	Active Shooter Incident
Tornado	Hazmat Release	Cyber attacks
Epidemic	Pipeline Explosion	Chemical Attack
Flood	Train Derailment	Explosive Attack
Drought	Radiological Release	Biological Attack
Wildfire	Industrial Accident	Radiological Attack

Table 2: Example Threats and Hazards by Category (Department of Homeland Security, 2018)

Phase 2 of COOP activation as it pertains to Capability 3 set forth by ASPR includes relocation (evacuation and transport) of personnel, records, and equipment to an alternative facility⁸ – that is, a facility at which the aforementioned PMEF may be carried out and patients/residents may continue to receive the medical care they need. HCC’s were directed to write an Evacuation and Transportation Plan and integrate it into their Coalitions.

3. Assumptions and Planning Considerations

The following assumptions and planning considerations serve as the basis for this document:

1. Most licensed health care facilities in Florida are required by statute or rule to have an approved Comprehensive Emergency Management Plan (CEMP) that must include evacuation and sheltering policies, procedures, responsibilities, and actions.⁹ These evacuation and sheltering policies, procedures, responsibilities, and actions within a facility’s CEMP are what facilities should adhere to in the event of evacuation.
2. Emergency or disaster situations may require evacuation and/or transport of a facility or multiple facilities in a municipality, county, or multiple counties within the region.
3. The BBHCC region is heavily rural, and counties may not be able to support themselves without aid from neighboring counties and/or State resources.
4. A regional Hazard Vulnerability Analysis (HVA) and Jurisdictional Risk Assessment (JRA) has been conducted that identifies threats and gaps. The BBHCC HVA and JVA are summarized on page three; facilities are responsible for completing their own specific HVA.
5. An evacuation may require substantial resources for transportation and communication. Facilities are responsible for identifying and securing these resources as warranted.

⁸ Ibid.

⁹ (Administration, Agency for Healthcare, 2022)

6. Receiving facilities may be necessary for certain facility types; securing Memorandums of Agreement (MOA) or Memorandums of Understanding (MOUs) for receiving facilities, transportation services, and supply of necessary resources are the responsibility of the evacuating facility.
7. Large scale disasters may require the evacuation of every type of facility previously mentioned as being members of the BBHCC.
8. Sufficient advanced warning may or may not be available prior to the need to evacuate and transport patients/residents.
9. The timeline for successful evacuation and implementation of COOP plans will vary depending on the facility type, size, resource availability, needs of patients/residents, and geographical location.
10. Some facilities may have policies that require family or other guardians to collect and assume responsibility for patients/residents.
11. Some patients/residents may require transport via specialized vehicles such as ambulances, wheelchair-lift equipped vehicles, etc.

4. Concept of Operations

4.1 Evacuation Types and Decision Making

Evacuation types may be split into two categories: pre-event and post-event evacuations. Pre-event evacuations will occur in advance of an impending non-spontaneous disaster, that is, an emergency or disaster situation in which there is sufficient advanced warning of a threat. Post-event evacuations will occur in the wake of a non-spontaneous or spontaneous disaster, when there was little to no advanced warning (spontaneous), or when a non-spontaneous disaster has caused substantial damage or otherwise impeded the ability of the facility/agency to carry out their PMEFs.¹⁰

Pre-event evacuation decisions¹¹ will be influenced by the nature of the event, as well as the guidance and/or declarations made by local officials. As the event begins its onset and conditions deteriorate, the opportunity for a safe and effective evacuation will begin to diminish¹². Ultimately, it will be the decision of the designated position or positions at a facility to initiate an evacuation at a certain specified threshold.

Post-event evacuation decisions¹³ will mostly be determined by an assessment made of the facility following the event, and whether that assessment confirms or rejects the ability of the

¹⁰ (Zane, 2010)

¹¹ A flowchart depicting Advanced Warning Evacuation Decision Making is available in Appendix A

¹² (Zane, 2010)

¹³ A flowchart depicting No Warning Evacuation Decision Making is available in Appendix A

facility to continue its operations in a safe environment. It is worth noting that a post-event evacuation may be warranted even if the facility itself is safe and operable, but is unable to be supported by other critical infrastructure that was rendered inoperable due to the event. ¹⁴

4.2 Evacuation Timeline and Considerations

Several of the actions established by the Florida Agency for Healthcare Administration (AHCA) for CEMP's¹⁵ should be noted for Evacuation and Transportation planning purposes. Although presented in a sequential manner, it is likely that there will be multiple of the following actions taking place simultaneously. The following are brief summaries of key points:

1. *Notification of Event* – The facility is made aware of a non-spontaneous or spontaneous event that is threatening or may threaten their facility and/or their ability to carry out normal medical operations.
2. *Notification to Staff* – The designated position responsible for communications make the proper internal personnel aware of the situation, and to take immediate action to protect lives if the situation warrants. Prior planning should indicate who is sending the notification, to whom it is being sent, and the method by which it will be sent. Pertinent information on both the situation and enactment of internal policies – such as placing all staff on emergency call during the event period – should also be relayed.
3. *Decision Making Point* – The facility position in charge of initiating evacuation makes the decision to evacuate, monitor, or shelter-in-place.
4. *Notification of Evacuation* – Notifications are made to staff, patients/residents, and their families as denoted in the facility plan.
5. *Enactment of MOUs/MOAs* – Understandings or Agreements previously made with receiving facilities, transportation services, and resource supply are enacted.
6. *Patient/Resident Transportation Preparation* – The facility goes through its processes and procedures to prepare for the transportation of patients. Actions may include patient rosters and tracking methods, gathering necessary medication, securing any special equipment needed to keep patients stable in the transport process and at the receiving site if it will not be provided, and the movement of patients/residents to the transportation staging area.
7. *Patient/Resident Transportation and Arrival at Alternative Site* – Patients/Residents are transported to the receiving site via the predetermined evacuation route and are set up to receive the best standards of care possible for the duration of their stay.

¹⁴ Ibid.

¹⁵ (Administration, Florida Agency for Healthcare, 1994)

8. *Home Facility Inspection* – Following the event and when it is safe to do so, an inspection of the home facility is made to determine its state and whether it can support regular operations. In the event it cannot, the proper contacts are made for rebuilding and repair to get back to a point of being able to sustain normal operations if possible.
9. *Supply Chain Assessment & Resource Availability* - Prior to transporting patients/residents to the home facility, the necessary communications should be made to assess the current flow of the supply chain that provides the facility with the resources they need to carry out normal operations.
10. *Patient/Resident Transport to Home Facility* – The decision is made to transport patients/residents' home. The general steps for this process are similar to those made in the initial evacuation.
11. *Return to Normal Operations* – The facility is able to return to its regular operations and standard of care.
12. *After-Action Report and Plan Updates* – When able, the facility administration and staff should review the series of events and update plans if warranted.

4.3 Further Considerations

There are three more important considerations that should be made when creating an Evacuation and Transportation plan that are often overlooked in the planning process and during evacuation operations alike that will be discussed briefly. They are estimated evacuation times, evacuation routes, and available resources.

Evacuation times refer to the total amount of time needed to safely get patients/residents out of the facility and staged for transport with necessary records and supplies, plus the actual time needed for transport to the alternative or receiving site.¹⁶ With pre-event evacuations, extra attention should be given to evacuation and transportation limitations imposed by the event. For example, larger facilities are unlikely to be able to evacuate and transport in a matter of hours before tropical storm force winds set in on the leading edge of a hurricane, whereas that timeline may be feasible for smaller facilities.

Pre-determined evacuation routes should be closely considered in both planning for evacuation and in an actual evacuation scenario, and are a large factor in the time needed to transport patients/residents.¹⁷ In cases of large-scale threat, traffic will likely be abnormally congested on main roadways, highways, and interstates. When determining an evacuation timeline, this facet

¹⁶ (Zane, 2010)

¹⁷ Ibid

should be closely monitored and may very well cause a shift in evacuation and transportation timeline and process.

Resources – including staff, transportation services, fuel, pharmaceuticals, and specialized equipment - that planning assumes will be available can become scarce prior to or immediately following an emergency or disaster event.¹⁸ For a number of reasons, any or all of these resources may not be available in the amounts needed. Contingencies and redundancies for critical resources needed should be discussed and planned for as best as possible.

¹⁸ (Zane, 2010)

Appendix A.

**Figure 1.
Advanced Warning Event Evacuation Decisions**

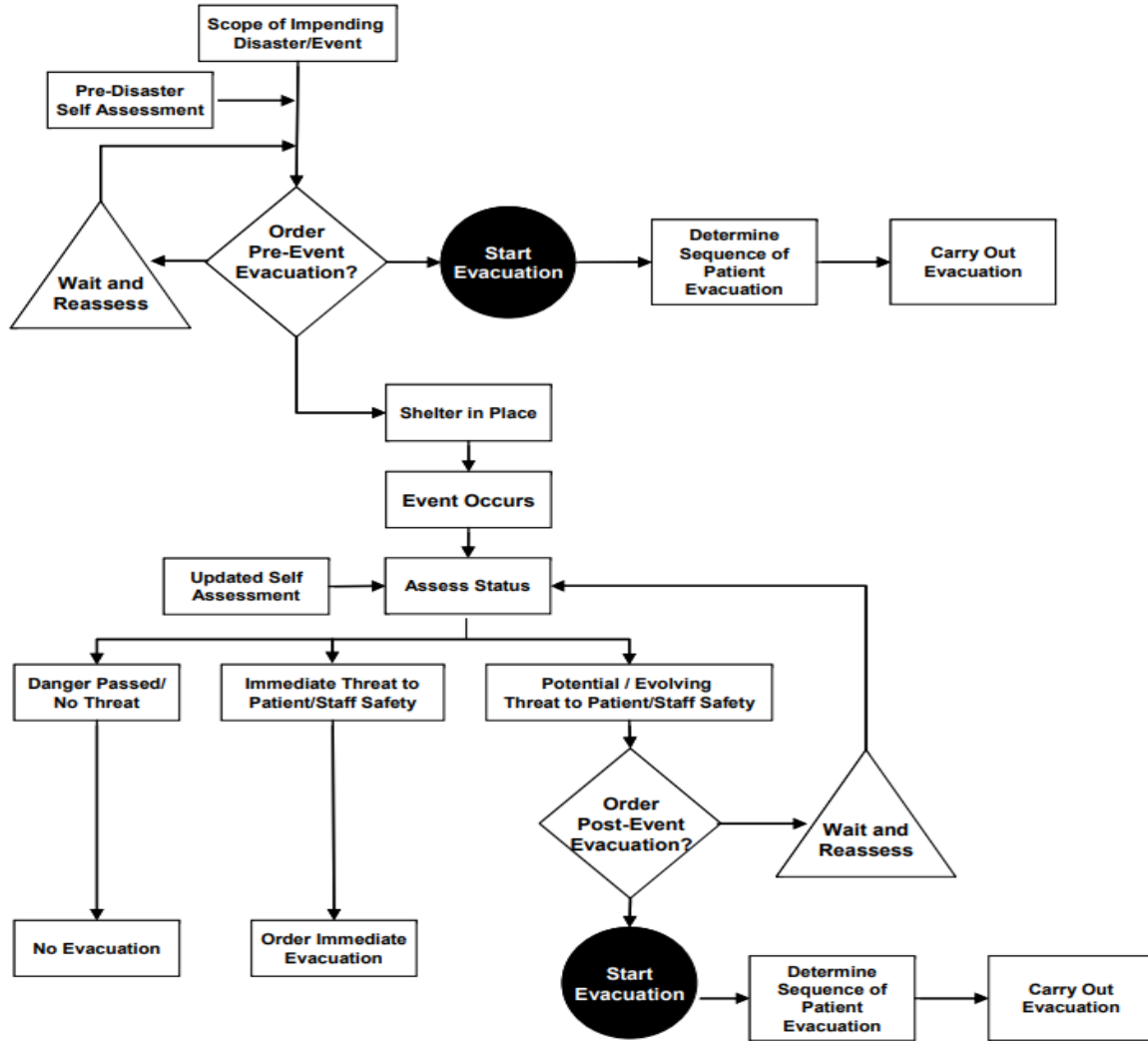


Figure 1 Advanced Warning Event Evacuation Decisions (Zane, 2010)

Appendix A.

**Figure 2.
No Advanced Warning Event Evacuation Decisions**

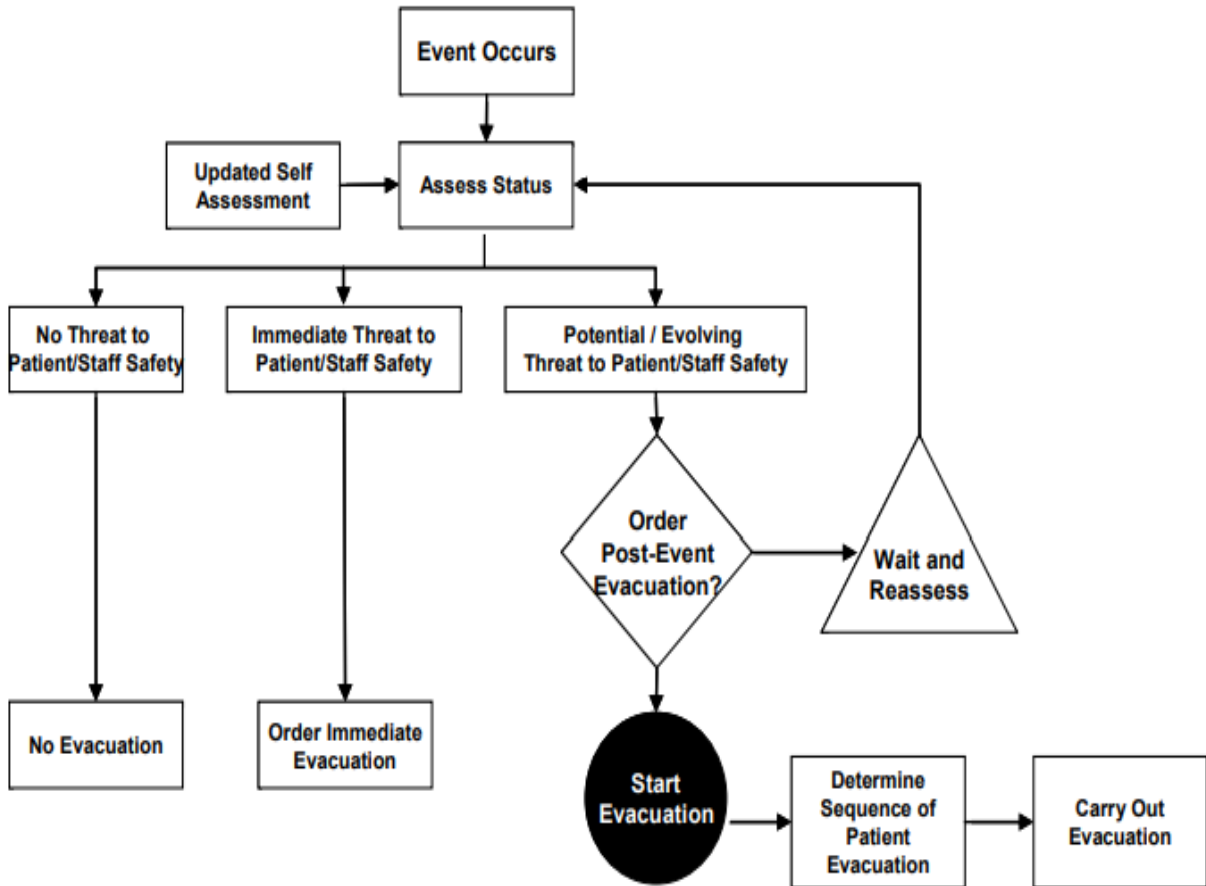


Figure 2 No Advanced Warning Event Evacuation Decisions (Zane, 2010)

Appendix B

Evacuation and Transportation Planning Support Resources

Agency for Healthcare Administration (ACHA) Emergency Preparedness Resources. Checklists for all current Comprehensive Emergency Management Planning Forms can be found towards the bottom of the page: https://ahca.myflorida.com/mchq/emergency_activities/index.shtml

Agency for Healthcare Research and Quality. Hospital Evacuation Decision Guide: <https://archive.ahrq.gov/prep/hospevacguide/hospevac.pdf>

Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE). Plans, tools, and templates for Hazard Vulnerability Analysis: <https://asprtracie.hhs.gov/technical-resources/3/hazard-vulnerability-risk-assessment/1#plans-tools-and-templates>

ASPR Tracie. Florida Department of Health Hospital Evacuation Toolkit: <https://asprtracie.hhs.gov/technical-resources/57/healthcare-facility-evacuation-sheltering/0#plans-tools-and-templates>

ASPR TRACIE. Hospital Continuity Planning Toolkit: <https://www.calhospitalprepare.org/continuity>

ASPR TRACIE. Continuity Planning for Long Term Care and Skilled Nursing Facilities. The document is the third one down from the “Non-Hospital Setting Continuity Planning” header: <https://asprtracie.hhs.gov/technical-resources/17/continuity-of-operations-coop-business-continuity-planning/110#non-hospital-setting-continuity-planning>

ASPR TRACIE. Topic Collection - Healthcare Facility Evacuation/Sheltering: <https://asprtracie.hhs.gov/technical-resources/57/healthcare-facility-evacuation-sheltering/0>

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