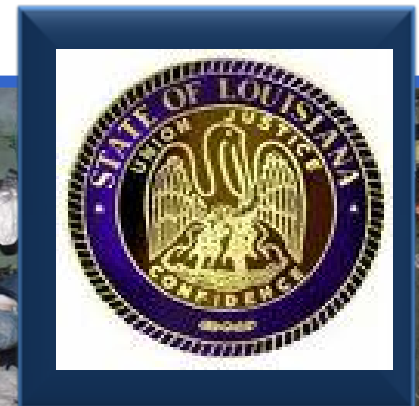




Medical Institution Evacuation Plan

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Catastrophic Planning

- How do you RELOCATE entire hospitals?
- How would you evacuate MULTIPLE hospitals concurrently?
- How many ambulances and aircraft are needed to relocate and successfully transfer patients to other hospitals in the nation?

Objectives

- To provide an overview of the Medical Institution Evacuation Plan (MIEP) – including assets required, timelines, command/control and communications procedures.
- To provide a working knowledge of hospital specific planning issues
- To provide exportable lessons learned, articulate barriers and to provide an overview of corrective actions from functional exercises and drills.

Which areas are vulnerable?



Out of the 35 Parishes within the six coastal regions, only 12 Parishes are vulnerable to storm surges:

Calcasieu
Cameron
Vermillion
Iberia

St. Mary
Terrebonne
Lafourche
St. Tammany

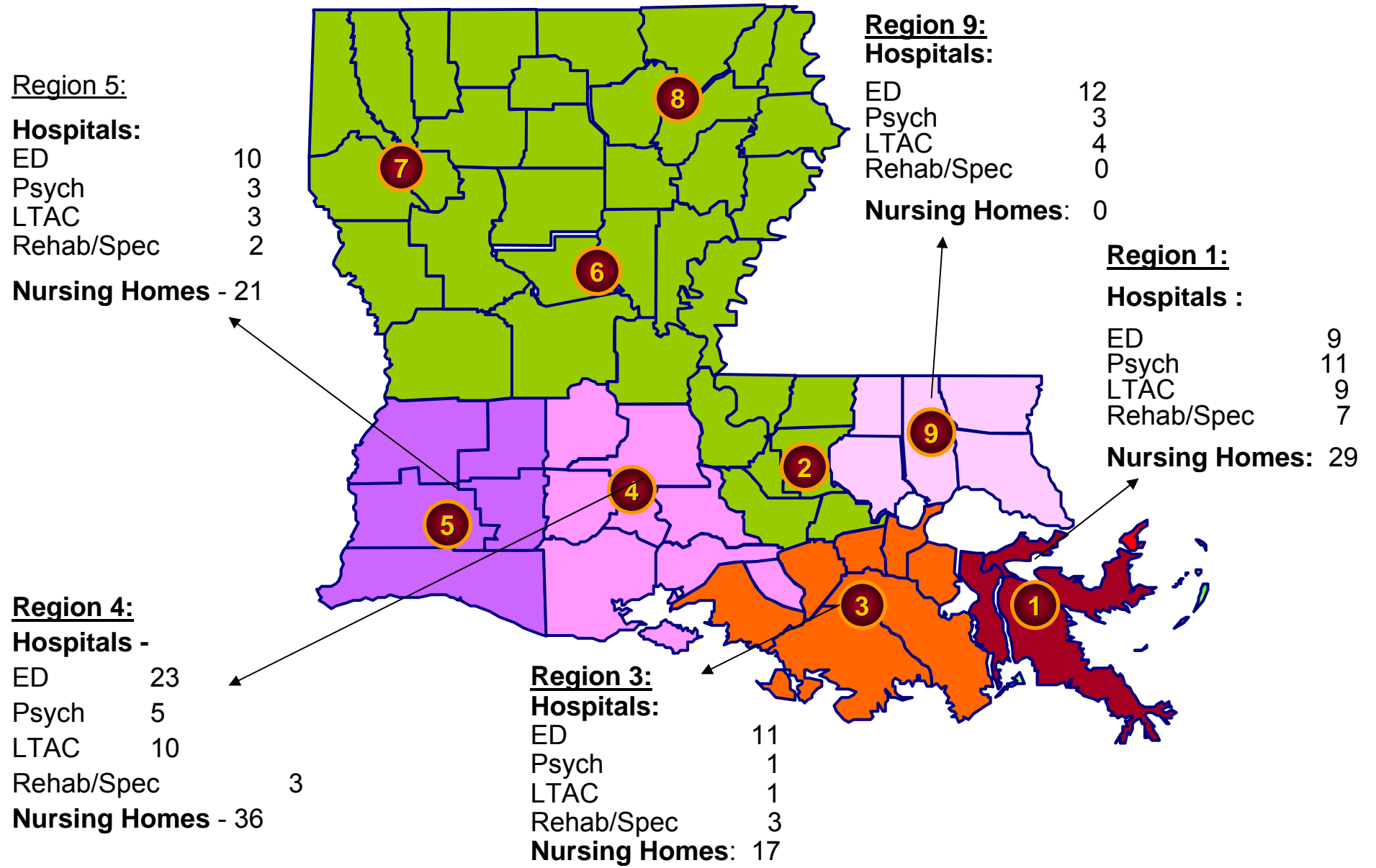
Jefferson
Orleans
Plaquemines
St. Bernard

Evacuation and Sheltering

*12 Coastal High Risk Parishes
65 hospitals*

- Initial Planning Expectation: ALL Hospitals evacuate with storm in the Gulf
- “Realistic” Expectation: blend of both SIP and EVAC
 - Sheltering In Place (SIP) – what resources are needed prior to and immediately following to support patients, staff, and guests?
 - Evacuation (EVAC) – what resources are needed to evacuate multiple hospitals concurrently?

How many patients need to be evacuated???



Volume Throughput

Number of Parishes: 12

Number of Hospitals w/ ED: 65

POTENTIAL THROUGHPUT:

Upper: 1000

Lower: 340

WORST CASE SCENARIOS:

<u>Tier III</u>	<u>Tier II</u>	<u>Total Tiers II and III</u>
Regions 1, 3, 9: 334	Regions 1, 3, 9: 729	= 1063
Regions 3 and 4: 85	Regions 3 and 4: 258	= 343
Region 4 and 5: 250	Region 4 and 5: 374	= 624

Patient Movement - Facts

- Medical institutions are responsible for having evacuation plans, including contracts or agreements in place to execute them. However, large-scale medical evacuation of an entire Region or multiple Regions will require private, local, State, and Federal assets to accomplish the mission.
- Individuals with special medical needs have the responsibility to self-evacuate whenever possible.
- Those who cannot self- evacuate will require assistance from the County/Parish or other local entities.
- If the local government is overwhelmed by the demand for medical evacuation, assistance from the State and Federal ESF 8 partners will be required.
- State and Federal assistance includes those elements required to successfully execute a medical evacuation and sheltering plan

Patient Movement - Facts

- Hospital CEO(s) as well as County/Parish Officials determine when mandatory evacuation of a facility will occur
- Medical Evacuees will remain within the State and/or Region to the greatest extent possible
- Medical evacuation has priority over general population
- TRANSCOM will provide support IAW the aeromedical evacuation CONOPS
- Non - NDMS patients will be evacuated by privately owned, local, State and Federal air and ground assets which include:
 - Ambulance
 - Buses
 - Para-transit Vehicles
 - Privately contracted services
 - Federally contracted helicopter and fixed wing aircraft
 - State owned aircraft (National Guard)
 - DoD (requires separate MA)

Assumptions

- The State Governor will begin the H-120 hrs actions (H=Tropical Storm Force Winds touching the coast) if it appears that his/her State is in jeopardy and will declare a State Emergency.
- Decision to evacuate will be made in a timely manner to allow execution of the evacuation plan
- The State is responsible for pick up and transportation of medical evacuees to the local departure airfields
- The President, at the request of the Governor, will make a pre-storm Emergency Declaration.
- State will provide an incident commander at each departing airfield.
- Patient movement to and from airheads and medical treatment facilities will be accomplished by a consortium of local, state and federally contracted assets.
- Alerted FCCs will have their respective patient reception operations fully functional and will coordinate the ground evacuation to NDMS participating hospitals.

Request Support and Pre-positioning of Assets

- The State declares an emergency and request a pre-incident declaration from the President
- Hospitals request assistance to evacuate
- The State notifies FEMA that Federal assistance is required
- FEMA passes MA and RFA to appropriate agencies (HHS, VA, DoD)
- Assets are pre-positioned or activated in anticipation of execution:
 - FCC are alerted and activated
 - Bed reporting initiated
 - DMATs prepositioned
 - The Federal Ambulance Contract is activated and assets are positioned in staging areas and airfields
 - DoD resources/personnel positioned (DCE, MASF, AE Crews, CCATTs, AELT Liaisons, JPMT)

Federal Medical Evacuation Movement

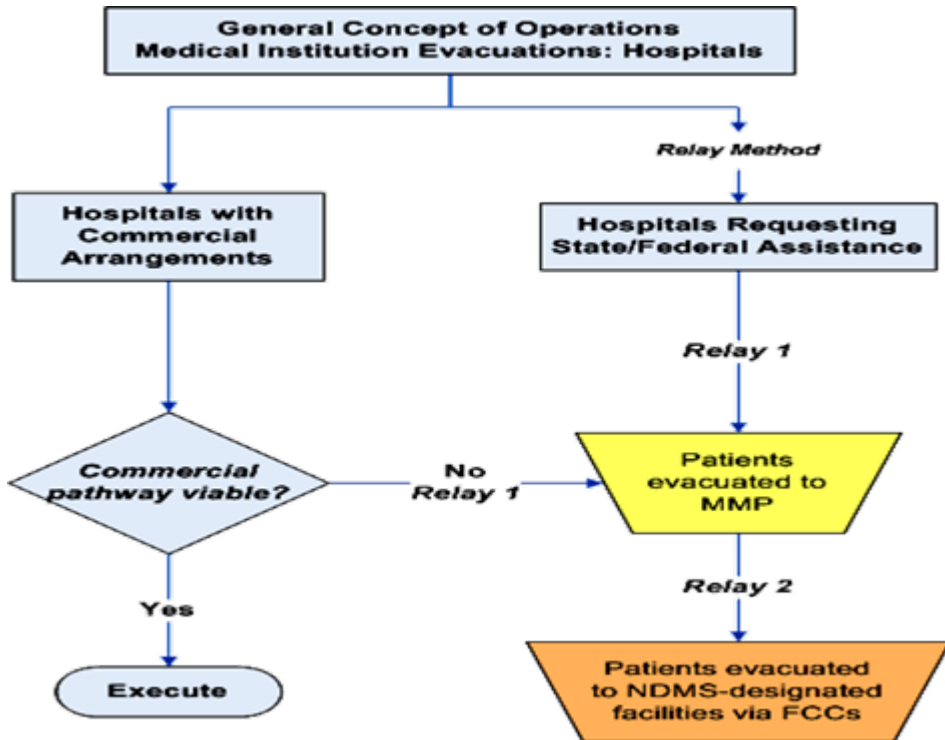
Upon a presidential declaration and/or approval of the MA/RFA, the Federal Government conducts medical evacuation of hospitalized patients and special medical needs population from designated airports and Patient Collection Points.

- Aeromedical evacuation of hospital patients will most likely be conducted through NDMS
- GPMRC will determine which FCCs have sufficient beds available to meet the demand and the acuity of the patients NLT H-54.
- The first load of NDMS patients departs from the DoD aircraft to designated FCCs NLT H- 48.
- State NG maybe tasked to evacuate non NDMS patients but will require significant DOD support

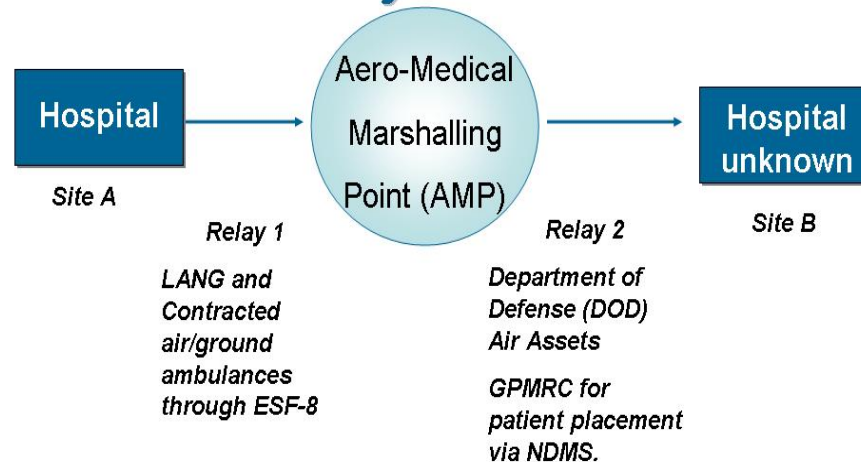
Support Personnel Evacuation

- Federal air evacuation ends at H-12 (H-Hr = Tropical Storm force winds reach the coast)
- Withdrawal of State and Federal personnel evacuation support personnel begins at H-12 and continues through H-Hour
- All personnel and essential equipment withdrawn by air and marshaled in areas outside the threat zone and prep for re-entry into the impacted area

Concept Of Operations



Safety-Net Plan



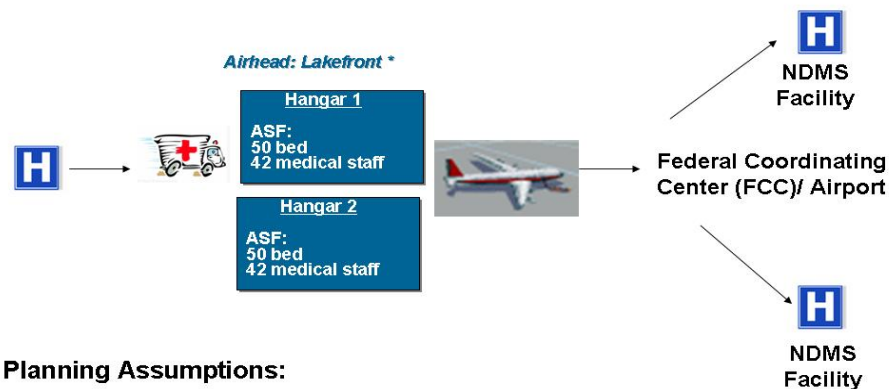
CONOPS: Where are the AMPs?



Aero-Medical Marshalling Point (AMP)

Air Medical Staging Facility Teams:

ROLE: "man" hangars and prepare patients for air transport
RESPONSIBILITY: DOD/NDMS



Planning Assumptions:
50 patients per C-130

Federal Coordinating Centers

- Coordinate NDMS Definitive Medical Care in assigned local areas
- Solicit and Organize Community Support Services (ambulance and other emergency service support)
- Enroll Non-Federal Local Hospitals in NDMS
- Coordinate Bed Availability
- Coordinate with Local / State Authorities on:
 - Local Patient Reception Plans
 - Annual Exercises
 - Operations During Activation
 - Reception and distribution of patients from impact areas to local hospitals



▲ Army FCC
 ■ Navy FCC
 ▲ Air Force FCC
 ◆ VA FCC

● Denotes which FCC(s) were Activated for Hurricane Dean and would likely be activated for a Gulf Coast event

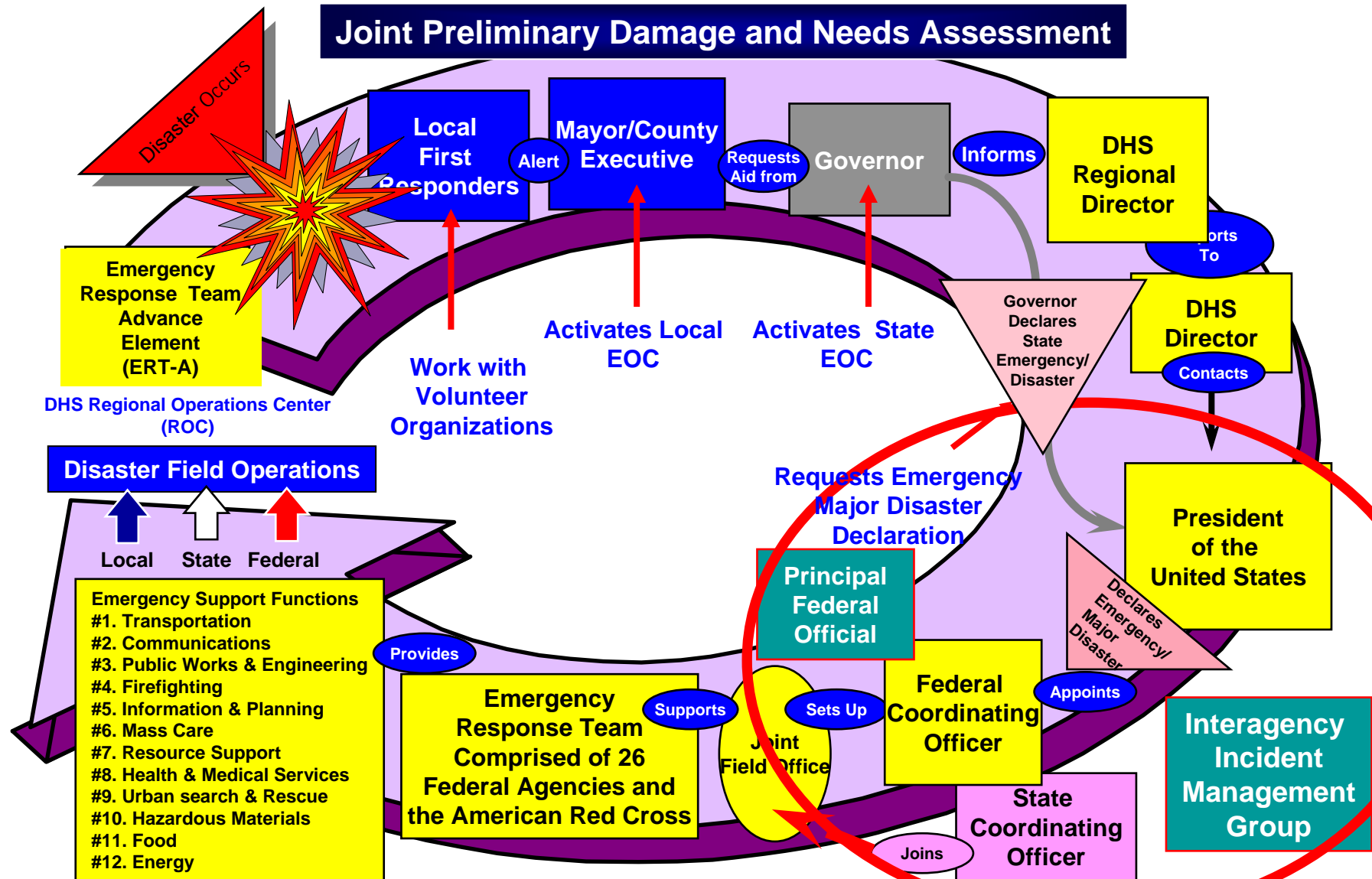
- There are 4 NDMS Reception sites in Texas: Dallas, San Antonio, Houston (all 3 VA), and El Paso (DoD)
- Each FCC is coordinated differently based on reception site capabilities and limitations; as well as local political considerations
- FCC's follow the NDMS guidelines to determine reception site locations and supporting medical capabilities
- Each FCC is run as a joint effort with local responders who serve in roles as:
 - Patient Reception Team members
 - Command and Control
 - Hospital Coordination
 - Local EMS Transportation
- Each FCC conducts local training at the reception site and is required to conduct a reception exercise (or actual reception) once every 3 years.
- Upon arrival of patients at reception site:
 - Patient reception team leader receives a manifest and medical briefing from the aircraft medical director
 - Patients are off-loaded, triaged and staged pending further regulating and ground transport to a local NDMS hospital
 - FCC directors track patients final destination and transmit that information to ESF 8 at the sending-State EOC

Abbreviated Timeline

H-hour:

- **120: Lean Forward!** Email alerts, notifications distributed, communications check
- **72 : Flag goes up!** All levels of government (local, state, federal) must watch this storm and be ready to mobilize an AMP. Form 1 is used to identify potential volume of patients so that number of aircraft can be estimated and organized for potential activation.
- **72- 54 Continuous updates to Form 1.** Refinement of data as threat becomes more imminent. Based on the direction and threat of the storm, AMP(s) are activated.
- **54: “No-kidding” numbers are ascertained.**
- **48: Wheels-up!** The first load of patients should be enroute to FCC
- **18: Clearing the Battlefield.** A meter-check is determined to see how many patients still require evacuation. This is the last chance to make any corrective actions. SMART listing identified.
- **12: AMPs CLOSED**

Extensive and Intensive planning required. Conduct your planning meetings NOW.



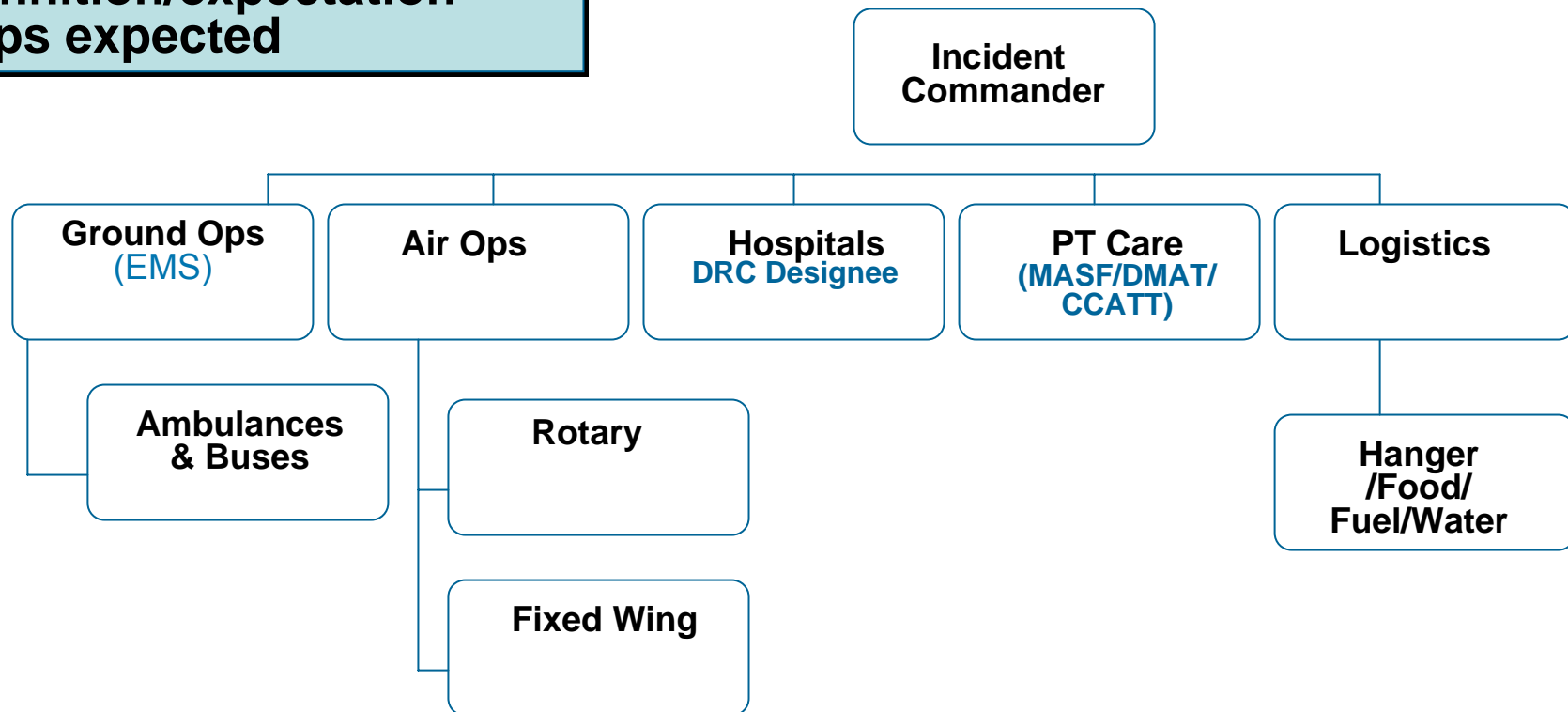
Communication Challenges

- ...The AMP has a MOG of 4...
- The tail will have lift-off at
- What do you mean by hyperbaric patient?
- GPMRC
- FCC
- CASF, MASF

Establish Clearly identified Command Structure at AMP. Patient movement cannot be marshaled off-site.

- Multiple resources
- Multiple agencies
- Definition/expectation gaps expected

Medical Marshalling Point Command Structure



Ground Transportation Resources are critical to secure in contractual arrangements

- Coordinate with ESF-1 Transportation for buses.
- Coordinate/ secure a dedicated number of ambulances to shuttle patients from hospital to AMP. (Planning factor: minimum of 50 per AMP)

Vet the Plan at all levels. Then hold your ground...

- High visibility project with multiple moving parts and uncertain variables.
- Manage expectations through engagement with planners at all levels (multiple meetings).
- Establish timelines, decision points, operational plans.
- Identify and articulate process algorithms.
- Exercise, exercise, and drill plans
- Then drill some more...

Hospital Issues

- When did you say we have to evacuate?? Is there a policy on that?
- Should we stay or should we go?
- Patient Definitions
- ANOTHER meeting?
- GPMR Who?

Hospitals: Should we stay or should we go?

- Decision made by the hospital depending on perceived threat of the incident
 - Governing Board
 - Medical Staff
- Mandatory evacuation – what does it mean?
- Reconfirm evacuation assets early
- Communicate decisions early and clearly

Hospitals: Sheltering in Place Issues

Hospital SIP primary concerns :

- 1) Staffing to support continued operations
- 2) Generators to support HVAC systems
- 3) Fuel for generators
- 4) Security

Shelter In Place

- Have a post-storm evacuation plan
- Hospitals that choose to SIP must plan to shelter a **minimum** of 36 to 48 hours.
 - ✓ Recommending 7 days of supplies
- Know resource requirements necessary to evacuate (patients, staff, and guests)

Hospitals: Communicate, communicate

- Know your ESF 8 linkages and their expectations
 - Local, Region, State
 - Federal
 - Region HHS linkage
 - Federal Coordinating Center
 - Department of Defense
 - Global Patient Movement Reception Center (GPMRC)
 - » Patient Definitions
 - » Patient Manifests

Partial Evacuation?

- Patient groups that should be closely evaluated for potential evacuation:
 - Neonatal ICU
 - Critical Care
 - Dialysis
 - Psychiatric

Patient Tracking Challenges

It's easy to lose Mama!

- Identify step-by-step communication process **IN ADVANCE**
- Identify redundant mechanisms
- Begin with evacuating hospital to final destination facility

Patient Movement Request

Hospitals fill White spaces

Originating Hospital:		Onload Airfield:			Julian Date:		Destination Airfield:		
MSN #:								TAIL#:	
Last Name	First Name, MI	Gender	ID No SSAN Bracelet No	Diagnosis	Litter / Ambulatory / Attendant	Ventilator Dependant ?	Electrical Dependant?	Cardiac Monitor?	CCATT
1		M / F			L / A / Att				
2		M / F			L / A / Att				
3		M / F			L / A / Att				
4		M / F			L / A / Att				
5		M / F			L / A / Att				

Green fields GPMRC will provide

Hospitals: Drill the detail

- Exercise, exercise, and drill plans
- Then drill some more...