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PUBLIC HEALTH
DIVISION

HHSA EMERGENCY OPERATIONS PLAN (EOP) – APPENDIX 12

HEALTHCARE EVACUATION PLAN

NAPA COUNTY HEALTH AND HUMAN SERVICES AGENCY (HHSA)

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1. INTRODUCTION

1.1. PURPOSE OF PLAN

The purpose of the Healthcare Facility Evacuation Plan is to serve as an operational guideline to facilitate the safe and orderly evacuation of healthcare facilities within Napa County. It outlines roles, responsibilities, concept of operations, action planning sequences, and other elements needed to preserve health and ensure patient safety and welfare during a healthcare facility evacuation.

Evacuation of a hospital or other healthcare facility is not a multi-casualty incident, and does not fall within the scope of the Napa County Multi-Casualty Incident Medical Response Plan.

This plan is congruent with the Napa County Sheriff's Emergency Evacuation Operation Procedures.

This plan uses the term "incident" to refer to the evacuation or possible evacuation of a health care facility. Inevitably, this incident may coexist with a separate incident, such as a wildfire or hazardous materials spill, which prompts consideration of evacuation.

1.2. PLANNING ASSUMPTIONS AND SCENARIOS

The evacuation of a healthcare facility (HCF) is a "worst case" situation. This document uses the term healthcare facility to include any licensed entity providing healthcare for patients or residents who stay overnight. This includes acute care hospitals, long term care facilities, and skilled nursing facilities such as Queen of the Valley, St. Helena Hospital, and the California Veterans Home-Yountville; it does not include ambulatory care clinics such as Clinic Ole.

For planning purposes, and based on likely hazards and vulnerabilities in Napa County, HCF evacuation would most likely occur in the following scenarios:

- Emergency (evacuation planning window less than two hours) due to wildfire, structure fire, or damage to buildings or infrastructure secondary to terrorism (e.g., bombing), hazardous materials release, or earthquake damage.

- Urgent (evacuation planning window greater than two hours) due to flood or fire.

This plan assumes HCF emergency operations plans (EOPs) cover the evacuation of patients from within the facility to a staging area outside of the facility, such as the parking lot. This plan focuses on the county's role in evacuation.

This plan takes an all-hazards approach to HCF evacuation. This means that this plan is not specifically oriented to evacuation due to wildfire, or to a terrorist attack. Instead, it provides a framework for response to all hazards.

The most likely scenarios to befall healthcare facilities in Napa County include:

- Wild lands fire forcing the evacuation of St. Helena Hospital or the California Veterans Home in Yountville.

- Earthquake damage or flooding impacting Queen of the Valley Medical Center.

- Terrorism affecting any facility.

- Fire, flooding, earthquake damage, and heat emergencies compounded by widespread power outages affecting long term care facilities.

- Hazardous materials incidents affecting any facility.

1.3. AUTHORITIES

In California, authority to order an evacuation rests with law enforcement (including sheriff's deputies and city police, as well as park rangers), the public health officer, and fire officials. All such officials have the authority under California Penal Code (section 409.5) to close an area, secure an area for a field command post, and order persons in the affected area to leave. The circumstances for such closures include menaces to public health or safety, including flood, storm, fire, earthquake, explosion, or other disaster.

The Health and Safety Code grants broad powers to Health Officers to promote public health or safety. Actions taken under this statutory authority are an exercise of police power as outlined in the U.S. Constitution, 5th and 14th Amendments and the California Constitution. Article 1, §§7, 15.

Health and Safety Code sections 101040 and 101080 support the local health officer's authority for declaring a state of emergency due to health threats such as toxic release and chemical agents.

Authority for patient health care management in an emergency, and the authority for establishing a unified command structure, appears in Health and Safety Code section 1798.6. Health and Safety Code section 1797.153 addresses the authority for the MHOAC in a planning role.

1.4. OBJECTIVES

The objective of this plan is to ensure the orderly and timely movement of patients/residents from single or multiple facilities which need to be evacuated to a safe location.

1.5. POLICIES

1.5.1. Unified incident command – It is the policy of Napa County that when contemplation or evaluation of HCF evacuation commences, and/or once a decision

is made to evacuate a HCF, the facility will be designated as an incident site. A unified incident command (IC) will be established at the facility, comprised of facility and public agency authorities (including emergency medical services, public health, fire, and law enforcement).

1.5.2. <u>Command and control</u> – Command of the HCF evacuation incident rests with the unified incident command at the evacuation site.

1.5.3. <u>Patient dispersal authority</u> – It is the policy of Napa County that control of patient dispersal during any HCF evacuation will be coordinated by the Medical Health Operational Area Coordinator (MHOAC) or her/his designee, in conjunction with facility officials and IC staff.

1.5.4. <u>Patient evacuation is not routine interfacility transfer</u> – It is the policy of Napa County that patient transfer from an evacuating healthcare facility to any receiving facility or site, including an alternate care site, is not a routine interfacility transfer, and thus is not to be governed strictly by the Coastal Valleys Emergency Medical Services Agency Interfacility Transfers policy. It is understood that many provisions of the Coastal Valleys EMS Agency Interfacility Transfers policy will need to be suspended to ensure the preservation of life and limb during an evacuation.

1.5.5. <u>Compliance with SEMS</u> – Healthcare facility evacuation will be conducted in compliance with SEMS.

2. CONCEPT OF OPERATIONS

2.1. Overview

The concept of operations (ConOps) for HCF evacuation in Napa County is to:

- Perform an initial situational assessment/data gathering;

- Ensure early communication between relevant initial incident commanders (e.g., fire, law enforcement, or health) and affected entities (e.g., MHOAC, relevant HCFs, relevant county agencies);

- Evaluate if and how quickly evacuation is needed;

- Develop an emergency evacuation plan;

- Implement that plan in an orderly fashion.

These steps – outlined below with greater detail – can be performed quickly, and are critical to a safe and effective evacuation. All of these elements are captured in Attachment A: HCF Emergency Evacuation Field Planning Guide.

2.2. ACTIVATION OF THIS PLAN

This plan may be activated by the MHOAC, the Napa County Health and Human Services Department Operations Center (HHSA DOC) director, or the Napa County Health Officer. Activation of this plan should be accompanied by activation of the HHSA DOC and a request for activation of the county area operations emergency operations center (AO EOC).

2.3. CONCEPT OF OPERATIONS IN DETAIL: SIX STEPS TO A SAFE HCF EVACUATION

HCF evacuations may be emergent (required in a minutes-to-hours time frame) or urgent/planned (unfolding in an hours-to-days time frame). The concept of operations and process outlined below applies to both, but differences are noted below. The steps are arranged in both logical and time sequence order.

Step 1: Initial assessment, evaluation, and notification: Do we have to move now?

During the initial assessment, emergency managers must gather enough information to make informed decisions. Data gathering should commence immediately upon perception of a possible threat, and should not be delayed pending establishment of incident command. Information may be gathered by many individuals, but should be coordinated by the MHOAC or local incident commander (fire or law enforcement).

Prior to the establishment of unified incident command, key players need to communicate the existence of a threat to the affected HCF(s) and to emergency managers. Regardless of the initial perception and response to the threat, HCF officials cannot assume fire, law enforcement, or county authorities are aware of the potential need to evacuate their facility; similarly, first responders to an incident cannot assume that nearby HCFs are aware of a potential threat.

Establish unified incident command as soon as possible, to facilitate communication, data gathering, and clear decision making. The unified incident command should include representatives of the affected facility, local law enforcement, fire (if appropriate), emergency services, and a liaison representing the MHOAC. Unified incident command should be established (at least temporarily) at the facility being evacuated.

Data gathering elements include:

- What is the threat?

- What area(s) require an evacuation order (meaning imminent or immediate evacuation is being ordered by an appropriate authority)?

- What area(s) require an evacuation warning (meaning a statement that an evacuation order may be issued at a foreseeable point in the near future or under foreseeable circumstances)?

- Where will the incident command post be located?

- Where will the staging area be located?

- What are the likely evacuation routes, or possible options?

- With respect to affected HCFs:

  o How many patients/residents?

  o What level of acuity (see below for details)?

  o Does the affected HCF have an agreement with a like facility to receive patients/residents during an evacuation? If so, what is the receiving facility (and is it out of harm's way)?

  o Does the affected facility have agreements or resources for transportation (e.g., wheelchair or gurney vans, shuttle busses)?

- What is the current bed availability at relevant receiving facilities, either at like facilities identified by memoranda of understanding with the threatened facility, or via polling of facilities using EMsystem or contacting the regional disaster medical health coordinator (RDMHC)?

- What is the predicted timeline? How fast will events or threats unfold?

All of the data gathered should be documented in writing, to facilitate briefings and planning.

This data gathering and assessment should lead to a decision by the MHOAC, hospital management, and/or local incident commanders that the facility(-ies) must evacuate immediately. There may be a variety of choices, including:

- Evacuating at a specific point in the future, or under specific circumstances. This is likely under a flood scenario.

- Sheltering in place. This is possible under some wildfire scenarios.

- Developing a staged/conditional evacuation plan, monitoring the situation, and reevaluating the need to evacuate periodically.

The more time – and more planning – that can occur before an evacuation, the safer and more orderly the evacuation is likely to be.

Step 2 – Evacuation planning: What are we doing, and how are we going to do it?

This is the step that represents developing an incident action plan. It is also the step at which the Health and Human Services Agency Departmental Operating Center should be activated if it has

not already been. If the evacuation needs to occur immediately, or if other circumstances warrant, the county Emergency Operations Center should be activated at this step as well.

There are three components to this step. If an emergent evacuation *is* needed, all elements of step 2 should occur simultaneously or in close proximity. The three components are:

- Development of an evacuation plan.

- Activate and staff up the HHSA DOC.

- Obtain/issue authorization for the evacuation.

If immediate evacuation is *not* indicated, an evacuation plan should be developed that addresses the establishment of a unified incident command and authorization for the (possible) evacuation in a timely fashion.

Evacuation Plan

The evacuation plan must address the following elements:

- Identify the necessary timeline for evacuation.

- Identify viable evacuation routes. This analysis needs to include coordination with fire, emergency services, meteorological, and other officials. An evacuation route that involves a route impassable due to seismic damage, flooding, or fire is not an evacuation route.

- Receiving facility(-ies) must be identified before patients are sent.

- Identify transportation resources.

- Steps to secure and clear evacuation routes.

- Provisions for the documentation and tracking of patient names and destinations.

- Communication with families, staff, HCFs, and the public at all stages of the evacuation.

- Reduction of additional demands on the receiving facilities.

- Health and safety during evacuation (for both patients and personnel performing the evacuation).

- Mutual aid and resources requirements.

- Obtaining and executing the appropriate orders and authorization.

- Provisions for sheltering in place, monitoring for a possible future evacuation, and any other likely conditions.

- Integration with response efforts under way to the same circumstances that are prompting the evacuation. In other words, an evacuation due to wild lands fire will occur simultaneously with residential and business evacuations, increased healthcare needs, transportation challenges, and other demands on emergency planners.

Activate the HHSA DOC

A well-staffed HHSA DOC is critical to the success of an evacuation. Evacuation planning, orchestration of mutual aid requests, communications management, and many other tasks all require both the human resources and the management structure provided by the HHSA DOC.

Authority to Order Evacuation

Obtaining/issuing the authorization for the evacuation may involve any or all of the following:

- Ordering the evacuation (contents of the evacuation order are discussed later in this plan).

- Issuing an evacuation warning (contents of the evacuation warning are discussed later in this plan).

- Declaring a public health emergency.

- Seeking a state-of-emergency declaration from the county.

(Note that if a facility is self-evacuated due to imminent fire or other immediate hazard, these are all secondary.)

Details for each of these components are given below this overview, as well as a formal evacuation plan template in Attachment B.

Step 3 – Notify and inform: Getting the word out

If the evacuation is emergent, step 3 should be incorporated into step 4 and executed simultaneously. If an immediate evacuation is not indicated, the evacuation plan should address this step first.

Notification includes multiple audiences and multiple messages, all of which are discussed in greater detail later in this plan. In summary, notification includes:

- Communicating the evacuation plan with the affected facilities,

- Communicating with the receiving facilities,

- Communicating with the public and families,

- Recalling staff for transferring and receiving facilities, and

- Recalling staff for all relevant emergency services and county departments.

During this stage, HCFs can begin reducing their censuses, implementing early/accelerated discharge, recalling staff, and taking other preliminary steps.

Step 4 – Activate resources and implement the evacuation plan

If the evacuation must occur immediately or in an emergent timeframe, activating resources is likely to occur as part of implementing the evacuation plan. If an immediate evacuation is not indicated, resources may be activated, requested, warned, or otherwise put on standby prior to actual evacuation. (This is referred to as a staged evacuation, and the activation of resources is part of the staging process.)

Resource activation includes placing mutual aid requests as needed, and securing transportation resources and other logistics support as needed.

Mutual aid requests should be based on projected need, as determined by the initial assessment. Possible resources and sources include:

- Ambulance strike teams from the California Emergency Medical Services Authority,

- Ambulances from neighboring and regional counties,

- Specialty transport from neighboring and regional counties (critical care transport, neonatal critical care transport),

- Receiving facilities in neighboring counties,

- Alternate care sites in Napa and neighboring counties to decompress acute care facilities, especially if the incident prompting the evacuation is increasing casualty counts (e.g., earthquake), and

- Volunteers to staff ACS or provide other help.

Mutual aid resources need to be coordinated through MHOAC, EMS, and RDMHC. Mutual aid resource coordination must include staging information, communications equipment distribution, field operations plan, command and control requirements, and communication operations information.

Transportation resources are discussed in greater length later in this plan. In short, transportation resources should match the number and types of patients, as summarized in Attachment E.

Evacuation support and logistics resources are also discussed in greater detail later in this plan. Resources to be considered include:

- Law enforcement for security and traffic management,

- Staging areas,

- Procurement of transpiration resources,

- Support of alternate care sites, if utilized,

- Personnel safety, and

- Patient tracking.

Step 5 – Monitor defined stages

If the evacuation does not need to occur within the next few hours, or if the need for evacuation is conditional (e.g., on rising flood waters, or wildfire direction), the evacuation plan may call for implementation of the evacuation in a staged or phased approach. Early phases would include reducing census, preparing receiving facilities, and acquiring and staging transportation resources. If this approach is used, moving to a later phase (for instance, initiating the transfer of patients) should have specific criteria associated with it (e.g., wind directions shift and fire crosses a specific point, flood waters rise to a specific level). In such cases, this step of the overall process involves routinely monitoring the change from one stage to another.

Step 6 – Deactivate the evacuation plan

Deactivation of the evacuation plan, including patient repatriation, is the final step, and is discussed in greater detail below.

2.4. ROLES AND RESPONSIBILITIES

Evacuating facility

Ensure all patients are moved with the following items physically with them:

1. Pertinent personal and medical information. This should include:

    a. Face sheet

    b. Patient identification sheet

    c. Medication list or medication administration record

    d. Physician orders

    e. Advance directives

2. Name of patients or resident's physician and telephone number.

3. Resident identification (arm band or disaster/triage tag).

4. Medications for a minimum of 72 hours if possible.

5. Change of clothes.

6. Family contact information, if available.

County HHSA and MHOAC

The Napa County Health and Human Services Agency, through the Public Health Officer, the Medical Health Operational Area Coordinator (if a separate person), and their designees are responsible for the following:

1. Providing incident command for the evacuation incident.

2. Evacuation planning.

3. Identifying receiving facilities if the evacuation facility has no agreement with like facilities or in addition to already identified facilities as needed.

4. Identifying and coordinating transportation resources.

5. Issuing and requesting appropriate declarations.

6. Ordering evacuations.

7. Ensuring appropriate communication between all relevant parties.

8. Tracking patient dispersal.

9. Activating and managing alternate care sites to support the evacuation.

Napa County Office of Emergency Services

County OES is responsible for providing support, coordination, and resources to the evacuation effort. Coordination with law enforcement, fire, County Roads, mutual aid, and other entities is crucial to the evacuation.

Receiving Facilities

Receiving facilities are responsible for receiving evacuated patients or residents. This means:

1. Activating the hospital incident command system.

2. Activating the hospital surge plan.

3. Reducing current census by:

    a. Early discharge of patients,

    b. Cancellation of elective procedures; and

    c. Ceasing admission of new patients.

4. Preparing to receive new patients by:

    a. Increasing staffing and recalling staff;

    b. Clearing parking lots for receiving areas; and

    c. Canceling visiting hours.

5. Preparing to receive staff from the evacuating hospitals as volunteers under disaster credentialing standards.

3. CRITICAL DECISION MAKING, AND THE DECISION TO EVACUATE

HCF evacuation is a last-resort decision. It is important to consider alternatives. If time permits, preparation of a detailed plan will help evaluate those alternatives.

3.1. EMERGENT VS. URGENT OR PLANNED

An emergent evacuation, executed in a period of minutes to a few hours after awareness of a threat, poses the greatest risk to patients. The decision to initiate an immediate evacuation is a decision to avoid imminent threat to life and limb, knowing that the rapid evacuation process may produce injury or exacerbate existing conditions. For instance, consider that an emergent evacuation may find patients in labor, patients in the operating room, and a full census.

An urgent or planned evacuation – even if only a few hours are given over to a detailed planning process – allows the staging of appropriate resources, reduction in census, adequate preparation of receiving facilities, and so on.

3.2. ALTERNATIVES

There are more alternatives to complete evacuation than may be immediately apparent. They include:

- Partial evacuation of certain zones, buildings, or other parts of a HCF (due to flooding or earthquake damage), with or without cohorting of patients;

- A staged evacuation;

- A conditional evacuation, in which patient transfers are made pending specific criteria (e.g., flood level rises above a certain point); and

- Sheltering in place (discussed more below).

The basic questions are: Is evacuation needed? Is it the best course? In what time frame? Are there better alternatives?

3.3. STAGED EVACUATIONS

A variety of staging approaches may be used:

- Evacuating the most fragile patients early, before a decision to evacuate the entire facility (assuming critical care transport can be arranged in a timely manner);

- Evacuating all non-essential staff, medical office buildings, etc., prior to the decision to evacuate;

- Evacuating ambulatory patients/residents via bus or van in a separate stage than more acute patients; and,

- Evacuation by specific building or section of the facility based on threat (assuming the threat does not uniformly affect the entire facility).

3.4. SHELTERING IN PLACE

The decision to shelter in place should be made by the unified incident command, as informed by projections of the threat at hand and analysis of current circumstances. Is the fire going to change direction? Is the flood likely to continue or abate? Are aftershocks likely to further damage the facility? The decision to shelter in place should reflect the approval of the MHOAC as well as the primary incident commanders (e.g., fire incident commander) and HCF facility managers.

Sheltering in place (SIP) requires securing a facility against the threat prompting consideration of evacuation, and requires that the facility be able to sustain basic operations while in sheltering mode. Different threats produce different approaches to sheltering in place:

- SIP for wildfire requires control of the heating/ventilation/air conditioning (HVAC) system, to ensure indoor air quality is acceptable. Doors and windows will remain closed; if air quality is particularly bad, entrances may be sealed with duct tape. Strategies may also include turning off HVAC systems, adding in-line air scrubbers or HEPA filters.

- SIP for hazardous materials are similar to wildfires, but limiting air transfer may be even more critical and less amenable to added air filtration.

- SIP for any incident will be dependent on available power. If the threat impinges on the physical plant, emergency generators, and local power grid, SIP becomes more problematic (and may require external power generation to be provided by the county).

- SIP must be a realistic, viable option. Sheltering in place against an encroaching wildfire in a facility that abuts significant vegetation or forested land is not realistic.

A facility that is sheltering in place should notify all building occupants (patients, staff, visitors, and vendors) of the reason, the expected duration, and exactly what occupants should/should not do. If the facility has a designated sheltering location, people should be moved to that area. Doors and windows should be closed and locked. Vents and cracks around doors/windows should be sealed with duct tape, if sheltering in place against smoke or hazardous materials. Provisions for communication with incident command and the HHSA DOC should be explicit.

Declaring an "all clear" following SIP should also be based on the decision of the unified incident command.

4. THE EMERGENCY EVACUATION PLAN

Each evacuation requires planning, even if it is just-in-time, brief planning. The more planning can occur, the safer, more efficient, and more effective the evacuation is likely to be. The emergency evacuation plan is the equivalent of the incident action plan.

A generic, HCF evacuation plan template is provided in Attachment B.

Some of the plan elements, such as transportation, are so important that separate sections of this document are devoted to those topics.

4.1. PLAN DEVELOPMENT

Development of the emergency evacuation plan should occur at the incident command post, in consultation with the Planning Section Chief in the HHSA DOC.

4.2. PLAN IMPLEMENTATION

Implementation of the emergency evacuation plan is the responsibility of the incident commander with support from the Medical Branch Director in the HHSA DOC.

4.3. STAGES AND MONITORING

If a plan can be developed that relies on specific stages, or which delays evacuation for a specific condition (change in fire or flood conditions), appropriate resources in the AO EOC structure should be tasked with monitoring for changes in relevant conditions. The Planning Division should prepare updated evacuation plans as conditions evolve.

If a staged plan is used, the plan should identify the criteria, frequency of monitoring, and delegated authority to execute the next stage of the plan.

4.4. DEACTIVATION

The deactivation process for a HCF evacuation will require its own plan, as there are many variables and many potential complications. The deactivation planning process should begin as early as is feasible, and should be conducted jointly with the affected HCFs and the county. Considerations include:

- Infrastructure status of the evacuated facility(-ies). Can the facility be reopened in a timely fashion, or is it seriously damaged? What repairs are required?

- Restoration of related services. What other services (such as municipal water supply) must be restored for the evacuated facility to function?

- Planning for repatriation of patients. Will patients/residents be repatriated to the facility from which they were evacuated, and at what point? Is repatriation to the evacuated facility impossible/infeasible, such that alternative plans must be made to decompress the receiving facility (e.g., discharge, transfer, etc.)?

- Actual repatriation of patients. Based on the planning elements identified above, actual repatriation of patients must be completed before the incident deactivation is completed.

- Coordination with the Fire Planning section, if relevant, for safety concerns.

- Deactivation planning should also include collection of all records, reports, rosters, and forms from each relevant branch and unit. This will facilitate development of the after action report

5. MUTUAL AID

Mutual aid should be sought as early as possible. If an emergent evacuation is not indicated – if some degree of detailed planning and staging can be accommodated – mutual aid resources should be notified of the possible need for specific requests. This is important because potentially available resources such as ambulance strike teams or Advanced Life Support (ALS) ambulances from regional sources will require time to reach a staging area. The more specialized the resource, the longer the delay to obtain the resource: neonatal critical care transport is less readily available than Basic Life Support (BLS) ambulances. If a planned evacuation is possible, resources could be staged at a convenient location within the county.

Mutual aid requests may include:

- Ambulance strike teams from the California Emergency Medical Services Authority;

- Ambulances from neighboring and regional counties;

- Specialty transport from neighboring and regional counties (critical care transport, neonatal critical care transport);

- Receiving facilities in neighboring counties; and,

- Support for alternate care sites in Napa and neighboring counties to decompress acute care facilities, especially if the incident prompting the evacuation is increasing casualty counts (e.g., earthquake).

Mutual aid requests should be coordinated through the MHOAC and the RDMHC/S.

6. TRANSPORTATION

Transportation is an obvious, yet complicated, aspect of HCF evacuation. This section outlines a variety of considerations.

6.1. MODES

The first consideration for evacuation transportation is the relationship between patient/resident level of care and the mode of transportation required (see Attachment E for further details).

> The kinds and numbers of transportation sought should match the types and numbers of patients/residents being evacuated.

Modes of transportation include (in decreasing level of specialization and staffing):

- Neonatal transport, a form of mobile intensive care unit,

- Mobile intensive care units/critical care transport,

- Advanced life support (ALS) ambulance,

- Basic life support (BLS) ambulance,

- Gurney van or wheelchair van, and

- Car, van, or bus, with or without medically trained individuals on board.

Transportation can be provided via vehicular and aeromedical means. Helicopter transfer of the sickest patients (e.g., neonatal intensive care, mobile intensive care) may be considered. However, helicopter transport of the majority of patients is not realistic due to the increased complexity of helicopter operations (e.g., ground safety given fires, smoke, or flooded areas, the

need for controlled landing zones, etc.) and the low number of patients capable of being moved via air.

6.2. STAGING AND COORDINATION

Staging is mandatory for any incident where the number of resources required exceeds the patient access points. This staging area should be close to, but not in the way of, the facility being evacuated. It is imperative to have a Staging Group Supervisor identified early in the process. The Staging Group Supervisor must have radio communications with incident command and all incoming resources. He/she must also have all required radio channels and frequencies assigned to the incident and the ability to disseminate the information to all incoming units. This person also needs to have a cache of radios that can be assigned to incoming units for use during the incident.

The staging area needs to be large enough for all resources. It needs controlled ingress and egress points. Access to sanitation facilities is also important for the staging area. It can be several miles from the incident location as long as the incident commander is aware of its proximity to the incident and travel time required to reach incident location.

Transportation planning should address:

- The transportation route from the evacuating to the receiving facilities.

- Transportation to a temporary receiving facility with subsequent movement to a final destination later (particularly if alternate care sites are used to decompress acute care facilities).

- Route safety.

A variety of transportation issues require coordination and consideration:

- Coordinate evacuation plans with communications and messages put out for public notice, especially if key roads are being converted to one-way traffic.

- Radio communication in route for all patient transport vehicles is important to improve overall coordination.

- Evaluate the need for police/sheriff escort of medical transport vehicles or for incoming shipments of critical materials (such as HEPA filters needed as part of a shelter-in-place operation).

- The County Roads department, in coordination with the Sheriff's Department, can provide barricades to assist with the closing of roads. The California Highway Patrol will not staff road closures unless the road department has been requested. (Note that the Law Enforcement Incident Commander may request County Roads representation at the AO EOC or at a field command post.)

- Road closure and one-way traffic routing on all roadways in unincorporated areas falls under the responsibility of the California Highway Patrol. CHP and CalTrans will conduct roadway closures at the request of the Law Enforcement Incident Commander. These closures and re-routing of traffic on routes such as State Highway 29 may effectively eliminate civilian traffic, or create a priority medical transportation corridor.

- Note that requests for CHP and CalTrans resources should start with calls to the on-duty CHP supervisor, rather than waiting for a formal OES mutual aid request.

6.3. EVACUATION ROUTES AND CAPACITIES

Considerations for patient evacuation routing are listed below:

- Use the fastest safe route available!

- Be aware that evacuation of residential and business areas typically produces slow-moving traffic patterns. Medical transport vehicles should not be expected to move at their usual speeds, and code 3 transport is likely to be inappropriate for most patients. The result of this is prolonged transportation times, even if the route is "just across the valley".

- Ask: Is the route being taken by the vehicles transporting patients ALSO going to be the main evacuation route for residential population? Are delays or prolonged travel times possible under evacuation circumstances that could challenge the evacuating patient (oxygen supply, water, food, medication needs in route, exposure to poor air quality, etc.).

6.4. HAZARD-SPECIFIC CONDITIONS

Evacuation routes should not subject patients to increased danger from fire, smoke, seismic instability, or other foreseeable risks. Road conditions and route safety fall under the AO EOC's Safety Officer's responsibility.

6.5. SOURCES OF TRANSPORTATION RESOURCES

Transportation resources, including those not traditionally given to medical transport – but which may be helpful for some residents of nursing homes and long-term care facilities – are listed in Attachment C.

7. SECURITY

Law enforcement (county sheriff, local city police, California Highway Patrol) have responsibility for security during an evacuation. Their objectives are to:

1. Prevent unsuspecting members of the public from entering the area.

2. Prevent looting of the evacuated area.

3. Promote controlled re-entry operations.

Security personnel are likely to be involved in evacuating an area's residents and businesses, as well as establishing and maintaining appropriate perimeters. In addition, law enforcement agencies will have responsibility for traffic control. Therefore, it is critical that all medical transportation be coordinated with law enforcement agencies. This includes transportation resources entering the security perimeter (e.g., mutual aid ambulances, private busses that might not be immediately recognized as part of the evacuation effort, etc.) as well as transports leaving the affected area. Consider whether police escorts will be needed for medical transports.

Law enforcement agencies also play a critical role in clearing transportation routes. This may not be needed, but should be considered in both route planning and resource allocation.

8. RECEIVING FACILITIES

Just as there is a relationship between patient/resident level of care required and the type of transportation required, there is a relationship between the evacuating facility and the receiving facility: patients should be sent to receiving facilities offering the same level of care as the site they are evacuating. Ideally, patients/ residents should be evacuated to "like" facilities identified by the evacuating facility prior to the incident (assuming the receiving facility is able to accommodate the incoming patients), or like facilities identified during an incident.

Alternative care sites (ACS) may be used, both as receiving facilities for those patients/residents that are medically stable but require monitoring, or who have reliable caretakers present. ACS may also be used to decompress acute care facilities, thus increasing the capacity of, say, the Queen of the Valley.

As soon as a facility is identified as a likely recipient of evacuees, the receiving facility should execute as many of these actions as are relevant:

- Activate the hospital's emergency operations plan (EOP);

- Activating the hospital surge plan.

- Reducing current census by:

    o Early discharge of stable patients;

    o Cancellation of elective procedures; and

    o Suspending admission of new patients.

- Cancel visiting hours.

- Clear parking lots for receiving.

- Preparing to receive staff from the evacuating hospitals as volunteers under disaster credentialing standards.

- Recall staff.

- Contact the California Department of Public Health's Licensing and Certification office to request waivers needed to increase the census.

9. PATIENT TRACKING

Tracking which patients were sent to which receiving facilities is the responsibility of the MHOAC or his/her designee. This information may need to be communicated to families, and will be necessary for repatriation. Attachment F provides a form that will serve as a coversheet and checklist for evacuating each patient. Attachment G contains a form which should be completed at the unified incident command post during the evacuation.

Each patient shall receive a prehospital Triage Tag that shall stay with the patient record through repatriation. Any patient documentation created during the incident shall include the Triage Tag number. Use of the triage number simplifies the problem of unique patient identifier, so that the county does not need to be confused by the medical record number (MRN) of the patient from the sending facility and the MRN assigned at a receiving facility.

10. COMMUNICATION

As the HHSA DOC and OA EOC are staffed up to support the evacuation, the positions of HHSA public information officer at the HHSA DOC, and the County Public Information Officer should be staffed. Communications issues – both in terms of message content and communication methods/channels – that must be addressed are listed below:

Audience	Message content	Communication mechanism
Families of patients	Details of the evacuation, patient transfer destinations, where to get status updates, warnings to the public to not go to the evacuated facility.	• Press release • 800-number • Press conference
Staff of evacuated facility	Whether or not to report for duty, where to report	• Direct calling of staff • Press conference
Staff of receiving facility	Staffing up to support surge, where to report for duty	• Direct calling of staff • Press conference
Interjurisdictional and interagency, operations	Status briefings to other jurisdictions, operational instructions, mutual aid requests, status reports, coordination of resources, tracking location of, and maintaining communication with ambulances in route, bed availability	• Radio • EMsystem • Conference calls

Procedures to activate and manage risk communication and materials used in risk communication are described in the Napa County HHSA/Public Health Division Crisis Emergency Risk Communication Plan (CERC).

11. SAFETY CONSIDERATIONS

The on-site Unified Command Safety Officer has responsibility for the safety of the HCF evacuation process. The HHSA DOC safety officer should evaluate risks and safety along the evacuation route. He/she should work in concert with the AO EOC safety officer and the sheriff's deputy conducting the local non-HCF evacuation. The following safety considerations should be followed and/or advised to relevant entities such as ambulance crews:

1. Beware of speeding evacuees. More people die of car accidents during evacuation than from the incident causing evacuation.
2. The incident causing the evacuation – flood, fire, hazardous materials release – may continue to pose dangers to patients being evacuated. Some conditions may pose significant risks to evacuated patients, such as smoke. This should inform evacuation route planning.
3. Keeping emergency lights activated may increase visibility is poor (due to rain, nighttime, or smoke).

12. ATTACHMENT A: HEALTHCARE FACILITY EVACUATION PLANNING FIELD GUIDE

Step 1: Initial assessment, evaluation, notification
- Initial assessment
  - Threat?
  - Timing?
  - Affected area now and projected?
  - Objectives?
  - Conclusion: Is evacuation needed? Is it the best course? In what time frame?
- Identify patient census/evacuation needs: Number of patients/residents at what level of care (see form – CAHF). How many patients need to be moved, using what level of service?
- Establish a unified incident command

Step 2 – Evacuation planning

Develop an *evacuation plan*
- Identify viable evacuation routes. This analysis needs to include coordination with fire, emergency services, meteorological, and other officials. An evacuation route that involves a route impassable due to seismic damage, flooding, or fire is not an evacuation route.
- Receiving facility(-ies) must be identified before patients are sent.
- Identify transportation resources
  - Critical care or neonatal transport; advanced life support; basic life support; gurney van
- Ensure health and safety during transfer
  - Evacuation through heavy smoke or other environmental hazards pose distinct risks for medical complications (and violate the "do no harm" concept)

Activate the HHSA DOC
- Activate and begin staffing up the HHSA DOC; consider activating the AO EOC.

Obtain appropriate *evacuation orders* and execute in writing
- Evacuation warning
- Evacuation notice
- State of emergency

Step 3 – Notify and inform
- Activate communication for families, staff
- Attend to public information and communications planning early
  - Recall staff for transferring and receiving facilities
  - Recall staff for all relevant emergency services and county departments
  - Communication with families
  - Evacuation notices for non-HCF residents

Step 4 – Activate resources and implement the evacuation plan
- Activate mutual aid and mobilize resources early – including regional and state level resources
- Secure and clear evacuation routes
- Initiate and complete transportation of patients/residents
- Document and track patient names and destinations
- Reduce additional demands on the receiving facilities:
  - Suspending patient admissions
  - Early discharge

Step 5 – Monitor defined stages
If the evacuation is planned, and can occur in stages, monitor the progression of stages and related circumstances (for instance, the rise of flood waters).

Step 6 – Deactivate the evacuation plan
- Commence deactivation planning early; depending on the cause – and damage – of the evacuation, plan deactivation and patient repatriation could take weeks.

ATTACHMENT B: EVACUATION PLAN TEMPLATE

1. Current situation:
    a. Threat
    b. Affected area
    c. Impacted or threatened healthcare facilities
2. Projected situation
    a. Weather or related forecast
    b. Timing and projections
3. Evacuation goals and concepts
    a. Evacuation vs. shelter-in-place vs. situational monitoring
        i. Staged vs. all-at-once evacuation
    b. Concept of operations
    c. Objectives, with strategy and responsible party for each objective
    d. Planning cycle, if staged evacuation
    e. (For staged evacuation)
        i. Stages
        ii. Criteria and authority to changes stages
4. Transportation and patient movement
    a. Transportation resources
    b. Considerations is using aeromedical transport
    c. Staging areas
    d. Collection points and times
    e. Vehicle assignments (personnel)
    f. Route planning
    g. Route securing and clearing
    h. Receiving facilities
    i. Patient tracking
5. Communications
    a. Public information
    b. Family-oriented resources
    c. Staff-focused communication and resources
    d. Communications with transportation resources
6. Security and safety
    a. Perimeter security: evacuating facility
    b. Perimeter security: receiving facility
    c. Safety and health during transport
7. Medical Support for Affected Facilities
    a. Alternate care sites, decompression of receiving facility
    b. Provision for medical care in county aside from the evacuation
8. Deactivation planning

ATTACHMENT C: TRANSPORTATION RESOURCES

Transportation Resources	Contact Information
Ambulances	
Piner Ambulance Service	(707) 224-3123
Angwin Volunteer Community Ambulance	(707) 965-2468
Buses	
California Veterans Home	(707) 944-4500 (day) (707) 944-4848 (night)
St. Helena Hospital	(707) 963-3611
Napa State Hospital	(707) 253-5000
Taxis	
Yellow Cab of Napa	(707) 226-3731
Valley Taxi	(707) 942-9009
Napa Valley Cab	(707) 257-6444
Northbay Taxi & Wheelchair	(707) 257-6200
Black Tie Taxi	(707) 259-1000
Wine Valley Taxi	(707) 251-9463
Napa Valley Limousine Services	(707) 258-0689
Tours D-Elegance	(707) 259-0400
Other	
Napa Valley Wine Tours	(888) 881-3309
Wine Country Helicopters	(707) 226-8470

ATTACHMENT D: EVACUATION ORDER FORM

Public Health Officer Evacuation Form

Note: Per guidance from the California Department of Public Health *Health Officer Practice Guide for Communicable Disease Control in California*, there is no express form, content or method of service statutorily mandated for evacuation orders. In general, evacuation orders should be in writing and posted on the subject area or site. However, facts and circumstance may dictate the use of an initial oral order which will be confirmed in writing at the earliest possible opportunity. As with any other Health Officer order the content and appropriate procedures for closure are fact dependent and must be determined by the particular circumstances.

MANDATORY EVACUATION ORDER
NAPA COUNTY PUBLIC HEALTH OFFICER

Date:

By order of the Napa County Health Officer, under California Penal Code section 409.5, I order the following evacuation:

Time of evacuation:

Location/facilities/area to be evacuated:

Duration of evacuation:

Purpose of evacuation:

Signature:	Date/time Signed:

ATTACHMENT E: EVACUATION DESTINATION CATEGORIES

From: Shelter Medical Group Report: Evacuation, Care and Sheltering of the Medically Fragile, California Emergency Medical Services Authority

EMERGENCY EVACUATION DESTINATION CATEGORIES *for* MEDICALLY FRAGILE PATIENTS and RESIDENTS		
LEVEL OF CARE	*SHELTER TYPE*	*TRANSPORT TYPE*
LEVEL I ***Description:*** *Patients are usually transferred from in-patient medical treatment facilities and require a level of care only available in hospital or Extended Care Facility.* ***Examples***: ☐ Bedridden, totally dependent, difficulty swallowing ☐ Requires dialysis ☐ Ventilator-dependent ☐ Requires electrical equipment to sustain life ☐ Critical medications requiring daily or QOD lab monitoring ☐ Requires continuous IV therapy ☐ Terminally ill	Like Facility Hospital/ECF	ALS
LEVEL II ***Description:*** *Patients have no acute medical conditions but require medical monitoring, treatment or personal care beyond what is available in public shelters.* ***Examples***: ☐ Bedridden, stable, able to swallow ☐ Wheelchair-bound requiring complete assistance ☐ Insulin-dependent diabetic unable to monitor own blood sugar or to self-inject ☐ Requires assistance with tube feedings ☐ Draining wounds requiring frequent sterile dressing changes ☐ Oxygen dependent; requires respiratory therapy or assistance with O_2 ☐ Incontinent; requires regular catheterization or bowel care	Medical Treatment Unit/Temporary Infirmary	BLS Wheelchair Van Car/Van/Bus

EMERGENCY EVACUATION DESTINATION CATEGORIES *for* **MEDICALLY FRAGILE PATIENTS and RESIDENTS**		
LEVEL OF CARE	*SHELTER TYPE*	*TRANSPORT TYPE*

LEVEL III
Description: *Patients are able to meet own needs or has reliable caretakers to assist with personal and/or medical care.*
Examples:
☐ Independent; self-ambulating or with walker
☐ Wheelchair dependent; has own caretaker if needed
☐ Medically stable requiring minimal monitoring (i.e., blood
   pressure monitoring)
☐ O_2 dependent; has own supplies
☐ Medical conditions controlled by self-administered medications
☐ Is able to manage for 72 hours without treatment or
   replacement of medications/supplies/special equipment
	ARC/
	Public Shelter
		Car/Van/Bus

ATTACHMENT F: PATIENT CRITICAL EVACUATION INFORMATION TRACKING FORM

Patient Critical Evacuation Information Tracking Form

NOTE: After completion of form, please make THREE copies: ONE for sending facility, ONE for EMS, and ONE for receiving facility.

Sending Facility: _____

Receiving Facility: _____

Patient Name: (PRINT) _____

Date of Birth: ____ /____/____ **Gender:**   Male   Female

Transferring Facility Medical Record Number: _____

Triage tag number (if used): _____

Method of Transport: Ambulatory   Wheelchair   Basic Life Support   Advanced Life Support

Emergency Contact: _____ **Telephone #_____**

Notified of Transfer : YES NO

Attending Physician: _____   **Notified of Transfer:** YES   NO

Primary Diagnosis: _____

Do Not Resuscitate: YES (attach copy)   NO
Advanced Directives: YES (attach copy)   NO
Healthcare Proxy: YES (attach copy)   NO

Sent with patient:			
	Face sheet	YES	NO
	Patient identification sheet	YES	NO
	Medication list/administration record	YES	NO
	Physician orders	YES	NO

Date transferred: _____   **Time of departure:** _____

Time of arrival at receiving facility: _____

Equipment owned by sending facility accompanying patient during transport:

COMMENTS:

ATTACHMENT G: PATIENT/RESIDENT EVACUATION TRACKING WORKSHEET

Patient Evacuation Tracking Worksheet			Incident/Facility name:			Date/Time Prepared::		
Patient ready?	Injury type	Mode of transport	Destination Facility	Ambulance Co. & ID	Patient or Resident name / ID #	Departure time	ETA	Facility advised?