FLORIDA HOSPITAL ASSOCIATION

2019 Update: Hospital Emergency Evacuation Toolkit

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Table of Contents

Introduction and Overview

In 2011, the Florida Department of Health led a group of hospital subject matter experts in developing the *Hospital Emergency Evacuation Toolkit – May 2011*. Many changes have been implemented to health care provider emergency management practices and requirements since that time.

Historically, the Florida Hospital Association (FHA) works with hospital and health systems, non-acute health care providers, and local, state and federal public health and medical agencies and organizations to develop better practices and programs around health care emergency management. FHA was part of the original group that developed the 2011 toolkit.

FHA serves as a support organization for Florida's State Emergency Response Team, Emergency Support Function – 8 for public health and medical services (SESF-8) acting as a liaison to the acute care hospital and health system provider community during a declared state of emergency.

The 2016, 2017 and 2018 Atlantic hurricane seasons caused a large number of acute and non-acute providers to evacuate their patient and client populations to other facilities – in and outside of Florida. During that time, FHA worked with SESF-8, the hospital community and local, state and federal public and private partners to assist in evacuation coordination from Hurricanes Hermine and Matthew (2016), Irma (2017) and Michael (2018).

These evacuations included partial and full evacuations and pre- and post-landfall evacuations. Some providers evacuated for the first time while others have evacuated in the past and were more experienced. Patients moved within health systems and without some over great distances. Many providers sheltered in place.

It is important to note, other emergency events across the U.S. shed provided valuable information and resources on hospital and health care facility evacuation and patient movement. The Joplin Tornado (2011), Hurricane Sandy (2012), mid-Atlantic and northeast blizzard (2016), Hurricane Harvey (2017), Hurricane Florence (2018), California wildfires (2018) – all were events that provided lessons on how to best conduct emergency operations, evacuate, move patients / clients, and sheltering in place.

The original *Hospital Emergency Evacuation Toolkit – May 2011* remains a significant reference guide for acute care providers for the development of an effective evacuation and patient movement plan. FHA recommends the toolkit as an essential planning aid for health care emergency management professionals. However, a review and update of the toolkit's information and resources is warranted given the lessons learned from the past three hurricane seasons.

FHA created an Emergency Preparedness and Response Task Force after the 2016 hurricane season to compare and contrast the lessons learned and areas in need of improvement within Florida's hospital community. The task force was developed as an interdisciplinary, executive-level group to capture all aspects of hospital emergency operations. The work of the task force

was structured around the 5 mission areas of emergency management: prevention, protection, response, mitigation and recovery. Their recommendations are included with this update.

As mentioned, FHA has an extensive history and interacts routinely with health care providers across the spectrum. Given these response and interaction activities, FHA began reviewing the 2011 toolkit for needed changes in 2017 with a focus on providing additional information and resources. Also, FHA's *Health Care Coalition: Compilation of Tools and Resources* and *Emergency Volunteer Management Planning Considerations and Resources* documents provide useful information for evacuation, patient movement and sheltering in place decision making.

This document applies the lessons learned by Florida's acute and non-acute health care providers and consolidates current information from across the country including additional resources and recommendations for evacuation plan revision.

John Wilgis, vice president of member and corporate services

Florida Hospital Association

Acknowledgements

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FHA Emergency Preparedness and Response Task Force

- Christopher Schmidt, VP – Quality and Experience, FlaglerHealth+ (Chair)
- Terry Smith, COO, Sacred Heart Hospital of Pensacola
- Scott Raynes, President, Baptist Hospital, Inc.
- Barbara Alford, VP/CNO, Tallahassee Memorial Healthcare
- Karen Ketchie, Former System Director – Emergency Management, Baptist Health
- Ashley Fisher, Safety Officer and Emergency Preparedness Coordinator, Halifax Health
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- George Mikitarian, President/CEO, Parrish Medical Center
- Randall W. Hartley, COO, Nemours Children's Hospital
- Connie Bowles, Former Emergency Management Coordinator, Lee Health
- Steve Wolfberg, Director, Emergency Management & Corporate Transportation, Cleveland Clinic Martin Health
- Steven Seeley, Interim Co-CEO, Jupiter Medical Center
- Dr. Stanley Marks, CMO, Memorial Regional Hospital

Health Systems

- AdventHealth
- Baptist Health
- Baptist Health Care
- Baptist Health South Florida
- BayCare Health System
- Broward Health
- Calhoun Liberty Hospital Association
- Central Florida Health

- Cleveland Clinic
- Community Health Systems, Inc.
- Encompass Health
- Flagler Health +
- Halifax Health
- HCA, Inc.
- Health First, Inc.
- Kindred Healthcare
- Lee Health
- Memorial Healthcare System
- NCH Healthcare System
- Orlando Health
- Sacred Heart Health System, Inc.
- Select Medical Corporation
- St. Vincent's HealthCare
- Tenet Healthcare
- University of Florida Health – Jacksonville
- University of Miami Health System

Health Care Coalitions

- Emerald Coast Health Care Coalition
- Big Bend Health Care Coalition
- Northeast Florida Health Care Coalition
- Tampa Bay Health and Medical Preparedness Coalition
- Central Florida Disaster Medical Coalition
- Heartland Health Care Coalition
- Suncoast Disaster Health Care Coalition
- Lee County Health Care Coalition
- Collier Health Care Emergency Preparedness Coalition
- Palm Beach County Healthcare Emergency Readiness Coalition
- Broward County Health Care Coalition
- Miami-Dade County Healthcare Preparedness Coalition
- Keys Health Ready Coalition

SESF-8 Support Agencies and Organizations and Professional Groups

- Florida Department of Health
- Florida Agency for Health Care Administration

- Florida Agency for Persons with Disabilities
- Florida Department of Elder Affairs
- Florida Department of Children & Families
- Florida Department of Agriculture & Consumer Services
- Florida Department of Business & Professional Regulation
- Florida Department of Environmental Protection
- Department of Veteran Affairs
- Florida State Fire Marshal
- Florida Medical Examiner Commission
- Florida Office of the Attorney General
- University of Florida Maples Center for Forensic Medicine
- Florida State University Laboratories
- Florida Health Care Association
- Florida Assisted Living Association
- End-Stage Renal Disease Network
- Poison Information Center Network
- Florida Association of Community Health Centers
- Florida Pharmacy Association
- Florida Crisis Consortium
- Red Cross
- Florida Fire Chiefs Association

Lessons Learned: Evacuation and Patient Movement

After each hurricane, FHA provided the Florida Department of Health an after action report highlighting the lessons learned, best practices, gaps, and areas in need of improvement. These included:

- 2016 After Action Report for Hurricanes Hermine and Matthew
- 2017 After Action Report for Hurricane Irma
- 2018 After Action Report for Hurricane Michael

As referenced in the introduction of this update, past events and other providers have shared information supporting the shared lessons below. And, FHA's Emergency Preparedness and Response Task Force lessons learned were captured. All of this information is consolidated below:

Evacuation

- There have been many hospital evacuations as a result of hurricane impact.
- Medical surge has been a significant problem for hospitals before, during and after a storm.
- Poor community preparedness complicates evacuation and patient movement efforts.
- There were many reports of over-crowded hospitals.
- Non-acute providers have struggled with evacuation for many reasons (e.g., ineffective planning, failure to activate their plans within a timely manner, inadequate resource support and poor integration with local partners).
- Life safety was put at risk and patient deaths occurred from some non-acute provider's failure to evacuate their facilities appropriately.
- Hospitals (and other health care providers) need information and resources that support the decision to close a hospital or divert patients.
- Providers that decide to evacuation, move patients or shelter in place should include timely notification of their decision to all hospitals and health care providers in the affected area.
- There is no statewide mutual aid agreement that supports hospital evacuation or patient movement.
- Expansion of mutual aid to provide or offer staff and resources to support hospitals that shelter in place and continue to respond to the emergency is needed.

- Providers should consider the implications of evacuation and sheltering in place on the local community's ability to provide health care services as part of the decision-making process.
- Hurricane Michael's speed and strength limited pre-landfall evacuation of hospitals in the area of impact.
    - Some hospitals were able to evacuate prior to landfall and suffered considerable damage to their structures, delaying their reopening of inpatient beds.
    - Other hospitals that partially evacuated were affected with facility damage further limiting inpatient capacity for the affected area and led to complete evacuation post-landfall.
- Re-entry and re-opening procedures for licensed, residential health care providers were provided by the Agency for Health Care Administration, albeit inconsistent from one year to the next.
- Hospitals that evacuated or partially closed experienced a limitation of resources to support re-opening and re-entry into an area due to road closures and roadblocks in mandatory evacuations zones.

Patient Movement

- There are not enough transportation assets available within Florida's communities for large-scale evacuation of acute and non-acute health care providers.
- Having federal ambulance strike team coordination and assistance with patent movement was very helpful.
- Health care providers across the spectrum are contracted with the same transportation vendor to support their patient movement plans; therefore, everyone is vying for the same resources when disaster strikes and there is a need to move patients around a local community, regionally across Florida or over state lines.
- SESF-8 supported community and regional patient movement post-storm for a limited duration.
- Hospitals that were significantly damaged and closed but provided emergency medical care through their emergency departments to impacted communities incurred significant financial costs for several months for day-to-day patient transport to other regional hospitals for definitive care.
- There is no state-wide patient tracking system.
- The Agency for Health Care Administration's (AHCA) required provider reporting platform, the Emergency Status System (ESS) does not support patient tracking.

- ESS does not provide individual providers awareness of the status of the local or regional health and medical community.
- There were many reports of over-crowded hospitals discharging patients to special needs and general population shelters.
- Non-acute providers sent patients to hospitals and special needs shelters as a response to inadequate plans and response.
- Inappropriate discharge or placement of patients creates undue medical surge on an already stressed health care provider, the health and medical system and risks life safety.
- Primarily, hospitals transferred patients within their own systems.

Sheltering in Place

- There is a need for coordinated discharge planning for patients for both pre- and post-landfall scenarios at all levels to support hospitals and other providers who are sheltering in place and need to free up bed space to provide definitive care to an impacted community or region of Florida.
- Hospitals across Florida who sheltered in place worked to provide shelter and medical care to non-acute providers, community special needs shelter evacuees, and displaced individuals from the community for extended periods of time.
- Hospitals that sheltered in place experienced a limitation of resources to support emergency operations due to road closures and roadblocks in mandatory evacuations zones.

Additional Lessons

- Florida does not have state-based system for disaster medical response teams to augment the delivery of emergency care to an affected area.
- Requesting a federal disaster medical assistance team is costly, takes time to deploy, and is limited in their duration for support.
- Florida's special needs sheltering system failed to provide adequate resources, both human and material, to meet the medical needs of individuals.
- There is a continual need for short- and long-term housing / sheltering for staff and family members of essential emergency response and medical personnel.
- Hospitals were challenged to consistently provide situational information, communicate key messages to providers, and to gain actionable intelligence within a specific area (e.g., unmet needs, evacuation, etc.) from providers.

Regulatory and Operational Changes

Centers for Medicare and Medicaid Services

On September 8, 2016 the Federal Register posted the final rule *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers*. The regulation went into effect on November 16, 2016. Health care providers and suppliers affected by this rule must comply and implement all regulations of this rule.

The purpose of the rule was to establish national emergency preparedness requirements for 17 provider and supplier types to ensure adequate planning for both natural and man-made disasters, and coordination with federal, state, tribal, regional and local emergency preparedness systems. The providers and suppliers impacted include:

1. Hospitals;
2. Religious Nonmedical Health Care Institutions (RNHCIs);
3. Ambulatory Surgical Centers (ASCs);
4. Hospices;
5. Psychiatric Residential Treatment Facilities (PRTFs);
6. All-Inclusive Care for the Elderly (PACE);
7. Transplant Centers;
8. Long-Term Care (LTC) Facilities;
9. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID);
10. Home Health Agencies (HHAs);
11. Comprehensive Outpatient Rehabilitation Facilities (CORFs);
12. Critical Access Hospitals (CAHs);
13. Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services;
14. Community Mental Health Centers (CMHCs);
15. Organ Procurement Organizations (OPOs);
16. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs); and,
17. End-Stage Renal Disease (ESRD) Facilities.

Each provider type has its own set of Emergency Preparedness regulations incorporated into its set of conditions or requirements for certification. Providers and suppliers must follow the Emergency Preparedness regulations to participate in the Medicare or Medicaid program.

The emergency preparedness regulation outlines four core elements which are applicable to all 17 provider types, with a degree of variation based on inpatient versus outpatient, long-term care versus non long-term care:

1. Risk Assessment and Emergency Planning (Include but not limited to):
    - Hazards likely in geographic area
    - Care-related emergencies
    - Equipment and Power failures
    - Interruption in Communications, including cyber attacks
    - Loss of all/portion of facility
    - Loss of all/portion of supplies
    - Plan is to be reviewed and updated at least annually
2. Communication Plan
    - Complies with Federal and State laws
    - System to Contact Staff, including patients' physicians, other necessary persons
    - Well-coordinated within the facility, across health care providers, and with state and local public health departments and emergency management agencies.
3. Policies and Procedures
    - Complies with Federal and State laws
4. Training and Testing
    - Complies with Federal and State laws
    - Maintain and at a minimum update annually

Additional information, resources and guidance is available on the Centers for Medicare and Medicaid Services Emergency Preparedness Webpage and in the resource section of this update.

The Joint Commission – Emergency Management Standards

In response to the Centers for Medicare & Medicaid Services' (CMS) final rule on emergency

preparedness, The Joint Commission updated its Emergency Management (EM) standards. The most significant changes are to the home health settings with 39 new or revised elements of performance (EPs), then ambulatory health care with 29. Hospitals and critical access hospitals each have 21 new requirements.

The Joint Commission began surveying to the updated EM requirements as of the rule's Nov. 15, 2017, implementation date. These updated requirements apply to accredited deemed hospitals, critical access hospitals, home health agencies, hospices and ambulatory surgical centers, as well as rural health clinics and federally qualified health centers.

New EPs were created to address key areas in preparedness and response, including the following:

- Continuity of operations and succession plans;
- Documentation of collaboration with local, tribal, regional, state and federal EM officials;
- Contact information on volunteers and tribal groups;
- Annual training of all new/existing staff, contractors and volunteers; and,
- Integrated health care systems.

Hospitals and critical access hospitals have an additional emergency and standby power system requirement, and hospitals have an additional requirement for transplant services.

View the standards for:

- Ambulatory Health Care
- Critical Access Hospital
- Hospital
- Home Care

State ESF-8 Patient Movement Support Standard Operating Guideline

In December 2013, the Florida Department of Health, Division of Emergency Preparedness and Community Support, Bureau of Preparedness and Response released the *State ESF8 Patient Movement Support Standard Operating Guide*. The purpose of the guide was to describe the State ESF8's plan to monitor and coordinate resources, in support of the movement of patients in impacted areas where local health and medical systems are overwhelmed and have requested assistance from State ESF8.

Monitoring and coordinating resources to support care and movement of persons with medical and functional needs in impacted counties is one of State ESF8's 11 core missions as described

in Florida's Comprehensive Emergency Management Plan (CEMP) Appendix VIII: ESF8 – Public Health and Medical Services.

State ESF8 support facility evacuation or decompression for noticed incidents or events (storm-related pre-landfall or post-impact) or no-notice incidents (tornados, mass casualty incidents, etc.) following the guide's framework for response.

Statewide healthcare system monitoring is conducted, and assistance provided when requested by local jurisdictions. This may include coordination and resource support from external partners through the State Emergency Response Team (SERT) or the Emergency Management Assistance Compact (EMAC).

The guide supports the following patient movement functions:

- Patient coordination - medical system monitoring and patient placement/destination coordination.
- Patient transportation – the physical movement of patients from one location to another.
- Emergency treatment and stabilization – helping to reconstitute necessary critical services to assure communities have access to appropriate care.
- Large-scale patient movement – moving a large number of patients from the impact area in bulk.
- Patient tracking – the ability to know, at any given time, the location and the status of a patient from the time of movement to the time of return.
- Patient return – transporting a patient back to their originating medical facility, a step-down facility, or their residence.

The guide has been successful in supporting hospital evacuations during Hurricanes Matthew (2016), Irma (2017) and Michael (2018).

Emergency Power Plan Rules

Following significant life safety issues in skilled nursing and assisted living facilities during the 2017 Hurricane Irma response, the Agency for Health Care Administration created new emergency power plan rules for these providers. Loss of power led to wide-spread evacuation and patient movement for these providers.

Each nursing home and assisted living facility must prepare a detailed plan, to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency power in the event of the loss of primary electrical power in that facility.

Nursing Home Rule 59A-4.1265, F.A.C. and Assisted Living Facility Rule 58A-5.036, F.A.C. detail the specific requirements and compliance matters with these important resident protections.

Recommendations

The past three hurricane seasons provided many lessons learned across Florida's health and medical community. Examples of best practices and worse-case scenarios played out and provided direction for acute and non-acute health care provider planning consideration.

The recommendations below frame the core concepts obtained by FHA to help hospitals and other providers ensure continuity of care and facility operations within in an impacted community remain intact.

Evacuation

1. The *Hospital Emergency Evacuation Toolkit – May 2011* remains a significant reference guide and resource for acute care providers for the development of an effective evacuation plan.
2. The additional evacuation and patient movement resources provided in this update should be reviewed for decision support and inclusion in a facility's emergency operation plan.
3. Accurate information, situational information, assessment of the impacts and challenges are needed to make an informed decision to evacuate or shelter in place. Provide alerts continuously, internally and externally.
4. All residential providers should share the decisions related to facility closure (partial or complete), evacuation, the diversion of patients, or the decision to shelter in place in a timely manner with all hospitals and health care providers in the affected area. Leaders should understand the significance of these decisions and their impact on patient care operations and plan accordingly.
5. Providers that decide to close or evacuate a facility should offer staff and resources to supporting hospitals and health care facilities that continue to respond to the emergency.
6. Executives and decision makers should possess an understanding of the regulatory criteria for other health care providers (e.g., ambulatory surgical centers, skilled nursing facilities, assisted living facilities, etc.) for closure, evacuation and re-opening / re-entry within and across a community / region.
7. Local and regional awareness through ESS of the status the health and medical community would aid decision-making and emergency operations.
8. Prioritize patient evacuations and discharges.
9. Establish timelines / triggers for evacuation and sheltering in place for decision-making and operational support and communication what delineates the decision.

10. Identify team members to remain in hospital for partial closure and provide them with the resources needed to ensure their safety while maintaining the integrity of the facility. Also, consider method for their extraction should it be needed.

11. Develop staging plan for transportation units assisting with evacuation.

12. Ensure emergency operations plan is reviewed and updated regularly and addresses closure, evacuation, sheltering in place, patient transfer and patient reception from an evacuating facility.

13. Evaluate equipment needs to support the safe evacuation of patients in austere environmental conditions (e.g., stairwells, rapid evacuation, etc.).

14. Understand the resources needed to effectively respond to the medical surge resulting from a large-scale, community-wide health care provider evacuation / closure.

15. The Agency for Health Care Administration should provide a consistent set of recommendations and procedures for re-entry and re-opening procedures to licensed, residential health care providers.

Patient Movement

1. Identify additional modes / methods of transportation, develop relationships with those companies, identify their points of contact, establish agreements and determine methods of payment prior to an event.

2. Ensure all transportation providers provide assurances and guarantees for contractual obligations.

3. Establish a mechanism to track patient movement from transfer to reception.

4. Send patient information packet / medical records, supplies, personnel, medication and food for special diets with patient, if needed or requested.

5. Ensure a list of receiving facilities is included with emergency operations plan. Update support agreements, key points of contact, and facility capability annually.

6. Florida should consider alternative mechanisms to develop, train, sustain, roster and activate volunteer medical teams to support evacuation or patient movement scenarios.

7. Ensure the continuity and standard of care is maintained when receiving patients from an evacuated facility.

Hospital and Health System Support

1. Define options to reduce overcrowding as a result of patient reception, sheltering of staff, their families and individuals from the community.

2. Collaborate among and across community health care providers to make available response plans to ensure awareness of the capacity and capability of hospitals, health systems and other providers.

3. Identify hospital liaisons to establish working relationships with county emergency management representatives to better coordinate information sharing, situational awareness and resources support. Maintain those relationships before, during and after a disaster event or incident.

4. Consider the need for additional medical staff and establish and exercise an emergency credentialing process.

5. Develop a short- and long-term plan for staff resiliency and retention (immediate needs vs. ongoing needs).

6. Consider staff tracking pre- and post-storm and provide mechanisms for staff downtime, relief and support.

7. Build a communication plan to better inform and engage staff including daily staffing briefings of the threats, situation and impacts.

8. Identify appropriate contacts and determine the best mechanism to access local, state and federal resource support.

9. Explore communication redundancies.

10. Consider the resources needed for business continuity and a mechanism to track those resources.

11. Hospital executives need to have a thorough understanding of how to request a medical assistance team (federal or other), where they would be located, the costs associated, and the capability and limitations of that asset request.

12. Florida should better utilize its mobile medical hospital to support local response and medical assistance teams.

13. “Blanket” CMS 1135 waivers should be requested through a Governor’s executive order.

Community Support

1. Develop and provide community education on personal preparedness; address the public perception that a hospital is a general population shelter.

2. Engage local media to assist with community outreach and to provide situational information.

3. Develop information management plan with the use of pre-scripted messages; trust but verify information before dissemination.

4. Involve all stakeholders within the impacted community so that resources are best utilized for everyone's benefit.

Security

1. Assess security risks and hazards in facility and community.
2. Develop a security staff augmentation plan.
3. Create a security plan for pharmaceutical supplies.
4. Provide equipment (and training on equipment) to support augmented security presence and make it readily available.
5. Provide security training to all employees.
6. Continually brief leadership on security issues.
7. Determine trigger for law enforcement coordination and support.
8. Develop, use and maintain a visitor management system to be able to identify people in your buildings.

Other Recommendations

1. Engage executives on incident command training.
2. Ensure processes are in place to accurately measure the budgetary impact of a disaster on hospital operational budgets.
3. Build trust at all levels to support emergency operations plan, decision-making and operations.
4. Recommendations for improvement to AHCA required hospital and health care provider reporting during evacuation and patient movement scenarios include:
    a. Provide a system that supports 24/7/365 monitoring;
    b. Coordinate the outreach to hospitals, and other licensed health care providers, to reduce the number of people contacting the provider and asking the same questions.
    c. Provide more training to end users;
    d. Develop a simpler reporting tool that provides critical information in a short format;
    e. Provide group access for hospital systems; and,
    f. Providing county / regional views of all providers reporting.

Available Resources

Decision Making Guides

- Agency for Healthcare Research and Quality, Hospital Evacuation Decision Guide
- Agency for Healthcare Research and Quality, Hospital Assessment and Recovery Guide
- New York City Department of Public Health and Mental Hygiene, Rapid Discharge Tool
- Occupational Safety and Health Administration, Decision Making – Evacuation or Shelter-in-Place?

Evacuation / Shelter in Place

- Arkansas Hospital Association, Template Policy on Healthcare Facility Patient Evacuation and Shelter in Place
- California Hospital Association, Shelter-in-Place Checklist
- California Hospital Association, Hospital Repopulation after Evacuation Guidelines and Checklist
- California Hospital Association, Hospital Evacuation Plan Checklist
- Colorado Health Care Coalition, Integrated Evacuation Planning Guide
- Colorado Health Care Coalition, Integrated Evacuation Plan Template
- Colorado Department of Public Health and Environment, Shelter-in-Place Functional Annex Development Toolkit
- District-of-Columbia Health Care Coalition, Evacuation Annex
- Federal Emergency Management Agency, Hospital Evacuation Principles and Practices
- Greater New York Hospital Association, 2018 Patient Evacuation Toolkit
- Harvard School of Public Health, Hospital Evacuation Resources
- John A. Hartford Foundation, the Florida Health Care Association and the University of South Florida, National Criteria for Evacuation of Nursing Homes
- Journal of Disaster & Emergency Medicine, Hospital evacuation: planning, assessment, performance and evaluation
- Massachusetts Department of Public Health and Harvard School of Public Health, Hospital Evacuation Toolkit
- Nevada Hospital Association Patient Tracking, Sheltering and Evacuation Protocol

- New York State Department of Health, Nursing Home Evacuation Worksheet
- NORC Walsh Center for Rural Health Analysis and VA Office of Rural Health Policy and Planning Group, Urban to Rural Evacuation Tool
- Sample transfer agreement
- State of Georgia, Regional Integrated Healthcare Community Evacuation Plan and Receiving Plan Template Guideline
- State of Georgia, Regional Integrated Healthcare Community Receiving Plan Template
- State of Georgia, Regional Integrated Healthcare Community Evacuation Plan Template

Alternate Care Site

- Agency for Healthcare Research and Quality, Disaster Alternate Care Facilities: Report and Interactive Tools
- Center for Infectious Disease Research and Policy, Alternate Care Site Planning Toolkit
- Florida Department of Health, Alternate Care Site Standard Operating Procedure, 2013
- Institute of Medicine (US) Forum on Medical and Public Health Preparedness for Catastrophic Events, Establishing Alternate Care Facilities

Patient Tracking

- Brigham and Women's Hospital, Harvard Medical School, and Elsevier, Managing Patient Information during a Mass Casualty Incident

Other

- U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, Technical Resources Assistance Center and Information Exchange, CMS Emergency Preparedness Rule Integrated Healthcare Systems Implications
- Florida Hospital Association, 2018 Emergency Volunteer Management Planning Considerations and Resources