New Jersey
Emergency Medical Services Task Force

NJEMSTF Plan Name	
Statewide Healthcare Facility Evacuation Plan	
Original Plan Creation Date	**Latest Plan Review Date**
January 2017	July 2024
Target Stakeholders	
Hospitals Long Term Care Facilities Nursing Homes Assisted Living Facilities	
For assistance activating this plan contact your County EMS Coordinator or call New Jersey EMS Task Force Operations Center (TFOC)	
(973) 878-9911	

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PROMULGATION STATEMENT

The New Jersey Department of Health hereby recognizes the New Jersey Emergency Medical Services Task Force Support Group, a NJ non-profit corporation, as the entity responsible for carrying out the duties of the Department as required by P.L.2017, c.116, which establishes that the Department of Health will manage, coordinate, and administer the activities of the New Jersey Emergency Medical Services Task Force.

ENDORSING SIGNATURES

We, the undersigned, have reviewed and approved these Guidelines for Incident Rehabilitation for use in local and county plan development.

New Jersey Emergency Medical Services Task Force (NJEMSTF)		
Name	**Date**	**Signature**
New Jersey Department of Health – Office of Emergency Medical Services (NJ DOH-OEMS)		
Name	**Date**	**Signature**
New Jersey Hospital Association (NJHA)		
Name	**Date**	**Signature**
New Jersey County Office of Emergency Management – Emergency Medical Services		
Name	**Date**	**Signature**

ACKNOWLEDGEMENTS

This project is a joint venture between the New Jersey EMS Task Force, New Jersey Hospital Association, New Jersey Department of Health, and the NJ County OEM EMS Coordinators. It reflects existing plans, standards, and best practices promulgated by the New Jersey Department of Health, the U.S. Department of Health and Human Services, and the Federal Emergency Management Agency.

DISCLAIMER

The information in this document, and its attachments, are extremely sensitive information and should be distributed to only those individuals and agencies that are directly involved with operations covered by this document. This material is considered **CONFIDENTIAL** and **FOR OFFICIAL USE ONLY**; distribution should thus be limited.

FORWARD

In order to continue housing and caring for patients following a disaster, hospitals and healthcare facilities must have certain critical elements in place. These include:

- Stable physical plant (structural integrity, building envelope, etc.)
- Reliable infrastructure (electricity, heating/cooling plant, potable water, etc.)
- Safe environment (clean air supply, physical security)
- Uninterrupted resource delivery (staffing, medications, supplies, etc.)

When some situation threatens one or more of these elements, facility leadership must quickly evaluate the extent to which the facility's continued ability to function is impacted and determine if the situation can be mitigated using internal or external resources. If the situation exceeds – or has the reasonable potential to exceed – the facility's ability to compensate, leaders must decide whether to evacuate patients and staff. Such an evacuation might include all patients or only certain categories of patients depending on time, available resources, and the specific circumstances at hand. An evacuation may be carried out proactively upon learning of a potential threat (an Advanced Warning Event such as a hurricane) or in response to a No Advanced Warning Event (such as an earthquake or terrorist attack.)

Whereas most emergency responses begin at the local level, certain events – such as the evacuation of a healthcare facility – will far exceed local resources. These incidents require significant assets and operational support from multiple disciplines and jurisdictions. This plan is intended to provide a flexible framework for well-coordinated evacuation of hospitals and other healthcare facilities using a combination of county, state, and/or federal resources.

AUTHORITY & REFERENCES

The following authorities and references establish the operational concepts contained in this plan:

Federal

- Emergency Medical Treatment and Labor Act (EMTALA)
- Center for Medicare and Medicaid Services (CMS)
- Assistant Secretary for Preparedness and Response (ASPR)
- Federal Emergency Management Agency (FEMA)
- National Incident Management System
- National Response Framework

State

- Emergency Management Act, N.J.S.A. App. A:9-33 et seq. (Authorizes the control of Traffic).
- State of New Jersey Emergency Operations & Response Plan – Emergency Support Function #8
- New Jersey Statewide EMS Staging Area Management Plan
- New Jersey Statewide Helicopter EMS Helibase Management Plan
- New Jersey Statewide EMS Ambulance Strike Team Plan References

Private Sector

- Facility Emergency Operations Plan
- Accrediting agencies

SCOPE AND LIMITATIONS

As of 2024, there are 71 hospitals with a total staffed bed count of 20,213 and hundreds of other healthcare facilities in New Jersey. Of those hospitals there are three (3) Level I Trauma Centers and seven (7) Level II Trauma Centers. Within the State, there are 421 EMS agencies licensed by NJ Department of Health.

New Jersey's Basic Life Support (BLS) Emergency Medical Services agencies include a combination of career and volunteer organizations. Advanced Life Support (ALS) resources are provided by a network of hospital-based Mobile Intensive Care Programs.

This plan is applicable to all hospitals, healthcare facilities and EMS organizations in the State of New Jersey. Although the plan provides guidance by which facility administrators may decide to evacuate, its focus is the evacuation process itself.

While parts of this plan reference various disaster scenarios by example, it is impossible to address every potential scenario that might lead to a hospital evacuation. This plan therefore serves as a general evacuation framework that must be applied to the situation at hand in combination with common sense and sound judgment.

The decision to evacuate, prioritization of patients for transport, and/or adoption of crisis standards of care are the sole responsibilities of the facility in question. No part of this plan should replace clinical judgment or usurp any facility's own decision-making authority.

Healthcare facility evacuations are complex incidents requiring the efficient integration of multiple specialized response entities. For this reason, the Evacuating (Sending) healthcare facility should implement a "Unified Command" with response partners.

PURPOSE

The purpose of this plan is to establish procedures for healthcare facilities, County OEM EMS Coordinators, and the New Jersey EMS Task Force to use when integrating with healthcare facility evacuation operations. This plan will outline requesting the NJEMSTF Incident Advance Team (IAT), NJEMSTF operational guidelines, special considerations, authority, use of EMS Strike Teams / Task Forces, other EMS assets, the Incident Command System (ICS), air medical assets, communications, alerting, notification procedure

PLANNING ASSUMPTIONS

- Healthcare facilities require evacuations under certain conditions.
- Each year, some of these facilities face internal and external disasters which may threaten to force the evacuation of some or all their patients.
- Hospitals and healthcare facilities will manage the incident using the National Incident Management System compliant Incident Command System (ICS) as defined by FEMA, or other nationally recognized Hospital Incident Command System (HICS).
- A plan for integrating a management team of EMS personnel into the healthcare facility Incident Command Structure is needed.

- Necessary staff and transportation resources will be available to support the evacuation using some combination of local, county, state, and private transportation assets.

- Other hospitals and healthcare facilities (either in-state or out-of-state) have the capacity to accept patients from the evacuated facility.

- When implementing this plan, hospitals will coordinate their operations with local and state emergency management partners to optimize allocation of scarce resources and ensure prioritization of care for the most vulnerable patients.

SITUATION OVERVIEW

Some emergency situations prompt the need to evacuate a hospital or other healthcare facility, in whole or in part, based on the criteria in Tab 2: Hospital Evacuation Decision-Making. This situation may be the result of a natural or human-caused event (see Hazard Analysis Summary below.) Specifics of the situation will inform key variables in the evacuation process for a given incident. These include:

- Warning Time: Advance Warning Events are incidents such as significant weather that come with enough warning time to consider Pre-Event Evacuation while the hospital structure and surrounding environment are not yet significantly compromised. No Advanced Warning Events include incidents such as utility failure, fire, earthquakes or terrorist attacks where there is little or no advance warning, and any evacuation decision is made after the facility has already been impacted.

- Scale of Evacuation: Some situations will require evacuation of the entire facility while others will only require evacuation for certain categories of patients or certain sections of the facility.

- Urgency of Evacuation: The level of immediate threat to patients and staff will determine whether the facility has time for an orderly, well-planned evacuation or if an immediate “drop everything and go” evacuation iswarranted.

- Scope of Impact: The facility’s ability to evacuate in a timely manner will depend in part on whether the precipitating event is localized (effecting only the facility itself) or widespread/regional in nature (such as flooding following a hurricane).

When considering evacuation of a healthcare facility, it is important to distinguish the precipitating event from the proximal reason(s) for evacuation. For example, hospital facilities aren’t evacuated because of a hurricane. It is evacuated because its ability to continue caring for patients is impacted by the effects of the hurricane such as flooding, utility disruption, or structural damage. This concept is of particular importance when considering pre-event evacuation, which should be based on an analysis of the Impending Event versus the facility’s infrastructure self-assessment (see Tab 1: Critical Infrastructure Assessment)

This plan shall serve as a Standard Operating Guideline (SOG) for healthcare facilities integrating with EMS resources for the purpose of evacuation.

The New Jersey Department of Health (NJDOH) will be notified of a pending healthcare facility evacuation. When the size and scope of the evacuation is beyond the capabilities of the healthcare facility's contracted ambulance provider a request for local, regional, and New Jersey EMS Task Force will be made from the Healthcare facility's Command Center to the respective Local/County OEM.

HAZARD ANALYSIS SUMMARY

A complete analysis of the hazards facing each healthcare facility is beyond the scope of this plan. Each facility covered by this plan must consider their current Threat and Hazard Risk Identification and Assessment (THIRA) in relation to their Critical Infrastructure Assessment (see Tab 1.) As described above, it is not a hazard itself that leads to evacuation but rather the effects of that hazard. The hazards that would most typically be expected to precipitate evacuation may include:

- Severe weather (hurricanes, tornadoes, nor'easter storms)
- Earthquakes
- Structure fire or explosion*
- Hazardous materials release*
- Technological failure*

* refers to both accidental and intentional events.

The proximal cause(s) of evacuation resulting from these hazards thus includes:

- Unstable physical plant (loss of structural integrity, damage to building envelope, etc.)
- Loss of reliable infrastructure (electricity, heating/cooling plant, potable water, etc.)
- Unsafe/hazardous environment (lack of clean air supply, physical security, etc.)
- Potential interruption of resource delivery (staffing, medications, supplies, etc.)

CAPABILITY ASSESSMENT

Incidents involving healthcare facility evacuation are generally well beyond the capabilities of any one facility or local jurisdiction. As a part of the pre-planning process, each facility covered by this plan must develop a realistic assessment of their vulnerabilities when faced with different types of hazards and their capabilities with respect to mitigating the effects of those hazards. For example, hospitals are equipped with large backup generators that mitigate the effects of a major power outage, allowing the facility to sustain operations despite a loss of service from the public grid.

Any time a healthcare facility is evacuated, patients and staff are placed at some level of risk. This is particularly true for the most acutely ill and unstable patients who require advanced interventions and equipment to keep them alive. (Some of these patients may in fact be too sick to move at all except under the most immediately life-threatening circumstances.) Due to the considerable life risks presented by evacuation, it is always preferable to shelter in place when possible. Before starting to evacuate, healthcare facilities must first determine if supplemental outside resources can be brought in and/or

patients redistributed within unaffected/undamaged areas of the facility. Even if such actions are not ultimately sufficient to keep the hospital operational in the long term, they may increase the available time for evacuation and thus reduce the risk to patients and staff.

CONSIDERATIONS

- Few if any healthcare facilities in New Jersey could manage EMS operations at a large-scale evacuation of a healthcare facility on their own.
- Consideration must be given for specialized assets that may be needed to transport a patient to another facility (i.e. – helicopter, ventilator, isolettes, bariatric, etc.)
- A total evacuation of a healthcare facility may overwhelm the private ambulance service contracted by the healthcare facility, as well as the local EMS agency.
- A coordinated system for managing a healthcare facility evacuation is necessary.

PRIMARY AGENCIES IN THIS PLAN:

- New Jersey EMS Task Force(NJEMSTF)
- New Jersey Hospital Association (NJHA)
- New Jersey Department ofHealth (NJDOH)
- New Jersey Healthcare Facilities
- Regional Medical Coordination Centers
- County OEM EMS Coordinators of New Jersey (ESF-8)
- New Jersey State Police Aviation Bureau / JEMSTAR
- Contracted and Local EMSProviders
- Local/County Office of Emergency Management
- Air Medical Companies
- Medical Transportation Association of NJ

APPLICABLE FEDERAL – STATE - LOCAL ORDERS

1. NJ Offices of Emergency Management – Local / County / State EVACUATION Order
    a. New Jersey Emergency Management Officials have the right to order a mandatory evacuation. This evacuation order can be implemented for any situation that threatens the health, safety or welfare of a community.
2. NJ Health Powers Act – Local / County / State EVACUATION Order
    a. C.26: 13-8 Powers of commissioner relative to facilities, property; hearing.
        i. During a state of public health emergency, the commissioner may exercise the following powers over facilities or property:
            - Facilities. To close, direct and compel the evacuation of, or to decontaminate or cause to be decontaminated, any facility of which there is reasonable cause to believe that it may endanger the public health.

CONCEPT OF OPERATIONS

Mission

The mission of the New Jersey EMS Task Force and New Jersey Healthcare Facility with respect to this plan is to facilitate continuation of care for all hospital patients in the region following any incident that threatens the sustainable operation of the region's healthcare facilities. When transporting and caring for patients under austere circumstances with limited resources, the plan seeks to do the best for the greatest number of patients under crisis standards of care.

Objectives and Priorities

With respect to both Pre-and Post-Event Evacuations, this plan's objectives include:

1. Guide hospital administrators and clinical staff in making appropriate decisions with respect to facility evacuation and transport prioritization.
2. Provide a framework for tracking patients during transport and for ensuring transfer of essential medical records to maintain continuity of care.
3. Ensure to the greatest extent possible safety of patients, hospital staff, and first responders during the evacuation process.

ROLES AND RESPONSIBILITIES

Sending Facility Leadership/Administration

- Appoint an Incident Commander (IC) and work with the IC to make decisions regarding facility evacuation in whole or in part.
- Establish a secure area to act as a hospital command post.
- Authorize internal resources needed to support evacuation.
- The sending facility has the primary responsibility of ensuring the safety of all patients being moved between locations.

Local EMS Providers

- The local EMS provider will undoubtedly have been involved in some aspects of a healthcare facility evacuation. It is recognized that with a few exceptions local EMS providers will not have the resources available to handle this type of operation without involvement of additional local, county, and state assets.

Local Office of Emergency Management

- The local Office of Emergency Management will play a vital role in managing resources available on the local level and act as a liaison with County and State resources.
- Serve as the sending facility's initial point of contact for evacuation planning.
- Initiate an EMMIT request in the NJOEM Resource Management System for the NJEMSTF IAT

Local and/or County Office of Emergency Management (OEM)

- Manage EMS and other supporting resources at the local level.
- Serve as liaison with county and state resources.
- Oversee mutual aid EMS resources to supplement contract ambulance service(s); coordinate with County OEM EMS Coordinators in other counties and State EMS Coordinator to obtain mutual aid

resources.

- Initiate, or approve the Local EMMIT request, to the SEOC.
- Manage and prioritize the deployment of EMS resources when multiple facilities are being evacuated simultaneously; coordinate evacuation timing between two or more Sending Facilities to optimize available transport resources.
- Request the use of the New Jersey EMS Task Force (NJEMSTF) through the Regional Emergency Medical Communication System (REMCS) when called for.
- Ensure continuation of EMS service countywide while evacuation is underway.
- When necessary, assign a local OEM staff person to serve as EMS Liaison Officer at the Sending Facility.

County OEM EMS Coordinators

- The County OEM EMS Coordinator that oversees the county in which the facility is in will be responsible for obtaining mutual aid EMS resources to supplement the private contract ambulances.
- This County OEM EMS Coordinator will coordinate with the other County OEM EMS Coordinators throughout the state as well as the State EMS Coordinator to obtain mutual aid resources.
- The County OEM EMS Coordinator may also officially request the use of the NJEMSTF through the Regional Emergency Medical Communication System (REMCS) in Newark.
- County OEM EMS Coordinators will work with the Facility ICS to assist in the evacuation while maintaining countywide provision of EMS.
- The County OEM EMS Coordinator may assign a provision of transport ambulances as part of a Ambulance Strike Team/Task Force and designee to serve as the EMS Liaison Officer at the healthcare facility.
- The County OEM EMS Coordinator will provide access to PPE and decon equipment in addition to logistical support at the healthcare facility.
- The County OEM EMS Coordinator will log into the D4H Incident Management System to enter and monitor resource requests, as well as update the situation board.

New Jersey EMS Task Force (NJEMSTF)

- The NJEMSTF and County OEM EMS staff will integrate into the Facility ICS and will be responsible for overall management for the EMS resources evacuating patients from the facility.
- The NJEMSTF will initiate an incident in the NJEMSTF D4H Incident Management System, and invite all identified personnel into the incident for access.
- The NJEMSTF will also provide Staging & Accountability, Communications, Helibase Management, Planning, situational awareness, a provision of Medical Ambulance Bus's (MABs) including loading and unloading crews, to assist as needed with the evacuation.
- If an EMS Branch Director was appointed by the Facility's Incident Management Team (IMT) the EMS Task Force Leader will report to the EMS Branch Director or other position as designated by the Facility's Incident Commander.
- If a Unified Command is established the Task Force Leader or County EMS Coordinator will become part of the Unified Command.
- Establish, as needed. The NJ EMS Task Force Operations Center (TFOC) to assist in coordination of resource requests, fulfilment, and tracking.

Regional Emergency Medical Communications Center (REMCS)

- REMCS – Statewide Air Medical and NJ EMS Task Force Operations Center will be responsible for obtaining mutual aid assistance or supplementing the healthcare facility's air medical capabilities for air medical resources to assist with the evacuation of patients from the facility.
- Assist the NJEMSTF with notifications or coordinator of assets, as needed.

Receiving Facility Command Staff

- Provide leadership and coordination for evacuation operations; ensure coordination of effort between all sections.
- Establish an Incident Action Plan (IAP) incorporating guidance from OEM/Sending Facility Leadership/Administration.
- Designate a receiving facility for each patient being evacuated and communicate to the NJEMSTF Leader and County OEM EMS Coordinator.
- Facilitate the safe and efficient transport of all patients and staff being evacuated from Sending Facility
- Provide tracking for all individuals transported.
- Monitor the NJEMSTF D4H Incident Management System's Patient Tracking dashboard.

Sending Facility's Clinical Staff

- Identify transport requirements and priority for each patient.
- Prepare patients for transport and ensure medical records are complete.
- Accompany unstable, critically ill, or injured patients during transport when necessary.
- Monitor the NJEMSTF D4H Incident Management System's Patient Tracking dashboard.

Private Ambulance Companies

- The private ambulance company contracted with the facility should be one of the first agencies notified of the possibility of an evacuation.
- The private ambulance company may obtain large numbers of resources internally or through the Medical Transportation Association (MTA) of New Jersey.
- These resources should be the primary means of transportation for the patients from the facility.

State Emergency Operations Center (SEOC)

- Support County OEM EMMIT resource requests at the state level.
- Request activation of FEMA's federal ambulance contract or Emergency Management Assistance Compact (EMAC) when NJ DOH determines out-of-state resources are needed.
- Request support/resources from the National Disaster Medical System (NDMS) when called for.
- Monitor the NJEMSTF D4H Incident Management System's Situation Board

Sending Facility's Ambulance Service

- Immediately deploy available EMS resources to the Sending Facility upon plan activation.
- Integrate operations with out-of-area ambulance strike teams and task forces as needed.
- Request/coordinate additional contract ambulance resources through the County EMS Coordinator.

Federal Emergency Management Agency (FEMA)/National Ambulance Contract/EMAC

- When requested through the State Emergency Operations Center (SEOC), deploy EMS and other transportation resources to assist in hospital evacuations, shelter staffing, and related mission assignments during large-scale incidents.
- Provide overhead, staging, planning, and logistics support for EMS and other transportation resources deployed under the federal ambulance contract.

New Jersey Hospital Association (NJHA)

- When requested, support the collection and collation of regional health information, situation awareness, the monitoring of health care system performance and capacity, support to health care system logistic requests in coordination with state and local agencies, and other operations as determined by NJDOH
- Update the hospital status' in the NJEMSTF D4H Incident Management System's Receiving Hospital portal.
- Monitor the NJEMSTF D4H Incident Management System's Patient Tracking dashboard

EVACUATE OR SHELTER-IN-PLACE

The decision to evacuate or establish a shelter-in-place lies with the Agency Administrator. To help make that decision, the following steps should be taken, and the resulting information should be evaluated.

Initial Actions

As soon as a healthcare facility recognizes a potential need to evacuate (SENDING FACILITY), staff should begin compiling a detailed census of all patients in the hospital and an assessment of the resources needed to move each. Clinical staff at the Sending Facility should apply consistent criteria in identifying patients for whom early discharge is a relatively safe option.

The number of patients requiring evacuation is typically much smaller than the total census, as many low-acuity, medically stable patients can safely self-evacuate or evacuate with family members.

Only a portion of those patients who must be evacuated to another facility will require ongoing medical monitoring and/or care during transport. Other patients being moved will require ambulatory assistance. Still, they may be evacuated by a vehicle such as a Medical Ambulance Bus (MAB) or wheelchair van rather than a Type IV ambulance.

To properly estimate the EMS and other vehicle resources needed for the planned evacuation, Sending Facility clinical staff should complete the **Evacuation Resource Worksheet: Evacuation Resource Requirements**. (FORMS Section)

Based on the needs of the incident, patients may be transferred to an intermediary site (e.g., a high school gymnasium or other large public building) to expedite the evacuation. The EMS Branch must determine from the Operations Section Chief if this approach will be utilized for this event.

This plan may be activated by a healthcare facility (the Sending Facility) when the size and scope of an evacuation are determined to be beyond the capabilities of the facility's resources.

The anticipated evacuation may be whole or partial, depending on the circumstances at hand.

Pre-Incident Notifications

When a hospital facility recognizes a situation that may require evacuation, the hospital's Incident Management Team (IMT) should immediately notify their local and/or county Office of Emergency Management (OEM) and the NJ EMS Task Force Operations Center. This contact is for purposes of advance notification only, and no response will be initiated until the Sending Facility formally requests it.

The notification to either the County OEM Coordinator and/or the NJ EMS Task Force will initiate the following notification chain: This notification should not cause a response until there is a "Request."

Notify	Notifier
Local / County OEM Coordinator	By healthcare facility
County EMS Coordinator	By County OEM Coordinator
REMCS	By County EMS Coordinator
NJ EMS Task Force Incident Advance Team	By REMCS and/or County EMS Coordinator
NJ EMS Task Force Operations Center (TFOC)	By NJEMSTF IAT
NJ Department of Health EMS Coordinator	By NJEMSTF Operations Center
NJEMSTF Modules, as needed	By NJEMSTF IAT

Incident Advance Team (IAT) and Resource Requests

Once the facility's IMT initiates a "Request" through the Local or County Office of Emergency Management, County OEM EMS staff and available NJEMSTF Incident Advanced Team (NJEMSTF IAT) personnel will respond to the healthcare facility incident command post (ICP). When possible, this response should include the following:

- One (1) NJEMSTF Leader
- One (1) County OEM EMS Coordinator
- Two (2) NJEMSTF Planners or Planning Specialist
- One (1) NJEMSTF Mobile Operations Center (MOC)

Additional NJEMSTF IAT members and County OEM EMS staff will meet at a Staging Area and provide support to the IAT. The IAT will integrate with healthcare facility IMT. The healthcare facility IMT will

provide a Briefing and will work with the County EMS Coordinator and NJEMSTF IAT Leader to assign the appropriate ICS positions. This request must be documented in the NJ OEM EMMIT Resource Request system.

During this initial response, the IAT should notify the Staging & Accountability Officers via cell phone or the Communicator to alert them of the potential for activation. This will give the Staging & Accountability personnel time to begin organizing resources. The IAT will decide to deploy the staging and accountability module. Ideally, this module should be onsite before or upon initiation of an evacuation. During this alert phase, the Staging & Accountability personnel should:

- Determine the closest available Staging Trailer to be deployed
- Determine the availability of a healthcare facility helipad or the nearest appropriate LZ to serve as a helispot
- Identify key management personnel available to respond
- Locate at least one, preferably two, sites near the healthcare facility to be utilized for incident staging
- Determine the possible need for and make recommendations on the use of the County or Regional Staging Area

During catastrophic incidents when in-state resources are overwhelmed, significant additional resources may be requested under FEMA's federal ambulance contract and/or the National Disaster Medical System (NDMS) through the State Emergency Operations Center (SEOC).

Briefing the NJ EMS Task Force Incident Advance Team

The SENDING Facility will provide an Incident and Safety Briefing to the County EMS Coordinator and the NJEMS Task Force IAT after Check-in and Assignment. The IAT personnel will integrate into the healthcare facility incident command structure. See above assignment.

During an initial briefing, the IAT must obtain the following information:

- Physical address of facility and location of Hospital Command Center / EOC
- Cause of the facility evacuation
    - Utility Issues
    - Fire / Gas Leak
    - Flooding
    - Structural Issue
- Situation Status and Incident Objectives
- Urgency of evacuation
- Scale of evacuation (estimated number of patients to be evacuated)
- Number of patients in the healthcare facility, broken down into acuity level and specialty transport resource requirements.
    - SCTU / ICU
    - Ventilator / Oxygen Dependent
    - Pediatric / NICU / Isolettes
- The healthcare facility's contracted ambulance service(s)
- Receiving facilities
- Availability of transportation resources (healthcare facility shuttle vans, buses, etc.)

In consultation with the NJEMSTF Leader and the County OEM/EMS Coordinator, the healthcare facility will choose which facilities receive their patients, considering the available transportation resources. EMTALA and CMS require the healthcare facility to determine where patients are transferred to and for the receiving facility to accept the patients before the transfer occurs. If transfer agreements cannot be made and MOUs are not sufficient to accommodate the entire patient population, the Facility's IMT will decide which facilities their patients will be transported to. The NJHA can be a resource when determining receiving facilities.

DECISION TO EVACUATE

Execute the Healthcare Facility Evacuation Plan

- Stand-Up the Hospital's Incident Command Post and activate the Hospital's Incident Management Team.
- Make ICS Assignments and prepare to brief responding resources.
- Plan on the formation of a UNIFIED COMMAND (Hospital-EMS-Law Enforcement-Fire)

Safety Note: MEDICAL UNIT - When the complexity, duration, and / or timing of the operation presents a risk to the wellbeing of the responders, the EMS Branch may request the formation of a Medical Unit. The Logistics Section Chief may assign a Medical Unit Leader. The Medical Unit may include a designated ambulance tent or MAB.

Notify Local or County OEM

When contacting the OEM to initiate hospital evacuation, the Sending Facility's Incident Management Team (IMT) should be prepared to provide the following preliminary information:

- Overview of situation and reason for evacuation
- Total number of patients and staff currently in the facility
- Estimated number of patients who will require assistance in evacuating
- Summary of ambulance and other vehicle assets currently available to the Sending Facility
- Special considerations (i.e., burn units, detox facilities, highly infectious patients, etc.)

Deployment of New Jersey EMS Task Force and Operations (Standard Mission Package)

Once the evacuation has been determined by Unified Command and the IAT, the following NJEMSTF resources shall be requested as soon as possible. Each position will integrate the following into the NJEMSTF Operations and the Facility Incident Command System:

Personnel (24)

- One (1) Staging Area Manager
- Three (3) Staging Specialists
- Ten (10) Mass Care Specialists
- Two (2) Communications Specialists and the nearest radio cache
- Four (4) Planning Specialists (D4H data entry)
- Four (4) Logistics Specialists

Assets and Specialized Vehicles (4)

- One (1) Staging Area Management Trailer
- One (1) EMS Command Center (ECC)
- One (1) Mass Care Response Unit (MCRU)
- One (1) Special Operations Vehicle (SOV)

Additional Assets / Resources as Needed (Incident Specific)

- Medical Ambulance Buses (see NJEMSTF Resources)
- Mass Care Response Units (MCRU)
- Special Operations Vehicle (SOV)
- Oxygen Generation Unit (see NJESMTF Resources)
- ASAPs / Gators (see NJEMSTF Resources)
- Gatekeeper Field Hospital System
- HVAC / Water Purification
- Advanced Communications Systems
- Generators (Electric)
- Site Support Unit

Staging Area Management

One Staging Area Management Trailer and at least four Staging Area personnel should be directed to the Incident Staging Area. These personnel will establish Incident Check-In and form single resources into Strike Teams and Task Forces as needed. They will coordinate with the EMS Branch Director in the healthcare facility incident command system. Status Check-in Recorders will report to the Resource Unit Leader. Status Check-in Recorders will provide timely resource information to the Resource Unit Leader in the healthcare facility Command Center. This can be accomplished through the NJEMSTF D4H Incident Management system.

Mass Care Specialists

The Mass Care Specialists will deploy from the Staging Area to the EMS Branch and receive a briefing and assignment. These personnel will assist with overseeing patient loading, unloading, and tracking destinations. This tracking can be accomplished through the NJEMSTF D4H Incident Management system.

Communications Specialists

The Communications Specialists will assist the Communications Unit Leader in developing the Incident Communications Plan in the NJEMSTF D4H Incident Management system on an ICS-205 form, ensuring interoperability among the healthcare facility, NJEMSTF, and transporting EMS agencies. The nearest radio cache should be sent to the scene to provide additional interoperable radios and radio hardware. One of these Specialists should function as an Incident Dispatcher under the direction of the EMS Branch Director to oversee communication with transporting Strike Teams / Task Forces.

Planning Specialists

The planning specialists should deploy to the healthcare facility's Incident Command Post and check in with the Planning Section Chief. NJEMSTF Planning Specialists will assist the Planning section with managing incident information and situational awareness.

Ambulance Strike Teams and Task Forces

Single-resource ambulances should be formed into Strike Teams or Task Forces before transporting patients from the healthcare facility. This improves accountability while maintaining a manageable Span of Control. Resources being sent in from other counties will likely be formed into Strike Teams or Task Forces by their County OEM EMS Coordinators; however, if they have not been, the following guidelines should be used for organizing:

- A **Type IV** Ambulance Strike Team consists of five (5) Basic Life Support Ambulances, staffed by at least two (2) EMTs, capable of transporting two (2) non-ambulatory patients, with common communications, and a leader in a separate non-transport vehicle
- A **Type II** Ambulance Strike Team consists of five (5) Advanced Life Support Ambulances, staffed by at least two (2) EMT-Paramedics, capable of transporting two (2) non-ambulatory patients, with common communications, and a leader in a separate non-transport vehicle
    - The New Jersey Department of Health Office of Emergency Medical Services may provide waivers to allow one (1) Paramedic to operate with one (1) EMT and/or utilize a non-licensed ALS vehicle. Five ambulances of this configuration would also meet the requirement for a Type II Ambulance Strike Team.

- An **Ambulance Task Force** consists of any combination of ALS and BLS resources, typically five (5) BLS ambulances and one (1) ALS vehicle, with common communications, and a leader in a separate non-transport vehicle.

- A **Type 1 Multi-Patient Medical Transportation Vehicle** (NJ Medical Ambulance Bus – MAB), is a climate-controlled vehicle staffed by a driver who is licensed and certified to operate the vehicle, and EMS staffing levels / training and medical equipment / supply levels commensurate with the mission assignment. The vehicle is minimally capable of transporting 10 seated patients and one wheeled ambulance cot patient.

- The **Staging Specialists** should ensure that a leader is designated for each Strike Team or Task Force prior to assignment, and that the leader has the ability to communicate with the Incident Dispatcher and the other units within his/her Strike Team

- The composition of each Strike Team / Task Force should be recorded and transferred to the **Resource Unit Leader** in the Healthcare facility Incident Command System as soon as possible.

When dispatched from Staging, the Strike Team / Task Force will report to the designated area for loading departing patients and report to the Transport Group Supervisor or designee. Strike Teams / Task Forces will follow the direction of the Transport Group Supervisor or designee when loading patients into ambulances.

The Planning Specialists should make it a priority to obtain addresses, maps, and/or directions to the receiving healthcare facilities. These directions or maps should be given to the Strike Team / Task Force Leaders prior to their departure from the sending healthcare facility.

Multiple Operation Periods

The NJEMSTF Planning Specialists should assist the EMS Branch or designee with planning for the next or multiple operation periods when it is potentially or known to be needed.

Communications

While it may be impractical to pre-designate a Communications Plan for each healthcare facility, it is critical that communications are centralized in the healthcare facility's incident command center and that the command center has access to all established communications links.

A general guideline for establishing communication should be:

- Mutualink, telephone or radio link between the healthcare facility Command Center and the MCC (if applicable), local OEM, and County OEM (if required) will be established.
- County OEM (Statewide Frequency) Radio – Communications between the healthcare facility Command Center and County OEM
- OEM EMS County Coordinators Talk Group (Statewide Frequency) – Communication between County OEM EMS Coordinators for resource acquisition
- VTAC or UTAC – EMS Operations – frequency to be determined by incident needs
- JEMS 3 (VHF) – Staging
- JEMS 4 (VHF) – Air / Ground communication between Air Medical Branch Director, Helispot Managers, Helibase Managers, and pilots
- Additional frequencies would be assigned as needed

Communications Plan

The Communications Unit Leader will develop the approved Incident Communications Plan as needed in the NJEMSTF D4H Incident Management system, on an ICS-205 form. The healthcare facility IMT may assign an NJEMSTF Communications Specialist to the Communications Unit to facilitate the process and plan development.

The Incident Dispatchers or Unified Command representative will provide all key stakeholders with updates via radio, web-conference, or telephone on a schedule determined by the MCC. These updates can also be made via email, or other agreed upon method of communication including the NJEMSTF D4H Incident Management Situation Board.

New Jersey EMS Task Force Positions to Establish

This section will describe the minimum required positions to be established for any Healthcare Facility Evacuation (positions specific for EMS / NJEMSTF operations). All positions filled will be part of the overall Hospital Incident Command System (HICS) when appropate. If the incident expands, additional positions may be established to meet the needs of the objectives and Incident Command System.

COMMAND STAFF

Incident Commander (IC) / Unified Command (UC): This position shall be filled by a Task Force Leader, Task Force Planner, or next most qualified member of the IAT. The IC / UC is responsible for the overall operations of the NJEMSTF activities during a Healthcare Facility Evacuation. He or she shall set the incident objectives in collaboration with the requesting facility and County EMS Coordinator.

Patient Accountability Officer (PAO): The main role of the PAO is to work with IC / UC and the Hospital Command Center (HCC) staff to ensure that all patients are tracked from start to finish. The PAO will work with the assigned planning specialist to import all patients into the D4H Patient Tracking System. Counts from sending facility and receiving facility will be checked periodically throughout the incident. In the event of a missing patient the PAO will work with the Operations Section Chief to investigate. The PAO will provide the final counts to the IC / UC and the end of the incident.

Safety Officer (SO): The Safety Officer is responsible for ensuring the safety and security of all personnel, patients, and equipment during the evacuation of a healthcare facility. This role involves assessing and mitigating risks, coordinating with emergency services, and implementing safety protocols to ensure a smooth and safe evacuation process.

Public Information Officer: The Public Information Officer (PIO) is responsible for managing communication between the EMS operation and the public during the evacuation of a healthcare facility. This role involves disseminating accurate information, handling media relations, and ensuring effective communication with all stakeholders to maintain transparency and public trust. When possible, the PIO will work with the facility PIO on all media releases regarding the evacuation. This role may be virtual.

GENERAL STAFF

Operations Section Chief (OSC): The Operations Section Chief is responsible for managing all EMS tactical operations during the evacuation of a healthcare facility. This role involves overseeing the deployment of EMS personnel, coordinating with other emergency services, and ensuring the effective execution of the evacuation plan to safeguard patients, staff, and resources. The following positions will fall under the OPC during the activation of this plan: S*taging Area Manager, Movement Group Supervisor, Evacuee Collection Point Group Supervisor, Transportation Group Supervisor, Receiving Group Supervisor.*

Planning Section Chief (PSC): The Planning Section Chief is responsible for overseeing all planning activities during the evacuation of a healthcare facility. This role involves developing and maintaining the incident action plan (IAP), collecting and analyzing information, and ensuring that the operations are strategically aligned to achieve the evacuation goals. The following positions will fall under the PSC during the activation of this plan: *Situation Unit Leader, Resources Unit Leader.*

Logistics Section Chief (LSC): The Logistics Section Chief is responsible for managing all logistical aspects of the evacuation of a healthcare facility. This role involves ensuring the provision and coordination of resources, supplies, and services required to support the evacuation operations. The Logistics Section Chief plays a crucial role in maintaining operational efficiency and effectiveness. The following positions will fall under the LSC during the activation of this plan: *Communications Unit Leader and Medical Unit Leader.*

OPERATIONS SECTION

Staging Area Manager: The Staging Area Manager is responsible for managing the staging area during the evacuation of a healthcare facility. This role involves organizing and coordinating the arrival, check-in, staging, and deployment of personnel, equipment, and supplies. The Staging Area Manager ensures that resources are imported to the D4H Staging Area section to provide real time availability of assets. The following positions will fall under the SAM: *Check-In / Check-Out and Staging Specialists.*

Evacuation Group Supervisor: This role will oversee the members assigned to evacuation crews that are physically moving the evacuee from location in facility to Evacuee Collection Point. Coordinate the assigned resources into evacuation crews. Ensure evac crews are giving proper location of the evacuee in the facility. Ensure the evac crew are aware of the Evacuee Collection Point (ECP). Utilize the D4H Patient Evacuation section to determine the status of the patients that require movement. The Evac Group Supervisor may also assign staff to each floor of the facility to ensure evac crew are assigned the correct patient for evacuation. The following positions will fall under the EGS: *Evacuation Crews*

Evacuee Collection Point Group Supervisor: The ECP Group Supervisor will establish an Evacuee Collection Point for evacuees coming from the facility. This area will serve as a "staging area" for those that are ready to be moved to transport. This may be inside of the facility (if possible) or outside to keep evacuees out of the elements and not to overwhelm Transport. The ECP should be in close proximity to Transport. While evacuees are in the ECP additional Triage and/or Treatment may be done if needed. The following positions will fall under the ECPGS: *Triage Unit Leader and Treatment Unit Leader.*

Transportation Group Supervisor: Transport Group Supervisor will oversee and establish the loading and transportation of all evacuees. The TGS will assign a Loading Unit Leader and manage loading crews. The TGS will utilize the D4H Patient Tracking section to confirm the receiving facility of each evacuee. When using Medical Ambulance Buses, ensure all that are being loaded are assigned the same receiving facility.

Receiving Group Supervisor: This position will be responsible for logging all evacuees that are arriving at the receiving facility. Utilize D4H to document the arrival and transfer of the evacuee to the receiving facility. If there is more than one receiving facility the RGS will assign members to each of the receiving facilities to ensure that all arriving evacuees are being tracked.

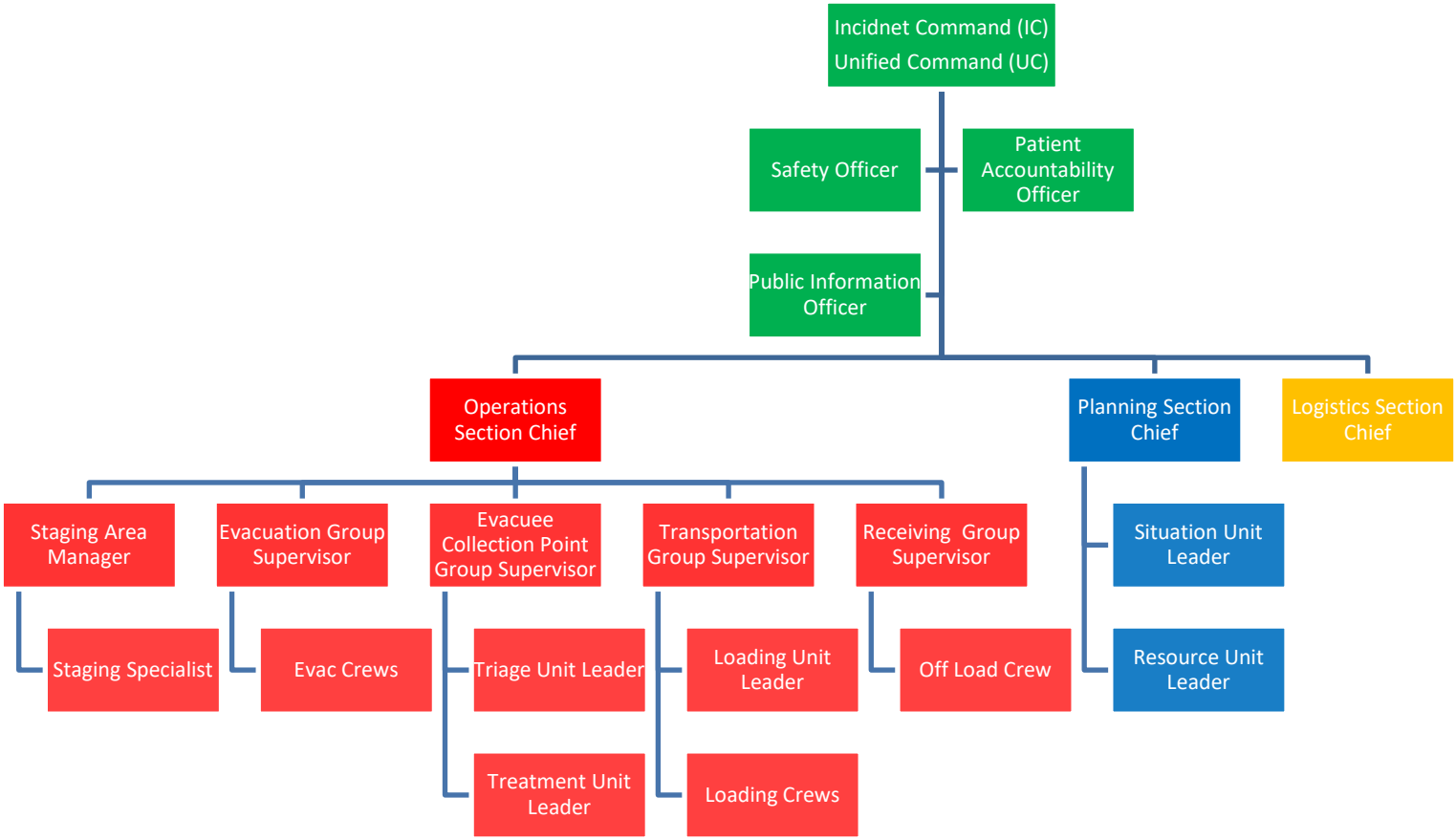
PLANNING

Situation Unit Leader: The Situation Unit Leader is responsible for collecting, analyzing, and disseminating information regarding the current status of the evacuation operation. This role involves maintaining situational awareness, providing accurate and timely updates, and supporting decision-making processes to ensure the effective management of the evacuation. Utilize the D4H Situation / Log section. Ensure stakeholders have access to the shareable public link in D4H.

Resource Unit Leader: The Resource Unit Leader is responsible for overseeing the tracking, allocation, and status of all resources involved in the evacuation of a healthcare facility. This role involves maintaining accurate records, ensuring resources are appropriately allocated, and supporting the operational needs of the evacuation effort. Utilize the D4H Resource Request Section.

NJ EMS Task Force Healthcare Facility EVAC Positions

Organizational Chart



PATIENT EVACUATION AND TRACKING

Patient Evacuation Sequence

One of the most difficult aspects of hospital evacuation is prioritizing patients for evacuation. This responsibility falls to the Sending Facility clinical staff in consultation with their EMS partners. Emphasis must be placed on doing the most good for the greatest number of patients.

Determining the evacuation sequence of patients is a triage process based on available resources and time. Unlike traditional triage concepts in Mass-Casualty Incident (MCI) scenarios, patient priority during a hospital evacuation may not be based solely on acuity. (See Tab 5: Patient Tracking and Transport.)

This process is typically approached differently in Pre-Event versus Post-Event Evacuation scenarios.

- In Advanced Warning scenarios where the hospital decides to evacuate Pre-Event in whole or in part, priority is often given to evacuating the sickest and most unstable patients first. These often take the most time and resources to evacuate and would be the most vulnerable if the hospital's operations become compromised by the anticipated event.
- In No Advanced Warning situations where the hospital decides to evacuate Post-Event, lower acuity patients are typically moved first in order to remove the greatest number of patients from the at-risk facility before concentrating on the smaller number of acutely ill and resource- intensive patients.

Patients Requiring Specialized Transportation Resources

Included in the Evacuation Plan should be a list of patients who require specialized transport resources or must be transferred to specialized receiving facilities.

The IAT should consult with the sending healthcare facility as well as the Medical Coordination Center or New Jersey Hospital Association to determine which facilities can accept these patients and the most appropriate means for transportation.

Examples of patients that might require specialized transportation include those with highly infectious diseases, immunocompromised patients or unstable post-op patients.

Use of Helicopters

The use of air medical helicopters should be encouraged when there is an increased urgency for rapidly transporting patients or when there are special needs patients who must be transported a great distance to a facility that can properly care for them. The EMS Branch and IAT should first evaluate the weather and other safety conditions prior to deciding on the use of helicopters.

The Air Medical Committee has developed a mutual aid plan to ensure additional helicopters can be acquired rapidly in the event of a disaster. The request for multiple helicopters should be made by the Unified Command to REMCS.

In addition to requesting mutual aid helicopters, REMCS should also be instructed to activate the nearest pre-designated Helibase as defined in the Statewide Helicopter EMS Helibase Management Plan. The NJEMSTF will then send at least two (2) qualified Helibase Managers to that airport facility to assist in managing the Helibase operations.

The NJEMSTF IAT will appoint an appropriate member of the NJEMSTF or NJ State Police Aviation Bureau to act in the capacity of Air Medical Branch Director under the Healthcare Facility Operations Section Chief. The Air Medical Branch Director will coordinate mission requests with the Evacuation Branch Director, REMCS, and the helicopter pilots. The Unified Command, Healthcare Facility Operations Section Chief, and Air Medical Branch Director will determine an appropriate Helispot to land helicopters to load patients. If the healthcare facility has a designated landing pad and it can be used safely, its use should be encouraged. However, should a larger area be needed, the Unified Command and Air Medical Branch Director should coordinate with local police and fire to establish the Helispot. Multiple Helispots may be utilized depending upon the needs of the incident, number of patients to be flow, and number and type of aircraft being utilized. Each Helispot needs to be managed by a Helispot Manager (a.k.a. "Landing Zone Coordinator"). Patients being transported by helicopter will be transferred with the same information and supplies as designated above. The Transportation Group Supervisor will note on his/her log which patients were transported by helicopter.

The Incident Dispatchers will not communicate with the helicopters; this will be handled by REMCS. The Air Medical Branch Director should be able to communicate with the helicopters via an air/ground frequency and with the Helibase Manager on a separate ground/ground frequency than those being used for other incident communications.

Determining Receiving Facility(ies)

Healthcare facility MOU's, transfer agreements and inter agency communications may determine receiving healthcare facility capabilities and where patients will go. Bed status availability is for planning purposes only and does not dictate where patients will be transferred to.

In the event the sending facility does not have a policy or preference addressing where the patients should be transported to, the Unified Command will determine the appropriate receiving facilities based upon:

- Urgency of evacuation
- Incident generated traffic patterns and congestion
- Availability of transport resources
- Receiving healthcare facility bed status
- Receiving healthcare facility's acceptance
- Specialty needs of the patients
- Distance from sending facility

Information to assist in determining the receiving healthcare facilities can be obtained by communicating with the Medical Coordination Center and/or Health Command Center.

The NJEMSTF Planner or Planning Specialist assigned to the healthcare facility's IMT Planning Section can obtain (if necessary) "Bed Status" from sources such as the Regional EMS Communications Centers (North Region – University Hospital REMCS, Central Region – Robert Wood Johnson's Med Central, and South Region – AtlantiCare's Medcom).

Preparing Patients for Transportation

Triage/Evacuation Tags: Appropriate Tags must be completed and applied to each patient being evacuated by the SENDING Facility's medical staff. The State of New Jersey Disaster Triage Tag or other approved Evacuation Tag shall be used. That patient shall be entered into the NJEMSTF D4H Patient Tracking system, or recorded on a patient transfer log if technology is unavailable.

Prior to loading patients into the ambulances, all patients must have a New Jersey Disaster Triage Tag or Evacuation Tag applied by the healthcare facility medical staff designating priority order for transfer. The Tag ID numbers will be used for patient tracking and documentation. If the Transport Group Supervisor finds that patients are arriving for transport without Triage Tags the EMS Branch Director will be notified immediately. No patient should leave the sending facility without a triage tag. The healthcare facility will determine the order in which patients are to be evacuated.

A Transportation Group Supervisor assigned to the EMS Branch Director should be tracking these tag numbers prior to leaving in the D4H Incident Management Patient Tracking system. The Transportation Group Supervisor should note the number and patient last name / first initial on the Transport Log. This information should be made available to the Healthcare facility's Situation Status Unit in the Planning Section or Patient Placement Group Supervisor in Operations if assigned as needed via written message form or photo copy. Radio transmission may be too time consuming and should be discouraged.

Upon arriving at the receiving facility, the Strike Team / Task Force Leader should report to the Patient Tracking Group Supervisor and note the Triage Tag numbers his / her team just transported on an Activity Log with the time arriving at the receiving facility. The EMS unit will be directed to transport the patient to the appropriate receiving location, which may not be the emergency department. The NJEMSTF will deploy a medical operations specialist to the receiving facility to update the NJEMSTF D4H system with arriving patients.

Tracking the progress of multiple single resource ambulances in an event like this can be extremely challenging. It is highly recommended that the patients be transported in groups by Strike Team/Task Forces instead. All ambulances in the Strike Team / Task Force should depart together and travel as a group to the receiving healthcare facilities. Only the Strike Team / Task Force Leader should communicate with the Incident Dispatcher unless there is an emergency. The NJEMSTF D4H Incident Management System and Patient Tracker has been set up specifically to assist in situational awareness as well as documentation of movements.

Each patient should be transported with their complete medical record, personal items and a three (3) day supply of medication.
However, the conditions of the incident may be such that there is not time to provide the above information or package personal items, the Sending healthcare facility will provide the following minimum data:

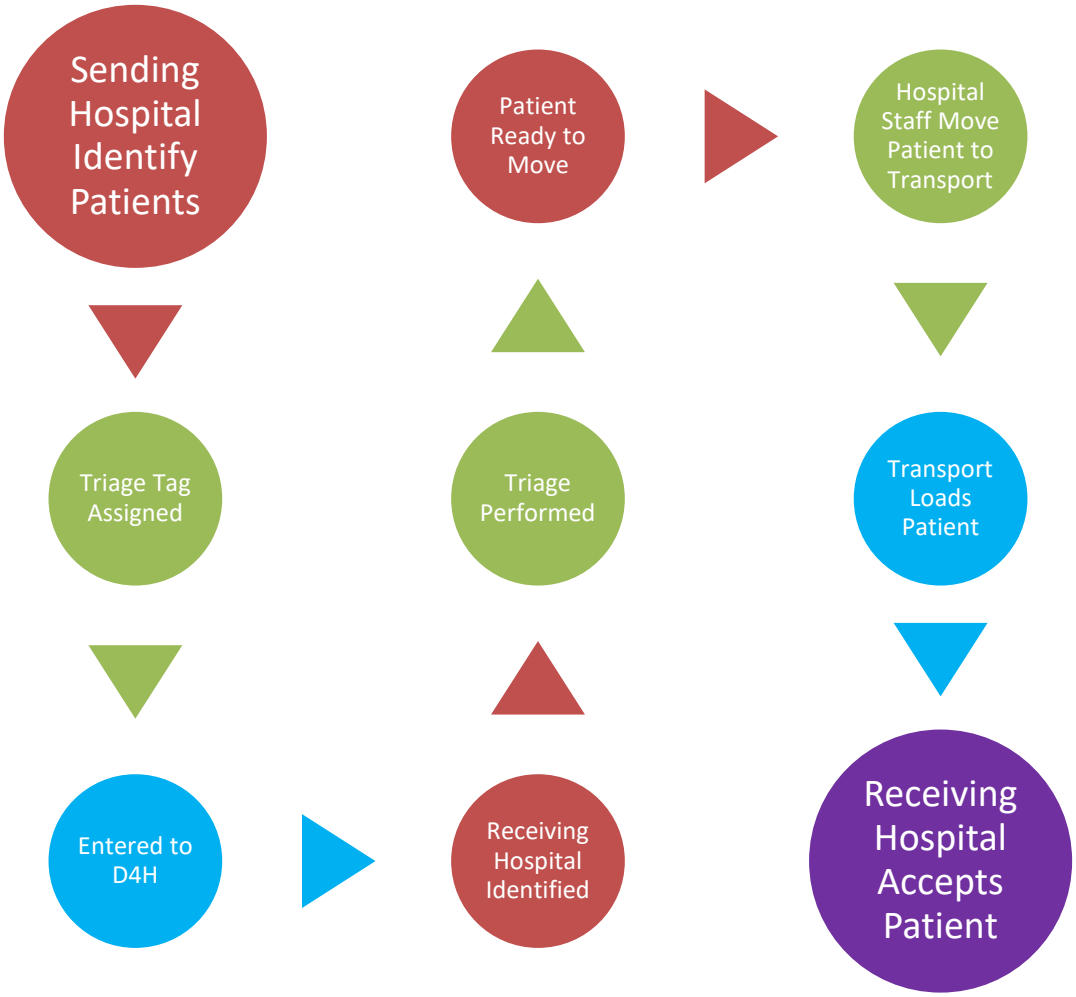
1. Medical Record or Triage Tag number
2. Allergies
3. Chief Complaint / Admitting Diagnosis
4. Private Medical Doctor contact information
5. Emergency Contact
6. Advanced Directives/POLST/DNR
7. Age of Patient

If time allows the following should be included:

1. Current Medications (MAR)
2. Sex, Language
3. Last set of Vital Signs
4. Disabilities

In ALL Cases as much of the current visit/admission information as possible should be included.

Tracking Patients



Tracking Algorithm – Note that the flow of information is a closed loop and integrates the EMS Task Force, EMS and the healthcare facility.

- RED specify the Sending Facility's responsibilities.
    - The Sending Evacuating Facility will place a TRIAGE / EVACUATION TAG on each patient to be evacuated.
        - One of the Bar Code / unique number stickers will be taken off the tag and placed on the patient's medical record face sheet.

    - The Sending Facility sends the master transfer Log to the Receiving Healthcare facility(s)
    - The Sending Facility assigns a "Transport Task Force Leader" who is responsible for managing the release of patients to EMS. This function is intensive and therefore it is not an individual, but a Task Force Leader. The Task Force may be made up of up to seven people depending on availability and need.
        - The Transport TF Leader is responsible for maintaining a log of all patients transferred to EMS (Attachment2)
        - The Transport TF Leader is responsible for issuing a Transport Form to each vehicle transporting patients. These are separated by TAG Color and are designed to record departure and arrival time as well as who received the patients at the receiving facility. It also records the EMS Agency and vehicle information.
- PURPLE specify the Receiving Facilities responsibilities.
    - The Receiving Facility's "Triage/Intake Task Force Leader" receives the Transport Form from the transporting EMS Unit cross checks the triage tag number and records the arrival time, if the Medical Record is with the patient and the Triage Intake FT Leader's name.
    - The Receiving Facility's Triage Intake TF Leader reports tag information to the Healthcare facility Command Center's Patient Tracking Group Supervisor.
- BLUE specify the EMS responsibilities.
    - The EMS Transport Group Supervisor is co-located with the Healthcare facility Transport Task Force Leader at the Collection/Transfer Point.
    - The EMS Transport Group Supervisor coordinates with the Regional EMS Communications Center. Where the Receiving facilities are outside the service area of the Regional EMS Dispatch Center the Center will either communicate patient and vehicle information directly to the Receiving Facility or transfer the information to the Regional EMS Dispatch Center responsible for EMS operations in the Receiving Healthcare facility's region. In any case the Regional EMS Dispatch Center must link by one of the above methods to the Receiving healthcare facility's Command Center to provide patient transfer information.

This process tracks the patients from the Sending Healthcare facility's Collection/Transfer Point to EMS. Upon arrival at the Receiving Healthcare facility(s) the patient, MR and triage tag numbers are confirmed and shared with the Receiving healthcare facility's Command Center who in turn sends patient receipt information back to the Sending Healthcare facility to close the loop.

HIPAA Privacy and Security

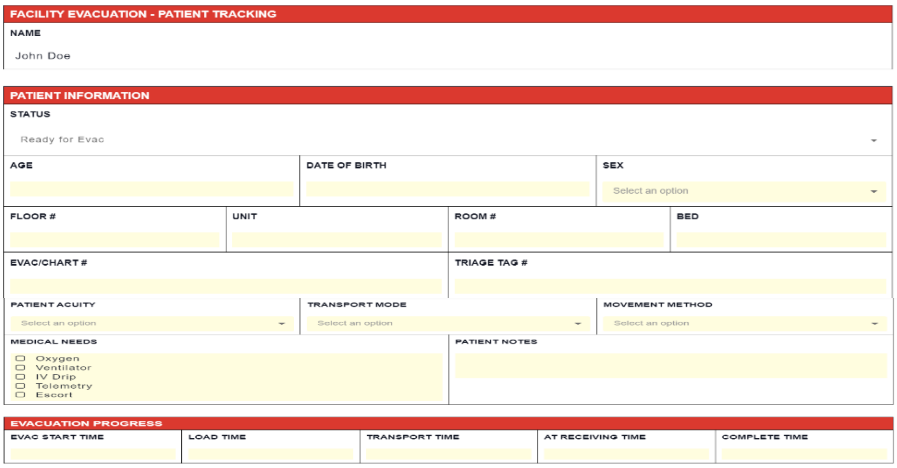
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects the privacy and security of certain health information. All healthcare providers, including hospital facilities and EMS agencies, are subject to the Standards for Privacy of Individually Identifiable Health Information and the Security Standards for the Protection of Electronic Protected Health Information. These documents address the technical and non-technical safeguards that "covered entities" must have in place to safeguard individuals' healthcare records and information. All responders involved in evacuating patients from the Sending Facility are bound by applicable provisions of HIPAA privacy and security rules.

However, HIPAA provides for a patient's healthcare records and information to be shared among the patient's healthcare team which includes the Sending Facility, the Receiving Facility, and the EMS providers transporting the patient during an evacuation.

D4H FACILITY EVACUATION - PATIENT TRACKING

The primary electronic software for patient tracking and Incident Management will be D4H. This platform provides real-time visibility into all aspects of the evacuation, offering a unified workspace to ensure every patient is tracked from start to finish. D4H is compatible with smartphones, tablets, and computers, allowing for flexible use across devices. Early entry of patient information into the system is crucial to ensure smooth and efficient operations. This will be accomplished by getting the list of patients to be evacuated from the SENDING FACLITY to the IAT / NJEMSTF Planning Section Chief, from there it will be assigned to planning specialist to input to the system.

Data Collection - EVAC



Name: Name of Patient

Status: The status of the patient in the evacuation process.

- Pending: Patient info is loaded into the D4H system.
- Ready for Evac: Patient has all documentation need for transport and is ready to be assigned a transport unit.
- Evac in Progress: Patient has been assigned a transport unit and is physically being moved from location in facility to the transport / loading area.
- Transporting: Patient is in the transporting unit and is on the way to the receiving facility.
- At Receiving: Patient has arrived the receiving facility and has been handed over to the staff.
- Cancelled: This patient is not being moved for any reason but still is being tracked. Use "Patient Notes" to describe why this patient was cancelled.

Age / Date of Birth / Sex (gender): When time permits.

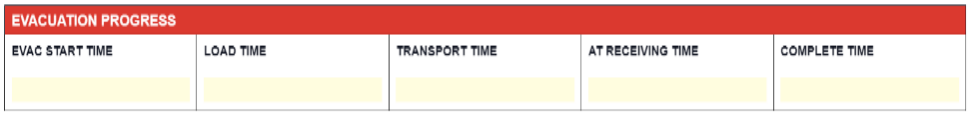
Floor / Unit / Room / Bed: Utilize these fields to pinpoint where the patient is located. This will help EMS personnel that are not familiar with the facility. When possible, crews should be teamed up with a representative from the facility.

EVAC / Chart # - Triage Tag #: This will be the method of non-technological tracking, either the NJ Triage tag, chart number, or if the facility has an evacuation tag. It is important to use this in conjunction withD4H system in the event of a loss of data / IT services.

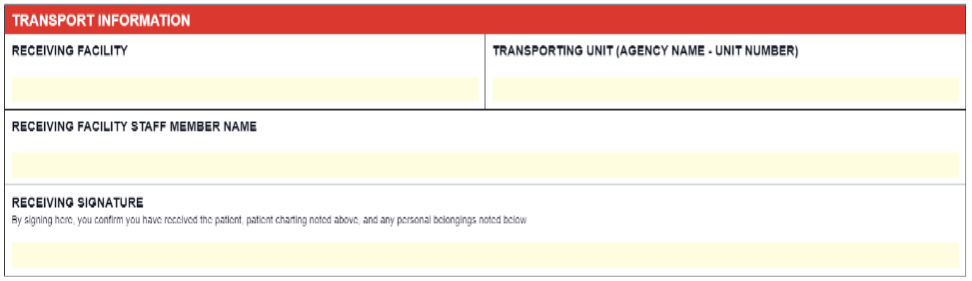
Patient Acuity / Transport Mode / Movement Method / Medical Needs: These data points with give the transportation unit and staging the information needed to assign the patient the proper vehicle to transport to the receiving facility and manage available resources.

Patient Notes: Provide any additional information that may be relevant to the transport of this patient.

Evac Start / Load / Transport / At Receiving / Complete Times: Here is where each step of the evacuation will time and date stamped.



Receiving Facility: Name of the facility the patient is being transported to. The facilities may be available in the drop down if they have been loaded.



Transporting Unit: The unit that is physically transporting the patient. May be available in the drop down if they have been loaded.

Receiving Facility Staff Member Name / Receiving Signature: This will be the representative of the receiving facility that is accepting the patient.

Personal Belongings Photo / Description / Sending Signature: Use these data points if the patient is being transported with personal items. If the device that is being used has a camera, you can take a photo of the items. Describe the items and if possible, have the sending facility sign confirming that the patient is leaving the facility with the items.

DEMOBILIZATION

Resource Re-Assignment

Strike Teams / Task Forces should depart from the receiving facility as a group when returning to the incident. The Strike Team / Task Force Leader should contact the Incident Dispatcher to determine if the resource is to return to the sending healthcare facility to pick up more patients or return to Staging to await assignment.

Demobilization Plan

The Demobilization Unit Leader will begin the development of the Demobilization Plan as soon as the position is assigned. Demobilization should occur in stages as Patient Care Units, Floors, Buildings and Complex evacuations are completed.

The NJEMSTF will remain in operation at the appropriate resource level until all patients requiring transportation have reached their receiving destinations or until the Healthcare facility Unified Command determines it can bedemobilized.

All NJEMSTF personnel and Ambulance Strike Teams / Task Forces should be demobilized utilizing a formal demobilization plan generated for the incident. The creation of the EMS Demobilization Plan should be started by one of the NJEMSTF Planning Specialists working with the Demobilization Unit Leader as early as possible in the incident to ensure an organized demobilization. This plan should include provisions for:

- Return of issued radios or other equipment
- Return of incident paperwork and unit activity logs
- Tracking of personnel time and equipment usage (to include time and mileage when possible)

When possible, the demobilization of all EMS and NJEMSTF resources should be tracked on ICS 221 Checkout Forms.

All incident forms (originals) shall be provided to the Documentation Unit Leader. The Documentation Unit Leader will provide copies of all documentation needed by the EMS Task Force or other agencies that operated under the healthcare facility's Incident Command System.

RECOVERY – REPOPULATION

EMS Task Force resources are designated for Emergency Response and are not intended or planned to be used as a non-emergency resource. As there should be no urgency to return the patients to the sending facility, the NJEMSTF will likely not be needed for planning the return.

Once the facility is deemed safe to re-occupy by the appropriate authorities the healthcare facility will implement their repopulation plan.

ADMINISTRATION – BILLING FOR SERVICES

Evacuation of a large healthcare facility can be a costly undertaking in terms of both emergency transportation and lost revenue. These are complex issues that are beyond the scope of this planning document. Each Sending Facility will need to address such financial considerations in their pre-incident planning process. However, during an emergency evacuation, financial ramifications must be secondary to the need to ensure continuity of care for all evacuated patients.

A state or federal disaster declaration will have a significant impact on cost reimbursement structures and Sending Facility staff should work closely with county OEM staff to coordinate this process. Consideration should also be given to requesting an 1135 waiver from the Center for Medicare and Medicaid Services (CMS) through the state Department of Health.

NOTE: Resources deployed under the Federal Ambulance Contract are under contract to the U.S. Government and will not bill or charge directly for services.

PLAN DEVELOPMENT AND MAINTENANCE

This plan shall be reviewed and modified every three years by the New Jersey EMS Task Force, New Jersey Hospital Association (NJHA), Long Term Care Facilities, New Jersey Department of Health and the County OEM EMS Coordinators. This plan may also be subject to modification following an exercise or any emergency response. All changes to the plan stemming from new information received from national, regional, or state guidance, as well as updates on NIMS standards, will be incorporated and tracked in a timely fashion and then disseminated to key partners and stakeholders. A general notification to response partners notifying them of updates and providing the newly updated plan will be sent out at the time of approval.

Each medical facility covered by this plan has the responsibility to carry out their own pre-incident planning activities as described throughout the plan. Such pre-incident planning should include:

- Complete a Critical Infrastructure Assessment (See Tab 1.)
- Identify qualified staff capable of filling key ICS roles during an evacuation and provide appropriate training to those individuals.
- Calculate a baseline evacuation time based on the hospital's typical patient census (See Tab 2.)
- Work with local and county emergency management officials to carry out periodic drills and exercises to test evacuation plans and procedures.

TAB 1: CRITICAL INFRASTRUCTURE ASSESSMENT

The Critical Infrastructure Assessment may be accessed in the separate Excel document. This section provides a detailed explanation of the function of the assessment tool.

The Critical Infrastructure Assessment, adapted from the Hospital Evacuation Decision Guide from the Agency for Healthcare Research and Quality (ARHQ) of the U.S. Department of Health and Human Services, contains two components – the first is the "steady-state" assessment, the second is the impact and mitigation assessment that is to be conducted in the alert/warning phase of the incident. These components are identified by their green and yellow headers, respectively. Complete the initial assessment during a period of normal hospital operations, and the other questions as your hospital begins to monitor a potential incident.

The assessment includes various fields for user input, but also will automatically provide information as you work across each row. To ensure an accurate assessment can be conducted, fields will either be a drop-down menu or provide space to enter a number for each field (except the "Mitigation Activities" column, where a space for free text is provided). To clear a field, you can either type over or select another drop-down item or press the backspace or delete key. To maintain the specific formulas needed to conduct an appropriate assessment, many cells in the worksheet have been locked.

As discussed elsewhere in this plan, a hospital evacuation decision is made due to the impacts of an event, not the actual event in and of itself (the loss of water service due to a hurricane, for example). This assessment/tool will aid decision makers in identifying vulnerable infrastructure and its potential impacts but will not recommend a specific point in which to evacuate. The decision to evacuate is a fluid one and relies heavily on the context of the incident. This assessment plays a singular role in the overall decision-making process. For additional information regarding evacuation decision making, see Tab 2: Evacuation Decision-Making.

Steady-State Assessment

The leftmost column ("Resources") provides a series of questions regarding your hospital's infrastructure. Simply answer each question in the "Implication" column, to the direct right (either drop-down or number). From there, the "Vulnerability" column will automatically populate based on accepted federal guidance—it states if the resource is more or less vulnerable.

It is recommended that these components be reviewed annually, however, if time permits, review and update this information as your hospital prepares for a "notice" event. (For example, upon the development of a tropical system in the Atlantic Ocean.)

Alert/Warning Assessment

As an incident develops, the remainder of the assessment should be completed. The first column to complete is "Impact Probability." This column asks if there is a potential that the resource (i.e. the asset described in the far-left column), may be impacted in the developing situation. Select yes or no from the drop-down menu.

Following the identification of if the resource will be impacted, is the scale to which it may be impacted ("Impact Potential" column). The options are: No Impact, Reduced Service, Major Disruption, Completely Destroyed/Unavailable.

To the right of the "Impact Potential" is the "Impact Indicator." This autocompleting column considers the resource's vulnerability, the impact potential, and impact potential. If a resource is identified as more vulnerable, there is a potential that it may be impacted, and the potential is greater than "no impact," the system will recommend that mitigation options be considered. If a resource does not meet those qualifications, the system will recommend that it be monitored.

The next column ("Mitigate?") asks if the specific resource can be mitigated (for example, additional fuel be delivered, a portable generator be delivered, patients be moved to a structurally sound portion of the building). The column to the right of that ("Mitigation Activities") provides a free text space to allow decision makers to list potential mitigation activities.

The final column ("Overall Vulnerability Assessment") provides a cursory vulnerability assessment based on the information provided in the worksheet. If the impact cannot be mitigated and the impact potential is either "Major Disruption" or "Completely Destroyed/Unavailable," the assessment will identify an increased vulnerability. Increased vulnerabilities do not necessarily mean that an evacuation is necessary; however, they do indicate specific resources that have an increased likelihood of failing and are essential to the facility.

TAB 2: EVACUATION DECISION MAKING

Decision-making guidance in this plan reflects recommendations from the Agency for Healthcare Research and Quality (ARHQ) of the U.S. Department of Health and Human Services. As described by the ARHQ's Hospital Evacuation Decision Guide, "No single formula or algorithm could possibly capture all of the nuances involved in the decision or the myriad different disaster scenarios that may lead to a hospital evacuation…" Instead, this plan provides a stepwise process by which hospital leadership should evaluate the situation confronting them and make educated decisions regarding the possible need to evacuate their facility.

Decision Team

Discussions regarding potential evacuation scenarios should begin well in advance of any approaching hazard, and a clear decision-making process should be established based on each facility's unique organizational considerations. During an actual incident, the formal decision to evacuate is ultimately made by the hospital's Incident Commander. However, such formal decisions must be made in consultation with senior hospital leadership (both clinical and administrative) as well as local/county emergency management and response officials. These decisions must also take into account pre-incident infrastructure assessments and a thorough consideration of the facility's known vulnerabilities relative to the threat/hazard at hand.

Evacuation may be considered in advance of an approaching hazard (in the case of Advanced Warning Events) or after the event has already impacted the facility (whether or not there was advanced warning.) Although these scenarios are somewhat different, the fundamental decision process is essentially the same as shown in Fig. 1: Decision-Making Algorithm. In both cases (Pre- and Post-Event), it is important

to make an evacuation decision as early as possible in order to allow sufficient time for a safe and orderly evacuation. In certain situations, such as an earthquake leading to obvious structural instability, the immediacy of the hazard requires a "drop everything and go" evacuation. Otherwise, evacuation decision-

makers need to estimate the amount of time that will be needed for full or partial evacuation and decide upon a sequence of evacuation that is feasible in that timeframe.

Estimating Evacuation Time

No credible formula or rule of thumb exists to predict evacuation time for a given hospital facility. As part of pre-disaster planning, the ARHQ recommends that hospital leadership calculate the baseline time that would be required to fully evacuate their facility. This baseline includes two interdependent considerations: the time to move everyone in the building to a pre-determined staging area, and the time it will take to transport patients from the staging area to receiving hospitals or other destinations. As defined in the ARHQ's evacuation time worksheet, this baseline evacuation time calculation should take into account a number of variables that include: number and types of patients, staff resources, transportation requirements and availability, hospital entry and egress points, local road and traffic conditions, and location of anticipated receiving sites.

As most of these factors are subject to considerable change during an actual disaster, the baseline evacuation time should be reviewed and updated in real time as part of the initial evacuation planning process.

DECISION-MAKING PROCESS

The following algorithm summarizes the typical process followed in making decisions regarding hospital evacuation.

Information Gathering

Attempt to gather as much information as possible about the threat(s) at hand. For Pre-Event Decisions, this would include intelligence, forecasts, etc. about the anticipated impacts of the event. For Post-Event Decisions this includes information about the impacts being experienced. In both cases, information must be gathered not just for the hospital facility in question but also for the surrounding area and for potential Receiving Hospitals.

Situation Assessment

Assess the affected hospital's situation (or anticipated situation) based on the threat/hazard at hand and in light of known vulnerabilities identified in the Critical Infrastructure Assessment (see Tab 1.) The outcome of this assessment should be a determination that the facility is or is not impacted by the event and, if impacted, to what extent.

Reassessment

Whether or not a facility is being evacuated, frequent reassessment must take place in order to determine if the situation has changed. In some cases, impacts may be greater than projected and any evacuation decision will have to be revisited. In other cases, conditions may have ameliorated and an evacuation may no longer be necessary.

Mitigation Options and Evacuation Alternatives

Once it is determined that the hospital facility has been impacted (or will likely be impacted) by the event at hand, decision makers must evaluate their facility's internal capabilities and determine whether or not they can mitigate event impacts such that the hospital can continue to safely care for some or all of its patients rather than moving them. If in-house capabilities are not sufficient for this purpose, it may still be possible to supplement these with outside resources (staff, equipment, and materiel) in order to safely shelter in place. Evacuation should always be a last resort.

Feasibility Analysis

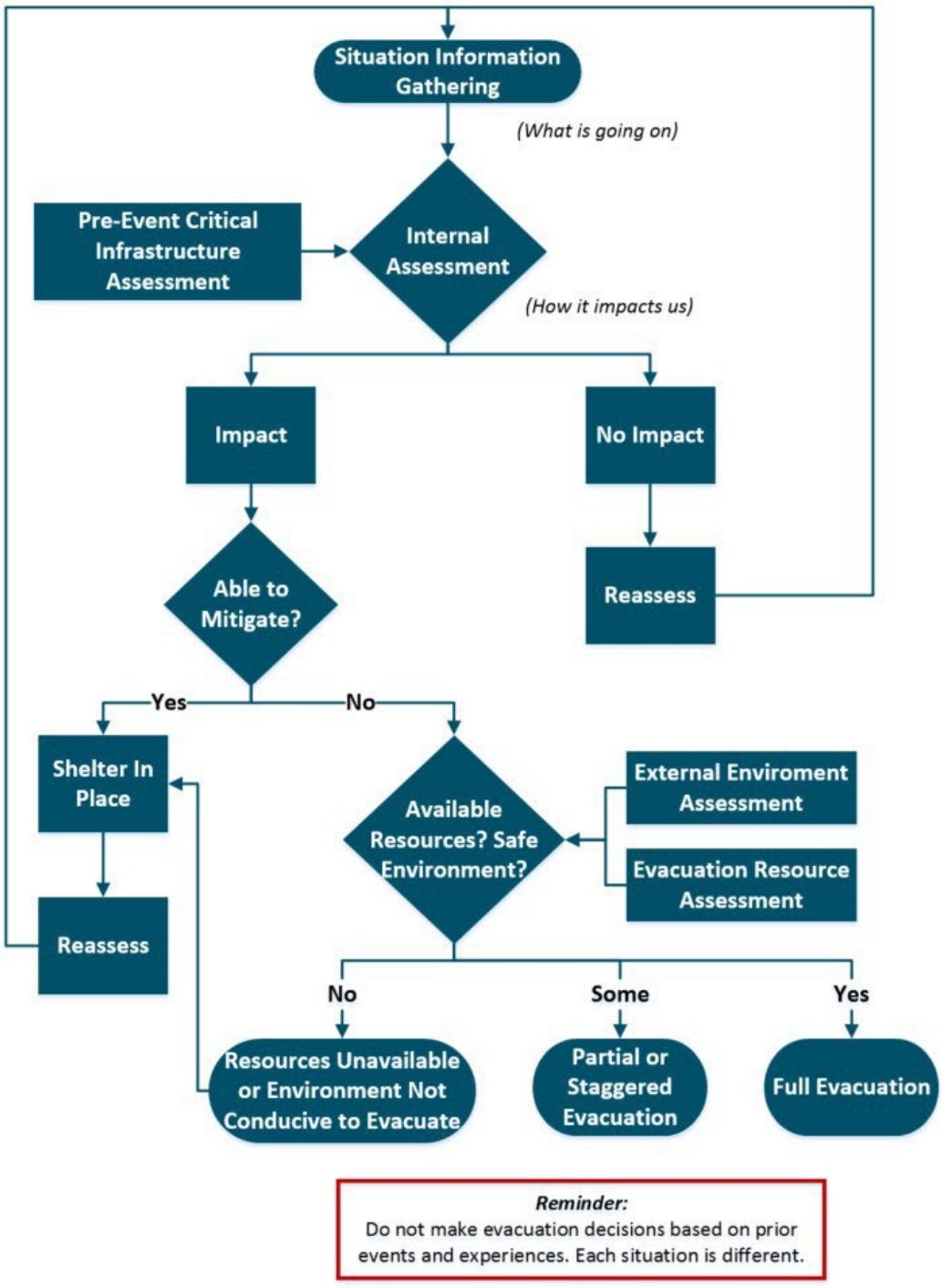
If it is determined that evacuation is the best option for patient care and staff safety, decision makers must next evaluate how feasible it will actually be to evacuate. This evaluation must consider factors such as available time to carry out the evacuation, local road and traffic conditions, potential exposure to environmental hazards, availability of resources to carry out an evacuation, (See Tab 3: Evacuation Resource Requirements) and other such factors.

Evacuation Decision

Decision makers must perform a risk/benefit analysis, weighing the facility's real or anticipated vulnerability against the feasibility of evacuation. The outcome of this process may be a full evacuation, a partial evacuation of only certain units, or no evacuation. In the latter case, patients and staff will shelter in place until the threat has passed. Meanwhile, decision makers will continue to reassess the situation as circumstances change.

FIGURE 1. DECISION MAKING ALGORITHM

Below is the complete algorithm. A separate PDF file contains a full-sized version of the algorithm and associated worksheets.



TAB 3: EVACUATION RESOURCE REQUIREMENTS

Patients being evacuated will require varying levels of resources. Some patients will be ambulatory and able to walk on their own to transport vehicles, while others may only require mobility assistance such as a wheelchair. Other patients will require ongoing medical monitoring and care from EMS providers and/or specialized hospital staff. The Evacuation Resources worksheet at the end of this tab can be used to prepare an initial estimate of the transportation resources necessary to evacuate a given facility.

In compiling their census, clinical staff should first identify:

- Those patients who may safely be discharged early in order to self-evacuate or evacuate with family members.
- Those patients who must remain hospitalized but are able to safely walk to transport vehicles and do not require ongoing medical monitoring or care during evacuation.
- Those patients who do not require ongoing medical monitoring or care during evacuation but do require assistance with ambulation (such as patients requiring wheelchair access.)

Clinical staff should categorize remaining patients as defined in the National Highway Traffic Safety Administration's Guide for Inter-facility Patient Transfer (2006) in order to estimate the EMS resources needed for evacuation. These categories are:

- **Stable with no risk for deterioration** – Oxygen, monitoring of vital signs, saline lock, basic emergency medical care (basic care)

- **Stable with low risk for deterioration** – Running IV, some IV medications including pain medications, pulse oximetry, increased need for ongoing assessment and interpretation skills (advanced care)

- **Stable with medium risk for deterioration** – EKG monitoring, basic cardiac medications such, heparin, nitroglycerin (advanced care +)

- **Stable with high risk for deterioration** – Requiring advanced airway device but stable, incubated, on ventilator, multiple vasoactive medication drips; includes patients whose condition has been initially stabilized but with likelihood of deterioration based on assessment or knowledge of provider regarding specific illness/injury (advanced care +).

- **Unstable** – Any patient who cannot be stabilized at the Sending Facility, who is deteriorating or likely to deteriorate, such as patients who require invasive monitoring, balloon pump, who are post-resuscitation, or who have sustained multiple-system trauma (critical care or available crew with time considerations).

Critical Care Transport

To determine the need to utilize Critical and Specialty Care Transport (CSCT) and/or to transport hospital staff with unstable patients across the life span, clinical staff will need to weigh the needs of multiple patients against available resources. During certain austere conditions, the Department of Health may

issue a waiver temporarily authorizing EMTs and Paramedics to provide limited advance critical and specialty care to patients who need it. Otherwise, Specialty Care Teams as defined by the Centers for Medicare & Medicaid Services (CMS) require care beyond that of a Paramedic. Such care in New Jersey is typically provided during transport by a Department of Health recognized registered nurse.

Consideration should be given to prioritizing certain patients for air transport, if available, depending on the distance to be travelled and/or the need for Critical and Specialty Care Transport (CSCT) teams and equipment such as an isolette. As defined in the AMR/FEMA Federal EMS Deployment Handbook, patient types who require a CSCT Air Transport Team care may include:

- High risk for decompensation
- Requiring mechanical ventilation
- High risk for deteriorating respiratory status
- Requiring invasive hemodynamics monitoring (arterial line and/or central venous pressure line)
- Requiring ongoing active resuscitation and/or lab monitoring
- Requiring aggressive fluid/blood product administration during transport
- Requiring vasopressor support
- Requiring invasive intra-cranial pressure monitoring
- Requiring cardiac pacing
- Unstable spinal fracture
- Undergone vascular reconstruction and is at a high risk for clot or hemorrhage
- Unstable angina, unstable arrhythmia, or recent myocardial infarction

When air medical transportation resources are limited, CSCT care may also be provided to patients being transported by ground specialty care ambulances. Additionally, it should be noted that not all Intensive Care Unit (ICU)/Critical Care Unit (CCU) patients automatically warrant CSCT transport. Conditions/interventions that may not in and of themselves require CSCT care include:

- Chest tube
- Epidural with level below T10
- Regional pain blocks
- Cardiac monitoring
- Blood or plasma administration

Decisions regarding the level and configuration of CSCT for each unstable, critically ill or injured patient should be made by Sending Facility clinical staff most familiar with the patient in consultation with EMS providers coordinating the evacuation.

EVACUATION RESOURCES WORKSHEET

This worksheet should be used by the Sending Facility to estimate the transportation resources that will be needed to complete the anticipated evacuation for all patient types. The calculations in this worksheet provide only a general guideline and clinical staff will need to review more acute patients on a case by case basis to determine the exact resources needed.

This worksheet is also provided as a Microsoft Excel document for easy calculation.

Sending Facility Name _____

Nature of Incident _____

Date/Time Worksheet Prepared _____

Worksheet Prepared By _____

TOTAL PATIENTS REQUIRING TRANSPORTATION

1. Total patients present in facility _____
2. Patients who can be discharged early _____
3. Patients who will remain at Sending Facility (partial evac. scenarios only) _____

4.* Total number of patients requiring transport *(Subtract Lines 2-3 from Line 1) _____

PATIENTS REQUIRING OTHER VEHICLE (NON-EMS RESOURCES)

5. Ambulatory patients not requiring ongoing medical care enroute _____
6. Non-ambulatory patients requiring wheelchair transportation _____
7. Ambulatory specialty patients such as psych, detox *(do not include in Line 5 or 6)* _____

8.* Total number of OTHER VEHICLE Patients *(Add Lines 5 through 7) _____

PATIENTS REQUIRING EMS TRANSPORTATION RESOURCES

9. Stable with no risk for deterioration _____
10. Stable with low risk for deterioration _____
11. Stable with medium risk for deterioration _____
12. Stable with high risk for deterioration _____
13. Unstable, but able to be transported by ground ambulance _____
14. Unstable, requiring air transport _____

15. **Total number of patients to be transported by EMS (*Add Lines 9-13)*** _____

SUMMARY OF EMS & OTHER VEHICLE RESOURCE REQUIREMENTS

Seats for ambulatory patients (bus or other such vehicle) ***(Enter Line 5*** _____

Seats for wheelchair patients ***(Enter Line 6)*** _____

Seats for specialized ambulatory patients ***(Enter Line 7)*** _____

BLS Ground Ambulances[1] ***(Divide Line 9 by 2 and enter the result)*** _____

ALS Ground Ambulances[2] ***(Divide Line 10 by 2, then add Lines 11-12)*** _____

ALS Air Transport patients [3] ***(Enter Line 13)*** _____

Critical Care Specialty Transport (CCST) teams [4] ***(Enter the total of Lines 11-14)*** _____

NOTE: The above calculations assume that each ambulance or other vehicle (such as a Medical Ambulance Bus (MAB) or wheelchair van) will make only one trip. If transport vehicles will be able to return and transport additional patients during the expected evacuation timeframe, resource estimates should be adjusted accordingly.

SPECIALIZED TRANSPORT RESOURCES

Patients requiring transport by Bariatric Ambulance _____

Patients requiring transport ventilators _____

Patients requiring a transport neonatal isolate unit _____

[1] Based on a typical two-patient configuration found in most BLS ambulances. When NJEMSTF Ambulance Buses are utilized, this number should be adjusted according to their capacity.
[2] Assumes that patients who are Stable with Low Risk for Deterioration may be transported two per ALS ambulance, with all other categories at risk for deterioration being transported alone. If NJEMSTF Ambulance Buses are utilized to transport ALS patients, adjust the number of ALS Ground Ambulances accordingly.
[3] The number of patients transported per aircraft will vary depending on configuration. Air resource requirements will need to be estimated by the Air Medical Branch Director. If patients will need to be transported by ground to aircraft, additional ALS Ground Ambulances may be needed.
[4] The composition of Critical Care Specialty Transport (CCST) teams may vary considerably and must be determined on a patient-by-patient basis.

TAB 4: RECEIVING FACILITY DETERMINATION

During a hospital evacuation, the Sending Facility will be responsible for determining a receiving healthcare facility for each patient in consultation with the NJEMSTF Leader and County OEM EMS Coordinator. These decisions will be based on existing healthcare facility Memoranda of Understanding (MOUs) and inter facility transfer agreements along with receiving facilities' capabilities and current bed availability. NOTE: All acute care hospitals in New Jersey have disaster plans allowing them to expand capacity in order to accept incoming patients.

Patient Transport Distance

Safety and clinical considerations for transported patients are of highest importance during an evacuation. Additionally, many transportation units will be expected to make multiple round trips in order to complete the evacuation. For this reason, the transport distance of patients by ground ambulances (both BLS and ALS) and other vehicles (i.e. MABs or wheelchair van) should not exceed 250 miles or 6 hours. This limit is consistent with the AMR/FEMA Federal EMS Deployment Handbook.

TAB 5: MEDICAL DIRECTION, STANDARDS OF CARE

EMS Scope of Practice

Each state defines and regulates the scope of pre-hospital practice within its jurisdiction. During a large-scale disaster, it is reasonable to expect that large numbers of out-of-state resource will be deployed to the incident through various means.

The State of New Jersey determines the scope of practice for all New Jersey licensed providers, who will follow New Jersey protocols and orders. The New Jersey practice levels are:

- **Emergency Medical Technician - (EMT):** Trained in basic life support care and validly certified in the State of New Jersey to provide basic emergency medical care and transportation for critical and emergent patients; Performs interventions with the basic equipment typically found on an ambulance.

- **Emergency Medical Technician - Paramedic (Paramedic):** Trained in advanced life support care and validly certified in the State of New Jersey to provide advanced emergency medical care and

transportation for critical and emergent patients; Performs interventions with basic and advanced equipment typically found on an ambulance.

Out-of-state providers will follow their home state protocols for their level of licensure unless special orders are issued for them by the New Jersey Office of Emergency Medical Services (OEM). Should any questions arise regarding scope-of-practice, the National EMS Scope of Practice Model shall define the minimum competencies for each nationally defined level of EMS provider. These include:

- **Emergency Medical Responder (EMR):** Possesses basic knowledge and skills necessary to provide lifesaving interventions while awaiting additional EMS response; Performs basic interventions with minimal equipment; May assist higher level personnel at the scene and during transport.
- **Emergency Medical Technician (EMT):** Provides basic emergency medical care and transportation for critical and emergent patients; Performs interventions with the basic equipment typically found on an ambulance.
- **Advanced Emergency Medical Technician (AEMT):** Provides basic and limited advanced emergency medical care and transportation for critical and emergent patients; Performs interventions with basic and advanced equipment typically found on an ambulance.
- **Paramedic:** Allied health professional; possesses complex knowledge and skills necessary to provide advanced emergency medical care and transportation for critical and emergent patients; performs interventions with basic and advanced equipment typically found on an ambulance.

Medical Direction

Pre-hospital Advanced Life Support (ALS) interventions in New Jersey require direct authorization from online Medical Command. In the event that the ALS provider is unable to communicate directly with Medical Command, they may revert to standing orders.

Crisis Standards of Care

During a mass casualty event, the overall goal of the health and medical response is to do the most good for the greatest number of people possible. When resources are limited or scarce, achieving this goal may at times require standards of care different from those applied on a routine basis. This issue is addressed by the U.S. Department of Health and Human Services, Agency for Health Care Research and Quality in their document Altered Standards of Care in Mass Casualty Events.

Although development and adoption of crisis standards of care is beyond the scope of this plan, it is the responsibility of the sending hospital facility to do so during a mass evacuation. EMS providers must also be prepared for the possibility of providing care under austere conditions involving limited personnel and equipment resources. For both hospitals and EMS providers, any discussion of altered care standards during disasters must anticipate that a scenario affecting multiple communities (as in the case of a widespread disease outbreak or massive flooding) will significantly delay the arrival of additional healthcare resource

APPENDIX I: NJ EMS TASK FORCE ASSETS

Medical Ambulance Bus (MAB)	Mass Care Response Unit (MCRU)
The Medical Ambulance Bus is a specialized vehicle designed to provide mass transportation of ambulatory and non-ambulatory patients during a healthcare facility evacuation. The MAB can transport up to 20 supine, 32 ambulatory, or 15 wheelchair patients. (or a combination of the above). Currently there are 20 MAB style units across the state of New Jersey. All MABs have on board oxygen and patient monitoring equipment. 	The Mass Care Response Unit is a specialized vehicle equipped to provide medical support and rehabilitation services to a large number of individuals during emergency situations such as natural disasters, mass casualties, or large-scale incidents. This unit is designed to quickly deploy to the affected area and can accommodate a significant number of patients. It is equipped with bulk medical supplies to address a variety of injuries and medical needs that may arise in such scenarios. The unit is also equipped with equipment to establish a triage, treatment, and transport area for any evolving incident. Also has a cache of patient moving devices. 
Special Operations Vehicle (SOV)	**Alternative Support Apparatus (ASAP)**
The Special Operations Vehicle is designed to provide comprehensive support during large-scale incidents or emergencies. This vehicle is equipped with logistical supplies and equipment tailored to sustain and manage operations in challenging environments. It features portable shelters to provide refuge and rest areas for responders, ensuring they have a place to recuperate and recharge during prolonged incidents. Lighting systems are integrated to illuminate work areas and ensure visibility during night operations or in low-light conditions. Power management capabilities enable the unit to generate and distribute electricity to power essential equipment, communication devices, and other operational needs. Additionally, emergency restroom facilities are included to maintain hygiene and comfort for personnel on-site. Overall, this special operations vehicle serves as a vital asset in enhancing the resilience and effectiveness of emergency response efforts during large-scale incidents by providing essential logistical support and facilities for incident operations. 	The Alternative Support Apparatus is a compact UTV (Utility Terrain Vehicle) style vehicle specifically engineered to reach patients in remote or limited access areas where traditional ambulances may not be able to navigate. Equipped with basic medical supplies and equipment similar to those found in standard ground ambulances, the ASAP ensures that necessary medical care can be provided promptly and efficiently, even in challenging terrains or rugged environments. Its agile design and off-road capabilities make it ideal for responding to emergencies in areas such as wilderness, remote trails, or disaster sites where traditional vehicles may struggle to reach. The ASAP serves as a crucial link in extending medical assistance to patients in need, ensuring timely intervention and transport to appropriate medical facilities. 

Oxygen Generation Unit (OGU)	**Tent Structures & Logistical Support**
The Oxygen Generation Unit (OGU) is a mobile system housed in a trailer, designed to produce and compress oxygen into a cascade system for refilling oxygen tanks on-site. It features an onboard generator that provides continuous power to the unit, enabling uninterrupted production of oxygen as long as it remains operational. This self-sustaining system offers a reliable and efficient solution for supplying oxygen in remote locations or during emergencies where access to conventional oxygen sources may be limited. The OGU plays a vital role in supporting medical operations, disaster response efforts, and other scenarios where a readily available oxygen supply is essential for patient care and safety.  	Our temporary tent structures and logistical support equipment offer a comprehensive solution for providing shelter, comfort, and essential services during emergency responses and long-term operations. Ranging from small to larger insulated tents, these structures provide private areas for decision-makers and command/control staff to operate efficiently, shielding them from the elements. Equipped with heating and cooling systems, the tents ensure a comfortable environment regardless of weather conditions. In addition to shelter, our equipment includes towable generators to provide reliable power for operations, ensuring continuous functionality of critical equipment and communication systems. Moreover, we offer water purification capabilities to ensure a safe and adequate supply of clean water for drinking, hygiene, and other needs. With our temporary tent structures and logistical support equipment, we aim to enhance the resilience and effectiveness of response efforts by providing essential infrastructure and services for personnel operating in challenging environments.

Requesting Specialized EMS Task Force Assets

Local Mutual Aid
Utilize local mutual aid agreements first if they exist. If an agency near you hosts one of these assets consider adding it to your mutual aid assignment.
County OEM EMS Coordinator
If no local mutual aid agreements exist and need a specialized asset, contact your County EMS Coordinator or Deputy Coordinator. They will be able to assist you with requesting the closest available unit.
NJEMSTF Operations Center – Regional Emergency Medical Communications System (REMCS)
If you have an issue contacting your County Coordinator you can call the Task Force Operations Center or REMCS and they will be able to assist you with getting the resources needed. See also New Jersey EMS Mutual Aid Response Guide. **New Jersey EMS Task Force Operations Center** (973) 878-9911 **Regional Emergency Medical Communications System (REMCS)** (973) 972-0911

NEW JERSEY EMS MUTUAL AID RESPONSE GUIDE FOR COUNTY OEM EMS COORDINATORS
ALGORYTHM FOR USING OR REQUESTING SPECIALTY STATEWIDE EMS ASSETS

IN COUNTY RESPONSE (Assignment being handled within County)

County OEM EMS Coordinator assures dispatch of local assets → County OEM EMS coordinator will contact REMCS with notification of incident, provide progress report & list specialty assets in operation or requested → EMS Agency responding with specialty EMS asset will notify REMCS when responding and after being demobilized

COUNTY TO COUNTY RESPONSE (Assignment being handled between counties)

County OEM EMS Coordinator will directly contact mutual aid County OEM EMS Coordinator, provide incident report and resource requests → County OEM EMS Coordinator will contact REMCS with notification of incident, provide progress report & list specialty assets in operation or requested → Mutual Aid OEM EMS Coordinator will confirm assets are responding with EMS agencies and report updates to requesting County OEM EMS Coordinator → EMS Agency responding with specialty EMS asset will notify REMCS when responding and after being demobilized

COUNTY REQUESTING NJ EMS TASK FORCE – INCIDENT ADVANCED TEAM

County OEM EMS Coordinator will notify REMCS of the incident and request EMS Task Force IAT to *Standby* or *Respond* → REMCS will make notification to NJEMSTF IAT via communicator. Microsoft Teams Meeting will be started by TFOC → The Task Force Leader on the IAT will speak with requesting county & assign members of the IAT to respond. Communications will be on Teams Meeting or designated radio frequency → Upon arrival, IAT members will assist the County OEM EMS Coordinator as needed. Situational updates to NJEMSTF Leadership and County OEM EMS Coordinators will be provided

NJ EMS TASK FORCE – TEAM ACTIVATION

The NJEMSTF Team activation will be coordinated by the NJEMSTF Leader & IAT based upon County OEM EMS Coordinator briefing → NJEMSTF Response will be coordinated through the IAT and TFOC → Upon arrival NJEMSTF members will operate under the OEM EMS Coordinator and NJEMSTF IAT → NJEMSTF IAT will notify the TFOC with updates → NJEMSTF IAT and EMS agency responding with specialty EMS assets will notify the TFOC when responding and after demobilization

Important Information
REMCS Dispatch – (973) 972-0911
NJEMS MACC/TFOC – (973) 878-9911
Radio Communications – County Coordinators
Updated 3/23

APPENDIX II: CRITICAL CONSIDERATIONS AND PROCEDURES

The following information contains details, information, instructions, and procedures that can be engaged in any emergency situation necessitating either a full or partial evacuation of the healthcare facility. This guideline can be used to develop a specific evacuation plan or to modify a facilities existing Emergency Operations Plan (EOP) to incorporate the necessary elements.

The plan should incorporate staff roles and responsibilities essential to this process. Staff training for employees on the evacuation plan will include techniques for lifting and carrying patients and knowledge of alternate evacuation routes. Drills and reviews must be conducted to ensure that the plan is workable. The plan should include back-up measures for all components and should be integrated with other pertinent protocols in the facility's comprehensive emergency operations plan.

It is recommended that each facility identify existing local, County and State transportation assets and identify existing plans of those agencies prior to contracting with private or services outside of the local structure. Each County OEM has an Emergency Medical Services Coordinator that can help identify these resources.

1. Activation

- Define who (title, not name) makes the decision to activate the plan.
- Define who (title, not name) is the alternate if primary person is not available.
- Define how the plan is activated and how it integrates with healthcare facility incident command system
- Define the type/level of evacuation that could occur (limited, entire building(s), entire campus)
- Describe the phases of implementation (i.e. staff notification, accessing available resources and equipment, preparation of patients and essential patient supplies and equipment).
- Define routes and exits identified for evacuation.

2. Securing Healthcare Facility Site

- Define the lockdown plan including ambulance diversion.
- Define the plan for communications to the NJDOH Health Command Center (HCC) and the appropriate local Office of Emergency Management (OEM) when evacuation is initiated.
- Describe the alternate sites identified for media center and labor pool including nursing and medical staff.
- Define the procedures in place for securing the facility including controlling gas, medical gases, water and electricity (potentially shutting down or activating generators).
- Describe how coordination with local public safety for determination of inner and outer perimeters for healthcare facility and staging area sites will be established.

3. Identification of the Receiving Facilities

- Identify alternate/receiving facilities.
- Secure written documentation that confirms the commitment of these facilities (Memorandum

of Understanding, Contract, etc.)

- Define process for reaffirming/updating agreements.
- Define the process for transferring patients:
    - Determine number and type of patients the receiving facility can/will accept at the time of the evacuation.
    - Notify identified facilities of the number and type of patients that will be evacuated to their facilities.
    - Assure communications links and patient tracking procedures are in place at all involved facilities.

4. Resources/Evacuation

- Identify resources/equipment available to move patients from rooms/floors and the procedure in place for inventory control.
- Identify the location of additional resources needed such as additional lighting sources, i.e., flashlights and batteries.
- Define the protocol for staff training on equipment use.
- Define the protocol to be utilized for on-going assessment of the patient status related to the type of equipment and transportation needs.
- Describe how communication will be maintained for staff and outside resources.

5. Resources/ Continuity of Care

The plan must address how continuity of care will be maintained during an evacuation for patients at all levels of clinical complexity and disability treated in the healthcare facility including:

- How to maintain continuity of care if the usual equipment is not available during the evacuation process.
- How equipment identified as necessary to provide continuity of care can be moved with the patient.
- What resources are available to maintain isolation precautions for the safety of staff and patients?
- How will staff be trained and drilled on this process?

6. External Transportation Resources

- Identify pre-designated areas to congregate patients according to predetermined criteria (I.E. acuity or mobility levels).
- Coordinate transportation vehicle needs/resources with patient needs (I.E.: patient acuity level, wheelchairs, life support, bariatrics)
- Identify secondary/alternate transportation resources to be available if needed.
- List the transportation resources identified – types and numbers (buses, vans, ambulances and MAVs).
- Secure written documentation that confirms the commitment of required transportation resources (Memorandum of Understanding, Contract). This can be accomplished either with private resources or a MOU with the County OEM.
- Define the process for reaffirming and updating agreements.

7. Patient Tracking

Forms in Appendix V should be used to assure the tracking of patients. When staff, equipment &/or supplies are also sent to receiving facilities, the Resource Unit Leader will track these resources. The minimum data set or full Medical Record will contain information on family/emergency contact as well as Private MD, admitting MD and other contact information.

8. Family/Responsible Party Notification

- Define the procedure to notify patient emergency contacts of an evacuation and the patient's destination
- Define the protocol to identify those patients who are unable to speak for themselves.
- Describe the process for assignment of staff members to conduct and track family/responsible party notification.

9. Governmental Agency Notification

- The protocol for emergency notification to public safety. Is established herein (see Activation of EMS Task Force Assets).
- The protocol for emergency notification of a patient evacuation to the New Jersey Department of Health and the appropriate Office of Emergency Management must be clearly identified in the facility's Emergency Operations Plan.

10. Room Evacuation Confirmation

- Define the protocol to verify that rooms have been evacuated (i.e. orange tags, chalk on door).
- Define the orientation and annual staff training protocols for room evacuation provided to all staff.
- Describe how the protocols will be tested during drills.
- Describe the mechanism used to communicate the room evacuation confirmation protocol to the responding fire department and other facility first responders.
- Describe the protocol to account for staff, visitors and non-employees (i.e., vendors, contractors) that may be on site during an evacuation.

11. Patient of Records and Supplies

- Describe the procedure for transport of Medication Administration Records (MAR's) patient care/medical records.
- Describe measures taken to protect patient confidentiality during transport.
- Describe the process to transport specialized treatment supplies.
- Define the protocol for the transfer of patient specific medications and records to receiving facility
- The protocol for the transfer of patient specific controlled substances must include the procedure to record receipt, full count and ensure the signature of both transferring and receiving personnel.

APPENDIX III: WAIVERS

Department of Health Licensing Standards or AIA Guidelines for Design and Control of Healthcare Facility and Health Care Facilities

A request for waiver from the requirements of the Department of Health Licensing Standards or AIA Guidelines for Design and Control of Healthcare Facility and Health Care Facilities shall be submitted to the Department of Health, Office of Certificate of Need and Healthcare Facility Licensure using the Application for Waiver Form available from at https://www.nj.gov/health/forms/cn-28.pdf

To obtain additional information regarding the waiver process, please call: **609-292-6552**

Centers for Medicare and Medicaid Services 1135 Waiver

When the president declares a major disaster or an emergency under the Stafford act or an emergency under the National Emergencies Act and the HHS secretary declares a public health emergency, the Secretary is authorized to take certain actions in addition to regular authorities under section 1135 of the Social Security Act. The Secretary may waive or modify certain Medicare, Medicaid, and children's health insurance program (CHIP) and Health Insurance Portability and Accountability Act (HIPAA) requirements as necessary to ensure to the maximum extent feasible that, in an emergency area during an emergency period, sufficient health care items and services are available to meet the needs of individuals enrolled in security act (SSA) programs and that the providers of such services in good faith who are unable to comply with certain statutory requirements are reimbursed and exempted from sanctions for noncompliance other than fraud or abuse. More information can be found at https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-emergency-preparedness/1135-waivers

APPENDIX IV: FORMS

The forms in this section are recommended for EMS personnel evacuating patients to other off-site facilities and for receiving facilities to enhance patient tracking and patient safety. All forms should be utilized in conjunction with the D4H system.

1. **Incident Advance Team (IAT) – Initial Tasks Checklist:** This form is to be used by the first arriving IAT member that is initiating a Task Force response to a Healthcare Facility Evacuation. **T**his highlights the most critical tasks that needs to be completed to ensure an appropate response in a timely manner. Note: additional task may be necessary and will be incident specific.

2. **Healthcare Facility Evacuation Assigned Positions Checklist:** This checklist will assist the Task Force Leader or first arriving member to assign the mission critical positions for this type of incident. ICS can expand and contract based off the needs and objectives for each incident. It is not the intent of this document to list all possible positions. Follow the ICS to expand if needed.

3. **Healthcare Facility Evacuation - Master Patient Tracking Form:** Utilize this form to capture the most basic patient data. This will serve as quick reference for those that are working the Hospital Command Center. Additional data will be collected in the D4H Patient Tracking section. If for some reason D4H goes offline, operations can continue while keeping patient tracking intact.

4. **Healthcare Facility Evacuation - Patient Transport Form:** This form will be used by the Transportation Group Supervisor to ensure accurate tracking of evacuees leaving the sending facility. Like the other forms, this captures the most basic information. Additional data will be logged into D4H

5. **Healthcare Facility Evacuation – Receiving Facility Form:** The Receiving Group Supervisor will use this form to check in evacuees as they arrive at the receiving facility. If there is more than one receiving facility use additional forms for each. The totals from each facility should match the transport from.

	Task	Date / Time	Notes
	Check-in with requesting facility command center.		
	Confirm initial briefing. -Conditions / Status (type of incident) -Total Patient Count -Breakdown (ICU / PED / NICU / Oxygen Dependent -Potential of facility evacuation		
	Touchbase with County EMS Coordinator or local EMS having authority. -Face to face or via other communications if not on location. -Insure NJEMSTF IAT and County EMS Coordinator / local EMS concur with the initial brief.		
	Determine additional resources needed. -Medical Ambulance Buses (MABs) -BLS / ALS Strike Teams -Specialty Care Transport Units (SCTUs) -Any other specialized resources		
	Update Incident Advance Team (IAT) -Via Teams meeting or radio system		
	Start D4H Incident in Operations Center -In advanced settings check boxes for: *Alert all invited users that this incident was created* *Create an activity in D4H Incident Reporting*		
	Ensure Task Force Operations Center is stood up. (physical or virtual)		
	Make notification to New Jersey Hospital Association (NJHA) via hotline number. 800-457-2262		
	Determine primary and secondary staging area. -Keep in mind quantity / size of requested assets.		
	Assign Operations Section Chief Under Operations will be: - Staging -Movement Group Supervisor - Evacuee Collection Point Group Supervisor - Transportation Group Supervisor - Receiving Group Supervisor		
	Assing Planning Section Chief Under Planning will be: - Patient Accountability Leader - Situation Unit Leader		

New Jersey EMS Task Force – Incident Advance Team (IAT)

Healthcare Facility Evacuation Assigned Positions Checklist

COMMAND STAFF				
☑	**Position**	**Name**	**TF ID #**	**Cell Phone #**
	Incident Commander (IC)			
	Unified Commander (UC)			
	Patient Accountability Officer			
	Safety Officer			
	Public Info Officer			
GENERAL STAFF				
☑	**Position**	**Name**	**TF ID #**	**Cell Phone #**
	Operations Section Chief			
	Planning Section Chief			
	Logistics Section Chief			
OPERATIONS SECTION				
☑	**Position**	**Name**	**TF ID #**	**Cell Phone #**
	Staging Area Manager			
	Evacuation Groups Supervisor			
	Evacuee Collection Point Group Supervisor			
	Transportation Group Supervisor			
	Receiving Group Supervisor			
PLANNING SECTION				
☑	**Position**	**Name**	**TF ID #**	**Cell Phone #**
	Situation Unit Leader			
	Resource Unit Leader			
	Documentation Unit Leader			
	Demobilization Unit Leader			

New Jersey EMS Task Force Operations Center (TFOC) 973-878-9911

New Jersey EMS Task Force – Incident Advance Team (IAT)

Healthcare Facility Evacuation - Master Patient Tracking Form

(to be used in conjunction with D4H)

Sending Facility	Date of Incident	Starting Patient Count	Ending Patient Count	Page		Page
					OF	

Triage Tag # / MR #	Patient Name	DOB	Floor	Bed	Transport Need (BLS / ALS / SCTU / MAB)	Transporting EMS Unit	Receiving Facility

New Jersey EMS Task Force – Incident Advance Team (IAT)

Healthcare Facility Evacuation - Patient Transport Form

(to be used in conjunction with D4H)

Sending Facility	Date of Incident	Starting Patient Count	Ending Patient Count	Page		Page
					OF	

Triage Tag # / MR #	Patient Name	DOB	Transporting EMS Unit	Transport Time	Receiving Facility

New Jersey EMS Task Force – Incident Advance Team (IAT)

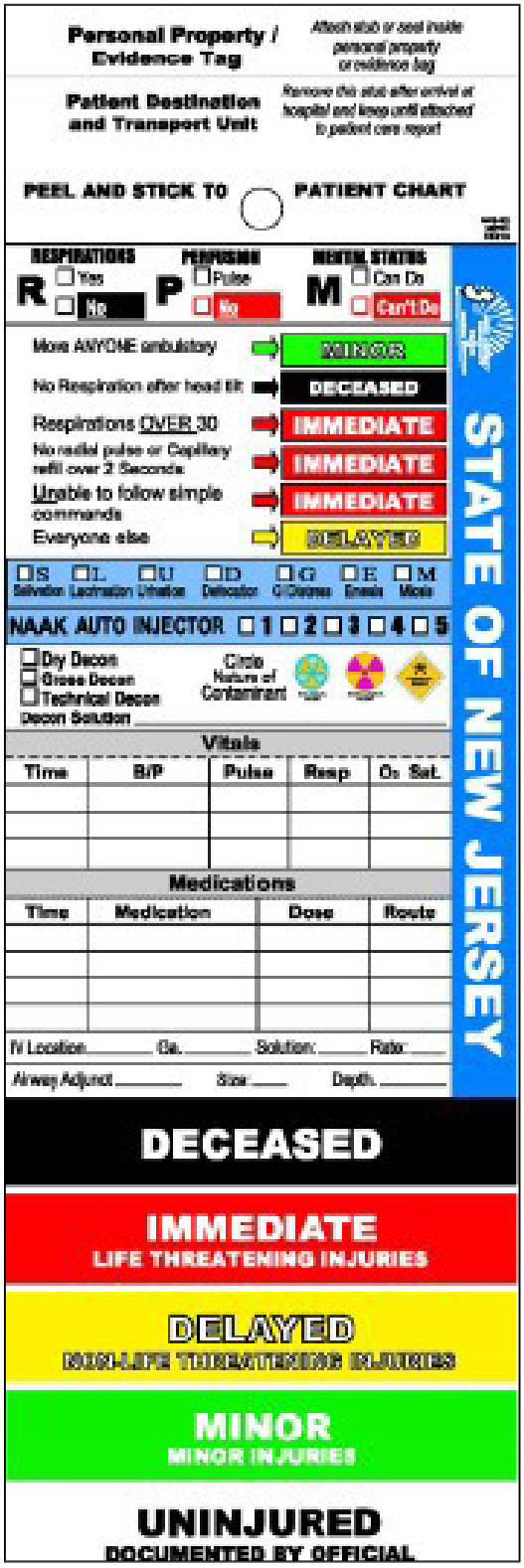
Healthcare Facility Evacuation – Receiving Facility Form

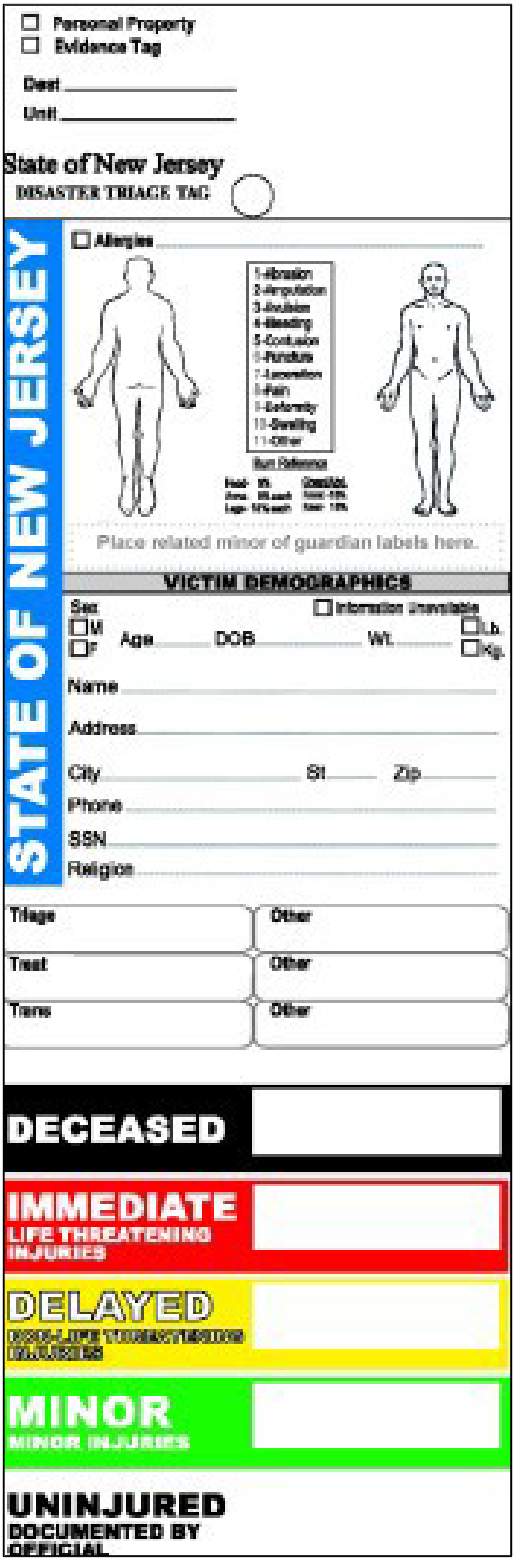
(to be used in conjunction with D4H)

Sending Facility	Receiving Facility	Date of Incident	Total Arrived at Receiving	Page		Page
					OF	

Triage Tag # / MR #	Patient Name	DOB	Transporting EMS Unit	Arriving Time

APPENDIX V: NJ DISASTER TRIAGE TAG





APPENDIX VI: RESOURCE TYPING

A critical component of resource management is ensuring that definitions of equipment, teams, units, and personnel are uniform and standardized. This practice is described as resource typing and is led by the Federal Emergency Management Agency (FEMA). The following resource types are provided in accordance with definitions from FEMA and the New Jersey Department of Health.

Emergency Medical Technician (EMT)

There is only one type of EMT – a Type 1. This individual is trained in basic life support care and validly certified or recognized by the Commissioner in accordance with the standards for Emergency Medical Technician-Basic certification as set forth in Revised N.J.A.C. 8:40A.

Basic Life Support is defined as a basic level of pre-hospital care that includes patient stabilization, airway clearance and maintenance, cardiopulmonary resuscitation (CPR) (to the level of the Professional Rescuer or Health Care Provider as issued by either the American Heart Association, the American Red Cross, the National Safety Council or other entity determined by the Department to comply with AHA CPR Guidelines), hemorrhage control, initial wound care, fracture stabilization, victim extrication and other techniques and procedures as defined in the National Education Standards and Scope of Practice.

This position is a published FEMA resource type.

Paramedic

There is only one type of Paramedic — a Type 1. This individual is trained in advanced life support care and validly certified or recognized by the Commissioner in accordance with the standards for Emergency Medical Technician-Paramedic certification as set forth at N.J.A.C. 8:41A.

Advanced Life Support is defined as an advanced level of pre-hospital, inter-facility or emergency medical care that includes basic life support functions, cardiac monitoring, cardiac defibrillation, telemetered electrocardiography, administration of anti-arrhythmic agents, intravenous (IV) therapy, administration of specific medications, drugs and solutions, utilization of adjunctive ventilation devices, trauma care and other techniques and procedures authorized in writing by the Commissioner.

This position is a published FEMA resource type.

Ambulance Strike Team/Task Force (ST/TF) Leader

There is only one type of Ambulance Strike Team/Task Force (ST/TF) Leader – a Type 1. This individual must certified as an Emergency Medical Technician or Paramedic. The Ambulance ST/TF Leader provides direct supervision and guidance to a group of EMS personnel, functioning as ambulance crews, who are able to respond as a deployable resource in a strike team or task force configuration. The Ambulance ST/TF Leader is responsible for supervising tactical assignments assigned to the Strike Team/Task Force. The Leader reports work progress and status of resources, maintains work records on assigned personnel, and relays other important information to their supervisor.

This position is a published FEMA resource type.

Ambulance (Ground)

There are four Types of Ground Ambulances. All ambulances must be licensed pursuant to Revised N.J.A.C. 8:40 and 8:41.

Be sure not to associate with ambulance design types (1-3) with the resource typing provided below.

Ambulance (Ground)				
	Type 1	**Type 2**	**Type 3**	**Type 4**
Maximum Patients	2	2	2	2
Level of Care	Advanced Life Support for HazMat Response	Advanced Life Support	Basic Life Support for HazMat Response	Basic Life Support
Staffing	1 ALS practitioner and 1 BLS practitioner (trained to work in HazMat Level B and specific threat conditions)[5]	1 ALS practitioner and 1 BLS practitioner	2 BLS practitioners (trained to work in HazMat Level B and specific threat conditions)[6]	2 BLS practitioners

This resource type is provided as interim guidance from FEMA.

Ambulance Strike Team

An Ambulance Strike Team is a group of five ambulances of the same type with common communications and a leader, in a separate command vehicle. It provides an operational grouping of ambulances complete with supervisory element for organization command and control. The strike teams may be all ALS or all BLS. All ambulances must be licensed pursuant to Revised N.J.A.C. 8:40 and 8:41.

There are four Types of Ambulance Strike Teams.

Ambulance Strike Team				
	Type 1	**Type 2**	**Type 3**	**Type 4**
Level of Care	Advanced Life Support for HazMat Response	Advanced Life Support	Basic Life Support for HazMat Response	Basic Life Support
Capability	5 Type 1 Ambulances; Capable of transporting a minimum of 10 litter patients total (2 per ambulance)	5 Type 2 Ambulances; Capable of transporting a minimum of 10 litter patients total	5 Type 3 Ambulances; Capable of transporting a minimum of 10 litter patients total	5 Type 4 Ambulances; Capable of transporting a minimum of 10 litter patients total

[5] Meets or exceeds standards as addressed by EPA, OSHA and NFPA 471, 472, 473 and 29 CFR 1910, 120 ETA 3-11 to work in HazMat Level B and specific threat conditions.

[6] Meets or exceeds standards as addressed by EPA, OSHA and NFPA 471, 472, 473 and 29 CFR 1910, 120 ETA 3-11 to work in HazMat Level B and specific threat conditions.

Ambulance Strike Team				
	Type 1	**Type 2**	**Type 3**	**Type 4**
Staffing	1 ALS practitioner, 1 BLS practitioner (trained to work in HazMat Level B and specific threat conditions)[7], and 1 Strike Team Leader in a separate command vehicle	1 ALS practitioner, 1 BLS practitioner, and 1 Strike Team Leader in a separate command vehicle	2 BLS practitioners (trained to work in HazMat Level B and specific threat conditions)[8] , and 1 Strike Team Leader in a separate command vehicle	2 BLS practitioners, and 1 Strike Team Leader in a separate command vehicle

This resource type is provided as interim guidance from FEMA.

Ambulance Task Force

An Ambulance Task Force is any combination of five ambulances of different types (ALS and BLS) with common communications and a leader, in a separate command vehicle. All ambulances must be licensed pursuant to Revised N.J.A.C. 8:40 and 8:41.

There is one Type of Ambulance Task Force – a Type 1. This typing is used to identify any group of five Type 1-4 ambulances accompanied by a Task Force Leader.

This resource type is provided as interim guidance from FEMA.

Air Ambulance (Rotary Wing)

There are four Types of Air, Rotary Wing Ambulances (also referred to as helicopters). All ambulances must be licensed pursuant to Revised N.J.A.C. 8:41.

Air Ambulance (Rotary Wing)					
	Type 1	**Type 2**	**Type 3**	**Type 4**	**Type 5**
Maximum Patients	2 or more litter patients	2 or more litter patients	2 or more litter patients	1 litter patient	Unique to the patient(s) being transported
Level of Care	Advanced Life Support	Advanced Life Support	Advanced Life Support	Advanced Life Support	Specialty transport trained and qualified to care for the specific patient and associated supporting

[7] Meets or exceeds standards as addressed by EPA, OSHA and NFPA 471, 472, 473 and 29 CFR 1910, 120 ETA 3-11 to work in HazMat Level B and specific threat conditions.

[8] Meets or exceeds standards as addressed by EPA, OSHA and NFPA 471, 472, 473 and 29 CFR 1910, 120 ETA 3-11 to work in HazMat Level B and specific threat conditions.

Air Ambulance (Rotary Wing)					
	Type 1	**Type 2**	**Type 3**	**Type 4**	**Type 5**
					equipment
Staffing	3 (pilot and 2 paramedics or 1 paramedic and 1 nurse or physician)	3 (pilot and 2 paramedics or 1 paramedic and 1 nurse or physician)	3 (pilot and 2 paramedics or 1 paramedic and 1 nurse or physician)	2 (pilot and 1 paramedic)	Appropriate level and number of staff/specialists required for the mission and to meet the standards of care for the specific patient
Aircraft	Day and night operations IFR and Full SAR including hoist capabilities	Day and night operations Plus IFR	Day and night operations Plus IFR	Day and night operations Plus IFR	Tailored to fit the mission
	NOTE: NVG capability must be requested specifically				

This resource type is provided as interim guidance from FEMA.

Multi-Patient Medical Transport Vehicle

A Multi-Patient Medical Transport Vehicle provides basic medical support, evacuation, and transportation services via multi-passenger vehicle. It may also be utilized to import personnel and or equipment/supplies into the area of need. In New Jersey, these are typically referred to as a Medical Ambulance Bus (MAB).

There are three Types of Multi-Patient Medical Transport Vehicles.

Multi-Patient Medical Transport Vehicle			
	Type 1	**Type 2**	**Type 3**
Maximum Patients	Climate controlled; Minimum of 10 seated patients AND 1 wheeled ambulance cot	Climate controlled; Minimum of 10 seated patients	Climate controlled; Minimum of 6 seated patients
Level of Care	Basic Life Support	Basic Life Support	Basic Life Support
Staffing	Driver (licensed and able to operate vehicle) and certified as an EMT Emergency medical staff specific to the mission/commensurate with the mission assignment	Driver (licensed and able to operate vehicle) and certified as an EMT Emergency medical staff specific to the mission/commensurate with the mission assignment	Driver (licensed and able to operate vehicle) and certified as an EMT Emergency medical staff specific to the mission/commensurate with the mission assignment

This resource type is provided as interim guidance from FEMA.

APPENDIX VII: INFORMATION SHEET

Appendix D, provided as a separate Excel document, contains information about each hospital's census, EMS, and equipment data. The document provides a master list to maintain and update hospital-specific data as well as three worksheets that contain specific reports.

Master List Worksheet

This sheet is where all data is entered and modified. Be sure to only update the information on this worksheet as it automatically feeds into the other three reports.

EMS Data

The EMS Data worksheet provides information regarding each hospital's EMS personnel, assets, and contracts. The number of EMTs, paramedics, and critical care nurses on staff are included, as well as the number of licensed EMS transport vehicles (i.e. ambulances) and non-transport ALS vehicles. Furthermore, the names of the hospital's primary and secondary EMS contract holders are provided.

Census Data

The Census Data sheet is provided as PivotTable. This means that the report provided may be modified and filtered to meet a specific need. By default, the report was designed to allow filtering by county and EMR Provider. Within the actual report, number of licensed beds, average hospital census, and emergency department surge capacity is provided. A grand total is included at the bottom.

If additional data has been added to the Master List Worksheet, this report must be refreshed. To do this, click within the report, look for the purple "PIVOTTABLE TOOLS" ribbon at the top of the window, click the tab labeled "ANALYZE," and click "Refresh."

Equipment Data

The Equipment Data Sheet is provided as a PivotTable. This means that the report provided may be modified and filtered to meet a specific need. By default, the report allows filtering by county. The report currently includes the number of evacuation chairs, evacuation sleds, portable adult ventilators, portable pediatric ventilators, portable neonatal ventilators, portable neonatal transport isolettes.

If additional data has been added to the Master List Worksheet, this report must be refreshed. To do this, click within the report, look for the purple "PIVOTTABLE TOOLS" ribbon at the top of the window, click the tab labeled "ANALYZE," and click "Refresh."

The images below are examples of evacuation chairs, sleds, and neonatal transport isolettes for reference.

Evacuation Chair

Sled

Neonatal Transport Isolettes

APPENDIX VIII: EVACUATION PLANNING SUMMARY

The following checklist summarizes the steps involved in planning and executing a hospital evacuation based on this plan. This checklist should be used as a reference during an evacuation in order to ensure that key steps aren't overlooked.

Activate Hospital Incident Command System (HICS)

- Designate Incident Commander and other key command and general staff positions

  Incident Commander _____
  Operations Section Chief _____
  Evacuation Branch Director ___
  EMS Branch Director _____

- Open Hospital Command Center (HCC)

  Location _____

Consider evacuation options and alternatives.

- Gather as much reliable information as possible about the threat/hazard at hand.
- Contact local or county Office of Emergency Management (OEM to discuss potential need for evacuation.
- Analyze the threat/hazard at hand to determine facility vulnerability based on the Critical Infrastructure (see Tab 1).
- Evaluate options to mitigate the threat and shelter in place rather than evacuating.
- Determine availability of Sending Facility's own contact ambulance and other vehicle resources.
- Identify those patients who may safely be discharged early.
- Determine total number of patients who will need to be evacuated to other healthcare facilities.
- Make an evacuation decision.
  __ *Full evacuation* *Partial evacuation* *Wait and reassess (shelter in place)*

  Reason for evacuation _____

Activate evacuation plan.

- Notify local or county OEM of decision to evacuate and request assistance.
- Transition to Unified Command.
  Unified Command _____

- _____
- _____

- Prepare detailed patient census.
- Draft and implement a tactical communications plan.
- Determine transport resource needs. (See Tab 3)
  ALS ground ambulances_____BLS ground ambulances_____Other Vehicle capacity _____

- Consider need for air transport.
  __ *Utilize air transport* *Do not utilize air transport*

Air Branch Director _____

- Consider other resource needs
  __ *Security at Sending Facility* *Traffic management, police escort for transport teams*

  __ *Backup staffing* *Specialized healthcare and transport equipment*

- Evaluate census and determine patient evacuation sequence.
- Obtain bed availability data for Receiving Facilities. (See Tab 4)
- Designate a Receiving Facility for each patient being moved from Sending Facility.

Transport patients to Receiving Facilities.

- Distribute patient tracking tags to all Sending Facility units being evacuated.
- Assemble medical records, medications, etc. for each patient being transported.
- Enter each patient into patient tracking system (electronic or paper based).
  Total patients transported from Sending Facility _____

- Receive confirmation of patient arrivals from each Receiving Facility.
  Total patients confirmed as arriving at Receiving Facilities _____

Demobilization

- Prepare demobilization plan.
- Account for all resources used in evacuation and release to their home agencies as soon as no longer needed.
- Gather paperwork from external agencies participating in the evacuation and compile as part of the Sending Facility's incident response record.
- Begin to prepare a hospital repopulation plan that will be used to return patients to the Sending Facility once it becomes feasible to do so.

APPENDIX IX: ACRONYMS AND DEFINITIONS

ACRONYMS	DEFINITIONS
Advanced Warning Event	A disaster that decision teams are tracking, as they consider whether it may warrant evacuating the facility.
AHRQ	Agency for Healthcare Research and Quality
Advanced Life Support (ALS)	An advanced level of pre-hospital, inter-facility or emergency medical care that includes basic life support functions, cardiac monitoring, cardiac defibrillation, telemetered electrocardiography, administration of anti-arrhythmic agents, intravenous (IV) therapy, administration of specific medications, drugs and solutions, utilization of adjunctive ventilation devices, trauma care and other techniques and procedures.[9]
ASAP	Alternate Support Apparatus
AST	Type IV Ambulance Strike Team
Basic Life Support (BLS)	A basic level of pre-hospital care that includes patient stabilization, airway clearance and maintenance, cardiopulmonary resuscitation (CPR), hemorrhage control, initial wound care, fracture stabilization, victim extrication and other techniques and procedures as defined in the National Education Standards and Scope of Practice.[10]
CMS	Center for Medicare and Medicaid Services
Critical Infrastructure	Assets, including physical systems, other support systems, and staff, that are essential to operating a hospital and providing a standard level of care to patients.
D4H	D4H is an Incident Management online portal, used to help manage and maintain situational awareness as well as patient tracking
DOH	New Jersey Department of Health
EOG	Emergency Operations Guide or Guidelines
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EMTALA	Emergency Medical Treatment and Labor Act
Evacuation	For the purposes of this document, evacuation is the movement of patients from a "Sending" healthcare facility to an offsite "Receiving" healthcare facility due to a pending danger or current vulnerability.
Evacuation Sequence	The numerical order in which hospital patients are evacuated
FEMA	Federal Emergency Management Agency
HCC	New Jersey DOH Health Command Center
HIPAA	Health Insurance Portability and Accountability Act
IAT	Incident Advance Team

[9] *Regulations Regarding Mobile Intensive Care Programs*. New Jersey Department of Health.

ACRONYMS	DEFINITIONS
IC	Incident Commander
ICP	Incident Command Post - The physical location from which emergency operations (including evacuation) are coordinated during an incident.
ICS	Incident Command System. A standardized, on-scene, all-hazards incident management approach that: Allows for the integration of facilities, equipment, personnel, procedures and communications operating within a common organizational structure. Enables a coordinated response among various jurisdictions and functional agencies, both public and private. Establishes common processes for planning and managing resources. ICS is flexible and can be used for incidents of any type, scope and complexity.
IMT	Incident Management Team
MAB	Medical Ambulance Bus
MCRT	Mass Care Response Trailer
MCRU	Mass Care Response Unit
Medical Command	Medical supervision provided to prehospital advanced life support providers by a licensed physician via radio, telephone or other direct means of communication.
MOC	Mobile Operations Center
MOU	Memorandum of Understanding
NDMS	National Disaster Medical System
NIMS	National Incident Management System - The NIMS provides a systematic, proactive approach guiding government agencies at all levels, the private sector, and nongovernmental organizations to work seamlessly to prepare for, prevent, respond to, recover from, and mitigate the effects of incidents, regardless of cause, size, location, or complexity, in order to reduce the loss of life or property and harm to the environment.
No Notice Incident	This type of evacuation is the most complex due to the lack of time available for planning, organizing and often results in an unintentional lack of compliance with established rules and regulations designed for normal operations. Emergency evacuations are the most dangerous to responders and patients and should always be avoided whenever possible. Examples of situations that may cause an emergency evacuation of a healthcare facility include: Structural damage/collapse, Fire, Hazardous Material Release.

ACRONYMS	DEFINITIONS
OEMS	NJ Department of Health, Office of Emergency Medical Services
OEMS State Coordinator	NJDOH OEMS appointed coordinator for EMS activities
Pre-Event Decision	The decision whether, faced with an Impending Event, to 1) preemptively evacuate a hospital, or 2) shelter in place.
Planned or NOTICE Incident	There is time to Plan and complete the evacuation before the emergency occurs. This is a situation that has the potential to cause enough damage to a hospital, other healthcare facility or the surrounding community that decision teams consider pre-event evacuation.
Post-Incident Decision	The decision in the aftermath of an incident, to evacuate a hospital or healthcare facility.
Post-Event Evacuation	An evacuation carried out after an event.
Pre-Incident Evacuation	An evacuation carried out prior to an Impending Event, when the hospital structure and surrounding environment are not yet compromised; A Pre-Event Evacuation is ordered when the anticipated effects of an impending disaster would either place patients and staff at risk or make an evacuation extremely dangerous or impossible at a later time.
Receiving Healthcare Facility	Hospital or other Healthcare Facility accepting patients from a “Sending” Facility.
Repopulation	The movement of evacuated patients back into the evacuated facility when safe.
Sending Healthcare Facility	Hospital or other Healthcare Facility evacuating and “Sending” patients to a “Receiving” Facility.
Shelter In Place	The decision not to evacuate a threatened hospital, either prior to a disaster or in its aftermath.
SitRep	Situation Report
ST	Strike Team – 5 of the same Kind and Type of Resources
STAM	Staging Area Manager
TF	Task Force – 5 mixed Kind and Type Resources
TFOC	Task Force Operations Center
TSU	Technology Support Unit
UASI	Urban Area Security Initiative
UC	Unified Command
UTF	Universal Transfer Form