

# **Shelter-in-Place vs. Evacuation Decision Criteria**

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# Problem Statement

- There is little or no guidance to assist state or local planners to make a shelter-in-place vs. evacuation decision in response to public health emergencies.

# Literature Review

- Completed a review of over 100 published documents:
  - Journal articles
  - Websites and associated documents
  - Presentations
  - Federal, state, and local government guidance and documents
- Findings
  - Sufficient information on evacuation processes and considerations
  - Sufficient information on SIP considerations and needed supplies
  - Little to no information on how to make the decision

# Structured Interviews

- Completed interviews with emergency planners (May – August 2009)
- Goal was to substantiate the literature review findings
  - 13 community planners
  - 4 hospital emergency planners
  - Used a structured discussion guide
- Focus was on “notice” events vs. “no-notice events”
  - Hurricane and flooding
- Key Point of discussion guide include:

# Key Questions in Interviews

- Do you use any tools for making a shelter-in-place or evacuation decision?
- Critical points for decision-making for evacuation or shelter-in-place?
- Who is involved in the decision-making process for facility evacuation? What is the hierarchy?
- What is the data used to determine an evacuation?
- Are you in need of a tool to assist with the decision-making process?

# Shelter-in-Place Key Elements

- As required by JCAHO standards, hospitals should have plans to stand alone for up to 96 hours.
- Plans usually include checklists for ensuring:
  - Sufficient supplies
  - Sufficient personnel
  - Building systems are functional and safe
  - Security personnel
  - Controlled access to the facility
  - Preparations are in place for a potential evacuation

# Evacuation Plan Key Elements

- As required by JCAHO standards and jurisdictional requirements, hospitals should have evacuation plans.
- Plans usually address:
  - Facility issues – Evacuation of vulnerable populations or high-risk areas
  - People issues – Staffing for triage and assessment, tracking and moving patients, moving staff
  - Support services issues – Shutdown of systems, equipment and supplies for evacuating, securing the facility
  - System issues – Hospital ICS, policies and procedures for ensuring a controlled evacuation.

# Coordination

- Coordination was NOT common nor consistent across communities or jurisdictions
- Ranged from:
  - Strong community oversight and control
  - to-
  - Facility-based decision

# Model 1: Strong Coordination

- Centralized coordinating body exists
- Usually the Emergency Management (EM) office or Emergency Operations Center (EOC)
- Reviews all congregate care facility emergency management plans
- Pre-identified flood zones which are required to evacuate when mandated by chief decision-makers
- Facilities outside of flood zones are secondary considerations

## Model 2: Less Formal Coordination

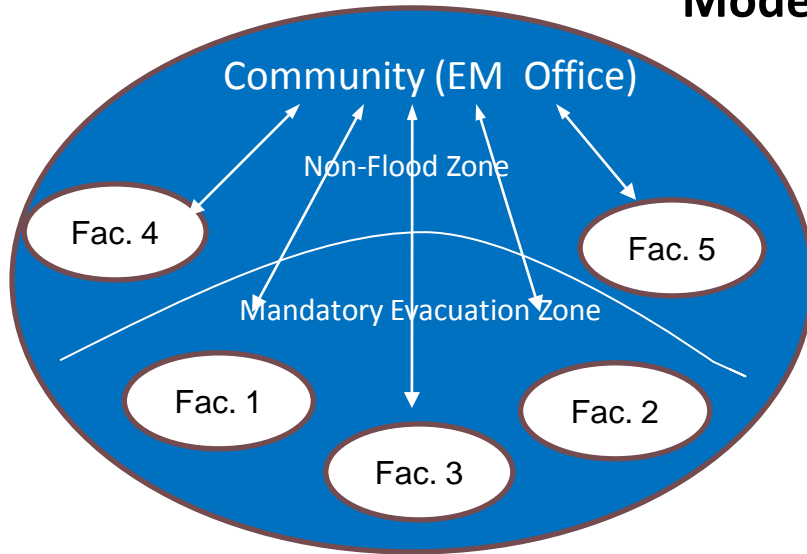
- Facility-based decision whether to SIP or evacuate
- Done in coordination with EM office or EOC and with other facilities
  - Can be problematic if using the same resources for evacuation

## Model 3: Corporate Coordination

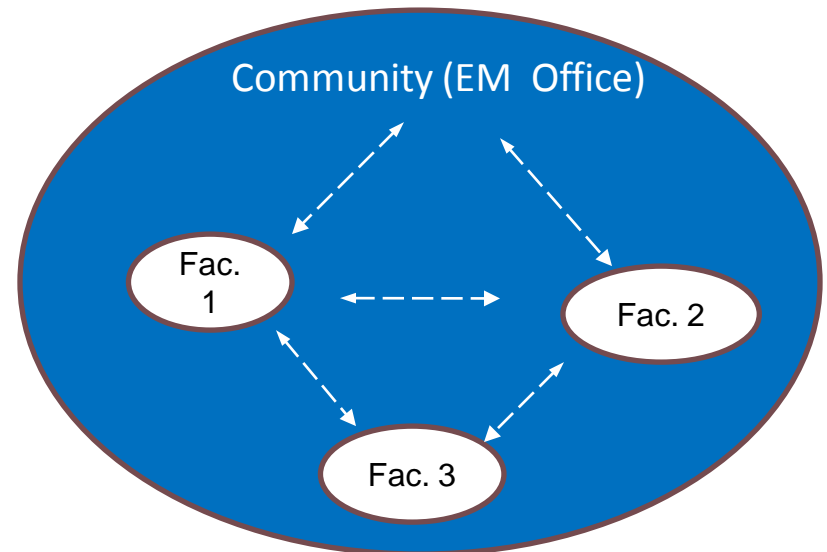
- Coordination across facilities within a healthcare corporation
- Movement of patients and resources is guided by corporate policy.
- Safer sites can be more readily used to move patients prior to event

# Comparison of Models

## Model 1



## Model 2



# Future Work

- Elaborate on best practices
- Identify partners/communities to test effectiveness
- Disseminate

# Questions?

- How do these results compare to your facility/community?
- Do you have healthcare facility emergency planners on your planning committees?
- Is there another model that represents how SIP vs. Evacuation is decided?
- Is a tool, or set of tools, going to be useful?

