CONSIDERATIONS FOR PREPARING FOR EVACUATION CATASTROPHES

1. This outline identifies issues that have been raised by hospitals operating in extraordinary conditions during a natural emergency, such as a hurricane, earthquake, etc. The points are intended to be suggestive. Each hospital will need to evaluate how its circumstances, and potential natural disasters, may alter these concerns.
   
a) There are differences between “predicted” and “unpredicted” disasters.

b) Hurricanes come with some predicted lead and evacuation times, enabling hospital to call in coverage teams and physicians to arrange for coverage.

c) Tornadoes, earthquakes, and other disasters occur without sufficient warning to plan, call in coverage teams, etc.

d) Hospitals with a regular risk of “predicted” disasters prepare differently than hospitals facing “unpredicted” disasters.

2. With respect to “predicted” disasters, plans should address not just staff coverage, but also ensuring coverage by independent physicians. Make sure that Medical Staff Bylaws address the obligation of each admitting physician to provide coverage, either personally or through a designee, to each admitted patient during a catastrophe that requires a general evacuation of the area.
   
a) Medical Staff may want to consider an alternative staffing model in which all the members of the Medical Staff rotate “call” for catastrophe coverage that addresses appropriate specialty coverage and staffing/patient ratios.

b) Alternatively, obligation would fall on each admitting physician to provide or arrange coverage, but that leaves questions of fall-back coverage issues if sufficient covering physicians do not cover, what happens if physicians arrange for a common physician to provide coverage so that there is a deficient staffing coverage ratio, and keeping a record at the hospital as to who is providing coverage for each patient.

c) Hospital may want to consider making substitute arrangements for coverage by hospitals or others.

3. With predicted disasters, decision regarding transfer of patients before storm hits:
   
a) Transfer trauma associated with transfer vs. possible diminished capacity to treat after the storm hits;
      
i) Need to assess the likelihood of catastrophic failures in ability to care for patients.

   ii) Need to assess the expected medical costs associated with transfer/transportation out of risk zone against possible risk of keeping patient in risk zone in the event of catastrophic failures.
b) Decisions will be evaluated with the benefit of hindsight;
c) Financial costs of transfer should not be controlling factor; and
d) Consideration of location of facility, back-up systems, risk of breaches to integrity of structure, etc.

4. Need for rigorous review of weakest links that might be the cause of precipitous failure:
   a) Concerns of potential flooding may have led to relocation of back-up power generators above area of potential flooding;
   b) But, if portion of wiring remains below area of potential flooding, that is the weakest link that will fail; and
   c) Consider difficulties of evacuating critically ill patients down several flights of stairs if a catastrophic power failure and back up generator failure:
      i) No elevator service;
      ii) Loss of Ventilator capabilities;
      iii) Need to manually ventilate patients while team carries patients down stairs; and
      iv) Considerations of logistical difficulties may impact decision on where to house most critical patients

5. Both staff coverage and physician coverage pose a much greater challenge for a hospital facing an unpredicted emergency:
   a) Consider how to call in staff and physicians if hospital is isolated with patients as a result of an “unpredicted” emergency; and
   b) Consider how to mandate coverage by independent contractor physicians not then at hospital.

6. Consider controls to make sure that each patient is assigned to at least one physician on premises for overall management of patient and ensure that such physician has control over care
   a) May need to transition management of patient at different times, but at any time, there should be a defined physician in control;
   b) Maintenance of medications;
   c) Changes in status, etc.; and
   d) Consider policy limiting physicians who have had no contact with patient giving orders for potentially lethal medications.
7. Hospital Within Hospital Issues

a) Agreement between tenant hospital and landlord hospital likely does not address many considerations that could become issues in a catastrophe:

i) Priority of evacuations: tenant and landlord facility;

ii) Coordination of evacuations between tenant and landlord;

iii) Access to landlord’s helicopter landing pad for evacuation of tenant patients; and

iv) Cooperation/assistance in evacuating patients.

b) Issues associated with access to services for which landlord is responsible in exigent circumstances compromising ability of landlord to provide those services (rationing and distributing limited resources between landlord and tenant):

i) Dietary services;

ii) Telecommunication facilities;

iii) Oxygen; and

iv) Other life supporting facilities/services provided by landlord hospital.

c) Issues associated with sharing responsibilities for nursing/physician/other services to cover shortages and unanticipated problems cutting across both landlord and tenant institutions:

i) Mixed staff;

ii) Line of authority between facilities; and

iii) Treatment by physicians who may not be credentialed by one of the facilities.

d) Issues associated with access to facility after catastrophe:

i) Access to medical records of Tenant facility;

ii) Removal of medical records by Landlord facility/Return of medical records;

iii) Removal/return of other PHI by Landlord facility; and

iv) Photographs taken by Landlord facility of Tenant facility’s space, including PHI of Tenant facility.
8. Evacuation issues:

a) What should be order of evacuation?
   i) Most critically ill first?
      (1) Issue of whether some of most critically ill would be able to survive evacuations.
   ii) Infants and new mothers first?
   iii) Strategy for evacuating patients with poor survival prognosis?

b) High-tech dependent patients needing evacuation in the event of power failure:
   i) Dialysis patients;
   ii) Ventilator patients;
      (1) Manual ventilation
      (2) Evacuation of patients with personnel to provide manual ventilation
         (a) Potential loss of staff coverage when needed staff evacuate with patients.
         (3) Carrying patients down stairs and onto evacuation vehicle all while manually ventilating patient.

c) Allocation of evacuation slots between host and tenant facility in hospital within hospital scenario.

d) How to prepare for evacuation in exigent circumstances and what should be sent with patient:
   i) Relevant medical records;
   ii) Quick assessment of patient’s circumstances so transferee facility can provide effective immediate care;
   iii) Twenty-four to forty-eight hours of medications, packaged and labeled for appropriate administration.
9. Mechanism for addressing ethical or other concerns raised by physician behavior:
   a) Traditionally, a physician who risks harming patients faces potential summary suspension to protect patients;
   b) Medical staff/summary suspension mechanism breaks down in the midst of catastrophes; and
   c) What is the mechanism to push back on physicians taking actions that otherwise would be subject to summary suspension or other discipline during catastrophes?

10. Issues associated with a hospital in a non-evacuation scenario
   a) Potential capacity constraints;
   b) Potential technical legal issues when hospital pushed beyond capacity in certain departments (ICU, NICU, overall bed capacity);
   c) Consideration of special legislation to provide for suspension of certain licensure obligations/capacity constraints?
   d) In absence of regulatory relief, there is precedent for qui tam relators bringing False Claims Act (FCA) case predicated on exceeding capacity and regulatory requirements; and
   e) Conflicts between EMTALA obligations and some possible FCA/regulatory theories.