# MEDICAL EVACUATION & COVID-19

Guidance for Resident Coordinators and Country Offices on medevac in the context of COVID-19

Last updated 8 March: For further advice contact the Occupational Safety and Health team of DHMOSH/DOS via osh@un.org.

## BACKGROUND

The 2019 coronavirus (COVID-19) has the potential to lead to increased rates of complex illness in staff members and their dependents, and hence to an increased need for medical evacuation (medevac). However wide-ranging limitations in movement between countries designed to slow the spread of COVID-19 globally requires that duty stations address an actual decrease in overall medevac capability.

Duty stations remain responsible for revising the administrative parts of their medevac plan, including:

- monitoring major changes in health care services available locally;
- monitoring for changes in airline destinations or airline passenger requirements (e.g. will patients with fever or respiratory symptoms be able to board?);
- determining if normal medevac locations still remain accessible based on visa and flight restrictions (if any);
- if a normal medevac location is unavailable, identifying suitable alternative locations with their insurer; and
- temporarily updating their entitlements policies to cover alternate medevac locations (reference is made to Organizational HR policy guidance)

Duty stations may also consider other administrative measures that take into account staff who may have additional risks, such as pre-existing illness, difficult visa circumstances, etc. These include flexible working arrangements, including advance home love or telework from another country to prevent return to a high-risk duty station from leave.

During the Ebola crisis, the World Health Organization established a process to assist UN where they would identify receiving hospitals, assist with national access to those hospitals, and then provide a dedicated aircraft with special isolation capability. This mechanism is annexed here. This mechanism will be available for critically ill staff needing high level care. Refer to document for critieria. This WHO capability *should not* be considered a major component of a health support plan until advised. If implemented, any request for use should initially be via medevac@un.org

## ADMINISTRATIVE ISSUES

**Authorization to travel:** This is largely unchanged. Senior staff should actively review their own Organizations entitlement policies, which may have been updated specifically due to COVID-19. In brief, financial authority (approval) for a medevac:

- comes from the Head of Office (or delegate) for the staff members Organization, and
- should be based on a medical recommendation from an authorized medical officer.
    - In locations with a UN medical service this is from a UN Medical Officer with delegated authority from the Medical Director;
    - In other locations, the recommendation should come from DHMOSH, HQ New York.
        - email medevac@un.org
        - For urgent cases via the UN DSS Security Operations Centre +1 (212) 963 6666 (24hr)

Note – in very urgent cases Heads of Office *should not wait* to hear from the supporting medical service – initiate medevac on medical advice and follow up with the supporting UN medical service to ensure reports, sick leave and other requirements can be completed.

**Location and Visas:** It is highly recommended that HR speak directly with their insurance provider for support and advice on suitable medical evacuation centers. They will also help arrange special assistance if needed and liaise with the receiving hospital regarding coverage. As visa and country access are likely to be affected, it is recommended that HR Offices establish visas or other access arrangements in the destination country as soon as possible, and to be aware of short notice changes.

Given that over 60 countries have restrictions of varying sorts in place, and the list of 'at risk' countries is increasing, choosing a suitable destination will be critical to an effective outcome. Each entity should review its own policies, but if a normal medevac location is unavailable, another location may need to be selected with the advice of the insurer and if necessary, DHMOSH NY. The current list of medevac locations is attached.

Whilst medevac is normally to the nearest recognized regional medical center, for likely longer evacuation period/convalescence the country of home leave/family leave travel may be considered. If visa or other restrictions in travel are in place, the location is best determined in conjunction with the insurer and if need be DHMOSH and senior HR staff.

**Sick leave:** Sick leave is generally covered during medevac. In those cases when a medevac would normally end but the staff member cannot return as would usually be the case due to mandatory quarantine (well persons who are exposed and need to stay home) requirements, further sick leave may be given, and if so, the medevac status may also be extended. If sick leave is not available, special leave with pay is recommended.

**Escorts:** Escorts who are required to undergo isolation will have DSA and related support according to individual Organizational policy for interrupted official travel.

# MEDICAL ISSUES

**Who can be evacuated:** The usual requirements for medevac are:

- For *international* staff members and eligible dependent family members may be evacuated to access urgent and essential care when the local medical facilities are inadequate or unavailable.
- For *locally recruited* staff members and eligible dependent family members have the additional requirement that the injury or illness must either be life-threatening or may result in loss of limb or eyesight.

In the context of COVID-19, the medevac-qualifying criteria would be that the patient suffers from a significant or deteriorating respiratory illness that cannot be managed locally. A mild or moderate illness and a general risk that the patient may get worse would not normally be considered sufficient to meet the medevac criteria unless there were other clear risk factors (such as age or immunocompromise) that were relevant. Such risk factors require to be assessed by a licensed physician and, unless in very urgent cases, reviewed and recommended by a UN Medical Officer with delegated authority from the Medical Director or DHMOSH, NY.

The development and prognosis for respiratory illness is likely to become clearer over the next few weeks, and will improve the ability to identify those who would benefit from medevac. However at this stage there is no intent to change the medical requirements for recommending medevac.

**Medevac window:** COVID-19 is known to progress quickly from moderate to severe illness, potentially during the space of 1-2 days. This provides an unusually small medevac window. Prior to this, the patient may appear well enough that the need for medevac is not considered, after this, the risks and complexity of medevac itself may be high. If medevac is to take place it needs to be identified and acted on quickly by both medical and administrative staff.

**Unrelated injuries and illness:** Unfortunately, the travel restrictions in play are directed at the location of origin of the patient, not whether they have respiratory illness or not. A receiving country may waive restrictions on travel for a seriously ill or injured patient, however this should not be assumed, and may require that a recent test establishes the patient definitively does not have the virus. This may not be compatible with the urgency of the condition.

**Air Ambulance:** The use of air ambulance is still under investigation. It is unclear if a regular air ambulance will be suitable for a COVID-19 patient. The WHO is investigating the feasibility of establishing a support capability to help critical UN staff get an air ambulance if it is required. Whether for COVID-19 or for another injury or illness, it may be that visa and hospital access restrictions still apply.

**Commercial aircraft:** Airlines are increasingly restricting flights to and from higher risk locations. HR are strongly recommended to check beforehand if the patient needs a clearance or other medical documents to board the aircraft.

**UN Aircraft:** Whilst it is more likely that a UN aircraft will be able to medevac patients, restrictions are still likely to apply and relate to the aircraft and its ability to be cleaned effectively for subsequent patients, or for the safety of the aircrew. The aircraft effectively becomes a 'healthcare facility' if treatment or care is given in flight, and this can lead to issues for the crew and their safety.

# SUGGESTED ACTION

Each duty station should consider the following:

- Undertake a review of medical services available locally, primarily regarding their ability to care for patients with severe acute respiratory symptoms. This may be done by the Clinic Physician in a location with a UN medical service, or by a recognized UN Examining Physician (UNEP) where there is no local UN medical service.
- Communicate this information to staff and ensure they know the broad healthcare support plan for COVID-19 in the location.
- Track regional restrictions in travel visas, and the availability and frequency of flights.
- Identify one or more medevac locations based on advice from their insurer.
- Clarify any remaining entitlements or HR issues, such as DSA for alternate locations or for isolation or interrupted travel.
- Develop options if either the healthcare support available locally, or the medevac capability changes significantly.

For any questions, please contact DHMOSH's Occupational Safety and Health team at osh@un.org