United Nations | COVID-19 Response

FRAMEWORK: SUPPORTING COVID-19 PATIENTS AFTER MEDICAL EVACUATION (Post-MEDEVAC Support)

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INTRODUCTION

1. This Framework addresses the provision of adequate non-medical support to COVID-19 patients who have been medically evacuated to a location outside of their home or duty location, as well as to eligible escorts who have accompanied them.

2. It sets out the key phases after a patient has been evacuated and corresponding roles and responsibilities of key actors with a view to supporting the patient and outlines a model of how these roles and responsibilities ought to be implemented.

SCOPE

3. This document considers the support needed by COVID-19 patients who have been medically evacuated to a location outside of their home or duty location while they are in a MEDEVAC location. It provides a guide to ensure such support is provided, acknowledging the approach may differ between locations and may be tailored accordingly. As such the elements outlined below are intended to complement and not supersede any existing architecture that can effectively facilitate the provision of such support.

AREAS OF RESPONSIBILITY FOR CARE POST-MEDEVAC

4. Following the arrival of a COVID-19 patient who has been medically evacuated in a receiving location[1], the specific needs of the patient will evolve, according to their clinical condition and speed of recovery. The range of support that may need to be provided to a patient will change as they progress through the following phases of what is necessarily an end-to-end system:

Initial hospitalization and treatment in Intensive Care Unit/High Dependency care

5. The provision of clinical care for COVID-19 patients is covered by the MEDEVAC System from the point of transportation by air from the country of departure until the discharge of the patient from an Intensive Care Unit or High Dependency (ICU/HD) care in the receiving Treating Medical Facility (TMF) as per the provision outlined in the MEDEVAC Framework document.

6. The referring entity retains responsibility for the provision of non-medical support for the patient and to any eligible accompanying escort in line with the rules of that entity for the entirety of the post-MEDEVAC period.

Treatment post-discharge from Intensive Care Unit / High Dependency care

7. Upon discharge from ICU/HD care, the referring entity re-assumes financial responsibility for the provision of medical care provided to the patient. This is in addition to responsibility for the provision of all and any non-medical care for the patient and any eligible accompanying escort.

[1] Note also the need to ensure the preparatory steps outlined in Annex A are considered prior to the arrival of the COVID-19 patient in the treating location.

Release and Recuperation

8. The referring entity retains full responsibility for supporting the patient during the required recuperation period following discharge from the Treating Medical Facility, and for supporting any eligible accompanying escort.

Repatriation

9. The referring entity retains responsibility for all aspects of the repatriation of COVID-19 patients, and any eligible accompanying escort in line with its organizational rules. In the unfortunate eventuality of the need to repatriate the remains of a COVID-19 patient, the referring entity is responsible for all aspects of this. The guidance/template document for the in-country Standard Operating Procedures on repatriating the remains of COVID-19 patients who have been medically evacuated outlines some of the key considerations associated with the repatriation of remains.

COORDINATING POST-MEDEVAC SUPPORT

10. As the advantages of establishing a diverse range of treatment hubs and facilities for use by COVID-19 patients under a unified system are clear, so too is the corollary requirement to ensure non-medical aspects of patient care are coordinated effectively post-MEDEVAC. This is not only to the benefit of patients but to all parties involved in the utilisation, facilitation and implementation of the MEDEVAC System as a whole.

11. While it is recognized that from location to location requirements and configurations may vary, the activities described in Annex A and the roles outlined in the dedicated supporting documents have been identified as key components of a fully functioning end-to-end system:

Patient Focal Point

12. As per the MEDEVAC Framework document, the primary responsibility for the provision of non-medical support to individual patients rests with the referring entity with which they are affiliated. Where the entity has a presence in a treating location, a dedicated entity Patient Focal Point should be nominated to proactively ensure that in all phases, any COVID-19 patient and any eligible escort receive the support they require. An indicative checklist for Patient Focal Points in those locations to which COVID-19 patients are evacuated is provided in the dedicated Terms of Reference.

13. Recognizing that the referring entity may not have a presence in all MEDEVAC locations, a dedicated Patient Focal Point for COVID-19 MEDEVAC patients should be identified at the relevant entity Headquarters and/or regional office by each referring entity within the MEDEVAC System. In such instances, the Office of the Resident Coordinator in the MEDEVAC location may designate an individual to provide additional in-person support to ensure the Patient Focal Point role can be fulfilled in its entirety, in conjunction with the referring entity.

Patient Coordination Officer (In-Country and Global)

14. It is anticipated that in established treatment hub locations and, if necessary, in ad hoc MEDEVAC destinations, Treating Medical Facilities will provide care to patients from a diverse range of entities covered under the COVID-19 MEDEVAC System, not all of which may have a physical presence in that location. To alleviate unnecessary pressure on the Treating Medical Facility and to ensure clear lines of communication, it is proposed that a Patient Coordination Officer be appointed to act as an intermediary between the Treating Medical Facility, the referring entity, and the Medical Coordination Unit in Geneva in which the Global Patient Coordination Officer may be embedded.

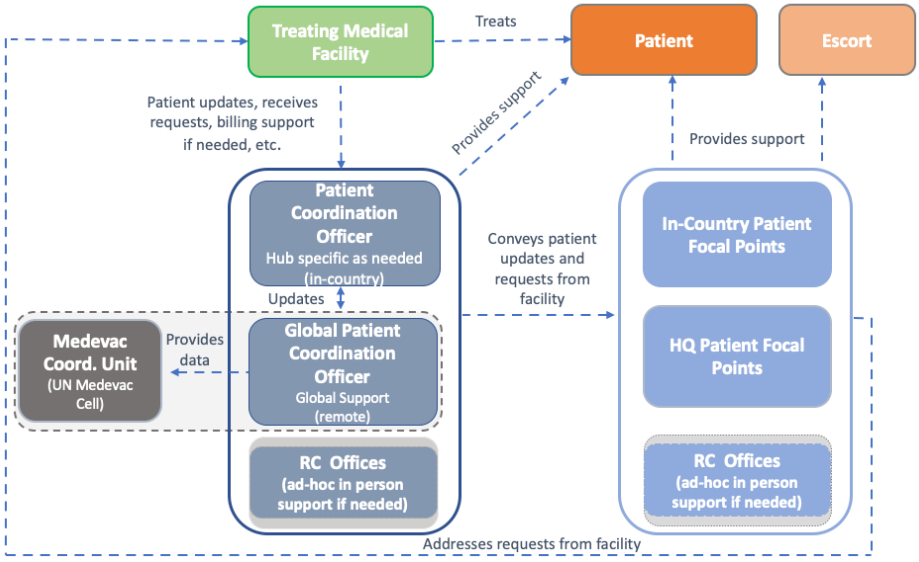
15. The Patient Coordination Officer would have overall responsibility for ensuring patient needs are identified and conveyed, obtaining and sharing regular updates on the status of each patient until they are repatriated, acting as a point of contact for all relevant parties, directing queries from the Treating Medical Facility as appropriate, and the collection of data to support monitoring and reporting mechanisms. Contingent on the local configuration and need, this role may be performed either remotely or in person. An outline of the in-country Patient Coordination Officer role is provided here and an outline of the (remote) Global Patient Coordination Officer is provided here.

Resident Coordinator's Office

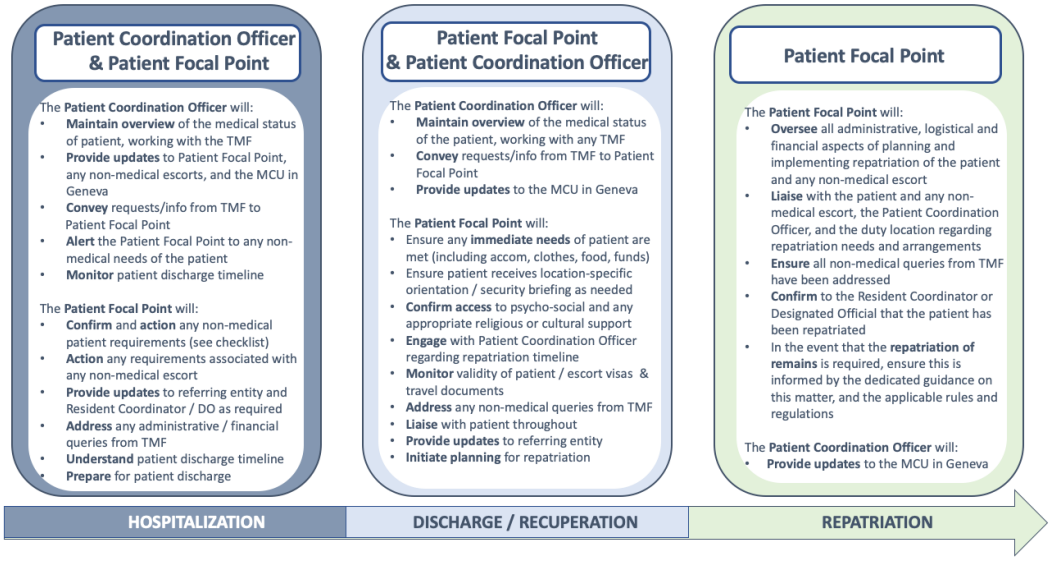
16. It is acknowledged that the Resident Coordinator's Office will in some locations likely be required to assume a supplementary or supporting role, depending on the local configuration, local capacity and presence. See the indicative schematic below for indications of where such support may be required.

17. The above elements are outlined in the indicative schematics below:

Post-MEDEVAC Support: Indicative Model



Overview of Key Responsibilities by Implementation phase



LIST of SUPPORTING DOCUMENTS

18. The following documents inform and support the Post-MEDEVAC Support Framework, many of which are accessible here. This list will be developed as further material is generated.

- Terms of Reference for Patient Focal Points in the Post-MEDEVAC Support process
- Terms of Reference for the Global Patient Coordination Officer
- Terms of Reference for the in-country Patient Coordination Officer
- Repatriation of remains Framework SOP

19. Additionally, the United Nations website on COVID-19 contains resources, guidelines and supporting material for reference. At the time of issuance, the website contains the following key documents:

- COVID-19 FAQ
- Guidance on home care and isolation
- Guidance on Telehealth
- Advice for Travelers

FURTHER GUIDANCE

20. This version is dated 01 October and may be superseded by newer versions as issued by the Task Force.

21. This document applies only to those patients who have been medically evacuated under the COVID-19 MEDEVAC system and is not intended to supersede or override guidance or instructions concerning any other matter.

ANNEX A: OVERVIEW OF KEY POST-MEDEVAC SUPPORT ACTIVITIES FOR COVID-19 PATIENTS IN TREATING LOCATIONS

1. This Annex outlines the key considerations in the planning for and provision of non-medical support to COVID-19 patients who have been medically evacuated. While the allocation of responsibilities may vary from location to location contingent on presence and capability, the steps outlined should be addressed to best facilitate the receipt of and provision of support for patients and any non-medical escort in the treating location.

2. Note that this Annex refers to a generic designated 'Patient Focal Point', in acknowledgement of the above, and in deference to the need to determine responsibility as appropriate at the local level. The Terms of Reference for the proposed roles of Patient Focal Point, the Global Patient Coordinator and the in-Country Patient Coordination Officer are outlined separately.

Preparatory Phase

3. The following activities should be initiated by the designated in-country Patient Focal Point or an agreed alternate:

    a) If the patient or any principle escort is known not to speak the language of the treating location, actively explore options for the provision of linguistic support, including as needed within the organization or affiliated entities, or through the representing consulate or embassy.

    b) Consult the Patient Coordination Officer and understand the quarantine requirements for any non-medical escorts who will accompany a COVID-19 patient, and ensure that sufficient provision/support is in place to enable them to meet these.

    c) Identify suitable accommodations for non-medical escorts, identify transportation to take them to this accommodation, and ensure they are provided with basic information, including any specific cultural or security briefing relevant to the location.

    d) Should the patient be a minor or be escorted by any minors, this should be taken into account during the planning phase, and the necessary measures to properly account for this be implemented

    e) Consult the allocated[2] Patient Coordination Officer and identify what psychosocial support capacities exist at a local level and establish a list of these [3]. Where these exist, organizational protocols and additional capacity at headquarters level should also be noted.

    f) Consult the Patient Coordination Officer and identify any recognised faith-based organisations who are in the location and can be called upon to provide guidance and any requisite services.

[2] The Patient Coordination Officer is to be confirmed by the UN Medevac Cell, in conjunction with the team supporting COVID-19 MEDEVACs in the respective receiving location, including the Resident Coordinator.
[3] This list should also be informed by any available capacity of the Critical Incident Stress Management Unit (CISMU), and the Staff Counsellors network

During Hospitalisation

4. During the period when a COVID-19 patient is hospitalised:

    a) The medical welfare of the patient will be overseen by the appropriate Treating Medical Provider (TMP) at the receiving Treating Medical Facility (TMF), in line with any agreed terms of reference.

    b) The Patient Coordination Officer will maintain an overview of the status of the patient and will update the Patient Focal Point, and any non-medical escorts as appropriate.

    c) The Patient Coordination Officer will convey any administrative or other non-medical information or requests made by the Treating Medical Facility to the Patient Focal Point. Financial information or requests should be conveyed directly by the TMF to Cigna unless advised otherwise.

    d) The Patient Coordination Officer or if appropriate, Patient Focal Point to establish contact with the patient, and to ensure any basic non-medical needs (to include the provision of a means of communication) are met, as far as is possible.

    e) The Patient Coordination Officer will provide regular updates on the status of the patient to the Medical Coordination Unit in Geneva.

    f) The Patient Focal Point should ensure that the patient and any non-medical escort has access to psycho-social support as required.

    g) The Patient Focal Point should ensure that regular updates are shared with appropriate personnel within the referring entity, and with the Resident Coordinator or other Designated Official as required.

    h) The Patient Focal Point should ensure that all administrative and any financial queries from treating medical facility are actioned and resolved.

    i) In conjunction with the Patient Coordination Officer, the Patient Focal Point to understand the patient discharge timeline, understand any requirements for the convalescence period and ensure that the requisite preparations are underway, including transportation, initial accommodation and provision to meet the basic immediate needs of the patient.

    j) The Patient Focal Point should review the checklist of activities and ensure this is developed and followed in line with the local context.

Release and Recuperation

5. At the point at which the patient is to be discharged from the TMF, the Patient Focal Point to review the checklist of activities and ensure they are followed, including but not limited to:

    a) The immediate needs of the patient are met, including clothing and toiletries, transportation to initial accommodation, access to communications and basic financial means;

b) The patient receives any required security briefing or orientation that is specific to the location they are in, and;

c) The patient and any non-medical escort continue to receive psycho-social support as required, and that they are directed to any appropriate religious or cultural support available.

6. The Patient Focal Point should liaise with both the patient and the Patient Coordination Officer to understand the possible patient repatriation timeline.

7. The Patient Focal Point should ensure that regular updates are shared with appropriate personnel within the referring entity, and with the Resident Coordinator or other Designated Official as required

8. The Patient Focal Point should ensure that the patient and any non-medical escort continue to hold valid visas and travel documentation. Identify any possible issues associated with the expiration of these before the anticipated date of repatriation and address this proactively.

9. The Patient Coordination Officer will continue to convey any administrative or financial queries from the treating medical facility to the Patient Focal Point.

Repatriation

10. The referring entity, through the Patient Focal Point retains responsibility for overseeing all administrative, logistical and financial aspects of the planning and implementation of the repatriation of the patient and any non-medical escort. This includes the confirmation of the repatriation location, in consultation with the patient and in accordance with the rules and regulations of the referring entity, and any required liaison with the duty station.

11. The Patient Focal Point should confirm to the Resident Coordinator / Designated Official and the Patient Coordination Officer the repatriation schedule, and should provide confirmation to these parties when a repatriation has been completed.

12. In the unfortunate event that a patient dies, the referring entity, through the Patient Focal Point is also responsible for overseeing all administrative, logistical and financial aspects of planning and implementation of the repatriation of remains, and the repatriation of any non-medical escort. Considerations associated with the repatriation of remains are captured in a dedicated Guidance Framework SOP.

Regulatory framework

13. The above responsibilities are to be completed in accordance with the relevant regulations, rules, policies and procedures of the entity with which the patient is associated, including those pertaining to confidentiality.

ANNEX B: GLOSSARY OF KEY TERMS

Patient Focal Point - The Head of a referring Entity or, at the discretion of the Head of Entity, a designated Patient Focal Point for activities supporting affiliated COVID-19 patients who have been medically evacuated to the receiving location. In cases where the referring entity has no physical presence in the receiving location, the primary Patient Focal Point may be located in a regional office or headquarters of the entity.

MEDEVAC - The process of evacuation from one medical facility to another. Once a casualty has been admitted to a medical facility, all onward movement for medical purposes is considered to be MEDEVAC.

Medical Coordination Unit (MCU) – Under the auspices of the WHO, the Geneva-based MCU is the point of contact for COVID-19 Coordinators and the Strategic Air Operations Centre (SAOC) for COVID-19 MEDEVACs within the UN MEDEVAC Cell. The MCU additionally maintains an overview of those patients who have been medically evacuated.

Model of Care (MOC) - Model created by United Nations Medical Directors (UNMD) to guide clinical decisions informing all MEDEVAC decisions relating to COVID-19 cases.

Patient Coordination Officer - A designated focal point to monitor the status of COVID-19 patients in the receiving location and to coordinate the provision of non-medical support to them, in conjunction with the Treating Medical Facility, the Patient Focal Point, the UN Medical Coordination Unit and others as required.

Recuperation – The period during which the COVID-19 patient remains in the receiving location to recovers from the illness following their discharge from the Treating Medical Facility and prior to their repatriation.

Referring Entity - An entity whose personnel and in some cases, dependents are designated as eligible under the MEDEVAC System, and which can make a request via the COVID-19 Coordinator for a COVID-19 MEDEVAC.

Repatriation – The return of a COVID-19 patient and any eligible escorts to the duty station from which they were MEDEVACed or to another authorized location.

Strategic Air Operations Centre (SAOC) – Aviation support and coordination hub, based in Brindisi, Italy. A key component of the UN MEDEVAC Cell.

Treating Medical Facility (TMF) – The facility responsible for receiving and providing treatment to COVID-19 patients who have been medically evacuated to the receiving location under the MEDEVAC System.

Treating Medical Provider (TMP) –The medical professional directly responsible for providing care for the COVID-19 patient within the Treating Medical Facility or in any subsequent capacity prior to the repatriation of the COVID-19 patient.

UN MEDEVAC Cell – A 24/7 Cell which provides coverage for all eligible entities with a full range of medical and air asset coordination services, with full visibility over all relevant medical and airframe assets across the UN system. A focal point for COVID-19 Coordinators requesting COVID-19 MEDEVACs.