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A LEGAL DUTY TO EVACUATE PATIENTS FROM HEALTHCARE FACILITIES IN EMERGENCIES

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### Introduction

The devastating physical impacts of Hurricane Isaac (August 2012) and Superstorm Sandy (October 2012) on the Gulf Coast and Northeast regions, respectively, are largely unavoidable. However, concurrent impacts of these and other natural disasters on the public's health, especially among at-risk patients in healthcare settings, can be obviated. Among the core lessons from prior disasters, including the 9/11 terrorist attacks and Hurricane Katrina in 2005, is the need for advanced planning and training for evacuations of patients at risk during impending disasters. When the streets flood, the power goes out, and back-up generators fail (as happened in New Orleans in 2005 and New York City in the aftermath of Superstorm Sandy), affected hospitals and other healthcare entities are no longer viable settings for healthcare delivery. In reality, they can become death traps for the most vulnerable patients. In such cases, patient evacuation is no longer a risky alternative; *it becomes the only alternative*.

Contrary to "shelter in place" recommendations, sometimes rapid evacuation of patients from healthcare facilities in major disasters is needed.<sup>1</sup> Planning and preparedness activities centered on patient evacuation within healthcare entities have increased over the last decade due, in part, to federal and state legal requirements, national accreditation standards, and benchmarks set through state, local, and community disaster preparedness plans. Despite known legal authority and a decade of consistent lessons on the pitfalls of poor planning, deficiencies in healthcare entity preparedness remain. As noted in a recent commentary in the *Journal of the American Medical Association*, a series of "common failures" among these entities were on display during Superstorm Sandy.<sup>2</sup> Inept preparedness and communication breakdowns contributed to the discontinuity of operations and eventual evacuation of several hospitals in New York City,<sup>3</sup> implicating the health and safety of thousands of patients, healthcare workers, and emergency personnel.

Future disasters may require patient evacuations for healthcare facilities in the interests of protecting patients and the public's health. As addressed below, not only are these healthcare entities legally obligated to prepare for major emergencies, failure to plan and execute patient evacuations may lead to liability, sanctions, de-licensure, and other legal and regulatory consequences.

### Legal Duties to Plan and Prepare for Major Emergencies

Patient evacuations are an essential component of comprehensive emergency planning and preparedness among healthcare entities.<sup>4</sup> Following 9/11/2001 and the ensuing anthrax attacks that same fall,<sup>5</sup> multiple federal and state laws require (or very strongly encourage) these entities to engage in effective preparedness and planning, especially hospitals.<sup>6</sup> In 2003, for example, Homeland Security Presidential Directive-8 authorized state and local governments to enhance national emergency preparedness in collaboration with several federal agencies.<sup>7</sup> Pursuant to the Directive, the Federal Emergency Management Agency ("FEMA") developed the National Incident Management System ("NIMS"). NIMS provides healthcare facilities and others with a consistent framework for effective disaster planning and response through coordination and pooling of state and

local governmental resources.<sup>8</sup> As of 2006, FEMA also requires hospitals receiving federal emergency preparedness funding to adopt standards consistent with their emergency plans.<sup>9</sup> As a result of the Public Health Service Act,<sup>10</sup> the federal government has funneled hundreds of millions of dollars through state agencies to hospitals to improve emergency preparedness.<sup>11</sup>

The Pandemic and All-Hazards Preparedness Act of 2006 (“PAHPA”)<sup>12</sup> reorganized federal public health emergency responses after Hurricane Katrina.<sup>13</sup> PAHPA authorizes the Department of Health and Human Services (“HHS”) to fund only those hospital preparedness programs that meet certain benchmark requirements.<sup>14</sup> The Centers for Medicare & Medicaid Services (“CMS”) requires participating hospitals to develop and implement comprehensive emergency plans, potentially including evacuation procedures.<sup>15</sup> A litany of corresponding state laws and licensing standards similarly require, fund, or strongly encourage hospitals and other healthcare entities to prepare for emergencies.<sup>16</sup> During declared emergencies, state or local governments (in some jurisdictions) may issue emergency orders to require healthcare entities to evacuate patients.<sup>17</sup> For instance, New York City Mayor Michael Bloomberg reportedly ordered the evacuation of New York Downtown Hospital and Manhattan Veterans Affairs Hospital before the arrival of Superstorm Sandy.<sup>18</sup>

### **\*21 Legal Ramifications for Failure to Plan and Evacuate**

From these legal provisions arise duties among healthcare entities to plan and prepare for response efforts, including patient evacuations. Failure to prepare may lead to various legal ramifications. For example, healthcare facilities that do not develop effective emergency response plans and engage in meaningful preparation in compliance with federal and state standards risk losing their accreditation through the Joint Commission.<sup>19</sup> The Commission requires hospitals (and other healthcare facilities, such as nursing homes) to plan for emergencies as a condition of their accreditation.<sup>20</sup> Its standards are tied specifically to NIMS components,<sup>21</sup> such as coordinated emergency response efforts with community organizations (*e.g.*, law enforcement), meaningful preparation and practice based on a flexible “all hazards” approach, and resilient communication systems.<sup>22</sup>

States can also withhold licensure or penalize healthcare facilities that fail to develop emergency preparedness plans in compliance with state regulations. In 2001, for example, the state health department sanctioned a Louisiana nursing home for statutory violations after an elderly patient died from overheating during an eight-hour bus evacuation in response to Hurricane George.<sup>23</sup> The facility’s evacuation plan had not been reviewed and approved by local emergency preparedness authorities as mandated by state licensing requirements.<sup>24</sup>

Hospitals that cannot remain operational during disasters due to poor emergency planning (which may necessitate patient evacuations) may be found in violation of federal law, risking penalties and loss of federal funding. Normally, the federal Emergency Medical Treatment and Active Labor Act (“EMTALA”) requires most hospitals to screen and stabilize incoming emergency room patients.<sup>25</sup> EMTALA compliance is mandated by CMS for all hospitals operating emergency rooms that receive federal Medicare payments.<sup>26</sup> HHS’ Secretary may temporarily waive EMTALA requirements for a 72-hour period in affected areas following declaration of both a national and public health emergency.<sup>27</sup> Absent a waiver, hospitals are expected to comply with EMTALA, including provisions requiring the safe transfer of patients with emergency medical conditions to appropriate facilities. HHS may penalize hospitals in violation up to \$50,000 per incident. Hospitals may also potentially face termination from eligibility for Medicare reimbursements. Additionally, patients may file a civil lawsuit if they are harmed as a result of an EMTALA violation.<sup>28</sup>

Healthcare facilities that fail to sufficiently plan and prepare for disasters also face an array of potential civil liabilities.<sup>29</sup> A facility’s inability to exercise reasonable care through advance emergency planning and meaningful practice can lead to claims of liability on the basis of negligence, wrongful death, and imputed negligence resulting from employees’ acts. Following Hurricane Katrina, for example, Tenet Health Systems, which operated Memorial Medical Center in New Orleans, settled claims brought by patient victims and families for \$25 million. Claimants alleged negligence not only for Tenet’s inept response and evacuation limitations, but also for its failure to plan and prepare properly for the emergency itself.<sup>30</sup> In another example following Katrina, administrators of a Louisiana nursing home decided not to pre-evacuate residents, resulting in the drowning deaths of 35 patients. Survivors and family members sued administrators in several consolidated actions based on wrongful death, negligence, and malpractice claims.<sup>31</sup> One case was dismissed on jurisdictional grounds. In the remaining cases, the courts ultimately did not find any actionable malpractice after an independent review of facility records.<sup>32</sup>

New liability claims against healthcare administrators and facilities may follow Superstorm Sandy. Reports suggest that nursing home administrators at Promenade Rehabilitation and Health Care Center in Queens, New York, for example, left patients without food, water, heat, and electricity due to severe staff shortages, scant supplies, and a flooded backup generator.<sup>33</sup> Furthermore, some patients may have been evacuated to shelters without their critical medical records.<sup>34</sup> Legislative (e.g., the federal Public Readiness and Emergency Preparedness (“PREP”) Act<sup>35</sup>) or other protections may insulate some healthcare actors or entities from liability for negligence in declared emergencies. However, most of these protections apply, if at all, to individuals and not the healthcare entities in which they are employed or volunteer.<sup>36</sup>

In addition to liability claims are potential legal arguments over emergency preparedness efforts that negatively impact patients and employees. Triage, evacuation, and other emergency responses that discriminate against patients based on their national origin or race may violate Title VI of the Civil Rights Act.<sup>37</sup> Disaster planning and responses that fail to accommodate the special needs of physically or mentally disabled patients may violate Title II and III of the Americans with Disabilities Act (“ADA”) and Section 504 of the Rehabilitation Act.<sup>38</sup> For example, New York’s Bellevue Hospital was unable to evacuate two obese patients during Superstorm Sandy due to inoperable elevators, forcing them to shelter-in-place at greater risk to the patients.<sup>39</sup> ADA claims may be brought privately or through the U.S. Department of Justice.<sup>40</sup> The Occupational Safety and Health Administration (“OSHA”) mandates advance planning and staff training for evacuation during disasters.<sup>41</sup> Staff shortages, insufficient training, and lack of personal protective equipment may all reflect deficient planning that places employees at risk of harm during emergencies.<sup>42</sup> OSHA violations for failing to provide safe employee workplaces range from \$7,000 to \$70,000.<sup>43</sup>

Healthcare facilities that must evacuate patients may not have to shoulder all costs related to disaster response. FEMA’s Public Assistance Grant Program significantly funds restoration efforts for damages caused by disasters.<sup>44</sup> Recently, NYU Langone Medical Center received an expedited \$114 million grant for patient evacuation and emergency repair costs following Superstorm Sandy.<sup>45</sup>

## Conclusion

Federal and state governments have prioritized effective emergency planning since 9/11 through legal requirements and related funding in support of preparedness efforts. Coextensively, healthcare facilities have a legal duty to plan and prepare for major emergencies, especially when the health and safety of vulnerable patients are at stake. Failure to develop emergency plans and evacuation strategies may lead to de-accreditation, loss of funding, civil liability, and sanctions. Healthcare entities must be able to demonstrate sufficient advance planning in compliance with legal standards, including evacuation procedures that accommodate patients’ special needs, and safeguard patients and employees alike.

## Footnotes

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