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PREFACE

Acknowledgements. This guide was developed by James G. Hodge, Jr., J.D., LL.M., Peter Kiewit Foundation Professor of Law; Director, Center for Public Health Law & Policy, Sandra Day O’Connor College of Law, Arizona State University (ASU), with research, drafting, and editing contributions from Sarah Wetter, J.D., M.P.H., Fellow, O’Neil Institute for National and Global Health Law, Georgetown University Law Center, Jennifer L. Piatt, J.D., Research Scholar, and Emily Carey, Joshua Kalanick, Elyse Pendergrass, Claudia Reeves, Hanna Reinke, and Nora Wells, Legal Researchers, Center for Public Health Law & Policy, and J.D. Candidates, ASU Sandra Day O’Connor College of Law.

Some portions of the guide are based in whole or part on a separate report (as of June 11, 2020) for the Region 1 Partnership for the Regional Disaster Health Response (RDHRS) led by colleagues at Massachusetts General Hospital in Boston.

Disclaimer. Please note that information provided in this guide does not constitute legal advice in any jurisdiction. Please consult with legal counsel in your respective jurisdiction for specific legal guidance.

Scope & Primary Purposes. With core funding from the Assistant Secretary for Preparedness and Response (ASPR), researchers based at the University of California-San Francisco (UCSF) Benioff Children’s Hospitals developed the Western Region Alliance for Pediatric Emergency Management (WRAP-EM) among 6 Western states (AZ, CA, NV, OR, UT, WA) beginning in 2018.

As part of its grant-funded activities, WRAP-EM set out an aggressive mission to improve emergency pediatric disaster response capabilities throughout its region. Its activities include (1) examining pediatric disaster care needs, (2) addressing gaps or weaknesses in emergency communication or access, and (3) identifying and solving challenges to delivering pediatric care amid crises. Essential to these collective efforts is a core assessment and analyses of law and policy issues arising in the real-time provision of pediatric care during public health crises or other emergencies.

Following a series of initial deliverables (see Appendices) and planning with WRAP-EM and specific state leaders, a blueprint outline of a detailed project report addressing law and policy issues was developed and refined by July 24, 2020, as continued impacts of the COVID-19 pandemic increased among multiple WRAP-EM states and other portions of the U.S. Substantial real-time learning stemming from the pandemic is thoroughly incorporated into this guide through July 9, 2021.

The core objective of this guide, as summarized below in the Introduction, is to produce a strategic assessment of legal or policy issues affecting the development of a regional model to enhance emergency pediatric disaster responses. While many of the findings in this guide are derived from core observations among WRAP-EM states (see below the illustration of aggregate legal findings based on Appendix: Table 6), key lessons and strategies may apply to other regions nationally.

Organization. The guide is divided into 5 major parts as follows:

I. EMERGENCY DECLARATIONS, POWERS & COMPACTS, examines the changing legal landscape extending from federal, state, tribal, and local declarations of emergencies,
disasters, and public health emergencies (PHEs), notably including analyses of powers extending from legal research across WRAP-EM states. A focus on the Emergency Management Assistance Compact (EMAC) illustrates the scope and utility of interjurisdictional agreements in facilitating resource allocation and legal protections in emergencies.

II. LICENSING, CREDENTIALING & PRIVILEGING, explores how varied licensure, credentialing/privileging requirements, and reciprocity provisions implicate health care worker (HCW) responses across jurisdictional borders.

III. TELEMEDICINE & TELEHEALTH APPLICATIONS, examines the emerging role of electronic medical treatment and collaboration at federal and state levels, including how laws, reimbursement measures, and fraud/abuse protections are altered during the COVID-19 pandemic.

IV. CIVIL LIABILITY, IMMUNITY & INDEMNIFICATION, assesses the liability risks for HCWs, entities, and volunteer health professionals (VHPs) during emergencies, including workers’ compensation benefits and corresponding liability protections for acts of ordinary negligence through multiple legal sources.

V. OTHER LEGAL ISSUES, addresses several key legal issues related to (1) allocating scarce resources during crisis standards of care (CSC); (2) application of emergency use authorizations (EUAs) to allow use of non-approved tests, medications, and treatments; (3) rights to reemployment; (4) health information privacy concerns underlying extensive data sharing practices in emergencies; (5) use of dashboard surveillance and technologies to monitor real-time needs, especially during the COVID-19 pandemic; and (6) legal issues related to reunification policies.

### Aggregate Table - WRAP-EM States’ Emergency Laws

<table>
<thead>
<tr>
<th>Topic</th>
<th>AZ</th>
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<th>NV</th>
<th>OR</th>
<th>WA</th>
<th>UT</th>
</tr>
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<tr>
<td>I. Emergency/Disaster Declarations</td>
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<td>II. Public Health Emergency Declarations</td>
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</tr>
<tr>
<td>III. Routine Licensure Reciprocity</td>
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<tr>
<td>IV. Emergency Licensure Reciprocity</td>
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<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>V. General Waiver Authority</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>VI. Specific Waiver Authority</td>
<td>✔</td>
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<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>VII. General Telehealth/Medicine Provisions</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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</tr>
<tr>
<td>VIII. Mental Health Specific</td>
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<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Telehealth/Medicine Provisions</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>IX. General Liability Protections</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>X. Explicit Liability Protections</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>
### ABBREVIATIONS

Please note the specific acronyms used in one or more places throughout the Guide:

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Term</th>
<th>Acronym</th>
<th>Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADA</td>
<td>Americans with Disabilities Act</td>
<td>JIC</td>
<td>Joint Information Center</td>
</tr>
<tr>
<td>ASPR</td>
<td>Assistant Secretary for Preparedness &amp; Response</td>
<td>MAA</td>
<td>Mutual Aid Agreement</td>
</tr>
<tr>
<td>CARES</td>
<td>Coronavirus Aid, Relief &amp; Economic Security</td>
<td>MAC</td>
<td>Multi-agency Coordination</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control &amp; Prevention</td>
<td>MHCC</td>
<td>Medical &amp; Health Coordination Center</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>MOU</td>
<td>Memoranda of Understanding</td>
</tr>
<tr>
<td>COE</td>
<td>Centers of Excellence</td>
<td>MRC</td>
<td>Medical Reserve Corps</td>
</tr>
<tr>
<td>CSC</td>
<td>Crisis Standards of Care</td>
<td>MSEHPA</td>
<td>Model State Emergency Health Powers Act</td>
</tr>
<tr>
<td>DEA</td>
<td>Drug Enforcement Agency</td>
<td>NAM</td>
<td>National Academy of Medicine</td>
</tr>
<tr>
<td>DMAT</td>
<td>Disaster Medical Assistance Team</td>
<td>NDMS</td>
<td>National Disaster Medical System</td>
</tr>
<tr>
<td>DOC</td>
<td>Department Operations Center</td>
<td>NEMA</td>
<td>National Emergency Management Association</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
<td>NIMS</td>
<td>National Incident Management System</td>
</tr>
<tr>
<td>EMAC</td>
<td>Emergency Management Assistance Compact</td>
<td>NLC</td>
<td>Nurse Licensure Compact</td>
</tr>
<tr>
<td>EMS</td>
<td>Emergency Medical Services</td>
<td>OCR</td>
<td>Office of Civil Rights (HHS)</td>
</tr>
<tr>
<td>EMSA</td>
<td>Emergency Medical Services Authority</td>
<td>OSCE</td>
<td>Tele-Objective Structured Clinical Examinations</td>
</tr>
<tr>
<td>EMT</td>
<td>Emergency Medical Technician</td>
<td>PAH</td>
<td>Pandemic &amp; All-Hazards Preparedness Act</td>
</tr>
<tr>
<td>EMTALA</td>
<td>Emergency Medical Treatment &amp; Active Labor Act</td>
<td>PAHPRA</td>
<td>Pandemic &amp; All-Hazards Preparedness Reauthorization Act</td>
</tr>
<tr>
<td>EOP</td>
<td>Emergency Operations Plan</td>
<td>PHA</td>
<td>Public Health Authority</td>
</tr>
<tr>
<td>ESAR-VHP</td>
<td>Emergency System for the Advance Registration of VHPs</td>
<td>PHE</td>
<td>Public Health Emergency</td>
</tr>
<tr>
<td>EUA</td>
<td>Emergency Use Authorization</td>
<td>PHI</td>
<td>Protected Health Information</td>
</tr>
<tr>
<td>FDA</td>
<td>Food &amp; Drug Administration</td>
<td>PPE</td>
<td>Personal Protective Equipment</td>
</tr>
<tr>
<td>FEMA</td>
<td>Federal Emergency Management Agency</td>
<td>PREP Act</td>
<td>Public Readiness &amp; Emergency Preparedness Act</td>
</tr>
<tr>
<td>GPS</td>
<td>Global Positioning System</td>
<td>REC</td>
<td>Regional Emergency Coordinator</td>
</tr>
<tr>
<td>GSA</td>
<td>Good Samaritan Act</td>
<td>REQ-A</td>
<td>Request for Assistance Form</td>
</tr>
<tr>
<td>HCC</td>
<td>Health Care Coalition</td>
<td>RDHRS</td>
<td>Regional Disaster Health Response</td>
</tr>
<tr>
<td>HCP</td>
<td>Health Care Provider</td>
<td>S-CHIP</td>
<td>State Children’s Health Insurance Program</td>
</tr>
<tr>
<td>HCW</td>
<td>Health Care Worker</td>
<td>SME</td>
<td>Subject Matter Expert</td>
</tr>
<tr>
<td>HHS</td>
<td>Department of Health &amp; Human Services</td>
<td>SNS</td>
<td>Strategic National Stockpile</td>
</tr>
<tr>
<td>HICS</td>
<td>Hospital Incident Command System</td>
<td>UCSF</td>
<td>University of California-San Francisco</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability &amp; Accountability Act</td>
<td>UEVHPA</td>
<td>Uniform Emergency Volunteer Health Practitioners Act</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
<td>USERRA</td>
<td>Uniformed Services Employment &amp; Reemployment Rights Act</td>
</tr>
<tr>
<td>IEMAC</td>
<td>International Emergency Management Assistance Compact</td>
<td>VHP</td>
<td>Volunteer Health Professional</td>
</tr>
<tr>
<td>ICS</td>
<td>Incident Command Systems</td>
<td>VSA</td>
<td>Volunteer Service Agreement</td>
</tr>
<tr>
<td>JA</td>
<td>Jurisdictional Agency</td>
<td>WRAP-EM</td>
<td>Western Region Alliance for Pediatric Emergency Management</td>
</tr>
</tbody>
</table>
INTRODUCTION

With core funding from ASPR, the WRAP-EM project charted an aggressive objective in 2018: develop a model to improve emergency pediatric disaster response capabilities throughout the Western region and nationally. Project leaders conceived that an effective regional pediatric program should leverage existing and new SME networks and personnel to improve disaster preparedness and responses in real-time through governmental authorities and private sector partners.

These lofty goals are being tested by the most significant public health threat in the nation’s history, specifically the COVID-19 pandemic. Facing millions of confirmed cases and tens of thousands of deaths in the region (especially in the nation’s most populous state, California), WRAP-EM leaders experienced significant law and policy barriers to their mission, working through multiple approaches to address them.

As each of the WRAP-EM states systematically declared formal states of emergency (along with every U.S. state, most territories, and extensive numbers of tribal and local governments), shifts in legal and policy roles emerged. To achieve WRAP-EM’s objectives, law and policy must be assessed and wielded in real time to generate solutions to barriers within a fluctuating legal environment as epidemiologic and other information about the pandemic surfaces.

This guide addresses these challenges in the backdrop of the COVID-19 pandemic to produce a “playbook” of viable lessons and options guiding system development now and for the future. At the core of these lessons are significant changes in the legal landscape underlying response efforts extending from multi-level emergency declarations. Although unpredictable in their scope, timing, and duration, emergency declarations facilitate an array of real-time legal solutions otherwise unavailable in routine events. Invocation of agreements like EMAC in response to COVID-19 opens new pathways to interjurisdictional exchanges and protections.

Among the more profound needs of an operational regional pediatric disaster health system is the capacity to exchange or utilize HCWs quickly and easily across borders physically or virtually. Immediate legal impediments related to licensing, credentialing, and privileging requirements can be resolved through routine and emergency exceptions facilitating cross-sharing, especially via telemedicine and telehealth initiatives.

Real-time health care responses invariably evoke fears of liability for HCWs, VHPs, entities, and others involved in delivering services when standards of care shift due to resource scarcity. Liability risks are real, but so are an extensive array of protections from claims for acts of ordinary negligence in emergencies. Enhanced workers’ compensation benefits and job protections may be extended to persons responding through organized channels on their own volition (and often at great risk). Additional concerns underlying emergency responses, such as temporary waivers of existing standards, rights to reemployment, health information privacy concerns, and dashboard data collections also arise.

As per the Checklist of Legal Issues Supporting Regional Coordination, below, extensive issues are solvable through real-time interpretations among multiple legal options. While many of these findings extend from core observations within WRAP-EM states, lessons and strategies may equally apply to other regions nationally, consistent with ASPR’s cohesive strategy for maximizing regional alliances in the 21st century.
**CHECKLIST OF LEGAL ISSUES UNDERLYING REGIONAL COORDINATION**

The table below presents a numbered series of key questions derived from issues and analyses discussed in this Guide for assessment and resolution (as needed) in regionally coordinating pediatric care and services in emergencies:

<table>
<thead>
<tr>
<th>Subject</th>
<th>#</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Declarations</strong></td>
<td></td>
<td>Have state/local governments adopted a statutory or regulatory definition of emergency, disaster, or other similar terms?</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Do state/local governments’ general emergency or disaster provisions also cover emergencies affecting the public’s health?</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Have state/local governments adopted a statutory or regulatory definition of a PHE or other similar terms (e.g., public health crisis or catastrophe)?</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Do state/local laws set procedures to follow in declaring a general emergency, disaster, or PHE?</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Do the declaratory procedures require specificity as to the type, nature, location, or duration of the emergency?</td>
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<tr>
<td>5</td>
<td></td>
<td>If a PHE is declared, are specific emergency powers assigned to state/local PHAs &amp; other relevant entities to facilitate emergency response efforts?</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>Do state/local laws require or provide for planning &amp; coordination of emergency response efforts among various state/local agencies?</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>Is there statutory or regulatory express authority on terminating emergency declarations or automatic termination under certain conditions?</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>Do state emergency laws authorize general or explicit waiver of statutory or regulatory provisions to facilitate response efforts?</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>Has the state invoked EMAC for purposes of seeking essential services or supplies during a declared emergency?</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>Has the state authorized the exchange of state/local agents with other jurisdictions for the purpose of emergency response efforts?</td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>Is state government able to deputize private HCWs or VHPs to garner state-based EMAC protections prior to their transfer out-of-state?</td>
</tr>
<tr>
<td>12</td>
<td></td>
<td>Does the state anticipate reimbursement for specific allocation of essential supplies or personnel pursuant to EMAC?</td>
</tr>
<tr>
<td>13</td>
<td></td>
<td>What types of HCWs are required to have state licensure or certification to practice medicine, nursing, or other professions in the state?</td>
</tr>
<tr>
<td>14</td>
<td></td>
<td>Has the state adopted provisions for reciprocity of state licensure or certification requirements for HCWs licensed in another state?</td>
</tr>
<tr>
<td>15</td>
<td></td>
<td>Has the state entered reciprocity agreements/compacts that recognize out-of-state licenses or certifications for HCWs (e.g., NLC)?</td>
</tr>
<tr>
<td>16</td>
<td></td>
<td>Does state law require hospitals to establish medical staff bylaws including provisions for credentialing/privileging in declared emergencies?</td>
</tr>
<tr>
<td>17</td>
<td></td>
<td>Have hospitals or other accredited health entities adopted disaster privileging policies in compliance with Joint Commission requirements?</td>
</tr>
<tr>
<td>18</td>
<td></td>
<td>Does state law require hospitals to have an emergency management plan governing hospital response in a declared emergency?</td>
</tr>
<tr>
<td>19</td>
<td></td>
<td>Do state emergency laws or medical boards authorize shifts in scope of practice during declared emergencies?</td>
</tr>
<tr>
<td>20</td>
<td></td>
<td>Under the federal Social Security Act § 1135 waiver, which telehealth services and HCPs are temporarily covered for Medicare beneficiaries during an emergency?</td>
</tr>
<tr>
<td>Subject</td>
<td>#</td>
<td>Question</td>
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<tr>
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<tr>
<td></td>
<td>23</td>
<td>Has the state suspended HIPAA Privacy Rule requirements for HCPs conducting rapid, good-faith administration of telehealth treatments?</td>
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<tr>
<td></td>
<td>24</td>
<td>Has the state adopted parity laws requiring private insurers to reimburse for telehealth services as for in-person care?</td>
</tr>
<tr>
<td></td>
<td>25</td>
<td>Has the state adopted or proposed new provisions impacting telehealth practice, including mental health treatment?</td>
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<td></td>
<td>26</td>
<td>Does the state provide HCPs with a legal pathway for interstate, telehealth practice under interstate compacts?</td>
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<tr>
<td></td>
<td>27</td>
<td>Is there specific legal recourse to protect patients and providers from acts of fraud and abuse arising from the expansion of telehealth services?</td>
</tr>
<tr>
<td>Liability &amp; Immunity</td>
<td>28</td>
<td>Are civil liability protections framed within state/local emergency, disaster, or PHE authorities or other relevant laws?</td>
</tr>
<tr>
<td></td>
<td>29</td>
<td>Does the state tort claims act provide civil liability protection for “discretionary acts” by state/local actors in declared emergencies?</td>
</tr>
<tr>
<td></td>
<td>30</td>
<td>Do state laws or compacts explicitly provide HCWs or VHPs with immunity from civil liability (e.g., VPAs, GSAs) when responding to an emergency?</td>
</tr>
<tr>
<td></td>
<td>31</td>
<td>Are there exceptions to civil liability protections for acts that involve gross negligence, recklessness, or willful or wanton misconduct?</td>
</tr>
<tr>
<td></td>
<td>32</td>
<td>Do HCPs face potential civil liability for their acts, or those of their employees, agents, or volunteers, in response to emergencies?</td>
</tr>
<tr>
<td></td>
<td>33</td>
<td>Does state law immunize HCPs for their own negligent acts or those of its employees, agents, or volunteers?</td>
</tr>
<tr>
<td></td>
<td>34</td>
<td>Are VHPs required to register with the state/local governments to qualify for workers’ compensation for injuries sustained in performance of their duties?</td>
</tr>
<tr>
<td></td>
<td>35</td>
<td>Are existing employers of VHPs required to provide workers’ compensation coverage for injuries sustained in performance of their duties as volunteers?</td>
</tr>
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<td></td>
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<td>Do CSC plans or implementation protocols require reporting of real-time information re: patient outcomes or available supplies like PPE?</td>
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<td>Are state/local governments prepared to use or implement new or emerging products or services authorized by FDA via EUAs?</td>
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<td>Do state/local laws support rights to reemployment of HCWs or VHPs temporarily assigned to emergency response efforts?</td>
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I. EMERGENCY DECLARATIONS, POWERS & COMPACTS

During pandemics like COVID-19 or other major events impacting the public's health, the legal environment is transformed in real time through declared states of emergency, disaster, or PHE. These declarations at federal, state, or local levels trigger an array of powers to facilitate public and private sector response efforts including: (1) offering flexible options to expedite responses; (2) waiving legislative or regulatory provisions impeding effective responses; (3) transitioning shifts from conventional standards of care to CSC; (4) allowing out-of-state HCW's to practice in-state via licensure reciprocity; (5) expanding professional scopes of practice for HCWs; and (6) instituting special liability protections from ordinary negligence for providers and entities.

Each of these authorities depends in part on the level and type of emergency declared. As summarized below and in Appendix 1. Emergency Declarations – A Brief Overview, the federal government, every state, many territories, and local governments may declare either general states of “emergency” or “disaster” in response to public health crises. The federal Department of Health and Human Services (HHS), many states, and some local governments may also declare states of PHE. Each of these declarations changes the legal landscape instantly to facilitate regional response efforts, including through supplemental emergency executive orders used extensively by governors in response to COVID-19.

Federal Declarations. An array of emergency declarations is available to federal authorities to respond to public health events/crises. The President can declare a state of emergency or disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (“Stafford Act”) upon request of any state governor when federal assistance is needed “to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe.” The President can also declare a state of emergency pursuant to the National Emergencies Act for incidents requiring a national response. On March 13, 2020, President Trump simultaneously declared emergencies under both of these acts in response to COVID-19. Together these declarations authorize emergency management agencies like FEMA and partners to coordinate emergency responses, mobilize funding, and activate specific programs.

Pursuant to the Public Health Service Act, HHS may declare a state of PHE to enable the distribution of key resources (see Focus, below), waive specified federal requirements related to Medicare or Medicaid reimbursement, set aside certain provisions of federal laws (e.g., HIPAA Privacy Rule), and authorize other emergency response activities. On January 31, 2020, HHS Secretary Alex Azar declared a PHE at the inception of the COVID-19 outbreak in the U.S., which took effect retroactively on January 27.

Focus - Strategic National Stockpile

HHS’ SNS is a national reserve of vaccines, drugs, and medical supplies allocated to supplement and resupply state and local resources when emergency response efforts exhaust resources. SNS medicines are distributed free to the public. As needs for certain supplies arise, HHS may increase SNS stocks. During the 2014 Ebola outbreak CDC ordered $2.7 million of PPE for SNS supplies, with each kit capable of meeting the care needs of an Ebola patient for 5 days. During the COVID-19 pandemic, SNS PPE supplies were quickly drained and repeatedly re-stocked. State requests to HHS trigger SNS asset deployment. Once the state receives the deployment, authority to distribute and dispense SNS assets transfers to state officials to assure efficient SNS management.
Some of HHS’ PHE powers are only authorized when coupled with a declaration of a national emergency. In response to the 2009/2010 H1N1 pandemic, for example, HHS immediately declared a state of PHE on April 26, 2009, just days after initial domestic cases were confirmed. Months later, on October 23, 2009, President Obama declared a national state of emergency. Coupled with HHS’ PHE declaration, the President’s subsequent declaration allowed for broader waivers of federal regulatory requirements (e.g., specific provisions of S-CHIP and EMTALA (see below)).

<table>
<thead>
<tr>
<th>Emergency Medical Treatment and Active Labor Act</th>
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<td>EMTALA normally requires Medicare-participating hospitals with EDs to receive, screen, and stabilize (or transfer, where warranted) any patient who comes to the hospital in an emergency condition and requests treatment. In some circumstances, transfer to specially equipped, designated facilities may be necessary, such as in response to Ebola in 2014. EMTALA may also apply to urgent care clinics, labor and delivery departments, and some psychiatric departments. In federally declared emergencies, such as in response to COVID-19, however, HHS and CMS may waive select EMTALA provisions, allowing for non-traditional reception, screening, and treatment of emergency patients in affected regions.</td>
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In 2013, Congress passed the Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA) to expand HHS’ PHE powers, in part, without the need for an additional national emergency declaration. These extensive powers assisted HHS Secretary Azar in responding through broader powers during COVID-19 for the 6 weeks prior to President Trump’s national emergency declarations on March 13, 2020. HHS’ Secretary has since renewed the PHE declaration for 5 consecutive 90-day periods, most recently on April 15, 2021.

State & Local Declarations. All states and territories (and some localities) are legally authorized to declare states of emergency or disaster in response to multifarious events, including crises that impact the public’s health (e.g., pandemics, bioterrorism events). Most states also authorize declarations of PHE, or like terms. Many of these states’ approaches are based on the Model State Emergency Health Powers Act (MSEHPA) originally developed by the Center for Law and the Public’s Health in response to the anthrax exposures in late 2001.

PHE declarations typically empower state public health officials (in collaboration with emergency management agencies) to focus on the public health aspects of emergencies. Though designed originally for application in bioterrorism events or widespread emerging infectious diseases like West Nile virus, H1N1, or COVID-19, states and localities have increasingly declared PHEs for multiple additional purposes, including:

- Contamination of public water supplies;
- Localized measles outbreaks;
- Release and threatened release of amphibole asbestos;
- Shortage of affordable, safe medical cannabis;
- Abuse of prescription medication and illegal drugs; and
- Food insecurity.

Some larger cities and counties may also be empowered to declare states of emergency depending on their degree of “home rule.” Home rule refers to the discretionary power allotted by states to local governments to address largely local matters. A 2010 study reviewing emergency...
legal authorities of 20 select local jurisdictions of various population sizes across the U.S. found that 19 (95%) of the localities authorized local officials to declare either an emergency or disaster. This included cities in WRAP-EM states like Phoenix, AZ and Salt Lake City, UT, which are authorized to declare local states of emergency.\(^1\) Like many larger cities, Seattle’s mayor declared an emergency in response to COVID-19 on March 3, 2020.\(^2\)

Figure 1, below, illustrates emergency/disaster and PHE statutory authorizations among WRAP-EM states, which are described further in Table 1 in the Appendix.

**Figure 1. WRAP-EM States Defining Emergency, Disaster, or PHE**

Timing. While all states are authorized to declare states of emergency in some form, predicting their declaration, scope, timing, and duration can be precarious. All states initiated their pandemic flu response plans in response to the spread of H1N1 in 2009/2010, for example, but only 12 states formally declared states of emergency, disaster, or PHE over the first 6 months of the pandemic. In response to the Ebola threat in the Fall 2014, only Connecticut declared a PHE.\(^3\)

In the unprecedented response to COVID-19, however, all 50 states and most territories declared varied states of emergency, but not all at the same time or duration. Some states’ declarations came before the determination of any known cases; other states only declared after COVID-19 cases arose in their jurisdictions. Among the WRAP-EM states, Washington first declared an emergency on February 29, 2020; California on March 4; Utah on March 6; Oregon on March 8; Arizona on March 11; and Nevada on March 12.\(^4\)

Gradual declarations of state or local emergencies over time complicate advance planning concerning regional roles and responsibilities. Potential legal changes invoked by the declarations are specious or unpredictable. During the COVID-19 pandemic, multiple state legislatures (e.g., CO, IL, KY, MI, OH) challenged gubernatorial emergency powers through legislative or judicial intervention. On May 13, 2020, the Wisconsin Supreme Court nullified an emergency “stay home” order issued by the Wisconsin Secretary of Health in a case brought by the state legislature.\(^5\)
Additionally, multiple state legislatures are curbing their governors’ emergency declaration powers in the wake of COVID-19, including WRAP-EM states Arizona and Utah.\textsuperscript{23} By July 1, 2021, only about a half of states remained in a formally-declared emergency, disaster, or PHE in response to COVID-19.

As a result, legal response efforts to similar infectious disease or other threats may have to be crafted differently in jurisdictions that (1) do not formally declare states of emergency compared to those that do; or (2) face legislative or judicial challenges to such declarations. This can complicate uniform response efforts across states within a specific region, but may also be addressed via effective, advance agreements, MOUs, contracts, or existing public health laws.

**Dual Declarations.** Other issues arise when state or local governments declare states of emergency coupled with a PHE. Issuance of two or more declarations in a single jurisdiction is possible because each type of declaration shares similar statutory definitions and constructs.\textsuperscript{24} In response to COVID-19, governors in Florida, Maryland, New Jersey, and Ohio, among other jurisdictions, issued emergency and PHE declarations. Overlapping declarations within and across jurisdictions can obfuscate response efforts when divergent actors are mobilized or authorized to act under different declarations pursuant to distinct powers and chains of command as experienced during Hurricane Katrina in 2005 and COVID-19 in 2020-2021.

**Interjurisdictional Coordination.** Lessons learned from infectious disease outbreaks include the need for strong, interjurisdictional coordination among varied actors to craft and effectuate organized responses to emergencies. Multiple logistical and other obstacles challenge the seamless sharing of personnel, PPE, information, and other resources across boundaries and between public and private sectors. Wise utilization of numerous legal tools can support effective sharing, collaboration, and coordination among and between responders before, during, and after declared emergencies. Some agreements may embrace a legal contractual approach, obligating parties to adhere to specific terms. Others, such as MOUs or compacts (see EMAC discussed below), enable flexibility for participants adapting to unforeseen circumstances.

**VHP Programs.** Congress passed the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (PL 107-188) to facilitate the effective use of VHPs during PHEs. The Act led to HHS’ establishment of the ESAR-VHP program in April 2004, which was subsequently reassigned to ASPR with the passage of the Pandemic and All-Hazards Preparedness Act (PAHPA) in December 2006.\textsuperscript{25} State-based ESAR-VHP programs follow federal guidelines and standards, as well as receive supplemental funding and technical assistance, to support their development. ESAR-VHP systems may be linked with MRC or other comparable systems to organize and allocate VHPs in emergencies.

In August 2007, the Uniform Law Commission finalized the model act known as UEVHPA\textsuperscript{26} to facilitate the deployment and use of VHPs in declared emergencies. VHPs include compensated and uncompensated individuals acting of their own volition during declared emergencies. The act provides reasonable safeguards to assure that VHPs are appropriately licensed and regulated. It also authorizes state governments to direct and restrict the scope and extent of services provided by VHPs to promote disaster recovery operations. Public and private sector VHPs are also entitled to workers’ compensation benefits and affirmative civil liability protections. However, not all benefits may convey during periods of volunteer service; some privately-employed VHPs report temporarily losing access to their health or other benefits through their employers during volunteer activities. Numerous jurisdictions have introduced or enacted UEVHPA, or portions thereof. Utah was the first WRAP-EM state to introduce and enact UEVHPA legislation in 2008, followed by Oregon (2009), Nevada (2011), and Washington (2018).\textsuperscript{27}
Practicing Legal Triage. Emergency declarations invoke emergency powers, but do not assure best practices are followed due to their lack of specificity and potential limitations stemming from constitutional requirements or contractual limitations. Framed in broad language, shaped by political realities, and subject to frontline fluctuations, emergency laws offer more so a menu of legal powers and options rather than definitive guidance.

For example, emergency declarations may allow for waivers of state-based laws or policies that otherwise hinder emergency response (see Appendix – Table 3). Figure 2, below, denotes WRAP-EM states with specific waiver authorities pursuant to emergency declarations. Effective utilization of waiver allowances entails legal triage decisions. Advance planning and artful, well-communicated interpretations in real time can alleviate specific legal impediments that may hinder regional responses and coordination. In California, Governor Gavin Newsom invoked specific authority to waive restrictions on delivery of pharmaceuticals and emergency necessities, as well as licensure and staffing requirements, for HCPs during the COVID-19 emergency. Arizona Governor Doug Ducey’s emergency declaration allowed the state’s Department of Health Services to waive HCW licensing requirements implemented by professional licensing boards.

Figure 2. WRAP-EM States Waiver Authorities

Without affirmative direction, regional responders may act unknowingly outside of legal boundaries. Alternatively, they may fail to act at all because of erroneous legal advice, liability fears, or other actual or perceived legal consequences. Neither of these outcomes is acceptable. As a result, emergency planners, public health practitioners, HCWs, and their legal counsel must be prepared to triage legal issues and solutions in emergencies to effectuate legitimate public health responses. They must make critical legal decisions balancing communal and individual interests in emergencies where facts may be unclear, resources are scarce, and communal well-being is imperiled.
**Emergency Management Assistance Compact (EMAC).** EMAC is an interstate mutual aid agreement (MAA) between all states (as well as D.C. and several territories) administered by NEMA. When activated (see Figure 3, below) EMAC allows for mutual assistance between states in response to any declared emergency or disaster. A formal declaration of emergency or disaster is typically required to invoke EMAC (with the possible exception related to emergency training exercises in which cross-state resources may be utilized). As resources become scarce, personnel or resources can be deployed quickly across state lines to facilitate efficient and effective responses.

**Figure 3: Role of EMAC & Allocations**

In multiple emergency scenarios, EMAC entails participation of individuals from numerous health and non-health related professions. Jurisdictions assist each other by providing requested goods (e.g., generators, temporary shelters, equipment) or services (e.g., security, medical personnel). Within 36 hours of Hurricane Katrina’s landfall in September 2005, for example, over 6,000 health care personnel were deployed to the affected regions through EMAC. In April 2020, California Governor Newsom loaned 500 ventilators to 6 states (DE, IL, MD, NV, NJ, and NY), as well as D.C., pursuant to their EMAC requests.

Out-of-state HCWs cannot normally legally practice in a state in which they are not licensed (see Part II). To facilitate interstate sharing of HCWs, EMAC authorizes a requesting state to recognize out-of-state medical or other licenses for purposes of rendering aid in declared emergencies or disasters, subject to limitations imposed by the requesting state’s governing body. Persons holding an out-of-state license, certificate, or permit are “deemed licensed, certified, or permitted by the state requesting assistance” when deployed through EMAC. These personnel must adhere to the requesting state’s scope of practice requirements and other requirements. Furthermore, individuals providing aid through EMAC are considered agents of the requesting state and are not liable for any acts or omissions conducted in good faith. States participating in EMAC exchanges of personnel to other states must also provide workers’ compensation benefits for persons they deploy. If these persons are injured or killed while active in response efforts, the sending state compensates personnel or their families through such protections.

In most jurisdictions, only public sector professionals can be deployed through EMAC. In response to Hurricane Katrina, however, some states deputized private sector individuals as state
agents or issued executive orders to allow private sector volunteers to be deployed. Some persons may enter VSAs or MOUs with their state emergency management agency prior to deployment. In Ohio, for example, state officials executed MOUs with county governments that authorized the use of local personnel for EMAC response efforts. In Connecticut, designating volunteers as "agents of the state" enabled the deployment of volunteers to New York to assist in EMAC responses for Hurricane Sandy in 2012.37

EMAC also provides a key pathway for states' mutual assistance during declared emergencies38 by facilitating the exchange of supplies (e.g., PPE, GPS units), equipment (e.g., ambulances, trailers), or even entire facilities (e.g., mobile field hospitals or units) provided to requesting states (see Figure 3, above). EMAC contracts also list the resources the requesting state must supply, including fuel, area maps, medical supplies, and lodging and meals for assisting personnel.39

Any state aiding another state must be reimbursed by the receiving state for costs incurred in providing the assistance or for expenses due to loss or damage incurred in the operation of equipment.40 The Request for Assistance (REQ-A) Form details expenses that are eligible for reimbursement.41 States may also donate resources and services to the requesting state. Referred to often as “zero-dollar missions” states may provide resources at no charge to the emergency-impacted state.42

**EMAC Applications During COVID-19.** COVID-19 presents unique EMAC applications. Unlike emergencies localized to a single state or region, all states experienced significant impacts from COVID-19. Health care systems nationally have strained to meet surging numbers of patients, including large hospitals (e.g., Harbor-UCLA Medical Center in Los Angeles), and smaller rural hospitals. Still, the spread of COVID-19 has not simultaneously hit all parts of the U.S. equally, allowing resources to be directed or re-directed to regions with high COVID-19 cases and hospitalizations. As different parts of the country reach epidemic peaks, EMAC facilitates the relocation of HCWs, PPE, ventilators, and medical supplies, among other essentials.

On March 27, 2020, FEMA Administrator Pete Gaynor commented to state and local emergency managers how some areas, like New York, Massachusetts, and Louisiana were in the center of the COVID-19 battle, while other jurisdictions still had relatively few cases. For example, on July 24, 2020, among the 6 WRAP-EM states, Arizona (156,301) and California (425,616) had experienced large spikes in rates of known infections. At that time, California reported more confirmed cases than New York, an original epicenter of the virus.43 Other WRAP-EM states, specifically Oregon (15,713), Utah (36,099), Nevada (40,885), and Washington (50,009) had relatively lower rates of known infections. Actual numbers of non-confirmed infections were much higher based on prevalent epidemiologic estimates. Suggesting a "collective responsibility" to blunt the spread of COVID-19, Gaynor requested jurisdictions with excess capacity to consider using EMAC to offer resources to struggling areas.44 Multiple states utilized EMAC in providing and receiving vital equipment and personnel during the pandemic.45
II. LICENSING, CREDENTIALING & PRIVILEGING

Professional licensure (or certification) of HCWs (e.g., physicians, nurses, EMTs, pharmacists, behavioral health professionals) is undergirded by specific state laws that vary across jurisdictions.\textsuperscript{46} State licensure requirements dictate the circumstances under which a health professional may practice her profession within the state, as well as the scope of practice for each profession. HCW licensing typically occurs through a state’s department of professional regulation or health department. Each profession typically has its own licensing board responsible for evaluating personnel, granting licenses, and conducting disciplinary hearings when necessary. Health professionals or others practicing without a license can be subject to criminal or civil penalties, depending on the jurisdiction.\textsuperscript{47}

Variations in state licensure or certification laws present practical and legal challenges within regional health systems. Inconsistencies can engender confusion about the appropriate scope of practice for licensed HCWs working actually or virtually across state lines. Potential legal constraints arise specifically when a HCW desires to practice or volunteer in a state where she is not licensed. Additional legal concerns may emerge if a worker’s license is restricted in one state and that practitioner engages in practice outside the scope of the restrictions in another state during emergencies.

Reciprocity. Despite legal barriers, several pathways to licensure in non-emergency and declared emergency environments may facilitate rapid deployment and use of HCWs from other jurisdictions. Figure 4, below, illustrates multiple routes authorizing HCWs to practice out-of-state. When an emergency has been declared, HCWs licensed or certified in a U.S. state may be able to obtain licensure reciprocity through existing processes (e.g., EMAC) or via waivers of licensing requirements from the state requesting assistance. Even outside of emergency declarations, licensed HCWs may be able to obtain licensure reciprocity through expedited or routine reciprocity processes.

\textbf{Figure 4: Pathways to Licensure Reciprocity}
In non-emergencies, licensure reciprocity among HCWs is available in some states for those who are licensed in good standing elsewhere. Examinations and other requirements are generally waived for reciprocity applicants, although application forms and fees may be required. Additional fees may also be charged by the applicant’s home state for certification of status. Most jurisdictions similarly offer “fast-track” licensure for military veterans and others with sufficient certification. For example, Arizona issues occupational or professional licenses to spouses of active duty service member who are sufficiently licensed elsewhere and who accompany that service member to an official permanent change of station within Arizona. While this type of reciprocity significantly reduces the time required to obtain licensure, it is not instantaneous, and thus of limited utility during a rapid, catastrophic emergency when HCWs are needed immediately.

Other licensure reciprocity structures facilitate cross-border exchanges of HCWs. Thirty-five states have adopted the NLC, including WRAP-EM states Arizona and Utah. NLC allows nurses to practice in any of the compact states pursuant to expedited application processes. Similar agreements may be adopted to extend reciprocity to other licensed personnel. For example, 18 states have enacted and been fully adopted into the PSYPACT Commission, including WRAP-EM states Arizona, Nevada, and Utah. Under PSYPACT, licensed psychologists in compact states may apply for telepsychology and temporary in-person practice privileges across state lines. Still, crafting licensure reciprocity may be tenuous given variations across states as to classifications, scope of practice, and other elements.

Emergency Laws. As discussed in Part I, declarations of emergency, disaster, or PHE may activate various legal authorities, compacts, or agreements that facilitate out-of-state licensure recognition for HCWs. Pursuant to EMAC, persons licensed or certified in any other compact jurisdiction are automatically “deemed licensed” by the requesting state (subject to any limitations or conditions imposed by the state’s governor). HCWs may thus provide services during an emergency as if they were licensed in the affected jurisdiction provided they are registered and deployed by their home jurisdiction via coordinated response efforts.

Many states’ laws provide significant flexibility in recognizing out-of-state licensure during an emergency. The aforementioned MSEHPA (see Part I) provides for recognition of out-of-state licenses among HCWs during a declared PHE. Figure 5, below, illustrates how all WRAP-EM states authorize non-emergency and emergency licensure reciprocity.
All 6 WRAP-EM states authorize licensure reciprocity for HCWs during routine operations outside of formal emergency declarations (see Appendix - Table 2). For example, Arizona law allows out-of-state HCWs to practice in the state provided they have been licensed or certified in their home state for at least 1 year. California’s Medical Board can grant physicians and surgeons licenses if they have held an unlimited and unrestricted license in another state for a minimum of 4 years and are board certified by the American Board of Medical Specialties.

All WRAP-EM states also have specific statutory or regulatory authority for licensure reciprocity during declared emergencies. Emergency declarations can trigger expedited processes for licensure reciprocity than otherwise allowed under routine provisions. In Nevada, the Governor may authorize out-of-state licensed, certified, or registered HCPs to practice for the duration of the emergency. In Oregon, the Medical Board may allow out-of-state licensed physicians to practice during a declared emergency. Oregon’s Medical Board may also allow Administrative Medicine, Inactive, Lapsed, and Retired physicians to reactivate to status during an emergency. To expedite reciprocity leading up to or during emergencies, WRAP-EM states may consider advance model agreements or executive orders authorizing and governing interstate licensure across multiple types of HCWs.

Among the states adopting UEVHPA (see Part I), VHPs can be granted temporary out-of-state license recognition for the duration of an emergency. However, they must be listed within volunteer registration systems, such as ESAR-VHP or MRC, and serve through coordinated efforts. "Spontaneous volunteers" may not legally be entitled to licensure reciprocity due to liability concerns, as discussed in Part IV, below. However, they may still carry out other roles, like coordination and communication activities, that do not require licensure.

Emergency Waivers. As noted in Part I, federal, state, and some local governments may suspend or waive legal provisions, including licensure laws, during a declared emergency. All 6 WRAP-EM states authorize some form of licensure reciprocity during the COVID-19 pandemic – either by allowing persons to apply for emergency licenses, or just by waiving in out-of-state licenses temporarily. Waiver of licensure provisions is generally accomplished via a governor’s executive order pursuant to formal declaration of emergency or disaster. Waivers may enable qualified HCWs from other states (or countries in some cases) and those with expired or inactive licenses, to assist response efforts depending on state law and the content of the waiver.

Pursuant to §1135 of the Social Security Act, HHS’ Secretary may waive or modify certain requirements for Medicare, Medicaid, S-CHIP, EMTALA, and the HIPAA Privacy Rule. Multiple §1135 waivers were authorized in 2009/2010 for the H1N1 influenza pandemic, in 2012 for Hurricane Sandy and extensively in 2020 in response to COVID-19. Two conditions precipitate the Secretary’s invocation of HHS’ waiver authority:

1. the President must declare a major disaster via the Stafford Act or an emergency under the National Emergencies Act; and
2. HHS’ Secretary must declare a PHE.

Once these conditions are met, the Secretary may modify: (a) certain conditions of participation or other certification requirements for HCPs; (b) requirements that HCPs hold a license in the state in which they provide health care services for purposes of reimbursement; and (c) limitations on payments for health care items and services provided to Medicare Advantage enrollees to allow use of out-of-network providers. Health care facilities may receive specific waivers or modifications. Even if such facilities do not comply with Medicare, Medicaid, or other requirements
while the waiver is in effect, facilities can continue to be reimbursed for covered services. Implementation of these waivers or modifications is usually delegated to CMS.

**Credentialing & Privileging.** Credentialing and privileging play a vital role in the ability of health care organizations and PHAs to assess the qualifications and shape the practice of licensed HCWs. Health professionals credentialed in their fields have additional opportunities to practice in health care organizations that require credentialed status. Likewise, many health care facilities require professionals to undergo clinical privileging prior to practicing in their facility. The level of privileges granted to a health professional within a specific facility affects that practitioner’s scope of practice. State laws generally require HCPs to formulate procedures governing credentialing and privileging for health professionals, frequently via a hospital’s medical bylaws.

Credentialing processes involve “obtaining, verifying, and assessing the qualifications of a health care practitioner to provide patient care, treatment, and services in or for a health care organization.” Credentialing determinations utilize criteria such as a HCW’s licensure, education, training, experience, and other qualifications. Hospitals and other HCPs may engage in credentialing internally or accept credentialing determinations made by external organizations, such as credential verification organizations.

Privileging processes constitute integral roles in the relationship between physicians (or other health professionals) and a health care organization. Privileging allows an organization to evaluate a professional’s credentials and qualifications, and to grant permission to engage in a defined scope of practice at a specific organization (with or without supervision) based upon these qualifications. Thus, a practitioner seeks clinical privileges to obtain necessary authorization to provide specific care, treatment, and services in an organization.

Privileging decisions are usually within the discretion of the organization and are made on a case-by-case basis with patient safety and quality of care as primary concerns. Determinations are based on the practitioner’s applicable experience, education, licensure, training, experience, and judgment. Unlike licensure and credentialing, however, privileges only apply within well-defined parameters of scope of practice, and only within the specific institution granting them. Thus, a health care professional who has satisfied credentialing and privileging requirements for one health care organization may not necessarily be offered privileges elsewhere.

Several legal and policy provisions may alter credentialing and privileging requirements in declared emergencies to facilitate the rapid assessment and deployment of HCWs and VHPs across facilities and jurisdictions. The Joint Commission requires medical staff bylaws to feature emergency management plans that include a means by which hospitals identify health professionals to provide care during emergencies. A hospital may grant disaster privileges to a health professional upon a showing by the individual of: (1) a hospital ID card; (2) a current license to practice and a valid picture ID issued by a governmental authority; (3) identification indicating that the individual is a DMAT member; (4) identification indicating that the individual has been granted authority to care for and treat patients under disaster circumstances; or (5) a hospital staff member attests to the individual’s identity.

The Joint Commission also requires hospitals to have policies regarding the granting of temporary clinical privileges when a new applicant is awaiting formal approval by the medical staff executive committee or “to fulfill an important patient care, treatment, and service need.” Prior to granting temporary privileges, the hospital must verify the professional’s licensure and competence. State or regional volunteer health registries like ESAR-VHP or MRC can play a
role in this process by advance reviews of VHPs’ credentials to determine if they are qualified to provide the type of care requested of them. Health facilities may also utilize the information provided by ESAR-VHP to grant temporary or disaster privileges to VHPs.

**Expanding Scope of Practice.** HCW’s legally-defined “scope of practice” details the services they may provide with a specific license or certification. Variations in the scope of practice between states can impinge HCWs working or volunteering across state lines in times of medical surge. Specific guidance may also derive from waiver authority used to recognize out-of-state HCW licensure during a declared emergency, restricting workers’ scope of practice as a condition of temporary license recognition. Some emergency laws explicitly address conflicting scope of practice provisions and determinations as to which set of standards controls. EMAC similarly provides for conditions and restrictions on scope of practice as determined by the state requesting assistance.79

Scope of practice restrictions limit who may provide what services and where services may be delivered. Temporary waivers or suspensions of state/local laws can set aside scope of practice restrictions, enabling HCWs to act consistent with their education and training even beyond what they are legally authorized to engage in normally. During the 2009/2010 H1N1 pandemic, Maryland authorized paramedics and Cardiac Rescue Technicians to vaccinate public safety personnel, HCPs, and the public.80 Other states have used similar authority to address significant public health crises. In California, for example, Governor Newsom is authorized to rescind or amend regulations relating to non-safety restrictions on the delivery of food products, pharmaceuticals, and other emergency necessities that are distributed to hospitals, jails, restaurants, and schools.81
III. TELEHEALTH & TELEMEDICINE APPLICATIONS

Telehealth and telemedicine are highly efficacious tools to assist patients in routine settings and PHEs. Though these terms are often used interchangeably, they have distinct meanings and scope. Telehealth broadly refers to the use of electronic and telecommunications technologies to provide health care and services at-a-distance. Telehealth encompasses clinical and non-clinical services. Telemedicine, often considered a subset of telehealth, refers to providing clinical care by a HCP (e.g., physician, nurse) via remote services (video/audio) to a distant patient in real time. 

A hallmark of telemedicine is two-way, real-time remote communication between a patient and a provider through video or audio technologies. In states effectuating routine or emergency licensure reciprocity (see Part II, above), the provider and the patient need not be in the same jurisdiction. During PHEs like COVID-19, telemedicine increases the accessibility of HCPs to meet surge capacities, facilitating patient communication with HCWs and VHPs located in other jurisdictions. In a group survey conducted in 2020, WRAP-EM researchers found that the use of telemedicine across region states dramatically increased during COVID-19 (see Figure 6).

Figure 6. Impact of the COVID-19 Pandemic on Telemedicine - Group Survey

| Background: | The Telemedicine group of the WRAP-EM consortium, as part of a larger initiative to address telecommunication during disasters, sought to evaluate the impact of the pandemic on delivery of care. |
| Methods: | A short survey was sent to the membership of WRAP-EM through a secure web portal. Current changes in telehealth practice resulting from the pandemic and its future projection with standard demographic data were queried. Qualitative results were analyzed by the Telemedicine group for tone and common themes. |
| Findings: | Forty-nine respondents included physicians (18, 37%), patients (12, 24%) and nurses (9, 18%). Respondents were from 12 different states, but most were from Arizona (19, 38%) and California (9, 18%). Most respondents had a positive impression (47, 96%) of telehealth utilities. Major themes included a large increase in utility, with most going from minimal use to 70-80% of all clinic visits, enhanced safety during the pandemic, increased access for patients and healthcare providers, more flexibility and timeliness of appointments, and decreased distractions during visits. Negative responses included concerns of over billing and need for future in-person visits. The table shows novel ways telemedicine is being utilized by respondents. |
| Conclusions: | Use of telemedicine has dramatically increased during the COVID-19 pandemic. It will have a lasting impact on the future delivery of healthcare. Limiting barriers to implementation is essential. |

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Novel Application of Telemedicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burn Care</td>
<td>As consistent with existing burn health treatment practices, teaching outside medical providers basic burn care to limit transfers</td>
</tr>
</tbody>
</table>
| Emergency Medicine | - Screening patients for symptoms before allowing entrance to waiting room  
- Use for general registration in waiting room  
- Home visits via Emergency Medical Technicians (EMTs) communicating with providers |
| Education | Tele-Objective Structured Clinical Examinations (OSCE) |

Beyond telemedicine, additional models for telehealth include provider trainings, provider-to-provider communications, administrative meetings, continuing medical education, and public
health and health administration. These models are conducted through a broad range of technologies. During infectious disease outbreaks like COVID-19, telehealth not only facilitates patient care, but also helps insulate providers and patients from potential disease exposure in hospitals, clinics, and other settings.

**Legal Authorities.** Federal and state laws may restrict who (e.g., type of provider), where (e.g., interjurisdictional) and how (e.g., video or audio only) telehealth and telemedicine can be practiced. Maximizing their appropriate use during PHEs may thus entail legal changes.

During the COVID-19 outbreak, several laws and regulations have been temporarily altered to remove barriers to telehealth. At the federal level, the Coronavirus Preparedness and Response Supplemental Appropriations Act allowed HHS to temporarily waive certain Medicare telehealth restrictions or requirements during the emergency.\(^\text{83}\) DEA also issued guidance that DEA-registered practitioners may prescribe schedule II-V controlled substances without the normally required in-person evaluation under certain conditions.\(^\text{84}\) Some states like Arizona may still require an in-person or audio-visual examination before a schedule II drug can be prescribed.\(^\text{85}\) HHS’ OCR issued guidance that non-compliance with HIPAA Privacy Rule regulatory requirements during “good-faith” telehealth applications would not result in penalties during the COVID-19 PHE.\(^\text{86}\) Multiple federal legislative proposals aim to remove additional telehealth barriers by:

- removing geographic restrictions;\(^\text{87}\)
- improving telehealth for underserved communities;\(^\text{88}\)
- establishing certain permanent key waivers due to COVID-19;\(^\text{89}\)
- conducting studies and reporting actions taken to expand telehealth access;\(^\text{90}\) and
- permitting HHS to waive additional Medicare requirements.\(^\text{91}\)

State laws have improved access to telehealth services in recent years. Twenty-nine states, including WRAP-EM states (AZ, CA, NV, OR, and WA), have enacted “parity” laws, requiring private insurers to reimburse for telehealth services as they would for in-person care.\(^\text{92}\) These laws generally do not restrict a patient’s location, unlike federal Medicare telehealth laws that have more restrictive “origination site” requirements. For example, Arizona recently enacted a law stating that “telehealth services may be provided and shall be covered regardless of where the enrollee is located or the type of site.”\(^\text{93}\) As discussed below (see CMS Reimbursements), Medicare “origination site” requirements were waived in light of COVID-19. Medicaid telehealth reimbursement requirements are largely proscribed by state law. Within Medicaid programs, 26 states explicitly allow personal homes as valid origination sites for telehealth, but reimbursement may be reserved only for those patients suffering from a chronic condition (e.g., congestive heart failure, diabetes, hypertension).\(^\text{95}\)

Licensing requirements likewise restrict physicians from administering telehealth services to out-of-state patients. Some states created initiatives to lesson restrictions on out-of-state telehealth practices. Arizona allows out-of-state health care providers to provide telehealth services to a patient within the state so long as that provider is licensed in another state and complies with applicable Arizona laws and rules.\(^\text{96}\) The Interstate Medical Licensing Compact (IMLC) between 30 states (e.g., AZ, NV, UT, WA) also facilitates physicians in providing medical services (including telehealth) across state lines.\(^\text{97}\) A state’s participation in the compact does not automatically allow physicians to practice across state lines (see also Part II). Rather, it streamlines the process for obtaining licensure in other states if physicians meet certain eligibility requirements. Eligible physicians do not receive
one “compact license” allowing them to practice in all states but must apply for IMLC licensure in each member state in which they seek to practice. 98 Additionally, the Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC) is supported by state legislation lessening restrictions on licensing requirements for specific physicians to practice via telehealth. Furthermore, PSYPACT specifically allows for cross-state telepsychology and temporary in-person psychological services between inducted states (including AZ, NV, UT) (see also Part II).

For example, Utah has recently enacted a law pursuant to the ASLP-IC that allows a licensed audiologist or speech-language pathologist to provide telehealth services in member states without having been licensed in that member state. 99 Similarly, Washington’s state legislature presented a bill in 2020 allowing licensed audiologists and speech-language pathologists to provide telehealth services in member states. 100

The COVID-19 pandemic’s impact on the need for telehealth also influenced many states to propose or enact telehealth legislation. Many of these newly enacted or proposed provisions regard consent, coverage, accessibility, and reimbursement for telehealth services. Five WRAP-EM states (AZ, CA, NV, UT, WA) added specific provisions aimed at improving telehealth services for mental health treatment. Washington State established a psychiatric consultation call center that provides health care providers with “on-demand” access to mental health and substance abuse clinical consultations for adult patients. 101 Three WRAP-EM states (CA, NV, WA) have proposed bills containing telehealth provisions including mental health initiatives (see Appendix - Table 4).

Other telehealth restrictions are temporary, addressed via state-based emergency declarations and gubernatorial executive orders expanding reimbursement and easing usual consent, licensure, and prescription requirements. Responding to the pandemic, every WRAP-EM state expanded its Medicaid program to cover telehealth services and provide parity of reimbursement for telehealth services. Some states proposed or enacted laws requiring telehealth services to be reimbursed the same as in-person (see Appendix - Table 4). 102

All WRAP-EM states waived telehealth provider licensure, certification, or registration requirements. 103 This allows HCPs licensed and in good standing in other states to temporarily be deemed licensed in WRAP-EM states to provide patients with telehealth care. Oregon Governor Kate Brown’s order expressly allows out-of-state licensed physicians to provide telehealth care to Oregon patients until the end of declared emergency. Some states prohibit specific requirements on telehealth technologies, allowing telephonic or email correspondence as sufficient mediums to deliver treatment. 104 However, 4 WRAP-EM states (AZ, NV, UT, WA) enacted or proposed legislation limiting telehealth technologies, such as the utilization of email for telehealth services. 105 For example, Utah prohibits health care entities from providing telemedicine treatment via email unless the provider established a provider-patient relationship with the patient or is otherwise allowed under Utah law. 106

CMS Reimbursements. Prior to COVID-19, CMS could only reimburse clinicians providing telehealth services for Medicare beneficiaries under limited circumstances. 107 For example, a Medicare beneficiary receiving such services had to (1) reside in a designated rural area; and (2) travel to a local medical facility to receive services from a physician in a different location.

On March 16, 2020, CMS reimbursement for telehealth services for Medicare beneficiaries was drastically expanded via President Trump’s Stafford Act emergency declaration and Social Security Act §1135 waiver. Under the waiver, Medicare “origination site” restrictions were lifted,
allowing Medicare reimbursement for office, hospital, and other health visits (including in one’s residence) conducted via telemedicine across the country. Under the waiver, a Medicare beneficiary living anywhere in the U.S. could receive covered telehealth services at home. In addition to physicians, other HCWs, including nurse practitioners, clinical psychologists, and licensed clinical social workers, were authorized to offer covered telehealth services to their patients. CMS also allowed telehealth providers to waive patient deductibles and co-payments for the duration of the emergency. On May 1, 2020, CMS further expanded the: (1) type of telehealth provider eligible for Medicare reimbursement (including physical and occupational therapists and speech pathologists); (2) list of allowable audio-only services (including behavioral health); and (3) type of facility that can bill for telehealth services (including federally qualified health clinics and rural health clinics).108

Absent further developments, expansion of Medicare coverage for telehealth services lasts only as long at the §1135 waivers remain in place. Many health care providers and patient-centered organizations have advocated for making these expansions permanent. On June 9, 2020, CMS Administrator Seema Verma expressed support for making permanent changes in response to COVID-19,109 which would require significant reforms to the CMS fee schedules via rule-making processes. On August 3, 2020, CMS proposed permanently expanding Medicare beneficiaries’ access to telehealth beyond COVID-19, including eliminating “origination site” restrictions to allow patients to receive Medicare-covered telehealth services at home, and reducing provider burdens by facilitating coding and billing processes.110 The Trump Administration finalized CMS’ proposal on December 1, 2020.111

Conversely, Medicaid already provides states broad flexibility in using telehealth services. Federal approval is not required for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services.112 States that expanded Medicaid coverage in light of COVID-19 within the realm of their routine authority may continue to do so permanently subject to state discretion.

States can also broaden access to telehealth using Medicaid emergency authorities, which require federal approval. As of June 15, 2020, all 50 states and D.C. have used §1135 waivers to allow out-of-state providers licensed in another state to provide care to Medicaid beneficiaries.113 Forty-eight states and DC (including all WRAP-EM states) have used other waiver strategies to amend home and community-based services to expand telehealth access.114 While these expansions terminate at the conclusion of declared emergencies, members of Congress, CMS officials, and other federal actors are considering new legislation and other options to make permanent specific legal reforms allowing greater use of telehealth practices after the COVID-19 pandemic subsides.115

**Fraud & Abuse Protections.** While the drastic expansion of telehealth services during COVID-19 carries clear health benefits, some are concerned over potential increases in billing fraud and abuse.116 For example, with increased telehealth reimbursement, providers may be more inclined to encourage health services for patients and overusing services. Marketers may seek to obtain Medicare or Medicaid beneficiaries’ billing IDs, and fraudulently bill the government for expenses. If telehealth expansions from COVID-19 become permanent, updates of federal protections against healthcare fraud, waste, and abuse will likely follow. Some states have countered COVID-19-related fraud and abuse in other contexts. Oregon State Attorney General Ellen Rosenblum partnered with the U.S. Attorney’s office to protect patients from scams surrounding COVID-19 testing and countermeasures, as well as fraudulent efforts to obtain personal identifying information.117 A Nevada task force was formed in April 2020 to handle COVID-19 fraud-related claims and protect health consumers.118 Similar efforts applied to state-
based Medicaid programs and licensed practitioners and insurers may help deter acts of fraud and abuse via telehealth expansions.
IV. CIVIL LIABILITY, IMMUNITY & INDEMNIFICATION

Health care providers (HCWs, hospitals, and other entities) face varied liability risks in emergencies due to inadequate supplies or facilities, atypical protocols, shifting standards of care, and other factors. As illustrated in Figure 7, below, civil, criminal, and administrative liability issues comprise a complex web of interconnected risks for HCWs and entities.

Despite heightened risks of liability, a series of legal protections extend to HCWs and entities from non-emergency laws and emergency declarations. Changes in the legal standards of care during crises also may help insulate providers from claims for injuries or deaths related to the provision of care. The dichotomy between potential for increased liability risks and availability of additional liability protections is examined below.

Potential Liability for HCWs & VHPs

Potential civil liability for HCWs and VHPs is typically grounded in legal claims of negligence, notably malpractice. Negligence claims against physicians typically require proof of a breach of an affirmative duty to meet the standard of care, or other requirement to perform, that caused patient harms leading to damages. Non-physicians following established protocols or standing orders may be protected from liability in some jurisdictions if they follow instructions from supervising physicians in good faith. However, HCWs are generally not protected if their actions: (1) are intentionally harmful, (2) are completely lacking in care (which may be referred to legally as “recklessness,” “gross negligence,” or “willful and wanton” negligence), or (3) constitute an inexcusable violation of statute or regulation, such as practicing without a license (often referred to in legal terms as “negligence per se”).

Properly developed treatment protocols and standard operating procedures can significantly reduce the risk of civil liability for HCWs to the extent they help establish and reinforce the appropriate standard of care. Deviations from protocols and standard procedures, in contrast, increase liability risks unless adequately justified. Yet prevailing circumstances, and not
protocols, generally determine the standard of care. Strict adherence to standing orders and similar tools may incentivize HCWs to ignore potential patient harms to protect against liability claims. Courts recognize that circumstances like medical surge may require deviation from standard procedures, but development and use of comprehensive adaptable protocols coupled with advance and real-time training can mitigate liability risks.

Additional liability claims may surface during emergencies. Patient abandonment occurs if a HCW with a duty to care ends a patient relationship without ensuring the patient has necessary care, adequate notice, or access to a competent replacement. In emergencies, abandonment claims may stem more so from a lack of personnel and resources. Like other claims, abandonment may be assessed based on medical and legal standards of care dependent on prevailing circumstances.

**Criminal Sanctions.** Beyond civil claims, HCWs may also be subject to criminal sanctions in limited circumstances. For example, if they completely ignore the risks or consequences of their actions they may be charged criminally. Criminal charges may also include assault (provoking fear of bodily harm), battery (physical touching without consent), false imprisonment, child endangerment, or abject failures to assist. In 2010, a New York EMT was charged with official misconduct for allegedly failing to assist a woman in distress in a restaurant where she and another EMT were taking a break. The EMTs never saw the woman despite being informed of her situation. Only after 3 years of legal proceedings were criminal charges eventually dropped.

**Administrative Sanctions.** HCW misconduct may also lead to administrative sanctions through formal complaints with employers or regulatory and oversight agencies. Complaints may stem from failures to maintain patient confidentiality or comply with “Do Not Resuscitate” orders, incompetence, unprofessional conduct, or other misconduct. Employers may conduct their own investigations under the guidance of regulatory bodies and pursuant to established disciplinary plans. Resulting sanctions may include employer discipline (e.g., suspension), censure, fines, or license probation or revocation orders. State regulatory agencies may report these adverse actions to the National Practitioners Data Bank.

In response to the 2014 Ebola outbreak, for example, Rhode Island’s EMS Chief collaborated on a joint statement regarding professional responsibility and HCW’s refusals to treat. The statement clarified that individual HCWs are “obliged to treat and/or care for Ebola patients” and failure to do so would result in an investigation and potential sanctions. In routine events and declared emergencies, disciplinary actions stemming from criminal convictions, negligence, fraud, substance abuse, or actions outside professional standards may impact individual licensure and livelihoods. In California, nurses’ licenses were suspended in April 2020 for refusing to treat COVID-19 patients without a N95 mask.

**Constitutional Claims.** Government officials and employees generally are not liable for their official actions unless they deprive a person of constitutional rights while acting “under color” of state law or policy, meaning their actions are or appear to be officially authorized. Resulting cases are often referred to as “§1983” claims (based on the applicable federal statute through which they are brought). Governmental HCWs may be subject to §1983 liability if they violate due process, equal protection, or other constitutional rights. These claims are difficult to prove because they require demonstration of an intent to harm the patient or violate his or her rights. In Davidson v. City of Jacksonville, a Florida federal court held that EMS professionals did not violate a disoriented and resistant patient’s due process right to be free from unreasonable seizure when they tied and carried him to an ambulance (based on mistaken belief that a stretcher would not fit into his bedroom) because they did not intend to harm him.
Additionally, §1983 claims generally do not apply to employees of private entities, even when they act on behalf of governmental agencies. In *Williams v. Richmond County*, a Georgia federal court stated that there likely was no “state action” (required for § 1983 claims) when HCWs employed by a private hospital took custody of a woman detained and handcuffed by police and transported her to a hospital at the officers’ request. The court held that even if this constituted state action, the workers did not display a deliberate indifference to serious medical needs in the form of unreasonable refusal, denial, or delay of treatment.\textsuperscript{136}

**Potential Entity Liability**

Entities that employ and supervise HCWs face their own liability risks during emergencies under multiple themes. Health care entities may be liable for their own negligence or that of their employed HCWs and volunteers. Under legal theories known as “corporate negligence,” health care entities must use reasonable care in maintaining facilities and equipment, ensuring competence among employees, providing required oversight and supervision, and developing and adopting policies to ensure adequate patient care.\textsuperscript{137} For example, a Florida regional medical center was held liable for the death of a 5-year-old child in 1990 because it failed to properly supervise, educate, train, and instruct paramedics who acted negligently in providing care.\textsuperscript{138} In 2013, California’s Supreme Court ruled that a HCP may be negligent for its maintenance or storage of an individual’s PHI regardless of the actual release or disclosure of that information.\textsuperscript{139} In 2019, the Vermont Supreme Court found that a patient could sue both the hospital and the employee for negligent disclosure of personal information to a third party.\textsuperscript{140} Entity liability may extend directly from noncompliance with provisions of EMTALA, HIPAA Privacy Rule, or multiple other federal or state legal requirements.

Governmental health entities may also face potential §1983 liability (noted above) for employees’ actions depriving individuals of constitutional rights. Municipalities are generally not liable for employees’ acts (for §1983 purposes\textsuperscript{141}) unless rights deprivations extend from formal municipal policies, widespread custom or practice, a conscious disregard of unconstitutional application of policy, or failure to train or supervise employees in a manner that amounts to deliberate indifference to constitutional rights of the public.\textsuperscript{142}

Similarly, ADA,\textsuperscript{143} federal Rehabilitation Act,\textsuperscript{144} and corresponding state laws prohibit public entities from discriminating against individuals with physical or mental disabilities through services or programs. ADA violations can occur through laws, policies, or programs in which discrimination is direct or indirect. Individuals with disabilities may require special accommodations. Failing to adequately account for the needs of vulnerable populations may result in liability for public entities and municipalities. Municipalities like New York City and Los Angeles County have been sued for failing to properly accommodate persons with disabilities in their emergency preparedness plans.

Discrimination concerns may also arise if HCWs or entities refuse to treat specific patients with certain conditions. In 1998, the U.S. Supreme Court determined that HIV infection was a disability under the ADA even in early, asymptomatic stages. Refusing to treat an HIV-positive patient may violate the ADA unless the condition poses a significant risk of infection to others under the circumstances, as determined by available medical and other objective evidence.\textsuperscript{145} Similar observations arise from ongoing efforts to successfully treat COVID-19 patients despite lack of efficacy of existing interventions pending further assessments.
**Liability Protections**

Despite multifarious risks of liability for HCWs, VHPs, and health care entities, there are also significant protections from liability during emergencies (illustrated in Figure 8 and summarized below). Federal and state legal protections include sovereign immunity for government actors, statutory protections for HCWs, emergency laws (e.g., based on MSEHPA and UEVHPA), interstate compacts (e.g., EMAC), and Good Samaritan Acts (GSAs). Together, these laws may immunize or indemnify persons or entities for acts of ordinary negligence (but not for gross negligence or willful, wanton, or criminal acts). In declared emergencies, additional protections are activated. Yet there is no universal protection to defend against all possible sources of liability, and no laws can fully prevent the filing of meritless claims.

**Figure 8: Liability Protections for Personnel & Entities**

<table>
<thead>
<tr>
<th>Sovereign Immunity</th>
<th>Statutory EMS Protections</th>
<th>Volunteer Protections</th>
<th>Good Samaritan Laws</th>
<th>PREP Act</th>
<th>Emergency Statutes</th>
<th>Mutual Aid Agreements, MOUs, and Compacts</th>
<th>Liability Insurance</th>
<th>Workers’ Compensation</th>
</tr>
</thead>
</table>

**Sovereign Immunity.** Legal principles of sovereign immunity protect many government entities and their personnel from civil liability related to official functions. In general, sovereign immunity protects a state (the “sovereign”) and its agencies from civil suits unless the state consents (usually via statutory law) to being sued. State “Tort Claims Acts” specify when state and local governments and their employees may be sued. These protections also extend to municipalities and their employees in some states. Employees who are held liable for acts in their official capacity may be indemnified by the state, meaning that the state assumes responsibility for expenses related to claims. Arizona’s Tort Claims Act broadly states that “public entities are granted absolute immunity for the exercise of a judicial, legislative, or discretionary function.” California’s Tort Claims Act affirms that “except as otherwise provided by statute, public entities are not liable for an injury, arising from an act or omission of the public entity or their employee.” In Utah, governmental entities and their employees are immune concerning all governmental functions “no matter how labelled, unless expressly waived in Act.” Personal liability of a government employee for negligent acts or omissions within the course and scope of employment is limited to $10,000 per claim.

Even in states where sovereign immunity applies, governmental entities are not always relieved of liability. In *Velazquez v. New York City Health and Hospital Corporation*, a court held that sovereign immunity did not bar a suit by a home attendant allegedly injured while attempting to prevent her client from falling down a stairwell due to the negligence of 2 municipal EMS workers. The court held that the attendant could recover from the municipality if she proved that the workers’ negligence endangered her client and that her injury resulted from an attempt to...
rescue the client from that danger. According to the court, when the practitioners undertook transportation of the client, they assumed a duty of reasonable care to her and the attendant.\textsuperscript{151}

**Statutory Protections & Limitations.** HCWs are often statutorily protected from civil liability in carrying out their duties at the scene of an emergency or during initial patient transport. Volunteer protection acts may also insulate personnel, but often apply only to volunteers associated with non-profit or governmental entities.\textsuperscript{152} Similar protections of the federal Volunteer Protection Act\textsuperscript{153} were further reflected in the federal Coronavirus Aid, Relief & Economic Security (CARES) Act concerning VHPs responding to COVID-19.\textsuperscript{154} Other state-based legal protections may explicitly immunize HCWs from liability during declared emergencies, as per Figure 9, below.

**Figure 9. WRAP-EM States Emergency Liability Protections**

All WRAP-EM states feature general or specific legal authorities to shield HCWs from legal liability during declared emergencies (see Appendix - Table 5). In Arizona, an emergency HCW engaging in emergency management activities is immune from claims except in cases of bad faith, willful misconduct, or gross negligence.\textsuperscript{155} Arizona HCWs are similarly “immune from civil liability for triage decisions” made in good faith and in reliance on COVID-19’s PHE declaration.\textsuperscript{156} In California, any physician or surgeon who renders services during an emergency is immune from liability unless harm was the result of a willful act or omission.\textsuperscript{157} A pending bill in California would immunize any HCW providing services “related to the COVID-19 pandemic” in good faith.\textsuperscript{158} Emergency responders in Nevada are not liable for acts or omissions in providing good-faith assistance.\textsuperscript{159} In Oregon, “registrants and volunteers who perform emergency health care services” are shielded from liability.\textsuperscript{160} HCPs are immune from liability during a PHE for good-faith efforts in Utah.\textsuperscript{161} Similarly, all privileges and immunities apply to out-of-state emergency responders acting in the state. Washington HCPs are not liable when responding to an emergency and “the procedures utilized for credentialing and granting practice privileges were substantially
consistent with the standards for granting emergency practice privileges adopted by the joint commission on the accreditation of health care organizations.¹¹⁸²

Governors may also be empowered to issue specific emergency executive orders or other legal requirements to extend liability protections for HCWs and entities for the duration of the declaration. In response to COVID-19, for example, Arizona Governor Ducey issued Executive Order No. 2020-27 on April 9, 2020, to immunize HCWs and facilities acting in good faith from civil liability claims.¹¹⁶³

**Good Samaritan Acts.** Many states’ GSAs protect persons who provide care at the scene of an emergency. New Hampshire explicitly includes the rendering of emergency care by *any person* at the scene of an emergency, or while in transit in an ambulance or other emergency vehicle.¹¹⁶⁴ Some states’ GSAs may only apply to persons responding to ad hoc emergencies or without a pre-existing duty to provide aid.¹¹⁶⁵ Courts may look to the legislative purpose in enacting such protections to determine how broadly to apply them.¹¹⁶⁶

**PREP Act.** In addition to a series of state law protections, HCWs and public and private entities may also be protected under the federal Public Readiness and Emergency Preparedness (PREP) Act.¹¹⁶⁷ During a federally declared emergency, the PREP Act provides significant liability protections with respect to the use of covered countermeasures defined by HHS’ Secretary. Covered countermeasures include pandemic and epidemic products, security countermeasures, and drugs, products, and devices approved under an EUA. Countermeasures may come initially from federally-owned caches (e.g., SNS) or from other public or private sources.¹¹⁶⁸ Protection under the PREP Act applies to all qualified persons (including institutional and governmental entities) who prescribe, administer, or dispense countermeasures and to officials, agents, and employees of these persons or entities.¹¹⁶⁹ In December 2014, for example, a PREP Act declaration was issued to provide liability protection related to 3 prospective vaccines for Ebola.¹¹⁷⁰ PREP Act liability protections are also widely invoked in response to COVID-19.¹¹⁷¹

**Workers’ Compensation.** Workers’ compensation is a government-administered system providing limited benefits to victims for work-related injuries or death, regardless of fault.¹¹⁷² Each state (and the federal government) has enacted workers’ compensation laws, which require work-related injuries to be reported and compensated in accordance with specific guidelines.¹¹⁷³ Every injury or death which occurs at work is subject to administration under workers’ compensation for covered employees, often including “occupational diseases” such as infectious diseases among HCWs. Generally, the employer is liable if the employee sustains an injury that arises out of or occurs in the course of employment. Injured employees typically file claims for limited reimbursement for direct costs of medical treatment, lost wages, and resulting disabilities. Most claims are paid via insurance coverage, although some large employers, including state governments, may be self-insured and administer their own claims.¹¹⁷⁴

Workers’ compensation is often the exclusive remedy for injured employees.¹¹⁷⁵ Direct lawsuits against employers outside the workers’ compensation system are largely forbidden.¹¹⁷⁶ Employers cannot generally settle workers’ compensation claims without advance approval of state workers’ compensation administrators. Other forms of health insurance including private insurance policies, Medicaid and Medicare, and automobile personal injury protection, may deny claims for medical charges where a workers’ compensation carrier is principally liable for these costs. Lost wages for time off work due to injury are compensable only where a claim is filed, and thus compensation for disabilities may only occur through filing a workers’ compensation claim.¹¹⁷⁷ Interstate agreements like EMAC (see Part I) may provide workers’ compensation protections for VHPs and emergency management workers.
Even if VHPs are covered through workers' compensation programs, benefits may still be elusive. Spontaneous or improperly registered VHPs may not be protected. In addition, the “employee” status of VHPs may not apply across state lines. Absence of workers’ compensation benefits poses a significant risk for workers who may face hazardous working conditions during emergencies. In emergencies like COVID-19, whether HCWs or VHPs may be covered depends to an extent on provisions related to occupational diseases, (i.e., diseases contracted during and resulting from employment). All states provide some form of coverage for occupational diseases under varying definitions. To receive compensation, however, states may also require: (1) the employment involve peculiar or unusual risks of the disease—beyond that of the general population; and (2) the disease must be attributable to a contact that occurred on the job. During a disease outbreak like COVID-19, it may be difficult to prove that a disease was contracted in the course of employment when the spread impacts the general population, especially when the burden of proof falls upon the worker. 

**Extending Workers’ Compensation**

Generally, workers’ compensation laws only cover “employees” and thus exclude unpaid volunteers or gratuitous workers. States may legislatively extend explicit coverage to VHPs, but otherwise these persons may be excluded from coverage. Each state’s law defines who are considered employees, often tied to direct payments (e.g., payroll or other significant form of compensation for services). Some courts have held that an emergency situation may create a presumption of employment through an implied contract for hire, but not typically when a VHP registers his or her willingness to offer services before the emergency situation arises. Conversely, some states explicitly cover VHPs under workers’ compensation provisions and assure compensation is rendered to members of civil preparedness forces (including MRCs).
VI. OTHER LEGAL ISSUES

Crisis Standards of Care. The concept of CSC refers to the substantial changes in typical healthcare operations and level of care that can occur during pervasive or catastrophic disasters. CSC was originally crafted by the National Academy of Medicine (NAM) in its 2009 report generated in the throes of the H1N1 pandemic, updated in 2012, and revisited in a 2019 workshop (just prior to the COVID-19 outbreak). NAM also responded in March 2020 to ASPR’s rapid request for guidance on salient issues for consideration related to medical triage decisions involving COVID-19 patients.\(^{180}\)

In all its guidance, NAM describes how the level of patient care in emergencies falls along a continuum from “conventional” to “contingency” to “crisis.”\(^{181}\) Conventional medical standards of care resonate professional norms and expectations. Although they are flexible depending on circumstances, they do not generally address the type of care provided in a PHE when resources are scarce and critical decisions must often be made.\(^{182}\) As illustrated in Figure 10, there are multiple facets, represented as pillars, critical to emergency responses in crises, including health care in hospitals and other settings, public health, EMS, and emergency management.

**Figure 10: CSC Systems Framework\(^{183}\)**

Shifting to CSC in declared emergencies requires a change in focus from individual to population needs. Under CSC, persons with the greatest needs tend to receive available care first until everyone requiring services can be assessed and initially treated.\(^{184}\) Tough decisions outside HCWs’ normal practices must be made. For example, during the COVID-19 pandemic, EMS workers were instructed in multiple states, including NY and NJ, to avoid CPR interventions for patients found at home whose heart rates flat lined as per EKGs performed on site.\(^{185}\) CSC implementation also requires coordination of public and private entities, as well as significant advance planning and engagement. All WRAP-EM states have crafted general CSC policies, and all (except Washington) have published COVID-19 specific CSC plans online.\(^{186}\) WRAP-EM colleagues have also crafted a model template related to pediatric CSC implementation in response to surges of COVID-19 patients (see Appendix 3).
Collectively, these plans address many areas, such as emergency management policies, community and stakeholder outreach, and ethical guidance. Sophisticated plans also entail modifications of public health laws, privacy laws, liability concerns, and other elements consistent with a systems framework approach. Assessing potential liability claims during crises is difficult (as noted in Part IV above) when the standards of care change in real-time. CSC decisions may be assessed under changing legal standards resulting in uncertainty over potential liability, necessitating specific liability protections.

One area of uncertainty regards HCPs’ responsibility to obtain patient consent prior to discharge. Some WRAP-EM states (e.g., CA, NV) clarify that such consent is unnecessary.187 Nevada regulations require that hospitals need only engage in discharge planning (and not consent) with inpatients,188 although specific hospitals may still seek consent in practice. Nevada’s legal requirements assimilate federal guidance regarding discharge which CMS temporarily waived during the COVID-19 PHE. Under the waivers, hospitals must ensure patients are discharged to appropriate settings with necessary medical information and goals, but no longer need to share information to help patients select post-acute care providers. CMS also waived the average length of stay requirement for long-term acute care hospitals, allowing them to discharge patients to meet emergency demands without losing their reimbursement status.189 Finally, concurrent with Nevada’s CSC guidance,190 CDC affirmed that COVID-19 patients can be discharged to their home or a separate facility when clinically indicated.191

CSC planning can also help mitigate potential controversial issues inherent in implementation. During the COVID-19 outbreak, numerous states’ CSC plans were criticized prior to or during implementation related to their potential impacts on persons with disabilities (as chronic conditions are a risk factor for survival) and unequal applications lending to care disparities in minorities, the elderly, or other vulnerable populations. HHS’ Office of Civil Rights opined in March 2020 that several states’ plans invoked unlawful, discriminatory criteria for making triage decisions. Several lawsuits also arose related to direct harms to prospective patients extending from anticipated CSC implementation.

Emergency Use Authorizations. PAHPRA significantly enhanced the authority of HHS and FDA to issue emergency use authorizations (EUAs) to allow use of otherwise non-approved tests, medications, or treatments. Prior to or during an HHS-declared PHE192 FDA can issue an EUA to allow emergency use of tests or drug products. EUAs were used during the 2009/2010 H1N1 pandemic, for example, to (1) allow unapproved uses of zanamivir (Relenza®) and oseltamivir (Tamiflu®) for treatment and prophylaxis of young children and hospitalized patients;193 and (2) use certain lots of antivirals beyond their expiration dates through a series of EUAs.194 During COVID-19, EUAs were heavily relied on to authorize use of an array of COVID infection and antibody tests, as well as experimental treatments. On May 1, 2020, FDA issued an EUA for the investigational antiviral drug remdesivir (Veklury®) for treating suspected or confirmed COVID-19 cases where symptoms are severe and require hospitalization.195 FDA also issued several EUAs for medical devices during COVID-19, including for personal respiratory protective equipment.196

EUAs permit the dispensing of products that are either (a) not yet approved for use or (b) approved but sought for an unapproved use.197 An EUA can help make available for a temporary period a specific product that might otherwise be off limits in non-emergencies. Prior to issuing an EUA, FDA’s Commissioner must conclude that:

1. a disease or other condition specified in the declaration poses a risk of serious or life-threatening disease or condition;
2. it is reasonable to believe that the drug or test may be effective in diagnosing, treating, or preventing the disease or condition;
3. known and potential benefits of use of the product outweigh the risks; and
4. no adequate, approved, and available alternative exists to address the disease or condition.198

Once issued, EUAs take effect nationally199 and may remain in effect for the duration of the emergency (up to 1 year unless revoked or renewed).200 FDA can also set conditions on activities carried out under an EUA to protect the public’s health. These include ensuring that HCWs and patients are informed of risks, benefits, and alternatives, and that adverse events are monitored by manufacturers, HCWs, or public health authorities.201

Through its expanded authority pursuant to PAHPRA,202 FDA can issue advance approval (prior to any declaration of emergency) if HHS determines that there is significant potential for a PHE involving a biological, chemical, radiological, or nuclear agent that affects (or has significant potential to affect) national security or the health and security of U.S. citizens abroad. FDA requirements on the distribution and administration of EUA-approved products cannot be more restrictive than conditions on the approved use of the medical product.203

Rights to Reemployment. In emergencies, various persons including VHPs or members of the National Guard or DMAT teams, may be called away from their employment to respond to requests by a hospital or other entity in another jurisdiction. They may seek assurance that their positions are retained when they return. Some states have enacted laws providing reemployment protection to individuals engaged in emergency response services. In addition, the federal government has adopted similar reemployment protections. For example, individuals who are members of federal governmental emergency response teams, such as a DMAT composed of civilian medical personnel, are given job, seniority, and wage protection in accordance with federal law when they are deployed for disaster response.204

The Uniformed Services Employment and Reemployment Rights Act (USERRA)205 provides reemployment protection to non-career members of uniformed services who are called up for duty and provide written notice to their employers. Employees are generally entitled to reemployment upon the termination of the uniformed service, unless doing so would impose an undue hardship on the employer or the employer’s circumstances have changed so much as to make reemployment impossible or unreasonable. USERRA also provides for protection from termination upon the return to work after uniformed service, as well as employees’ seniority rights and benefits during their period of absence. Essentially during an employee’s period of uniformed service, employers must treat employees as though the employees are on furlough or leave of absence.206

Some states also offer limited employment protections for practitioners responding to PHEs via Disaster Service Volunteer Leave Acts.207 These acts provide state employees who are disaster service volunteers with employment protection, subject to exceptions. In Rhode Island, state employees who are certified disaster volunteers of the American Red Cross may be granted up to 10 days of leave per year to provide services, without loss of any other allocated time off.208 Connecticut law similarly offers up to 15 days of leave for state employees volunteering as firefighters, with ambulance services, with the American Red Cross, or as part of search and rescue teams.209

Arizona, California, Nevada, Oregon, and Washington feature paid sick and safe leave for employees caring for themselves or ill family members. All WRAP-EM states have issued
additional guidance for employees using paid sick leave for COVID-19 related purposes. California Governor Gavin Newsom provided specified food industry workers impacted by the pandemic with 2 weeks of paid sick leave. Seattle’s City Council ordained paid sick and safe time for certain gig economy workers. Several California localities have issued additional emergency orders providing supplemental sick leave and emergency leave that exceeds state protections.

**Health Information Sharing & Privacy.** Planning, preventing, and responding to a potential or actual emergency event requires extensive coordination and information sharing among public health authorities, HCWs, and hospitals. HCWs and VHPs need identifiable data to provide clinical, therapeutic, or pharmaceutical care. Public health authorities (PHAs) (broadly defined via the HIPAA Privacy Rule to include governmental public health agencies and their contractual partners) gather identifiable data through epidemiologic or environmental investigations, surveillance, laboratory testing, and other activities.

In PHEs like COVID-19, options for exchanging non-identifiable data may be compromised in some cases. PHAs may not have sufficient time or resources to selectively de-identify some patient health information prior to its exchange. The use of non-identifiable health data may also lead to inaccuracies or duplications that may thwart prevention or response efforts. For example, PHAs may need to instantly and accurately verify the numbers of persons who may have contracted a contagious condition. Sharing identifiable health information facilitates these efforts and also offers opportunities for PHAs to efficiently help those in need or at risk. Federal, state, and local health information privacy requirements should be carefully considered in planning for emergencies to assess how they may address the practical need for uses and disclosures of identifiable information in emergency situations.

Among other laws, the protection of health information privacy in many settings is federally regulated primarily by the HIPAA Privacy Rule. It provides a national floor of privacy protections that treats all identifiable health data as private, and thus entitled to considerable protections and security assurance. Individuals cannot bring direct claims under the Privacy Rule, but violations are prosecuted by HHS’ OCR.

Although the Rule seeks to protect patient privacy, it also allows considerable exchanges of PHI without written authorization of patients or their guardians for legitimate public health purposes, especially during emergencies. Some provisions of the Rule may also be effectively waived temporarily during national emergencies, such as COVID-19. Considerable information about the application of the Rule to public health and research uses and disclosures of identifiable health data in routine events and during emergencies is available from CDC and HHS’ OCR.

Additional health information privacy protections may be found in state and local privacy laws and public health departmental (or other state agency) policies. These varied privacy and security provisions address the responsible acquisition, use, disclosure, and storage of identifiable health data by PHAs, HCPs, insurers, and others. Individual and communal interests in these health data are often weighed to protect the public’s health while respecting individual privacy.

**Dashboard Data Acquisition & Uses.** Federal and state health information privacy laws may impact the conduct of syndromic surveillance activities as well even if specific patient data are not collected. For example, during the COVID-19 pandemic, multiple states used emerging technologies to create real-time surveillance dashboards regarding available PPE and other essential resources. Relying on data from specific hospitals and other providers, these information
sources provided instant assessments of the availability of key resources as well as potential patient placements, facilitating the implementation of CSC. However, some corporate and other entities in the information chain raised privacy and other concerns about requested data. Proprietary interests, for example, may stymie the reporting of PPE supplies against the backdrop of potential CSC re-allocation strategies. As analyzed extensively in Appendix 4: Dashboard Data Acquisition & Uses During the COVID-19 Pandemic: Legal & Policy Issues, absent resolution, these issues can limit the flow of accurate syndromic or other non-identifiable data, inhibiting effective CSC responses.

**Family Reunification.** WRAP-EM’s reunification model policy provides a template for hospitals within WRAP-EM states hosting hospital reception sites for family reunification during mass disasters. In an emergency, hospitals may assist or directly facilitate reuniting separated families within and across states, including children and persons with specialized health needs. As per WRAP-EM’s model policy, hospitals must be prepared to verify people’s identities and the status of legal guardianship for unaccompanied children during reunification.

Implementing family reunification efforts in the wake of mass disasters or PHEs raises multiple legal and policy considerations affecting varied parties. These include liability risks and protections, accommodations for specific sociocultural and health demographics, and health information privacy concerns. Unique legal concerns also arise when children are involved in reunification efforts, including questions of custody and informed consent.

**Liability Risks and Protections.** Post-disaster treatment facilities, volunteers, and aid organizations involved in family reunification efforts may be exposed to liability for varied claims including civil, criminal, or constitutional violations; medical malpractice; discrimination related to resource allocation decisions; health information privacy breaches; or express violations of specific federal and state laws. Facilities that have inadequately planned for emergencies could face specific liability. For example, if a hospital lacks procedures to confirm legal guardianship of a child and discharges the child to someone without legal custody, legal consequences for the hospital could arise.

To protect against liability, persons and entities involved in family reunification through care and mobilization areas for victims and workers during a mass disaster should seek to meet legal requirements. Facility requirements for reunification centers may vary depending on the nature of the disaster. During a pandemic, hospitals should align with government officials to consider environmental controls and safety measures recommended by CDC, OSHA, EPA, or other federal or state agencies, and ensure the availability of certified personal protective equipment.

Despite risks of liability, an “umbrella” of legal protections may also be available, especially concerning VHPs, depending on the type of emergency declared and resulting waivers. As noted in Parts I, II, and IV, emergency declarations may (1) trigger suspensions, alterations, or waivers of statutory laws and regulations, (2) invoke state- or hospital-level disaster plans or mutual aid agreements, (3) expand practitioner scopes of practice, and (4) allow real-time allocation and mobilization of essential resources. Each of these shifts in the legal landscape affect liability risks, and potentially offer enhanced protections.

**Disabilities and other Accommodations.** Emergency responders should also be aware of legal considerations surrounding accommodations for those with specific medical needs or cultural backgrounds. Federal laws like the Stafford Act, Civil Rights Act of 1964, and the Rehabilitation Act of 1973, along with general equal protection concerns, may be implicated.
The Stafford Act provides financial assistance to those with “serious needs,” relaxes agency regulatory requirements to benefit those who are disadvantaged, and supports professional counseling services for at-risk workers and victims. The Post-Katrina Emergency Management Reform Act of 2006 mandates that disability coordinators be appointed and involved in disaster preparedness and relief efforts.

While the ADA does not explicitly address emergency preparedness and relief, resulting litigation resonates its relevance in disasters. For example, in a class action case in 2011, Communities Actively Living Independent and Free v. City of Los Angeles, a disability advocacy organization and disabled woman alleged that Los Angeles violated the ADA and the federal Rehabilitation Act, in addition to California law, by failing to properly accommodate persons with disabilities in their emergency plans. The City argued that its emergency preparedness plans could adapt ad hoc in a disaster and that it was not required under the ADA to formulate a plan until specifically requested by those with disabilities. The Department of Justice asserted that emergency preparedness accommodations for those with disabilities must be made in advance. Additionally, persons with disabilities should be involved in the planning process per Title II of the ADA. The court ruled against the City, finding that emergency planning falls under the ADA and Rehabilitation Act, and that those with disabilities had been excluded in the City’s plans for evacuation and temporary housing. In 2018, Arizona settled in a case alleging it had discriminated against the deaf and hard of hearing under the ADA and Rehabilitation Act when it failed to provide meaningful access to emergency services by forgoing a texting option for 911 resources.

Health Information Privacy. Family reunification efforts may also involve copious medical and personal information gathered and shared between various stakeholders, heightening concerns over privacy breaches under federal and state data protection laws (as discussed above in Part V). Requirements to assure the privacy of personal or medical records depend on the users and purposes of data acquisition and disclosure, as well as characteristics of the data subject (e.g., their age, condition, status). “Routine use” exceptions under the federal Privacy Act may allow sharing of personal information to facilitate family reunification efforts. Similarly, the HIPAA Privacy Rule stipulates that covered entities (including hospitals) may disclose health information “without patient consent in disaster situations.” During COVID-19, additional HIPAA Privacy Rule requirements were temporarily waived by HHS to allow for greater data exchanges in the interests of public health. Oregon state law requires that health benefit plans cover telemedicine services for those affected during emergencies, whether privacy and security standards are met.

Custody. Legal questions of child custody may implicate family reunification efforts involving minors. Where a parent has previously lost custody of a child, it may be difficult to track such information in disasters. To avoid inappropriate reunifications, hospitals should check the identity of the alleged guardian and verify his or her legal custody interests of the child. Legal custody may be determined through inquiries and coordinated efforts among several entities, including “child welfare agencies, law enforcement, and the judicial system.”

In emergencies, prior custody arrangements for children may not generally be displaced. For example, during the COVID-19 pandemic, the Arizona Administrative Office of the Courts issued custody guidelines stating that guardians should “follow . . . existing parenting plan[s] as closely as possible,” though “the Court remains available to hear essential matters, including entering new orders in emergency situations.” Likewise, the Judicial Branch of California stated “generally, child custody and visitation . . . orders must be followed.” Mutually agreed upon minor changes to a parenting plan may be made, but any substantive changes to extend beyond
exigencies must be approved by a judge. Oregon’s Statewide Family Law Advisory Committee similarly advised that parenting plans should be followed “as closely as possible.” Multiple Oregon courts formally adopted these measures. Washington Governor Jay Inslee clarified that public health orders, including stay-at-home orders, were not meant to “prevent compliance with private parenting plans.” Generally, whenever legal custody pre-disaster is established, the child may be released to that individual lawfully entitled to custody.

As per reunification guidance issued by FEMA, if disputes occur between individuals with joint legal custody, the hospital should release the child to the parent with primary physical custody. If issues of joint custody cannot be confirmed by the hospital, law enforcement and child services may become involved. Concerning children located in states where they do not usually reside, their state of primary residence should be contacted to coordinate reunification efforts. Increased concerns of human trafficking, specifically of women and children, during and after emergencies may support additional procedural measures and protections governing the release of minors to alleged guardians through reunification.

If a legal guardian cannot be located, or if a located guardian is limited (e.g., incapacitated) or in a position that could harm the child (e.g., experiencing homelessness or severe mental health issues), hospitals should not automatically release the child into an unauthorized person’s custody. Rather, they should contact law enforcement, child services, and other relevant agencies to coordinate appropriate next steps in the child’s best interests. Hospitals may also consider the psychological repercussions of a disaster on children and whether alleged guardians can properly care for the child under the circumstances. Scrutiny may be heightened for “children with disabilities, children with special health care needs, youth involved in juvenile justice systems, and to families otherwise in distress.”

Informed Consent. When children have been separated from their legal guardians during mass disasters, issues of informed consent to medical procedures, including vaccinations, testing, and treatment, can be complicated. If there is an immediate threat to a child’s life during a disaster necessitating treatment, informed consent of a guardian may be waived. For example, California law states that in emergency situations, such as an unconscious individual in need of life-saving surgery, “consent is implied.” However, legal obligations to acquire informed consent are tenuous when injuries are less severe, involve only psychological harms, or when care may be provided in a non-traditional facility. States like Arizona and California specifically carve out special exceptions for telehealth and telemedicine during emergencies. In Arizona, a parent’s consent for mental health treatment and screening of a minor through telemedicine may be waived if necessary to “prevent serious injury or loss of life.” In California, eligibility for the Medi-Cal Minor Consent program can be assessed remotely, enabling approved minors (ages 12 and older) to consent to mental health care without a parent’s permission. Furthermore, in the case, In re S.P., a California court of appeal found that a state public health officer or designated doctor could override a vaccine exemption for a minor under certain circumstances to protect public health. Though reunification efforts often occur during declared emergencies, certain disaster events may require prolonged involvement in the care of unaccompanied minors, justifying vaccination overrides in California. Reunification efforts may allow state actions taken in the best interests of unaccompanied children and others unable to protect or care for themselves.

Legal issues underlying hospital family reunification efforts during and after mass disasters are resolvable. Emergency declarations lend to specific waivers of existing legal standards and invoke special protections and entitlements for persons at risk of harm, especially minors and persons with disabilities. Proactive efforts to assess and resolve potential legal issues involved in family reunifications can help avoid further legal controversies that may arise during exigencies.
Table 1: Emergency Declaration Authorities
(as of July 1, 2021)

This table provides state statutory/regulatory authorities for emergency declarations in all WRAP-EM states, as categorized in columns I & II:

I. **Emergency/Disaster** cites legal authorities for state declarations of “emergency,” “disaster,” and similar terms, as well as specific information on personnel responsible for issuing declarations.¹

II. **Public Health Emergency** cites legal authorities for specific declarations of a PHE based in part on the MSEHPA,² or other statutory bases for emergency/disaster declarations premised on public health concerns, as well as specific information on personnel responsible for issuing declarations.

<table>
<thead>
<tr>
<th>State</th>
<th>I. Emergency/Disaster</th>
<th>II. Public Health Emergency</th>
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<tbody>
<tr>
<td>AZ</td>
<td>The governor may proclaim a state of emergency, which shall take effect immediately in an area affected or likely to be affected if the governor finds that circumstances described in section 26-301, paragraph 15 exist. (ARIZ. REV. STAT. ANN. § 26-303(D), amended by S.B. 1382, 55th Leg., 1st Reg. Sess. (Ariz. 2021)) The governor may declare an emergency arising from major disasters as provided in this section and incur liabilities therefor, regardless of whether or not the legislature is in session. (ARIZ. REV. STAT. ANN. § 35-192(A))</td>
<td>During a state of emergency or state of war emergency proclaimed by the governor in which there is an occurrence or imminent threat of an illness or health condition . . . the department shall coordinate all matters pertaining to the public health emergency response of the state. (ARIZ. REV. STAT. ANN. § 36-787(A), amended by H.B. 2570, 55th Leg., 1st Reg. Sess. (Ariz. 2021)) Beginning January 2, 2023, the governor may issue an initial proclamation with respect to a state of emergency for a public health emergency as described in section 36-787 for a period of not more than thirty days. The governor may extend the state of emergency for not more than one hundred twenty days, but any extension may not be for a period of more than thirty days. The state of emergency shall terminate after one hundred twenty days, unless the state of emergency is extended, in whole or in part, by passage of a concurrent resolution of the legislature. The</td>
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¹ The terms “emergency,” “disaster,” “emergency declaration,” “disaster declaration,” “catastrophe” and “emergency proclamation” were used to find these and other emergency declarations potentially affecting the public’s health.

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<tr>
<th>State</th>
<th>I. Emergency/Disaster</th>
<th>II. Public Health Emergency</th>
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<td>legislature may extend the state of emergency as many times as necessary by concurrent resolution, but any extension may not be for a period of more than thirty days. If a state of emergency for a public health emergency is not extended pursuant to this subsection, the governor may not proclaim a new state of emergency based on the same conditions without the passage of a concurrent resolution by the legislature consenting to the new state of emergency. ([ARIZ. REV. STAT. ANN. § 26-303(G), amended by S.B. 1819, 55th Leg., 1st Reg. Sess. (Ariz. 2021)).</td>
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<tr>
<td>CA</td>
<td>The Governor is hereby empowered to proclaim a state of emergency in an area affected or likely to be affected thereby when: (a) He finds that circumstances described in subdivision (b) of Section 8558 exist; and either (b) He is requested to do so (1) in the case of a city by the mayor or chief executive, (2) in the case of a county by the chairman of the board of supervisors or the county administrative officer; or (c) He finds that local authority is inadequate to cope with the emergency. ([CAL. GOV'T CODE § 8625])</td>
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<td>“State of emergency” means the duly proclaimed existence of conditions of disaster or of extreme peril to the safety of persons and property within the state caused by [various] conditions. ([CAL. GOV'T CODE § 8558(b)])</td>
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<td>In times of extraordinary stress and of disaster, resulting from storms, floods, fire, or other calamitous events the director [of the Department of General Services] may declare the existence of an emergency … to protect the health, safety, convenience, and welfare of the general public of the state. ([CAL. GOV'T CODE § 14970])</td>
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<tr>
<td>NV</td>
<td>The provisions of this section are operative only during the existence of a state of emergency or declaration of disaster. The existence of such an emergency or disaster may be proclaimed by the Governor or by resolution of the Legislature if the Governor in his or her proclamation, or the Legislature in its resolution, finds that … the safety and welfare of the inhabitants of this State require an</td>
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<td>Upon receiving a report pursuant to subsection 1, the Governor shall determine whether a public health emergency or other health event exists that requires a coordinated response for the health and safety of the public. If the Governor determines that a public health emergency or other health event exists that requires such a coordinated response, the Governor shall issue an executive order. ([NEV. REV. STAT. § 439.970(2)])</td>
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<tr>
<td>State</td>
<td>I. Emergency/Disaster</td>
<td>II. Public Health Emergency</td>
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<td>OR</td>
<td>The Governor may declare a state of emergency by proclamation at the request of a county governing body or after determining that an emergency has occurred or is imminent. (OR. REV. STAT. § 401.165) “Emergency” means a human created or natural event or circumstance that causes or threatens widespread loss of life, injury to person or property, human suffering or financial loss. (OR. REV. STAT. § 401.025) As used in this Article, “catastrophic disaster” means a natural or human-caused event that: (a) Results in extraordinary levels of death, injury, property damage or disruption of daily life in this state: and (b) Severely affects the population, infrastructure, environment, economy or government functioning of this state. The Governor may invoke the provisions of this Article if the Governor finds and declares that a catastrophic disaster has occurred. (OR. CONST. ART. X-A, § 1) Upon the occurrence of a public health emergency, the Governor may declare a state of public health emergency as authorized by ORS 433.441 [(Proclamation of public health emergency)] to 433.452 [(Detaining persons exposed to reportable condition or condition that is basis for state of public health emergency)] to protect the public health. (OR. REV. STAT. § 433.441(1))</td>
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<tr>
<td>State</td>
<td>I. Emergency/Disaster</td>
<td>II. Public Health Emergency</td>
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<tr>
<td>UT</td>
<td>A state of emergency may be declared by executive order of the governor if the governor finds a disaster has occurred or the occurrence or threat of a disaster is imminent in any area of the state in which state government assistance is required to supplement the response and recovery efforts of the affected political subdivision or political subdivisions. (UTAH CODE ANN. § 53-2a-206(1))</td>
<td>“Public health emergency” means an occurrence or imminent credible threat of an illness or health condition, caused by bioterrorism, epidemic or pandemic disease, or novel and highly fatal infectious agent or biological toxin, that poses a substantial risk of a significant number of human fatalities or incidents of permanent or long-term disability. Such illness or health condition includes an illness or health condition resulting from a natural disaster. (UTAH CODE ANN. § 26-23b-102(9))</td>
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<tr>
<td>WA</td>
<td>The governor may, after finding that a public disorder, disaster, energy emergency, or riot exists within this state or any part thereof which affects life, health, property, or the public peace, proclaim a state of emergency in the area affected. (WASH. REV. CODE ANN. § 43-06-010(12))</td>
<td>The secretary [of the Department of Health] or his or her designee or the local health officer may declare a public health emergency. (WASH. REV. CODE § 70A-125-030)</td>
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</table>
Table 2: Licensure Reciprocity For HCWs in Emergencies  
(as of July 1, 2021)

This table provides state statutory/regulatory authorities allowing for licensure reciprocity of HCWs for emergency purposes (see Table 1 for more information re: declarations and Table 4 for more information re: licensure related to telehealth or telemedicine) as categorized in columns I & II:

I. **Routine Licensure Reciprocity** cites legal authorities and explanations of potential licensure reciprocity for HCWs outside of formal emergency declarations.

II. **Emergency Licensure Reciprocity** cites legal authorities and explanations of potential licensure reciprocity for HCWs in declared emergencies.

<table>
<thead>
<tr>
<th>State</th>
<th>I. Routine Licensure Reciprocity</th>
<th>II. Emergency Licensure Reciprocity</th>
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<tbody>
<tr>
<td>AZ</td>
<td>An occupational or professional license or certificate shall be issued. . . to a person who establishes residence in this state or without an examination to a person who is married to an active duty member of the armed forces of the United States and who is accompanying the member to an official permanent change of station to a military installation located in this state if all of the following apply: 1. The person is currently licensed or certified in at least one other state in the discipline applied for and at the same practice level as determined by the regulating entity and the license or certification is in good standing in all states in which the person holds a license or certification. 2. The person has been licensed or certified by another state for at least one year… (plus 7 additional listed criteria). (ARIZ. REV. STAT. ANN. § 32-4302)</td>
<td>During a state of emergency or state of war emergency declared by the governor in which there is an occurrence or imminent threat of an illness or health condition caused by bioterrorism, an epidemic or pandemic disease or a highly fatal infectious agent or biological toxin and that poses a substantial risk of a significant number of human fatalities or incidents of permanent or long-term disability, the [Arizona Department of Health Services] shall coordinate all matters pertaining to the public health emergency response of the state. [It] has primary jurisdiction, responsibility and authority for. . . granting temporary waivers of health care institution licensure requirements necessary for implementation of any measures required to adequately address the state of emergency or state of war emergency. (ARIZ. REV. STAT. § 36-787) A pharmacist who is not licensed in this state, but who is currently licensed in another state, may dispense prescription medications in those affected counties, cities or towns in this state during the time that a declared state of emergency exists pursuant to this section if both of the following apply: (1) The pharmacist has proof of licensure in another state [and] (2) The pharmacist is engaged in a legitimate relief effort during the period of time an emergency has been declared pursuant to this section. (ARIZ. REV. STAT. ANN. § 32-1910(E))</td>
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<td></td>
<td>Adopted Interstate Medical Licensure Compact (ARIZ. REV. STAT. ANN. § 32-3241)</td>
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<td>State</td>
<td>I. Routine Licensure Reciprocity</td>
<td>II. Emergency Licensure Reciprocity</td>
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<td>CA</td>
<td>The [medical] board shall issue a physician's and surgeon's certificate to an applicant who... holds an unlimited license as a physician and surgeon in another state or states, or in a Canadian province or Canadian provinces...&lt;br&gt;Upon review and recommendation, the board may determine that an applicant for a physician's and surgeon's certificate has satisfied the medical education requirements of Sections 2084 and 2135 and the examination requirements of Section 2170 if the applicant... holds an unlimited and unrestricted license as a physician and surgeon in another state and has held that license continuously for a minimum of four years prior to the date of application... meets the postgraduate training requirements in Section 2096 and is certified by a specialty board that is a member board of the American Board of Medical Specialties... is not subject to denial of licensure. ... has not been the subject of a disciplinary action by a medical licensing authority or of an adverse judgment or settlement resulting from the practice of medicine that, as determined by the board, constitutes a pattern of negligence or incompetence. (CAL. BUS. &amp; PROF. CODE § 2135, 2135.5)&lt;br&gt;No status on adopting Interstate Medical Licensure Compact.</td>
<td>Whenever any person holds a license, certificate, or other permit issued by any state party to [EMAC] evidencing the meeting of qualifications for professional, mechanical, or other skills, and when such assistance is requested by the receiving party state, such person shall be deemed licensed, certified, or permitted by the state requesting assistance to render aid involving such skill to meet a declared emergency or disaster, subject to such limitations and conditions as the governor of the requesting state may prescribe by executive order or otherwise. (CAL. GOV'T CODE § 179.5)&lt;br&gt;Any out-of-state personnel, including, but not limited to, medical personnel, entering California to assist in preparation for, responding to, mitigating the effects of, and recovering from COVID-19 shall be permitted to provide services in the same manner as prescribed in Government Code 179.5, with respect to licensing and certification. Permission for any such individual rendering service is subject to the approval of the Director of the Emergency Medical Services Authority for medical personnel and the Director of the officer of Emergency Services for non-medical personnel and shall be in effect for a period of time not to exceed the duration of this emergency. (Gavin Newsom, Proclamation of a State of Emergency (Mar. 4, 2020))</td>
</tr>
<tr>
<td>NV</td>
<td>The [medical] Board shall, except for good cause, issue a license by endorsement to practice medicine to an applicant who has been issued a license to practice medicine by [D.C.] or any [U.S.] state or territory... if: &lt;br&gt;(a) At the time the applicant files his application with the Board, the license is in effect;  &lt;br&gt;(b) The applicant:  &lt;br&gt;(1) Submits to the Board proof of passage of an examination approved by the Board;  &lt;br&gt;(2) Submits to the Board any documentation and other proof of qualifications required by the Board;  &lt;br&gt;(3) Meets all statutory requirements to obtain a license to practice medicine in this State except that the applicant is not required to meet the requirements set forth in NRS 630.160.  &lt;br&gt;(4) Completes any additional requirements relating to the fitness of the</td>
<td>During the period when a state of emergency or declaration of disaster exists or continues, the Governor may... authorize providers of emergency medical services and providers of mental health services who are not licensed, certified or registered, as applicable, in this State but hold a license, certificate, registration or similar credential in good standing in another state, [D.C., P.R.,] or any territory or insular possession subject to the jurisdiction of the United States to practice their profession within their scope of practice as if they were licensed, certified or registered, as applicable, in this State for the amount of time necessary to assist in responding to the emergency or disaster. (NEV. REV. STAT. ANN. § 414.070)&lt;br&gt;[While an emergency declaration is in effect, a volunteer health practitioner who is registered or provisionally registered with a registration system that complies with NRS 415A.210 and who is licensed and in good standing in the state upon which the practitioner’s registration or provisional registration is based may practice in this State to the extent authorized by this chapter, as though the</td>
</tr>
<tr>
<td>State</td>
<td>I. Routine Licensure Reciprocity</td>
<td>II. Emergency Licensure Reciprocity</td>
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<td>applicant to practice required by the Board; and (c) Any documentation and other proof of qualifications required by the Board is authenticated in a manner approved by the Board. (NEV. REV. STAT. ANN. § 630.1605)</td>
<td>The waiver and exemption of professional licensing requirements shall apply to qualified providers of medical services during this declared emergency who currently hold a valid license in good standing in another state, providers of medical services whose licenses currently stand suspended for licensing fee delinquencies, providers of medical services whose licenses currently stand suspended for failure to meet continuing medical education requirements, and providers of medical services who have retired from their practice in any state with their license in good standing. (Steve Sisolak, Declaration of Emergency, Directive 011 (Mar. 12, 2020))</td>
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<tr>
<td>OR</td>
<td>A physician, other than a podiatric physician and surgeon, who lawfully has been issued a license to practice in another state or territory (or D.C.), the qualifications and licensing examinations of which are substantially similar to those of the State of Oregon, may be licensed by the Oregon Medical Board to practice medicine in this state without taking an examination, except when an examination is required under subsection (3) or (4) of this section [stating that a person who completing a licensing examination 10+ years ago, or who has ceased the practice of medicine for 12 or more consecutive months, may be required by the board to take an examination, and that a person who volunteers at a health clinic and whose application is based on a license issued in another state or territory may be required by the Oregon Medical Board to take a national licensing examination if the person has ceased the practice of medicine for 24 or more consecutive months immediately prior to filing the application.] (OR. REV. STAT. ANN. § 677.120)</td>
<td>In the event of an emergency declared by the Governor of Oregon, the Oregon Medical Board may allow Emeritus and Locum Tenens physicians and/or physician assistants to provide medical care in Oregon under special provisions, subject to such limitations and conditions as the Governor may prescribe. In the event of an emergency declared by the Governor of Oregon, the Oregon Medical Board may allow Administrative Medicine, Inactive, Lapsed, and Retired physicians and/or physician assistants to reactivate to Active status in Oregon under special provisions, subject to such limitations and conditions as the Governor may prescribe. During a state of emergency declared under ORS 401.165 or a state of public health emergency proclaimed under ORS 433.441, a health care provider who is licensed, certified or otherwise authorized or permitted by the laws of another state to administer health care services and who is registered under ORS 401.654 may administer health care services in this state as if the health care provider were licensed in this state. (OR. REV. STAT. ANN. § 401.655)</td>
</tr>
<tr>
<td>UT</td>
<td>An applicant for licensure as a physician and surgeon by endorsement who is currently licensed to practice medicine in any state other</td>
<td>Upon the declaration of a national, state, or local emergency, a public health emergency as defined in Section 26-23b-102, or a declaration by the president of</td>
</tr>
<tr>
<td>State</td>
<td>I. Routine Licensure Reciprocity</td>
<td>II. Emergency Licensure Reciprocity</td>
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<td>than Utah, a district or territory of the United States, or Canada shall: (a) be currently licensed with a full unrestricted license in good standing in any state, district, or territory of the United States, or Canada; (b) have been actively engaged in the legal practice of medicine in any state, district, or territory of the United States, or Canada for not less than 6,000 hours during the five years immediately preceding the date of application for licensure in Utah (plus additional qualifications…) (UTAH CODE ANN. § 58-67-302(2))</td>
<td>the United States or other federal official requesting public health-related activities, the Division [of Occupational and Professional Licensing] may in collaboration with the relevant board: (a) suspend the requirements for permanent or temporary licensure of individuals who are licensed in another state for the duration of the emergency while engaged in the scope of practice for which they are licensed in the other state; (b) modify… the scope of practice restrictions under this title for individuals who are licensed under this title as (a physician, a nurse, a certified nurse midwife, a pharmacist, pharmacy technician, or pharmacy intern, a respiratory therapist, a dentist and dental hygienist or a physician assistant). (UTAH CODE ANN. § 58-1-307)</td>
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<td>An individual who is licensed in good standing as a physician in another state with no licensing action pending and no less than 10 years of professional experience may engage in the practice of medicine without being licensed if: the services are rendered as a public service and for a noncommercial purpose, no fee is charged, received, or expected for the services rendered beyond the amount necessary to cover the cost of malpractice insurance, and the individual does not engage in unlawful or unprofessional conduct. (UTAH CODE ANN. § 58-67-305(7))</td>
<td>(1) The following persons may provide emergency medical services to a patient without being licensed under this chapter: (a) out-of-state emergency medical service personnel and providers in time of disaster. (UTAH CODE ANN. § 26-8a-308)</td>
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<td>Adopted Interstate Medical Licensure Compact (UTAH CODE ANN. § 58-67b-101)</td>
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<td>WA Any applicant who meets the requirements of RCW 18.71.050 and has been licensed under the laws of another state, territory, or possession of the United States, or of any province of Canada, or an applicant who has satisfactorily passed examinations given by the national board of medical examiners may, in the discretion of the commission, be granted a license without examination on the payment of the fees required by this chapter: PROVIDED, That the applicant must file with the commission a copy of the license certified by the proper authorities of the issuing state to be a full, true copy thereof, and must show that the standards, eligibility requirements, and examinations of that state are at least equal in all respects to those of this state. (WASH. REV. CODE ANN. § 18.71.090)</td>
<td>(1) While an emergency declaration is in effect, a volunteer health practitioner, registered with a registration system that complies with RCW 70.15.040 and licensed and in good standing in the state upon which the practitioner's registration is based, may practice in this state to the extent authorized by this chapter as if the practitioner were licensed in this state. (2) A volunteer health practitioner qualified under subsection (1) of this section is not entitled to the protections of this chapter if the practitioner is licensed in more than one state and any license of the practitioner is suspended, revoked, or subject to an agency order limiting or restricting practice privileges, or has been voluntarily terminated under threat of sanction. (WASH. REV. CODE ANN. § 70.15.050)</td>
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<tr>
<td>Adopted Interstate Medical Licensure Compact (WASH. REV. CODE ANN. § 18.71B.010)</td>
<td>Governor Inslee issued Proclamation 20-32 on March 26, 2020 “to waive and suspend specified statutes that prevent, hinder or delay necessary action to prevent a shortage of licensed health care providers.”</td>
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</table>
# Table 3: Emergency Waiver Authorities
(as of July 1, 2021)

This table provides state statutory/regulatory authorities allowing for temporary waivers of existing statutory, regulatory, or judicial laws or policies impacting health care services or public health or safety during declared emergency as categorized in columns I & II:

I. **General Waiver Authority** cites legal authorities and explanations of general authorities to waiver laws during declared emergencies (see Table 1 for more information re: declarations).

II. **Specific Waiver Authority** cites legal authorities and explanations of specific authorities to waiver laws during declared emergencies.

<table>
<thead>
<tr>
<th>State</th>
<th>I. General Waiver Authority</th>
<th>II. Specific Waiver Authority</th>
</tr>
</thead>
</table>
| AZ    | A. During a state of war emergency, the governor may: (1) Suspend the provisions of any statute prescribing the procedure for conduct of state business, or the orders or rules of any state agency, if the governor determines and declares that strict compliance with the provisions of any such state, order or rule would in any way prevent, hinder or delay mitigation of the effects of the emergency.  
E. During a state of emergency: (1) The governor shall have complete authority over all agencies of the state government and the right to exercise, within the area designated, all police power vested in the state by the constitution and laws of this state in order to effectuate the purposes of this chapter. (ARIZ. REV. STAT. ANN. § 26-303(A)(1),(E)(1))  
A. State agencies when designated by the governor, and counties, cities and towns may make, amend and rescind orders, rules and regulations necessary for emergency functions but such shall not be inconsistent with orders, rules and regulations promulgated by the governor.  
B. Existing laws, ordinances, orders, rules and regulations in conflict with this chapter or orders, rules or regulations issued under the authority of this chapter. | During a state of emergency … declared by the governor in which there is an occurrence of an illness or health condition … the department shall coordinate all matters pertaining to the public health emergency response of the state. The department has jurisdiction, responsibility, and authority for:  
(6) Establishing, in conjunction with applicable professional licensing boards, a process for temporary waiver of the professional licensure requirements necessary for the implementation of any measures required to adequately address the state of emergency or state of war emergency.  
(7) Granting temporary waivers of health care institution licensure requirements necessary for implementation of any measures required to adequately address the state of emergency or state of war emergency. (ARIZ. REV. STAT. ANN. § 36-787(A)(6-7)) |
<table>
<thead>
<tr>
<th>State</th>
<th>I. General Waiver Authority</th>
<th>II. Specific Waiver Authority</th>
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<tr>
<td>CA</td>
<td>The Governor may make, amend, and rescind orders and regulations necessary to carry out the provisions of this chapter. (CAL. GOV. CODE. § 8567 (a))</td>
<td>(a) The governor may make, amend, or rescind orders and regulations during a state of emergency that temporarily suspend any state, county, city, or special district statute, ordinance, regulation, or rule imposing nonsafety related restrictions on the delivery of food products, pharmaceuticals, and other emergency necessities distributed through retail or institutional channels, including, but not limited to, hospitals, jails, restaurants, and schools. (CAL. GOV. CODE. § 8627.5 (a))</td>
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<td>During a state of war emergency or a state of emergency the Governor may suspend any regulatory statute or statute prescribing the procedure for conduct of state business, or the orders, rules, or regulations of any state agency … where the Governor determines and declares that strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder or delay the mitigation of the effects of the emergency. (CAL. GOV. CODE. § 8571)</td>
<td>(a) Whenever the Governor has proclaimed a state of emergency and the President has declared an emergency or a major disaster to exist in this state, the Governor may . . . temporarily suspend or modify for not to exceed 60 days any public health, safety, zoning, or intrastate transportation law, ordinance, or regulation when by proclamation he or she declares the suspension or modification essential to provide temporary housing for disaster victims. (CAL. GOV'T CODE ANN. § 8654(a)(3))</td>
</tr>
<tr>
<td>NV</td>
<td>In performing his or her duties under this chapter and to effect its policy and purpose, the Governor may: (a) Make, amend and rescind the necessary orders and regulations to carry out the provisions of this chapter within the limits of the authority conferred upon the Governor in this chapter, with due consideration of the plans provided by the Federal Government. (NEV. REV. STAT. ANN. § 414.060(3)(a))</td>
<td>The Administrator [of the Employment Security Division] may . . . suspend, modify, amend or waive any requirement of [§ 612] for the duration of a state of emergency or declaration of disaster proclaimed pursuant to NRS 414.070 and for any additional period of time during which the emergency or disaster directly affects the requirement of [§ 612] if the Administrator determines the action is in the best interest of the . . . general health, safety and welfare of the citizens of this State. (NEV. REV. STAT. ANN. § 612.220(5))</td>
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<td>OR</td>
<td>During a state of emergency, the Governor has authority to suspend provisions of any order or rule of any state agency, if the Governor determines and declares that strict compliance with the provisions of the order or rule would in any way prevent, hinder, or delay mitigation of the effects of the emergency. (OR. REV. STAT. ANN. § 401.168(2))</td>
<td>If the Governor by proclamation has declared a state of emergency under ORS 401.165, the Governor may waive the one-week waiting period required by ORS 657.155 for persons making a claim for unemployment benefits who reside within the geographical area subject to the proclamation and specified by the Governor. (OR. REV. STAT. ANN. § 401.186)</td>
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<tr>
<td>State</td>
<td>I. General Waiver Authority</td>
<td>II. Specific Waiver Authority</td>
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<tr>
<td>UT</td>
<td>The governor may suspend the provisions of any order, rule, or regulation of any state agency, if the strict compliance with the provisions of the order, rule or regulation would substantially prevent, hinder, or delay necessary action in coping with the emergency or disaster. (UTAH CODE ANN. § 53-2a-209(3))</td>
<td>[The governor may] temporarily suspend or modify by executive order, during the state of emergency, any public health, safety, zoning, transportation, or other requirement or a statute or administrative rule within this state if such action is essential to provide temporary housing[.] (UTAH CODE ANN. § 53-2a-204(1)(j))</td>
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<tr>
<td>WA</td>
<td>The governor after proclaiming a state of emergency and prior to terminating such may, in the area described by the proclamation, issue an order or orders concerning waiver of suspension of statutory obligations or limitations in the following areas: (g) Such other statutory and regulatory obligations or limitations prescribing the procedures for such conduct of state business, or the orders, rules, or regulations of any state agency if strict compliance with the provision of any statute, order, rule, or regulation would in any way prevent, hinder, or delay necessary action in coping with the emergency unless (i) authority to waive or suspend a specific statutory or regulatory obligation or limitation has been expressly granted to another statewide elected official, (ii) the waiver or suspension would conflict with federal requirements that are a prescribed condition to the allocation of federal funds to the state, or (iii) the waiver or suspension would conflict with the rights, under the First Amendment, of freedom of speech or of the people to peaceably assemble. (WASH. REV. CODE ANN. § 43.06.220(2)(g))</td>
<td>The governor after proclaiming a state of emergency and prior to terminating such may, in the area described by the proclamation, issue an order or orders concerning waiver or suspension of statutory obligations or limitations in the following areas: (a) Liability for participation in interlocal agreements; (b) Inspection fees owed to the department of labor and industries; (c) Application of the family emergency assistance program (d) Regulations, tariffs, and notice requirements under the jurisdiction of the utilities and transportation commission; (e) Application of tax due dates and penalties related to the collection of taxes. (f) Permits for industrial, business, or medical uses of alcohol. (WASH. REV. CODE ANN. § 43.06.220(2)(a-f))</td>
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</tbody>
</table>
# Table 4: Telehealth & Telemedicine Legislation or Bills (as of July 1, 2021)

This table provides state legislative updates from February 1, 2020 – July 1, 2021, related to telehealth & telemedicine operations across WRAP-EM states, as categorized in columns I & II:

I. **General Telehealth/Medicine Provisions** summarizes legislative bills or enactments relating generally to telehealth or telemedicine;  
II. **Mental Health Specific Telehealth/Medicine Provisions** summarizes legislative bills or enactments relating to telehealth/medicine involving mental health care.

<table>
<thead>
<tr>
<th>State</th>
<th>I. General Provisions</th>
<th>II. Mental Health Specific Provisions</th>
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</thead>
</table>
| AZ    | Telehealth is the "use of audio, video or other electronic media . . . for the practice of health care, assessment, diagnosis, consultation or treatment and the transfer of medical data." (ARIZ. REV. STAT. ANN. § 36-3601(4)(a))  
A health care provider determines whether the healthcare service is provided in-person or via telehealth. (ARIZ. REV. STAT. ANN. § 36-3605)  
"Telehealth services may be provided and shall be covered regardless of where the enrollee is located or the type of site." (ARIZ. REV. STAT. ANN. § 20-1057.13(A)(7))  
A health care provider who is not licensed in Arizona may provide telehealth services to a person within AZ if the provider holds a current license to practice in another state, acts in compliance with AZ laws and rules, maintains liability insurance, consents to AZ’s jurisdiction for litigation from providing telehealth, and follows the states community care standard. (ARIZ. REV. STAT. ANN. § 36-3606(A))  
A provider who is authorized to write, dispense, or administer prescription drugs and devices is not required to provide an in-person examination of the patient before issuing a prescription unless | A mental health screening or treatment of a minor may not be performed without first obtaining written consent from the parent or legal guardian of the minor unless an emergency exists that requires mental health treatment or screening on the minor to prevent serious injury or loss of life. (ARIZ. REV. STAT. ANN. § 36-2272)  
Corporations, health care service organizations, and disability insurers “shall reimburse health care providers at the same level of payment for equivalent in-person behavioral health and substance use disorder services . . . if provided through telehealth using an audio-only format.” (ARIZ. REV. STAT. ANN. §§ 20-841.09(A)(2), 20-1057.13(A)(2), 20-1376.05(A)(2)) |
specifically prescribed by federal law. (ARIZ. REV. STAT. ANN. § 36-3602(e)).

The physical or mental health examination may be conducted via a telehealth encounter; however, Schedule II drug prescriptions (referring to the federal Controlled Substances Act) require an in-person or audio-visual examination. (ARIZ. REV. STAT. ANN. § 36-3606(A))

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<tr>
<th>CA</th>
<th>Providers may remotely enroll individuals through telehealth into “Family Planning, Access, Care, and Treatment (Family PACT), Presumptive Eligibility for Pregnant Women, and Every Woman Counts programs. . .” (A.B. 32, 2021 Leg., Reg. Sess. (Cal. 2021)) County eligibility workers may remotely determine eligibility for the Medi-Cal Minor Consent program. (A.B. 32, 2021 Leg., Reg. Sess. (Cal. 2021)) Telehealth services shall be reimbursed by Medi-Cal to the same extent and payment rate as an in-person service. (A.B. 32, 2021 Leg., Reg. Sess. (Cal. 2021))</th>
</tr>
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</table>

"Mental health consultations via a telehealth consultation program provided pursuant to Section 1367.626 of the Health and Safety Code or Section 10123.868 of the Insurance Code are covered [by Medi-Cal]."

By July 1, 2022, health care service plans and health insurers shall provide children, pregnant, and postpartum persons who suffer from mental illness the ability to obtain mental health treatment through a telehealth consultation program. (A.B. 935, 2021 Leg., Reg. Sess. (Cal. 2021))

"Health care services furnished through audio-only telehealth, including by telephone, by a federally qualified health center or a rural health clinic . . . shall be reimbursed pursuant to Section 14132.722.” (A.B. 32, 2021 Leg., Reg. Sess. (Cal. 2021))

"[M]ental health services that are excluded from the benefits provided by county mental health plans under the specialty mental health services waiver, furnished through audio-only telehealth, shall continue to be reimbursed at the applicable prospective payment system per-visit rate indefinitely, except if the federally qualified health center or rural health clinic elects an alternative payment methodology that covers those services.” (A.B. 32, 2021 Leg., Reg. Sess. (Cal. 2021))

| NV | Nevada’s Department of Health and Human Services shall establish a data dashboard that tracks data relating to the access to telehealth by different groups and populations in the state. Telehealth is “the delivery of services from a provider of health care to a patient at a different location through a synchronous interaction using information and audio-visual communication technology, not including audio-only technology. . .” A healthcare provider may establish a relationship with a patient using telehealth when it is clinically

A health insurance policy, benefit plan, benefit contract, or dental plan "must include coverage for services provided to an insured through telehealth to the same extent and, for mental health services except for when such services are provided through audio-only interaction, in the same amount as though provided in person or by other means.” (S.B. 5, 81st Leg., Reg. Sess. (Nev. 2021))

|  |  |
appropriate to do so. Such regulations governing this process may be adopted by the State Board of Health.

A health insurance policy, benefit plan, benefit contract, or dental plan must include coverage for telehealth services, except for audio-only interactions, to the same extent as in-person services. (S.B. 5, 81st Leg., Reg. Sess. (Nev. 2021))

| OR | “‘Telemedicine’ means the mode of delivering health services using information and telecommunication technologies to provide consultation and education or to facilitate diagnosis, treatment, care management or self-management of a patient's health care.” |
|    | The Oregon Health Authority shall reimburse telemedicine health services including audio only, video only, and audio and video health services to the same extent as in-person services. (OR. REV. STAT. ANN. § CH. 117, § 2) |
|    | During a state of emergency, a health benefit plan or dental-only plan shall cover telemedicine services to enrollees residing in affected areas regardless of whether the technology being utilized for the telemedicine service meets the required standards for the privacy and security of protected health information. |
|    | “A health benefit plan and a dental-only plan may not . . . [r]estrict a health care provider to delivering services only in person or only via telemedicine . . . [nor] [r]equire an enrollee to have an established patient-provider relationship with a provider to receive telemedicine health services from the provider or require an enrollee to consent to telemedicine services in person.” |
|    | A health benefit or dental-only plan may not restrict a provider from providing telemedicine services across state lines if the services are within the provider's scope of practice, the provider is established or operates a clinic or health care facility in Oregon, the provider has an established relationship with the patient, or the patient was referred to the provider by their primary care provider located in Oregon. (OR. REV. STAT. ANN. § 743A.058) |
|    | A provider offering telehealth services shall “establish a provider-patient relationship during the provision of care.” |
|    | The state board shall distribute money to local education agencies to provide mental health services. |

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the patient encounter in a manner consistent with the standards of practice, determined by the Division of Professional Licensing . . . " (UTAH CODE ANN. § 26-60-103(1)(b))

Pursuant to the Audiology and Speech-Language Pathology Interstate Compact, "[m]ember states shall recognize the right of an audiologist or speech-language pathologist, licensed by a home state . . . to practice audiology or speech-language pathology in any member state via telehealth under a privilege to practice as provided in the Compact and rules promulgated by the Commission." (UTAH CODE ANN. § 58-41a-102)

Support through contracts for health services, including telehealth services. UTAH CODE ANN. § 53F-2-415(2)(a)

A health benefit plan shall cover mental health treatment through telemedicine services if the treatment is covered through in-person services and "the health benefit plan determines treatment of the mental health condition through telemedicine services meets the appropriate standard of care . . ." (UTAH CODE ANN. § 31A-22-649.5(2)(a)(ii))

The Division of Substance Abuse and Mental Health shall award fund money to mental health and substance abuse treatment entities within the state for the purpose of "providing through telehealth or in-person services, mental health therapy to qualified individuals." (UTAH CODE ANN. § 62A-15-1702(4)(a))

**WA**

Health care professionals, other than a physician licensed under 18.71 RCW or an osteopathic licensed under 18.57 RCW, who provide telemedicine services shall complete telemedicine training. (WASH. REV. CODE ANN. § 43.70.495(2))

"A health plan offered to employees, school employees, and their covered dependents . . . issued or renewed on or after January 1, 2017, shall reimburse a provider for a health care service provided to a covered person through telemedicine if . . . [b]eginning January 1, 2023, [b]eginning January 1, 2023, [b]eginning January 1, 2023, [b]eginning January 1, 2023, for audio-only telemedicine, the covered person has an established relationship with the provider."

"If a provider intends to bill a patient or the patient's health plan for an audio-only telemedicine service, the provider must obtain patient consent for the billing in advance of the service being delivered."

"Audio-only telemedicine" means the delivery of health care services through the use of audio-only technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment." (S.H.B. 1196, 67th Legis. Serv., Reg. Sess. (Wash. 2021))

Pursuant to the Audiology and Speech-Language Pathology Interstate Compact, "[m]ember states shall recognize the right of an audiologist or speech-language pathologist, licensed by a home state . . . to practice audiology or speech language pathology in any member state via telehealth . . ." (WASH. REV. CODE ANN. § 43.70.495(2)(a))

An originating site for telemedicine services includes a "licensed or certified behavioral health agency."

"Upon initiation or renewal of a contract with the authority, behavioral health administrative services organizations and managed care organizations shall reimburse a provider for a behavioral health service provided to a covered person who is under 18 years old through telemedicine or store and forward technology if . . . [b]eginning January 1, 2023, for audio-only telemedicine, the covered person has an established relationship with the provider." (S.H.B. 1196, 67th Legis. Serv., Reg. Sess. (Wash. 2021))

The Washington state health care authority and University of Washington’s department of psychiatry and behavioral sciences shall create a psychiatric consultation call center to provide health care providers “with on-demand access to psychiatric and substance use disorder clinical consultation for adult patients.” Such services may occur via telemedicine if it is clinically appropriate and technically feasible. (WASH. REV. CODE ANN. § 71.24.062 (1))
under a privilege to practice as provided in the compact and rules promulgated by the commission.” (H.B. 1043, 67th Leg., Reg. Sess. (Wash. 2021))
Table 5: Emergency Liability Protections  
(as of July 1, 2021)

This table provides state statutory/regulatory authorities allowing for temporary liability protections of physicians, nurses, or other HCWs during declared emergencies (see Table 1 for more information re: declarations) as categorized in columns I – II:

<table>
<thead>
<tr>
<th>State</th>
<th>I. General Liability Protections</th>
<th>II. Specific Liability Protections</th>
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<tbody>
<tr>
<td>AZ</td>
<td>This state and its departments, agencies, boards, commissions and all political subdivisions are not liable for any claim based upon the exercise or performance, or the failure to exercise or perform, a discretionary function or duty by any emergency worker, except for willful misconduct, gross negligence or bad faith of the emergency worker, in engaging in emergency management activities or performing emergency functions pursuant to this chapter or title 36, chapter 6, article 9. (ARIZ. REV. STAT. ANN. § 26-314)</td>
<td>Notwithstanding any provision of the Arizona Revised Statutes, law, associated regulations, rules, policies, or procedures, an Arizona healthcare professional, an Arizona healthcare institution licensed pursuant to A.R.S. Title 36, Chapter 4, any entity operating a modular field treatment facility, or other site whether or not it is a licensed healthcare institution, designated by the Director of the Arizona Department of Health Services for temporary use in support of the State’s COVID-19 response or an Emergency Medical Care Technician, is immune from civil liability for triage decision made in the course of providing medical devices based on good-faith reliance of mandatory or voluntary state-approved protocols under the public health emergency declaration for COVID-19. (E.O. 2020-27, Apr. 9, 2020 (renewed by E.O. 2020-42, June 25, 2020, and E.O. 2020-63, Dec. 31, 2020; expired on Mar. 31, 2021))</td>
</tr>
</tbody>
</table>

If the governor declares a state of emergency for a public health pandemic pursuant to title 26, chapter 2, a person or provider that acts in good faith to protect a customer, student, tenant, volunteer, patient, guest or neighbor or the public from injury from the public health pandemic is not liable for damages in any civil action for any injury, death or loss to person or property that is based on a claim that the person or provider failed to protect the customer, student, tenant, volunteer, patient, guest, neighbor or public from the effects of the public health pandemic unless it is proven by clear and convincing evidence that the person or provider failed to act or acted and the failure to act or action was due to that person’s or provider’s willful [sic] misconduct or gross negligence. A person or provider is

If the governor declares a state of emergency for a public health pandemic pursuant to title 26, chapter 2, a health professional or health care institution that acts in good faith is not liable for damages in any civil action for an injury or death that is alleged to be caused by the health professional’s or health care institution’s action or omission while providing health care services in support of this state’s response to the state of emergency declared by the governor unless it is proven by clear and convincing evidence that the health professional or health care institution failed to act or acted and the failure to act or action was due to that health professional’s or health care institution’s willful misconduct or gross negligence. . . . Subsection A of this section applies to any action or omission that is alleged to have occurred during a person’s screening, assessment, diagnosis or treatment and that is related to the public health pandemic that is the subject of the state of emergency or any action or omission that occurs in the course of providing a person with health care services and that is unrelated to the public health pandemic that is the subject of the state of emergency if the health professional’s or health care institution’s action or omission was in
<table>
<thead>
<tr>
<th>State</th>
<th>Provision</th>
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</thead>
<tbody>
<tr>
<td>CA</td>
<td>Any physician or surgeon (whether licensed in this state or any other state), hospital, pharmacist, respiratory care practitioner, nurse, or dentist who renders services during any state of war emergency, a state of emergency, or a local emergency at the express or implied request of any responsible state or local official or agency shall have no liability for any injury sustained by any person by reason of those services, regardless of how or under what circumstances or by what cause those injuries are sustained; provided, however, that the immunity herein granted shall not apply in the event of a willful act or omission. (CAL. GOV'T CODE § 8659) Pursuant to Government Code § 8659, any health care professional or provider identified in that section—or any person (including, but not limited to, any pharmacy technician) subject to the supervision or otherwise following the instructions of such health care professional or provider, consistent with applicable state directives and guidance (including, but not limited to, any applicable state waivers)—who participates in the State’s [COVID-19] vaccine administration program shall be covered by the liability protections specified in Government Code section 8659, to the extent that the administered vaccines have been authorized for use under federal law. . . . Nothing in this Order shall be construed to restrict, diminish, or otherwise limit any other immunity that would otherwise be available to any person under any applicable provision of law. In light of the emergency that currently exists throughout the State, and the urgent need to address that emergency by vaccinating Californians against COVID-19 as swiftly as possible, such immunities may include (but need not be limited to) immunities conferred by state law—including, but not limited to, Business and Professions Code section 2395 and Health and Safety Code section 1799.106—in connection with emergency services or care at the scene of an emergency. (E.O. N-02-21, Jan. 27, 2021) Except as provided in subsection (b), a covered health care provider shall not be liable for damages under any law of the United States or of any State (or political subdivision thereof) for any harm caused by any act or omission of such covered health care provider in the course of arranging for or providing health care services if such health care services were provided in good faith or were withheld for reasons related to the COVID–19 pandemic. (H.R. 7059, 116th Cong., 2d Sess. (Calif. 2020) (pending; referred to the House Committee on the Judiciary))</td>
</tr>
<tr>
<td>NV</td>
<td>An emergency responder of an assisting participant is an agent of the requesting participant for the purposes of tort liability and immunity. An assisting participant or its officers or employees providing assistance under this chapter are not liable for any act or omission while providing or attempting to provide such assistance in good faith. As used in this subsection, “in good faith” does not include willful misconduct, gross negligence or recklessness. (Nev. Rev. Stat. Ann. § 414A.180) Except as otherwise provided in NRS 41.505, any person in this State who renders emergency care or assistance in an emergency, gratuitously and in good faith, except for a person who is performing community service as a result of disciplinary action pursuant to any provision in title 54 or chapter 437 of NRS, is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, by that person in rendering the emergency care or assistance or as a result of any act or failure to act, not amounting to gross negligence, to provide or arrange for further medical treatment for the injured person. (NEV. REV. STAT. ANN. § 41.500, amended by S.B. 217, 81st Leg., Reg. Sess. (Nev. 2021))</td>
</tr>
<tr>
<td>OR</td>
<td>Registrants and volunteers who perform emergency health care services in accordance with ORS 401.651 through 401.670 and these rules are agents of the state under 30.260 through 30.300 for the purposes of any claims arising out of services that are provided under 401.651 through 401.670 and these rules pursuant to directions from a public body and that are within the course and scope of the registrant's or volunteer's duties, without regard to whether the registrant or volunteer is compensated for the services. (OR. ADMIN. R. 333-003-0210)</td>
</tr>
<tr>
<td>UT</td>
<td>A person or entity owning a building or other facility and an operator of or an employee in a building or facility is immune from liability with respect to any decisions or actions related to emergency or public health conditions, as described in Subsection 63G-7-201(2)(b)(iii), while acting under the general supervision of or on behalf of any public entity. (UTAH CODE ANN. § 63G-8-201) A health care provider is immune from civil liability for any harm resulting from any act or omission in the course of providing health care during a declared major public health emergency if: (i) (A) the health care is provided in good faith to treat a patient for the illness or condition that resulted in the declared major public health emergency; or (B) the act or omission was the direct result of providing health care to a patient for the illness or condition that resulted in the declared major public health emergency; and (ii) the acts or omissions of the health care provider were not: (A) grossly negligent; or (B) intentional or malicious misconduct. (UTAH CODE ANN. § 58-13-2.7) Any emergency responder from another state who enters into this state while responding to an emergency has the same authority to act, including providing care, as does any emergency responder of this state. . . . All privileges and immunities from liability, exemption from law, ordinances, and rules, and any other benefits, which apply to an emergency responder while performing duties in the responder's state of residence or state of employment as a responder, apply when the emergency responder is acting as an emergency responder in Utah. (UTAH CODE ANN. § 53-2a-506, amended by H.B. 302, 60th Leg., Gen. Sess. (Utah 2013))</td>
</tr>
<tr>
<td>State</td>
<td>Provision</td>
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<tr>
<td><strong>WA</strong></td>
<td>Except as provided in subsection (2) of this section, any health care provider credentialing or granting practice privileges to other health care providers to deliver health care in response to an emergency is immune from civil liability arising out of such credentialing or granting of practice privileges if: (a) The health care provider so credentialing or granted practice privileges was responding to an emergency; and (b) the procedures utilized for credentialing and granting practice privileges were substantially consistent with the standards for granting emergency practice privileges adopted by the joint commission on the accreditation of health care organizations. (WASH. REV. CODE ANN. § 4.24.810)</td>
</tr>
<tr>
<td><strong>UT</strong></td>
<td>A minor . . . may consent to . . . vaccinations against epidemic infections and communicable diseases . . . and . . . [a] health care provider who provides medical services to a minor in accordance with the provisions of this section is not subject to civil or criminal liability for providing the services described . . . without obtaining the consent of another person prior to rendering the medical services. (UTAH CODE ANN. § 26-10-9, amended by H.B. 286, 64th Leg., Gen. Sess. (Utah 2021))</td>
</tr>
</tbody>
</table>
Table 6 - Aggregate of Emergency Statutes & Regulations
(as of July 1, 2021)

This table marks (√) specific legal provisions across states’ statutory/regulatory codes (see Tables 1-5 for more information re: states’ authorities) as categorized in rows I – X:

<table>
<thead>
<tr>
<th>Legal Authority</th>
<th>AZ</th>
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<th>UT</th>
<th>WA</th>
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<tr>
<td>I. Emergency/Disaster Declaration Authority <em>(Table 1)</em></td>
<td>✓</td>
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<tr>
<td>II. Public Health Emergency Declaration Authority <em>(Table 1)</em></td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>III. Routine Licensure Reciprocity <em>(Table 2)</em></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>IV. Emergency Licensure Reciprocity <em>(Table 2)</em></td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tr>
<tr>
<td>V. General Waiver Authority <em>(Table 3)</em></td>
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<td>✓</td>
<td>✓</td>
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<tr>
<td>VI. Specific Waiver Authority <em>(Table 3)</em></td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>VII. General Telehealth/Medicine Provisions <em>(Table 4)</em></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>VIII. Mental Health Specific Telehealth/Medicine Provisions <em>(Table 4)</em></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>IX. General Liability Protections <em>(Table 5)</em></td>
<td>✓</td>
<td></td>
<td></td>
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<td>✓</td>
<td></td>
</tr>
<tr>
<td>X. Explicit Liability Protections <em>(Table 5)</em></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</table>
Appendix 1:

Emergency Declarations – A Brief Overview
Please see below brief explanations of emergency declarations in response to COVID-19 at federal, state/tribal, and local levels. Link to our Network website for considerable, additional information:

- **Federal Public Health Emergency** – Under §319 the Public Health Services Act (42 U.S.C. 247d), the Secretary of Health and Human Services (HHS) may declare a federal PHE in response to “significant outbreaks of infectious disease or bioterrorist attacks.” A PHE declaration enables HHS to accelerate procurements and federal fund distribution, investigate causes and solutions, promote coordination and social distancing measures, and temporarily waive some federal laws. This declaration also speeds the use of medical countermeasures by allowing for emergency use authorization of products under 21 U.S.C. 360bbb-3.

- **Federal Stafford Act Emergency/Disaster** – The President may make an emergency or disaster declaration under the Stafford Act, 42 U.S.C. 5121–5208, triggering FEMA to provide financial and other assistance to help affected communities respond and coordinate federal responses. Usually made at the request of specific states, Stafford Act declarations frequently respond to natural disasters, but have also been issued **during COVID-19** to engage FEMA support and funding, among other authorities.

- **Federal National Emergency Act** – Under 50 U.C.S. 1601–1651, the President may declare a national emergency to access myriad powers, expressly defined in law or potentially implied by Constitutional authority. These powers may include redirecting federal funding or staff to address emergencies and some waivers of specific federal laws. In the COVID-19 pandemic, an emergency declaration on March 13, 2020 resulted in select waivers of federal regulations to increase access to health services, testing, and other interventions.

- **State/Tribal Emergency or Disaster** – State and tribal governments may draw on their sovereign police powers (e.g., powers to protect the public’s health and safety) and statutory or constitutional authorizations to declare emergency or disaster declarations. Once declared, resulting powers include ready allocation of funds, coordination tools, and facilitating emergency services. Additional powers granted vary by jurisdiction and type of emergency, but may include public health powers such as surveillance, travel restrictions, or quarantine and isolation.

- **State/Tribal Public Health Emergency** – Over 30 states and various tribes have statutes and rules enabling them to declare PHEs based in large part on the Model State Emergency Health Powers Act. PHEs specifically enable responses to bioterrorism or infectious agents, like COVID-19, that present a high probability of causing death or disability. State and tribal PHEs grant powers such as closing roads or businesses, imposing social distancing, testing and screening, quarantine and isolation, or licensing reciprocity and liability protections for HCWs.

- **Local Emergency or Public Health Emergency** – Depending on authorities provided via state governments, cities and counties may enact ordinances to invoke declarations of local emergencies entailing various powers such as freeing up resources, coordinating local responses, or rapidly issuing emergency policies. Several localities have used these powers
during the COVID-19 pandemic, for example, to enact shelter-in-place orders. Local emergency powers must generally align with state-based exercises of powers for purposes of uniformity.

This document was developed by James G. Hodge, Jr., J.D., LL.M., Director, Network for Public Health Law – Western Region, ASU Sandra Day O’Connor College of Law, and Walter Johnson, Legal Researcher, and J.D. Candidate (2020), ASU Sandra Day O’Connor College of Law. Legal information provided in this document does not constitute legal advice or representation. For legal advice, please consult specific legal counsel in your state.

Supporter:

The Network for Public Health Law is a national initiative of the Robert Wood Johnson Foundation. The Network provides information and technical assistance on issues related to public health laws and policies.
Appendix 2:

WRAP-EM Charter Guidelines
Charter Guidelines

**Background and Purpose**

On September 30, 2019, the U.S. Department of Health and Human Services’ Office of the Assistant Secretary of Preparedness and Response (ASPR) awarded grants to 2 centers nationally to support the creation of Pediatric Disaster Care Centers of Excellence (COE).

Per ASPR descriptions, these pilot projects are intended to define the delivery of pediatric clinical care when existing systems are stressed or overwhelmed by enhancing rapid sharing of expertise and assets throughout a state or region. These FOA funds demonstration projects to help identify issues, develop best practices, and demonstrate the potential effectiveness and viability of this concept. COEs will be expected to develop and/or improve their capability and capacity to provide highly specialized care to pediatric patients within and outside their own region. Recipients should have existing pediatric preparedness capabilities and the capacity to manage pediatric patients within their own state and within a self-defined multi-state region during a disaster.

The Western Region Alliance for Pediatric Emergency Management (WRAP-EM) was formed in 2019. The founding membership of WRAP-EM includes a broad collection of individuals from public and private entities from Washington, Oregon, California, Nevada, and Arizona. The administrative lead for WRAP-EM is an Academic Healthcare Institution (UCSF).

As the operational framework has developed, it became clear to the organization of the need for clearly expressed guidelines establishing expected functions, goals, boundaries, and institutional relationships.

This charter document responds to these needs beginning with key definitions, organizational descriptions, and clarifications of the institutional relationships to provide direction for the structure and function of WRAP-EM. The intent is to define an organizational structure, made up of multiple public and private entities across the 5 state region that aligns with planning and response principles of Incident Command Systems (ICS), the National Incident Management System (NIMS), and individual state emergency management operations from across the region.

**Definitions**

*Alliance* -- (as used in the WRAP-EM grant application) an association or relationship based on an affinity in interests furthering the common interests of the members.
**Coalition** -- an alliance for joint action; as used in the HPP grant, describes public and private groups whose participation is needed in a local, regional, or state jurisdiction.

**Consortium** -- used by ASPR to describe a coalition of multiple states (see Figure 1 below).

**Emergency Management Assistance Compact (EMAC)** -- a resource-sharing agreement signed by all states which offers assistance during governor-declared states of emergency or disaster through a straightforward system that allows states to send personnel, equipment, and commodities to assist with response and recovery efforts in other states.

**Emergency Operations Center (EOC)** -- different facilities and virtual structures providing incident support to personnel in the field that are organized according to standard ICS structure. The National Incident Management System (NIMS) and supporting documents use the term EOC to refer to all facilities, including emergency coordination centers that support on-scene actions and, like on-scene personnel, can be shared across organizational and jurisdictional lines. Unlike on-scene personnel, there is no national structure like ICS guiding all EOCs, although most share elements of the ICS structure.

**Healthcare Coalition (HCC)** -- defined by ASPR as a group of individual healthcare and response organizations in a specified geographic area playing critical roles in developing health care delivery system preparedness and response capabilities. Organizations agree to collaborate to maximize surge capacity and capability during public health emergencies by facilitating information sharing, mutual aid, and response coordination.

**Jurisdictional Agency (JA)** – as per NIMS, an agency having jurisdiction and responsibility for a specific geographical area or a mandated function, typically a local, state, tribal, or federal government agency responsible for emergency response and recovery.

**Multi-agency Coordination (MAC) Group** – as defined by SEMS, “the participation of agencies and disciplines involved at any level of the organization working together in a coordinated effort to facilitate decisions for overall emergency response activities, including the sharing of [scarce] resources and the prioritization of incidents.” NIMS defines the primary function of a MAC system to coordinate activities above the field level and to prioritize the incident demands for critical or competing resources, thereby assisting the coordination of the operations in the field.

**National Disaster Medical System (NDMS)** -- a federally coordinated system that augments the nation’s emergency medical response capacity by providing for large-scale patient movement from disaster areas to non-impacted adjacent regions.
WRAP-EM Organization

The operational nature of WRAP-EM best aligns with a coalition framework defining the public private partnership that is at the core of the operational goals. Utilization of the term coalition potentially creates confusion within the current defined tiered response infrastructure (see Figure 1 below). Therefore, the organization will use the more vague label of “alliance” with the predetermined goal of advancing a public and private collaborative community. This includes support and liaison functions for both the health care coalitions already established in Tier 1 of NDMS response capabilities, as well as the defined Tier 3 federal entities.

In addition, the described support and liaison role will include collaborations with other Tier 2 regional response programs regionally and throughout the United States. Although not clearly defined in the tiered ASPR response infrastructure, WRAP-EM will collaborate with other private regional and national entities (e.g., hospital systems, corporations, professional societies, and advocacy groups) to integrate all preparedness and response resources into an operational pediatric focused disaster capability program (see Appendix A).

Figure 1
WRAP-EM Scope:

Preparedness versus Response Organization³

It is expected that WRAP-EM may operate as a pediatric preparedness program as well as bolstering response operations during actual events.

Preparedness Roles:

- Promote the pediatric specific perspective to ongoing preparedness efforts on local and regional levels, including support to the health care coalition planning and readiness missions and integration with the EMSC pediatric readiness programs throughout the region and nationally.

- Development of a pediatric focused community that can provide breadth of expertise. This conceptually will assist with filling local and regional level identified gaps in preparedness programs, create a high-level resource for public and private participating organizations, and operationally function to problem solve identified challenges with collaborations not previously available.

- Conducts emergency management program activities, including committee meetings, Emergency Operations Plan (EOP) development, preparedness planning, training, exercises, resource management, program evaluation and improvement.

- Assists as requested on policy, operations, or legal issues pertaining to pediatric-specific concerns in any specific jurisdiction.

- Assists with education and integration of planning efforts across all of the ASPR infrastructure tiers (local, state, regional and federal).

Response Roles:

- WRAP-EM collaborators include a broad range of private healthcare organizations (hospitals, systems and transport organizations), public entities (emergency managements, EMS, county administration, and HCC’s), academic institutions, professional societies, and disaster response teams. Many of these entities make up the key components of local and state level emergency response capability for adults and children. WRAP-EM serves as a platform for integration and collaborations for all these entities.

WRAP-EM is not a federal response organization within the current NDMS, FEMA, EMAC or DOD framework. However, as an ASPR grant recipient, it will function collaboratively with all of those entities in a support role, especially when there are needs for connecting federal entities with other WRAP-EM member organizations.

WRAP-EM's response function may also include pediatric specific deployable assets as defined in the ASPR grant objectives, potentially including pediatric specific teams, embedded personnel, or resource and just-in-time education support.

WRAP-EM's response function may also include telehealth support across the region as needed and supported by the individual member organizations.

WRAP-EM response functions may also include just-in-time provision of resources or tools, shared between member organizations. This may include support and development of specific tools (i.e., psySTART and TRAIN) and the EMSC pediatric readiness programs to address needs and gaps across the region.

Facilitating information sharing among participating healthcare organizations and JAs to promote common situational awareness about an incident and promote a common operating picture regarding the regional healthcare response.

Facilitating resource support by expediting the mutual aid process or other resource sharing arrangements among coalition members; assist regional mutual aid so that all healthcare organizations can optimally contribute to or benefit from available regional, state, and federal response assistance.

Promoting consistent and effective healthcare response actions among HCCs across the affected region(s); and

Facilitating the interface between HCC and relevant jurisdictional authorities to establish effective support for healthcare system resiliency and medical surge.

**Functions limitations of WRAP-EM**

**Jurisdictional Authorities:**

While WRAP-EM objectives are consistent with MAC systems, others are beyond its authority. WRAP-EM activity may include public agency representatives with policy and decision-making authority who convene as needed to help resolve strategic issues or arbitrate resource allocations. Similarly, WRAP-EM may include situation assessment, information sharing, and support for policy level decision-making. However, incident prioritization, resource allocation, and EOC functions are not within its scope of operations.
WRAP-EM authority to operate is based on the voluntary endorsement and support of its member organizations and relevant JAs in its geographic area. It is primarily responsive to its member organizations’ concerns. The members are primarily responsible to the JAs in which each operates. WRAP-EM does not compete with or intrude on JAs’ incident management responsibilities.

**Assumptions for WRAP-EM response function:**

- WRAP-EM must work according to ICS/NIMS principles.
- WRAP-EM may function in support of Jurisdictional EOC’s and if requested may fill liaison or consultative roles.
- WRAP-EM response activity must be organized through each State’s Office of Emergency Services, most often through the health and medical branch (ESF-8 [Public Health and Medical Emergency Support Function]), when activated.
- WRAP-EM will not create a separate response organization or any formal coordination center that is not integrated with and supportive of existing jurisdictional response plans.
  - However, WRAP-EM members may function at a local, state, or regional level to provide information, subject matter expertise, and recommendations to their local or state EOC, and carry out requested planning tasks.
- All facilities utilize Hospital Incident Command System (HICS) or equivalent systems. WRAP-EM may provide support and consultative role on a local or health care HICS activated team as requested, but not establish independent HICS teams.
- WRAP-EM personnel involved in any response function will remain employed by their “home” organization and therefore may have primary responsibility for elements of their home organization’s response.

**WRAP-EM Planning**

WRAP-EM may engage in cataloging state and local emergency response plans and engaging in gap analysis planning activities to potentially produce recommendations or guidance for opportunities for improvement or alignment of these plans. WRAP-EM is not authorized to alter or mandate changes to state or local response plans.

While alignment of plans and policies may be evaluated for potential areas of optimization, differences and inconsistencies between jurisdictions may exist. This includes state and local unique approaches to EOPs and management of crisis standards of care. These documents naturally will have different guidance for triggers, mechanisms for managing scarce resources, processes for adjustments, and definitions of scope or authority at different tiers of government. While WRAP-EM may serve in an advisory capacity as requested for evaluation and development of documents such as these,
authority over these plans remains with the respective appropriate state government agency. WRAP-EM will not develop or promote any plans that interfere or contradict established state authority over these plans.

**WRAP-EM integration in response**

**Command and control** (see ICS/NIMS org chart below). WRAP-EM acts more like a collective HCC than a subdivision of the health and medical operations branch. While there may be a pediatric task force or division for a specific public health emergency within the state or local response organization, the functions of the pediatric coalition for grant purposes and during responses must align with and have a connection with the Planning Section in the NIMS-SEMS organizational chart. Within the hospital setting, WRAP-EM would operate in the HICS Technical Specialist role.

State Emergency Management Agencies support local agencies to respond to the public health and medical needs of affected populations. In a large event, there will likely be a unified command with key agencies making shared decisions. ASPR and other federal agencies may set up a command post at state EOCs to support response efforts.

In most situations, the appropriate relationship between an HCC and JA is an interface with ESF-8 position in the jurisdiction’s EOC. ESF-8 is often operated under the authority of the local Public Health department. Alternatively, the primary interface may be directly with a Department Operations Center (DOC). State and local health departments use DOCs to manage their emergency responses.

The HCC should establish a flexible response interface with the relevant JAs that is consistent with the reporting line and authority structure of the jurisdiction’s EOP. In many locales, a formal position has been established for a healthcare representative in the jurisdiction’s EOC (often at the ESF 8 desk), who reports to the Public Health authority leading ESF 8. This function may be filled by an HCC representative serving as the liaison. In some areas of the country with limited or no local public health capabilities, the HCC may coordinate directly with the relevant State authorities.

A state or local jurisdiction may include a pediatric surge group in its EOC or MACS; however, a multi-state pediatric consortium cannot commit resources or prioritize response activities. They are best seen in a coordinating role or as a subject matter expert (SME) or advisory role, especially related to information gathering and sharing and making recommendations to prioritize and coordinate resources.

**Internal organizational structure.** Although each state may have different emergency management structure for ESF-8, standard roles with description of work within each state of the regional alliance/consortium may include:

- An ESF-8 pediatric liaison within each state represents their pediatric provider network and supports a task force to determine resource needs.
• Pediatric alliance coordinator coordinates with the liaison and represents the multi-state coalition for activation decisions, situation status, potential resource requests, coordination of clinical protocols.

• Pediatric representative, which could be either the liaison or the coordinator or a third position, represents the pediatric organization within the state health and medical emergency management structure.

• SMEs provide input into clinical protocols and resource needs.

As with all emergency management positions, each needs a detailed scope of work and multiple potential individuals to fill the position. Contact should be through an organizational structure that is 24/7, such as a duty officer, and not an individual.

**Activation and lead state for WRAP-EM response.** WRAP-EM should develop a mechanism for activation. One option is that any state can activate the alliance to better coordinate the response to pediatric patients due to a large-scale emergency. If the disaster involves multiple states, activation could be by mutual agreement.

There could be a permanent or regularly alternating lead state, but a better option may be for the state that is the primary operational area for a disaster is the lead. Alternatively, the lead role could be delegated when organized.

Potential proposals among Nebraska and Region 1 grant coalitions may include other states’ use of RDHRS centers (Mass General, U of Nebraska) are unrealistic for Western states in WRAP-EM.

**Information Sharing.** A regional pediatric consortium could play an important role in information sharing through standard teleconferencing or video conferences consistent with typical interactions by EOCs and response agencies:

1. Situation awareness sessions focused on a specific stakeholder group or broad partners. These typically include bi-direction communication with information being passed up to the lead agency and down to the partners. For example, a call with consortium representatives from each state that includes an ESF-8 emergency manager could share situation status within their states and available resources. It might also include acute care facilities and other pediatric providers.

2. Resource/operational planning sessions including response leaders and EOC ESF-8 representatives to help coordinate resources requests and availability. While there may be a pediatric request or report, these sessions would not be run by the multi-state pediatric consortium.

In an event of a pandemic or other public health event where all states are impacted, the alliance/consortium could still help coordinate clinical protocols and discuss pediatric surge options.
**Communications.** The regional consortium would not issue any press or public communications which are typically the function of state EOCs and Joint Information Centers (JICs). JICs coordinate messaging disseminated through the Emergency Management Agency, Governor, or Health Officer. The consortium could determine standard communication messages for pediatric care to disseminate through each state health department or EOC, to provide to pediatric professional organizations such as AAP, and to provide to their healthcare facilities.

**Resource requests or offers.** Resource requests and coordination coordinated by WRAP-EM must be routed through the State health and medical branch or State ESF-8 representative to an EOC. The appropriate place to route requests or information may be a DOC of the responsible public health or medical agency, including in cases where one state experiences a large emergency but a neighboring state was not yet involved or activated. Interstate movement of resources must be approved through federal or state EMAs.

**Example:** California’s Medical and Health Coordination Center (MHCC) is located within its Department of Public Health and shared by the Emergency Medical Services Authority (EMSA). EMSA may also open its own DOC to manage EMS and field health care operations. Both Departments have a representative at the State EOC that typically function within the Operations Section. The State Public Health Officer and EMS Director may serve on an executive decision-making group (MAC) known in California as the Unified Command Group.

A multi-state or regional pediatric coalition within one state (multiple local HCC coalitions) must not bypass its state EOC, health agency DOC, or a hospital command center for situation status, bed availability, or resource needs.

**EMAC** should be the initial mechanism for interstate resource requests. ASPR expects resources requests to go first to other states through EMAC commonly used for staffing support or hard assets. Response assets specific to WRAP-EM might include pediatric strike teams.

**Coordination with federal agencies.** In a large multi-state event, ASPR regional emergency coordinators (RECs) will typically send a representative or staff a coordination group at the State EOC and/or have a representative at an ESF-8 operation center. While they may discuss available resources and even preposition resources, requests must

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formally come through the state EOC. The regional consortium should notify and include RECs in any situation status and planning sessions.

**Patient care.** There is existing precedence for patients obtaining care directly across state lines or via facility transfer on a day to day basis that does not require use of the emergency management system or EMAC. This occurs routinely in border areas that have an urban area in one state and limited rural capabilities across the border of a neighboring state. Under current agreements, EMS personnel can transport across state lines working under the scope of practice of their home jurisdiction. Routine protocols and procedures are used by agreement among local jurisdictions and healthcare systems.

**Appendix A**

**WRAP-EM Organization Chart**

![WRAP-EM Organization Chart](image-url)
Appendix 3:

Pediatric Crisis Standards of Care Template – COVID-19
Pediatric Crisis Standards of Care Template – COVID-19

Ethical rational:
Utilize academy consultative report. May overlap with adult standards

Definitions:
Crisis standards of care (CSC) refer to substantial changes in usual health care operations due to a pervasive or catastrophic disaster that necessitate rational utilization of scarce resources like space, personnel, and equipment to provide the best possible delivery of health care to the greatest number of patients.

Triggers:
CSC may arise at any level of government or within regional or specific hospital or other health care settings based often on formally-declared emergencies or corresponding executive orders that change the legal and ethical landscapes to facilitate shifts in prevailing health care delivery.

Practical Considerations:
CSC should be considered only in circumstances when healthcare demands exceed capabilities (e.g., beds, equipment, or staffing) of a community or institution after all contingency level efforts have been implemented. These efforts may include expansion of facility capabilities beyond standard operations, lawful and permissive transfers of patients, supplementation of capabilities with alternative resources and alternative care sites, and flexing of standard legal guidelines.

Legal Considerations:
The National Academy of Medicine has specified a series of legal concerns underlying implementation of CSC that are relevant in any institution or community as espoused in its recent rapid expert consultation to ASPR re: COVID-19. These include concerns among health care workers and entities re: potential liability for key decisions impacting patients. General and specific liability protections for workers and entities are addressed in the Network for Public Health Law resource, Legal Liability Protections for Emergency Medical/Public Health Responses, and other online resources.

Scope:
CSC standards may be implemented on an institutional, regional or state levels at the discretion of the appropriate level HICS or EOC incident command.

Pediatric specific guidance:
CSC implementation should focus on optimizing the best possible health care delivery to the most patients by prioritizing resources as follows:

- Delivery of care in lower level settings and with minimal resources wherever possible (examples include keeping patients in ward settings rather than transferred to intensive care units, utilization of alternative oxygen support rather than ventilators, intentional delays in procedures, minimal necessary pharmaceuticals, or expanded nursing ratio care settings).
- Resource intensive care support and operative interventions to patients with anticipated short- or long-term needs.
Practical implementation of these goals can be assisted with pre-determined guidelines for care delivery. Notwithstanding concerns over the potential for unintended disparate impacts of scoring systems among vulnerable populations, several models have been developed to implement CSC decisions in real-time. Many of these have not been validated well for children, but may be in place institutionally for adult patients, such as the SOFA score (see Appendix). The most reliable of pediatric scores to assist with this process is the PELOD 2 (See Appendix). Alternatively, each pediatric CSC plan may appropriately opt to define individual physiologic parameters as a guide (See Appendix WA state algorithm).

**Appendix - PELOD-2 Scoring**

<table>
<thead>
<tr>
<th>Organ Dysfunctions and Variables</th>
<th>Points by Severity Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Neurologic*</td>
<td></td>
</tr>
<tr>
<td>Glasgow Coma Score</td>
<td></td>
</tr>
<tr>
<td>≥11</td>
<td></td>
</tr>
<tr>
<td>5-10</td>
<td></td>
</tr>
<tr>
<td>3-4</td>
<td></td>
</tr>
<tr>
<td>0-2</td>
<td></td>
</tr>
<tr>
<td>Mean arterial pressure (mm Hg)</td>
<td></td>
</tr>
<tr>
<td>Lactate (mmol/L)</td>
<td></td>
</tr>
<tr>
<td>≤5.0</td>
<td></td>
</tr>
<tr>
<td>5.0-10.9</td>
<td></td>
</tr>
<tr>
<td>11.0</td>
<td></td>
</tr>
<tr>
<td>Respiratory*</td>
<td></td>
</tr>
<tr>
<td>PaO2 (mm Hg)/FiO2</td>
<td></td>
</tr>
<tr>
<td>≤60</td>
<td></td>
</tr>
<tr>
<td>50-60</td>
<td></td>
</tr>
<tr>
<td>≥60</td>
<td></td>
</tr>
<tr>
<td>Invasive ventilation</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Hematologic</td>
<td></td>
</tr>
<tr>
<td>WBC count (x 10^9/L)</td>
<td></td>
</tr>
<tr>
<td>≥9</td>
<td></td>
</tr>
<tr>
<td>≤9</td>
<td></td>
</tr>
<tr>
<td>Platelets (x 10^9/L)</td>
<td></td>
</tr>
<tr>
<td>≥142</td>
<td></td>
</tr>
<tr>
<td>≤142</td>
<td></td>
</tr>
</tbody>
</table>

All variables must be calculated, but measurements can be done only if justified by the patient’s clinical status. If a variable is not measured, it should be considered normal. If a variable is measured more than once in 24 to the worst value is used in calculating the score. PaO2/FiO2 fraction of inspired oxygen.

**Respiratory dysfunction:** Glasgow Coma Score used for the lowest value. If the patient is intubated, record the end tidal Glasgow Coma Score bottom section. Assess only patients with known or expected lab acute central nervous system disease. NURSE reactions; nonreactive pupils must be ≥2mm. Do not assess after anesthetic or sedative. agitation.

**Cardiovascular dysfunction:** Heart rate and mean arterial pressure do not assess during sedation or anesthetic. agitation.

**Respiratory dysfunction:** PaO2/FiO2 ratio is considered normal in children with open cardiac heart disease. PaO2 can be measured from arterial, capillary, or venous samples. Invasive ventilation: the use of mask ventilation is not considered invasive ventilation.

Log odds mortality = -6.61 + 0.47 x PELOD-2 score.

Probability of death = 1/(1 + exp(-log(odds mortality))).

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1. Crisis Capacity: Adaptive spaces, staff and supplies are not consistent with usual standards of care, but provide sufficiency of care in the setting of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant adjustment to standards of care. (Richard et al, 2009)
3. Letouzé, Stéphanie; Duhamel, Alain; Salvanon, Julie; Grandbastien, Bruno; Lacroix, Jacques; Leclerc, Francis; on behalf of the Groupe Francophone de Réanimation et d’Urgences Pédiatriques (GFRUP); Critical Care Medicine 41(7):1766-1773, July 2013. doi:10.1097/CCM.0b013e3182835bbd


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This Worksheet, along with the corresponding Pediatric Critical Care Algorithm, are to be used by "Triage Teams" during a declared emergency event whereby an appropriate healthcare official has implemented crisis standards of care. It is recommended that a "Triage Team" be comprised of senior medical personnel, preferably not those primarily taking care of the individual patient under consideration. Please see "Scarce Resource Triage Team Guidelines" for further information.

STEP 1: Screen Pediatric Patients for ICU care During Scarce Resources

Proceed to the following after reviewing goals of care with patient and family (e.g. limited code status). The goals of care should reflect the best interest of the patient.

For the following conditions consider available staffing and resources. If resources are inadequate, consider transferring the following patients to out-patient or palliative care with appropriate resources and support as can be provided.

1. Pre-existing or Persistent encephalopathy, coma or vegetative state
2. Severe acute trauma (e.g. non-survivable head injury)
3. Severe burns with Low Survival burn scores based on the Triage Decision for Burn Victims table (See Table A). See Burn Scarce Resource Card for management of critical burn patient outside of a Burn Center.
4. Significant underlying disease process that predict poor survival*

*Examples of underlying diseases that predict poor survival, despite standard treatment, include but are not limited to:
- Known severe chromosomal abnormalities with poor prognosis
- Known severe metabolic, neuromuscular, cardiac, oncologic or pulmonary disease with poor prognosis
- Extreme prematurity at the limits of viability
STEP 2: Determine if patient meets ICU Inclusion Criteria

2A: Patients must have at least one of the following INCLUSION CRITERIA:

- Requires ventilatory support, either invasive or non-invasive
- Clinical evidence of impending respiratory failure
  - Refractory hypoxemia (SpO2<90% on FiO2>0.85)
  - Respiratory acidosis (pH<7.2)
- Inability to protect or maintain airway

2B: To determine critical care resource allocation the following should be considered:

- Expected duration of need of critical care resource
- Prognosis with consideration to both current epidemiology and underlying illness
- Response to current treatment
- Degree of Organ Dysfunction as measured by the Pediatric Logistic Organ Dysfunction (PELOD) score.

*Please see Step 6 regarding use of scoring systems.

*Examples of underlying diseases that predict poor survival, despite standard treatment, include but are not limited to:

- Known severe chromosomal abnormalities with poor prognosis
- Known severe metabolic, neuromuscular, cardiac, oncologic or pulmonary disease with poor prognosis
- Extreme prematurity at the limits of viability

---

**Table 2**

<table>
<thead>
<tr>
<th>Age</th>
<th>SBP (mmHg)</th>
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<tbody>
<tr>
<td>0-28 days</td>
<td>&lt;60</td>
</tr>
<tr>
<td>1 month - 1 year</td>
<td>&lt;70</td>
</tr>
<tr>
<td>1 year - 10 years</td>
<td>(age in years x 2) + 70</td>
</tr>
<tr>
<td>&gt;10 years</td>
<td>&lt;90</td>
</tr>
</tbody>
</table>
STEP 5: Critical care waiting list

If a patient meets ICU inclusion criteria and resources are not available, patient will be placed on an ICU waiting list. As resources become available their clinical situation will be re-assessed and they will be re-triaged based on criteria outlined in Step 6. If a clear distinction cannot be made between patients of similar triage priority, the resource will be allocated to the patient who has been waiting the longest.

STEP 6: Admit to ICU

Patient data collection outlined on Step 6 of the Algorithm will be continuous and ongoing. It is recommended that every 24 hours of a patient’s ICU stay, their clinical condition will be reviewed and they will be determined to be “Improving”, “Unchanged” or “Worsening”. This determination must not only take into account data points as outlined in Step 6 but must also include updated epidemiology, critical care resource availability and census demands.

Pediatric prognostic scoring systems currently available (e.g. PELOD2) are unable to accurately predict patient outcomes and thus should not be used as a sole indicator of prognosis especially in a disaster situation. When considering critical care resource allocation in a crisis, it is recommended that decisions be made by a Triage Team. Decisions should be made based on best clinical judgment with full knowledge of regional resource availability. (Ped Crit Care 2011)

Other Pediatric Considerations

All patients receiving critical care before the onset of crisis standards will be re-assessed based on the same criteria as all incoming critical care patients. The same Data as outlined in Step 2 should be obtained and resources re-allocated if needed dependent on the Triage Team assessment and decisions.

The use of ECMO should be decided on an individual basis by the PICU and/or NICU attending, nursing supervisor and ECMO representative based on prognosis, suspected duration of ECMO, availability of staff and other resources.

<table>
<thead>
<tr>
<th>Percent TBSA burn size</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1.9</td>
</tr>
<tr>
<td>2-4</td>
</tr>
<tr>
<td>5-19</td>
</tr>
<tr>
<td>10-19</td>
</tr>
<tr>
<td>20-29</td>
</tr>
<tr>
<td>30-39</td>
</tr>
<tr>
<td>40-49</td>
</tr>
<tr>
<td>50-59</td>
</tr>
<tr>
<td>60-69</td>
</tr>
<tr>
<td>≥ 70</td>
</tr>
</tbody>
</table>

Table B


Appendix 4:

Dashboard Data Acquisition & Uses During the COVID-19 Pandemic: Legal & Policy Issues
PREFACE

Acknowledgements. This guide was developed by James G. Hodge, Jr., J.D., LL.M., Peter Kiewit Foundation Professor of Law; Director, Center for Public Health Law & Policy, at the Sandra Day O’Connor College of Law, Arizona State University (ASU), with research, drafting, and editing contributions from Emily Carey, Claudia Reeves, and Hanna Reinke, Senior Legal Researchers, Center for Public Health Law & Policy, and J.D. Candidates, ASU Sandra Day O’Connor College of Law.

Disclaimer. Please note that information provided in this guide does not constitute legal advice in any jurisdiction. Please consult with legal counsel in your respective jurisdiction for specific legal advice.

ABBREVIATIONS

Please see below specific acronyms used in one or more places throughout the report:

ADHS – Arizona Department of Health Services
CDC – Centers for Disease Control & Prevention
CMS – Centers for Medicare & Medicaid Services
CSC – Crisis Standards of Care
EMT – Emergency Medical Technician
EHR – Electronic Health Record
HCW – Health Care Worker
HHS – Health & Human Services
HIPAA – Health Insurance Portability & Accountability Act
LTC – Long-term care facility
NHS – National Health Service
OCR – Office of Civil Rights
PHA – Public Health Authority
PHI – Protected Health Information
PPE – Personal Protective Equipment
I. INTRODUCTION

During the COVID-19 pandemic, multiple states, localities, and health care systems are using emerging technologies to create real-time surveillance dashboards regarding available PPE and other essential resources. Through data reported by hospitals, labs, and other HCPs, these dashboards provide instant assessments of the availability of key resources as well as patient placements, facilitating the implementation of CSC.

However, multiple practical and legal issues arise related to dashboard data acquisitions, uses, and disclosures, especially among corporate and other business entities sharing key information. Actual or potential allegations of health information privacy infringements can skew the accuracy of dashboard data and alter their design or implementation. Liability risks may stymie specific data sharing. The potential to uncover corporate vulnerabilities, proprietary interests, or trade secrets underlying dashboard data collections thwart greater participation. Reallocation strategies of patients, medicines, ventilators, or PPE based on needs revealed via dashboard “snapshots” implicate business concerns over preparedness planning, stockpiling, or profits.

Absent real-time resolutions, these issues can limit the flow of accurate syndromic or other data, inhibiting effective CSC responses designed to save lives in the throes of the pandemic. This brief assessment examines (1) the scope and purpose of dashboards supporting allocation of key health care resources in public health emergencies; (2) emerging practical and legal issues underlying data gathering through multiple sources; and (3) potential options to assure implementation of dashboards populated with accurate, reliable data to improve the public’s health.

II. USE OF DASHBOARD ASSESSMENTS DURING THE COVID-19 PANDEMIC

COVID-19 dashboard assessment systems provide real-time, hospital-level data (e.g., patient data, critical resource information, PPE availability data) to improve health outcomes across regions. Primary purposes of these systems include:

- addressing resource scarcity issues through detailed information about local or regional healthcare system capacity;\(^\text{245}\)
- assisting in CSC implementation;
- providing overviews of key data and metrics to support reopening phases;\(^\text{246}\) and
- assessing whether public health or healthcare initiatives are effectively slowing the spread of COVID-19.\(^\text{247}\)

Dashboards entail systematic collections of real-time data across a wide array of sources and types, illustrated in Table 1, below.
The data help PHAs, HCWs, and emergency managers make informed decisions as essential resources dwindle. The data provide real-time, demographic-specific information and statistics to help:

- Monitor the availability of resources to test, treat, and protect patients and personnel;
- Make projections regarding additional resource needs;
- Acquire resources in real-time based on specific needs and shortages;
- Provide benchmark metrics to track COVID-19’s spread and resource consumption over time;
- Compare metrics that advance cross-state resource allocation;\(^{248}\)
- Inform patient transfer decisions;\(^{249}\) and
- Track patient-specific information (in some cases).\(^{250}\)

<table>
<thead>
<tr>
<th>Table 1: Types of COVID-19 Dashboard Data Collected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COVID-19 General Metrics</strong></td>
</tr>
<tr>
<td>• Total cases, recoveries and deaths</td>
</tr>
<tr>
<td>• Positive and negative test results</td>
</tr>
<tr>
<td>• Patient identifiable and non-identifiable information (e.g., race, ethnicity, gender, age group, annual income, poverty level status, zip code)</td>
</tr>
<tr>
<td><strong>Critical Resource Metrics</strong></td>
</tr>
<tr>
<td>• Peak resource use and hospital admission</td>
</tr>
<tr>
<td>• Number of direct care staff</td>
</tr>
<tr>
<td>• Daily number and % of hospital beds (e.g., adult and pediatric ICU beds, surgical beds, medical beds, isolation room beds) and ventilators available</td>
</tr>
<tr>
<td>• Equipment and medical supply shortages (e.g., fluids, ECMO circuits, medications, O2 tanks, sanitizer)</td>
</tr>
<tr>
<td>• PPE available for healthcare workers (e.g., N95 and surgical masks, face shields, gloves, goggles)</td>
</tr>
<tr>
<td>• Number of hospitals struggling to obtain and replenish key resources and PPE</td>
</tr>
<tr>
<td>• Projections of all future beds and ventilator needs</td>
</tr>
<tr>
<td>• Status of ventilators available for loan</td>
</tr>
<tr>
<td>• Syndromic data (e.g., collection of COVID-19 symptoms among ER visitors)</td>
</tr>
</tbody>
</table>

These data help PHAs, HCWs, and emergency managers make informed decisions as essential resources dwindle. The data provide real-time, demographic-specific information and statistics to help:

- Monitor the availability of resources to test, treat, and protect patients and personnel;
- Make projections regarding additional resource needs;
- Acquire resources in real-time based on specific needs and shortages;
- Provide benchmark metrics to track COVID-19’s spread and resource consumption over time;
- Compare metrics that advance cross-state resource allocation;\(^{248}\)
- Inform patient transfer decisions;\(^{249}\) and
- Track patient-specific information (in some cases).\(^{250}\)
Most dashboards are operated either by state and local PHAs or healthcare associations. Michigan’s Health & Hospital Association assembles data (e.g., bed capacity frequency, laboratory testing capacity, number of patients using ventilators, PPE inventory, staffing shortages, units reserved for treatment) on behalf of the Michigan Department of Health and Human Services. In multiple states, gubernatorial executive orders require advanced surveillance of COVID-19 cases or symptoms. Hospitals and other providers must self-report specific data points to state or local PHAs via healthcare response and communication software such as EMResource or alternative forms per specified timelines. In Arizona, Governor Ducey’s Advanced Surveillance Advisory requires hospitals to report 38 different metrics related to the hospital’s resource capacity and patient information to Arizona’s Department of Health Services (ADHS) every 24 hours.

Several hospitals coordinate directly with ventilator manufacturers for some data sharing. Others acquire third party companies that assist with data gathering services. LocatorX uses its National Medical Device Registry to track ventilator availability and loan status for participating hospitals. Other healthcare analytics companies offer dashboard assessments using big data analysis at set fees. MedeAnalytics’ dashboard technology assists healthcare companies manage “financial, operational, and healthcare resources.”

Other private sector companies form coalitions to assist front-line workers. Notably, Amazon, Epic, Mayo Clinic, and other entities partnered to form a dashboard “[focusing] on staff, space, and other resources.” Similarly, HealthCatalyst partnered with several top EHRs manufacturers and clinical researchers to pool EHRs from over 2 dozen health systems. At the federal level, CMS derives ICU bed availability through cost reports self-reported via health systems and hospitals.

III. EMERGING CONCERNS RELATED TO DATA ACQUISITION, USE AND DISCLOSURE

Undeniable benefits are derived from gathering large amounts of data to generate accurate “snapshots” of real-time public health or medical trends related to COVID-19. However, various concerns arise over dashboard implementation, particularly over widespread use of sensitive patient and employee data. As examined below, issues related to efficiency, public opinion, and purpose extend across multiple sectors including HCPs, HCWs, PHAs, and corporate entities.

**Health Care Providers.** Substantial practical issues underlying dashboard data and implementation involving HCPs (e.g., hospitals, labs, clinics) include reporting miscues, non-uniform data gathering, efficiency, and accuracy.

**Untimely Reporting.** Local, state, and federal authorities largely rely on PHAs and HCPs to self-report data to populate dashboards, but these efforts are stymied by untimely data reporting. On March 23, 2020, Michigan Governor Gretchen Whitmer issued an Executive Order with Robert Gordon, the Director of Michigan’s Department of...
Health and Human Services. Similar to surveillance orders in Arizona (noted above), Michigan requires HCPs to track medical supplies and COVID-19 deaths daily with prompt dissemination to relevant governmental agencies. While the order sets consequences for failures to timely report, ultimately hundreds of HCPs across the state participate, lending to inevitable delays that skew overall data results.

Non-uniformity. Types of data reported have also led to problems when synthesizing dashboards. Some HCPs report extensive data regarding patients and employees. Others share far more limited information. Across the U.S., LTCs constitute known “hotspots” for COVID-19 infection. However, states (1) disagree on which types of these facilities must report data and (2) employ different metrics to report data. Some report data specific to individual LTCs; others provide mass data representing all LTCs in an entire county. Incomplete reported data compound comparative analyses that could shed light on resource allocations and patient transfers.

Non-uniform data sharing not only obfuscates accurate dashboards but also leads to efficiency concerns, particularly when attempting to track medical supplies such as gloves and masks for providers. Absent uniform systems to catalogue these products, determining available supplies is time consuming. At the University of Kentucky Chandler Hospital, for example, a specific team works extensively to track current PPE usage and needs. Some researchers suggest that medical supplies should be barcoded at production to facilitate their monitoring in the field and avoid confusion in reporting.

Accuracy. Concerns over data accuracy are also prevalent. On June 6, 2020, ADHS Director Dr. Cara Christ admitted that her staff erred by “over reporting the number of hospital beds currently available and in use in Arizona” on ADHS’ COVID-19 dashboard. Predictable miscalculations can alter dashboard data and their reliability, complicating efforts among HCWs and providers to equitably distribute patients and supplies.

Health Care Workers. Dashboard systems often lack the requisite specificity to help HCWs address patient needs. Only 5.8% of COVID-19 cases reported to CDC from February 12 - March 28, 2020 included relevant clinical details (e.g., underlying health conditions, risk factors from respiratory infections) that can be useful for practitioners in treating other patients’ cases. Accordingly, dashboards may not provide sufficient information to facilitate patient treatment, requiring practitioners to seek such real-time guidance from additional sources.

Public Health Authorities. The reliability of COVID-19 data used by PHAs is questionable at times. Floridians have suggested the state may be underreporting positive COVID-19 cases after the termination of the state’s lead dashboard architect, Rebekah Jones. Jones stated that her desire for greater transparency regarding Florida’s dashboard data ultimately led to her dismissal, leading to questions over data accuracy. Vulnerable communities are also leery of data sharing with PHAs. In Tennessee, local police departments called off an agreement with the state’s department of health that would allow it to receive the names and addresses of those testing positive.
for COVID-19. Distrust within communities of color arose over fears that the information could be turned over to law enforcement or ultimately lead to deportation.  

**Corporate Entities.** Involvement of corporate entities in gathering dashboard data may dis-incentivize patient cooperation. Some patients may be worried that corporate juggernauts (e.g., Microsoft, Google, Apple) will initially use their data to build dashboards, but later retain the information for profit. Some private companies populate their own dashboard systems as a more efficient alternative to HCP self-reporting. On April 10, Apple and Google jointly promoted Bluetooth technology that notifies persons when they come within a certain radius of a COVID-19 positive individual. Emerging technologies tend to heighten fears that individualized data will not be properly secured, despite laudable purposes of data acquisitions.

### I. EMERGING LEGAL ISSUES REGARDING DASHBOARD DATA

Legal issues related to dashboard data may be actual or purported depending on the extent of data acquired, used, or disclosed to effectuate specific public health or health care objectives. Substantial concerns center around potential health information privacy violations, risks of liability, disclosure of corporate information, and reallocation of essential resources extending from implementation of dashboard technology and data sharing.

**Health Information Privacy.** Entities providing identifiable data for dashboards may have reservations about sharing or releasing information. Privacy considerations extend from an array of privacy laws and policies at federal, state, and local levels. Premier among these laws is the HIPAA Privacy Rule, which generally restricts unwarranted acquisitions, uses, or disclosures of PHI by covered entities (e.g., HCPs, insurers, clearinghouses). The Rule offers multiple exceptions including uses or disclosures of PHI to PHAs “to prevent or control spread of disease” such as through dashboard surveillance activities. HHS’ OCR has clarified that covered entities under the Rule may disclose PHI to law enforcement, PHAs, and select others without patients’ express written authorization.

Still, many HCPs and HCWs are concerned about releasing sensitive COVID-19 data for several reasons. Large-scale data collections implicates public trust. As noted above, some entities are reticent to share PHI with law enforcement or first responders. In Pennsylvania, pending litigation pits two police unions against local health officials to force disclosure of patient names and addresses. Concerns arise as well over exposing systemic, structural and institutionalized racism and revealing barriers to health care access for certain communities.

Employers collecting personally-identifiable health data for dashboard and tracking purposes must also respect privacy. Lawsuits have already emerged against large corporations assisting with dashboard software development, alleging patients’ PHI was provided to private tech firms without patient consent. Contact tracing efforts involving smart phone technologies to reveal locations of persons with COVID-19 foster privacy
suspicions, heightened by shared dashboard usage. In June 2018, patients sued the American Cancer Society and other HCPs in California for sharing private medical information with Facebook without their knowledge. They alleged Facebook marketed their data for profit. A federal appellate court ultimately dismissed the case, finding consent to the data collection by the plaintiffs’ acceptance of Facebook’s Terms and Policies.

Identifiable health data culled directly from hospitals’ EHRs may breach patient confidentiality. Physicians have professional and legal duties to keep sensitive patient information confidential. Indiana health officials, for example, were initially reluctant to release numbers of ventilators for dashboards because of patient confidentiality, potentially revealing which patients’ conditions were severe enough to require ventilator assistance. Health officials assented later, presumably after recognizing the urgent public health needs for accurate ventilator data.

Liability Risks. National data-sharing infrastructures may reveal specific vulnerabilities in planning and preparedness that implicate liability concerns. Hospitals and other entities might find their own failures to plan are exposed upon releasing certain COVID-19 data. Exposing these weaknesses through data collection could contribute to claims of negligence or other legal grounds against HCPs and LTCs. Nursing home administrators express frustration over the lack of centralized databases for LTC providers to self-report or investigate COVID-19 patients and residents. For example, to the extent Elmhurst Hospital (NY) reportedly lacks a permanently integrated health system, logistics of patient transfers are legally problematic.

Medical malpractice liability is an additional factor in dashboard data collection. Typical medical malpractice insurance policies only cover a physician’s specialty and may not apply during implementation of CSC in declared emergencies. Multiple and extensive legal protections from liability already exist, including through federal and state emergency declarations, but national and state medical societies routinely seek immunity from medical malpractice suits arising from COVID-19 treatment. Yet, since much of the data reporting comes from HCPs and HCWs, sharing inaccurate or untimely data could lead to medical malpractice liability.

Corporate Concerns. Corporations carefully guard and protect specific data owned or controlled by the entity that implicate current or future business interests and profits, including corporate proprietary interests and trade secrets. They may also be leery of the potential for governmental takings of specific property for public health purposes to the extent it exposes potential risks for their enterprises.

Proprietary Interests. Some dashboard data are derived through cooperative efforts among private corporations. State or local PHAs might rely on private entities to voluntarily release data about patient medical information, physical location, or hospitals for dashboard purposes. As mentioned, Apple, Google, and other large tech companies are currently tracking such data through collection from their social media users, and creating their own dashboards using proprietary technology.
Interplays between private corporations and government agencies breed concerns over corporate proprietary interests. Proprietary interests relate to commercially valuable, private information that is not otherwise lawfully ascertainable.\textsuperscript{294} Release of such corporate information is highly problematic. Biotech and pharmaceutical companies, for example, have recently refused to share information to collaborate on a COVID-19 vaccine.\textsuperscript{295} Similar issues and resulting legal battles may arise over requests among corporations, like medical device companies and hospitals, to share data with PHAs. This might include proprietary data about clinical trials, lab results, x-rays, or inoculation data to compare recovery rates with vaccination data.\textsuperscript{296} Some hospitals’ EHRs may also contain proprietary information.\textsuperscript{297} As the chief information officer of Nashville General Hospital explained, sharing data with other local hospitals can decrease a competitive advantage in the market.\textsuperscript{298} Consequently, hospitals and medical data analytics companies may seek private EHR vendors to cull data from their systems to properly package the records to share with PHAs.\textsuperscript{299}

\textbf{Trade Secrets}. Trade secrets are any “formula, pattern, compilation, program, device, method, technique, or process that (i) derives independent economic value . . . and (ii) is the subject of efforts that are reasonable . . . to maintain its secrecy.”\textsuperscript{300} Real-time data releases amid the COVID-19 pandemic may risk exposure of trade secrets.\textsuperscript{301} The United Kingdom’s National Health Service (NHS), for example, initially granted intellectual property rights to large corporations like Google and Microsoft, allowing them to profit from access to its data. Terms of the deal were later changed following threats of legal action, resulting in NHS commanding sole use of the dashboard’s intellectual property.\textsuperscript{302} Releasing data and cooperating with dashboard operators can financially expose corporate entities if certain trade secrets or proprietary interests are revealed.

\textbf{Governmental Takings and Reallocation of Resources}. COVID-19 dashboard data are used to justify specific reallocations of limited PPE, medical, and other resources. Under existing emergency declarations, federal, state and local governments may be authorized as well to “take” essential medical supplies or other resources from private entities to equitably spread to areas of greatest need. Compensation to owners must be provided. However, the sheer act of taking essential supplies in unanticipated ways may alter HCPs’ best efforts to adequately plan or prepare for their own risks and response activities.\textsuperscript{303} Consequently, the mere premise of taking essential supplies may thwart transparent and accurate data reporting among specific enterprises concerned about their own exposure to risks.\textsuperscript{304}

V. \hspace{0.5cm} LEGAL OPTIONS FACILITATING DASHBOARD IMPLEMENTATION

Dashboard technologies can provide real-time assessments of specific resources within and across regional health systems. Stated simply, accurate and timely data sharing through dashboards can save lives, especially as HCPs shift to CSC when resources are scarce and patient demands rise. Supporting the fullest use of these technologies consequently furthers the public’s health during the COVID-19 pandemic. Practical and legal issues (described above) may limit or inhibit dashboard data acquisitions, uses, or disclosures, but they are not intractable. Rather, multiple options
and solutions are available to facilitate greater or extended use of dashboards in real time. These include:

1. Specifying fundamental surveillance requirements for HCPs, HCWs, and other data sources for dashboards to help assure timely and accurate reporting. Gubernatorial orders in Michigan\textsuperscript{305} and Arizona,\textsuperscript{306} for example, identify requirements for surveillance efforts. Digital technologies may be implemented in promotion of more efficient data collection;\textsuperscript{307}

2. Clarifying direct roles and responsibilities among state or local PHAs to oversee dashboard maintenance and implementation via private sector entities (e.g., health care associations). Arizona’s Advanced Surveillance Advisory\textsuperscript{308} sets data metrics that hospitals report to ADHS for dashboard implementation;

3. Tying robust participation in dashboard systems among HCPs to their continued licensure, accreditation, or other state-based assessments. Failure to participate in state-based public health reporting requirements may lead to licensure investigations of HCPs and HCWs under numerous state laws. In assessing HCPs for accreditation, the Joint Commission examines infection disease control practices, including adherence to state or local public health reporting requirements.

4. Setting and applying stronger penalties to participating HCPs who fail to report accurate or complete data, or inappropriately use or disclose data, related to dashboard surveillance purposes. In May 2020, for example, CMS imposed monetary fines against LTCs that failed to timely report relevant COVID data;\textsuperscript{309}

5. Promoting intra-state or regional agreements, alliances, or partnerships among affected HCPs for responsible data sharing and uses regarding dashboard technologies. HCA Healthcare recently partnered with Google Cloud to facilitate an anonymous data sharing platform for hospitals, released in April 2020;\textsuperscript{310}

6. De-identifying patient- or provider-specific data populating dashboards as extensively as possible without completely diminishing their use to make real-time allocation decisions. Cerner Corporation partnered with Amazon Web Services, for example, to provide access to de-identified COVID-19 data that may aid in making treatment and supplies allocation decisions;\textsuperscript{311}

7. Committing to using dashboard data principally for implementing CSC or facilitating other critical information needs extending from public health emergencies (e.g., avoiding commercial for-profit use);\textsuperscript{312}

8. Limiting the array of entities outside health care settings having access to dashboard data to those with a legitimate public health purpose or need for such information. In Tennessee, for example, officials decided to stop sharing patient-specific data with law enforcement and first responders, favoring implementation of universal precautions to prevent infections;\textsuperscript{313}
9. Immediately correcting misreported data or other inaccuracies within dashboard systems to assure the integrity of system operations. In May 2020, Georgia health authorities quickly corrected the posting of misleading information on its dashboard, similar to ADHS’ efforts in Arizona noted in part III, above.\(^{314}\)

10. Providing greater protections from liability for HCPs, HCWs, and others providing or using dashboard data, especially related to unanticipated shifting of resources or patients. As noted in part IV, above, extensive liability protections may apply, especially related to emergency declarations and executive orders. In some states, real-time legislative reforms during the pandemic provide new or enhanced protections. In New York, for example, legislators recently amended the state’s Good Samaritan statute to provide broad civil immunity to HCPs while administering medical services related to COVID-19.\(^{315}\)

11. Allowing corporate entities sufficient leeway to withhold proprietary or other secretive information from dashboard data gathering to the extent they can demonstrate real and substantial risks of harm. Connecticut protects vendors by redacting public contracts revealing COVID test pricing on grounds that such information constitutes trade secrets.\(^{316}\)

12. Providing sufficient advance notices of potential re-allocations of PPE, tests, medications, or other supplies via government, or between health care enterprises, through alerts (e.g., circuit breakers) imbedded into dashboard systems. Pennsylvania’s enhanced dashboard features a “hospital preparedness” tab showing numbers of patients on ventilators and ECMOs, which could include alerts or notices when certain levels are reached.\(^{317}\) San Diego’s dashboard includes triggers (alongside current levels) that may lead to modifications of existing health orders.\(^{318}\)

13. Clarifying the “triggers” for implementation of CSC supported via trends revealed via dashboard data. After multiple requests among HCPs and others to implement state-wide CSC plans, Arizona health authorities invoked the CSC plan on June 29, 2020,\(^{319}\) justified in part by real-time analysis of dashboard data; and

14. Closely following pre-set guidance in state or regional CSC plans for the fair and equitable distributions of resources or sharing of burdens underlying dashboard use (and plan for the delicate balance of ethical considerations and patient needs in allocation procedures).\(^{320}\) The time for ad hoc decision-making related to patient care in response to COVID-19 or future public health emergencies ends when CSC plans are invoked, often based on dashboard assessments as noted above. In such cases, pre-set guidance for population-based patient care, implemented with sufficient flexibility, undergirds dashboard data acquisitions, uses, and disclosures.
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