Emergency System for Advance Registration of Volunteer Health Care Personnel (ESAR-VHP)

Hospital Implementation Issues and Solutions Focus Group Meeting Report

Department of Health and Human Services
Health Resources and Services Administration
Healthcare Systems Bureau
Division of Healthcare Preparedness
ESAR-VHP Program

Initial Report – November 15, 2004

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Table of Contents

A. Executive Summary……..2

B. Background and General Description of Meeting……..7

C. Summary of Meeting Discussion…….11

1. Discussion of Hospital Implementation Issues and Solutions……...11
    a. Hospitals and Public Health Authorities……11
        i. Credentialing, Privileging, and Identification……12
        ii. Training……..16
        iii. Recruitment and Volunteer Advocacy……...18
        iv. Common Data Definitions and Naming Conventions……...20
        v. Regionalizing and Nationalizing the ESAR-VHP…….22
    b. Legal, Regulatory and Policy Matters……...23
        i. Legal and Regulatory Issues/Authorities and Emergency Operations……..24
    c. ESAR-VHP Technology and Support Systems…….28
        i. System Design and Content……...29
        ii. Security, Privacy, and Communications……31
        iii. Funding and Cost……...33
        iv. Operations and Maintenance……..34

Attachment 1……36

A. Executive Summary

Background and General Description of Meeting

In disasters, hospitals proximate to the disaster site often experience an influx of health professional volunteers willing to help care for victims. However, history has shown us that it is difficult for hospitals to effectively use these volunteers due to the inability to verify the identities of volunteer physicians and nurses, or their basic licensing or credentialing information, including training, skills, competencies and employment.

In response to the Nation's inability to make optimum use of volunteer health personnel, Congress passed the *Public Health Security and Bioterrorism Preparedness and Response Act of 2002*. Section 107 of the Act directs the Secretary of Health and Human Services (HHS) to develop an Emergency System for Advance Registration of Health Professions Volunteers. The Health Resources and Services Administration (HRSA) has created the office of "Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)" which is in the process of establishing standardized, volunteer registration systems within each state (and in the Territories) that will include readily available, verifiable, up-to-date information of the volunteer's identity, licensing, credentialing, accreditation, and privileging in hospitals or other medical facilities that might need volunteers. Establishment of these nationally accepted guidelines to build their state systems would afford each state the ability to quickly identify, and better utilize, health professional volunteers in emergencies and disasters. Development of these state ESAR-VHP systems, built on agreed upon guidelines and standards will ultimately enable the development of a "virtual" system by allowing the aggregation of state registration systems for use regionally in the event of a catastrophic multi-state disaster.

HRSA has partnered with the American Hospital Association (AHA) to further identify and address potential hospital implementation issues and solutions for the advanced registration of volunteer health professionals (ESAR-VHP) program. What follows is a summary of the key findings and recommendations culled from the discussions of the first in a series of four planned Hospital ESAR-VHP Implementation Issues and Solutions Focus Group (HIFG) meetings.

Credentialing, Privileging, and Identification

The HIFG discussed issues related to: Verifying the identity of volunteers in an event; access to information regarding credentials, competencies, and hospital privileges; and mechanisms to ensure that the information is current and accessible in a disaster.

- The components and structure of the ESAR-VHP system should be as simple as possible to allow its early deployment and use in extreme circumstances.

- Adopt a minimum set of data elements for credentialing that are acceptable to hospitals as a minimum for establishing the credentials, privileges and identification of volunteers.
- There was a general consensus to provide a recognized card/badge with static information to allow the immediate identification of a volunteer, supported by additional, constantly updated information contained in a centralized state ESAR-VHP database.
- The ESAR-VHP system must support credentialing that is flexible over time – both in the immediate aftermath of a disaster to allow limited but expeditious verification of credentials as well as in later stages to allow more complete credentialing.

Training

The HIFG discussed the minimum level of training that would be necessary:

- There will be a need for volunteers deployed to an incident to receive "just in time" training that will provide an orientation to the incident and the functioning of the particular hospital in which they will be working.
- Essential competencies include training in incident command systems (nomenclature and standard roles), basic infection control, disaster awareness and safety training.
- Assigning volunteers to pre-determined levels based on training and competencies may assist hospitals in determining how their services may best be used.

Recruitment and Volunteer Advocacy

The HIFG discussed the options for encouraging hospital participation in volunteer recruitment and improving the ability to recruit health care professionals, including:

- Providing financial incentives for hospitals to participate.
- Providing the business case for hospital involvement.
- Assuring liability immunity for hospitals and health care professionals that participate in ESAR-VHP.
- Obtaining support and buy-in for the state's ESAR-VHP from the trade and professional associations that represent hospitals and the health care volunteers.
- Informing hospitals that employ health profession volunteers about the activation of the system in a disaster and providing the opportunity for them to "release" their staff.
- Creating a non-burdensome registration process and giving volunteers choices about when, how and where they will provide services.

Common Data Definitions and Naming Conventions

The HIFG discussed hospital interests and concerns including:

- In order to foster interoperability, guidelines should create uniform nomenclature and a standard data dictionary for the core data set that applies in every state ESAR-VHP.

Time must be provided, however, for states and health care facilities to adopt and implement these standards.

- Examine all databases that may provide useful examples of common definitions and nomenclature. Some potentially useful databases include those of the Federation of State Medical Boards and the Nation Council of State Boards of Nursing.

Regionalizing and Nationalizing the ESAR-VHP

The HIFG discussed, from the hospital perspective, issues regarding the interoperability of state-based ESAR-VHP systems and their ability to be used in other jurisdictions. Discussions centered on:

- The need to focus on establishing core uniformity through the ESAR-VHP guidelines at the outset rather than having to rely on interstate compacts to make it interoperable later.
- Regional and national interoperability will be more likely if ESAR-VHP is: (1) built on non-proprietary systems; (2) as simple as possible at the outset (defining core data elements and standard definitions); (3) linked to existing databases for accessing and updating core data elements; and (4) Web-based, secure, and easy to operate and maintain.

Legal and Regulatory Issues

The HIFG discussed extensively liability concerns from the perspective of the individual volunteer, the hospital that is receiving volunteers, and the hospital that is donating volunteers. Key principles emerged from the discussion including:

- The provision of liability protection and the ability to clearly communicate liability protections to potential volunteers will be key to ensuring the success of the state-based ESAR-VHP system.
- While the ESAR-VHP is a state-based system, it is also intended to support the deployment of volunteers across state lines in appropriate circumstances. Federal liability protection should be provided when volunteers cross state lines to help with a disaster.

This discussion also raised many critical liability questions that we expect will be addressed in the report from the Center for Law and the Public's Health, including: State-declared versus undeclared emergencies or public health emergencies; distinctions between volunteers (paid versus unpaid) and employees for purposes of liability or workers compensation coverage; legal distinctions in liability for services provided on hospital sites versus offsite; changes in the standard of practice in catastrophic disasters; malpractice insurance/private health insurance/disability and workers' compensation; and the impact of resource-sharing agreements between hospitals.

Authorities and Emergency Operations

Based on the knowledge that some state governmental systems are more centralized than others, the HIFG raised questions and issues regarding authorities and emergency operations of ESAR-VHP that should be considered in the HRSA guidelines including:

- Who other than a state agency will have the authority to activate the ESAR-VHP? A local health department? Individual hospitals?
- What are the emergency operations implications for a database that is managed by a private entity rather than a governmental entity?
- How will existing volunteer programs organized under different agencies, such as the Medical Reserve Corps, be coordinated with or potentially integrated into the ESAR-VHP? Coordination with these other volunteer programs is crucial for an effective disaster response.
- How will the activation and operation of a state's ESAR-VHP change if the disaster is terrorism-related?

System Design and Content

An effective and efficient ESAR-VHP system must be designed with consideration of hospital needs in mind and with system content that is adequate to ensure the prompt availability of the right volunteers to the right hospital at the right time. The key concerns and recommendations raised by the HIFG include:

- A call for ESAR-VHP guidelines to establish one core system that is simple, based on a uniform and commonly defined set of minimum data elements, interoperable across state lines, linked to other databases to update information, and leverages multiple software platforms without being vendor specific.
- Core recommended data elements include: Name and contact information, degree, hospital in which the individual has privileges, physician/nurse specialty(s), state license number, state license board check for disciplinary actions, National Practitioner Databank check of liability actions, date of last reappointment, and status (actively practicing, inactive/retired).

Security, Privacy and Communications

The HIFG discussed questions related to: Who may access data; under what conditions may data be accessed; how to guarantee the integrity of data; and how to protect confidential data elements. The following key considerations were raised by the HIFG:

- The information contained in certain fields must be accessible only in a disaster and then only by designated individuals responsible for activating or otherwise utilizing the system. This would include elements such as contact information, sensitive professional information and personal medical information.
- Information contained within the ESAR-VHP database should never be used for purposes other than that for which the system is designed.

- The privacy principle of "minimum necessary" is relevant to this system. That is, volunteers should be asked to provide the minimum necessary data to the system, and when the system is activated, only the minimum necessary data should be shared with designated entities and individuals.

Funding and Cost

The HIFG discussed ways to make the ESAR-VHP more economically viable and sustainable over time. Ideas included:

- Integrating the ESAR-VHP into other existing systems or populating and updating the database automatically through linkages with other databases.
- Using Web-based, electronic enrollment forms.
- Recruiting through the routine health care professional license renewal process.

Operations and Maintenance

Ideas from the HIFG to keep the ESAR-VHP data up-to-date and accurate:

- System should provide the capability for volunteers to personally update certain data elements.
- Maintenance of state ESAR-VHP systems should be as least labor intensive as possible and ideally be capable of automatic updates through links with data sources containing verified information. The potential for developing systems that can automatically be updated should be explored.
- Flagging capability within the database for data that expires over time that will alert the volunteer/entity to update information.
- To ensure the sustainability of ESAR-VHP over time, it is important that ESAR-VHP be, to the maximum extent possible, a "byproduct" of other systems as opposed to a centralized separate system.
- Consideration for future "swipeable" smart card system that could update educational and training data elements automatically.

B. Background and General Description of Meeting

Background

While the terrorist attacks of September 11, 2001, and the subsequent anthrax attacks have increased the nation's interest in and attention to public health emergency preparedness, hospitals have always had plans in place to address man-made and natural disasters that occur in their communities. Most of these plans provide for the supplementation of hospital staff in order to address the expected surge in patients presenting to the hospital with injuries or illnesses. In most cases, these provisions involve extending the shifts of health care professionals, including physicians, nurses and other caregivers who are already at the facility, and calling in staff that are off-shift at home or on vacation. In certain larger-scale emergencies, affected hospitals may draw upon the resources of other hospitals in the community that may not be directly impacted by the immediate emergency or disaster.

In addition to health care facilities' internal ability to "surge-in-place," and their limited ability to draw upon community resources to supplement existing staff, experience has shown us that in natural disasters, such as floods and earthquakes, and in man-made disasters, such as train derailments and industrial chemical accidents, large numbers of health care professionals often arrive unsolicited at health care facilities volunteering to help. However, health care facilities generally are unable to utilize these volunteer health care professionals to the full extent of their experience and training because of a lack of ability to verify their identity, licensing, credentials and employment. Liability concerns also inhibit facilities from using volunteer health care professionals.

This is similar to what occurred in the aftermath of the September 11, 2001 attacks. New York City hospitals reported that despite an influx of health professional volunteers willing to respond to the World Trade Center tragedy, they were unable to use the volunteers because hospital administrators were unable to verify their identities, basic licensing or credentialing information, including training, skills, competencies and employment. The loss of telecommunications precluded hospitals from contacting sources that could have provided some credentialing or privileging information. Further complicating matters, there is no single effective and efficient system to preregister volunteer health care personnel for emergencies, nor is there one acceptable method for verifying their credentials and qualifications.

As a result of these kinds of concerns, in Section 107 of Public Law (P.L.) 107-188, the *Public Health Security and Bioterrorism Preparedness and Response Act of 2002*, Congress authorized the development of an ESAR-VHP, a national system to assist medical professionals in volunteering for emergencies and disasters by providing verifiable, up-to-date information regarding the volunteers' identities, licensing, credentialing, accreditation, and privileging to hospitals or other medical facilities that

can utilize their services. The Secretary of HHS has directed HRSA to carry out this section. HRSA will carry out this mandate through the development and implementation of guidelines and standards for a state-based ESAR-VHP system that will have the capability to be interoperable across state lines. In the 2005 National Bioterrorism Hospital Preparedness Program (NBHPP) cooperative agreement guidance, HRSA will provide the 62 NBHPP cooperative agreement awardees with a uniform set of guidelines for use in the development of state-developed and managed systems of volunteer health personnel.

In May 2004, HRSA's Division of Health Care Emergency Preparedness convened an ESAR-VHP focus group, which helped to more clearly identify and begin to assess ESAR-VHP development and implementation issues, and set an agenda for the development of formal ESAR-VHP guidelines and standards. Among the most challenging implementation issues identified by the focus group were ESAR-VHP hospital implementation issues such as: Credentialing, privileging and verification; positive identification of volunteers in an emergency; training; consistent funding; hospital and provider liability and workers' compensation issues.

HRSA subsequently contracted with the AHA to further elucidate hospital implementation issues and provide solutions to address them. The purpose of the AHA's contract effort, referred to as "Hospital Implementation Issues and Solutions," is to:

- Identify and assess ESAR-VHP development and implementation issues for hospitals;

- Identify possible solutions or options for addressing issues; and,

- Provide timely input into the development, testing, implementation and refinement of ESAR-VHP Guidelines and Standards.

This contract effort is one of several efforts that are being undertaken to develop and implement the ESAR-VHP Guidelines. Other efforts include:

- "Technical and Policy Guidelines Development Support" – A contract with ManTech International and partners Collaborative Fusion, the American Medical Association, and Joint Commission Resources, which will include assessments of the entire spectrum of advance registry development, operation, implementation features and implementation issues, including but not limited to, design and content, credentialing and privileging, training, operations and maintenance, communications, security and privacy, authorities, emergency operation; and recruiting, funding, regionalizing and nationalizing the state-based ESAR-VHPs.

- "Legal and Regulatory Issues and Solutions" – A contract with the Center for Law and the Public's Health, which will identify and assess state and federal legislative and regulatory issues associated with implementing an advance volunteer health care personnel registry.

The AHA agreed to host a series of four ESAR-VHP Hospital Issues Focus Group (HIFG) meetings with subsequent summary reports identifying issues and potential options and solutions. The HIFG meetings would include emergency preparedness experts from state, regional and metropolitan hospital associations; representatives from hospitals of various sizes, locations and types; and representatives from a number of relevant national organizations, such as the Joint Commission on Accreditation of Health Care Organizations, the Federation of State Medical Boards, the National Council of State Boards of Nursing, the National Association of Psychiatric Health Systems and the Association of State and Territorial Health Officials.

The HIFG meetings are scheduled to coincide with the following critical steps in the development and implementation of the national ESAR-VHP.

- Preliminary ESAR-VHP guidelines and standards will be completed by January 2005. The AHA convened its HIFG in October 2004 to gather input to assist HRSA in the ESAR-VHP guideline development process. A report will be provided to HRSA in November 2004.

- The guidelines will be pilot-tested by 10 NBHPP awardees from January through June 2005. Therefore, the AHA will reconvene the HIFG during the spring of 2005 to identify and discuss implementation issues and potential solutions for the states participating in the ESAR-VHP Phase I pilot program and will provide a report to HRSA shortly after the HIFG meeting.

- In the fall of 2005, the AHA will reconvene the HIFG to identify and discuss the issues identified during the implementation of the ESAR-VHP Phase II, 20 state roll-out. A report describing these Phase II discussions will be delivered to HRSA shortly after the HIFG meeting.

- In late summer/early fall of 2006, AHA will reconvene the HIFG for a final meeting to review progress and identify and address any remaining issues during the ESAR-VHP Phase III roll-out in the remaining 32 NBHPP states/jurisdictions. A final report will be submitted by October 2006.

General Description of Meeting

The first HIFG meeting was held on October 12-13, 2004, at the Ronald Reagan International Trade Center in Washington, DC. In attendance were 47 individuals (see attachment 1) representing: 28 state hospital associations; 9 metropolitan/regional hospital associations; 8 hospitals/health systems and one state department of health. Overall, 37 states were represented. Also, 10 representatives from national organizations and other ESAR-VHP contract efforts, four HRSA representatives and three AHA staff were present.

Early in the meeting, participants were provided with brief background and status presentations from the HRSA's ESAR-VHP program, the Technical and Policy Guidelines Development Support team, the Legal and Regulatory Issues and Solutions team, and the Hospital Implementation Issues and Solutions team. The balance of the two-day meeting involved detailed discussions of hospital issues and potential solutions and options along three general categories, including: (1) Hospital and Public Health Authorities; (2) Legal, Regulatory, and Policy Matters; and (3) ESAR-VHP Technology and Support Systems. These three categories were further divided into 10 primary issue topics intended to track the 10 national working groups being convened by the Technical and Policy Guidelines Development Support team. These discussions were facilitated and directed by James Bentley, Ph.D., AHA's senior vice president for strategic policy planning.

C. Summary of Meeting Discussion

1. Discussion of Hospital Implementation Issues and Solutions

Dr. Bentley began the meeting by noting that the focus group is not involved in a theoretical discussion, highlighting the recent series of hurricanes in Florida that led to a call to AHA from hospitals in that state seeking assistance to relieve physically and mentally exhausted nurses. Caregivers and relief workers from as far away as Utah offered to assist the Florida hospitals.

Dr. Bentley urged meeting participants to keep several things in mind. First, in terms of the state-based ESAR-VHP systems' capability to connect regionally or nationally if faced with a massive catastrophic multi-state disaster, it is important to remember that hospitals are sometimes the donors of volunteer health professionals and are sometimes the recipients. Further, he urged meeting participants to be both listeners and active participants in the discussion. He noted that many states were just beginning their ESAR-VHP programs, while others had programs well underway, and encouraged participants to provide input into what will or will not work in their states.

Further, he reminded participants that there are a number of "givens" in this discussion that cannot be changed. First, Congress mandated the development of an emergency advanced registration system for health profession volunteers. Second, HRSA has decided that, initially, these systems must begin with requiring the advance registration of three categories of health care professionals — physicians, registered nurses and behavioral health professionals (including social workers, psychologists, psychiatrists, and therapists). While the agency does not exclude the enrollment of other types of health professionals, these categories represent the minimum necessary. Finally, he noted that he would be encouraging participants to focus their comments not only on issues but also on potential options and solutions.

a. Hospitals and Public Health Authorities

The first major category discussed by the HIFG participants involved issues related to hospital needs for the ESAR-VHP program and public health authorities that must be established in order for a ESAR-VHP system to function within a state. This section includes issues such as: (i) credentialing, privileging, and identification; (ii) training; (iii) recruitment and volunteer advocacy; (iv) common data definitions and naming conventions; and (v) regionalizing and nationalizing the ESAR-VHP.

A summary of the major points raised in this discussion, as well as some concerns, options, solutions and best practices are outlined below.

i. Credentialing, Privileging, and Identification

The HIFG participants discussed issues related to verifying the identity of volunteers in an event; access to information regarding volunteers' credentials (including current licenses, certifications, and specialty information), competencies (training), and hospital privileges; and mechanisms to ensure that the information is current and accessible in emergency circumstances.

This discussion is meant to provide information to support the work of *HRSA's ESAR-VHP Working Group on Credentialing, Privileging, and Identification Issues*. This working group will examine the range of credentialing, privileging, and identification issues associated with ESAR-VHP systems, specifically for physicians, registered nurses, and behavioral health professionals and will determine appropriate credential information for each discipline. Also, this group, along with the *Systems Design and Content* and the *Regionalization and Nationalization* working groups, will examine and set objectives on how volunteer credentialing information needs to be assembled, validated, and presented in order to provide ESAR-VHP system portability from state to state. Further, these working groups will help to identify and establish long-term objectives that allow for uniform and consistent processes to classify and categorize volunteers based on credential status and training and determine how to assign basic disaster privileging to registered volunteers.

Several guiding principles emerged from the HIFG discussion:

- The system should be as simple as possible to allow its early deployment and use in extreme circumstances. Too much dependence on technology could put the system at risk.

- The system should, to the extent possible, take advantage of existing databases and identification systems so as not to "recreate the wheel."

- The information contained within the ESAR-VHP system must be accessible and accurate, and the entire system must be sustainable.

- For the system to work, liability exposure concerns must be addressed.

- The system should be structured to be flexible enough to accommodate the needs of the health care system both in the immediate aftermath of an event and in situations where demands on the health care system are sustained over time.

- The system should be structured to permit the sharing of volunteer database information across state lines when needed. This is important when a disaster occurs near two or more state borders or when a disaster within a specific state overwhelms its existing health care resources.

Major discussion items related to these points include:

- Minimum data elements: Hospitals require a minimum set of data to credential health care professionals in a disaster. Among the items proposed were:

    - Name and contact information.
    - Training and degree information.
    - Hospital(s) where the individual has privileges.
    - Physician specialty(s).
    - Nursing specialty(s).
    - State license number.
    - Date of last reappointment.
    - State license board check of disciplinary actions taken against license.
    - National Practitioner Databank check of liability actions.
    - Status (actively practicing, inactive/retired).

- There is a need for a physical badge/card or other form of physical identification, so that hospitals may immediately verify the identity of the volunteer and have access to basic "static" information regarding his/her credentials/status. Considerations include:

    - Creating a common badging structure using a standardized format that is agreed to in advance by the hospitals within the community. Such a badge may include a photograph of the volunteer, the name and title of the volunteer, and an identification number that links to a database providing more information about the volunteer.

    - Adapting existing forms of identification or creating a separate form of identification for ESAR-VHP volunteers. One option is to add information to an existing form of identification that is routinely carried by the volunteer (e.g. existing hospital identification badge/card, driver's license, hospital parking pass). Another option is to create an entirely separate, standardized form of identification that is provided only to those who volunteer for the state's ESAR-VHP system.

        - An important caution regarding the use of existing forms of identification, such as a driver's license, is that ESAR-VHP partners may not have the ability or authority to piggy-back onto

those systems. Using other systems available in the state may require new regulations and laws passed by the state general assemblies.

- An important caution regarding identity theft: Health care professionals are being advised not to carry their licenses with them. Therefore, it may not be reasonable to expect nurses or physicians to have in their possession a copy of their licenses or other documents verifying their current licenses. Further, reliance on a paper document for license verification may be difficult because many states are pursuing electronic license renewal.

- Protecting the volunteer's confidential information by limiting the information contained on badge identifications. Information, such as medical specialty, phone number, and address, should be considered confidential and should not be featured on a badge.

- Badge forms could include: Wearable badges, wallet-sized cards and folders containing relevant information.

- Idea: Static information could be contained within a provider identification number with imbedded intelligence. Specifically, a coding system could be applied to a provider number that would easily allow hospitals receiving volunteers to decipher pertinent information about the volunteer based upon the numbers and letters contained within the provider number and their location.

- Ensuring access to current information: A card/badging system should also include connectivity, so that there is "real-time" access to current information about the volunteer, such as revocation of licensure or termination from the state's ESAR-VHP program. Options discussed included:

  - A government-issued "membership card" with basic static information visible on the card plus some connectivity to an updateable real-time database.

  - Real-time data could be accessed via an imbedded computer chip or a swipeable magnetic strip that allows the card to be linked to a real-time database.

  - Volunteers should be able to access and update certain information in this real-time database, such as phone numbers and address information. Other information should be updated either manually or automatically

with other approved entities, such as state licensing boards, to ensure that information about the volunteer is accurate and current.

- Static information about the volunteer (name, profession, etc.) must be accessible under worst-case circumstances, such as power outages where electronic systems are inaccessible.

- Static information could be displayed on the identification card using standardized color-coding to indicate level of training/competencies.

- Redundancy is critical both regarding access to real-time database (information must be available to be retrieved via satellite, 800 megahertz radio, ham radio, cellular, ground lines, hand synchronization) and with regard to static information (visual, smart-chip, barcode, etc.).

- Cost/obsolescence concerns: While redundancy is important, states must consider the cost of using multiple technologies and obsolescence issues.

- Key principle is multi-state interoperability/accessibility: Information contained within a real-time database must be shareable among multiple states, thus ensuring interoperable systems in the event that volunteers must be drawn from across state lines. This is a particular concern for small states that may need assistance from other nearby states in the event of a large-scale emergency.

- Key principle is simplicity: Keep the system simple so that it may continue to be utilized over time. Simplicity will permit the state-based ESAR-VHP systems to be deployed/activated sooner.

- Key principal: To the extent feasible, state ESAR-VHP systems should make maximum use of existing databases, such as those operated by state boards of nursing, state medical boards, and other organizations such as the National Council of State Boards of Nursing and the Federation of State Medical Boards. Developing ways to automatically update the ESAR-VHP database should also be explored.

- Key principle: Unless liability exposure issues are addressed for both the volunteer health care professional and the facility where the volunteer will provide services, the system will not operate effectively.

- Key principle: The ESAR-VHP system must support credentialing requirements that can flex over time.

- In the immediate aftermath of an emergency (within the first 72 hours), the system must support minimal levels of credentialing to allow the hospital incident commander to verify that the volunteer's identity and license status. In this level of verification, the volunteer health care professionals will be supervised.

- In a longer-scale event (lasting beyond 72 hours), the ESAR-VHP system must be capable of providing more complete and verified information, so that volunteers may be utilized to the full extent of their licenses, credentials and competencies.

- Other considerations regarding the ESAR-VHP database:

  - Physicians may have different levels of privileges at each of the facilities in which they practice. Thus the database should include the most comprehensive information available on a physician's privileges. Participants acknowledged that hospitals might be reluctant to release a volunteer's hospital privileging information.

  - Hospitals receiving volunteers will always control how volunteers are used in their facility, regardless of the information contained within the ESAR-VHP database.

  - Initially, hospitals are unlikely to entrust unfamiliar volunteers with complex tasks. Instead, hospitals may rely on their own internal staff for complex activities and delegate more basic tasks to volunteers under supervision. Over time, however, hospital medical staff can observe the volunteers and allow their roles to evolve to more closely match their competencies.

  - The system needs to support two types of volunteers: Those who are pre-registered within the ESAR-VHP system and are officially deployed to the hospital and those that are also pre-registered and present themselves to a hospital without notice. The hospital must be able to verify volunteers' credentials regardless of whether or not they have been formally deployed to the hospital.

ii. Training

The services of a volunteer health professional pre-registered with a state's ESAR-VHP system would be most useful if the volunteer underwent emergency response training prior to an event. The discussion at the meeting centered on the question, "From a hospital perspective, what is a reasonable minimum level of training necessary for a pre-

registered volunteer health professional to have prior to being deployed to a health care facility involved in disaster response?"

This discussion is meant to provide assistance and advice to the *HRSA's ESAR-VHP Working Group on Training*. This working group is tasked with identifying the necessary objectives to enable a standard framework for training volunteer personnel in the ESAR-VHP system. It will examine issues such as how ESAR-VHP systems may facilitate efforts underway to provide training to volunteers, how continuing medical education is integrated, how information and data on coursework and development of emergency preparedness competencies are tracked and validated, the need for required training and exercises by discipline or function, and systems conventions for identifying and authenticating an individual's training and competencies in a disaster scenario. This team will also focus on how basic training standards may be established, and how ESAR-VHP systems are structured to ensure that volunteers are aware of and are able to receive ongoing training.

The group discussed a number of issues related to the need to train volunteers. There were several major themes that emerged from the discussion:

- Training versus orientation: Participants agreed that regardless of whether a health care professional is required to receive a certain level of training prior to being accepted into a state's ESAR-VHP system, there will undoubtedly be a need for deployed volunteers to receive "just in time" training that will provide: An orientation to the incident (e.g. managing the care of a patient exposed to a specific biological/chemical agent); the functioning of the particular facility in which they will be providing services to ensure patient and health care worker safety (e.g. explaining the facility's code for fire); the safety hazards specific to the incident (e.g. use of respirators); and anything else that is germane to the specific disaster at hand. It is critical that both types of training be included and defined in the ESAR-VHP guidelines.

- Minimum expectations regarding volunteer health professional competencies: Several types of training were cited as absolutely essential for volunteers, including:

    - Incident command system training (ICS), such as the Hospital Emergency Incident Command System, to foster an understanding of nomenclature and standard roles within an ICS are key to a volunteer functioning in a disaster.

    - Basic infection control training and training in the use of personal protective equipment.

    - Basic disaster awareness and safety training.

- Minimum expectations for training of volunteers may differ depending on whether the disaster is an immediate crisis with a limited response timeframe (e.g. an explosion) versus a protracted disaster scenario involving a public health emergency (e.g., disease outbreak).

- Training mandate versus training opportunity: Some concern was expressed that setting a minimum level of training could harm efforts to recruit volunteers. These HIFG participants supported providing training opportunities for volunteers rather than a mandate for training. This led to a discussion about establishing a tier of volunteers based on level of training achieved.

    - Tiering volunteers based on levels/types of training: Participants agreed that it might be helpful to establish a tiered system in which specific types and levels of training are defined, and volunteers are assigned to these pre-established tiers/levels based on their training. Volunteer activities in a disaster would be linked to these tiers. That is, volunteers at the lowest level, with little or no specified training, could be assigned simple tasks, while those with advanced training (e.g. hazmat training) could handle more complex, or scene-specific activities.

- Facility-based versus office-based (or inactive) health care volunteers: Certain assumptions may apply differently to volunteers who practice in facility-based settings (i.e., hospitals) versus those who work in physician offices or are no longer in active practice. That is, most facility-based health care professionals will be considered up-to-date or trained in such topics as incident command systems, respiratory protection measures, and other infection control practices. However, health care professionals who are no longer in active practice (e.g. retired) or working in non-institutional settings may not be assumed to have this type of minimum training.

- Using training as a way to screen out volunteers: In disasters, hospitals often experience an excess of volunteers. Some participants suggested that establishing minimum training requirements could be a way to turn away volunteers who may not be best suited to respond to a particular disaster.

iii. Recruitment and Volunteer Advocacy

In this discussion, participants discussed the role that hospitals may play in forming the state's ESAR-VHP and how hospitals should assist in the recruitment, enrollment and training of volunteers. This discussion was intended to assist *HRSA's ESAR-VHP Recruitment and Volunteer Advocacy Working Group* in its mission. This working group will examine issues related to recruitment and registry of medical volunteers, including

identifying the best and most effective approaches for states to recruit and register volunteers for ESAR-VHP systems and developing the necessary information and awareness needed to properly engage medical volunteers to fully participate in the state-based ESAR-VHP system. This team will also assess the feasibility of integrating disciplines other than physicians, registered nurses, and behavioral health professionals into the ESAR-VHP framework.

The participants' discussion indicated that hospital and health care professional participation in the state-based ESAR-VHP could be encouraged through:

- Paying hospitals to play: States may consider providing extra funds for those hospitals that assist in recruiting volunteers under the ESAR-VHP or awarding HRSA bioterrorism preparedness funds based on participation in ESAR-VHP recruitment.

- Providing the business case for getting involved in ESAR-VHP: Hospitals and health care professionals are interested in protecting their investments and allowing their facilities to remain in operation in the event of disaster.

- Making it personal: It is important to inform facility leadership and potential volunteers about the implications of terrorism to their families and their communities.

- Liability protection: Assurances of immunity from liability exposure for both the volunteer health care professional and hospitals involved in donating and receiving volunteers are critical. Immunity measures must address both declared and non-declared emergencies and degradation in the standard of care caused by limited available resources in a disaster.

- Providing choices: Volunteers need to be given the opportunity to choose: (1) what kind of event they are willing to volunteer for (any disaster, bioterrorism, natural disaster, etc.); (2) how long they are willing to be deployed in a particular event; and (3) how far they are willing to travel to an event.

- Managing expectations: In recruiting volunteers, the system should make it clear that in a disaster, the volunteers' skills and training may not be used in the same way or to the full extent that they are used in their normal practice. This is particularly important if volunteers are brought from across state lines.

- Ensuring priority prophylaxis/antidotes/medical treatment to volunteers and their families.

- Ensuring a simple and non-burdensome registration process for volunteering.

- Obtaining support and buy-in for the state's ESAR-VHP from the trade and professional associations representing hospitals and the health care volunteers.

- Providing opportunities for education and training to volunteers.

- Assuring financial viability and continuation of livelihood: Volunteers need to be paid if their service extends beyond a certain threshold of time and for any expenses involved in their volunteer activities. As with jury duty or military reserve duty, the volunteer's regular job must be guaranteed.

- Establishing clear expectations and providing up-front information to volunteers regarding the length of expected deployment and creation of a system to assure that family commitments are taken care of.

- Clarifying how other volunteer networks are integrated into the ESAR-VHP system: Multiple entities recruit health care volunteers for disaster assistance (e.g. National Guard, Medical Reserve Corps, Disaster Medical Assistance Teams, American Red Cross). There needs to be some explanation of how these organizations work together and if there is any potential for integration of systems, including a description of the hierarchy among these networks.

- Opportunity for the home hospital to "release" its volunteers: For hospitals acting as "donors" in an event, there must be assurances in place that the act of releasing volunteers to an event will not put the on-going operation of the donating hospital at risk.

- Communications process: Providing assurances to "donor" hospitals that there will be a communications process established to ensure that in a disaster in which the ESAR-VHP system is activated, there will be communication between the state ESAR-VHP system and the donor facilities informing them that the health professional volunteers in their employment have been deployed.

iv. Common Data Definitions and Naming Conventions

This section of the discussion focused on hospital interests and concerns regarding common data definitions and naming conventions. While the ESAR-VHP is a state-based system, the intention is to make the system interoperable at the national level using common nomenclature, common definitions, and core data elements that can be shared across state lines. In order for this to occur, it is critical that terms such as "volunteer", "privileges" and "credentials" have consistent definitions.

As with previous topics, this discussion of the HIFG was intended to provide assistance to the *HRSA's ESAR-VHP Working Group on Common Data Definitions and Naming Conventions*, which will research existing industry conventions and standards for data definitions as part of the process of establishing specific definitions for primary and secondary data requirements. Also, the group will assemble all of the data fields that are currently being collected by states and chart the common elements.

Issues and recommendations that emerged from the discussion of HIFG participants include:

- Minimum data set: The ESAR-VHP guidelines should identify the minimum core set of data necessary for the system to function. These minimum data elements should be collected by all state ESAR-VHP programs (see pages 29-31, System Design and Content). Beyond this core set of data, however, states should be allowed to customize the information they collect.

- National data definitions: Although the ESAR-VHP is a state-based system, it is meant to be interoperable on a regional or national basis to support the deployment of volunteers across state lines, if necessary, in a disaster. Therefore, the guidelines should adopt uniform nomenclature and a standard data dictionary for the minimum data set, which should be used in each state's ESAR-VHP system.

- Acceptance of uniform nomenclature standards: While the participants understood the difficulty of establishing and implementing uniform nomenclature and definitions across states, most agreed that this may be one area in which establishing mandatory national standards to be adopted by all states and health care facilities within the states, is the best approach. Time must be provided, however, for states and health care facilities to adopt and implement these standards. Standardization can promote quality of care, patient safety and efficiencies in operations within the health care system.

- Leverage existing data sets: The nomenclature and definitions used in existing comprehensive databases, such as those maintained by the Federation of State Medical Boards and the National Council of State Boards of Nursing , should be considered for use in the ESAR-VHP guidelines. Further, any agreement in standard terminology, descriptors, and definitions found between these data sets should be identified and given serious consideration for adoption in the ESAR-VHP guidelines.

- Concerns related to standard definitions for mid-level practitioners, advance practice nursing and behavioral health professions: Establishing and adopting standard terminology and definitions related to physicians and registered nurses

may not be as contentious and complex as establishing other nursing, mid-level practitioner, and behavioral health profession standard nomenclature and definitions, given the range of professions, disciplines, and competencies for these professionals.

v. Regionalizing and Nationalizing the ESAR-VHP

The ESAR-VHP is at its core a state-based, advanced registration program for volunteers. However, because the system is intended to assist in disasters that may cross jurisdictions or that may overwhelm the health care system within a particular jurisdiction, each state's ESAR-VHP not only needs to work within the state, it also needs to be able to work at the regional and national levels. In this section of the report, we identify, from the hospital perspective, issues and recommendations related to the regionalization of systems that are state-based.

This discussion is intended to provide assistance to the *HRSA's ESAR-VHP Working Group on Regionalizing and Nationalizing the State ESAR-VHP Systems*. This working group will examine the guideline objectives necessary to ensure that ESAR-VHP systems are designed to accommodate existing procedures, methodologies, functions, and mechanisms to facilitate regional and national sharing of information and volunteer personnel. This work group will assess cross-jurisdictional issues, which potentially cut across federal, state, and local governments, as well as address implications for the international use of volunteers, particularly for those states bordering Canada and Mexico.

Issues and recommendations that arose from the HIFG discussion included:

- Up-front core uniformity: Applying more rigors to establishing core uniformity through the ESAR-VHP guidelines at the outset is better than doing it later and having to rely on interstate compacts to make it interoperable. Therefore, as noted elsewhere, the ESAR-VHP guidelines should identify the minimum core set of data and uniform definitions of these data elements that are necessary for the system to function. These minimum data elements should be collected by all state ESAR-VHP programs. Beyond this core set of data, however, states may customize the information they collect.

- Concerns regarding separately awarded municipalities: Three intrastate municipal areas – Chicago, New York City and Los Angeles – receive NBHPP funding separate from the funds that their states receive. There is confusion about whether these three municipalities must establish separate ESAR-VHP systems from their states or if there may be a single state ESAR-VHP system that integrates volunteers from those three areas. HRSA placed Illinois, New York and

California into implementation phases earlier than their separately funded municipalities so that the states will take the lead to ensure one state system is developed. States with awardee municipalities will be expected to work cooperatively to identify the best approaches to develop their state-based ESAR-VHP system. The group urged HRSA to clearly set out this view in any forthcoming guidance documents.

- In order to foster interoperability at the regional and national levels, the state-based ESAR-VHP systems must:

    - Be built on non-proprietary information technology systems.

    - Be as simple as possible at the outset, so as to promote state participation but allow for expansion over time. The guidelines should clearly identify the initial set of core data elements that states will be required to collect. Other data elements that are currently being collected by states or that are expected to eventually be required should also be described in the guidelines, so that states may consider adding them voluntarily to their databases.

    - Permit states, to the maximum extent feasible, to link to existing databases for accessing and updating core data elements.

    - Be Web-based, secure, and easy to operate and maintain.

b. Legal, Regulatory and Policy Matters

The second major category discussed by HIFG participants involved concerns and recommendations related to legal, regulatory and policy matters. This discussion is meant to inform the following two efforts.

- *Legal and Regulatory Issues:* The team from the Center for Law and the Public's Health are tasked with identifying, discussing, and providing timely input to HRSA and its partners on legal and regulatory issues that may impact or relate to the development and implementation of the ESAR-VHP. This will include: (1) identifying the legal framework (including possible resolutions or options) of existing federal and state laws during the development and implementation of ESAR-VHP guidelines and (2) providing recommendations for potential amendments, additions, or supplements to existing laws.

- *Authorities and Emergency Operations*: *HRSA's ESAR-VHP Authorities and Emergency Operations National Working Group* will examine the steps necessary

for states to identify and make recommendations on the authorities necessary to oversee activities related to the development and the regular (routine) and emergency operations of a state ESAR-VHP. This includes identifying the fundamental issues related to the establishment of clear and formal authorities within a state to plan, develop, and administer the ESAR-VHP for use in an intrastate and multi-jurisdictional scenario. Authorities may include internal authorities to authorize the response readiness of volunteers, technical authorities to utilize and change the system, and necessary governmental authorities to activate the state system. In addition, this group will address the issues around information access rights in an interstate, multi-jurisdictional crisis.

i. Legal and Regulatory Issues/Authorities and Emergency Operations

The HIFG discussion began with a request from the facilitator that the participants remember to consider three perspectives in reviewing legal and liability issues related to establishing an ESAR-VHP: The individual volunteer (e.g. nurse, physician, social worker); the institution receiving volunteers, and the institution offering volunteers. Each perspective is important to consider because legal concerns vary depending on the actor, setting, and circumstances.

Two key principles emerged from the discussion including:

- The provision of liability protections and the ability to clearly communicate liability protections to potential volunteers will be essential to ensuring the success of the state-based ESAR-VHP systems. We learned from the smallpox vaccination program that liability protection cannot be an afterthought or described in unclear terms.

- While the ESAR-VHP will be a state-based system, it is also intended to support the deployment of volunteers across state lines in appropriate circumstances. The interoperability of the system, however, will be difficult to administer if liability issues are only addressed through a patchwork system of state and insurer solutions. Therefore, HIFG participants believe that federal liability protection should be provided when volunteers cross state lines.

The discussion raised many critical questions that the group was unable to answer. However, the upcoming report from the Center for Law and the Public's Health will address and respond to many of these questions. Center representatives, James G. Hodge, Jr., J.D., LL.M., Principal Investigator, and Lance Gable, JD, MPH, Project Director, encourage HIFG members to contact them for more information or if the member has interest in working on these issues (jhodge@jhsph.edu; Gable1@law.georgetown.edu).

These questions and concerns identified by the HIFG participants included:

- Injured parties: It is important to recognize that liability protections must address two kinds of injured parties. One is the injured patient, and the other is the injured volunteer. Injuries to patients are addressed through the tort system and have civil liability implications. Injuries to volunteer health care personnel will mostly be addressed through workers' compensation systems, provided the injuries occur in the performance of work activities. The report being prepared by the Center for Law and the Public's Health will address these issues.

- Paid versus unpaid volunteers: There are important definitional issues here related to whether the "volunteer" is paid or not. For example, certain types of liability protections only apply to uncompensated volunteers. Nevertheless, in a disaster involving a longer-term need for volunteers, it is necessary that the volunteer be paid by someone for their services. The effect of compensation and other definitional issues on the eligibility of volunteers for liability protections thus has important consequences for the ESAR-VHP system.

- Site of volunteer services: There is also the question of whether the potential for civil liability exposure will vary depending on the site of service. For example, volunteers may be deployed within a structured environment, such as a hospital. In other circumstances, the volunteer may work in a more unstructured environment, such as a point of distribution (e.g., triage tent). As expectations of the legal standards of care in these differing settings vary, so may liability for actual harms.

- Interhospital agreements: Often hospitals within a particular community have memoranda of understanding (MOUs) in place that involves the sharing of resources. How do these MOUs interact with the ESAR-VHP system? Will the activation of the ESAR-VHP in a particular state have any legal impact on the existing MOUs between hospitals? Does the presence of MOUs impact upon the liability of the parties involved? Should the MOUs be amended to incorporate the ESAR-VHP system?

- Declared versus undeclared emergencies: There is also the distinction between an event in which the governor has officially declared an emergency versus an undeclared emergency. Statutes authorizing emergency or public health emergency declarations may employ additional powers when an emergency is declared, including qualified immunity from liability. It is important to examine the issue of how the activation of the ESAR-VHP system will differ in a declared versus undeclared disaster. In Connecticut, liability protections for volunteers who provide services within a hospital (e.g., workers compensation, disability) are

only provided if the Governor declares the disaster. This is also the case in some other states.

- Database home: Does the location of the ESAR-VHP registry affect liability protection? Would registering volunteers within a state's emergency management agency put them under an umbrella of protection due to the state's governmental sovereign immunity? Conversely, if the registry is housed and operated outside of government, do liability protections convey?

- Standard of care: How will liability protection be addressed in a large-scale emergency involving degradation in the standard of care? That is, if the emergency is of such a scale that military or public health triage is required, how would potential liability change?

- Phases of response: To what extent does liability protection differ during the period before an emergency occurs (when volunteers are deployed prior to an emergency, e.g., expected hurricane), during an emergency, and after an emergency (with a return to normal service after their volunteer service concludes)?

- Malpractice insurance issues: Does a physician's malpractice insurance cover medical practice performed beyond state borders? That is, if a physician's insurance carrier is located in a particular state and the physician leaves that state to provide volunteer services in another state, would the protection extend to the services provided in the other state? This may very well be addressed solely within the insurance contract.

- Workers' compensation/disability: How will questions of workers' compensation and death, dismemberment, and disability issues be addressed through the ESAR-VHP? During the smallpox vaccination program, most state workers' compensation programs avoided making broad policy statements, indicating instead that claims would be handled on a case-by-case basis.

- Private health insurance: Will a volunteer's private health insurance carrier cover injuries that a volunteer receives while providing services under the ESAR-VHP (in the event that workers compensation does not cover the injury)?

- Hospital liability exposures: What liability exposures do hospitals and other healthcare institutions face for their own actions and the actions of their employees and volunteers? Are there exposures for hospitals that send volunteers to the site of a remote disaster? Are there liability exposures for hospitals that agree to receive volunteers? How will those issues be resolved? The group continued to support a national solution to these kinds of issues.

- Alternative care facility: Other institutional liability questions were raised relating to situations in which a hospital in a community is tasked to manage and operate an alternative care facility in a large-scale disaster.

- Abandonment: Is there potential liability exposure from a health care professional's regular patients if that professional volunteers in an emergency? That is, can these patients claim they have been abandoned and file suit?

Other authority and emergency operations issues that were discussed and need to be considered by the *National Working Group* include:

- Activation: Who will have the authority to activate the ESAR-VHP system? While the system is defined as being state-based and HRSA supplemental funds are directed to the state department of health, is it possible for the system to be activated by a region's health department, local health department or even by individual hospitals within a jurisdiction?

- Ownership: Who "owns" the ESAR-VHP? If it resides within the public health department, then the focus on its activities may be public health-related. If it resides within the emergency management office, then the focus changes.

- Coordination with other volunteer initiatives: The group strongly believes that the guidelines for ESAR-VHP should clearly identify how existing volunteer programs organized under different agencies, such as the Medical Reserve Corps, American Red Cross, and Disaster Medical Assistance Teams will be integrated into ESAR-VHP. Coordination with these other volunteer programs is crucial in terms of organization, activation and an effective response to a disaster.

- Impact of terrorism: If the event is related to terrorism, there will be involvement from law enforcement and homeland security/emergency management offices within the jurisdiction. Health care response to an event (i.e., providing lifesaving care to victims) differs from the law enforcement/homeland security response (i.e., preserving evidence). There are unanswered questions related to who is in charge of a terrorism-related event.

- Freedom of Information Act (FOIA): Are the state-based ESAR-VHP databases subject to FOIA requests?

- Incorporating flexibility: It is important to preserve flexibility in the system so that states do not have to exhaust all of their volunteer resources in order to activate the system so that volunteers can be brought from across state lines. This

would be the case in disasters or emergencies that occur near state borders. This also supports the need for interstate compacts.

While most of the discussion surrounding legal, regulatory and policy matters primarily generated questions that should be answered, there were some ideas raised for models of liability protection to consider and further evaluate. These include:

- Emergency Management Assistance Compact (EMAC): EMAC is a national interstate mutual aid agreement that addresses legal issues of liability, workers' compensation, licensure reciprocity, and reimbursement. It currently includes 48 states, two territories and the District of Columbia as members. The HIFG participants suggested that the liability protections contained within EMAC might provide a solution that could be applied to state ESAR-VHP programs. This issue deserves further evaluation.

- Another idea that was raised involves the question of whether it is possible to provide a legally supportable incentive for individuals to volunteer for the ESAR-VHP by extending liability protections that apply to ESAR-VHP activities to their everyday practice. Another possibility to consider is having states provide a professional liability insurance subsidy to those health care professionals who volunteer.

- Another option to explore is the model posed by the military. Participants noted that individual liability issues do not exist in the military model.

- Another possible option to explore is whether and how the American Red Cross provides coordinated liability protections for its volunteers operating under ESF 6 (mass care). United Way was also cited as a potential model to explore.

c. ESAR-VHP Technology and Support Systems

The last major category discussed by the HIFG participants involved technology and support systems features of the ESAR-VHP and related hospital concerns and recommendations. There are four separate areas that were discussed within this category including: (i) system design and content; (ii) security, privacy, and communications; (iii) funding and cost; (iv) operations and maintenance.

A summary of the major ideas brought forward in these discussions, including concerns and recommended approaches and solutions are outlined below.

i. System Design and Content

The design and content of the ESAR-VHP system is of critical importance to hospitals, which will be among the key contributors and beneficiaries of the system. An effective and efficient ESAR-VHP system must be designed with consideration of hospital needs in mind and with system content that is adequate to ensure the prompt availability of the right volunteers to the right hospital at the right time.

This discussion of the HIFG is meant to provide input into the proceedings of the *HRSA's ESAR-VHP Working Group on System Design and Content.* This working group will examine the necessary elements of the system design and information content for a state ESAR-VHP that will achieve consistency and interoperability among ESAR-VHP systems. It will focus on technical issues related to system architecture, application interfaces, data collection processes, data and information requirements, and data definitions and standards which will best facilitate intrastate and interstate interoperability. This group will also advise on the minimum system information and data sets necessary for interoperability.

The major issues and recommendations raised during this HIFG discussion included:

- A call for ESAR-VHP guidelines to establish a minimum set of data elements to be used for the ESAR-VHP state-based systems. Participants reiterated the concern that unless states are required to adopt the ESAR-VHP guidelines, and that only one system be permitted per state, there would be difficulties both intra- and inter-state with systems that are not interoperable. Several key points taken from other discussions within this report are relevant here:

    - There needs to be a core set of data elements that all states must collect, and the data definitions must be standardized for this core data set.

    - The ESAR-VHP system in the states must be interoperable, so that states can share data regarding volunteers.

    - The ESAR-VHP guidelines should leverage the benefits of multiple possible software platforms without being vendor specific.

- Proximity searches: The system should be designed to support the ability to search the database by zip code or by other measures of proximity in order for the hospital to be able to receive local volunteers first.

- Some HIFG participants suggested using existing versus new, custom made software systems for state-based ESAR-VHP. These participants recommended that HRSA evaluate several existing software systems, including PeopleSoft,

Missouri's volunteer license verification system and the various systems used by local Medical Reserve Corps units as potential models. Other participants believed that trying to mold existing systems to meet new needs would be cumbersome and difficult to train individuals on. These participants preferred allowing states to build a system from the ground up, so that it could meet both state and HRSA specifications.

- Among the minimum data elements recommended were:
  - Name
  - Contact information (address, phone numbers, email addresses)
  - Degree
  - Hospital(s) in which individual has privileges
  - Physician specialty(s)
  - Nursing specialty(s)
  - State license number
  - State license board check of disciplinary actions taken against license
  - National Practitioner Databank check of liability actions
  - Date of last reappointment
  - Status (actively practicing, inactive/retired)

- Other recommended data elements:
  - Volunteer choice (distance willing to travel, maximum duration of service, type of disaster)
  - Immunization status
  - Languages spoken
  - Photograph
  - Disaster education/training (e.g. incident command system, bioterrorism, hazardous materials, etc.)
  - Special qualifications (e.g. water sports, climbing, hiking)
  - Other registries for which individual has volunteered/enrolled
  - Military/public health experience

- Access to confidential information: Certain fields must only be accessible in a declared disaster and only by designated individuals responsible for activating the system. This would include elements such as home address, contact information, and vaccination status.

- Caution about collecting competency information: Due to liability and privacy concerns, participants did not believe hospitals would be willing to provide information on the competencies, specific privileges, or disciplinary actions taken against their physician or nursing staff.

- Caution against overly complex/burdensome process: The number of required data elements should be kept to the absolute minimum so as to avoid creating an overly burdensome registration process for potential volunteers.

ii. Security, Privacy, and Communications

This section of the discussion addresses privacy, security, and communications issues that are critical for the successful development and implementation of the state-based ESAR-VHP system. Core considerations are: Who may access the data? Under what conditions may data be accessed? How will the integrity of the data be guaranteed? How will confidential data elements be protected?

As in the other sections of this report, this discussion is intended to provide *HRSA's ESAR-VHP Working Group on Security, Privacy, and Communications* with the relevant issues and recommendations from a hospital perspective. The stated objective of this working group is to examine the privacy and security requirements of the ESAR-VHP along with system communication requirements. Key issues to be assessed include: Information and physical system security, volunteer privacy controls, and privacy policies. This group will also assess objectives and best practices for system communication and related communications policies.

Drawing from this HIFG discussion and other discussions that touched upon security and privacy concerns, key issues and recommendations include:

- Access to sensitive information: The information contained in certain fields must be accessible only in a disaster (declared or undeclared is an open question) and then only by designated individuals responsible for activating or otherwise utilizing the system. This type of sensitive information would include elements such as contact information (such as home address, phone numbers), sensitive professional information (such as license status, competencies, disciplinary actions), and medical information (such as vaccination status).

    - While some of this sensitive information may be otherwise publicly available through other sources (e.g., physician and nurse license number, home address/phone number), it must still be protected within the state's ESAR-VHP system.

    - Incorporating biometric data (such as fingerprinting, iris scans, facial recognition systems) would raise particular privacy concerns among health care personnel, could negatively effect volunteer recruitment and would require special levels of protection in the system.

- Improper uses of data: Information contained within the ESAR-VHP database should never be used for purposes other than that for which the system is designed. Improper uses include regulatory enforcement, recruitment of health care personnel for peacetime employment purposes, marketing/commercial purposes, and for research purposes.

- Appropriate uses of data: The system should be reserved exclusively for the recruitment and deployment of volunteers for disasters and other emergencies and to allow hospitals and other receiving facilities to verify the identity and credentials of volunteers who arrive at the disaster care location.

- Ownership of the database matters: Different privacy and confidentiality, as well as legal and liability, concerns arise depending on who owns and maintains the ESAR-VHP database. That is, if the database is owned by the state department of health or other governmental entity, concerns about how the data will be used (e.g. whether it will be used for regulatory enforcement purposes) and trust and credibility issues may be raised by potential volunteers and from hospitals providing information to the system. On the other hand, if the database is housed within a private entity, such as a hospital or hospital association, concerns regarding potential use of the data for workforce recruitment and marketing/commercial purposes may arise.

- HIPAA privacy principles: While it is unlikely that the ESAR-VHP system would be subject to Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules, the HIPAA principle of "minimum necessary" is relevant to this system. That is, volunteers should be asked to provide the minimum necessary data to the system, and when the system is activated, only the minimum necessary data should be shared with entities and individuals who need it and only under circumstances defined by the state's ESAR-VHP program.

- Methods of populating the database: If the ESAR-VHP database developed by a state is one in which the volunteer simply provides information that directly populates the database, then, by this action, permission to use the data is granted. If it is a database in which the volunteer gives the ESAR-VHP system permission to draw down individual data from another database (e.g. state medical licensing board database), then access must be separately granted from this separate database in order to obtain the information, and the two systems must agree on terms of use. The decision on whether to base a state's ESAR-VHP system on a database that is populated by the individual professional or from another database has implications for how the information may be accessed, by whom, and under what circumstances.

iii. Funding and Cost

This section of the discussion addresses concerns and ideas regarding the funding and costs of the ESAR-VHP system from the hospital perspective. While participants were told that the ESAR-VHP system was a critical benchmark of the NBHPP grant, and that using NBHPP funds for establishing their ESAR-VHP system was permitted, participants still expressed two concerns. First, given a perception that the initial supplemental funding ($200,000 per state) provided to state NBHPP grantees from the federal government to establish and/or implement the ESAR-VHP system is inadequate to establish a fully functioning system, the participants discussed ways to make the system more economically viable. Second, as there are concerns that the federal ESAR-VHP system funding will not be sustained over time, the participants discussed ways to establish other sustainable funding sources.

This discussion is meant to provide input into the activities and recommendations of the *HRSA's ESAR-VHP Working Group on Funding and Cost*. This working group will compile strategies and approaches used by states to address the range of funding and cost issues associated with all elements of the ESAR-VHP system, including planning, development, operation, and activation. They will also develop strategies and recommendations on how states can seek to fund the development of their ESAR-VHP systems, such as pooling resources and coordinating development efforts. Additionally, they will determine any necessary system requirements or objectives that reduce system operating costs or limit liability costs and risk to individuals and institutions involved with the ESAR-VHP system during a disaster.

Drawing from this HIFG discussion that touched upon funding and cost considerations, key issues and recommendations include:

- Linking to other systems: Costs can be reduced by linking the ESAR-VHP system to another existing system, thereby avoiding the cost of creating an entirely new system or of collecting additional data elements that are already stored in another electronic system.

- Web-based, electronic enrollment forms: The forms used to enroll volunteers should be Web-based rather than paper-based to reduce staff costs involved in entering and deciphering handwritten data entries. Further, the forms should be set up with fields whose data can be directly added to a central database.

- The ESAR-VHP system should be as least labor intensive as possible. It needs to be able to exist within the labor force already in place and be integrated in such a way that there is no additional work involved for those who will access and use the system.

- Recruiting through health care professional license renewal forms: Soliciting volunteers through a check box on the license renewal forms provided by state licensing bodies may reduce recruitment costs.

- One idea to promote sustainable funding for ESAR-VHP would be to add a checkbox to state income tax returns for individuals to provide donations to fund the system. This is a similar approach used in income tax forms nationally to help fund the Federal Elections Commission and is an approach some states have used to fund state-based initiatives.

iv. Operations and Maintenance

The sustainability and effective functioning of the ESAR-VHP system depends on its ability to be activated appropriately and to have current information.

This discussion is meant to provide input into the activities and recommendations of the *HRSA's ESAR-VHP Working Group on Operations and Maintenance*, which will examine system elements that states may incorporate to provide for effective operation and maintenance of ESAR-VHP systems. Activity on this issue topic will center on assessing existing systems to determine best approaches and objectives, which should be incorporated into the guidelines, standards, and definitions. Issues to be considered by this working group include the processes and frequency for validating volunteer information, the need for information redundancy, and technical mechanisms to activate the system.

Ideas from the HIFG participants on keeping ESAR-VHP data up-to-date and accurate:

- Personal update capability: System should provide the capability for volunteers to personally update certain data elements.

- Automatic update from linked databases: For data elements that are maintained by other databases within the state, electronic links should be established to automatically update such information when it changes. This would be the case, for instance, with physician and nurse license information that is currently maintained by each discipline's state licensure board.

- Flagging capability for expiring data: For data elements that must be periodically updated, there should be a flagging system within the ESAR-VHP that identifies when a data element has expired (e.g. CPR certification) or for information that needs to be regularly updated (e.g. contact information). Such a flagging system should be linked to a communication mechanism (such as email) reminding the

volunteer to update the information. Once the volunteer updates data, it should then pushed out to update the database for all users.

- Smart card capability: Although perhaps a technology that is expensive and thus limited, some participants supported the future use of a "swipe-able" smart card system that could update educational and training data elements with the ESAR-VHP database automatically upon completion of the training.

- Keeping retired/inactive volunteers engaged: To obtain current information for volunteers who may not be actively practicing in their disciplines or who are retired, it would be helpful to create opportunities to communicate with them and at the same time obtain updated information. Special consideration needs to be given to volunteers who reside in different states during different times of the year. Such ideas could be involving them in disaster training or educational opportunities.

- Sustainability of ESAR-VHP over time: Disasters occur infrequently and it would be expected that the ESAR-VHP would be deployed only on rare occasions. As a result, it is unlikely that volunteers will remember to change their contact information or other information contained within the system. In order to ensure the continued sustainability of the ESAR-VHP system over time, it is therefore important that ESAR-VHP be, to the maximum extent possible, a "byproduct" of other systems as opposed to a centralized separate system.

Attachment 1

American Hospital Association
Emergency System for Advance Registration of
Volunteer Health Professional Personnel (ESAR-VHP) Meeting

October 12 and 13, 2004

Confirmed Participant List

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