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

Hospital Implementation Issues and Solutions Second 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

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Executive Summary

When disasters strike, hospitals close to the event often experience an influx of health professional volunteers willing to help care for victims. History, however, has shown that hospitals have difficulty effectively using these volunteers due to an 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 this national dilemma, 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) office of Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) has released the "*ESAR-VHP Program Interim Technical and Policy Guidelines, Standards, and Definitions*" (Guidelines) in order to help each state and territory establish standardized volunteer registration systems that will include readily available, verifiable, up-to-date information of the volunteer's identity, licenses, credentials, accreditation, and privileges in hospitals or other medical facilities that might need volunteers. By following these Guidelines, states will be able to quickly identify, and better utilize, health professional volunteers in emergencies and disasters. Development of these state ESAR-VHP systems also are intended to allow the portability of state registration systems for regional use 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 ESAR-VHP program.

This report summarizes key findings and recommendations culled from the discussions of the second Hospital ESAR-VHP Implementation Issues and Solutions Focus Group (HIFG) meeting, held May 24-25,2005. This meeting was the second in a series of four planned HIFG meetings scheduled throughout 2005-2006. This second meeting sought to provide HRSA with critical input and potential solutions to key hospital implementation and operational issues in the 10 ESAR-VHP pilot states – Connecticut, the District of Columbia, Illinois, Massachusetts, Minnesota, Missouri, Ohio, Texas, West Virginia and Wisconsin. Participants included teams from each state, including representatives from state, regional and metropolitan hospital associations, state departments of health, and a diverse range of hospital representatives.

<u>Emergency Credentialing Standards and Levels Issues</u>
If the state's ESAR-VHP system can provide as much verified information as possible in advance about each volunteer, then a more expeditious and effective appropriate disaster response can be implemented. The AHA and its member hospitals, therefore, prefer that

a state-based ESAR-VHP system verify the information on volunteers up to Level 1 so that hospitals can grant initial clinical privileges to volunteers. In the immediate aftermath of a disaster, a volunteer with Level 1 verified information arriving at a hospital would be permitted to begin providing services more quickly, and with less supervision, within the scope of practice of that volunteer's discipline, than a Level 3 or 4 volunteer, for whom a hospital has less information.

The final decision on how individual volunteer services will be used, regardless of a health care professional's verified information, must be left to the hospital. For instance, the ESAR-VHP emergency information verification levels do not relieve the hospital of its duty to perform due diligence to verify credentials, and then grant specific privileges to volunteers (which is a requirement from the Joint Commission for the Accreditation of Healthcare Facilities (JCAHO) for the disaster privileging standard). The level of privileges granted will depend on the amount of verified information available for the volunteer and will change over the course of the disaster response as the hospital's staff are able to observe the volunteer and assess the volunteer's skills and competencies. When large disasters involve many victims, hospitals likely will be more flexible in the amount of verified information required before allowing a volunteer to perform patient care services, determining the scope of services the volunteer can provide, and the amount of supervision the volunteer needs.

Some hospital officials, however, are confused as to whether ESAR-VHP would eliminate the need for hospitals to credential health care professional volunteers during an emergency. JCAHO representatives noted during the meeting that while ESAR-VHP will assist hospitals' credentialing activity by providing advance verification of a volunteer's information, hospitals still are required to conduct internal credentialing and privileging activities. Therefore, confusion may be reduced if the terminology within the next version of the Guidelines were changed to a more accurate description such as "emergency *information verification* standards" and "emergency *information verification* levels."

The AHA encourages the development of hospital-based models for state ESAR-VHP, which result in a more clearly identified pool of volunteers best qualified to assist in a hospital setting.

Legal Liability and Regulatory Issues

Significant gaps and inconsistencies in legal protections at the state and federal level remain. In the meeting, representatives from each of the 10 ESAR-VHP pilot states described existing protections and the variety of activities and efforts taking place to improve those protections. Key remaining gaps include protections for hospitals utilizing volunteers in emergencies and for volunteers who cross state lines to provide their services. The answers to these complex legal questions are dependent on the nature of

the disaster, and whether and the way in which the disaster is declared in a state and the existing state laws.

While some participants called for federal level solutions to liability exposures, legal experts indicated that there are no discussions about enacting federal legislation. It is critical, then, that state governments work with the health care professional and hospital communities to assess existing protections in state law and in mutual aid agreements, determine where the gaps are, and address these through the revision of state law or through expanded mutual aid.

Hospital representatives asked that HRSA evaluate relevant existing (and proposed) provisions in state and federal law and mutual aid agreements, and prepare and publish model legislation and best practices featuring the most comprehensive protections. This approach could be adopted at the state level for consistency across states.

The group also discussed certain other practices and procedures that individual hospitals can take to reduce their liability risks. These include: creating systems that promote compliance with JCAHO standards; establishing minimum standards for privileging; overseeing and supervising all health professionals within the facility; training employees in the organization's policies and procedures, including how to screen health care professional volunteers; and designating authority to certain staff members who have been trained and are responsible for these activities in an actual disaster.

Worker's Compensation Issues

When recruiting volunteers to participate in state-based ESAR-VHP systems, hospitals need to be able to tell volunteers responding to an emergency how they will be protected or compensated if they are injured while helping.

Since worker's compensation is a state-based system, these legal and management issues can be addressed only at the state level. When addressing these issues, states should include all of the relevant stakeholders – hospital associations; hospital representatives (including larger hospitals and health care systems that are self-insuring for worker's compensation); state medical associations and physician leaders; state nursing and other health professional associations; and insurance carriers. As each state ESAR-VHP is developed, stakeholders need to evaluate current worker's compensation laws, including their application to declared emergencies that may involve in-state and out-of-state volunteers. If unacceptable gaps in a state's worker's compensation protections are identified, the solutions should be developed by consensus from the stakeholders within the state and could include a variety of approaches including revising state law, compacts, memoranda of understanding, or other contractual agreements.

The meeting attendees recommended the development of a Web-based tool that contains current summary information about state-based and other protections for volunteers in

each state that will help health care professionals understand their existing protections and the risks associated with becoming an ESAR-VHP volunteer. Such a tool would provide answers to hospitals and potential volunteers, both in state and out of state, about worker's compensation coverage available.

State Licensure and License Portability Issues

State license reciprocity laws and other agreements among states are more clearly addressed consistently across the states than liability and worker's compensation provisions. States should review existing state law and memoranda of understanding in order to assess what coverage health professional volunteers have and what gaps remain. Some of the potential issues that should be explored and proactively addressed within state ESAR-VHP systems include the different scope of practice laws between states for a particular professional discipline and addressing volunteers who do not have active licenses – such as retirees or students in medical, nursing or other professional schools.

The meeting attendees recommended the development of a tool that summarizes license reciprocity provisions across states, including existing state laws and mutual aid agreements. Such a tool should include whether there must be a state-declared disaster in the requesting state; whether or not one state can deploy volunteers to a state in crisis in the absence of their own state declaring a disaster; how to handle non-registered or "spontaneous" volunteers; and whether different professions have different reciprocity provisions.

States also will need to overcome barriers to expanding inter-state reciprocity of licensure. State professional licensing boards may resist providing broad reciprocity, since these often depend on licensing fee revenues for funding. Also, the physician community could resist due to sensitivities related to the practice of telemedicine, and make it more difficult for physicians to volunteer in a state in which they're not licensed.

Hospital Role In Facilitating Recruitment of Capable Volunteer Health Care Personnel

The more involved and invested the hospital, medical and nursing leadership are in recruitment efforts within the state, the more likely it is that the state ESAR-VHP programs can recruit greater numbers of hospital-ready volunteers. To maximize volunteer recruitment states can work with individual hospitals or hospital regions to develop an ESAR-VHP education and recruitment campaign; speak at hospital-sponsored educational meetings; and provide hospitals with materials about the program, such as posters and articles for newsletters. Non-hospital recruitment efforts can include recruiting through health care professional license renewal forms; providing information at non-hospital-based educational seminars; and using actual emergencies as a platform to recruit volunteers into the program for the future.

One of the most important factors in a successful recruitment campaign will be ensuring that, in advance of any recruitment effort, state departments of health can give clear and

comprehensive answers to anticipated questions about volunteering commitments from health care professionals and hospitals as well as system activation details (including how employer hospitals will be informed); liability and worker's compensation protections; and reimbursement. A coordinated effort should ensure that hospitals and health professionals within the state know about the program and receive answers to these questions.

Each state ESAR-VHP system should be developed to include an employing hospital notification process so that hospitals helping to recruit volunteers will not be concerned about a potential workforce shortage in an emergency. Ideally the state's ESAR-VHP operational guidelines will explicitly state that hospitals will have the opportunity to release staff for the purposes of a deployment. At the very least, the meeting attendees commented on the need to ensure that the state ESAR-VHP activation plans include planning on how they will communicate with hospitals about members of their staff who have volunteered are being deployed elsewhere in response to an event. AHA also recommends that hospitals develop internal policy statements to require staff to inform supervisors of an ESAR-VHP deployment request.

Regional/Interstate Planning for ESAR-VHP Systems

Participants were briefed on work done to date to evaluate issues that exist when ESAR-VHP systems and volunteers are used across state borders, including lessons learned from an exercise conducted between Illinois and Missouri. This will contribute to the development of the ESAR-VHP as a regional and in the future a national system.

More work remains, however, including working with hospitals to determine whether and how they would use volunteers from other states. The AHA looks forward to working with HRSA and its contractors on the development of this concept of operations to ensure that the hospital perspective is clearly articulated and incorporated in the initiative.

Participants urged HRSA to ensure that federal agencies coordinate and plan with the states to consistently address any vulnerabilities. They also asked that measurable objectives or metrics to test the effectiveness of a concept of operations be developed.

Activation Protocols and Issues Involved in ESAR-VHP System Activation in an Emergency

A series of logical steps and procedures will be involved with the use and activation of a state's ESAR-VHP program in an emergency – beginning with basic activation functions such as volunteer notification and confirmation, and extending to details of logistics of volunteer assembly and orientation, transportation, housing, feeding, and release and debriefing of volunteers. Protocols also should address the number of jurisdictions needing and providing volunteers.

While all states recognized that, in reality, disaster response planning within and between states would need to include each step, states varied in their view as to which of these steps fell under the purview of ESAR-VHP activation and which steps were the responsibility of the affected community. None of the states indicated that they viewed their responsibility under ESAR-VHP to extend to all of the areas of logistical planning, indicating that these would be a community responsibility or, in certain extreme circumstances, a responsibility of the federal government. Further, most states will begin with planning for activations related to emergencies that are contained entirely within their own state and, over time, gradually expand their planning to activations that extend into contiguous states within their region of the country, with national level activation as ultimate goal.

Placing too much focus on activation and operational issues concerned those who worried about the sustainability of federal funding for ESAR-VHP. Participants agreed that the most important mission at this time is to ensure that all states develop ESAR-VHP databases that are interoperable and adequately populated with capable health care professionals. While HRSA staff confirmed this mission, they noted that without a concept of operations for activation, a database alone would not be useful. Further, a review of activation and operational issues may find database implications.

Another issue raised during this discussion is how the state-based ESAR-VHP systems fit into the federal response structure. HHS representatives indicated that federal officials are interested in working with the states so that information contained within state databases can be accessed with the individual volunteer's prior approval in the event of a large-scale incident that would require a federal response. The meeting attendees strongly recommended that if a state-based ESAR-VHP is to be used by federal officials, then this intent must be clearly communicated to health care professionals who are considering registering for the system within their state.

Background and General Description of Meeting

Background

While the terrorist attacks of Sept. 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 plans include supplementing hospital staff to meet 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 affected 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 spontaneous 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 Sept. 11, 2001 attacks. New York City hospitals reported that despite an influx of health professional volunteers responding to the World Trade Center tragedy, hospitals 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 was no single effective and efficient system to pre-register volunteer health care personnel for emergencies, nor was 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 Emergency System for the Advanced Registration of Volunteer Health Professionals (ESAR-VHP), a national system to assist medical professionals willing to volunteer in the event of emergencies and disasters by providing hospitals and other medical facilities with verifiable, up-to-date information

regarding the volunteers' identities, licensing, credentialing, accreditation, and privileging. The Secretary of the Department of Health and Human Services (HHS) has directed the Health Resources and Services Administration (HRSA) to implement this provision.

HRSA has been carrying out this mandate through the development and implementation of guidelines and standards for a state-based ESAR-VHP system that will be interoperable across state lines. In June 2005, HRSA released an electronic version of the "*ESAR-VHP Program Interim Technical and Policy Guidelines, Standards, and Definitions*" (Guidelines) report (Version 2, June 2005). The Guidelines are a collaborative product with 10 national working groups, comprised of states (grant awardees), and relevant federal agency, association and organizational representatives. The Guidelines cover the spectrum of advance registration issues and components encompassing ESAR-VHP planning, authorities and emergency operations, system design and content, recruitment and retention of volunteers, credentialing, privileging and identification, emergency credentialing, training, operations and maintenance, funding and cost, security and privacy, regionalizing and nationalizing, and common definitions. The Guidelines are a "living document" that will be refined and updated as new information is processed.

In the 2005 and 2006 National Bioterrorism Hospital Preparedness Program (NBHPP) cooperative agreement guidance documents, HRSA now requires that the 62 NBHPP cooperative agreement awardees use these guidelines in the development of state-developed and managed systems of volunteer health personnel. The NBHPP Critical Benchmark #2-4 - *Surge Capacity: Emergency System for Advance Registration of Volunteer Health Professionals* requires that states "Develop a system that allows for the advance registration and credentialing of clinicians needed to augment a hospital or other medical facility to meet patient/victim care and increased surge capacity needs." The ESAR-VHP implementation is taking place in a phased approach from January 2005 to December 2006. As part of the implementation effort, HRSA is providing assistance to each state in the development and operation of their ESAR-VHP.

In August 2004, HRSA contracted with the AHA to further identify hospital implementation issues and provide solutions. 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 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 its partners Collaborative Fusion, the American Medical Association and Joint Commission Resources which will include assessments of the 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 and emergency operation; recruiting; funding; and 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; state department of health personnel; and representatives from a number of relevant national organizations, such as the JCAHO and the National Association of Medical Staff Services (NAMSS).

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 were under development during the fall and winter of 2004, through early 2005. The AHA convened its HIFG in October 2004 to gather input to assist HRSA in the ESAR-VHP guideline development process. In attendance were individuals representing state, metropolitan and regional hospital associations; hospitals and health systems; a state department of health; and representatives from national organizations. Overall, 37 states were represented. A report was provided to HRSA in November 2004.

- The guidelines were pilot-tested by 10 NBHPP awardees from January through June 2005. The AHA convened a HIFG meeting of 10 state teams on May 24 and 25, 2005 to identify and discuss implementation issues and potential solutions for the states participating in the ESAR-VHP Phase I pilot program. This report to HRSA is the outcome of the Phase I 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.

Preparation for May 24-25 2005 HIFG Meeting

The second HIFG meeting was intended to provide HRSA with critical input and potential solutions to key hospital implementation and operational issues in the 10 pilot states of Connecticut, the District of Columbia, Illinois, Massachusetts, Minnesota, Missouri, Ohio, Texas, West Virginia, and Wisconsin.

The AHA asked state hospital association preparedness contacts in these states to bring a team to the May meeting. Each team included representatives from: (1) any metropolitan or regional hospital associations within the state; (2) the state health department bioterrorism coordinator responsible for the NBHPP grant and/or a representative from the agency responsible for implementing the state's ESAR-VHP; and (3) representatives from one or two member hospital(s) that already are actively involved in development of the state ESAR-VHP or who are likely to become involved in the state's ESAR-VHP implementation. State hospital associations were asked to include a diverse representation of hospitals (e.g. urban/rural) and ensure that individuals invited have an operational understanding of how credentialing and privileging should work within a hospital in an emergency.

Each attendee was asked to come prepared to discuss key topics from the hospital perspective recommended for discussion by AHA's project advisory group and by HRSA staff, such as emergency credentialing levels; legal liability, workers compensation and regulatory issues; license portability and reciprocity; a hospital's role in facilitating recruitment of capable volunteer health care personnel; the regionalization of ESAR-VHP systems; and, issues related to ESAR-VHP system activation in an emergency. Teams were provided with issue papers on some of these topics in advance of the meeting.

In addition, HRSA requested that the 10 state department of health bioterrorism coordinators update summary documents describing progress to date to implement the state's ESAR-VHP system, with a special focus on issues of interest to hospitals. To help facilitate updating these papers and ensure that members of each state's team were familiar with each other, AHA hosted 10 separate team conference calls in early May.

Final versions of the 10 state ESAR-VHP summaries were distributed to all meeting participants prior to the May 24 and 25 meeting.

General Description of Meeting

The second HIFG meeting took place on May 24 and 25, 2005 in Washington, DC, with more than 75 individuals in attendance, including 10 state teams, seated by state; representatives from several national organizations; members of the AHA's Project Advisory Group; and staff from AHA, HRSA and other HHS agencies. Early in the meeting, participants were provided with background briefings and status reports on ESAR-VHP program activities and tools, the Guidelines work related to hospital implementation, an update on hospital legal and regulatory issues, and a JCAHO update. The balance of the two-day meeting involved detailed discussions of hospital implementation issues, potential solutions and options on the following topics:

- emergency credentialing standards and levels issues
- legal liability and regulatory issues
- worker's compensation issues
- state licensure and license portability issues
- the hospital role in facilitating recruitment of capable volunteer health care personnel
- regional/interstate planning for ESAR-VHP systems
- activity protocols and issues involved in ESAR-VHP system activation in an emergency
- other miscellaneous issues ("parking lot")

Emergency Credentialing Standards and Levels Issues

Background

HRSA staff briefed participants on the *Interim ESAR-VHP Technical and Policy Guidelines, Standards, and Definitions* and their intent to assist in the development of a health care workforce emergency surge capacity. Discussion focused on whether the level to which health care professional volunteers information is verified in advance of an emergency affects the extent to which hospitals and others utilize volunteers. This could, in turn, affect the quality and responsiveness of a state's surge capacity efforts. Connecticut and Wisconsin department of health representatives also gave presentations on their Phase I hospital-based ESAR-VHP models.

The schema for classifying health professionals into one of several levels is described in Section 4.0 of the Guidelines. This includes a description of information verification standards; definitions for the information elements; and acceptable information verification sources for physicians, registered nurses, and five behavioral health occupations. A set of "Emergency Credentialing" Levels is defined for each of the seven health professions being evaluated initially, with different levels providing hospitals with different amounts of verified information about the volunteers. "Emergency Credentialing" Level 1 is the highest and most stringent level of verification defined, reflecting the verified information required for hospital use of personnel.

For example, for a physician to be classified as a Level 1 ("hospital ready") provider, information must be collected and verified that demonstrates the individual practitioner has an unencumbered license, a medical degree, American Board of Medical Specialties (ABMS) specialty board certification, and a Drug Enforcement Agency license. In addition, the individual must have active hospital privileges, not be excluded from the ability to bill Medicare/Medicaid, and not be in the National Practitioner Databank. A Level 2 provider ("office-based") includes all these elements, except verification of hospital privileges would be replaced by a verification of active clinical practice. To be a Level 3 provider, the physician would only be required to have a verified unencumbered license. Level 4 providers are those for which no information has been verified.

Summary of Discussion

The participants were asked to consider the following questions in their discussion:

- Do emergency credentialing standards for Level 1 (hospital ready) personnel meet hospital needs?

- How would hospitals utilize volunteers who have only Level 3 (verified license)?

- Are there any preferences or best practices regarding states using primary source versus hospital verification of volunteers' credentials?

In general, the AHA believes that the more verified information the state's ESAR-VHP system provides in advance about each volunteer, the more expeditiously and effectively an appropriate response to the disaster could be mounted. In that sense, hospitals prefer that a state-based ESAR-VHP system verify the information on volunteers up to Level 1. Hospitals generally find Level 1 to be useful to granting initial clinical privileges to a volunteer. Some hospitals indicate that they would accept a Level 1 volunteer only within their institution. However, it is important to note that the levels in the guidelines are not an hierarchy describing the quality of services a volunteer could provide or their competencies, but instead are a platform for describing the amount of validated relevant information available for each volunteer. In this context, verifying information to a higher level is helpful to ensure that the activation and deployment of health care professional volunteers is done in the most timely, appropriate and targeted way.

In a disaster involving the need for outside assistance from volunteer health care professionals, the affected hospital most likely would put to work first their own staff and staff with whom they are familiar, and put them in more responsible or critical positions. For volunteers who are unfamiliar to the hospital, the hospital would be able to use those with a higher level of verified information more effectively and more expeditiously than those who have less information available. Therefore, in the immediate aftermath of a disaster, a volunteer with Level 1 verified information arriving at a hospital would be permitted to begin providing services more quickly, with less supervision and within the scope of practice of that volunteer's discipline, than a volunteer at Level 3 or 4, for whom a hospital has less information.

When asked how hospitals would utilize volunteers whose information was verified only up to Level 3 (verified license), hospital representatives indicated that:

- While Level 3 (and 4) health care volunteers will have an important role to play in helping in the event of a disaster, these volunteers would less likely be permitted to provide services in a hospital setting. Instead, this type of volunteer would be suited for providing services in non-acute community-based settings (e.g. points of distribution, alternative care settings), that are typically considered for volunteers recruited by organizations such as the Medical Reserve Corps (MRC), American Red Cross, etc.

- Level 3 (and 4) volunteers also would be suited to address the need for regular, non-disaster related medical services that will be demanded even in the midst of a disaster – such as non-complicated labor and delivery, treating minor illnesses and injuries, etc. In a major disaster, hospital beds will be filled with seriously ill

victims, but there will be a need for health care professionals to provide services in other settings, such as alternate care sites and points of distribution.

- To the extent that Level 3 (and 4) volunteers will be utilized within hospital-based settings, their services generally would be more heavily supervised and limited to activities that involve less or no complex patient care. This frees up the hospital's own staff and the Level 1 volunteers to do more complex tasks. In this way nurses who are not currently employed or school nurses can contribute in the time of a disaster.

- As noted elsewhere, the circumstances of the disaster, such as the numbers of injured and ill would also affect hospital willingness to allow Level 3 (or 4) health care professional to practice within their institutions and the kinds of services such professionals would be permitted to provide.

It is also important to distinguish between credentialing and privileging. Credentialing is the process in which hospitals verify the education, licenses, specialty, practice and other information of the health care professional. Privileging allows a hospital to grant permission to an individual health care professional to perform specific clinical services within the hospital. Privileging can be thought of as describing the health care professional's competency – a health care professional is deemed to have the necessary skill set and level of experience to be able to provide the services for which they have been privileged.

Some hospital officials, however, are confused as to whether the ESAR-VHP would eliminate the need for hospitals to credential health care professional volunteers during an emergency. This confusion is partially due to the terminology used by HRSA in their Guidance, which references "emergency *credentialing* standards" and "emergency *credentialing* levels." But, as noted by the JCAHO representative at the HIFG meeting, ESAR-VHP systems do not remove the responsibility for hospitals to conduct internal credentialing and privileging activities. Instead, ESAR-VHP will assist hospitals by providing advance verification of a volunteer's information to assist hospitals in its credentialing. Therefore, confusion may be reduced if the terminology within the next version of the Guidelines were changed to a more accurate description such as "emergency *information verification* standards" and "emergency *information verification* levels."

In addition, while ESAR-VHP systems will provide information to assist in hospital credentialing of volunteers during a disaster response, hospitals still are required to grant privileges to health care professionals who will be providing services to patients in the hospital. The emergency information verification levels also do not eliminate the need for the hospital to perform their due diligence in terms of granting specific privileges to volunteers. This is a requirement of the JCAHO disaster privileging standard. The level

of privileges granted will depend on the amount of verified information available for the volunteer and will change over the course of the disaster response as the hospital's staff are able to observe the volunteer and get a better sense of the volunteer's skills and competencies. For example, a volunteer who has been verified as a Level 1 trauma surgeon may not at first be privileged to perform complex trauma surgeries within the receiving hospital or may be privileged to only perform surgeries under supervision. In general, however, to the extent that the volunteer starts with a higher level of verified information, the process to grant privileges can proceed more efficiently.

Disaster response also will be somewhat dependent on the scope of the disaster especially the numbers and acuity of the ill or injured patients presenting to the hospital. In a large scale disaster with many injured or ill victims, hospitals likely will be more flexible regarding the amount of verified information they require before allowing a volunteer to perform patient care services, the scope of services the volunteer is privileged to provide, and the amount of supervision the volunteer will be assigned. Disaster response must be flexible in this regard. Ultimately deciding how an individual volunteer's services will be used in a disaster, regardless of a health care professional's verified information, must be left to the hospital incident commander to determine.

But in making a decision about how to utilize a volunteer within the hospital, more information regarding competencies is helpful in order to grant detailed privileges. Many hospitals in the United States also require certain demonstrated skill sets, which would be defined in terms of standard competencies (e.g. certification in cardiopulmonary resuscitation or Advanced Cardiac Life Support) in order to work in the emergency department, the operating room or other hospital departments. The mandatory elements contained within the ESAR-VHP levels and standards, as they are currently described in the Guidelines, do not completely encompass the kinds of information that many hospitals would ideally like to have in requesting volunteers to supplement their staff in a disaster. Officials should consider adding certain data elements to the mandatory list. These determinations should be health profession specific and should be developed in consultation with the AHA, state hospital associations and individual hospitals.

One type of competency which should be captured in some way within the ESAR-VHP database is the level of experience of a nurse who is not certified in a specific clinical specialty. Many nurses have worked for substantial periods in a given clinical specialty, but they may not have obtained certification in that specialty. And while information regarding nursing specialty certification is important, hospitals also would benefit from knowing about actual work experience. There should be a way to capture nursing clinical experience, in the absence of certification, within the ESAR-VHP Guidelines.

Other types of information not currently mandatory within the Guidelines, but which hospitals indicate they would find useful, are the size and type of institution in which the volunteer practices. This could include whether the volunteer's place of employment is a

trauma center (and its level), a burn center, or has some other specialized and recognized designation.

The AHA encourages the development of hospital-based models for state ESAR-VHPs, such as are currently in place in Connecticut and Wisconsin. Developing hospital-based state ESAR-VHP systems is likely to result in a pool of volunteers who are most useful for practicing in a hospital. In these kinds of models, hospitals are involved directly in the verification of information on volunteers and in updating such information. For a hospital-based ESAR-VHP model to be successful, it is critical to involve hospital interests from the start, including involving the state hospital association, hospital credentialing staff and the state's association of medical staff services. It is also helpful to use an iterative process as the state develops the system. As each element of the system is developed, it needs to be tested with hospitals and/or their representatives.

Further, once the ESAR-VHP database begins to register volunteers, it is important that information updates occur at least quarterly, if not more often. ESAR-VHP systems also should be designed to ensure that health professionals who have relevant restrictions, limitations or stipulations on their license are not able to register as volunteers and should be removed from the volunteer lists as soon as possible, if such restrictions are identified.

There are also important considerations regarding how information within a state's ESAR-VHP is verified. The Guidelines describe three ways to verify information: (1) primary source verification that is authorized by the state directly; (2) using a credentials verification organization (CVO) or (3) delegating the information verification role to the hospital(s) in which the volunteer normally practices, thereby treating the hospital as the CVO.

While hospitals generally indicate they would accept of any of these methods of information verification, there was detailed discussion regarding the third option —using hospitals as CVOs instead of primary source verification. Most of the pilot states supported such an approach. Having a high proportion of JCAHO-accredited hospitals (who would share similar credentialing standards) or having communities in which hospitals already were involved in sharing information regarding staff credentials through pre-existing Memoranda of Understanding (MOUs) were factors that seem to lead to a higher level of comfort for this approach. Representatives from Connecticut, the District of Columbia, Massachusetts, Chicago, and Texas supported this approach as a viable option. However, representatives from Missouri, who said they have a larger number of hospitals that are not JCAHO-accredited and where hospitals have significantly different kinds of staff credentialing systems in place, had more serious concerns about the liability inherent in providing and accepting hospital-verified credentials information. There was also some concern around sharing hospital verified, rather than primary source verified, information across state lines. Finally, representatives from Texas noted that in Texas

verification of nursing information must be primary source only and only through the Texas board of nurse examiners.

Other suggestions and considerations raised in the course of discussion on emergency credentialing levels include:

- Developing and disseminating a scope of service or "job description" for volunteers whose information is verified to a Level 2, 3 or 4. As a start, HRSA should explore a "Top 10" list that Yale-New Haven is preparing, which will outline activities that volunteers will be asked to perform during a disaster and include "just in time" training modules to help prepare volunteers to perform these activities.

- Developing hospital plans to handle spontaneous volunteers. Even with an active state-based ESAR-VHP system, it is likely that spontaneous volunteers will arrive at the site of the disaster and at hospitals offering their services. In the absence of any verified information, a spontaneous volunteer could be registered into the system as Level 4. A practice model Ohio already uses for its MRCs may work for other states. In the event of a disaster, spontaneous volunteers would be directed to a volunteer reception center that would be set up to perform limited information verification (e.g. verifying state licensure) and potentially provide on-site "just in time" training. These spontaneous volunteers then could be treated as Level 3 ESAR-VHP volunteers. Such volunteers could work at an alternate care site, perform hospital intake, or other functions that don't involve direct patient care or involve only limited or non-complex patient care activities.

- Identifying and verifying information for clinical and non-clinical personnel who are not typically licensed by states but who would be critical to helping a hospital run in a disaster. Examples include phlebotomists, hospital security and food services workers.

Legal Liability and Regulatory Issues

Background

James Hodge and Lance Gable from the Center for Law and the Public's Health presented background information on legal concepts for liability issues and how these may apply to hospital concerns about ESAR-VHP system development. They noted that much of hospitals and health care providers concern regarding the way information is recognized, verified and utilized during an emergency response is related either directly or indirectly to concerns about the very real risk of liability. However, legal provisions and some specific hospital activities may help reduce that risk.

Potential legal exposures that hospitals and health care volunteers face include civil and criminal liability. Because there are ways of protecting against civil liability through immunity or indemnification, which cannot be offered for criminal liability, only civil liability was discussed in any detail at the meeting. Civil liability is the potential responsibility that a person or institution may owe for their actions, or failures to act, that result in injuries or losses to others. The kinds of actions that are subject to civil liability include negligence, intentional torts, privacy violations, misrepresentation, discrimination, and breach of contract.

For health care providers, however, the most important concern has been liability for negligence. Four major elements are necessary to establish negligence:

1. Duty: The duty the volunteer health professional owes the patient and the duty that the hospital supervising the volunteer owes the patient.

2. Breach of duty: This involves the question of whether or not the person providing the care, or the entity supervising the care, has taken reasonable steps to ensure the provision of quality care, according to the prevailing standard of care.

3. Causation: There must be a factual link between the breach of the duty and the person who allegedly committed the breach. This includes the concept of "proximate cause" which could draw in not only the health care professional volunteer who provided the care, but also the hospital in which the volunteer is practicing and the hospital that verified the volunteer's information.

4. Damages: The individual alleging negligence must have been injured or harmed in a quantifiable way.

Hospitals also can face corporate liability in two ways. The first is vicarious liability, in which the actions of employees or volunteers who commit negligent acts can be imputed to the hospital itself. This can occur through the theory of "respondeat superior," under

which the employer – the hospital – is responsible for the acts of its employees. Further, under the theory of "ostensible agency," hospitals can be held liable for the actions of non-employee professionals – such as physicians who are not employees but have hospital privileges. And second, hospitals bear corporate liability for their own actions, such as failing to adopt policies and procedures to protect the safety of patients. This would include the way that the hospital has conducted itself in terms of the duty to use reasonable care, maintaining safe and adequate facilities, the duty to select and retain competent professionals, the duty to oversee all persons who are practicing their professions in the hospital, and the duty to formulate, adopt and enforce the types of policies that will ensure that the other criteria are met.

There are a host of existing legal solutions, many of which were discussed at the meeting, including the federal Volunteer Protection Act (VPA), state specific volunteer protection acts, state Good Samaritan Acts, state emergency powers acts, mutual aid agreements, the Emergency Management Assistance Compact (EMAC), memoranda of understanding between entities, insurance coverage, and JCAHO standards. These all provide a legal environment in which various levels of protections exist to either eliminate liability or to indemnify against liability.

However many significant gaps and ambiguities remain in protections and coverage. For example, EMAC has gaps in what it covers in relationship to hospital-based health care personnel. The two main concerns are (1) that EMAC protections do not apply to health professional volunteers who are responding *within* a state and (2) ambiguity remains regarding whether hospital-based personnel who volunteer under ESAR-VHP and cross state lines would be considered to be part of the state's response and thus eligible for EMAC protections. The federal VPA also has some significant gaps for ESAR-VHP system volunteers and related entities. VPA does not apply if volunteers are being compensated and its protections would not extend to organizations that employ or supervise the volunteers, such as hospitals.

Summary of Discussion

The participants were asked to consider the following questions in their discussion:

- What are the existing legal protections for volunteers and institutions utilizing volunteers in each state?

- What are the remaining gaps in each state and what does each participating Phase I State recommend as a potential solution?

- Are there circumstances in which a federal-level solution would be preferable to a state-based solution? If so, what circumstances and what kind of a solution?

The discussion made it clear that significant gaps and inconsistencies in legal protections remain at the state and federal level. Representatives from each of the 10 ESAR-VHP pilot states described existing protections and their efforts to improve those protections, which include a wide variety of state activities. In general, existing state and federal protections tend to be more favorable to the volunteer health professional than they are to the hospital. The group also learned that institutional liability is more apt to fall on the receiving hospital than on the hospital whose staff volunteered and participated.

Representatives also were concerned about the applicability of legal protections when volunteers cross state lines to provide their services. Legal experts at the meeting indicated that these complex issues are dependent on the nature of the disaster, and whether, and the way in which, the disaster is declared in a state.

While some participants called for federal level solutions for legal liability exposures, legal experts indicated there has been no discussion in Congress about enacting Federal liability protection. In the short term, it is critical that state governments work with their health care professional and hospital communities to assess existing protections in the wide variety of state laws and mutual aid agreements, and determine where the gaps are. Any identified gaps could be addressed through revising of state law or expanding mutual aid.

Even in the absence of a comprehensive federal statutory solution, however, or the will to craft one, many of the participants felt strongly that the federal government could take steps to provide some uniformity to protect health care professional volunteers deployed through a state's ESAR-VHP system. In particular, hospital representatives suggested the evaluation of relevant existing (and proposed) provisions in state and federal law, and mutual aid agreements, and prepare and publish model legislation and best practices that sets out the most comprehensive protections. This approach could be adopted at the state levels in order to facilitate consistency across states.

The group also discussed certain other practices and procedures that individual hospitals can take to reduce their risks of liability. The practices, that all hospitals should adopt, include:

- Creating systems that promote compliance with JCAHO standards (such as disaster privileging), and follow good procedures and practices to assess the qualifications of volunteers;

- Establishing minimum standards for privileging;

- Overseeing and supervising all health professionals within the facility to ensure they are not engaging in activities that are negligent or in any way endanger patients in the facility;

- Training employees in the organization's policies and procedures, including how to screen health care professional volunteers as they arrive, the use of available databases, and ensuring their ability to assess and evaluate volunteers using the information in those databases; and

- Designating authority to certain staff members who have been trained and are responsible for these activities in an actual disaster.

Worker's Compensation Issues

Background

James Hodge, with the Center for Law and Public's Health, also provided background on worker's compensation. Hospitals and health care professional volunteers are concerned about responsibility for death, disability and injuries to the volunteers themselves and whether there are ways to protect volunteers from foreseeable injuries that may occur in responding to emergencies. The ability to answer questions regarding worker's compensation coverage for health professionals in a disaster will be important for those considering volunteering for the state-based ESAR-VHP system.

Worker's compensation is not a liability-based system but rather a social welfare system designed to pay for any injuries that occur to workers in any setting at the workplace. Worker's compensation is not comprehensive and does not provide 100 percent restitution to the injured person. It also generally pays only after other coverage is depleted, such as other medical insurance coverage.

Essential questions that must be addressed related to worker's compensation coverage, as they are applied to ESAR-VHP volunteers are:

1. Who is an employee for the purposes of workers compensation? In general, unless someone is compensated, they are not covered under worker's compensation. Therefore, uncompensated volunteers would not be covered. However, some state laws (e.g. Minnesota and Connecticut) view volunteers responding during emergencies as employees, which would then create a responsibility for worker's compensation coverage. But absent such a state law or regulation extending worker's compensation to a category of volunteers in ESAR-VHP, unpaid volunteers traditionally would not be considered employees. In some states (e.g. Connecticut) provisions covering volunteers are narrowly drawn to encompass only registered volunteers.

2. Who is an employer for the purposes of volunteers? The hospital which employs a health care professional under ordinary circumstances generally would not be considered their employer for purposes of worker's compensation if that professional is injured in the course of volunteering their services in a disaster at another hospital. This is because the volunteer is not acting within the scope of their employment at the time of this service. The delineation of which entity would be responsible depends primarily on state law provisions for the state in which the volunteer is providing services. Some state laws would define the responsible "employer" to be the state, in which case the volunteer would be covered through the state worker's compensation plan. But if this is not the case, state law may allow that the host hospital's worker's compensation coverage

might apply to injuries sustained by a volunteer practicing on their premises. In general, it is the law of the state in which the volunteer is injured that will apply.

3. When is a volunteer acting within the scope of his or her employment? Coverage under worker's compensation would apply only when the individual is engaged in the functions of employment. Some states have laws (or are considering laws) in which the workplace for the purposes of volunteers will be defined as the particular hospital in which these volunteer efforts are being undertaken. But this answer varies widely between states. Some employers can, through contractual obligations, assume responsibility for volunteers that practice on their premises in times of emergency, but there are increased worker's compensation premiums to account for these additional risks. This is an area that may require state legal reform or strong clauses in worker's compensation coverage contracts.

4. Is a volunteer actually injured in the course of emergency responses? Injuries that occur or arise outside of the workplace, with limited exceptions, would not be covered. This would be difficult to determine if the injury is an illness that is pervasive in the community in which the volunteer is providing services because the volunteer would have to prove that they contracted the illness while they were providing professional services in the workplace.

Summary of Discussion

The participants were asked to consider the following questions in their discussion:

- What are the existing worker's compensation provisions for volunteers and institutions utilizing volunteers in each state?

- What are the remaining worker's compensation gaps in each state and what does each participating Phase I state recommend as a potential solution?

One of the main lessons learned from the smallpox vaccination program is that it is critical to be able to clearly answer questions related to how those responding to an emergency will be protected or compensated if they are injured in the course of providing services. When recruiting volunteers to participate in state-based ESAR-VHP systems, similar questions are just as likely to emerge. Health care professionals will demand unambiguous answers to questions regarding worker's compensation coverage, and, in the absence of clear answers, will be far less likely to volunteer. A clear answer, even if it is to clarify that the volunteer would not be covered if they are injured, is likely to be received better than an ambiguous response or no response, which would discourage the health professional from volunteering.

Since worker's compensation is a state-based system, these legal and management issues can be addressed only at the state level. In discussions related to ESAR-VHP volunteers, states should include all of the relevant stakeholders including state, metropolitan and regional hospital associations; hospital representatives; state medical associations and physician leaders; state nursing and other health professional associations; and insurance carriers. Since many larger hospitals and health care systems are self-insuring for worker's compensation, these institutions need to be considered stakeholders as well.

In the course of developing each state ESAR-VHP, stakeholders need to look at the existing state authorities for a declared emergency and what sort of provisions are in place regarding the declaration of emergency. Current worker's compensation laws must be evaluated and assessed, including their application for declared emergencies that will involve in-state and out-of-state volunteers.

It would be helpful for each state to develop documents and tools to help health care professionals understand their existing protections and the risks of volunteering to become an ESAR-VHP volunteer. The meeting attendees recommended the development of a tool that contained current summary information about state-based and other protections for volunteers in each state. Such a tool should be Web-based and allow users to obtain answers to questions about worker's compensation coverage available within the state and for volunteers coming from other states.

If unacceptable gaps in a state's worker's compensation protections are identified, solutions also should be addressed by consensus from the state's stakeholders and could include a variety of approaches such as revising state law, compacts, memoranda of understanding, or other contractual agreements. Developing consensus could take significant time and effort, especially if solutions involve expanding state worker's compensation coverage to volunteers in a disaster. These kinds of approaches are likely to meet with initial resistance from insurance carriers who would be concerned about the cost of including non-state employees in a state-based worker's compensation plan.

Regardless of the difficulties and time involved, taking these steps will significantly impact a state's ability to recruit volunteers. These considerations, a key component of a successful advanced registry system, are part of the complex set of issues involved in developing a successful state ESAR-VHP.

Other worker's compensation issues include:

- Ensuring that worker's compensation protections apply to volunteers who are injured in the course of training exercises. State law would have to define training as employment-based for this to be covered.

- Addressing the issue of how physicians are, or should be, covered by worker's compensation if they are not employees of either their home hospital or the hospital in which they are volunteering, but rather are independent contractors. In many cases, private physicians do have their own worker's compensation coverage for themselves and their employees. Some hospitals also have provisions in their worker's compensation plans that would provide specific coverage for additional or uncompensated expenses for physicians who are contracted to provide services for their hospital. These issues, while state and institution specific, should be clearly addressed and articulated to physicians who are considering volunteering for a state-based ESAR-VHP.

- Answering questions about whether and how individuals who are registered as MRC volunteers are covered under worker's compensation.

- Answering questions regarding how worker's compensation coverage addresses injuries in which there is a pre-existing condition.

- Clarifying how to provide for volunteer protection in smaller scale events. There may be different ways to address worker's compensation for volunteers in such smaller-scale events that do not involve the declaration of a state public health emergency. This would include developing memoranda of understanding between hospitals, with specific contractual obligations written into hospital worker's compensation contracts.

- Concern about a patchwork quilt approach to worker's compensation in disasters that involve bringing volunteers across state lines. This could lead to disincentives to volunteer for emergencies that happen in other states. Some of those in attendance called for a national level of baseline automatic coverage for health professional volunteers who cross state lines, such as through EMAC, VPA or other mechanisms to provide such assurances. However, a federal solution was generally not thought to be feasible for worker's compensation since these are clearly state-based systems.

State Licensure and License Portability Issues

Background

Health care professional license portability issues are critical since one of the main goals in developing ESAR-VHP systems is to provide for surge capacity and help facilitate the use of volunteers who cross state borders. Lance Gable discussed how licensure laws for different professions apply across state lines, under which circumstances those lines can be crossed by professionals, and approaches used by different states and regions that could be adapted into models for other states.

The only time that volunteer health care professionals can practice in another state is when they are authorized to do so by the receiving state. This type of authorization is usually established in legislation, in a mutual aid agreement, or in some other regulatory process. However, in the absence of a specific authority through one of these mechanisms, the health care professional cannot cross state lines to practice in another state because licensing systems for health care professionals are state-based systems. A professional's license applies only to the state in which it was granted, unless there is a reciprocity agreement or some other kind of recognition of the license elsewhere.

There are three basic approaches used among the states to provide professional licensure reciprocity, including:

1. Emergency declarations: Some states have emergency powers laws providing that, pursuant to a state declaration of emergency, there will be recognition of licenses for health care professionals from other states. These usually treat licenses of the professionals in other states as being equivalent to the licenses in the state where the emergency is occurring. In most situations these are broad waivers of the normal licensure requirements for certain categories of professionals if an emergency has been declared. Three examples discussed include a Connecticut law that allows for the temporary suspension of license requirements for out-of-state health professionals who come to Connecticut during a declared public health emergency; an Ohio law that allows for waiver of nurse licensure requirements in a declared disaster; and an Illinois law that provides for more generalized emergency reciprocity for any person licensed in another state to practice in Illinois in a declared disaster.

2. Mutual aid agreements: Mutual aid agreements, such as EMAC and the International Emergency Management Assistance Compact (IEMAC), often have generalized licensure reciprocity. EMAC, which has been ratified by 48 states and has provisions that allow for licensure reciprocity, is activated when a state in the compact requests assistance from one of the other member states. While this

is broad reciprocity, it does have some limitations such as it is subject to the limitations and conditions the governor of the requesting state puts on the request and it applies to "officers or employees of the state" who are sent to another state, but there is ambiguity about whether it would apply to private employees who are not working for the state. The IEMAC, an international agreement between certain New England states and provinces in eastern Canada, has more expansive language that allows "any person or entity" – not just state employees – to have licensure reciprocity and immunity from liability.

3. Non-emergency reciprocity agreements: These kinds of agreements or provisions will apply regardless of whether there is a state of emergency, but are usually specific to certain professions. One example, the Nurse Licensure Compact, includes 28 states and allows nurses licensed in these states to practice in other states. There does not need to be an emergency declaration or any other sort of special circumstances. Another example is a Minnesota statute that provides for license reciprocity for licensed nurses in four bordering states of Iowa, North Dakota, South Dakota and Wisconsin.

Summary of Discussion

In their discussion, the participants were asked to consider whether their state adequately addresses inter-state licensure portability and reciprocity issues and what problems, solutions and gaps remain.

Compared to liability and worker's compensation provisions, the state laws and other agreements addressing license reciprocity are much more clearly set out and addressed more consistently across the states. States involved in implementing the ESAR-VHP are encouraged to work with state legal counsel and conduct a careful review of the provisions that already may exist in state laws and memoranda of understanding in order to assess to what extent health professional volunteers would be covered and what gaps remain.

The meeting attendees suggested it would be helpful to develop a tool that summarizes, in an easy to reference format, license reciprocity provisions across states, including existing state laws and mutual aid agreements. Such a tool should include whether there must be a state-declared disaster in the requesting state; whether or not the sending state can deploy volunteers in the absence of their own state declaring a disaster; how to handle non-registered or "spontaneous" volunteers; and whether different professions have different reciprocity provisions.

Several barriers to expanding inter-state reciprocity of licensure exist. There may be resistance to providing for broad reciprocity from state professional licensing boards. Many state licensing boards are reluctant to extend reciprocity to other state's

professionals because they depend on the revenues obtained from licensing fees to fund their activities. This type of resistance is reduced when the licensing boards are funded through an appropriated amount and their activities are not tied to the collection of fees. In addition, the proliferation of the practice of telemedicine across state lines has resulted in a move toward protectionism among the physician community who fear encroachment into their practice within a state. In some states this has resulted in legislation and regulation prompted by state medical societies, making it more difficult to practice in the state without a license from that particular state. It is worth evaluating these laws to determine whether they provide some exception for emergency circumstances.

However, states in which there are hospitals that are part of multi-state hospital systems or chains may have an advantage in negotiating emergency or non-emergency license reciprocity through legislation or mutual aid agreements. This is because multi-hospital systems often have a need to share health care professionals across state lines in the normal course of their business. These kinds of negotiations are occurring now in Minnesota.

Other areas related to license portability that should be addressed within state ESAR-VHP systems include:

- The different state scope of practice laws for health care professionals and their implications when these volunteers cross state lines to provide services. For example, in some states psychologists are permitted to prescribe drugs and in other states they are not. The untested assumption is health care professional volunteers providing services in another jurisdiction are subject to limitations that are the lesser of: (1) the scope of practice for equivalent licensed professionals within the jurisdiction in which they are volunteering or (2) the scope of practice for which they have been deemed competent in the jurisdiction in which they have been licensed.

- How to handle health professions that may require licenses in some but not all states. The untested assumption is that most emergency declaration provisions in state law are written broadly enough to accommodate equivalent license certification or permits in other states, including different terminologies, as long as the skills in the profession are equivalent.

- Addressing individuals who want to volunteer under ESAR-VHP but who are retired professionals who no longer have active licenses or are students in medical, nursing or other professional school. Because they are not licensed in their jurisdiction, they generally will not be permitted to practice in another state, regardless of license reciprocity provisions in the state's law. States should proactively and explicitly address in their ESAR-VHP how retired professionals and students will be managed in disaster situations.

Hospital Role in Facilitating Recruitment of Capable Volunteer Health Care Personnel

Background

Hospitals can play a key role in facilitating the recruitment of health care professionals for the state-based ESAR-VHP systems. The involvement of hospitals and hospital associations throughout the entire process of planning and recruitment is critical to ensuring that the system includes adequate numbers of hospital-ready volunteers.

Summary of Discussion

Participants were asked how their state addressed the issue of the hospital's role in facilitating recruitment of volunteers. States can involve hospitals by working with individual hospitals or hospital regions in the development of an ESAR-VHP education and recruitment campaign; presenting topics at hospital-sponsored educational meetings; and providing hospitals with written materials about the program such as posters and articles for newsletters. Recruitment efforts that do not involve hospitals directly include recruiting through health care professional license renewal forms; providing information at non-hospital-based educational seminars; and using actual emergencies as a platform to recruit volunteers into the program in the future.

It is expected that one of the most important factors in a successful recruitment campaign is ensuring that, in advance of any recruitment effort, the state department of health has clear and comprehensive answers to questions that health care professionals and hospitals will ask. The more information that is clearly articulated in advance of recruitment efforts, the more likely it is that the system will be able to successfully recruit adequate numbers of capable health care volunteers. There also should be a coordinated effort undertaken to educate and inform hospitals and health professionals within the state about the program and the answers to these questions. These kinds of questions can be predicted and include such issues as:

- the nature of the commitment expected from the volunteer, including assurances that the system is truly voluntary, length of expected deployments, and choice in deployment;
- the conditions under which the system would be activated;
- the extent and type of liability protections in place for the volunteer and the donating and receiving hospitals;
- the provision of worker's compensation in the event of injuries to the volunteer;

- whether the system includes financial compensation; and

- how the system will communicate with hospital employers about a system activation that may affect their workforce and formally releasing their employees prior to their deployment.

A good example is Connecticut where, in advance of having hospitals sign onto the ESAR-VHP system, a planning process answered many of the expected questions regarding the activation and protections within the state's planned ESAR-VHP program. Answers were sent to various stakeholders such as legal council, physician executives, nurse executives and other professional groups. The result is that all hospitals in the state participate in the state's ESAR-VHP system.

Some states only now are beginning to plan for recruitment of volunteers into the ESAR-VHP system. Experience and lessons learned from developing other volunteer programs also is helpful in developing best practice for ESAR-VHP. For instance, many localities have experience in recruiting volunteers for MRCs, decontamination teams, mass immunization teams or other voluntary initiatives that they can draw upon as a source for best practices for recruiting volunteers. Some states and districts are taking more of a "hands-off" approach to hospital involvement. In Missouri and the District of Columbia the hospitals within various regions already have mutual aid agreements that involve sharing of staff and the expectation is that the ESAR-VHP will be activated only if local mutual aid resources are not adequate and will focus on non-hospital based staff, such as office-based physicians and nurses.

One particular issue of concern to hospitals is whether, by participating in recruiting volunteers, the hospital will find itself without adequate personnel in an emergency, particularly one that involves an infectious agent that can spread rapidly from one community to another. This concern must be addressed, ideally by explicitly providing within the state's ESAR-VHP operational guidelines that the hospitals will have the opportunity to release staff for the purposes of a deployment. The meeting attendees commented on the need to ensure that the state ESAR-VHP activation plans include planning on how they will communicate with hospitals about members of their staff who have volunteered and how and when they are planned to be deployed. AHA also recommends that hospitals develop internal policy statements to require staff to inform their supervisors of an ESAR-VHP deployment request. For example, at Norwalk Hospital in Connecticut, a human resources policy clarifies that for those hospital employees who volunteer in outside programs their first obligation is to their place of employment and that they are required to get permission from the hospital before they are deployed to an outside event. Such a policy could be used as a model for other hospitals involved in state ESAR-VHPs. Each state ESAR-VHP system should be developed in such a way that it will include an employing hospital notification process.

In addition, hospitals can have several different levels of involvement in recruitment initiatives. This spans from merely providing information to its staff about the state's program to actively recruiting teams from the hospital for purposes of volunteer registration. In general, the more involved and invested the hospital, medical and nursing leadership is in recruitment efforts within the state, the more likely that the state ESAR-VHP programs would be to recruit greater numbers of hospital-ready volunteers. To date, however, the 10 pilot states are primarily using the hospitals in their community as a resource for marketing the program and verifying information provided by individual volunteers. This level of involvement may change over time as the ESAR-VHP initiative rolls out over Phases II and III of its implementation.

Regional/Interstate Planning for ESAR-VHP Systems

Background

Atila Omer from Collaborative Fusion presented a report on the progress of an initiative involving regional and interstate planning for ESAR-VHP systems. This was an update on work that evaluates issues that exist when ESAR-VHP systems and volunteers are used across state jurisdictions. This goes beyond the development of ESAR-VHP standards and guidelines and moves toward developing a concept of operations to make the ESAR-VHP operational as a regional or even a national system. Collaborative Fusion and HRSA are working to formalize best practices for a concept of operations involving how these systems need to work, and providing direct instruction to the states to ensure these systems are interoperable in an emergency declaration.

More work remains, however. In particular, HRSA and Collaborative Fusion will work with hospitals in Chicago and other cities to determine how and whether they would use volunteers who cross state lines, and will continue to develop a concept of operations to regionalize the ESAR-VHP. A final report from Collaborative Fusion will be presented at the conclusion of this initiative. The AHA looks forward to working with HRSA and its contractors on the development of this concept of operations to ensure that the hospital perspective is clearly articulated and incorporated in this initiative.

Omer described an exercise between Missouri and Illinois that was intended to test the ability to utilize volunteer health professionals across state lines. The scenario involved an influenza epidemic centered in the Chicago metropolitan area that escalates and exhausts all of the health care personnel resources within the state of Illinois. The scenario was intended to test the ability for states to coordinate the identification of hospital and public health human resources needs and the provision of these resources, with communication occurring via the established chain of command within the states, which could serve to coordinate and help recruit and find health professional volunteers. The exercise commences at the point where the governor of Illinois has declared a state of emergency and requested assistance. Federal authorities are providing assistance to locate these resources. The state of Missouri offers to help recruit 450 volunteers – 300 registered nurses and 150 physicians — to assist Chicago hospitals. Among the assumptions made are that the Federal Tort Claims Act (FTCA) is invoked, in coordination with federal authorities, to provide some liability protections. The scenario also included the activation of EMAC in order to better understand its state-to-state compact elements.

In general, the exercise made it clear that where utilizing one state's ESAR-VHP system across state lines initially appears straightforward, it brings in very complex issues regarding system activation and logistics that need to be clearly addressed by states and

regions in advance of actual activation. Coordination within and between states is essential.

Key findings from the exercise are:

- The need to appropriately conduct volunteer staging and communicate expectations to volunteers is essential and makes the concept of spontaneous volunteers unworkable in this type of scenario.

- Health professional volunteers, especially those crossing state lines and those traveling long distances to volunteer, need as much information as possible. This includes clearly communicating their liability protections, worker's compensation provisions, and other key issues.

- The donating state, because it holds the data regarding the numbers, types and availability of volunteer resources, must work closely with hospitals and other groups involved in the state's operations to develop a strategy for communications, staging, and the logistics on how volunteers will be delivered to the affected state.

- For the affected state, involvement of emergency management through the state's emergency operations center is essential, especially in developing and implementing agreements such as EMAC.

- Verifying volunteer information must be done both by the donor and the affected states. The donor state would need to perform the basic information verifications in advance of deploying the volunteers and then the affected state, via a staging area within the state, would perform those verifications as well.

- Because of concerns about depleting resources in an adjoining donor state, it is unlikely that in a large-scale event, particularly one that could grow in magnitude, such as an infectious disease, needed human resources would come from a single adjoining state. Rather, in an event that could escalate, it is more likely that the volunteers would need to come from multiple states within the region so as to minimize the impact on any single state's resources.

- A great deal of regional planning must take place within the "donor" state before it can effectively call out its volunteers. This helps to ensure that the hospitals in the donor state are not left with inadequate resources to respond to their daily responsibilities or to an escalation of the emergency from the affected state that impacts them directly. This involves identifying the right type and numbers of volunteers, developing an adequate notification system for volunteers and having

a state authority work with those volunteers prior to deployment to ensure that they fully understand their mission and have their questions answered.

- The receiving state must make all accommodations for volunteers through its emergency management function, including transportation, lodging, facilities, food, safety, and providing an orientation to the volunteers.

- In a scenario involving cross-state jurisdictions, the federal government likely will be involved early in the response. Federal resources, such as DMATs, would be deployed to the affected state quickly but the bulk of the needed personnel to provide for surge capacity would still need to be coordinated through the state.

Summary of Discussion

Additional considerations for HRSA were raised in the discussion and include:

- Coordination and planning between federal departments and agencies (Department of Homeland Security, the Federal Emergency Management Agency, HHS) and the states to ensure that vulnerabilities are addressed in a consistent way since disasters affecting multiple states will involve not only those states but also likely include a federal level response.

- Develop a way to evaluate whether the concept of operations for regionalizing the ESAR-VHP will work.

- Reviewing certain federal programs, such as DMATs or the National Disaster Medical System (NDMS), as potential models for addressing logistical issues around transporting, housing, feeding, and protecting volunteers.

Activation Protocols and Issues Involved in ESAR-VHP System Activation in an Emergency

Summary of Discussion

The participants were asked to consider the following questions in their discussion:

- How is the state ESAR-VHP system activated and who may activate?
- How would/should a hospital involved in a disaster response make a request for volunteers?
- How would/should a hospital involved in a disaster response be able to access information for volunteer deployment?
- In a system activation, how is a volunteer's "home" hospital notified or otherwise involved in the decision to deploy volunteers? Are they given the opportunity to "release" their staff prior to formal deployment?
- How are volunteers managed in a deployment?
- If the ESAR-VHP system is activated, how at the local level will the health care community work with emergency management?

In theory, a series of steps, which logically build upon one another, likely would be involved in an activation of a state's ESAR-VHP program in the event of a disaster. The series of steps in activation may include:

1. Notifying health professionals who are registered in the database that their services are needed.
2. Confirming participation of volunteers in a deployment.
3. Assembling volunteers who have been deployed in-state or across state lines to "staging areas."
4. Orientation/reception of volunteers.
5. Transporting volunteers.
6. Housing and feeding of volunteers.
7. Release of volunteers at conclusion of their service.
8. Debriefing and support services for volunteers.

States, however, have taken different perspectives regarding how many of these steps they perceive are their responsibility under the auspices of their state's ESAR-VHP program.

There are two planning dimensions to these steps. The intrastate dimension relates to activation of a state's ESAR-VHP database for the purpose of providing volunteer services to hospitals and other settings within the state. The interstate dimension is more complex and involves activation planning for disasters that have impacts across state lines. It is clear that most states will begin planning for activations related to

emergencies contained entirely within their own state and, over time, gradually expand their planning to activations that extend into contiguous states within their region of the country, with national level activation as a longer term goal.

Representatives from each state discussed the scope of their responsibility under ESAR-VHP and the considerations surrounding activation. While all states recognized that, in reality, disaster response planning within and between states would need to extend to all of these steps, states varied in their view of which of these steps fell under the purview of ESAR-VHP activation and which were the responsibility of the affected community. Some states, such as Missouri and Texas, viewed ESAR-VHP activation issues as extending only to notifying volunteers of a request for their services, and perhaps confirmation and tracking their deployment. Other states viewed ESAR-VHP as extending beyond this to assembly and orientation. However, none of the states indicated that they viewed their responsibility under ESAR-VHP to extend to all of the areas of logistical planning, such as arranging for the transportation, housing and feeding of volunteers. Most states believed that such a level of operational planning, while needing to take place, would be a community responsibility or, in certain extreme circumstances, a responsibility of the federal government.

The level to which a state has developed, or plans to develop, activation protocols, depends on several factors. First, there is concern that federal funding for ESAR-VHP will cease or be greatly reduced in some states and this has created a concern for both the short and long-term sustainability of the program. These states tend to view their role in developing ESAR-VHP activation protocols as quite limited – perhaps extending only to notification. Another factor that impacts this decision is how developed the state's ESAR-VHP program is to date. That is, states such as Connecticut, which are further along in planning and implementing their ESAR-VHP program, are also further along in their planning for activating their systems. States such as Texas, Illinois and Missouri, whose ESAR-VHP systems are not as far along, are initially taking a much more limited view of their role in developing activation protocols and plans.

Some states were concerned that the original intent of the ESAR-VHP – to develop and populate databases of volunteers at the state level that would be interoperable across states – has been forgotten and that it was too early to focus on operational issues. All states present agreed that the most important mission at this time is ensuring that all states develop ESAR-VHP databases that are interoperable and adequately populated with capable health care professionals.

Indeed, HRSA and Collaborative Fusion representatives confirmed this mission, stating that the primary objective is making the state systems interoperable to allow for portability of volunteers. However, they noted that in the absence of a concept of operations for activation, a database alone would not be useful. Further, there may be database implications that result from a review of activation and operational issues. For

instance, planning for volunteer deployment across state lines may require that the ESAR-VHP database include elements reflecting a volunteer's willingness to respond to disasters that occur in other states.

Another issue raised during this discussion is how the state-based ESAR-VHP system fits into the federal response structure. HHS representatives indicated that while these are state-controlled and state-owned databases, federal agencies are interested in working with the states so that in the event of a large-scale incident in which there would need to be a federal response, federal personnel could have limited access to a health care professional's information. Access to a health care professional's information would be contingent upon the health care professional giving prior approval. The meeting participants felt strongly that if a state-based ESAR-VHP is to be used by federal officials, then this intent must be clearly communicated to health care professionals who are considering registering for the system within their state. Potential volunteers must understand up-front that there is a possibility that HHS will have access to their information and that the federal government may be able to make decisions about their deployment.

Other considerations raised regarding operational and activation issues include:

- In developing its ESAR-VHP system, a state should ensure that their system can be activated to deploy volunteers when another state declares an emergency and requests assistance. Thus ESAR-VHP systems must be able to be activated, or at least accessed, when a state has a state-declared emergency, and also when another state has declared an emergency and has made a request for assistance.

- The state-based entity that controls the ESAR-VHP database should provide for a centralized notification system to ensure that all the system users are aware of deployment activity and the remaining capacity in real time.

"Parking Lot" Issues

Summary of Discussion

Several issues raised during the two-day meeting either: were not included on the planned agenda; required a longer discussion than planned in the agenda; or were outside the scope of ESAR-VHP. These issues were labeled as "Parking Lot" issues and briefly discussed. They are summarized below.

- EMAC: Representatives were concerned about EMAC's ambiguity and whether it can cover hospital-based health care personnel. The two main concerns were (1) that EMAC protections do not apply to health professional volunteers who are responding within a state and (2) that ambiguity remains regarding whether hospital-based personnel who volunteer under ESAR-VHP and cross state lines would be considered to be part of the state's response and thus eligible for EMAC protections. It is important that any remaining ambiguities regarding EMAC's scope of coverage be cleared up and explained in order to maximize the willingness of health care professionals to volunteer in state-based ESAR-VHP systems.

- Volunteer Protection Act (VPA): There was interest in clarifying how the federal VPA protections might apply to volunteers and entities that utilize the volunteers in the ESAR-VHP systems at the state level. Interested parties were directed to the ESAR-VHP Legal and Regulatory Issues Report. The key limitations under the VPA, for the purpose of ESAR-VHP, is that VPA does not apply if volunteers are being compensated nor would it apply to organizations that employ or supervise the volunteers, such as hospitals.

- Funding for off-site, acute care center supplies: There was concern about who would pay for supplies and equipment needed in off-site acute care centers.

- Uniform Data, Common Communication Standards, and Authorized Uses: Participants continued to ask for a nationally agreed upon core data set that would be interoperable between states. They also support the development of a clearly defined process, outlining how a state needing assistance from another state would request and receive information about available volunteers. The communication process needs to guarantee a commonly understood nomenclature so that both the donating and the requesting state understand what is needed and what is being sent. Finally, there remains concern from some that the state ESAR-VHP system data will be aggregated and used by the federal government in the "federalization" of health care personnel. Therefore, HRSA should clearly outline authorized uses and authorized users of the state databases.

- Baseline Training: Because of the multitude of training programs and curricula that are available, there needs to be a nationally defined and standardized baseline training structure or defined core competencies for volunteers within the state ESAR-VHP systems. Some participants, however, were concerned that requiring any training in order to be an ESAR-VHP registered volunteer would be a disincentive for recruitment purposes. Currently states are taking very different approaches to required training for volunteers. These include training requirements for basic disaster life support; incident command system training; NIMS compliant awareness training; and discipline specific training. There was general agreement that on-site orientation and training would be necessary in all circumstances. This "just-in-time" orientation needs to include at least a situational briefing, orientation to unfamiliar equipment and supplies, and an understanding of how the response system in the community works, the main players, and their roles. HHS representatives recommended that states should adopt NIMS-compliant Incident Command Training in their ESAR-VHP systems as this may be a requirement for funding after 2006.

- Other Agency Orientation: There was a call for better orientation and education of other state agencies, such as state emergency management and law enforcement, regarding the development of state ESAR-VHP systems.

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

May 24 – 25, 2005
Marriott Metro Center
Washington, DC

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