

D R A F T

FOR DISCUSSION ONLY

UNIFORM EMERGENCY VOLUNTEER HEALTHCARE SERVICES ACT

NATIONAL CONFERENCE OF COMMISSIONERS

ON UNIFORM STATE LAWS

MEETING IN ITS ONE-HUNDRED-AND-FIFTEENTH YEAR
HILTON HEAD, SOUTH CAROLINA
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UNIFORM EMERGENCY VOLUNTEER HEALTHCARE SERVICES ACT

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By

NATIONAL CONFERENCE OF COMMISSIONERS
ON UNIFORM STATE LAWS

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DRAFTING COMMITTEE ON UNIFORM EMERGENCY VOLUNTEER HEALTHCARE SERVICES ACT

The Committee appointed by and representing the National Conference of Commissioners on Uniform State Laws in drafting this Act consists of the following individuals:

RAYMOND P. PEPE, 17 N. Second St., 18th Floor, Harrisburg, PA 17101-1507, *Chair*

ROBERT G. BAILEY, University of Missouri-Columbia, 217 Hulston Hall, Columbia, MO 65211

STEPHEN C. CAWOOD, 108 1/2 Kentucky Ave., P.O. Drawer 128, Pineville, KY 40977-0128

KENNETH W. ELLIOTT, City Place Building, 204 N. Robinson Ave., Suite 2200, Oklahoma City, OK 73102

THOMAS T. GRIMSHAW, 1700 Lincoln St., Suite 3800, Denver, CO 80203

THEODORE C. KRAMER, 45 Walnut St., Brattleboro, VT 05301

AMY L. LONGO, 8805 Indian Hills Dr., Suite 280, Omaha, NE 68114-4070

JOHN J. MCAVOY, 3110 Brandywine St. NW, Washington, DC 20008

DONALD E. MIELKE, 7472 S. Shaffer Ln., Suite 100, Littleton, CO 80127

JAMES G. HODGE, JR., Johns Hopkins Bloomberg School of Public Health, 624 N. Broadway, Baltimore, MD 21205-1996, *Reporter*

EX OFFICIO

HOWARD J. SWIBEL, 120 S. Riverside Plaza, Suite 1200, Chicago, IL 60606, *President*

LEVI J. BENTON, State of Texas, 201 Caroline, 13th Floor, Houston, TX 77002, *Division Chair*

AMERICAN BAR ASSOCIATION ADVISOR

BRYAN ALBERT LIANG, California Western School of Law, 350 Cedar St., San Diego, CA 92101, *ABA Advisor*

PRISCILLA D. KEITH, 3838 N. Rural St., Indianapolis, IN 46205-2930, *ABA Section Advisor*

EXECUTIVE DIRECTOR

WILLIAM H. HENNING, University of Alabama School of Law, Box 870382, Tuscaloosa, AL 35487-0382, *Executive Director*

Copies of this Act may be obtained from:

NATIONAL CONFERENCE OF COMMISSIONERS
ON UNIFORM STATE LAWS
211 E. Ontario Street, Suite 1300
Chicago, Illinois 60611
www.nccusl.org

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UNIFORM EMERGENCY VOLUNTEER HEALTHCARE SERVICES ACT

Prefatory Note

The human devastation in the Gulf Coast states from Hurricanes Katrina and Rita demonstrated significant shortcomings in the ability of the nation's emergency services delivery system to efficiently and expeditiously incorporate the services provided by private sector healthcare practitioners into disaster relief operations. This includes employees and volunteers of nongovernmental disaster relief organizations who were needed to provide surge capacity in affected areas and to provide timely healthcare services to hundreds of thousands of victims of the disaster.

Although the U.S. Public Health Service, the Armed Forces, the Federal Disaster Medical Service, and healthcare professionals employed by state and local governments provided much-needed healthcare services, the magnitude of the disaster swamped the ability of these organizations to effectively handle relief operations. While thousands of healthcare professionals quickly volunteered to provide assistance, state-based emergency response systems lacked a uniform process and legal framework to recognize out-of-state professional licenses and other benefits necessary to authorize and encourage these volunteers to provide healthcare services in many affected areas. In some jurisdictions, volunteer healthcare practitioners were not adequately protected against exposure to tort claims or injuries or deaths suffered by the volunteers themselves.

Still, as numerous media reported, thousands of doctors and other healthcare practitioners from across the country set aside their practices and traveled to the Gulf Coast to provide emergency healthcare services to those in need. Many of these volunteers came through organized systems, such as the federally-funded, state-based Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP), or local-based units of the Medical Reserve Corps (MRCs). Many volunteer healthcare practitioners, however, went to affected areas spontaneously and without association with any organized system. Often this impaired rather than assisted in the response efforts. Some of these volunteers were turned away or used for purely administrative tasks because their out-of-state professional licenses were not recognized, the entities hosting them were concerned about liability, or for other reasons. The Metropolitan Medical Response System program, part of the federal Department of Homeland Security (DHS), references a report on its website:

Volunteer physicians are pouring in to care for the sick, but red tape is keeping hundreds of others from caring for Hurricane Katrina survivors. The North Carolina mobile hospital waiting to help ... offered impressive state-of-the-art medical care. It was developed with millions of tax dollars through the Office of Homeland Security after 9-11. With capacity for 113 beds, it is designed to handle disasters and mass casualties. It travels in a convoy that includes two 53-foot trailers, which on Sunday afternoon was parked on a gravel lot 70 miles north of New Orleans because Louisiana officials for several days would not let them deploy to the flooded city. 'We have tried so hard to do the right thing. It took us

30 hours to get here,’ said one of the frustrated surgeons, Dr. Preston “Chip” Rich of the University of North Carolina at Chapel Hill. That government officials can’t straighten out the mess and get them assigned to a relief effort now that they’re just a few miles away ‘is just mind-boggling,’ he said.

Rather than treating the injured, sick and infirm, some qualified physicians, nurses and other licensed healthcare practitioners found themselves: (1) waiting in long lines in often futile attempts to navigate through a semi-functioning bureaucracy; or (2) providing other forms of assistance, such as general labor, which failed to utilize their desperately needed healthcare skills. Others proceeded to treat victims at the risk of violating existing state statutes and potentially facing criminal or administrative penalties or civil liability. Out-of-state practitioners providing medical treatment also faced the real possibility of noncoverage under their medical malpractice policies.

While the magnitude of the emergency presented by Hurricanes Katrina, Rita, and Wilma exceeded the scope of disasters experienced in this country for many decades, foreseeable emerging events pose similar threats. Future storms (especially in the New York City and New England area); major earthquakes in San Francisco, Los Angeles or other heavily urbanized areas; volcanic eruptions in the Pacific Northwest; tidal waves on the east and west coasts; incidents of terrorism involving weapons of mass destruction, including nuclear, biological and chemical agents; and flu or other pandemics may overwhelm the resources of disaster healthcare delivery systems. To help meet patient surge capacity and protect the public’s health, reliance on private sector health practitioners and nongovernmental relief organizations may be needed.

This presupposes that the legal environment supports the deployment and use of intra- and inter-state volunteer healthcare practitioners. In fact, there are some existing major legal gaps and deficiencies that may stymie, rather than encourage, widespread volunteer healthcare practitioner activities during emergencies. The U.S. Congress continues to examine some of these gaps through the introduction of multiple bills since September, 2005. Similarly, it has directed the Department of Health and Human Services (DHHS) to establish the Disaster Medical Relief Service consisting of “intermittent federal employees” who enjoy interstate professional licensing recognition and protections from civil liability via federal law.

As first responders, states (and their local subsidiaries) are uniquely positioned to identify and remedy these gaps as well. Many state governments have recognized the need to grant emergency licensing recognition on an interstate basis and to afford disaster relief workers (which may include volunteer healthcare practitioners) with protection from civil liability. Every state has ratified the Emergency Management Assistance Compact (EMAC), which provides for licensing reciprocity, relief from civil liability, and workers’ compensation protections to “state forces” deployed to respond to emergencies. The provisions of EMAC, however, in most jurisdictions apply only to state employees or local employees incorporated into “state forces” pursuant to mutual aid agreements. Although some jurisdictions have developed mechanisms to incorporate private sector volunteers into state forces under EMAC, no uniform or consistent approach has been developed to promote the use of private sector volunteers. Many state laws underlying the declaration of public health emergencies (including many recently enacted laws

based on the Model State Emergency Health Powers Act developed by the *Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities*) also provide for interstate healthcare licensure recognition in many jurisdictions. Many state disaster management laws often also provide broad authority to waive other legal or regulatory requirements during emergencies, including licensing requirements for healthcare practitioners.

Unfortunately, no uniform system exists to efficiently and expeditiously recognize licensing privileges for healthcare practitioners on an interstate basis and to uniformly provide civil liability protections and workers' compensation coverage for these volunteers. The lack of a uniform, well-understood system able to function automatically even during periods of emergencies when communications systems are disrupted and governmental officials are preoccupied with other pressing responsibilities significantly impaired the ability of states to use volunteer healthcare practitioners following Hurricanes Katrina and Rita. This act seeks to remedy these deficiencies.

Concerning the deployment and use of volunteer healthcare practitioners during emergencies, a uniform legal approach among the states presents several key advantages:

- Lacking uniformity, separate state-by-state enactments create inconsistencies and dilemmas in legal authorities or protections at a time when their solution is unwieldy, if not unworkable;
- An ad hoc, state-by-state approach is less likely to benefit from the focused participation of the key national constituencies that may support a uniform law; and
- Even the best single-state bill cannot anticipate or reflect the valid concerns of other states.

The Uniform Emergency Volunteer Healthcare Services Act (UEVHSA) provides uniform legislative language to facilitate organized response efforts among volunteer healthcare practitioners. UEVHSA's provisions address the following:

- Application of its coverage to declared states of emergency, disaster, or public health emergency (or like terms at the state or local level);
- The coverage of volunteer healthcare practitioners who are registered with ESAR-VHP, MRC, or other similar systems and volunteer based on their own volition);
- Procedures to recognize the valid and current licenses of volunteer healthcare practitioners in other states for the duration of an emergency declaration;
- Requirements for volunteer healthcare practitioners to adhere to scope of practice standards during the emergency (subject to modifications or restrictions);
- Reduction of the exposure of volunteer healthcare practitioners, or those who employ, deploy or host them, to significant disciplinary sanctions or civil liability based on actions (or failures to act) during a declared emergency; and
- Workers' compensation protections for volunteer healthcare practitioners.

1 **UNIFORM EMERGENCY VOLUNTEER HEALTHCARE SERVICES ACT**

2
3 **SECTION 1. SHORT TITLE.** This [act] may be cited as the Uniform Emergency
4 Volunteer Healthcare Services Act.

5 **SECTION 2. DEFINITIONS.** As used in this [act]:

6 (1) **“Comprehensive healthcare facility”** means a healthcare entity that provides
7 comprehensive inpatient and outpatient services on a regional basis. The term includes tertiary
8 care and teaching hospitals.

9 (2) **“Coordinating entity”** means an entity that acts as a liaison to facilitate
10 communication and cooperation between source and host entities but does not provide healthcare
11 or veterinary services in the ordinary course of its activities as liaison.

12 (3) **“Credentialing”** means obtaining, verifying, and assessing the qualifications of a
13 healthcare practitioner to provide patient care, treatment, and services in or for a healthcare
14 entity.

15 (4) **“Disaster relief organization”** means an entity that provides emergency or disaster
16 relief services that include healthcare or veterinary services provided by volunteer healthcare
17 practitioners and that (A) is designated or recognized as a provider of such services pursuant to a
18 disaster response and recovery plan adopted by the [*name of appropriate agency or agencies*], or
19 (B) conducts its activities in coordination with the [*name of appropriate agency or agencies*].

20 (5) **“Emergency”** means an emergency, disaster, public health emergency or similar
21 term as defined by the laws of this state[, a political subdivision of this state, or a municipality or
22 other local government within this state].

23 **Legislative Note:** The terms “emergency,” “disaster,” and “public health emergency” are the

1 *most commonly used terms to describe the circumstances that may lead to the issuance of an*
2 *emergency declaration referred to in this [act]. States that use other terminology should*
3 *consider amending this definition to reflect their terminology.*
4

5 (6) **“Emergency declaration”** means a declaration of an emergency issued by a person
6 authorized to do so by the laws of this state [, a political subdivision of this state, or a
7 municipality or other local government within this state].

8 (7) **“Emergency Management Assistance Compact (EMAC)”** refers to the mutual aid
9 agreement ratified by Congress and signed into law in 1996 as Public Law 104-321, and
10 subsequently enacted by this state and codified at [cite].

11 (8) **“Emergency System for Advance Registration of Volunteer Health Professionals**
12 **(ESAR-VHP)”** means the state-based program created with funding through the Health
13 Resources Services Administration under Section 107 of the federal Public Health Security and
14 Bioterrorism Preparedness and Response Act of 2002, P.L. 107-188, to facilitate the effective
15 deployment and use of volunteers to provide healthcare services during emergencies.

16 (9) **“Entity”** means a corporation, business trust, trust, partnership, limited liability
17 company, association, joint venture, public corporation, government, or governmental
18 subdivision, agency, or instrumentality, or any other legal or commercial organization. The term
19 does not include an individual.

20 (10) **“Good faith”** means honesty in fact.

21 (11) **“Healthcare entity”** means an entity that provides healthcare or veterinary
22 services.

23 (12) **“Healthcare practitioner”** means an individual licensed in any state to provide
24 healthcare or veterinary services.

1 (13) **“Healthcare services”** means the provision of care, services including advice or
2 guidance, or supplies related to the health or death of individuals, or to populations, including
3 (A) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and
4 counseling, service, assessment, or procedure concerning the physical or mental condition, or
5 functional status, of an individual or that affects the structure or function of the body; (B) sale or
6 dispensing of a drug, device, equipment, or other item to an individual in accordance with a
7 prescription; and (C) mortuary services.

8 (14) **“Host entity”** means a healthcare entity, disaster relief organization, or other entity
9 in this state that uses volunteer healthcare practitioners to provide healthcare or veterinary
10 services while an emergency declaration is in effect.

11 (15) **“Individual”** means a natural person.

12 (16) **“License”** means official permission granted by a competent governmental
13 authority to engage in healthcare or veterinary services otherwise considered unlawful without
14 such permission. The term includes permission granted by the laws of this state to an individual
15 to provide healthcare or veterinary services based upon a national certification issued by a public
16 or private entity.

17 (17) **“Medical Reserve Corps (MRC)”** means a local unit consisting of trained and
18 equipped emergency response, public health, and medical personnel formed pursuant to Section
19 2801 of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002,
20 P.L. 107-188, to ensure that state and local governments have appropriate capacity to detect and
21 respond effectively to an emergency.

22 (18) **“Person”** means an individual or an entity.

1 (19) **“Privileging”** means the authorization granted by an appropriate authority, such as
2 a governing body, to a healthcare practitioner to provide specific care, treatment, and services at
3 a healthcare entity subject to well-defined limits based on factors that include license, education,
4 training, experience, competence, health status, and specialized judgment.

5 (20) **“Scope of practice”** means the extent of the permission to provide healthcare or
6 veterinary services granted to a healthcare practitioner by a license issued to the practitioner in
7 the state in which the principal part of the practitioner’s services are rendered, including any
8 conditions imposed by the licensing authority.

9 (21) **“Source entity”** means a healthcare entity, disaster relief organization, or other
10 entity located in any state that employs or uses the services of healthcare practitioners who
11 volunteer to provide healthcare or veterinary services while an emergency declaration is in
12 effect.

13 (22) **“State”** means a state of the United States, the District of Columbia, Puerto Rico,
14 the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction
15 of the United States. The term also includes an Indian tribe or nation.

16 (23) **“Veterinary services”** means the provision of care, services including advice or
17 guidance, or supplies related to the health or death of an animal, or to animal populations,
18 including (A) diagnosis, treatment, or prevention of any animal disease, injury, or other physical,
19 dental, or mental condition by the prescription or administration of any vaccine, medicine,
20 surgery, or therapy; and (B) the use of any procedure for reproductive management.

21 (24) **“Volunteer healthcare practitioner”** means a healthcare practitioner who, as an
22 act of the practitioner’s own volition, provides healthcare or veterinary services in this state

1 while an emergency declaration is in effect.

2 **Comment**

- 3 1. A **comprehensive healthcare facility** includes public or private (for-profit or nonprofit)
4 healthcare entities (as defined in Section 2(11)) that provide comprehensive inpatient or
5 outpatient services on a regional basis. As used here, regional means that the facility draws
6 from an extensive patient base that exceeds a single, small local community. A
7 comprehensive healthcare facility is distinguishable from a healthcare entity by the breadth
8 of its healthcare services as well as its regional base. As noted, this includes tertiary care and
9 teaching hospitals. The term is specifically defined to delineate the type of healthcare entity
10 that may operate a registration system for volunteer healthcare practitioners under Section
11 4(b)(2).
12
- 13 2. A **coordinating entity** facilitates the deployment of volunteer healthcare practitioners during
14 an emergency. Its function(s) may entail coordination, referral, or transportation of volunteer
15 healthcare practitioners between the source and host entities, or it may simply deal with host
16 entities. For example, a state ESAR-VHP program may serve as a coordinating entity during
17 an emergency by helping to deploy volunteer healthcare practitioners to a host entity. As
18 well, entities such as charities, churches, or other nonprofits may help facilitate the use of
19 volunteer healthcare practitioners, without actually hosting the volunteers to provide
20 healthcare or veterinary services. The purpose for defining this term is to recognize the
21 important role of coordinating entities in helping to provide registered volunteers during
22 emergencies (thus limiting the potential for spontaneous voluntarism) and extend to these
23 entities liability protections pursuant to Section 7(c) and (d).
24
- 25 3. The **credentialing** process should assess the basic skills or competencies for healthcare
26 practitioners and utilize criteria including their licensure, education, training, experience, and
27 other qualifications that may aid in this determination. This is distinct from the privileging
28 process (defined in Section 2(19)) in that credentialing does not grant any authority to engage
29 in the provision of healthcare services. Notably, as stated in Section 5(c), neither
30 credentialing nor privileging by healthcare entities during emergencies is affected by the
31 provisions of this Act.
32
- 33 4. A **disaster relief organization** is an entity that provides disaster relief services or
34 assistance in response to an emergency declaration. For example, the American Red Cross
35 may be viewed as a disaster relief organization. Other members of the National Voluntary
36 Organizations Active in Disaster, Inc. (NVOAD) that provide similar services may also be
37 considered disaster relief organizations. Pursuant to Section 4(b)(2), a disaster relief
38 organization may implement registration systems for volunteer healthcare practitioners. Also,
39 under Section 9(b), a preexisting employment relationship among its members does not
40 compromise their volunteer status. Under this Act, however, the protections afforded are
41 limited to those members engaged in the provision of healthcare or veterinary services,
42 distinct from general disaster relief services, as defined in subsections 2(13) and (2)(23).
43
- 44 5. An **emergency** is broadly defined to encompass the array of circumstances that may give rise

1 to an emergency declaration at the state, or in states in which the optional language in the
2 definition is selected, the local, level. Although nearly every state has defined the conditions
3 that constitute a “general emergency” or “disaster,” many states have not incorporated a
4 “public health emergency” within their legal framework. Other states may use different
5 terminology (e.g., catastrophe, crisis) for what constitutes an emergency. In such cases, this
6 different terminology may be substituted for the language in the definition. The particular
7 emergency circumstances that warrant invocation of this Act and the appropriate response are
8 left to the discretion of the state legislative or administrative authority. No matter how a state
9 defines “emergency,” its declaration is the trigger through which the protections of this act
10 go into effect.
11

- 12 6. An **emergency declaration** pursuant to Section 3(a) activates the response and recovery
13 efforts at the state, or, in states in which the optional language in the definition is selected,
14 local level. Such a declaration also invokes the provisions of this act related to the use,
15 deployment, and protection of volunteer healthcare practitioners who comply with the
16 provisions of this act.
17
- 18 7. The **Emergency Management Assistance Compact (EMAC)** provides for mutual
19 assistance between states entering into compacts to manage declared emergencies. Under
20 Section 10, the Act supplements the implementation of EMAC by states without imposing
21 requirements for the use of volunteer healthcare practitioners, and encourages their
22 incorporation into response efforts through mutual aid agreements.
23
- 24 8. The **Emergency System for Advance Registration of Volunteer Health Professionals**
25 **(ESAR-VHP)** is a model registration system specifically mentioned in Section 4(b) of this
26 Act that allows for an efficient assessment of a volunteer’s identity, licensure, credentialing,
27 accreditation, and privileging status in hospitals or other medical facilities. It is provided as
28 an example of a registration system that provides organized information to ensure an accurate
29 assessment of a volunteer healthcare practitioner’s ability to provide healthcare services
30 during an emergency. These systems have arisen from a federal grant program authorized by
31 Section 107 of the Public Health Security and Bioterrorism Preparedness and Response Act
32 of 2002. Congress directed the Department of Health and Human Services (DHHS) to
33 “establish and maintain a system for the advance registration of health professionals, for the
34 purpose of verifying the credentials, licenses, accreditations, and hospital privileges of such
35 professionals when, during public health emergencies, the professionals volunteer to provide
36 health services.” In response, the Health Resources and Services Administration (HRSA), a
37 division of DHHS, created the ESAR-VHP Program to assist states and U.S. territories to
38 develop their emergency registration systems through the provision of grants and guidance.
39 The Program has distributed resources to nearly every states and many U.S. territories and
40 developed guidelines and standards for these systems. Although these jurisdictions are
41 receiving federal assistance, ESAR-VHP systems are completely jurisdiction-based.
42 Jurisdictions are responsible for designing, developing, and administering their respective
43 systems consistent with federal guidelines. Thus, ESAR-VHP is not a federal system, but
44 rather a national system of jurisdiction-based emergency volunteer registries.
45
- 46 9. An **entity** may include any form of private organization or artificial legal persons, but not an

individual.

10. **Good faith** means only honesty in fact and does not include compliance with customary standards for the delivery of services by volunteer healthcare practitioners pursuant to Section 6. Emergency conditions, including the need to triage patients for care, may make compliance with customary standards irrelevant or impossible. Instead, as recognized by Section 6(g), the conduct of healthcare practitioners during emergencies must be evaluated in light of exigent circumstances.
11. A **healthcare entity** is an entity engaged in the provision of healthcare or veterinary services (as defined in Sections 2(13) and 2(23)) in its ordinary course of business or activities. The term does not include individual healthcare practitioners.
12. A **healthcare practitioner** is an individual, not an entity, who is licensed in any state, including the host state, to provide healthcare or veterinary services, or that retain a national certificate that is recognized by the host state as equivalent to licensure for purposes of providing healthcare services to individuals or human populations or veterinary care services to animals or animal populations. The inclusion of veterinary practitioners within the term does not imply or suggest that veterinarians are authorized to provide human health care services during emergencies, nor does it imply or suggest that nonveterinarians are authorized to provide veterinary services.
13. **Healthcare services** are broadly defined based on a similar definition of the term from the HIPAA Privacy Rule, 45 C.F.R. 160.103, to include those services that relate to the health or death of individuals or populations that, under Section 6, are provided by volunteer healthcare practitioners during an emergency response. They include direct patient health services, public health services, provision of pharmaceutical products, and mortuary services for the deceased. On an individual level, healthcare services include transportation, diagnosis, treatment, and care for injuries, illness, diseases, or pain related to physical or mental impairments. On the population level, healthcare services may include the identification of injuries and diseases, and an understanding of the etiology, prevalence, and incidence of diseases, for groups or members within the population. This may entail public health case finding through testing, and screening, or medical interventions (e.g., physical examinations, compulsory treatment, immunizations, or directly observed therapy (DOT)). On a broader scale, states may implement traditional public health activities including surveillance, monitoring, and epidemiologic investigations. Non-healthcare services include any service that is not enunciated in Section 2(13), and does not provide direct health benefits to individuals or populations. For example, ancillary services (e.g., administrative tasks, medical record keeping, transportation of medical supplies) that do not ameliorate the harm suffered by, or improve the health of, individuals or populations are not healthcare services.
14. A **host entity** is a healthcare entity, disaster relief organization, or other entity that uses volunteer healthcare practitioners to provide healthcare or veterinary services during an emergency. Unlike a coordinating entity (which facilitates the use or deployment of volunteers) and a source entity (from which the volunteers may be employed or sent), the host entity is responsible for actually delivering healthcare services to individuals or human

1 populations or veterinary services to animals or animal populations during the emergency.
2 Host entities may thus include disaster relief organizations, hospitals, clinics, emergency
3 shelters, doctors' offices, outpatient centers, or any other place where volunteer healthcare
4 practitioners may provide healthcare or veterinary services. Host entities have the authority
5 under Section 6(c) to restrict the types of services that volunteer healthcare practitioners can
6 provide.
7

8 15. An **individual** means a natural person as distinguished from an entity.
9

10 16. A **license** is distinct from certification or other recognition that may be used to designate
11 competency in a particular profession(s) or area(s) of practice. It is a state-granted
12 designation that regulates the scope of practice and prohibits unlicensed persons from
13 providing services reserved for licensed practitioners. An authorization to provide healthcare
14 or veterinary services pursuant to a national certification is included in the definition to
15 clarify that a tangible certificate or prior government authorization may not in some
16 circumstances be necessary for a governmental permission to constitute a license. Nothing in
17 this definition, however, is intended to allow individuals holding national certifications to
18 provide healthcare or veterinary services except as otherwise authorized by law. Instead,
19 pursuant to Section 6(a) and (d), an individual holding a national certification may function
20 as a volunteer healthcare practitioner only to the extent authorized to do so by the laws of the
21 state in which the individual primarily practices and by the laws of the host state in which an
22 emergency is declared.
23

24 17. The **Medical Reserve Corps (MRCs)** Program was created in 2002 as a community based
25 and specialized component of Citizen Corps, a component of the USA Freedom Corps
26 initiative launched in January, 2002. Its purpose is to pre-identify, train, and organize
27 volunteer medical and public health practitioners to render services in conjunction with
28 existing local emergency response programs. There are presently 408 MRCs across the
29 nation in ten regions. Some states explicitly reference MRC units via statutes that afford
30 protection to volunteer healthcare practitioners during an emergency. These states include
31 Connecticut (Conn. Gen. Stat. § 19a-179b), North Carolina (N.C. Gen. Stat. § 1-539.11),
32 Oklahoma (59 Okl. St. § 493.5, and 76 Okl. St. § 32), Utah (Utah Code. Ann. § 26A-1-126),
33 and Virginia (Va. Code Ann. §§ 2.2-3601, 2.2-3605, 32.1-48.016, and 65.2-101).
34 MRC units consist of personnel with and without a background in healthcare services. The
35 "medical" component of the units does not limit membership to medical professionals.
36 Individuals without medical training are permitted to join and fill essential supporting roles.
37 The protections of this Act, however, only extend to volunteer healthcare practitioners who
38 are duly registered under Section 4 and adhere to the scope of practice requirements pursuant
39 to Section 6.
40

41 18. A **person** is defined broadly so as to encompass any natural person or entity.
42

43 19. **Privileging** decisions entail the grant of authority to individuals to provide specific types of
44 healthcare services, in addition to the general adherence to scope of practice guidelines
45 established by state licensure boards. Privileging determinations are unique to the entity
46 granting the privileges to the practitioner and do not necessarily extend to services provided

1 under another entity absent its express authority. Notably, as stated in Section 5(c), neither
2 credentialing nor privileging by healthcare entities during emergencies is affected by the
3 provisions of this Act.
4

- 5 20. The **scope of practice** is established by licensure boards of the state in which a practitioner is
6 licensed and primarily engages in practice. The scope of practice also includes any conditions
7 that may be imposed on the practitioner's authorization to practice, including instances where
8 state law recognizes the existence of a license but declares practice privileges to be
9 "inactive." This Act defers to relevant state laws to determine whether a practitioner with an
10 inactive license may act as a volunteer healthcare practitioner. To the extent the law or the
11 state in which an individual is licensed and primarily engages in practice allows a practitioner
12 with an inactive license to practice, either generally, only during emergencies, or only in a
13 volunteer capacity, such an individual may practice in a "host state" consistent with the
14 requirements of this Act. On the other hand, if the law of the state in which an individual is
15 licensed only allows an individual with an inactive license to practice if the license is
16 renewed or reactivated (typically by satisfying continuing education requirements and paying
17 additional registration fees), then the individual may only function as a volunteer healthcare
18 practitioner following the renewal or activation of the license.
19
- 20 21. A **source entity** deploys volunteer healthcare practitioners directly, or via a coordinating
21 entity, to a host entity during an emergency. Source entities are not typically engaged in the
22 oversight or management of volunteer healthcare practitioners during a declared emergency
23 and does not retain the responsibility to verify the licensure status and good standing of the
24 volunteers who provide healthcare or veterinary services. A source entity may include, for
25 example, the public or private sector employer of healthcare practitioners who subsequently
26 choose to volunteer in response to an emergency declaration.
27
- 28 22. A **state** is any territory or insular possession subject to the jurisdiction of the United States,
29 including an Indian tribe, band, or Native American population. The term does not include
30 foreign governments, their territories, or possessions.
31
- 32 23. **Veterinary services** are services pertaining to the health or death of animals or animal
33 populations as distinct from healthcare services provided to humans as defined in Subsection
34 2(13). Volunteer healthcare practitioners that provide veterinary services must also register
35 under Section 4 and adhere to the scope of practice requirements under Section 6 to avail
36 themselves of the protections of this Act.
37
- 38 24. A **volunteer healthcare practitioner** is any individual who is licensed, in good standing,
39 and voluntarily proffers healthcare or veterinary services during a declared emergency. There
40 is no mention of compensation to the volunteer in this definition. Unlike many existing
41 federal and state legal definitions of volunteers that require the individual act without
42 compensation, this definition and the Act do not require such a finding. Under Section 9(a),
43 the volunteer status of a healthcare practitioner is not compromised by any compensation
44 awarded to the practitioner prior to, during the course of, or subsequent to the declared
45 emergency. Such compensation, however, must not arise from a preexisting employment
46 relationship with the host entity (other than a disaster relief organization).

SECTION 3. AUTHORIZATION FOR VOLUNTEER HEALTHCARE PRACTITIONERS TO PROVIDE HEALTHCARE OR VETERINARY SERVICES.

(a) Volunteer healthcare practitioners are authorized to provide healthcare or veterinary services in this state while an emergency declaration is in effect subject to the requirements of this [act].

(b) While an emergency declaration is in effect, the [*name of appropriate agency or agencies*] may limit, restrict, or otherwise regulate (1) the duration of practice by volunteer healthcare practitioners, (2) the geographical areas in which volunteer healthcare practitioners may practice, (3) the class or classes of volunteer healthcare practitioners who may practice, and (4) any other matters necessary to coordinate effectively the provision of healthcare or veterinary services.

Comment

The legal landscape for responding to natural disasters, public health threats, or other exigencies changes instantly with the declaration of a state of emergency. State licensing requirements, however, may prevent, hinder, or delay response efforts and possibly increase the health threat to individuals or populations. Accommodations must be made to ensure the efficient deployment and use of volunteer healthcare practitioners to meet surge capacity in existing healthcare facilities, emergency shelters, or other places where healthcare or veterinary services are needed. Subsection (a) authorizes volunteer healthcare practitioners to provide healthcare or veterinary services for the duration of the emergency. Subsection (a) must be interpreted *in pari materia* with the other provisions of this act. As a result, subsection (a) only authorizes volunteer healthcare practitioners to provide healthcare or veterinary services in the state if all of the other requirements of the Act are satisfied, such as registration, compliance with scope of practice limitations, and compliance with any modifications or restrictions imposed by the host state or host entity during an emergency.

An emergency is initiated with its declaration (as determined in accordance with existing state or local laws) and is usually terminated usually upon subsequent proclamation by an authorized state or local agency or official. A reasonable interpretation of subsection (a) may allow for preparatory acts in anticipation of the emergency declaration. Thus, in the event of an impending emergency (e.g., hurricane impacting a Gulf state), a state of emergency may be forthcoming, but not yet declared. To the extent that volunteer healthcare practitioners may be

1 needed to provide healthcare services in anticipation of the emergency, such services may
2 reasonably be considered within the scope of this act. For example, volunteer healthcare
3 practitioners may be needed to assist in the treatment of patients being evacuated from a
4 jurisdiction facing a potential emergency (e.g., hurricane) prior to the formal declaration of the
5 emergency. Whether such acts are of close proximity to the response to an emergency pursuant
6 to this act is left to the discretion of government authorities.

7
8 While subsection (a) authorizes volunteer healthcare practitioners to provide healthcare
9 or veterinary services during a declared emergency, subsection (b) clarifies that these services
10 may be subject to limits, restrictions, or regulations set forth by the appropriate emergency
11 management or public health agency that is principally responsible for overseeing or managing
12 emergency response efforts. These limits, restrictions, or regulations may relate to (1) the
13 duration of practice by volunteer healthcare practitioners, (2) the geographical areas in which
14 volunteer healthcare practitioners may practice, (3) the class or classes of volunteer healthcare
15 practitioners who may practice, and (4) any other matters necessary to coordinate effectively the
16 provision of healthcare or veterinary services. Additional restrictions concerning the services
17 provided by volunteer healthcare practitioners by the state licensing board or other agency that
18 regulates healthcare practitioners are also permitted during the emergency pursuant to Section
19 6(b).

20 21 22 **SECTION 4. VOLUNTEER HEALTHCARE PRACTITIONER REGISTRATION** 23 **SYSTEMS.**

24 (a) For the purpose of this [act], a registration system is a system that:

25 (1) facilitates the registration of volunteer healthcare practitioners prior to the
26 time their services may be needed;

27 (2) includes organized information about the practitioners that is accessible by
28 authorized personnel; and

29 (3) can be used to verify the accuracy of information concerning whether the
30 volunteers are licensed and in good standing.

31 (b) This [act] applies only to volunteer healthcare practitioners registered with a
32 registration system that is:

33 (1) an ESAR-VHP or MRC system;

(2) operated by a disaster relief organization, licensing board, national or regional association of licensing boards or healthcare practitioners, comprehensive healthcare facility, or governmental entity; or

(3) designated by [*name of appropriate agency or agencies*] as a registration system for purposes of this [act].

(c) While an emergency declaration is in effect, the [*name of appropriate agency or agencies*], or a person or persons authorized to act on behalf of the [*agency or agencies*], including a host entity, may confirm whether volunteer healthcare practitioners utilized in this state are registered with a registration system. Confirmation is limited to determining the identities of the practitioners and whether they are licensed and in good standing with the system.

(d) The [*name of appropriate agency or agencies*] may establish procedures for the efficient confirmation of volunteer healthcare practitioners pursuant to subsection (c).

Comment

A registration system is defined in subsection (a) to clarify the types of systems of volunteer healthcare practitioners that may qualify its registrants for the protections of this Act during emergencies. Although the qualities and design of these registration systems may vary, some essential components are set forth, including that the system must (a) facilitate the registration of volunteer healthcare practitioners *prior* to the time their services may be needed; (b) include organized information about the volunteers that is accessible by authorized personnel; and (c) be capable of being used to verify the accuracy of information concerning whether the volunteers are licensed and in good standing. Any system that meets these basic requirements and is not within subsections (b)(1) or (2) may be approved by the appropriate agency via regulation pursuant to subsection (b)(3).

Under subsection (a), the requirement to “facilitate” registration prior to the time services is needed to (1) discourage the deployment of “spontaneous volunteers” at the time of a disaster, (2) encourage practitioners to register in advance of emergencies, and (3) have the opportunity to obtain specialized training appropriate to the provision of healthcare or veterinary services during emergencies. This Act does not, however, mandate advanced registration in recognition of the possibility that large scale disasters may create needs for more practitioners than those who register in advance. Instead, a registration system is only required to make it possible for volunteers to register prior to the time they are needed and to encourage them to do so.

1
2 Under subsection (b), registration systems include ESAR-VHP and MRC systems.
3 ESAR-VHP systems are set forth as models as they contain the core system requirements
4 provided under subsection (a) and are interoperable among states. For host entities that use
5 interstate volunteer healthcare practitioners, the interoperability of registration systems is
6 imperative to allow efficient data sharing and thereby ensure a timely response effort.
7 The minimum data elements of the ESAR-VHP system, for example, include a practitioner's
8 name, contact information, degree(s), hospital(s) in which the individual enjoys privileges,
9 specialty(ies), state license number, state license board check of disciplinary actions taken
10 against the licensee, National Practitioner Databank check of liability actions, date of last
11 reappointment, and status of the license (e.g., active, inactive or retired). Entities establishing
12 registration systems may choose to expand on these elements and also include the volunteer's
13 choice of service (e.g., distance willing to travel, maximum duration of service, type of disaster),
14 immunization status, languages spoken, photograph, disaster training or education, special
15 qualifications, and public health experience. Additional considerations in developing and
16 implementing a registration system may include security safeguards, privacy concerns, and the
17 accessibility of data by authorized personnel.
18

19 Subsection (b)(2) approves registration systems operated by disaster relief organizations,
20 licensing boards, national and regional associations of licensing boards or healthcare
21 practitioners, comprehensive healthcare facilities (as defined in Section 2(1)), or governmental
22 entities. As used here, regional is a subset of national and means a multistate association of
23 licensing boards or healthcare practitioners. The entities listed in subsection (b)(2) typically use
24 registration systems in their ordinary course of business or activities. For purposes of this Act,
25 however, a registration system operated by such entities is subject to all the requirements of
26 subsection (a) as explained in this Official Comment.
27

28 Subsection (b)(3) authorizes the appropriate state agency or agencies to designate for the
29 purposes of this act a registration system other than those set forth in subsections (b)(1) and (2).
30

31 Subsection (c) gives discretion to a state agent or designee (including host entities) to
32 confirm the identity and status within a registration system of a volunteer healthcare practitioner.
33 Confirmation is strongly recommended, but not required, noting that potential exigencies may
34 prevent confirmation in some instances. Confirmation is limited to identification and an
35 assessment of good standing of volunteer healthcare practitioners within the system. This
36 provision is a security safeguard that allows state officials to ensure that volunteer healthcare
37 practitioners capable of providing healthcare or veterinary services during an emergency are
38 appropriately registered with a registration system. Another purpose of this provision is to
39 prevent fraudulent attempts or acts of unlicensed individuals posing as qualified healthcare
40 practitioners during emergencies. The primary purpose, however, is to ensure the timely
41 approval of registered volunteer healthcare practitioners to provide healthcare or veterinary
42 services to individuals or populations affected by an emergency.
43

44 Subsection (c) does not, however, authorize states to review and approve the credentials
45 and qualifications of individual volunteers or to establish requirements on a state-by-state basis

1 to confirm the registration of volunteers. These authorizations or requirements may undermine
2 a fundamental goal of the act to establish uniformity across states for the recognition of volunteer
3 healthcare practitioners that can function automatically if necessary if communications are
4 disrupted and access to state officials to secure authorizations is impossible or impractical during
5 an emergency.

6
7 Cases may arise where a volunteer healthcare practitioner is thought to be registered with
8 a registration system and suitable for providing healthcare or veterinary services, but this cannot
9 be confirmed due to technical limitations resulting from the emergency or other factors.
10 Accordingly, procedures should be in place to allow for alternative forms of confirmation
11 without jeopardizing the health of individuals or populations. Subsection (d) grants states
12 flexibility to establish procedures for confirmation pursuant to Subsection (c). The nature of such
13 procedures is left to the discretion of the appropriate state (or local) emergency management or
14 public health agency that is principally responsible for overseeing or managing emergency
15 response efforts.

16
17
18 **SECTION 5. INTERSTATE LICENSURE RECOGNITION FOR VOLUNTEER**
19 **HEALTHCARE PRACTITIONERS.**

20 (a) While an emergency declaration is in effect, a volunteer healthcare practitioner
21 licensed and in good standing in another state may practice in this state to the extent authorized
22 by this [act] as if the person had been licensed in this state.

23 (b) A volunteer healthcare practitioner who is subject to a suspension, revocation, or
24 disciplinary restriction, or who has voluntarily terminated a license under threat of sanction, in
25 any state is not entitled to the protections from administrative sanctions provided by Section 6 or
26 the protections from civil liability provided by Section 7 of this [act].

27 (c) This [act] does not affect credentialing and privileging standards of a healthcare
28 entity, nor does it preclude a healthcare entity from waiving or modifying such standards while
29 an emergency declaration is in effect.

30 **Comment**

31
32 This Section addresses the need for licensure recognition of volunteer healthcare
33 practitioners who are licensed outside the state in which an emergency is declared. Out-of-state

1 volunteers can be a critical resource to meet surge capacity in the host jurisdiction. Absent
2 recognition of their licensure status during the emergency, however, these practitioners may not
3 be authorized to perform healthcare or veterinary services in the state. Subsection (a) provides
4 that a host state shall recognize the out-of-state license of a volunteer healthcare practitioner as
5 being of equivalent status to a license granted by the host state's licensure board during an
6 emergency. This is subject to all of the requirements of the [act], including requirements that (1)
7 the volunteer healthcare practitioner be duly licensed in another state and in good standing; (2)
8 that an emergency exist (as defined in Section 2(5)); (3) that the practitioner be registered with a
9 registration system; and (4) that the practitioner comply with the scope of practice limitations
10 imposed by the act, the laws of the host state, and any special modifications or restrictions to the
11 normal scope of practice imposed by the host state or host entity pursuant to Sections 6(b) and
12 (c), respectively.

13
14 Subsection (b) restricts the protections from administrative sanction and civil liability of
15 this act to volunteer healthcare practitioners who are not subject to a suspension, revocation, or
16 disciplinary restriction, or who have not voluntarily terminated their license under threat of
17 sanction, in any state. This is consistent with the requirements underlying the provision of
18 services in Section 6 such that practitioners who meet any of the aforementioned criteria have
19 had their qualifications questioned with respect to their ability to adequately provide healthcare
20 services.

21
22 Subsection (c) provides that licensure recognition under Subsection (a) is distinct from
23 the credentialing and privileging processes as defined in Sections 2(3) and 2(19), respectively.
24 Credentialing and privileging standards can be an essential prerequisite to the actual delivery of
25 healthcare services in specific settings. The Joint Commission on Accreditation of Healthcare
26 Organizations (JCAHO), for example, requires hospitals to be prepared to engage in rapid
27 credentialing procedures as needed to respond to emergency events. Subsection (c)
28 acknowledges the distinctions between credentialing and privileging, and specifically notes that
29 the act is not intended to interfere with the enforcement or waiver of these requirements during
30 an emergency.

31
32 Waivers or modifications of credentialing or privileging standards during emergencies
33 have no effect on registration requirements under Section 4 or adherence to scope of practice
34 considerations under to Section 6.

35
36 Any authority to provide healthcare or veterinary services granted pursuant to a waiver or
37 modification shall only apply for the duration of an emergency (as defined in Section 2(5)) and
38 shall cease when the emergency declaration is no longer in effect. At this point, the licensure
39 recognition for an out-of-state volunteer health practitioner is no longer valid, and the
40 practitioner must revert to strict compliance with the normal licensing laws of the host state.

1 **SECTION 6. PROVISION OF VOLUNTEER HEALTHCARE OR VETERINARY**
2 **SERVICES.**

3 (a) Subject to subsection (d), a volunteer healthcare practitioner, including a practitioner
4 licensed in another state and authorized to provide healthcare or veterinary services in this state
5 pursuant to this [act], must adhere to the scope of practice for similarly situated practitioners
6 established by the licensing provisions, practice acts, or other laws of this state.

7 (b) The [*name of appropriate agency or agencies*] may modify or restrict the healthcare
8 or veterinary care services that a volunteer healthcare practitioner may provide pursuant to this
9 [act].

10 (c) A host entity may restrict the healthcare or veterinary services that a volunteer
11 healthcare practitioner may provide pursuant to this [act].

12 (d) Nothing in this [act] authorizes a volunteer healthcare practitioner to provide services
13 that are outside the practitioner's scope of practice even if a similarly situated practitioner in this
14 state would be permitted to provide the services.

15 (e) A volunteer healthcare practitioner shall not be subject to administrative sanctions for
16 unauthorized practice if the practitioner provides healthcare or veterinary services in good faith
17 and does not know of any restrictions or modifications under subsections (b) or (c) or that a
18 similarly situated practitioner in this state would not be permitted to provide the services.

19 (f) For conduct that occurs while an emergency declaration is in effect and for which a
20 volunteer healthcare practitioner is not protected under subsection (e), a licensing board or other
21 disciplinary authority in this state:

22 (1) may impose administrative sanctions if the practitioner is licensed in this state

1 without regard to the state in which the conduct occurs;

2 (2) may impose administrative sanctions if the practitioner is not licensed in this
3 state and the conduct occurs in this state; and

4 (3) must report any administrative sanctions to the appropriate licensing board or
5 other disciplinary authority in any other state in which the practitioner is known to be licensed.

6 (g) In determining whether to impose administrative sanctions under subsection (f), a
7 licensing board or other disciplinary authority shall consider the nature of the exigent
8 circumstances in which the conduct took place, the practitioner's scope of practice, and the
9 practitioner's education, training, experience, and specialized judgment.

10 **Comment**

11
12 Subsection (a) provides that volunteer healthcare practitioners may only render healthcare
13 services within their scope of practice, as defined in Section 2(20), in the host state. The term
14 "scope of practice" may have different meanings depending on how it is used. In the healthcare
15 professions (e.g., medicine, nursing, etc.), the "scope of practice" typically refers to the standards
16 that separate one health profession from another governed by state licensure laws unique to each
17 profession. Idaho, for example, precludes a healthcare practitioner providing charitable medical
18 care from acting outside the scope of practice "authorized by the provider's licensure,
19 certification or registration." Idaho Code § 39-7703 (2005). Therefore, nurses are restricted from
20 performing physician services because such conduct would constitute acting outside the scope of
21 practice for nurses.

22
23 Another interpretation of "scope of practice" refers to the general services being provided
24 *for* a specific entity that a volunteer healthcare practitioner is serving. Alabama, for example,
25 requires all volunteers to act "within the scope of such volunteer's official functions and duties
26 for a nonprofit organization, ...hospital, or a governmental entity..." Ala. Code §6-5-336(d)(1).
27 Consequently, the scope of practice (i.e. functions and duties) would not stem exclusively from
28 the explicit licensure requirements under state law. Rather, the types of services would stem from
29 the privileging requirements set forth by the organization in which the volunteer is serving.

30
31 Under this act, "scope of practice," as defined in Section 2(20), limits the types of
32 services volunteer healthcare practitioners can perform to those services unique to their
33 profession and further restricts the types of services they may provide as determined by a state
34 licensing board or other agency (pursuant to subsection (b)) or host entity (pursuant to subsection
35 (c)). Nonetheless, the scope of practice may differ among individuals depending on the state(s)
36 where they are principally licensed.

1
2 As stated in subsection (a), any volunteer healthcare practitioners (whether in-state or
3 out-of-state) must adhere to the applicable scope of practice for similarly situated practitioners in
4 the host state during the emergency. For practitioners licensed in the host state before the
5 emergency, this requirement reflects the norm that they must adhere to the state's scope of
6 practice for their profession. For out-of-state practitioners who are not licensed in the host state
7 before the emergency, this requirement is consistent with the recognition pursuant to Section 5(a)
8 that out-of-state practitioners are to be viewed as licensed in the state for the duration of the
9 emergency. Through subsection (a), the scope of practice requirements for similarly situated
10 practitioners is coupled with their receipt of a temporary license as provided in Section 5(a).
11 This helps ensure uniformity in the scope of practice among various practitioners from other
12 jurisdictions.

13
14 Subsection (b) authorizes the state licensing board or other appropriate state agency (or
15 agencies) to modify or restrict the scope of practice during an emergency. This provision must be
16 considered *in pari materia* with the licensure laws and regulations of the host state. The rationale
17 is to empower state agencies to adapt their emergency response plans to unforeseeable
18 circumstances stemming from an emergency to meet patient needs or protect the public's health.
19 In some instances, this may require empowering volunteer healthcare practitioners to provide
20 services that are not typically allowed under existing state licensure laws. During an emergency
21 there may be legitimate reasons for a state to modify or restrict the healthcare services that a
22 volunteer healthcare practitioner may provide consistent with overriding public health objectives
23 or patient needs.

24
25 Subsection (c) authorizes a host entity to restrict the services that volunteer healthcare
26 practitioners may provide (provided the restrictions are not contrary to any modifications or
27 restrictions made pursuant to subsection (b)). Subsection (c) recognizes the need to empower
28 host entities to make decisions in real time to allow for an efficient and effective emergency
29 response. This provision does not authorize a host entity to alter the scope of practice of a
30 particular profession as defined by state licensure boards or other appropriate agencies. The host
31 entity may not modify a service, but may restrict the types of services a volunteer healthcare
32 practitioner may provide consistent with their statutorily-defined scope of practice. Therefore, a
33 hospital acting as a host entity cannot authorize a nurse to provide services that only a physician
34 may perform. However, the hospital may limit the types of services that a volunteer healthcare
35 practitioner is authorized to perform. A hospital, for example, may delegate different
36 responsibilities among volunteer healthcare practitioners that limit what the practitioners may be
37 able to do in the treatment of patients or provision of public health services during a non-
38 emergency. This population-based approach to the delivery of healthcare services is consistent
39 with the underlying public health objective of this act to assure the health and well-being of
40 affected members of the population.

41
42 Subsection (d) clarifies that this Section (nor any other provisions of the act) does not
43 authorize a volunteer healthcare practitioner to provide services that are outside the practitioner's
44 scope of practice even if a similarly situated practitioner in this state would be permitted to
45 provide the services. This restriction, which principally applies to practitioners whose licensure

1 during non-emergencies is principally out-of-state, helps ensure that volunteer healthcare
2 practitioners do not provide services during emergencies that they would not be entitled to
3 provide in their usual course of business or activities. This is significant in instances where a
4 volunteer healthcare practitioner is licensed in more than one state. For example, a physician
5 may principally practice medicine in Maryland, although he is also licensed in Illinois and
6 Louisiana. Consider the situation where Louisiana declares a state of emergency, and the
7 physician is deployed from Maryland to Louisiana to provide services. With the recognition of
8 licensure pursuant to Section 5(a), the practitioner is permitted to practice in state as if licensed
9 in state for the duration of the emergency. If the scope of practice for a similarly situated
10 practitioner in Louisiana allows the practitioner to provide services that are outside of the
11 practitioner's scope in Maryland, these services shall not be provided by the practitioner pursuant
12 to subsection (d). The impetus for this restriction is to make sure that out-of-state practitioners do
13 not provide services for which they are not competent to provide, based on their licensure status
14 in their principal state of practice. If Illinois offered another variation on the practitioner's scope
15 of practice that was more limited than the scope of practice in Louisiana, this need not be
16 considered by the practitioner in the performance of services since the practitioner does not
17 principally engage in practice in Illinois. To require practitioners to adhere to the scope of
18 practice in every jurisdiction in which they are licensed during an emergency would be overly
19 confusing to practitioners and may interfere with the provision of essential healthcare services to
20 individuals and populations.

21
22 Thus, for the purposes of the example stated above, the practitioner may be limited in the
23 provision of healthcare services in Louisiana during the emergency only to the extent that the
24 scope of practice in Maryland is more restrictive than that for similarly situated practitioners in
25 Louisiana. Simply stated, the volunteer healthcare practitioner is permitted to do whatever a
26 similarly situated physician in Louisiana can do, unless such action is outside the practitioner's
27 scope of practice in Maryland. The practitioner's Illinois licensure is inconsequential to this
28 determination.

29
30 Subsection (e) provides that administrative sanctions for unauthorized practice shall not
31 apply to volunteer healthcare practitioners provided that they (1) act in good faith, and (2) are
32 unaware of any restrictions or modifications to the scope of practice subject to subsections (b)-
33 (c) or that a similarly situated practitioner in this state would not be permitted to provide the
34 services. This provision recognizes that volunteer healthcare practitioners that are already
35 registered under Section 4 and authorized to provide healthcare services must exercise their best
36 judgment during exigent circumstances. It would be inapposite with the purposes of this [act] to
37 facilitate voluntarism to require them to second-guess every judgment consistent with their scope
38 of practice requirements under Subsection (a) and (d) because of concerns over administrative
39 sanctions. Provided they are acting in good faith and without knowledge of modifications or
40 restrictions on the scope of practice during the emergency, they should not be subject to
41 administrative sanctions during or following the emergency.

42
43 However, if a volunteer healthcare practitioner is expressly informed of a restriction of
44 modification to the scope of practice, or should have known that a specific act exceeded the
45 boundaries of applicable standards, administrative sanctions may be imposed, as noted in

subsection (f). This subsection authorizes a state licensing board or other disciplinary authority to impose administrative sanctions on any volunteer healthcare practitioner whose conduct is in violation of any subsection heretofore provided and for which subsection (e) does not afford protection. Subsection (f)(1) authorizes the state from which the volunteer healthcare practitioner was deployed to impose sanctions regardless whether the services were provided within the state. Subsection (f)(2) authorizes the host state to impose sanctions regardless whether the practitioner was licensed in that state in non-emergencies. In other words, the host state may impose sanctions based on the out-of-state practitioner's "temporary licensure" status. Subsection (f)(3) mandates any state that imposes sanctions upon a volunteer healthcare practitioner to inform the licensing board or other disciplinary authority in all states where the practitioner is known to be licensed. This service may help licensing boards or other disciplinary authorities for healthcare practitioners across the states to note outstanding sanctions against any practitioner licensed in their state.

Subsection (g) requires the state licensing board or other disciplinary authority to examine the conduct of a volunteer healthcare practitioner potentially subject to administrative sanction against a backdrop of mitigating factors, including the practitioner's scope of practice, education, training, experience, and specialized judgment. This requirement recognizes that during exigent circumstances, numerous factors may influence a volunteer healthcare practitioner's actions or omissions.

SECTION 7. NO LIABILITY FOR VOLUNTEER HEALTHCARE

PRACTITIONERS; EXCEPTIONS; NO VICARIOUS LIABILITY.

(a) Subject to subsection (b), volunteer healthcare practitioners authorized to provide healthcare or veterinary services pursuant to this [act] are not liable for civil damages for acts or omissions within the scope of their responsibilities as volunteer healthcare practitioners.

(b) Subsection (a) does not apply to: (1) willful, wanton, grossly negligent, reckless, or criminal conduct of, or an intentional tort committed by, a volunteer healthcare practitioner; (2) an action brought against a volunteer healthcare practitioner (A) for damages for breach of contract, (B) by a source or host entity, or (C) the operation of a motor vehicle, vessel, aircraft, or other vehicle by a volunteer healthcare practitioner for which this state requires the operator to have a valid operator's license or to maintain liability insurance, other than an ambulance or

1 other emergency response vehicle, vessel, or aircraft.

2 (c) Source, coordinating, and host entities are not vicariously liable for the acts or
3 omissions of volunteer healthcare practitioners while an emergency declaration is in effect.

4 (d) Source, coordinating, and host entities are not liable for civil damages for acts or
5 omissions relating to the operation or use of, or reliance upon information provided by, a
6 registration system unless the acts or omissions constitute an intentional tort or are willful,
7 wanton, grossly negligent, reckless, or criminal in nature.

8 **Comment**

9
10 Subsection (a) provides that volunteer healthcare practitioners are generally not liable for
11 acts or omissions within the scope of their responsibilities during an emergency. As used in this
12 section, “responsibilities” encompasses the provision of services that provide a direct health
13 benefit to individuals or human populations or to animals or animal populations. Responsibilities
14 may also include health-related activities that allow for the efficient provision of healthcare or
15 veterinary services. Examples include assistance in patient care where support staff are
16 unavailable (e.g., transporting a patient in the immediate vicinity where healthcare services are
17 being provided), and other activities that may be outside the typical scope of healthcare or
18 veterinary services, but are still conducive to the provision of patient care. Health-related
19 services are distinguishable from services that are of a nonhealth-related nature and afford no
20 direct health benefit to individuals or populations (e.g., the operation of a non-emergency motor
21 vehicle, administrative services, etc.). Whether a service is health-related or nonhealth-related
22 will depend largely on the circumstances and consideration for whether the acts or omissions are
23 integral to the provision of direct health benefits.

24
25 Subsection (b) provides exceptions to the protections from liability provided to volunteer
26 healthcare practitioners under subsection (a). A volunteer healthcare practitioner may be liable
27 (1) for engaging in willful, wanton, grossly negligent, reckless, or criminal conduct, or for
28 committing an intentional tort; (2) in an action for damages for breach of contract or an action
29 brought by a source or host entity; and (3) for the operation of a motor vehicle or other craft for
30 which the state requires the volunteer to hold a valid license or maintain liability insurance.
31 These exceptions may include situations in which a volunteer healthcare practitioner exceeds the
32 scope-of-practice requirements in the course of providing healthcare or veterinary services. For
33 example, a lab technician will be deemed to have exceeded the scope of practice of a similarly
34 situated practitioner by performing surgery on an individual. A lack of education, training, and
35 licensure will often be sufficient to constitute, at the very least, grossly negligent conduct
36 pursuant to Subsection (b)(1). The fact that a volunteer practitioner exceeds the scope of
37 authority, however, does not of itself constitute conduct for which liability protection is not
38 available.

1
2 Subsection (b)(2)(A) exempts breaches of contract from the protection provided by
3 subsection (a). At its core, subsection (a) provides protection for malpractice. If a volunteer
4 healthcare practitioner has executed a valid contract to provide healthcare services, the
5 obligations imposed by that contract may only be avoided if there is a valid excuse under the law
6 governing the contract. For example, in *Sullivan v. O'Connor*, 363 Mass. 579, 296 N.E. 2d 183
7 (Mass. 1973), a doctor was found by a jury to have promised a particular result and was held
8 liable for breach of contract even though the jury determined that he had not committed
9 malpractice. Subsection (b)(2)(A) would not provide protection to the doctor for the contract
10 claim.

11
12 Subsection (b)(2)(B) provides that a volunteer healthcare practitioner is not afforded civil
13 liability protection for an action brought by a source or host entity. This section is not intended to
14 be an avenue for third-party claims that might indirectly expose the practitioner to the type of
15 liability for which subsection (a) is intended to provide protection. For example, a plaintiff might
16 file a claim against a hospital (as a host entity) for negligent supervision of a volunteer healthcare
17 practitioner. In response, the hospital might file a third-party claim against the practitioner. If
18 the practitioner's conduct was not within subsection (b), the practitioner would not be liable to
19 the hospital. Rather, the purpose of Section (b)(2)(B) is to provide an avenue for source and host
20 entities to seek redress against a volunteer healthcare practitioner for blatant misconduct that
21 may not necessarily have a direct health effect on individuals or populations. Examples may
22 include mismanagement of materials during a response effort or conversion of property or goods
23 provided for the sole purpose of distribution to affected individuals or populations of an
24 emergency. Such claims by the source or host entity against the volunteer healthcare practitioner
25 are allowed pursuant to this Section (b)(2)(b) (and Section (b)(1) if the volunteer's actions
26 constitute a crime or other willful misconduct).

27
28 Section (b)(2)(C) exempts civil liability protections for injuries resulting from the
29 operation of a non-emergency vehicle for which the host state requires the operator to hold a
30 valid operator's license or maintain liability insurance. This provision is consistent with other
31 federal statutes that provide certain exceptions to civil liability protections afforded to volunteers
32 (e.g., the federal Volunteer Protection Act, 42 U.S.C.S. § 14503(a)(4)). The intent is to preclude
33 liability protections for actions of a volunteer healthcare practitioner that are outside their scope
34 of responsibilities as volunteers. Thus, a volunteer healthcare practitioner driving an ambulance
35 or other emergency vehicle transporting patients to a triage site is acting within the scope of his
36 responsibilities, and may not be found liable for injuries resulting from a vehicular accident
37 (provided he did not act willfully or engage in other misconduct). The same practitioner who
38 finishes a shift as a volunteer at a host entity and has a vehicular accident driving across town
39 later that evening to eat out at a restaurant is liable for damages caused by the negligent
40 operation of the vehicle.

41
42 Subsection (c) provides vicarious liability protection for source, coordinating, and host
43 entities for acts or omissions of their volunteer healthcare practitioners. These entities are often
44 concerned about their potential liability in the deployment or use of volunteer healthcare
45 practitioners during emergencies. To alleviate these concerns and thereby facilitate the full use

1 of volunteer healthcare practitioners, the act provides protection from vicarious liability. As
2 discussed below, such protections are consistent with the legal nature of vicarious liability.

3
4 Vicarious civil liability applies when an employer is responsible for the torts of its
5 employees or agents, despite the fact that the employer itself may not have engaged in any
6 negligent activities. Liability under this doctrine can attach pursuant to the theories of respondeat
7 superior and ostensible agency.

8
9 Respondeat superior provides for vicarious liability when a negligent healthcare provider
10 is an employee or an agent of an entity and has acted in the course of the employment. The
11 theory presumes that the employer has control over, and is therefore responsible for the acts of,
12 its employees. The extent of civil liability in such circumstances depends on the level of control
13 exerted by the employer over the actions of the employee. In most jurisdictions, the employer
14 will only be liable for acts of the employee undertaken within the scope of employment.
15 Hospitals, for example, may be held liable for the acts of nurses, residents, interns, and certain
16 behavioral health professionals since these health practitioners are often considered employees.
17 Similarly, a physician who exercises control and authority over other healthcare practitioners
18 (e.g., nurses, supporting staff, etc.) can be held liable for their negligence. In one case, a surgeon
19 was vicariously liable for an error in a sponge count performed by the nursing staff after surgery,
20 although the surgeon did not participate in the count. *Johnson v. Southwest Louisiana Ass'n*, 693
21 So.2d 1195 (La.App.1997) (holding that the surgeon had a nondelegable duty to remove
22 sponges from the patient's body).

23
24 The primary issue in applying respondeat superior is whether an individual is a servant
25 (e.g., employee) subject to the control of the master (e.g., employer), or an independent
26 contractor. The employer's right to control is what distinguishes an employee from an
27 independent contractor. Typically, entities are not held liable for the negligent actions of
28 independent contractors. Therefore, during an emergency, a hospital would not be vicariously
29 liable for the acts or omissions of a volunteer healthcare practitioner that provides healthcare
30 services to individuals or populations within the hospital provided that the volunteers were
31 looked upon as independent contractors (and not as agents) of the hospital.

32
33 The theory of ostensible (or apparent) agency imputes liability to entities where (1) the
34 patient looks to the entity rather than the individual healthcare practitioner to provide care, and
35 (2) the entity holds the healthcare practitioner out as its employee. Civil liability under the theory
36 of ostensible agency is particularly relevant in emergency situations. When a patient enters the
37 emergency room, he generally looks to the institution to provide him with care and has no
38 knowledge of the nature of the employment relationship between the physician and the hospital.
39 Moreover, by permitting the physician to practice in the emergency room, the hospital is holding
40 out that individual as its employee. This scenario may not be applicable during an emergency for
41 a number of reasons. First, the host entity is not expected to exert the same degree of control over
42 the healthcare practitioner tantamount to the normal operations of an emergency room. Also,
43 volunteer healthcare practitioners are not agents of an entity where no employment relationship
44 exists between the entity and the practitioners, and where they are not presented as providing
45 healthcare services pursuant to a legal obligation (e.g., a duty to perform under a contract).

1
2 Subsection (d) clarifies that source, coordinating, and host entities are not liable for civil
3 damages for acts or omissions relating to the operation or use of, or reliance upon information
4 provided by, a registration system. This provision supports the essential roles of these entities in
5 the operation and use of registration systems (as defined in Section 4(a)) and the critical need for
6 these systems to effectively respond to emergencies. Provided that the acts or omissions that
7 may lead to liability do not constitute an intentional tort or are not willful, wanton, grossly
8 negligent, reckless, or criminal in nature, entities shall not be civilly liable.
9

10
11 **SECTION 8. WORKERS' COMPENSATION COVERAGE.** A volunteer

12 healthcare practitioner who is deployed to this state while an emergency declaration is in effect
13 and is not covered by workers' compensation insurance or other insurance providing comparable
14 benefits shall be considered an employee of this state for purposes of workers' compensation
15 coverage during the period of deployment.

16 **Comment**
17

18 This section provides that the host state must afford workers' compensation coverage to
19 volunteer healthcare practitioners that are not covered by workers' compensation insurance or
20 other comparable coverage during their deployment. Workers' compensation is a no-fault system
21 that provides an expeditious resolution of work-related claims. Injured workers relinquish their
22 right to bring an action against employers in exchange for fixed benefits. This welfare system is
23 convenient to the employer by allowing for a predictable and estimable award. It is also in the
24 interests of the workers since they are not required to demonstrate who is at fault; rather, a
25 worker must only demonstrate that the injury suffered arose out of or in the course of
26 employment. Workers' compensation programs thus protect employees from the harms (or
27 deaths) they incur in the scope of their services. However, most workers' compensation systems
28 have a major limitation: they do not typically cover the activities of volunteers.
29

30 Section 8 is necessary to provide some avenue of redress for injuries incurred by
31 volunteer healthcare practitioners while providing healthcare or veterinary services during an
32 emergency. Volunteer healthcare practitioners are not "employees" in the traditional sense of the
33 term. However, in the course of providing healthcare or veterinary services during an
34 emergency, they will be exposed to many of the same risks of harm that are faced by employees
35 of the host entity, state or local governments, or other employers.
36

37 Under this section, a volunteer healthcare practitioner that has no other source of
38 insurance for work-related injuries or death is entitled to the same workers' compensation
39 benefits as employees of the state. Accordingly, the host state's law governs the grant of any
40 workers' compensation award to a volunteer and determines whether an employer, rather than

1 the state, is mandated to provide workers' compensation coverage. This section is not intended to
2 supplant the workers' compensation benefits that would otherwise be available to volunteer
3 healthcare practitioners provided by an entity or other person in the host state or the state from
4 where they were deployed. Some employers, for example, may laudably choose to extend their
5 workers' compensation benefits to its employees who choose to volunteer outside the employer's
6 workplace during an emergency. In addition, some state laws may mandate workers'
7 compensation coverage for individuals even when providing voluntary service away from their
8 regular place of employment. This section is only meant to afford workers' compensation
9 coverage when no other coverage applies.

10
11 This section is not intended to allow redress for volunteer healthcare practitioners who
12 may attempt to circumvent the exclusive remedy provisions of workers' compensation to pursue
13 tort suits against a host entity.

14 15 16 **SECTION 9. EFFECT OF COMPENSATION ON VOLUNTEER STATUS.**

17 (a) The prospective, concurrent, or retroactive provision of monetary or other
18 compensation to a healthcare practitioner by any person for the provision of healthcare or
19 veterinary services while an emergency declaration is in effect does not preclude the practitioner
20 from being a volunteer healthcare practitioner under this [act] unless the compensation is
21 provided pursuant to a preexisting employment relationship with the host entity that requires the
22 practitioner to provide healthcare or veterinary services in this state.

23 (b) This section does not apply to a healthcare practitioner who is not a resident of this
24 state and who is employed by a disaster relief organization providing services in this state while
25 an emergency declaration is in effect.

26 **Comment**

27
28 Subsection (a) provides that a volunteer healthcare practitioner's status as a "volunteer"
29 will not be affected by any compensation afforded to the practitioner prior to, during, or after the
30 emergency. This section is inapposite to many existing legal definitions of "volunteer," often
31 characterized as an individual who does not receive compensation for services. The purpose of
32 this provision, however, is to recognize that the principal basis for defining a volunteer
33 healthcare practitioner (Section 2(25)) is not whether the practitioner is compensated (unless
34 such compensation is pursuant to an employment relationship with the host entity to provide
35 healthcare or veterinary services in this state), but rather whether the practitioner's actions are

1 volitional. In other words, compensation outside an employment relationship with a host entity
2 is inconsequential in establishing whether an individual is or is not a volunteer. What matters is
3 that the volunteer is acting freely in choosing to provide healthcare or veterinary services in
4 emergency circumstances. The effect of this section will be to expand the pool of potential
5 volunteer healthcare practitioners who may enjoy the protections of this act to those who may be
6 compensated in some way (except for those who are in-state employees of the host entity).
7

8 Part of the justification for this more expansive view of voluntarism relates to the positive
9 effects of compensation to support volunteers during emergencies. Many prospective volunteer
10 healthcare practitioners are licensed individuals working in existing healthcare entities. They
11 may seek to volunteer knowing that their existing employers will continue to compensate them
12 even while they are away. The volunteers may be able to use their sick or vacation days for this
13 purpose, or their employers may simply allow them to volunteer without using these benefits.
14 Some disaster relief organizations may provide some nominal sums to volunteer healthcare
15 practitioners to support their efforts. Compensation in these or other instances encourages
16 certain individuals, who may not otherwise be able to act, to involve themselves in relief efforts.
17 As well, compensation may provide an alternative avenue to the benefits afforded to a healthcare
18 practitioner under the workers' compensation laws pursuant to Section 8. This would, in fact,
19 reduce the burden on host states to accommodate injured volunteers during an emergency.
20

21 Subsection (a) provides that a preexisting employment relationship with a host entity to
22 provide healthcare or veterinary services in the host state precludes a healthcare practitioner from
23 being a "volunteer" for purposes of the act. This is distinct from the mere provision of
24 compensation because it indicates that the practitioner is doing nothing out of the ordinary. The
25 practitioner is merely adhering to the terms of the employment contract. This is significant for a
26 number of reasons.
27

28 First, an individual cannot concurrently be an employee and a volunteer within a host
29 entity because it would obfuscate the legal obligations and protections afforded under existing
30 state laws. An employee has a duty to provide services that stems from his obligation to adhere
31 to the terms of an employment relationship. As provided in the Comment to Section 7, these
32 terms cannot be waived simply because the state declares an emergency (absent a valid exception
33 or pursuant to a state-authorized directive).
34

35 Second, dual status as an employee and volunteer would undermine the purpose of, and
36 protections afforded under, this act. The purpose of the act is to create an environment that
37 integrates volunteer healthcare practitioners into an emergency response. Converting employees
38 into volunteers would be inconsistent with this objective by potentially negating preexisting
39 duties of healthcare practitioners. A healthcare practitioner that was previously obligated to
40 provide a particular service should not be encouraged to abscond from that responsibility upon
41 the declaration of an emergency. The activities as an employee will be essential within a
42 preexisting framework that affords clearly defined benefits and protections.
43

44 A unique situation may arise where a corporation conducts its business through multiple
45 locations and deploys staff to provide healthcare or veterinary services at a site that has been

1 affected by the emergency. A pharmaceutical chain, for example, may have thousands of
2 locations throughout the United States, each of which is owned by the corporation. Each
3 employee at any store location is an employee of the larger corporation. During a large-scale
4 event, some of the chain's stores could be overwhelmed with demands for prescription orders
5 from existing and new patients. The corporation might seek to deploy pharmacists from out-of-
6 state to voluntarily assist in stores within the geographic area impacted by the emergency.
7 During a declared emergency, these pharmacists would qualify as "volunteer healthcare
8 practitioners." The employees that were under a preexisting employment contract with the store
9 in the host state that received the assistance, however, would still be employees subject to the
10 terms of their relationship with the corporation. These employees would not be considered
11 volunteers due to their preexisting employment obligation to provide services in the host state.
12

13 Subsection (b) waives the preexisting-employment exemption for out-of-state employees
14 of disaster relief organizations. This provision is in accord with the nature and role of disaster
15 relief organizations in an emergency response and existing federal statutes acknowledging the
16 same. The purpose of this provision is not to create a special class of employees but rather to
17 recognize the vital role of disaster relief organizations that are asked by state or local authorities
18 to oversee and manage emergency response efforts. Consequently, they can act as de facto
19 government agencies for purposes of emergency responses.. Unlike government agencies, their
20 volunteers are not afforded the benefits and protections of government employees.
21

22 Disaster relief organizations are often nonprofit organizations that are self-sustaining and
23 must unilaterally bear the costs associated with their efforts. The federal Volunteer Protection
24 Act (VPA) recognizes their vital role during an emergency response and affords volunteers
25 protection from civil liability if they were (1) acting in the scope of their responsibilities, (2)
26 properly licensed for any relevant activities or practice in the State in which the harm occurred,
27 (3) had not engaged in reckless, grossly negligent, willful or criminal misconduct, and (4) had
28 not caused harm resulting from the operation of a motor vehicle, vessel, aircraft, or other vehicle
29 for which the State requires the operator or the owner of the vehicle, craft, or vessel to (a)
30 possess an operator's license, or (b) maintain insurance. *See* 42 U.S.C. § 14503 (a)(1)-(4).
31

32 The federal VPA can be distinguished from this act in two important respects. First, the
33 VPA provides that volunteers cannot be compensated beyond reimbursement for expenses
34 incurred or minimal compensation. *See* 42 U.S.C. § 14505(6). Under Subsection (a), however,
35 the provision of monetary or other compensation does not affect the volunteer status of volunteer
36 healthcare practitioners so long as it is not pursuant to a preexisting employment relationship
37 with the host entity. Second, pursuant to the VPA, volunteer organizations or entities are
38 vicariously liable for harm caused by a volunteer to a third party. *See* 42 U.S.C. 14503(c). States
39 may also subject the protections afforded upon a demonstration that volunteer programs have
40 adhered to risk management procedures, and provided a financially secure source of recovery for
41 individuals who suffered harm as a result of actions taken by a volunteer on behalf of the
42 organization or entity. *Id.* at (d). Section 7(c) of this act, however, affords protection from
43 vicarious liability for source, coordinating, and host entities for the acts or omissions of volunteer
44 healthcare practitioners while an emergency declaration is in effect. In effect, this act improves
45 on the protections afforded under the federal VPA to members of disaster relief organizations.

1
2
3 **SECTION 10. RELATION TO OTHER LAWS.**

4 [(a)] This [act] does not limit protections from liability or other benefits provided to
5 volunteer healthcare practitioners by other laws. Except as provided in subsection (b), this [act]
6 does not affect requirements for the use of volunteer healthcare practitioners in this state
7 pursuant to EMAC.

8 [(b) The [*name of appropriate agency or agencies*] may incorporate into EMAC state
9 forces a volunteer healthcare practitioner who is not an employee of this state, a political
10 subdivision of this state, or a municipality or other local government within this state.]

11 ***Legislative Note:*** *References to other emergency assistance compacts to which the state is a*
12 *party should be added.*

13
14 **Comment**

15
16 Subsection (a) clarifies that this act does not supplant other protections from liability or
17 benefits afforded to volunteer healthcare practitioners under other laws. For example, the act
18 does not limit or preclude the benefits afforded members of disaster relief organizations under
19 such legislation as the federal Volunteer Protection Act, 42 U.S.C.S. §14501 *et seq.*

20
21 The purpose of subsection (b) is to create a statutory path to allow non-governmental,
22 private sector volunteers to be incorporated into state forces for the limited purpose of facilitating
23 their deployment and use during an emergency through EMAC. During Hurricane Katrina,
24 many states sought to deploy volunteers through EMAC to provide them greater protections and
25 fulfill state responsibilities pursuant to this compact. In many states, this required the hasty
26 execution of agreements or issuance of executive orders authorizing the volunteers to become
27 temporary state agents. To avoid future delays, this provision authorizes the appropriate state
28 agency to incorporate any private sector volunteers into state forces as needed to deploy them via
29 EMAC.
30

31 **SECTION 11. REGULATORY AUTHORITY.** The [*name of appropriate state*
32 *agency or agencies*] [is] [are] authorized to promulgate regulations to implement the provisions
33 of this [act]. In doing so, the [*name of appropriate state agency or agencies*] shall consult with,

1 and consider the recommendations of, the entity established to coordinate the implementation of
2 EMAC and shall also consult with, and consider the regulations promulgated by, similarly
3 empowered agencies in other states in order to promote uniformity of application of this act and
4 thereby make the emergency response systems in the various states reasonably compatible.

5 **Comment**

6
7 The purpose of this section is to recognize that the procedures required to implement this
8 act will be unique to each state. Therefore, this section affords them the authority to establish
9 regulations to fulfill this objective. Agencies are expected to consult with the intrastate agencies
10 or entities responsible for coordinating and managing the emergency response, along with
11 interstate partners pursuant to existing mutual aid compacts (e.g., the Emergency Management
12 Assistance Compact (EMAC), the Interstate Civil Defense and Disaster Compact (ICCDC), the
13 Nurse Licensure Compact (NLC), and the Southern Regional Emergency Management
14 Assistance Compact, etc.) to ensure consistency among regulations and the interoperability of
15 procedures during an emergency.
16
17

18 **SECTION 12. UNIFORMITY OF APPLICATION AND CONSTRUCTION.** In
19 applying and construing the provisions of this [act], consideration must be given to the need to
20 promote uniformity of the law with respect to its subject matter among states that enact it.

21 **Comment**

22
23 Uniformity of interstate recognition of licensure for volunteer healthcare practitioners,
24 and the grant of particular privileges and protections for those volunteers who provide healthcare
25 or veterinary services during an emergency to individuals or populations, are the principle
26 objectives of this act.
27

28 The goal of uniformity among the states may be enhanced by use of interoperable
29 registration systems as defined in Section 2(20) and pursuant to Section 4. Examples may
30 include ESAR-VHP systems that consist of thorough substantive and technical criteria that meet
31 essential system requirements and provide additional security safeguards with respect to
32 accessibility by authorized personnel, privacy concerns, and interoperability with other systems.
33

34 **SECTION 13. SEVERABILITY.** The provisions of this [act] are severable. If any
35 provision of this [act] or its application to any person or circumstance is held invalid, such does

- 1 not affect other provisions or applications of this [act] which can be given effect without the
- 2 invalid provision or application.