



The Uniform Emergency Volunteer Health Practitioners Act

The National Conference of Commissioners on Uniform State Laws

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Final Act - (prefinal - 10/17/06)

UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT

NATIONAL CONFERENCE OF COMMISSIONERS
ON UNIFORM STATE LAWS

WITH PREFATORY NOTE AND COMMENTS

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NATIONAL CONFERENCE OF COMMISSIONERS

ON UNIFORM STATE LAWS

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HEALTH PRACTITIONERS ACT

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UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT

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UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT

Prefatory Note

During many emergencies and disasters that threaten individuals and community health and safety, emergency response planners count on volunteer health practitioners (e.g., physicians, nurses, public health workers, lab technicians, emergency medical responders, psychologists) to provide patient surge capacity at existing health facilities and shelters. Some of these volunteers are organized, trained, and directed to respond through governmental programs (e.g., Disaster Medical Assistance Teams (DMAT), Medical Reserve Corps (MRC)) and private sector efforts (e.g., American Red Cross). Others simply show up at the site of a disaster or at nearby health care facilities. These “spontaneous volunteers” are ready to help but lack organization, identification, credentials, and, ultimately, utility. Rather than assisting in the emergency efforts, their presence can actually impede effective emergency responses.

These and other critical lessons concerning volunteer health practitioners were illustrated during the Gulf Coast hurricanes of 2005. Human devastation in the Gulf Coast states from Hurricanes Katrina

and Rita revealed significant shortcomings in the ability of the nation's emergency services delivery system to efficiently and expeditiously incorporate into disaster relief operations the services provided by private sector health practitioners. This includes employees and volunteers of nongovernmental disaster relief organizations who were needed to provide surge capacity in affected areas and to provide timely health 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 health practitioners employed by state and local governments provided much-needed health services, the magnitude of the disaster swamped the ability of these organizations to effectively handle relief operations. While thousands of health practitioners 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 health services in many affected areas.

Still, as numerous media reported, thousands of doctors and other health practitioners from across the country set aside their practices and traveled to the Gulf Coast to provide emergency health 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 health 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.

This doctor's concerns were echoed by Dr. Dan Diamond, a family practitioner, who belongs to

Northwest Medical Teams, a group of volunteer medical personnel. Dr. Diamond expressed frustration when his unit could not be deployed to New Orleans following Hurricane Katrina because its members were not licensed to practice in the affected areas. *State Laws Become Roadblock to Medical Response in Crisis*, San Francisco Chronicle, September 2, 2006. Dr. Juliette Saussy, Director of Emergency Services in New Orleans, recalled how “We needed doctors...[and] [i]t was pandemonium in the area.” *Id.* Eventually, Dr. Diamond and six doctors went to the New Orleans Convention Center where they met Dr. Saussy to offer their services. Dr. Diamond adds that “if we could have been there three days earlier, it would have made a huge difference.” *Id.*

Rather than treating the injured, sick and infirm, some qualified physicians, nurses and other licensed health 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 health 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. These impediments became especially problematic in the aftermath of Hurricane Katrina when, according to the Council of State Governments (CSG), the most pressing need immediately after the storm was the availability of medical volunteers. Glenn Cambre, attorney supervisor for the Louisiana Department of Health and Hospitals, explains:

“The main thing we worked on was allowing out-of-state medical professionals who wanted to volunteer and come help, to waive the requirement of having them licensed in our state if they could show they were validly licensed in the state that they were coming from...We had to keep renewing that executive order because we had so much need for help.” (CSG Quarterly, Winter 2006).

Current systems are not sufficient to integrate public health and medical personnel. The Association of State and Territorial Health Officials (ASTHO) reported that public health and medical emergency response personnel are not typed to a national standard like first responders in other disciplines. This complicates the use of volunteer health practitioners for both requesting and deploying states. *State Mobilization of Health Personnel During the 2005 Hurricanes 1* (ASTHO, July 2006).

After Hurricane Katrina struck, the federal government encouraged interstate licensure reciprocity to ensure that sufficient health items and services were available to meet the needs of individuals enrolled in the Medicare, Medicaid and SCHIP programs. The Secretary of Health and Human Services executed a waiver of all requirements that physicians and other health practitioners hold

licenses in the state in which they provide services if they had a license from another state. The American Medical Association also urged its physicians and other medical professionals with any state license to commit to short-term, long-term or rotating coverage, emphasizing that their services were “urgently needed.” *HHS Coordinating Volunteer Physicians to Help Hurricane Katrina Victims* (AMA Press Release, September 2, 2005).

While the magnitude of the emergency presented by Hurricanes Katrina and Rita 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 health 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 health practitioners. In fact, there exist major legal gaps and deficiencies that may stymie, rather than encourage, widespread volunteer health practitioner activities during emergencies. The U.S. Congress continues to examine some of these gaps through the introduction of multiple bills since September, 2005. It has also 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 health 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 of 2001 developed by the *Center for Law and the Public’s Health at Georgetown and Johns Hopkins Universities*) also provide for interstate health licensure recognition in many jurisdictions. A number of state disaster management laws also provide broad authority to waive other legal or regulatory requirements during emergencies, including licensing requirements for health practitioners.

Unfortunately, no uniform system exists to efficiently and expeditiously recognize licensing privileges for health practitioners on an interstate basis. 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 health practitioners following Hurricanes Katrina and Rita. This act seeks to remedy these deficiencies.

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

- Ø 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;
- Ø 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
- Ø Even the best single-state bill cannot anticipate or reflect the valid concerns of other states.

The Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) provides uniform legislative language to facilitate organized response efforts among volunteer health practitioners. UEVHPA's provisions address the following:

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

UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT

SECTION 1. SHORT TITLE. This [act] may be cited as the Uniform Emergency Volunteer Health Practitioners Act.

SECTION 2. DEFINITIONS. In this [act]:

(1) “Disaster relief organization” means an entity that provides emergency or disaster relief services that include health or veterinary services provided by volunteer health practitioners and that:

(A) is designated or recognized as a provider of those services pursuant to a disaster response and recovery plan adopted by an agency of the federal government or [name of appropriate governmental agency or agencies]; or

(B) regularly plans and conducts its activities in coordination with an agency of the federal government or [name of appropriate governmental agency or agencies].

(2) “Emergency” means an event or condition that is an [emergency, disaster, or public health emergency] under [designate the appropriate laws of this state, a political subdivision of this state, or a municipality or other local government within this state].

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

(4) “Emergency Management Assistance Compact” means the interstate compact

approved by Congress by Public Law No. 104-321, 110 Stat. 3877 [cite state statute, if any].

(5) “Entity” means a person other than an individual.

(6) “Health facility” means an entity licensed under the laws of this or another state to provide health or veterinary services.

(7) “Health practitioner” means an individual licensed under the laws of this or another state to provide health or veterinary services.

(8) “Health services” means the provision of treatment, care, advice or guidance, or other services, or supplies, related to the health or death of individuals or human populations, to the extent necessary to respond to an emergency, including:

(A) the following, concerning the physical or mental condition or functional status of an individual or affecting the structure or function of the body:

(i) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care; and

(ii) counseling, assessment, procedures, or other services;

(B) sale or dispensing of a drug, a device, equipment, or another item to an individual in accordance with a prescription; and

(C) funeral, cremation, cemetery, or other mortuary services.

(9) “Host entity” means an entity operating in this state which uses volunteer health practitioners to respond to an emergency.

(10) “License” means authorization by a state to engage in health or veterinary services that are unlawful without the authorization. The term includes authorization under the laws of this state to an individual to provide health or veterinary services based upon a national certification issued by a public or private entity.

(11) “Person” means an individual, corporation, business trust, trust, partnership, limited liability company, association, joint venture, public corporation, government or governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.

(12) “Scope of practice” means the extent of the authorization to provide health or veterinary services granted to a health practitioner by a license issued to the practitioner in the state in which the principal part of the practitioner’s services are rendered, including any conditions imposed by the licensing authority.

(13) “State” means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States.

(14) “Veterinary services” means the provision of treatment, care, advice or guidance, or other services, or supplies, related to the health or death of an animal or to animal populations, to the extent necessary to respond to an emergency, including:

(A) diagnosis, treatment, or prevention of an animal disease, injury, or other physical or mental condition by the prescription, administration, or dispensing of vaccine, medicine, surgery, or therapy;

(B) use of a procedure for reproductive management; and

(C) monitoring and treatment of animal populations for diseases that have spread or demonstrate the potential to spread to humans.

(15) “Volunteer health practitioner” means a health practitioner who provides health or veterinary services, whether or not the practitioner receives compensation for those services. The term does not include a practitioner who receives compensation pursuant to a preexisting employment relationship with a host entity or affiliate which requires the practitioner to provide health services in this state, unless the practitioner is not a resident of this state and is employed by a disaster relief organization providing services in this state while an emergency declaration is in effect.

Legislative Notes

Definition of “emergency”: The terms “emergency,” “disaster,” and “public health emergency” are the most commonly used terms to describe the circumstances that may lead to the issuance of an emergency declaration referred to in this [act]. States that use other terminology should insert the appropriate terminology into the first set of brackets. The second set of brackets should contain references to the specific statutes pursuant to which emergencies are declared by the state or political subdivisions, municipalities, or local governments within the state.

Definition of “emergency declaration”: The references to declarations issued by political subdivisions, municipalities or local governments should be used in states in which these entities are authorized to issue emergency declarations.

Definition of “state”: A state may expand the reach of this [act] by defining this term to include a

foreign country, political subdivision of a foreign country, or Indian tribe or nation.

Comment

1. A **disaster relief organization** is an entity that provides disaster relief services or assistance in response to an emergency declaration. For example, the American Red Cross may be viewed as a disaster relief organization. Other members of the National Voluntary Organizations Active in Disaster, Inc. (NVOAD) that provide similar services may also be considered disaster relief organizations. Also, pursuant to the definition of "volunteer health practitioner", a preexisting employment relationship with its members does not compromise their volunteer status. Under this Act, however, the protections afforded are limited to those members engaged in the provision of health or veterinary services, as distinct from general disaster relief services.
2. An **emergency** is broadly defined to encompass the array of circumstances that may give rise to an emergency declaration at the state, or in states in which the optional language in the definition is selected, the local level. Although nearly every state has defined the conditions that constitute a "general emergency" or "disaster," many states have not incorporated a "public health emergency" within their legal framework. Other states may use different terminology (e. g., catastrophe, crisis) to describe an emergency. In such cases, this different terminology should be substituted for the language in the definition. The particular emergency circumstances that warrant invocation of this Act and the appropriate response are left to the discretion of the state legislative or administrative authority. No matter how a state defines "emergency," its declaration is the trigger through which the protections of this Act go into effect.
3. An **emergency declaration** pursuant to Section 3 activates the response and recovery efforts at the state, or, in states in which the optional language in the definition is selected, local level. Such a declaration also invokes the provisions of this Act related to the use, deployment, and protection of volunteer health practitioners who comply with the provisions of this Act.
4. The **Emergency Management Assistance Compact (EMAC)** provides for mutual assistance between states entering into compacts to manage declared emergencies. Under Section 9, the Act supplements the implementation of EMAC by states without imposing requirements for the use of volunteer health practitioners, and it encourages their incorporation into response efforts through mutual aid agreements.
5. An **entity** may include any form of private organization or artificial legal person but does not include an individual.
6. A **health facility** is an entity engaged in the provision of health or veterinary services in its ordinary course of business or activities. The term does not include individual health

practitioners.

7. A **health practitioner** is an individual, not an entity, who is licensed in any state, including the host state, to provide health or veterinary services or who holds a national certificate that is recognized by the host state as equivalent to licensure for purposes of providing health services to individuals or human populations or veterinary 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 services during emergencies, nor does it imply or suggest that nonveterinarians are authorized to provide veterinary services.

8. **Health 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 provided by volunteer health practitioners that relate to the health or death of individuals or populations and that are necessary to respond to an emergency. They include direct patient health services, public health services, provision of pharmaceutical products, and mortuary services for the deceased. On an individual level, health services include transportation, diagnosis, treatment, and care for injuries, illness, diseases, or pain related to physical or mental impairments. On the population level, health 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. Nonhealth services are services that do not provide direct health benefits to individuals or populations. For example, ancillary services (e.g., administrative tasks, medical record keeping, transportation of medical supplies) are not health services.

9. A **host entity** is a health entity, disaster relief organization, or other entity that uses volunteer health practitioners to provide health or veterinary services during an emergency. Unlike entities that facilitate the use or deployment of volunteers or source entities (through which the volunteers may be employed or sent), the host entity is responsible for actually delivering health services to individuals or human populations or veterinary services to animals or animal populations during the emergency. Host entities may thus include disaster relief organizations, hospitals, clinics, emergency shelters, doctors' offices, outpatient centers, or any other places where volunteer health practitioners may provide health or veterinary services. Host entities have the authority under Section 8(d) to restrict the types of services that volunteer health practitioners may provide.

10. A **license** is distinct from certification or other recognition that may be used to designate competency in a particular profession or area of practice. It is a state-granted designation that regulates the scope of practice. Licensing laws prohibit unlicensed persons from providing services reserved for licensed practitioners. An authorization to provide health or veterinary

services pursuant to a national certification is included in the definition to clarify that a tangible certificate or prior government authorization may not in some circumstances be necessary for a governmental permission to constitute a license. Nothing in this definition, however, is intended to allow individuals holding national certifications to provide health or veterinary services except as otherwise authorized by law. Instead, pursuant to Sections 8(a) and (e), an individual holding a national certification may function as a volunteer health practitioner only to the extent authorized to do so by the laws of the state in which the individual primarily practices and by the laws of the host state in which an emergency is declared.

11. A **person** is defined broadly to encompass individuals and entities.

12. The **scope of practice** is established by licensure boards of the state in which a practitioner is licensed and primarily engages in practice. The scope of practice also includes any conditions that may be imposed on the practitioner's authorization to practice, including instances where state law recognizes the existence of a license but declares practice privileges to be "inactive." This Act defers to relevant state laws to determine whether a practitioner with an inactive license may serve as a volunteer health practitioner. To the extent the law or the state in which an individual is licensed and primarily engages in practice allows a practitioner with an inactive license to practice, either generally, only during emergencies, or only in a volunteer capacity, such an individual may practice in a "host state" consistent with the requirements of this Act. On the other hand, if the law of the state in which an individual is licensed only allows an individual with an inactive license to practice if the license is renewed or reactivated (typically by satisfying continuing education requirements and paying additional registration fees), then the individual may only function as a volunteer health practitioner following the renewal or activation of the license.

13. A **state** is any territory or insular possession subject to the jurisdiction of the United States. States implementing this Act may also choose to include within the definition of "state" an Indian tribe, nation, or foreign government and its political subdivisions.

14. **Veterinary services** are services pertaining to the health or death of animals or animal populations as distinct from health services provided to humans or human populations.

15. A **volunteer health practitioner** is an individual who voluntarily provides health or veterinary services during a declared emergency. Unlike many existing federal and state legal definitions of volunteers that require the individual act without compensation, this definition and the Act contain no such requirement. Thus, the volunteer status of a health practitioner is not compromised by any compensation awarded to the practitioner prior to, during the course of, or subsequent to the declared emergency. Such compensation, however, must not arise from a preexisting employment relationship with a host entity or affiliate unless the practitioner does not reside in the state in which the emergency is declared and is employed by a disaster relief

organization providing health or veterinary services in that state while an emergency declaration is in effect.

This definition is inapposite to many existing legal definitions of “volunteer” that often characterize a volunteer as an individual who does not receive compensation for services. The federal Volunteer Protection Act (VPA) affords volunteers various protections (including from civil liability), but they cannot be compensated beyond reimbursement for expenses incurred or minimal compensation. *See* 42 U.S.C. § 14505(6). In Colorado, for example, a volunteer may not receive compensation other than reimbursement for actual expenses incurred. C.R.S. 13-21-115.5 (3)(c)(I). This characterization also holds in many states that afford civil liability protections for volunteers. In Delaware, for example, only “medical providers who provide their services without compensation” are entitled to liability protections as volunteer health practitioners. 10 Del. C. § 8135 (c)(1) (2006).

This definition recognizes, however, that the principal basis for defining a volunteer health practitioner is not whether the practitioner is compensated but whether the practitioner’s actions are volitional. In other words, compensation outside an employment relationship with a host entity is inconsequential in establishing whether an individual is or is not a volunteer. What matters is that the volunteer is acting freely in choosing to provide health or veterinary services in emergency circumstances. This definition thus expands the pool of potential volunteer health practitioners who may enjoy the protections of this act to those who may be compensated in some way

Part of the justification for this more expansive view of voluntarism relates to the positive effects of compensation to support volunteers during emergencies. Many prospective volunteer health practitioners are licensed individuals working in existing health facilities. They may seek to volunteer knowing that their existing employers will continue to compensate them even while they are away. The volunteers may be able to use their sick or vacation days for this purpose, or their employers may simply allow them to volunteer without using these benefits. Some disaster relief organizations may provide some nominal sums to volunteer health practitioners to support their efforts. Compensation in these or other instances encourages certain individuals, who may not otherwise be able to act, to involve themselves in relief efforts.

Many disaster relief entities may receive reimbursement for expenses incurred or services provided through particular government agencies. Sometimes, such expenditures can impede the participation of major volunteer organizations. The MRC, for example, reported that one barrier to the participation of some of its local units was that they were “not eligible for Federal Emergency Management Agency reimbursement for services rendered in an emergency (American Red Cross and Salvation Army are currently eligible).” *Medical Reserve Corps Hurricane Response Final Report* 18 (March 13, 2006). The Administration on Aging (AoA) reiterated that health providers “need to be reimbursed for care provided to patients in hurricane-affected areas and evacuee areas.” *Summary of Federal Payments Available for Providing Health Care Services to Hurricane Evacuees and Rebuilding Health Care Infrastructure 2* (Agency on Aging, October 2005). This is particularly necessary to “facilitate their ongoing operations and compensate for additional costs and unanticipated utilization of services.”

A preexisting employment relationship with a host entity to provide health or veterinary services in the host state precludes a health practitioner from being a “volunteer” for purposes of the act. This is distinct from the mere provision of compensation because the practitioner is adhering to the terms of the employment contract. This is significant for a number of reasons. First, an individual cannot concurrently be an employee and a volunteer within a host entity. This would obfuscate the legal obligations and protections afforded under existing state laws. An employee has a duty to provide services that stems from the employment relationship.

Second, dual status as an employee and volunteer would undermine the purpose of, and protections afforded under, this act. The purpose of the act is to create an environment that integrates volunteer health practitioners into an emergency response. Converting employees into volunteers would be inconsistent with this objective by potentially negating preexisting duties of health practitioners. A health practitioner that was previously obligated to provide a particular service because of an employment relationship should not be encouraged to abscond from that responsibility upon the declaration of an emergency.

A unique situation may arise where a corporation conducts its business through multiple locations and deploys staff to provide health or veterinary services at a site that has been affected by the emergency. A pharmaceutical chain, for example, may have thousands of locations throughout the United States, each of which is owned by the corporation. Each employee at any store location is an employee of the larger corporation. During a large-scale event, some of the chain’s stores could be overwhelmed with demands for prescription orders from existing and new patients. The corporation might seek to deploy pharmacists from out-of-state to voluntarily assist in stores within the geographic area impacted by the emergency. During a declared emergency, these pharmacists would qualify as “volunteer health practitioners.” The employees that were under a preexisting employment contract with the store in the host state that received the assistance, however, would still be employees subject to the terms of their relationship with the corporation. These employees would not be considered volunteers due to their preexisting employment obligation to provide services in the host state.

The current definition waives the preexisting-employment exemption for out-of-state employees of disaster relief organizations. Disaster relief organizations are often nonprofit organizations that are self-sustaining and must unilaterally bear the costs associated with their efforts. This definition is in accord with the nature and role of disaster relief organizations in an emergency response and existing federal statutes acknowledging the same. The purpose of this exception is not to create a special class of employees but rather to recognize the vital role of disaster relief organizations that are asked by state or local authorities to oversee and manage emergency response efforts.

SECTION 3. APPLICABILITY TO VOLUNTEER HEALTH PRACTITIONERS. This [act]

applies to volunteer health practitioners registered with a registration system that complies with

Section 5 and who provide health or veterinary services in this state for a host entity while an

emergency declaration is in effect.

Comment

Under existing state and local laws, an emergency is initiated with its declaration (as determined in accordance with existing state or local laws) and is terminated usually upon subsequent proclamation by an authorized state or local agency or official. The legal landscape for responding to natural disasters, public health threats, or other exigencies changes instantly with the declaration of a state of emergency. Accommodations must be made to ensure the efficient deployment and use of volunteer health practitioners to meet surge capacity in existing health facilities, emergency shelters, or other places where health or veterinary services are needed. This section authorizes volunteer health practitioners to provide health or veterinary services for the duration of the emergency and must be interpreted *in pari materia* with the other provisions of this act. As a result, this section only authorizes volunteer health practitioners to provide health 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.

This act applies only during the declared emergency, and thus a state that wants to invoke its provisions in anticipation of an impending disaster so that volunteer health practitioners are more readily available when the disaster occurs must declare an emergency under laws of the state other than this act.

SECTION 4. REGULATION OF SERVICES DURING EMERGENCY.

(a) While an emergency declaration is in effect, [name of appropriate governmental agency or agencies] may limit, restrict, or otherwise regulate:

- (1) the duration of practice by volunteer health practitioners;
- (2) the geographical areas in which volunteer health practitioners may practice;
- (3) the types of volunteer health practitioners who may practice; and
- (4) any other matters necessary to coordinate effectively the provision of health or veterinary

services during the emergency.

(b) An order issued pursuant to subsection (a) may take effect immediately, without prior notice or comment, and is not a rule within the meaning of [state administrative procedures act].

(c) A host entity that uses volunteer health practitioners to provide health or veterinary services in this state shall:

(1) consult and coordinate its activities with [name of the appropriate governmental agency or agencies] to the extent practicable to provide for the efficient and effective use of volunteer health practitioners; and

(2) comply with any laws other than this [act] relating to the management of emergency health or veterinary services, including [cite appropriate laws of this state].

Comment

While Section 3 authorizes volunteer health practitioners to provide health or veterinary services during a declared emergency, Section 4(a) clarifies that these services may be subject to limits, restrictions, or regulations set forth by the appropriate emergency management or public health agency that is responsible for overseeing or managing emergency response efforts. These limits, restrictions, or regulations may relate to (1) the duration of practice by volunteer health practitioners, (2) the geographical areas in which volunteer health practitioners may practice, (3) the class or classes of volunteer health practitioners who may practice, and (4) any other matters necessary to coordinate effectively the provision of health or veterinary services. New Jersey, for example, provides that the Governor shall issue an order that specifies the geographic area subject to the declaration, the conditions that brought about the emergency, and its expected duration. N.J. § 26:13-3 (a) (2006). The New Jersey Commissioner of Health and Senior Services is also required to coordinate the response between state and local authorities and collaborate with relevant federal government authorities and private organizations and companies. *Id.* at (c). Additional restrictions concerning the services provided by volunteer health practitioners by the state licensing board or other agency that regulates health practitioners are also permitted during the emergency pursuant to Section 8(c).

Under subsection (c)(1), host entities are required to consult and coordinate their activities with the agency(ies) responsible for managing the emergency response to ensure that all volunteer health practitioners are being used in an efficient and effective manner. Section 10 provides each specified agency with authority to promulgate regulations that spell out what is required of host entities to meet this requirement. The regulations might, for example, require that host entities provide the agency, as practicable given the circumstances, a list of the volunteer health practitioners available and their specialties so that the agency can order their deployment strategically as part of its overall response plan. During the response to Hurricane Katrina, medical and public health professionals had to improvise and use their own initiative because efforts to deploy them from staging areas were extremely time-consuming and failed to adequately get them to areas where their services were most needed. *The Federal Response to Hurricane Katrina: Lessons Learned* 46 (The White House, February 2006). Subsection (c)(1) ensures that all volunteer health practitioners are acting in concert to secure the public health objective(s) as set forth by the appropriate state or local agency. It precludes host entities and the volunteers that provide care under them from acting pursuant to their own judgments where such judgments may conflict with the objectives as set forth by the appropriate government agency.

Under subsection (c)(2), host entities must adhere to all laws relating to the management of emergency health or veterinary services. This caveat builds upon subsection (c)(1) by setting the initial parameters of conduct during the emergency response. Namely, the laws relating to the management of health or veterinary services in the host state shall govern unless they are modified or restricted by the appropriate state agency(ies) pursuant to Section 8.

SECTION 5. VOLUNTEER HEALTH PRACTITIONER REGISTRATION SYSTEMS.

(a) To qualify as a volunteer health practitioner registration system, a system must:

(1) accept applications for the registration of volunteer health practitioners before or during an emergency;

(2) include information about the licensure and good standing of health practitioners which is accessible by authorized persons;

(3) be capable of confirming the accuracy of information concerning whether a health practitioner is licensed and in good standing before health services or veterinary services are provided under

this [act]; and

(4) meet one of the following conditions:

(A) be an emergency system for advance registration of volunteer health-care practitioners established by a state and funded through the Health Resources Services Administration under Section 319I of the Public Health Services Act, 42 USC Section 247d-7b [as amended];

(B) be a local unit consisting of trained and equipped emergency response, public health, and medical personnel formed pursuant to Section 2801 of the Public Health Services Act, 42 U.S.C. Section 300hh [as amended];

(C) be operated by a:

(i) disaster relief organization;

(ii) licensing board;

(iii) national or regional association of licensing boards or health practitioners ;

(iv) health facility that provides comprehensive inpatient and outpatient health-care services, including a tertiary care and teaching hospital; or

(v) governmental entity; or

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

(b) While an emergency declaration is in effect, [name of appropriate agency or agencies], a person authorized to act on behalf of [name of governmental agency or agencies], or a host entity, may confirm whether volunteer health practitioners utilized in this state are registered with a registration system that complies with subsection (a). Confirmation is limited to obtaining identities of the practitioners from the system and determining whether the system indicates that the practitioners are licensed and in good standing.

(c) Upon request of a person in this state authorized under subsection (c), or a similarly authorized person in another state, a registration system located in this state shall notify the person of the identities of volunteer health practitioners and whether the practitioners are licensed and in good standing.

(d) A host entity is not required to use the services of a volunteer health practitioner even if the practitioner is registered with a registration system that indicates that the practitioner is licensed and in good standing.

Legislative Note: *If this state uses a term other than “hospital” to describe a facility with similar functions, such as an “acute care facility”, the final phrase of subsection (b)(4) should include a reference to this type of facility – for example, “including a tertiary care, teaching hospital, or acute care facility.”*

Comment

A registration system is defined in subsection (a) to clarify the types of systems of volunteer health practitioners that may qualify its registrants for the protections of this act during emergencies. These systems are akin to existent registries used by states during a public health emergency. In New Jersey, for example, the commissioner is authorized to establish a registry of health practitioners, public health workers, and volunteers within its Emergency Health Care Provider

Registry. Members may be required to fulfill training requirements related to the provision of such services as a condition of registration. N.J. Stat. § 26:13-6 (2006). Many state health departments or their relevant divisions maintain electronic registries that allow prospective volunteers to register online. Wisconsin's Division of Public Health, for example, maintains the Wisconsin Emergency Assistance Volunteer Registry (WEAVR), a secure electronic database within its Health Alert Network and Public Health Information Network (with funding from the Health Resources and Services Administration (HRSA), a division of the federal Department of Health and Human Services (DHHS), as part of its Emergency System for Advance Registration of Volunteer Health Professionals Program (ESAR-VHP)).

Although the qualities and design of these registration systems may vary, some essential components are set forth, including that the system must (1) facilitate the registration of volunteer health practitioners *prior* to, or during, the time their services may be needed; (2) include organized information about the volunteers that is accessible by authorized personnel; and (3) be capable of being used to verify the accuracy of information concerning whether the volunteers are licensed and in good standing.

Under subsection (a)(1), the requirement to facilitate registration prior to, or during, the time services is needed is necessary to (1) discourage the deployment of non-registered "spontaneous volunteers" at the time of a disaster, (2) encourage practitioners to register in advance of emergencies, and (3) give practitioners, if the system so provides, the opportunity to obtain specialized training appropriate to the provision of health or veterinary services in emergencies. This allows volunteers to integrate themselves into the existing response efforts and enables the managing agency to efficiently deploy forces to the appropriate affected areas.

In Oklahoma, shelters were set up to receive up to 5,000 evacuees from areas impacted by Hurricane Katrina in 2006. The Oklahoma State Department of Health, however, did not have the manpower to fully staff these shelters. To meet surge capacity, members of the state's MRC units were contacted through the state-managed database, issued state identification, and deployed in a single day. *State Mobilization of Health Personnel During the 2005 Hurricanes 6* (ASTHO, July 2006). Moreover, the state utilized the MRC website to process over 3,000 calls from potential volunteers and track volunteers that had been deployed. This led to their effective utilization. As one commenter noted, "[v]olunteer physicians are most effective following a disaster if they understand the importance of re-establishing the needed infrastructure, and if they arrive on scene as part of an organized response, having been trained in disaster medicine and public health." Doug Campos-Outcalt, *Disaster Medical Response: Maximizing Your Effectiveness*, *Journal of Family Practice* 2006;55(2): 113. Other examples underscore the vital roles that such organizations play in emergency response efforts.

The National Medical Reserve Corps office reported that one important factor that contributed to its success in response to Hurricane Katrina was that its "teams of volunteers were identified, credentialed, trained, and prepared in advance of the emergency." *Medical Reserve Corps*

Hurricane Response Final Report 2 (March 13, 2006). The American Medical Association (AMA) collaborated with Dr. David J. Brailer, National Coordination for Health Information Technology, to expand KatrinaHealth.org, an electronic database of prescription medical records through which authorized pharmacists and physicians can access records of medications evacuees were using before the storm hit, including specific dosages. A report that summarized the implementation challenges in utilizing KatrinaHealth included variations across states and between institutions which can “create havoc when disasters, evacuees, and volunteer providers cross jurisdictional boundaries.” *Lessons from KatrinaHealth 19* (June 13, 2006). Few mechanisms existed to coordinate the large number of health practitioners willing to volunteer. In Dallas, emergency medical providers ultimately created “a new care network on the fly;” in Houston, they used the medical school’s existing open-source courseware to post messages and exchange information. *Lessons from KatrinaHealth 20* (June 13, 2006). Despite the publicized numbers of registered federal volunteers, a doctor who worked in three different shelters and makeshift clinics in Mississippi for a total of thirty-four days reported that “these measures did not solve the coordination issues on the ground.” *Lessons from KatrinaHealth 21* (June 13, 2006).

As of February 2006, the American Nurses Association (ANA) reported that there was still a need for mental health and substance abuse registered nurses (RNs) in affected regions. The ANA collaborated with the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to recruit licensed RNs with expertise in mental health and substance abuse treatment. In total, the ANA recruited over 100 psychiatric/mental health or gerontological RNs to work with SAMHSA.

The National Association of County and City Health Officials (NACCHO) examined the response of five local health departments that assisted evacuees fleeing the Gulf coast in the wake of Hurricane Katrina. Although there were ample volunteers to assist in the recovery efforts, NACCHO observed that their contributions were not sufficiently planned and coordinated. “[P]rior and just-in-time training, assessment of knowledge and skills, and systematic assignments all must improve.” *Shelter from the Storm: Local Public Health Faces Katrina 22* (NACCHO, February 2006). NACCHO further noted that “a greater national calamity, such as a smallpox outbreak, would require human resources beyond what public health professionals could deliver on their own.” *Shelter from the Storm: Local Public Health Faces Katrina 22* (NACCHO, February 2006).

To improve the state’s ability to respond to a disaster, the Massachusetts Department of Public Health (DPH) has begun registering physician and registered nurse volunteers in its System for Advance Registration of Volunteer Health Professionals (MSAR). DPH’s hospital preparedness coordinator emphasized that “it is vitally important to identify, register, and pre-credential volunteers *prior* to a disaster.” *Vital Signs* (Publication of the Massachusetts Medical Society, Section on Public Health, 2006).

It is thus critical that health departments at the state and local levels be able to coordinate volunteers and collaborate with all available entities to ensure an efficient and effective response.

This section fosters collaboration by establishing minimal system requirements and encouraging prior registration to facilitate the rapid deployment of volunteer health practitioners.

Spontaneous volunteers have, on occasion, stymied emergency response efforts and added to the existing burden facing health practitioners in charge of overseeing a specific disaster site. HRSA noted that after the attacks on September 11, 2001, thousands of spontaneous volunteers presented themselves at ground zero in New York City to provide medical assistance. In most cases, however, authorities were unable to distinguish qualified personnel from those that were not qualified. *See ESAR-VHP Interim Technical and Policy Guidelines, Standards, and Definitions* Section 1.2 (HRSA, June 2005). The unsolicited presentation of volunteers coupled with the lack of a coordinated mechanism to integrate their services reduced the effectiveness of the overall response effort. A former Director of New York's Emergency Management Office, observed that "[V]olunteers just show[ed] up ... To accommodate them we had to set up another city. We had to feed them and take care of sanitation and other things. But we just couldn't use them." *Id.* Prior registration enables agencies to request, receive, and deploy the necessary volunteer personnel to wherever their services are required and integrate themselves into the ongoing response efforts.

This Act does not, however, mandate prior registration in recognition of the possibility that large scale disasters may create needs for more practitioners than those who register in advance. This is evident from response efforts for Hurricane Andrew in 1993 and the four storms during the hurricane season that struck Florida in 2004. In neither situation were response efforts completely sufficient to alleviate public health and individual health concerns. The large scale mortality and morbidity caused by Hurricane Katrina further demonstrated that what may be perceived as adequate preparation cannot compensate for unforeseeable circumstances. *Katrina as Prelude: Preparing for and Responding to Future Katrina-Class Disturbances in the United States*, p.5, Testimony before the U.S. Senate Homeland Security and Governmental Affairs Committee submitted by Herman B. Leonard and Arnold M. Howitt (March 8, 2006). Therefore, a registration system must be able to allow volunteers to register during an emergency, as well as prior thereto.

ESAR-VHP is listed in subsection (a)(4)(A) as an example of a registration system that provides organized information to ensure an accurate assessment of a volunteer health practitioner's ability to provide health services during an emergency. These systems have arisen from a federal grant program authorized by Section 107 of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002. Congress directed DHHS to "establish and maintain a system for the advance registration of health professionals, for the purpose of verifying the credentials, licenses, accreditations, and hospital privileges of such professionals when, during public health emergencies, the professionals volunteer to provide health services." In response, HRSA created the ESAR-VHP Program to assist states and U.S. territories to develop their emergency registration systems through the provision of grants and guidance. HRSA has distributed resources to nearly every state and many U.S. territories and developed guidelines and standards for these systems. Jurisdictions are responsible for designing, developing, and administering their respective systems consistent with federal guidelines. Thus, ESAR-VHP is not a federal system, but rather a national system of jurisdiction-based emergency volunteer registries.

Under subsection (a)(4)(B), a registration system operated by a Medical Reserve Corps (MRCs) is also sufficient. The MRCs program was created in 2002 as a community based and specialized component of Citizen Corps, part of the USA Freedom Corps initiative launched in January, 2002. The program's purpose is to pre-identify, train, and organize volunteer medical and public health practitioners to render services in conjunction with existing local emergency response programs. There are presently 408 MRCs across the nation in ten regions. Some states explicitly reference MRC units via statutes that afford protection to volunteer health practitioners during an emergency. These states include Connecticut (Conn. Gen. Stat. § 19a-179b), North Carolina (N.C. Gen. Stat. § 1-539.11), Oklahoma (59 Okl. St. § 493.5, and 76 Okl. St. § 32), Utah (Utah Code. Ann. § 26A-1-126), and Virginia (Va. Code Ann. §§ 2.2-3601, 2.2-3605, 32.1-48.016, and 65.2-101). MRC units consist of personnel with and without a background in health services. The "medical" component of the units does not limit membership to medical professionals. Individuals without medical training are permitted to join and fill essential supporting roles. The protections of this act, however, only extend to volunteer health practitioners who are duly registered under Section 4 and adhere to the scope of practice requirements pursuant to Section 8.

For host entities that use interstate volunteer health practitioners, the interoperability of registration systems is imperative to allow efficient data sharing and thereby ensure a timely response effort. The minimum data elements of the ESAR-VHP system, for example, include a practitioner's name, contact information, degree(s), hospital(s) in which the individual enjoys privileges, specialty(ies), state license number, state license board check of disciplinary actions taken against the licensee, National Practitioner Databank check of liability actions, date of last reappointment, and status of the license (e.g., active, inactive or retired). States establishing ESAR-VHP registration systems may choose to expand on these elements and also include the volunteer's choice of service (e.g., distance willing to travel, maximum duration of service, type of disaster), immunization status, languages spoken, photograph, disaster training or education, special qualifications, and public health experience. Additional considerations in developing and implementing a registration system may include security safeguards, privacy concerns, and the accessibility of data by authorized personnel.

Subsection (a)(4)(C) approves registration systems operated by disaster relief organizations, licensing boards, national and regional associations of licensing boards or health practitioners, or governmental entities. As used here, regional is a subset of national and means a multistate association of licensing boards or health practitioners. The entities listed typically use registration systems in their ordinary course of business or activities.

Subsection (a)(4)(C) also approves registration systems operated by comprehensive health facilities, which include public or private (for-profit or nonprofit) facilities that provide comprehensive inpatient or outpatient services on a regional basis. As used here, regional means that the facility draws from an extensive patient base that exceeds a single, small local community. A comprehensive health facility is distinguishable from a health entity by the breadth of its health

services as well as its regional base. As indicated in the act, this includes tertiary care and teaching hospitals. For purposes of this act, a registration system operated by such entities is subject to all the requirements of subsection (a)(1)-(3).

Subsection (a)(4)(D) authorizes the appropriate state agency or agencies to designate for the purposes of this act a registration system other than those set forth in subsections (a)(4)(A)-(C), provided these systems meet the essential requirements in subsection (a)(1)-(3).

Subsection (b) permits a state agency or its designee, or a host entity, to confirm the identity and status within a registration system of a volunteer health practitioner. Confirmation is strongly recommended, but not required, noting that potential exigencies may prevent confirmation in some instances. Confirmation is limited to identification and an assessment of good standing of volunteer health practitioners within the system. This provision is a security safeguard that allows state officials to ensure that volunteer health practitioners capable of providing health or veterinary services during an emergency are appropriately registered with a registration system. Another purpose of this provision is to prevent fraudulent attempts or acts of unlicensed individuals posing as qualified volunteer health practitioners during emergencies. The primary purpose, however, is to ensure the timely approval of registered volunteer health practitioners to provide health or veterinary services to individuals or populations affected by an emergency.

Subsection (b) does not, however, authorize states to review and approve the credentials and qualifications of individual volunteers or to establish requirements on a state-by-state basis to confirm the registration of volunteers. These authorizations or requirements may undermine a fundamental goal of the act to establish uniformity across states for the recognition of volunteer health practitioners that can function automatically if necessary (e.g. communications are disrupted) and access to state officials to secure authorizations is impossible or impractical during an emergency.

Cases may arise where personnel authorized to manage the emergency response are unaware of the identities of volunteer health practitioners and whether they are licensed or in good standing. Subsection (c) mandates any entity that uses a registration system to provide, upon request of an authorized person, the names of all volunteer health practitioners within the system and the most current status of their licensure and standing. This provision empowers authorized personnel to directly acquire information pertaining to the identities and qualifications of volunteers without resorting to additional requests or alternative procedures that may hinder the response efforts.

Subsection (d) grants host entities the authority to choose whether or not they will engage the services of a volunteer health practitioner in response to an emergency declaration. The decision to use a volunteer is not predicated on the mere affirmation of licensure and good standing. There may be many reasons why a host entity chooses not to use the services of a particular practitioner or class of practitioners. This may include, for example, ample availability of existing full-time or part-

time employees or volunteers that are required to provide a particular service. As well, a host entity is under no legal obligation to engage the services of a volunteer aside from any pre-existing agreements that may have been entered into by the relevant parties. This act does not set any additional requirements beyond those imposed upon individuals or entities that seek to avail themselves of the privileges and protections of the act.

SECTION 6. RECOGNITION OF VOLUNTEER HEALTH PRACTITIONERS LICENSED IN OTHER STATES.

(a) While an emergency declaration is in effect, a volunteer health practitioner, registered with a registration system that complies with Section 5 and licensed and in good standing in the state upon which the practitioner's registration is based, may practice in this state to the extent authorized by this [act] as if the practitioner were licensed in this state.

(b) A volunteer health practitioner qualified under subsection (a) is not entitled to the protections of this [act] if the practitioner is licensed in more than one state and any license of the practitioner is suspended, revoked, or subject to an agency order limiting or restricting practice privileges, or has been voluntarily terminated under threat of sanction.

Comment

This Section addresses the need for licensure recognition of volunteer health practitioners who are licensed outside the state in which an emergency is declared. Out-of-state volunteers can be a critical resource to meet surge capacity in the host jurisdiction. Some states have enacted laws recognizing interstate licensure reciprocity. The Louisiana Health Emergency Powers Act, R.S. 29:769(e), provides for the temporary registration of certain health providers licensed in another jurisdiction of the United States. Louisiana's Department of Health and Hospitals may now issue temporary registrations to "licensed, certified, or registered" health practitioners in another jurisdiction whose licenses, certifications or registrations are "current and unrestricted and in good standing..." R.S. 29:769(e)(1). According to the *Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities*, at least 13 other jurisdictions have passed legislation since 2001 to similarly authorize interstate licensure recognition during declared emergencies. Absent recognition of their licensure status during the emergency, however, these practitioners may

not be authorized to perform health or veterinary services in the state.

Subsection (a) provides that a host state shall recognize the out-of-state license of a volunteer health practitioner as being of equivalent status to a license granted by the host state's licensure board during an emergency. This is subject to all of the requirements of the act, including requirements that (1) the volunteer health practitioner be duly licensed in another state and in good standing; (2) that an emergency exist (as defined in Section 2(2)); (3) that the practitioner be registered with a registration system; and (4) that the practitioner comply with the scope of practice limitations imposed by the act, the laws of the host state, and any special modifications or restrictions to the normal scope of practice imposed by the host state or host entity pursuant to Section 8.

Interstate licensure recognition is essential to facilitate volunteer deployment during emergencies. The American Red Cross (ARC) reported over 219,500 Red Cross disaster relief workers from all fifty states, Puerto Rico, and the Virgin Islands responded to Hurricane Katrina. *Facts at a Glance: American Red Cross Response to Hurricane Katrina and Rita* (January 19, 2006). The MRC reported that over 1,500 MRC members were willing to deploy outside their local jurisdiction on optional missions to the disaster-affected areas with their states agencies; almost 200 volunteers from 25 MRC units were activated by HHS, and over 400 volunteers from 80 local MRC units were deployed to support the ARC disaster operations in Gulf Coast areas. *Medical Reserve Corps Hurricane Response Final Report 1* (March 13, 2006).

The American Public Health Association (APHA) reported that health volunteers from New York, South Carolina, and Florida were deployed to Mississippi after Hurricane Katrina struck. According to Roger Riley, the past president of the Mississippi Public Health Association, "the Florida Department of Public Health was a particular godsend" as it provided employees, mobile clinics, and other vital support. *The Nation's Health* (APHA October 2005). APHA also helped link public health workers with organizations seeking help by publicizing volunteer opportunities on its official website.

Allowing for interstate licensure recognition for health practitioners is consistent with efforts to suspend licensure requirements for non-health related professionals that proffer their services to affected individuals. The American Bar Association (ABA) Task Force, for example, advocated for the suspension of unlicensed practice rules by various states impacted by Hurricane Katrina so that lawyers from other jurisdictions might volunteer to assist in the affected areas. Twenty states acted upon its request. *In the Wake of the Storm: The ABA Responds to Hurricane Katrina* 10 (2006).

Subsection (b) restricts this act's protections from administrative sanction to volunteer health practitioners whose licenses are not subject to a suspension, revocation, or disciplinary restriction, or who have not voluntarily terminated their license under threat of sanction, in any state. This is consistent with the requirements underlying the provision of services in Section 8 such that practitioners who meet any of the aforementioned criteria have had their qualifications questioned as to their ability to adequately provide health services.

SECTION 7. NO EFFECT ON CREDENTIALING AND PRIVILEGING.

(a) In this section:

(1) “Credentialing” means obtaining, verifying, and assessing the qualifications of a health practitioner to provide treatment, care, or services in or for a health facility.

(2) “Privileging” means the authorizing by an appropriate authority, such as a governing body, of a health practitioner to provide specific treatment, care, or services at a health facility subject to limits based on factors that include license, education, training, experience, competence, health status, and specialized skill.

(b) This [act] does not affect credentialing or privileging standards of a health facility and does not preclude a health facility from waiving or modifying those standards while an emergency declaration is in effect.

Comment

This Section acknowledges the distinctions between credentialing and privileging, and specifically notes that the act is not intended to interfere with the enforcement or waiver of these requirements during an emergency. The credentialing process, as defined under subsection (a)(1), assesses the basic skills or competencies for health practitioners and utilizes criteria including their licensure, education, training, experience, and other qualifications that may aid in this determination. During an emergency, some states have enacted laws that encourage entities to assess a volunteer’s skills and training through direct contact with the applicable licensure board or other means. In Maine, for example, private institutions are required to (1) make a “reasonable attempt” to contact the appropriate licensing board for any available information about that health care worker, and (2) may rely on (i) information “available from the [licensing boards] ...regarding appropriate screening of the worker,” (ii) the “representation of a volunteer health care worker registry that is operated or certified in accordance with federal or state requirements regarding appropriate screening of the worker that is registered on that registry,” (iii) the “representation of the employing or privileging entity regarding appropriate screening of the worker,” or (iv) the “representation of a retired or unemployed worker’s most recent employer or privileging entity if that employment or

privileging occurred within the previous 24 months.” 22 M.R.S.A. § 816, sub-§1-A. One advantage of Wisconsin’s WEAVR system (see Official Comments to Section 4) is that it is fully functional as both a volunteer registry and as a real-time credentialing system. The Wisconsin Disaster Credentialing System was developed as an adjunct to WEAVR to verify all credentials of volunteers through primary source verification. *State Mobilization of Health Personnel During 2005 Hurricanes 2*, (Association of State and Territorial Health Officials, July 2006). This is distinct from the privileging process, defined in subsection (a)(2), in that credentialing does not grant any authority to engage in the provision of health services. Subsection (a) thus allows states to retain the flexibility to proffer guidelines and recommendations for intrastate entities that choose to integrate out-of-state volunteers. It also distinguishes the assessment of such volunteers under subsection (a)(1) from the actual grant of authority under subsection (a)(2) to provide health services.

Privileging decisions (under subsection (a)(2)) entail the grant of authority to individuals to provide specific types of health services, in addition to the general adherence to scope of practice guidelines established by state licensure boards. Privileging determinations are unique to the entity granting the privileges to the practitioner and do not necessarily extend to services provided under another entity absent its express authority.

Credentialing and privileging standards can be an essential prerequisite to the actual delivery of health services in specific settings. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), for example, requires hospitals to be prepared to engage in rapid credentialing procedures as needed to respond to emergency events. In 2003, the Commission recommended the creation of a credentialing database to support a national emergency volunteer system for health practitioners. *Health Care at the Crossroads: Strategies for Creating and Sustaining Community-wide Emergency Preparedness Systems* 24, 36 (JCAHO White Paper, March 2003). This would provide rapid access to information on volunteer clinicians during the planning and implementation of an emergency response. *Id.* at 36. To date this database has not been established.

Waivers or modifications of credentialing or privileging standards during emergencies have no effect on registration requirements under Section 5 or adherence to scope of practice considerations under Section 8.

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

SECTION 8. PROVISION OF VOLUNTEER HEALTH OR VETERINARY SERVICES;

ADMINISTRATIVE SANCTIONS.

(a) Subject to subsections (b) and (c), a volunteer health practitioner shall adhere to the scope of practice for a similarly licensed practitioner established by the licensing provisions, practice acts, or other laws of this state.

(b) Except as otherwise provided in subsection (c), this [act] does not authorize a volunteer health practitioner to provide services that are outside the practitioner's scope of practice, even if a similarly licensed practitioner in this state would be permitted to provide the services.

(c) [Name of appropriate governmental agency or agencies] may modify or restrict the health or veterinary services that volunteer health practitioners may provide pursuant to this [act]. An order under this subsection may take effect immediately, without prior notice or comment, and is not a rule within the meaning of [state administrative procedures act].

(d) A host entity may restrict the health or veterinary services that a volunteer health practitioner may provide pursuant to this [act].

(e) A volunteer health practitioner does not engage in unauthorized practice unless the practitioner has reason to know of any limitation, modification, or restriction under this section or that a similarly licensed practitioner in this state would not be permitted to provide the services. A volunteer health practitioner has reason to know of a limitation, modification, or restriction or that a similarly licensed practitioner in this state would not be permitted to provide a service if:

(1) the practitioner knows the limitation, modification, or restriction exists or that a similarly licensed practitioner in this state would not be permitted to provide the service; or

(2) from all the facts and circumstances known to the practitioner at the relevant time, a reasonable person would conclude that the limitation, modification, or restriction exists or that a similarly licensed practitioner in this state would not be permitted to provide the service.

(f) In addition to the authority granted by law of this state other than this [act] to regulate the conduct of health practitioners, a licensing board or other disciplinary authority in this state:

(1) may impose administrative sanctions upon a health practitioner licensed in this state for conduct outside of this state in response to an out-of-state emergency;

(2) may impose administrative sanctions upon a practitioner not licensed in this state for conduct in this state in response to an in-state emergency; and

(3) shall report any administrative sanctions imposed upon a practitioner licensed in another state to the appropriate licensing board or other disciplinary authority in any other state in which the practitioner is known to be licensed.

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

Legislative Note: *The governmental agency or agencies referenced in subsection (c) may, as appropriate, be a state licensing board or boards rather than an agency or agencies that deal[s] with emergency response efforts*

Comment

Subsection (a) provides that volunteer health practitioners may only render health services that would be within the scope of practice of a similarly situated practitioner in the host state. Outside this act, the term “scope of practice” may have different meanings depending on how it is used. In the health professions (e.g., medicine, nursing, etc.), the “scope of practice” typically refers to the standards that separate one health profession from another governed by state licensure laws unique to each profession. Idaho, for example, precludes a health practitioner providing charitable medical care from acting outside the scope of practice “authorized by the provider’s licensure, certification or registration.” Idaho Code § 39-7703 (2005). Therefore, nurses are restricted from performing physician services because such conduct would be outside the scope of practice for nurses.

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

Under this act, “scope of practice” is defined in Section 2(12) to mean the extent of authorization to provide health or veterinary services established by the licensure boards of the state in which a practitioner is licensed and primarily engages in practice. This limits the types of services volunteer health practitioners can perform to those services unique to their profession. Nonetheless, the scope of practice may differ among individuals depending on the state(s) where they are principally licensed. The services a practitioner provides may be modified or restricted by a state licensing board or other agency pursuant to subsection (c) or restricted by a host entity pursuant to subsection (d).

The prescriptive authority of nurse practitioners, for example, varies widely across states. Currently, fourteen states allow nurse practitioners to prescribe medications, including controlled substances, independent of physician involvement. Eighteenth Annual Legislative Update, *Nurse Practitioner* 31(1):12-38 (January 2006). Arkansas, for example, does not require physician collaboration or supervision for an advanced practice nurse. The Arkansas State Board of Nursing may grant a certificate of prescriptive authority to an advanced practice nurse upon (1) submission of proof demonstrating completion of a board-approved pharmacology course that includes preceptorial experience in the prescription of drugs, and (2) execution of a collaborative practice agreement with a physician who is licensed in Arkansas. A.C.A. § 17-87-310 (2006). Thirty-three states, however, require nurse practitioners to have some degree of physician involvement prior to prescribing medications. Illinois, for example, provides that advanced practice nurses may prescribe medications pursuant to a collaborative agreement with a physician. 225 ILCS 65/15-20(a). Some states have also recognized the potential overlap of services between professions, concluding that the governing law is that of the host state. Kansas’ Attorney General, for example, issued an opinion concerning whether chiropractic manual manipulation was a procedure within the scope of

practice of medicine and surgery. Although chiropractic manipulation may involve methods of practice “authorized to one or the other profession or both,” it is not within the scope of practice of medicine and surgery as defined by Kansas state law even though it may be within the scope of practice under standards that such practitioners are generally held to as members of the chiropractic profession. Att’y Gen. Opinion No. 96-12, 1996 Kan. AG LEXIS 12.

As indicated above, (a) requires that a volunteer health practitioner (whether in-state or out-of-state) must adhere to the applicable scope of practice for similarly situated practitioners in the host state during the emergency. For practitioners licensed in the host state before the emergency, they must, of course, adhere to the state’s scope of practice for their profession. For out-of-state practitioners who are not licensed in the host state before the emergency, the requirement to adhere to the host state’s scope of practice is consistent with the recognition pursuant to Section 6(a) that out-of-state practitioners are to be viewed as licensed in the state for the duration of the emergency. Through subsection (a), the scope of practice requirements for similarly situated practitioners is coupled with their recognition of a temporary license as provided in Section 6(a). This helps ensure uniformity in the scope of practice among various practitioners from other jurisdictions.

Subsection (b) clarifies that this section (nor any other provisions of the act) does not authorize a volunteer health practitioner to provide services that are outside the practitioner’s own scope of practice even if a similarly situated practitioner in this state would be permitted to provide the services. This restriction, which principally applies to practitioners whose licensure during non-emergencies is out-of-state, helps ensure that they do not provide services during emergencies that they would not be entitled to provide in their usual course of business or activities. This is significant where a volunteer health practitioner is licensed in more than one state.

For example, consider a nurse who may principally practice nursing in Illinois, although also licensed in Arkansas and Kentucky. If Louisiana declares a state of emergency, the nurse may be deployed from Illinois to Louisiana to provide services. With the recognition of licensure pursuant to Section 6(a), the practitioner is permitted to practice in state as if licensed in state for the duration of the emergency. In Arkansas, the nurse may independently prescribe drugs without the supervision of a physician whereas in Illinois or Kentucky this may only be done with some degree of physician involvement or delegation of prescriptive authority (see scope of practice discussion above). The nurse’s scope of practice will be limited to the services authorized in Illinois, not those authorized in Arkansas or Kentucky, since Illinois is the place of principal practice. It would not matter whether a similarly situated practitioner would be allowed to independently prescribe medications in Louisiana – the nurse could not do so under subsection (b) of this act. Simply stated, the volunteer health practitioner is permitted to do whatever a similarly situated physician in the host state may do unless such action is outside the practitioner’s scope of practice in her principal state of practice or is impermissible because of a restriction by a state licensure board or other agency under subsection (c) or a restriction imposed by a host entity under subsection (d).

The impetus for these restrictions is to make sure that out-of-state practitioners do not provide

services for which they are not competent, or that are not legally permissible in the host state, based on their licensure status in their principal state of practice. In the example provided above, if Arkansas offered another variation on the practitioner's scope of practice that was more limited than the scope of practice in Louisiana, this need not be considered by the practitioner in the performance of services since the practitioner does not principally engage in practice in Arkansas. To require practitioners to adhere to the scope of practice in every jurisdiction in which they are licensed during an emergency would be overly confusing and may stymie the provision of essential health services to individuals and populations.

Subsection (c) authorizes the state licensing board or other appropriate state agency (or agencies) to modify or restrict the scope of practice during an emergency. This provision must be considered *in pari materia* with the licensure laws and regulations of the host state. The rationale is to empower state agencies to adapt their emergency response plans to unforeseeable circumstances stemming from an emergency to meet patient needs or protect the public's health. In some instances, this may require empowering volunteer health practitioners to provide services that are not typically allowed under existing state licensure laws. In New Jersey, for example, the Commissioner of Health and Senior Services may waive any rules and regulations concerning professional practice in the state during an emergency. R.S. 26:13-18b(2). During an emergency there may be legitimate reasons for a state to modify or restrict the health services that a volunteer health practitioner may provide consistent with overriding public health objectives or patient needs.

Subsection (d) authorizes a host entity to restrict the services that volunteer health practitioners may provide. Host entities need to make decisions in real time to allow for an efficient and effective emergency response. This provision does not authorize a host entity to alter the scope of practice of a particular profession as defined by state licensure boards or other appropriate agencies. Therefore, a hospital acting as a host entity cannot authorize a nurse to provide services that only a physician may perform. However, the hospital may limit the types of services that a volunteer health practitioner is authorized to perform. A hospital, for example, may delegate different responsibilities among volunteer health practitioners that limit what the practitioners can do in the treatment of patients or provision of public health services during a non-emergency. This population-based approach to the delivery of health services is consistent with the underlying public health objective of this act to assure the health and well-being of affected members of the population.

Subsection (e) provides that administrative sanctions for unauthorized practice may not be imposed against a volunteer health practitioner unless the practitioner has reason to know of any limitation, modification, or restriction on the services that a health practitioner may provide (pursuant to subsections (c) and (d)) or that a similarly situated practitioner in this state would not be permitted to provide the services (pursuant to subsection (a)). This provision recognizes that volunteer health practitioners that are already registered under Section 5 and authorized to provide health services must exercise their best judgment during exigent circumstances. It would be inapposite with the purpose of this Act -- to facilitate voluntarism -- to require volunteers to second-guess their every judgment because of concerns over administrative sanctions. So long as they are providing services

that are within their normal scope of practice (subsection (b)) acting without actual knowledge that they should not do so or could not reasonably conclude from the facts known to them that they should not do so, they should not be subject to administrative sanctions during or following the emergency. However, if a volunteer health practitioner is expressly informed that certain services should not be provided or the practitioner should have so concluded, there is no immunity from administrative sanctions.

Subsection (f) authorizes a state licensing board or other disciplinary authority to impose administrative sanctions on any volunteer health practitioner whose conduct is inconsistent with licensure or other laws and for which subsection (e) does not afford protection. Subsection (f)(1) makes clear that a state licensing board or other appropriate disciplinary authority may sanction a health practitioner licensed in that state for conduct that occurs outside the state in response to an emergency that also occurs outside the state. Subsection (f)(2) authorizes the licensing board or disciplinary authority in the state in which the emergency occurs to sanction practitioners licensed in other states for conduct that occurs in the state in which the emergency occurs. This latter authority is a natural consequence of the practitioners' "temporary licensure" status. Subsection (f) (3) requires any state that imposes sanctions upon a volunteer health practitioner to inform the licensing board or other disciplinary authority in all states where the practitioner is known to be licensed. This may help licensing boards or other disciplinary authorities in all states to record and 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 health practitioner potentially subject to administrative sanction against a backdrop of mitigating factors, including the practitioner's scope of practice, education, training, experience, and specialized skill. This requirement recognizes that during exigent circumstances, numerous factors may influence a volunteer health practitioner's actions or omissions.

SECTION 9. RELATION TO OTHER LAWS.

(a) This [act] does not limit rights, privileges, or immunities provided to volunteer health practitioners by laws other than this [act]. Except as otherwise provided in subsection (b), this [act] does not affect requirements for the use of health practitioners pursuant to the Emergency Management Assistance Compact.

(b) [Name of appropriate governmental agency or agencies], pursuant to the Emergency Management Assistance Compact, may incorporate into the emergency forces of this state

volunteer health practitioners who are not officers or employees of this state, a political subdivision of this state, or a municipality or other local government within this state.

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

Comment

Subsection (a) clarifies that this act does not supplant other protections from liability or benefits afforded to volunteer health practitioners under other laws. For example, the act does not limit or preclude the benefits afforded members of disaster relief organizations under state good Samaritan laws or under the federal Volunteer Protection Act, 42 U.S.C.S. §14501 *et seq.*

Subsection (b) creates a statutory path to allow private sector volunteers to be incorporated into state forces for the limited purpose of facilitating their deployment and use during an emergency through EMAC. During Hurricane Katrina, many states sought to deploy volunteers through EMAC to provide them greater protections and fulfill state responsibilities pursuant to this compact. In many states, this required the hasty execution of agreements or issuance of executive orders authorizing the volunteers to become temporary state agents. To avoid future delays, this provision authorizes the appropriate state agency to incorporate any private sector volunteers into state forces as needed to deploy them via EMAC.

SECTION 10. REGULATORY AUTHORITY. [Name of appropriate governmental agency or agencies] may promulgate rules to implement this [act]. In doing so, [name of appropriate governmental agency or agencies] shall consult with and consider the recommendations of the entity established to coordinate the implementation of the Emergency Management Assistance Compact and shall also consult with and consider rules promulgated by similarly empowered agencies in other states to promote uniformity of application of this [act] and make the emergency response systems in the various states reasonably compatible.

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

Comment

The purpose of this section is to recognize that the procedures required to implement this act will be unique to each state. States are authorized to establish regulations to fulfill their objectives. Agencies are expected to consult with the intrastate agencies or entities responsible for coordinating and managing emergency responses, along with interstate partners pursuant to existing mutual aid compacts (e.g., the Emergency Management Assistance Compact (EMAC), the Interstate Civil Defense and Disaster Compact (ICCDC), the Nurse Licensure Compact (NLC), and the Southern Regional Emergency Management Assistance Compact) to ensure consistency among regulations and the interoperability of procedures during an emergency.

***[SECTION 11. CIVIL LIABILITY FOR VOLUNTEER HEALTH PRACTITIONERS;
VICARIOUS LIABILITY.]***

RESERVED

Legislative Note: Final action regarding Section 11 of the Act has been deferred until the 2007 Annual Meeting of the National Conference of Commissioners on Uniform State Laws. At that time, the Drafting Committee will present to the Conference for consideration its final recommendations relating to the limitation of civil liability for damages for volunteer health practitioners and organizations that use and maintain registration systems for volunteer health practitioners. Because many States have existing laws pertaining to liability limitations and a uniform approach to liability limitations may play a critical role in promoting the use of volunteer health practitioners, States considering adoption of this Act prior to final action by the National Conference regarding Section 11 should carefully review their existing laws, the laws of other states, provisions of the Emergency Management Assistance Compact, and the work of the Drafting Committee, which is available at <http://www.law.upenn.edu/bll/ulc/ulc>.

[SECTION 12. WORKERS' COMPENSATION COVERAGE.]

RESERVED

Legislative Note: Final action regarding Section 12 of the Act has been deferred until the 2007 Annual Meeting of the National Conference of Commissioners on Uniform State Laws. At that time, the Drafting Committee will present to the Conference for consideration its final recommendations regarding the provision of workers' compensation coverage for volunteer health practitioners

without other forms of workers' compensation or disability insurance coverage. Because the establishment of a reasonably uniform system to compensate volunteer practitioners for injuries sustained while responding to emergencies is critical to an effective system of legislation to promote the use of volunteer health practitioners, States considering adoption of this Act prior to final action by the National Conference regarding Section 12 should carefully review the laws of other states providing workers' compensation coverage to volunteers responding to emergencies, provisions of the Emergency Management Assistance Compact, and the work of the Drafting Committee, which is available at <http://www.law.upenn.edu/bll/ulc/ulc>.

SECTION 13. UNIFORMITY OF APPLICATION AND CONSTRUCTION. In applying and construing this uniform act, consideration must be given to the need to promote uniformity of the law with respect to its subject matter among states that enact it.

Comment

Uniformity of interstate recognition of licensure for volunteer health practitioners, and the grant of particular privileges and protections for those volunteers who provide health or veterinary services during an emergency to individuals or populations, are two principle objectives of this act.

The goal of uniformity among the states may be enhanced by use of interoperable registration systems pursuant to Section 4. Examples may include ESAR-VHP systems that consist of thorough substantive and technical criteria that meet essential system requirements and provide additional security safeguards with respect to accessibility by authorized personnel, privacy concerns, and interoperability with other systems.

SECTION 14. REPEALS. The following acts and parts of acts are repealed:

(1)

(2)

SECTION 15. EFFECTIVE DATE. This [act] takes effect

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