



# Legal Resource Guide

As of April 3, 2023

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## PREFACE

**Acknowledgement.** This guide was developed by **James G. Hodge, Jr.**, J.D., LL.M., Peter Kiewit Foundation Professor of Law; Director, Center for Public Health Law & Policy, Sandra Day O'Connor College of Law (SDOC), Arizona State University (ASU). Contributors include **Erica N. White**, J.D., Research Scholar, Center for Public Health Law & Policy, SDOC, ASU, **Summer Ghaith**, Senior Legal Researcher, **Gus Vanderdonck**, Legal Researcher, and **Cleo Goeckner**, Legal Extern, Center for Public Health Law & Policy, SDOC, ASU.

**Additional Sources.** Substantial information in this guide is based in part on existing RDHRS Legal Resource Guides produced for Region 1 RDHRS (New England States)<sup>1</sup> and the Western Regional Alliance for Pediatric Emergency Management (WRAP-EM) (Western States).<sup>2</sup>

**Disclaimer.** Please note that information provided in this document does not constitute legal advice in any jurisdiction. Please consult with legal counsel in your respective jurisdiction for specific legal guidance. The document is owned and managed by the Mountain Plains RDHRS. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of ASPR, HHS, or the jurisdictions noted throughout the document.

**Scope & Primary Purposes.** With core funding from the Administration for Strategic Preparedness and Response (ASPR), the Mountain Plains Regional Disaster Health Response System (MPRDHRS) project began in 2020 with an aggressive mission to create a regional disaster health community across 6 states (CO, MT, ND, SD, UT, WY) demonstrating “how a RDHRS can improve medical surge and clinical specialty capabilities – including trauma, burn, or other specialty care – during a national emergency.”<sup>3</sup> The end goal of these efforts is to “save more lives”<sup>4</sup> through activities to:

- “Build a partnership for disaster health response to support clinical specialty care;
- Align plans, policies, and procedures for clinical excellence in disasters;
- Increase state-wide and regional medical surge capacity;
- Improve state-wide and regional situational awareness, such as the availability of hospital beds; and
- Develop metrics and test the regional system’s capabilities.”<sup>5</sup>

Recognizing how these collective goals and objectives implicate extensive law and policy issues, MPRDHRS sought assistance from legal subject matter experts (SMEs) related to several components of the continued development and expansion of the project. Specifically, MPRDHRS leaders sought expert guidance on federal, state, and local processes for emergency declarations, legal waivers during emergencies, liability protections, asset allocations, alternate care systems, and interstate coordination considerations for healthcare assets.

Following initial discussions and planning with region and state leaders, a **blueprint** outline addressing these and other issues was developed and refined. This outline and extensive charting of existing state laws in the 6 Mountain Plains states established the basis for content in this guide with ongoing refinements by MPRDHRS colleagues based on reviews of initial drafts.

As summarized in the **Introduction**, below, the core objective is to produce a strategic assessment guide of legal or policy issues affecting the development of a regional health disaster program in the Mountain Plains states. While many of the findings in this guide extend from core observations of laws and policies among Region VIII states (see the illustration of aggregate legal

findings based on **Appendix: Table 5**), key lessons and strategies may equally apply to other ASPR regions nationally.

### Aggregate Table – MPRDHS Emergency Laws



Topic	CO	MT	ND	SD	UT	WY
I. Emergency/Disaster Declarations	✓	✓	✓	✓	✓	✓
II. Public Health Emergency Declarations	✓	✓		✓	✓	✓
III. Routine Licensure Reciprocity	✓	✓	✓	✓	✓	✓
IV. Emergency Licensure Reciprocity	✓	✓	✓	✓	✓	✓
V. General Waiver Authority	✓	✓	✓	✓	✓	✓
VI. Specific Waiver Authority	✓	✓	✓	✓	✓	✓
VII. General Liability Protections	✓	✓	✓	✓	✓	✓
VIII. Explicit Liability Protections	✓	✓	✓	✓	✓	✓

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

**I. EMERGENCY DECLARATIONS**, examines the changing legal landscape extending from federal, state, and local declarations of emergencies, disasters, and public health emergencies (PHEs), notably including analyses extending from legal research across Mountain Plains states.

**II. EMERGENCY MANAGEMENT ASSISTANCE COMPACT**, illustrates the scope, purposes, and utility of interjurisdictional agreements, specifically versions of EMAC executed among all 6 region states facilitating resource allocation and legal protections in emergencies.

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

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

**V. OTHER LEGAL ISSUES**, examines additional key legal issues related to (1) telehealth and telemedicine initiatives; (2) allocating scarce resources during Crisis Standards of Care (CSC); (3) use of emergency use authorities to authorize otherwise non-approved tests, medications, and treatments; (4) rights to reemployment; (5) health information privacy concerns

underlying extensive data sharing practices in emergencies; and (6) family reunification efforts and potential legal concerns.

## ABBREVIATIONS

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

Acronym	Term	Acronym	Term
<b>ACS</b>	Alternate Care Sites	<b>MRC</b>	Medical Reserve Corps
<b>ADA</b>	Americans with Disabilities Act	<b>MSEHPA</b>	Model State Emergency Health Powers Act
<b>ASPR</b>	Administration for Strategic Preparedness & Response	<b>NAM</b>	National Academy of Medicine
<b>CDC</b>	Centers for Disease Control & Prevention	<b>NEA</b>	National Emergencies Act
<b>CMS</b>	Centers for Medicare & Medicaid Services	<b>NEMA</b>	National Emergency Management Association
<b>CSC</b>	Crisis Standards of Care	<b>NLC</b>	Nurse Licensure Compact
<b>DEA</b>	Drug Enforcement Agency	<b>OCR</b>	Office of Civil Rights
<b>DHSEM</b>	Division of Homeland Security and Emergency Management	<b>PAHPA</b>	Pandemic & All-Hazards Preparedness Act
<b>DMAT</b>	Disaster Medical Assistance Team	<b>PAHPRA</b>	Pandemic & All-Hazards Preparedness Reauthorization Act
<b>ED</b>	Emergency Department	<b>PHA</b>	Public Health Authority
<b>EMAC</b>	Emergency Management Assistance Compact	<b>PHE</b>	Public Health Emergency
<b>EMS</b>	Emergency Medical Services	<b>PHI</b>	Protected Health Information
<b>EMT</b>	Emergency Medical Technician	<b>PPE</b>	Personal Protective Equipment
<b>EMTALA</b>	Emergency Medical Treatment & Active Labor Act	<b>PREP Act</b>	Public Readiness & Emergency Preparedness Act
<b>ESAR-VHP</b>	Emergency System for the Advance Registration of VHPs	<b>REQ-A</b>	Request for Assistance Form (EMAC)
<b>EUA</b>	Emergency Use Authorization	<b>RDHRS</b>	Regional Disaster Health Response State Children's Health Insurance Program
<b>FDA</b>	Food & Drug Administration	<b>S-CHIP</b>	State Children's Health Insurance Program
<b>FEMA</b>	Federal Emergency Management Agency	<b>SME</b>	Subject Matter Expert
<b>GSA</b>	Good Samaritan Act	<b>SNS</b>	Strategic National Stockpile
<b>HCW</b>	Health Care Worker	<b>UEVHPA</b>	Uniform Emergency Volunteer Health Practitioners Act
<b>HHS</b>	Department of Health & Human Services	<b>USERRA</b>	Uniformed Services Employment & Reemployment Rights Act
<b>HIPAA</b>	Health Insurance Portability & Accountability Act	<b>VHP</b>	Volunteer Health Professional
<b>HIV</b>	Human immunodeficiency virus	<b>VSA</b>	Volunteer Service Agreement
<b>IEMAC</b>	International Emergency Management Assistance Compact	<b>SNS</b>	Strategic National Stockpile
<b>MAA</b>	Mutual Aid Agreement	<b>UEVHPA</b>	Uniform Emergency Volunteer Health Practitioners Act
<b>MCM</b>	Medical Countermeasure	<b>USERRA</b>	Uniformed Services Employment & Reemployment Rights Act
<b>MOU</b>	Memoranda of Understanding	<b>VHP</b>	Volunteer Health Professional
<b>MPRDHRS</b>	Mountain Plains Regional Disaster Health Response System	<b>VSA</b>	Volunteer Service Agreement

## INTRODUCTION

With core funding from ASPR, the MPRDHRS project charted an aggressive objective in mid-2020: *create a regional disaster health community designed to coordinate emergency resources and responses*. Following initial pilot activities, project leaders conceived how an effective regional program should be able to leverage existing and new SME networks and personnel to improve disaster medical preparedness in specialized areas of care (e.g., burn trauma) but also respond in real-time with governmental authorities and other regional systems.

These goals were set in the backdrop of the COVID-19 pandemic, the most significant infectious disease threat in U.S. history. With hundreds of thousands of confirmed cases and tens of thousands of deaths in the region, especially in its largest city, Denver, MPRDHRS leaders experienced actual law and policy barriers to their laudable goals, as well as multiple states' solutions to many of these barriers.

As each of the Mountain Plains states systematically declared formal states of emergency (along with every U.S. state), legal and policy roles emerged. Achieving MPRDHRS objectives required real-time law and policy solutions to barriers within an ever-changing legal environment. Even as COVID-19 recedes, monkeypox virus presents new challenges for PHAs and HCWs (e.g., doctors, nurses, physician assistants, EMTs, mental health professionals).<sup>6</sup>

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

Among the more profound needs of an operational RDHRS is its capacity to help move patients and facilitate exchange of HCWs seamlessly across borders whether physically or virtually. Immediate legal impediments related to HCW licensing, credentialing, and privileging requirements are resolvable through routine and emergency exceptions facilitating cross-sharing of personnel and supplies.

Real-time health care responses in any emergency invariably evoke fears of liability for HCWs, VHPs, entities, and others involved in delivering services especially when standards of care are shifting as resources become scarce. Risks of liability are real, but so is an extensive array of liability protections from acts of ordinary negligence in emergencies. Enhanced workers' compensation benefits and job protections may be extended for persons responding through organized channels on their own volition (and often at great risk). Additional concerns underlying emergency responses, such as temporary waivers of existing standards, rights to reemployment, and health information privacy concerns over data sharing also arise.

As per the following **Checklist of Legal Issues Supporting Regional Coordination**, extensive legal issues arising during emergencies are solvable through real-time interpretations and applications among multiple legal options. While many of the findings in this guide extend from core observations within Region 8, lessons and strategies may equally apply to other regions nationally, lending to a cohesive strategy for maximizing interstate alliances in the 21<sup>st</sup> century.



## CHECKLIST OF LEGAL ISSUES UNDERLYING REGIONAL COORDINATION

*The table below presents a numbered series of key questions derived from issues and analyses discussed in the guide for any jurisdiction to assess and resolve (as needed) to facilitate regional coordination of public health/health care services in emergencies:*

Subject	#	Question
<b>Emergency Declarations</b>	1	Have state/local governments adopted a statutory or regulatory definition of an “emergency,” “disaster,” or other similar terms?
	2	Do state/local governments’ general emergency or disaster provisions also cover emergencies affecting the public’s health?
	3	Have state/local governments adopted a statutory or regulatory definition of a PHE or other similar terms (e.g., public health crisis or catastrophe)?
	4	Do state/local laws set procedures to follow in declaring a general emergency, disaster, or PHE?
	5	Do the procedures to declare require specificity as to the type, nature, location, or duration of the emergency?
	6	If a PHE is declared, are specific emergency powers assigned to state/local PHAs & other relevant entities to facilitate emergency response efforts?
	7	Do state/local laws require or provide for planning & coordination of emergency response efforts among various state/local agencies?
	8	Is there statutory or regulatory express authority on terminating emergency declarations or automatic termination under certain conditions?
	9	Do state emergency laws authorize general or explicit waiver of statutory or regulatory provisions to facilitate response efforts?
<b>EMAC</b>	10	Has the state invoked EMAC or NEMAC, if applicable, for purposes of seeking essential services or supplies during a declared emergency?
	11	Has the state authorized the exchange of state/local agents with other jurisdictions for the purpose of emergency response efforts?
	12	Is state government able to deputize private HCWs or VHPs to garner state based EMAC protections prior to their transfer out-of-state?
	13	Does the state anticipate reimbursement for specific allocation of essential supplies or personnel pursuant to EMAC?
<b>Licensing &amp; Privileging</b>	14	What types of HCWs are required to have state licensure or certification to practice medicine, nursing, or other professions in the state?
	15	Does state law provide for civil or criminal penalties for HCWs or VHPs practicing without a license?
	16	Has the state adopted provisions for reciprocity of state licensure or certification requirements for HCWs who are licensed in another state?
	17	Has the state entered reciprocity agreements/compacts that recognize out-of-state licenses or certifications for HCWs (e.g., NLC)?
	18	Does state law require hospitals to establish medical staff bylaws including provisions for credentialing/privileging in declared emergencies?
	19	Have hospitals or other accredited health entities adopted disaster privileging policies in compliance with Joint Commission requirements?
	20	Does state law require hospitals to have an emergency management plan governing hospital responses to a declared emergency?
	21	Do state emergency laws or medical boards authorize shifts in scope of practice during declared emergencies?

<b>Subject</b>	<b>#</b>	<b>Question</b>
<b>Liability &amp; Immunity</b>	22	Are civil liability protections framed within state/local emergency, disaster, or PHE authorities or other relevant laws?
	23	Does the state tort claims act provide civil liability protection for “discretionary acts” by state/local actors in declared emergencies?
	24	Do state law or compacts explicitly provide HCWs or VHPs with immunity from civil liability (e.g., VPAs, GSAs) when responding to an emergency?
	25	Are there exceptions to civil liability protections for acts that involve gross negligence, recklessness, or willful or wanton misconduct?
	26	Do health care entities face potential civil liability for their acts, or those of their employees, agents, or volunteers, in response to emergencies?
	27	Does state law provide liability protections for health care entities (or their employees, agents, or volunteers)?
	28	Are VHPs required to register with the state/local governments to qualify for workers’ compensation for injuries sustained in performance of their duties?
	29	Are existing employers of VHPs required to provide workers’ compensation coverage for injuries sustained in performance of their duties as volunteers?
	30	Do workers’ compensation laws cover occupational diseases contracted during the performance of employed or volunteer activities?
	<b>Other Legal Issues</b>	31
32		Are there any parity laws or federal waivers in place that may affect financial reimbursement and coverage for telehealth services?
33		Has the state suspended regulatory (e.g., licensure) requirements for HCPs conducting rapid, good-faith administration of telehealth treatments?
34		Has the state adopted or proposed new provisions impacting telehealth practice, including mental health treatment or interstate compacts?
35		Have state/local governments crafted pre-existing CSC plans to facilitate emergency response efforts?
36		Are state/local governments prepared to implement CSC decisions in real-time through advanced training or preparedness activities?
37		Do state/local CSC plans, where available, provide or allow for front-line responders’ specific decisions & appeals regarding allocation of scarce resources?
38		Do state/local CSC plans include provisions to ensure equal application as to avoid discrimination in implementation?
39		Do CSC plans or implementation protocols require reporting of real-time information re: patient or group-level outcomes or available supplies like PPE?
40		Are state/local governments prepared to use or implement new or emerging products or services authorized by FDA via EUAs?
41		Does FDA’s issuance of specific EUAs preempt state/local laws that conflict with implementation (e.g., licensing or scope of practice limitations)?
42		Do state/local laws support rights to reemployment of HCWs or VHPs temporarily assigned to response efforts outside their employment?
43		Do state/local laws include paid sick & safe time protections for HCWs & VHPs temporarily disabled by infection or other injuries in emergencies?
44		Are state/local health information privacy laws sufficiently flexible to allow exchanges of PHI to protect public health & maximize patient care?
45		Do state/local emergency laws explicitly allow waivers of health information privacy laws that may limit the flow of essential public health data?
46		Are state/local legal protections of PHI in a declared emergency sufficient to assure patient confidentiality notwithstanding compelling state needs?

## I. EMERGENCY DECLARATIONS

During pandemics like COVID-19 in 2020, more limited outbreaks like monkeypox in 2022, or other events impacting the public's health, the legal environment is transformed in real-time through declared states of emergency, disaster, or PHE.<sup>7</sup> These declarations at federal, state, or local levels trigger an array of powers to facilitate public and private sector response efforts by: (1) offering flexible options to expedite responses; (2) waiving legislative or regulatory provisions impeding effective responses; (3) transitioning care from conventional standards to CSC;<sup>8</sup> (4) authorizing patient transfers across jurisdictions; (5) allowing out-of-state HCW's to practice in-state via licensure reciprocity; (6) expanding professional scopes of practice for HCWs;<sup>9</sup> and (7) instituting special liability protections from ordinary negligence for providers and entities.<sup>10</sup>

Each of these authorities depends in part on the level and type of emergency declared.<sup>11</sup> As summarized below, the federal government, every state, many territories and tribal governments, and localities may declare either general states of "emergency" or "disaster" in response to public health crises. HHS, many states, and some local governments may also declare states of PHE. These declarations can change the legal landscape instantly and significantly to facilitate regional response efforts, including through supplemental emergency executive orders used extensively by governors in response to COVID-19.

For example, on August 12, 2020 Colorado Governor Jared Polis issued Executive Order D-2020-163, which suspended several statutes allowing the Division of Homeland Security and Emergency Management (DHSEM) to establish alternate care sites (ACS) to accommodate a potential surge of COVID-19 infections.<sup>12</sup> Governor Polis signed two similar Orders (D 2020 189<sup>13</sup> and D-2021-034<sup>14</sup>) in September 2020 and February 2021, creating additional ACS. The designations lasted for 30 days with the potential for extensions (see **Part IV. Subpart CSC** for additional discussion).

### ***Federal Declarations***

An array of emergency declarations is available to federal authorities to respond to public health events/crises. The President can declare a state of emergency or disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act ("Stafford Act")<sup>15</sup> generally at the request of any state governor when federal assistance is needed "to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe."<sup>16</sup> For example, on April 8, 2020, Wyoming Governor Mark Gordon requested a major disaster declaration concerning COVID-19, seeking funding and resources for all the state's counties and tribes.<sup>17</sup>

The President can also declare a state of emergency pursuant to the National Emergencies Act (NEA)<sup>18</sup> for incidents requiring a national response.<sup>19</sup> On March 13, 2020, President Trump simultaneously declared emergencies under both the Stafford Act and NEA in response to COVID-19.<sup>20</sup> Together these declarations authorized emergency management agencies to coordinate responses, mobilize funding, and activate specific programs. Both declarations were extended under the Biden administration.<sup>21</sup> On February 18, 2022, the NEA declaration was extended beyond March 1, 2022,<sup>22</sup> without designating an end date. On March 1, the Stafford Act declaration was extended through July 1, 2022.<sup>23</sup>

Pursuant to the Public Health Service Act,<sup>24</sup> HHS may also declare a state of "public health emergency" (PHE)<sup>25</sup> to enable the distribution of key resources in the national SNS, waive

specified federal requirements related to Medicare or Medicaid reimbursement, temporarily set aside certain provisions of federal laws (e.g., HIPAA Privacy Rule), and conduct other emergency response activities. On January 31, 2020, HHS Secretary Alex Azar declared a PHE at the inception of the COVID-19 outbreak in the U.S., which took effect retroactively on January 27. This was most recently renewed for the 10th time by HHS Secretary Xavier Becerra on July 15, 2022. On August 4, 2022, Secretary Becerra declared a separate PHE for the national monkeypox outbreak.<sup>26</sup>

Some of HHS' PHE powers are only authorized when coupled with a declaration of a national emergency. In response to the 2009/2010 H1N1 pandemic, for example, HHS immediately declared a state of PHE on April 26, 2009, just days after initial domestic cases were confirmed. Only months later, on October 23, 2009, President Obama declared a national state of emergency. Coupled with HHS' PHE declaration, the President's subsequent declaration allowed for broader waivers of federal regulatory requirements (e.g., specific provisions of S-CHIP and EMTALA (see text box below)).<sup>27</sup>

### ***Emergency Medical Treatment and Active Labor Act (EMTALA)***

EMTALA normally requires Medicare-participating hospitals with EDs to receive, screen, and stabilize (or transfer, where warranted) any patient who comes to the hospital in an emergency condition and requests treatment. In some circumstances, transfers to specially equipped, designated facilities may be necessary, such as in response to Ebola in 2014. EMTALA may also apply to urgent care clinics, labor and delivery departments, and some psychiatric departments. In federally-declared emergencies, such as in response to COVID-19, HHS and CMS may waive some EMTALA provisions, allowing for non-traditional reception, screening, and treatment of emergency patients.

In 2013, Congress passed the Pandemic and All-Hazards Preparedness Reauthorization Act<sup>28</sup> (PAHPRA) to expand HHS' PHE powers without the need for an additional national emergency declaration. PAHPRA authorizes funding for public health and medical preparedness programs, amends the Public Health Service Act to allow state health departments flexibility in reassigning personnel to respond to emergencies, authorizes funding, research, and development for medical countermeasures (MCMs) under the Project BioShield Act.<sup>29</sup> These extensive powers assisted HHS Secretary Azar in responding to COVID-19 for the 1.5 months prior to President Trump's dual national emergency declarations on March 13, 2020.

### ***State & Local Declarations***

All states and territories (and some tribal governments and localities) are legally authorized to declare states of emergency or disaster in response to multifarious events, including public health crises (e.g., pandemics, bioterrorism events). As of 2011, 33 states and D.C. also authorize declarations of PHE, or like terms.<sup>30</sup> Many of these states' approaches are based on the Model State Emergency Health Powers Act (MSEHPA) originally developed by the *Center for Law and the Public's Health* in response to the anthrax exposures in late 2001.<sup>31</sup>

PHE declarations typically empower state public health officials (in collaboration with emergency management agencies) to focus on the public health aspects of emergencies. Though designed originally for application in bioterrorism events or widespread emerging infectious

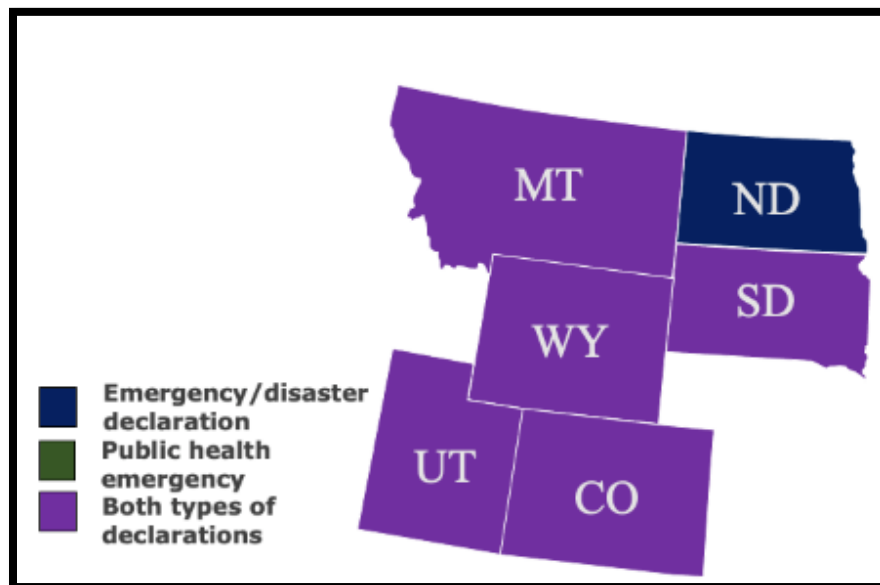
diseases like West Nile virus, H1N1, or COVID-19, states and localities have increasingly declared PHEs for other purposes, including:

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

Some larger cities and counties may also be empowered to declare states of emergency depending on their degree of “home rule.” Home rule refers to the discretionary power allotted by states to local governments to address largely local matters. A 2010 study<sup>32</sup> reviewing emergency legal authorities of 20 select local jurisdictions of various population sizes across the U.S. found that 19 (95%) of the localities authorized local officials to declare either an emergency or disaster. This included cities in region states like Denver, CO, and Billings, MT, both of which were authorized to declare local states of emergency. Colorado specifically authorizes “political subdivisions” to declare local emergencies.<sup>33</sup> On March 11, 2020, Eagle County Health Service District declared a local emergency supplementing state and county emergencies in response to COVID-19;<sup>34</sup> on March 12, the Eagle River Fire Board of Directors followed suit.<sup>35</sup>

**Figure 1**, below, provides a brief illustration of emergency/disaster and PHE statutory authorizations among region states, which are chronicled in Table 1 in the Appendices.

**Figure 1. Region States Defining Emergency, Disaster, or PHE**



### ***Timing of Declarations***

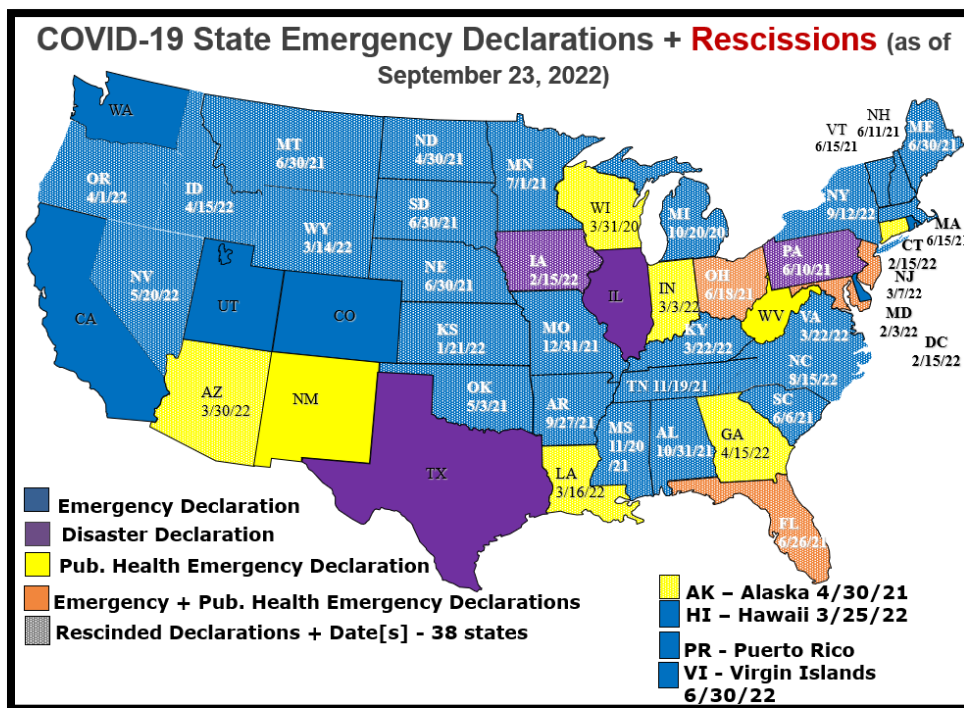
While all states are authorized to declare states of emergency in some form, predicting their scope, timing, and duration can be precarious. While all states initiated their pandemic flu response plans in response to the spread of H1N1 in 2009/2010, for example, only 12 states

formally declared states of emergency, disaster, or PHE over the first 6 months of the pandemic. In response to the Ebola threat in the Fall 2014, only Connecticut declared a PHE.<sup>36</sup>

In the unprecedented response to COVID-19, all 50 states and most territories formally declared varied states of emergency within a relatively short period of time (largely March 2020) but not all declared on the same date. Some states' declarations came before the determination of any known cases; other states only declared after the rise of COVID-19 cases in their jurisdictions became manifest. Among Mountain Plains states, Utah declared COVID-19 an emergency on March 6, 2020; Colorado on March 10; Montana on March 12; and North Dakota, South Dakota, and Wyoming on March 13.<sup>37</sup>

Gradual declarations of state or local emergencies over time complicate advance planning concerning regional roles and responsibilities. Potential legal changes invoked by the declarations are unpredictable. During the COVID-19 pandemic multiple state legislatures (e.g., CO, IL, KY, MI, MT, OH) challenged gubernatorial emergency powers through legislative or judicial intervention. Multiple state legislatures curbed their governors' emergency declaration powers as public health impacts of COVID-19 lessened, or, in some cases, worsened.<sup>38</sup> By July 1, 2021, only about a half of states remained in a formally declared emergency or disaster. By September 23, 2022, only 12 states remained under states of emergency (see **Figure 2** below).

**Figure 2. Status of State-based Emergency Declarations re: COVID-19**



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

## ***Dual Declarations***

Other issues arise when state or local governments declare states of emergency coupled with a PHE. Issuance of two or more declarations in a single jurisdiction is possible because each type of declaration shares similar statutory definitions and constructs.<sup>39</sup> In Delaware, for example, an influenza pandemic could simultaneously trigger statutory declarations of emergency, disaster, and PHE.<sup>40</sup> In response to COVID-19, governors in Florida and Maryland, among other jurisdictions, issued both emergency and PHE declarations. Overlapping declarations within and across jurisdictions can obfuscate response efforts when divergent actors are mobilized or authorized to act under different declarations pursuant to distinct powers and chains of command.

## ***Interjurisdictional Coordination***

Lessons learned from the 2014 Ebola outbreak and 2009/2010 H1N1 and 2020 COVID-19 pandemics include the need for strong, interjurisdictional coordination among varied actors to craft and effectuate organized responses to emergencies. Multiple logistical and other obstacles challenge the seamless sharing of personnel, supplies, information, and other resources across boundaries and between public and private sectors. Wise utilization of numerous legal tools can support effective sharing, collaboration, and coordination among and between responders before, during, and after declared emergencies. Some agreements may embrace a legal contractual approach, obligating parties to adhere to specific terms. Others, such as MOUs or compacts (like EMAC—see **Part II**), may avoid binding parties by enabling flexibility for participants needing to adapt to unforeseen circumstances.

## ***VHP Programs***

Congress passed the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (PL 107-188) to facilitate the effective use of VHPs during PHEs. The Act led to HHS' establishment of the ESAR-VHP program in April 2004, which was subsequently reassigned to ASPR with the passage of the Pandemic and All-Hazards Preparedness Act (PAHPA) in December 2006.<sup>41</sup> State-based ESAR-VHP programs follow federal guidelines, standards, and definitions and receive supplemental funding and technical assistance, to support their development. ESAR-VHP systems may be linked with MRC or other comparable systems to organize and allocate VHPs in emergencies.

In August 2007, the Uniform Law Commission finalized the UEVHPA<sup>42</sup> to facilitate the deployment and use of VHPs in declared emergencies. VHPs include compensated and uncompensated individuals acting of their own volition during declared emergencies. As discussed in various sections below, the Act provides reasonable safeguards to assure that VHPs are appropriately licensed and regulated. It also authorizes state governments to regulate, direct, and restrict the scope and extent of services provided by VHPs to promote disaster recovery operations. Public and private sector VHPs are also entitled to workers' compensation benefits and affirmative civil liability protections. Numerous jurisdictions have introduced or enacted UEVHPA, or portions thereof, including Colorado, North Dakota, and Utah.<sup>43</sup>

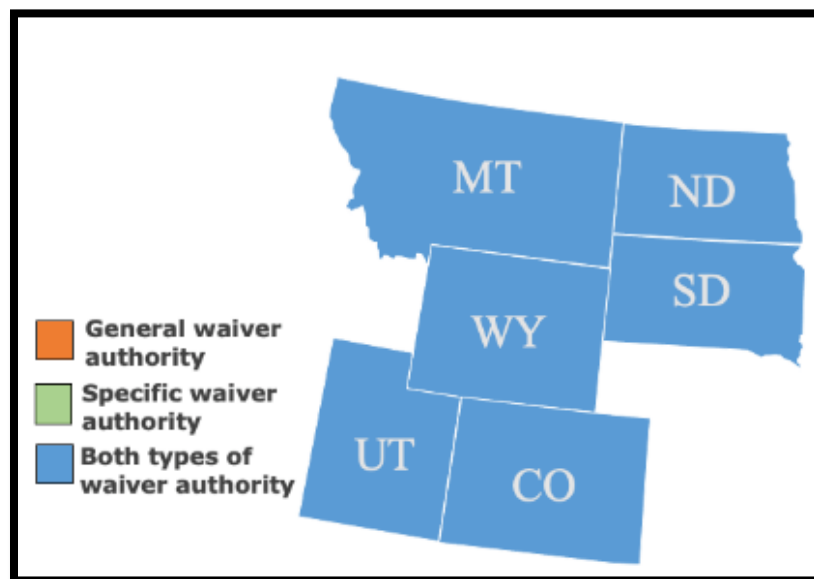
## ***Practicing Legal Triage***

Emergency laws might fail to ensure best practices due in part to their lack of specificity and potential limitations stemming from constitutional requirements or contractual limitations.

Framed in broad language, shaped by political realities, and subject to frontline fluctuations, emergency laws offer more so a menu of legal powers and options rather than definitive guidance. As a result, legal triage efforts may be warranted to identify legal issues and develop real-time solutions to achieve optimal public health results in light of various and fluctuating constraints and contexts.

For example, emergency declarations may allow for waivers of state-based laws or policies that otherwise hinder emergency response.<sup>44</sup> **Figure 3**, below, denotes MPRDHRS states with specific waiver authorities pursuant to emergency declarations. Colorado’s governor is authorized, for example, to temporarily suspend or modify state laws or rules if it is essential to provide temporary housing for disaster victims.<sup>45</sup> North Dakota law allows for the suspension or extension of provisions to grant relief from deadlines during a judicial emergency.<sup>46</sup> Whether and when to activate emergency powers entail real-time assessments grounded in existing knowledge of available legal tools and options.

**Figure 3. Region States Waiver Authorities**

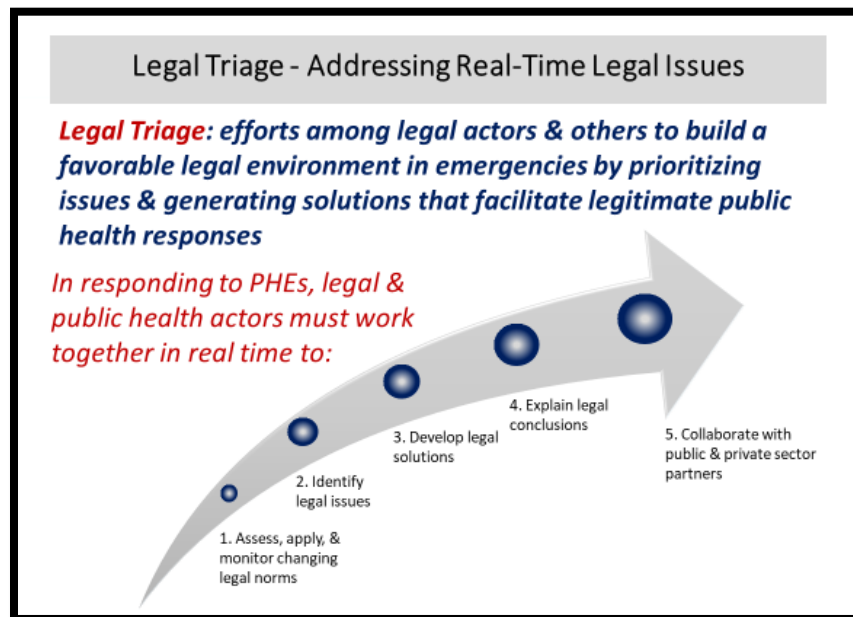


As evinced during the COVID-19 pandemic from 2020-2022, a primary facet of legal triage is determining best practices or options to protect the public’s health while balancing constitutional, political, and economic interests. In response to some public measures enacted during the COVID-19 pandemic, multiple states, including some in Region VIII, introduced and passed legislation<sup>47</sup> aiming to explicitly limit the options available to public health authorities to address PHEs. This included bills forbidding local health authorities and governors from taking specific actions that some lawmakers viewed as unwarranted infringements on individual rights or economically burdensome. In 2021 Montana’s legislature, for example, introduced and enacted House Bills 121<sup>48</sup> and 257,<sup>49</sup> which allowed local governing bodies (e.g., county councils) to rescind local board of health emergency orders, barred local ordinances regulating business closures, and prohibited quarantining of persons believed to be infected or exposed to COVID-19 but not yet ill. That same year, Montana also passed House Bill 702,<sup>50</sup> which banned mandatory vaccine requirements for employment and outlawed discrimination based on vaccination status. North Dakota House Bill 1323,<sup>51</sup> enacted over the governor’s veto in 2021, prohibited state officials from requiring individuals to wear face masks, shields, or other protective coverings.



Advance planning and well-communicated interpretations of legal statutes in real-time can alleviate or avoid legal impediments that might hinder disaster responses and coordination while respecting individual rights. Careful planning can also avoid confusion, since without affirmative direction regional responders may act unknowingly outside of legal boundaries. Alternatively, they may fail to act where they are authorized to do so because of erroneous legal advice, liability fears, or other actual or perceived legal consequences. Neither of these outcomes is acceptable. As a result, emergency planners, public health practitioners, HCWs, legislators and their respective legal counsels must be prepared to work together to triage legal issues and solutions in emergencies to effectuate legitimate public health responses. As per **Figure 4**, below, they must make critical legal decisions that balance communal and individual interests in emergencies where facts may be unclear or science is evolving, resources are scarce, and communal well-being is imperiled.<sup>52</sup>

**Figure 4. Emergency Legal Triage**



Manifold options exist to address state-level limitations on public health authorities. This includes deference to federal responses.<sup>53</sup> During the COVID-19 pandemic, for example, Presidents Trump and President Biden issued or retained multiple emergency classifications of COVID-19, each of which carried explicit authorities that can preempt contrary state responses. The PREP Act, for example, disallowed conflicting state actions related to medical countermeasures and HCW licensure and liability during the pandemic.<sup>54</sup> Bills proposed in 2021 in Montana,<sup>55</sup> South Dakota,<sup>56</sup> and Utah<sup>57</sup> aiming to limit state interpretations of federal public health measures based on state attorney general interpretations may be inconsequential in the face of federal preemption. Federal spending conditions placed on funds received by states can set strict guidelines for how funds are spent, essentially overriding contrary state laws or policies. Violations of federal spending guidelines may result in funds that are “clawed-back” by federal authorities.<sup>58</sup> State governors may also lawfully side-step legislative public health constraints through their executive authorities to issue emergency waivers. And, in many cases, PHAs can find additional legal routes to accomplish critical public health objectives by relying on alternative powers not subject to legislative limitations.<sup>59</sup>

## II. EMERGENCY MANAGEMENT ASSISTANCE COMPACT

The Emergency Management Assistance Compact (EMAC) is an interstate mutual aid agreement (MAA) between all states (as well as D.C. and several territories) administered by NEMA. When activated (see **Figure 5**, below) EMAC allows for mutual assistance between states in response to any declared emergency or disaster. As resources become scarce, personnel or resources can be deployed quickly across state lines to facilitate efficient and effective responses. Although EMAC does not specifically provide for patient transfers, deployed EMAC personnel and resources may facilitate patient movement (for example, by opening temporary health care sites or providing transportation).

**Figure 5. EMAC Organization**<sup>60</sup>



In multiple emergency scenarios, EMAC entails participation of individuals from numerous health and non-health related professions. Jurisdictions assist each other by providing requested goods (e.g., generators, temporary shelters, equipment) or services (e.g., security, medical personnel). Within 36 hours of Hurricane Katrina's landfall in September 2005, for example, over 6,000 HCWs were deployed to affected regions through EMAC.<sup>61</sup> While EMAC can be a primary pathway for the deployment, the utility of HCWs on site in any emergency depends on other laws, policies, and response coordination efforts.

States may also utilize international emergency aid. The Northern Emergency Management Assistance Compact (NEMAC) (see Figure 6) was congressionally approved in 2013, led by Sen. Herb Kohl (WI) and Sen. John Hoeven (ND), to allow Central and Prairie regions of the United States and Canada to enter into an agreement to facilitate cross border emergency management assistance through mutual aid.<sup>62</sup> Through NEMAC Illinois, Indiana, Ohio, Michigan, Minnesota, Montana, New York, North Dakota, Pennsylvania, and Wisconsin, may participate in

cross-border mutual assistance efforts with Alberta, Manitoba, Ontario, and Saskatchewan. Like EMAC, NEMAC addresses liability, workers compensation, licensure, and reimbursement issues across and between the select U.S. states and Canadian provinces.<sup>63</sup>

**Figure 6. NEMAC Parties**



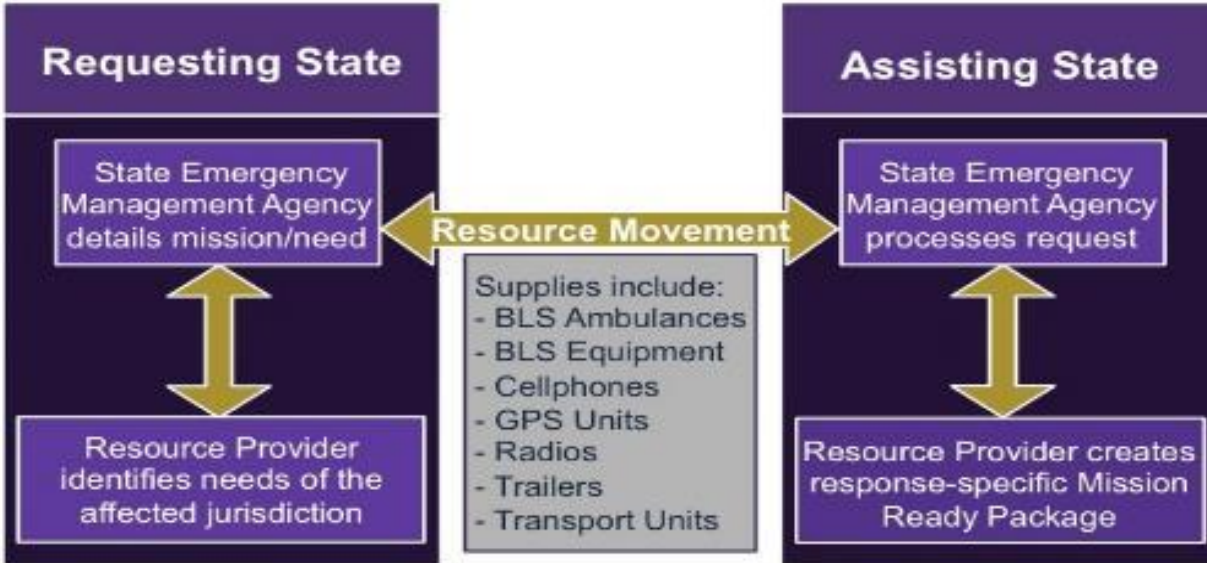
Out-of-state HCWs cannot normally legally practice in a state in which they are not licensed (see **Part. III**). To facilitate interstate sharing of HCWs, EMAC authorizes a requesting state to recognize out-of-state medical or other licenses for purposes of rendering aid in declared emergencies or disasters, subject to limitations imposed by the requesting state’s governing body. Persons holding an out-of-state license, certificate, or permit are “deemed licensed, certified, or permitted by the state requesting assistance” when deployed through EMAC.<sup>64</sup> These personnel must adhere to the requesting state’s scope of practice requirements and other requirements.

Furthermore, individuals providing aid through EMAC are considered agents of the requesting state and are not liable for any acts or omissions conducted in good faith.<sup>65</sup> States participating in EMAC exchanges of personnel to other states must also provide workers’ compensation benefits for persons they deploy.<sup>66</sup> If these persons are injured or killed while active in response efforts, the sending state will compensate personnel or their families through such protections.

In most jurisdictions, only public sector professionals can be deployed through EMAC. In response to Hurricane Katrina, however, some states deputized private sector individuals as state agents or issued executive orders to allow private sector volunteers to be deployed through EMAC. Some persons may enter into volunteer services agreements (VSAs) or MOUs with their state emergency management agency prior to deployment. In Ohio, for example, state officials executed MOUs with county governments that authorized the use of local personnel for EMAC response efforts. In South Dakota, a Joint Power Agreement enables deployed personnel to be considered employees of the state. This agreement was successfully used in an EMAC response to North Dakota to assist with mass care during a major flood event in 2009.<sup>67</sup>

In declared emergencies EMAC also facilitates the exchange of supplies (e.g., PPE, GPS units), equipment (e.g., ambulances, trailers), or even entire facilities (e.g., mobile field hospitals or units) to requesting states (see **Figure 7**, below).<sup>68</sup> EMAC contracts list the resources the requesting state must supply, including fuel, area maps, medical supplies, and lodging and meals for assisting personnel.

**Figure 7. Role of EMAC & Allocations**



Any state aiding another must be reimbursed by the receiving state for any cost incurred in providing the assistance or for expenses due to loss or damage incurred in the operation of equipment.<sup>69</sup> The REQ-A<sup>70</sup> details expenses that are eligible for reimbursement.<sup>71</sup> States may also donate resources and services to the requesting state. Referred to often as “zero-dollar missions” states may provide resources at no charge to the emergency-impacted state. REQ-As between states must reflect a \$0 cost estimate to show the state is donating the resource or service.<sup>72</sup>

COVID-19 presented unique EMAC applications. Unlike emergencies such as Hurricane Katrina that were localized to a single state or region, all states experienced significant impacts from COVID-19. Health care systems nationally strained to meet surging numbers of patients, including large hospitals (e.g., Denver Health), and smaller rural hospitals (e.g., West River Regional Medical Center in Hettinger, ND<sup>73</sup>). Still, the spread of COVID-19 did not hit all parts of the U.S. equally or coextensively, allowing resources to be directed or re-directed to regions with high COVID-19 cases and hospitalizations. As different parts of the country reached epidemic peaks, EMAC facilitated the temporary relocation of HCWs,<sup>74</sup> PPE, ventilators, and medical supplies, among other essentials. On March 27, 2020, FEMA Administrator Pete Gaynor requested jurisdictions with excess capacity consider using EMAC to offer resources to struggling areas.<sup>75</sup> On April 9, 2020, for example, California Governor Newsom loaned 500 ventilators to 6 states (e.g., DE, IL, MD, NV, NJ, and NY), as well as D.C., via their EMAC requests.<sup>76</sup>

### III. LICENSING, CREDENTIALING & PRIVILEGING

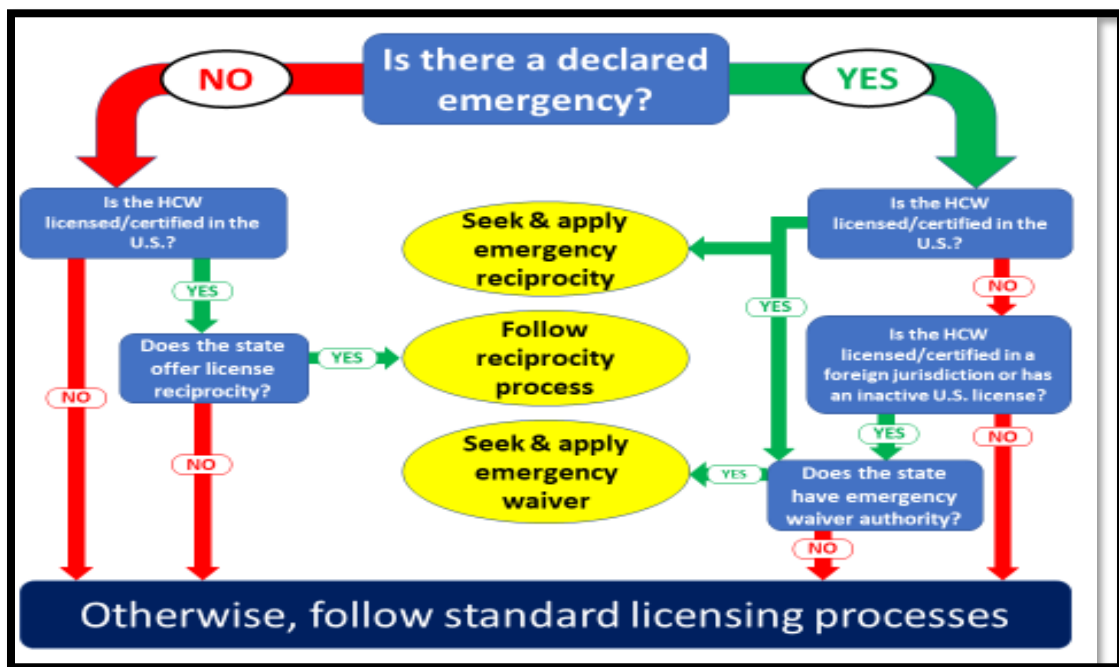
Professional licensure (or certification) of HCWs (e.g., physicians, nurses, EMTs, pharmacists, behavioral health professionals) is undergirded by specific state laws that vary across jurisdictions.<sup>77</sup> State licensure requirements dictate the circumstances and scope under which a health professional may practice. HCW licensing typically occurs through a state's department of professional regulation or department of health. Each profession usually has its own licensing board responsible for evaluating personnel, granting licenses, and conducting disciplinary hearings. Health professionals or others practicing without a license can be subject to criminal or civil penalties, depending on the jurisdiction.<sup>78</sup>

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

#### *Reciprocity*

Despite potential legal barriers, several pathways to licensure in non-emergency and declared emergency environments may facilitate rapid deployment and use of HCWs from other jurisdictions. **Figure 8**, below, illustrates multiple routes authorizing HCWs to practice out-of-state. When an emergency has been declared, HCWs licensed or certified in a U.S. state may be able to obtain licensure reciprocity through existing processes (e.g., EMAC – see **Part II**) or via waivers of licensing requirements from the state requesting assistance. Absent an emergency declaration, licensed HCWs may obtain licensure reciprocity through expedited or routine processes.

**Figure 8: Pathways to Licensure Reciprocity**



In non-emergencies, reciprocity among HCWs is available in some states for those who are licensed in good standing elsewhere.<sup>79</sup> Examinations and other requirements are generally waived for reciprocity applicants, although application forms/fees may be required. Additional fees may also be charged by the applicant's home state for certification of status. Most jurisdictions similarly offer "fast-track" licensure for military veterans and others with sufficient certification.<sup>80</sup>

Other licensure reciprocity structures facilitate cross-border exchanges of HCWs. Thirty-nine states have adopted the Nurse Licensure Compact (NLC), including all of the Mountain Plains states.<sup>81</sup> NLC allows nurses to practice in any of the compact states pursuant to expedited application processes. Similar agreements may be adopted to extend reciprocity to other licensed personnel. Twenty-nine states have enacted and been fully adopted into the PSYPACT Commission, including Colorado and Utah. Colorado enacted PSYPACT legislation which went into effect in April 2018, while Utah enacted PSYPACT legislation in March 2017.<sup>82</sup> Under PSYPACT, licensed psychologists in compact states may apply for telepsychology and temporary in-person practice privileges across state lines.<sup>83</sup>

A separate compact provides similar interstate licensure recognition and protections for EMS workers. The Recognition of EMS Personnel Licensure Interstate CompAct authorizes the EMS Compact, which is managed by a multi-state commission. Each participating state appoints a commissioner. This compact facilitates movement of licensed EMS personnel across state lines, standardizes their licensure requirements, mandates uniform background checks of personnel (via the Federal Bureau of Investigations), and establishes a national EMS database.<sup>84</sup> Five Mountain Plains states (CO, SD, ND, UT, WY) are participants in the Model EMS Compact.

### **Emergency Laws**

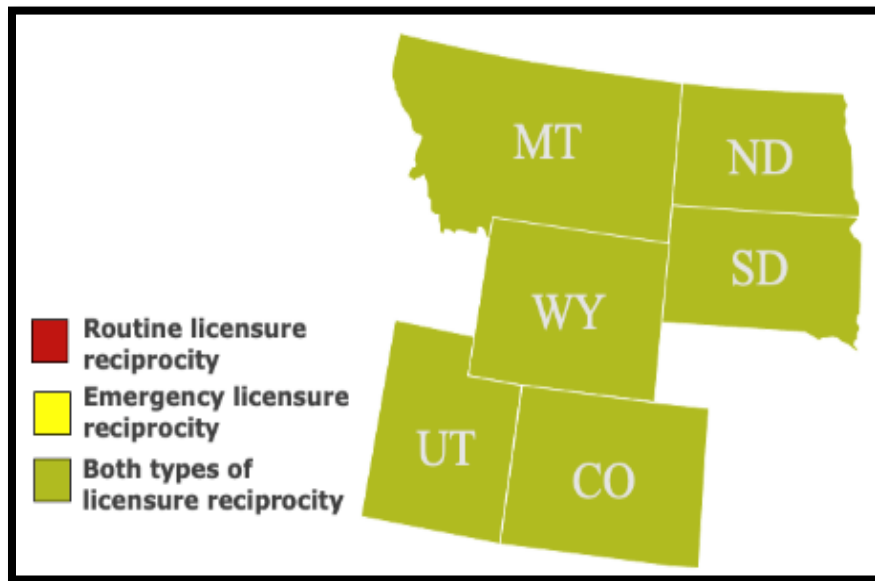
While these types of reciprocity, above, can significantly reduce the time required to obtain licensure, they are not instantaneous and can be of limited utility during a rapid, catastrophic emergency when HCWs are needed immediately. As discussed in **Part I**, declarations of emergency, disaster, or PHE may activate various compacts and agreements that can speed up and facilitate out-of-state licensure recognition for HCWs.

Pursuant to EMAC (see **Part II**), persons licensed or certified in any other compact jurisdiction are automatically "deemed licensed" by the requesting state (subject to any limitations or conditions imposed).<sup>85</sup> HCWs may thus provide services in response to the emergency to the same extent as if they were licensed in the affected jurisdiction so long as they are registered and deployed by their home jurisdiction as part of coordinated response efforts. Many states' laws provide significant flexibility in recognizing out-of-state licensure during an emergency. The aforementioned MSEHPA (see **Part I**) provides for recognition of out-of-state licenses among HCWs during a declared PHE.<sup>86</sup>

As per Figure 9, below, all 6 Mountain Plains states authorize licensure reciprocity for HCWs during routine operations outside of formal emergency declarations (see **Appendix - Table 2**). For example, Colorado law allows physicians residing and employed in another state to practice *pro bono* in state without a Colorado license.<sup>87</sup> Wyoming law permits physicians who are licensed and in good standing elsewhere to be brought in for consultation by a physician licensed in Wyoming to practice medicine for no more than 12 days per year.<sup>88</sup> North Dakota law provides for licensing for applicants with a current valid letter of qualification issued through the interstate medical licensing board.<sup>89</sup>

Mountain Plains states also have specific statutory or regulatory authority for licensure reciprocity during declared emergencies. In Montana, a VHP who possesses an active license in another state may practice as if the person is licensed in-state during declared emergencies.<sup>90</sup> In Utah, a national, state, or local emergency, or a PHE declaration enables the Division of Occupational and Professional Licensing to suspend the requirements for a permanent or temporary license for those licensed in other states for the duration of the emergency.<sup>91</sup>

**Figure 9. Region States Licensure Reciprocity**



Several state health departments have ordered the granting of temporary licenses amid the COVID-19 declared emergency. For example, Colorado issued an Order temporarily suspending some State Board of Nursing Rules to facilitate the completion of nursing school to make more professionals available.<sup>92</sup> On March 20, 2020, North Dakota issued an executive order suspending licensure requirements for specific health practitioners for the duration of the declared state of emergency.<sup>93</sup> Montana Governor Steve Bullock suspended licensure requirements for out of state health care professionals on April 21, 2020 until the end of the declared state of emergency.<sup>94</sup> On December 18, 2020, South Dakota Governor Kristi Noem ordered the extension of some emergency healthcare licenses until June 30, 2021.<sup>95</sup>

Among states adopting the UEVHPA (see **Part I**) VHPs can be granted temporary out-of-state license recognition for the duration of an emergency.<sup>96</sup> However, they must be listed within volunteer registrations systems, such as ESAR-VHP or MRC, and serve through coordinated efforts. “Spontaneous volunteers”<sup>97</sup> may not legally be entitled to licensure reciprocity. Public and private entities may be reluctant to fully utilize spontaneous volunteers who cannot be fully vetted in advance due to liability concerns, as discussed in **Part IV**. Still, they may carry out other roles, like coordination and communication activities, that do not require medical licensure.

### **Emergency Waivers**

As noted in **Part I**, federal, state, and some local governments may suspend or waive legal provisions, including licensure laws, during a declared emergency. All 6 Mountain Plains states authorized some form of licensure reciprocity during the COVID-19 pandemic – including by

waiving in out-of-state licenses temporarily.<sup>98</sup> Waiver of licensure provisions is generally accomplished via a governor's executive order pursuant to formal declaration of emergency or disaster. Waivers may enable qualified HCWs from other states (or countries in some cases) and those with expired or inactive licenses, to assist response efforts depending on state law and the specifications of the waiver.

Pursuant to § 1135 of the Social Security Act, HHS' Secretary may waive or modify certain requirements for Medicare, Medicaid, S-CHIP, EMTALA, and the HIPAA Privacy Rule.<sup>99</sup> Multiple §1135 waivers were authorized, for example, in 2009/2010 for the H1N1 influenza pandemic, in 2012 for Hurricane Sandy,<sup>100</sup> and extensively beginning in 2020 in response to COVID-19. Two conditions precipitate the Secretary's invocation of HHS' waiver authority:<sup>101</sup>

- (1) the President must declare a major disaster via the Stafford Act or an emergency under the NEA; and
- (2) HHS' Secretary must declare a PHE.<sup>102</sup>

Once these conditions are met, the Secretary may modify: (a) certain conditions of participation or other certification requirements for health care providers; (b) requirements that HCWs hold a license in the state in which they provide health care services for purposes of reimbursement; and (c) limitations on payments for health care items and services provided to Medicare Advantage enrollees to allow use of out-of-network providers.<sup>103</sup> Health care facilities may receive specific waivers or modifications facilitating their reimbursement.<sup>104</sup>

### ***Credentialing & Privileging***

Credentialing and privileging play a vital role in the ability of health care organizations and PHAs to assess the qualifications and shape the practice of licensed HCWs. Health professionals credentialed in their fields have additional opportunities to practice in health care organizations that require such status. Likewise, many health care facilities require professionals to undergo clinical privileging prior to practicing in their facility. The level of privileges granted to a health professional within a specific facility affects that practitioner's scope of practice. State laws generally require hospitals and other health care organizations to formulate procedures governing credentialing and privileging for health professionals, frequently via a hospital's medical bylaws.<sup>105</sup>

Credentialing processes involve "obtaining, verifying, and assessing the qualifications of a health care practitioner to provide patient care, treatment, and services in or for a health care organization."<sup>106</sup> Credentialing determinations utilize criteria such as a HCWs licensure, education, training, experience, and other qualifications.<sup>107</sup> Hospitals and other health organizations may engage in credentialing internally or accept credentialing determinations made by external organizations, such as credential verification organizations.

Privileging processes entail the integral role in the relationship between physicians (or other health professionals) and a health care organization. Privileging allows an organization to evaluate a professional's credentials and qualifications, and to grant permission to engage in a defined scope of practice at a specific organization (with or without supervision) based upon these qualifications.<sup>108</sup> Practitioners seek clinical privileges to obtain necessary authorization to provide specific care, treatment, and services in an organization.

Privileging decisions are usually within the discretion of the organization and are made on a case-by-case basis with patient safety and quality of care as primary concerns.<sup>109</sup> Determinations are based on the practitioner's applicable experience, education, licensure,



training, experience, and judgment.<sup>110</sup> Unlike licensure and credentialing, however, privileges only apply within well-defined parameters of scope of practice, and only within the specific institution granting them.

Several legal and policy provisions may alter credentialing and privileging requirements in declared emergencies to facilitate the rapid assessment and deployment of HCWs and VHPs across facilities and jurisdictions. The Joint Commission requires medical staff bylaws to feature emergency management plans that include a means by which hospitals identify health professionals to provide care during emergencies. A hospital may grant disaster privileges to a health professional upon a showing by the individual of: (1) a hospital ID card; (2) a current license to practice and a valid picture ID issued by a governmental authority; (3) identification indicating that the individual is a DMAT member; (4) identification indicating that the individual has been granted authority to care for and treat patients under disaster circumstances; or (5) a hospital staff member attests to the individual's identity.<sup>111</sup>

The Joint Commission also requires hospitals to have policies regarding the granting of temporary clinical privileges when a new applicant is awaiting formal approval by the medical staff executive committee or "to fulfill an important patient care, treatment, and service need." Prior to granting temporary privileges, the hospital must verify the professional's licensure and competence.<sup>112</sup> State or regional volunteer health registries like ESAR-VHP or MRC can play a role in this process by advance reviews of credentials of VHPs to determine if they are qualified to provide the type of care requested of them. Health facilities may also utilize the information provided by ESAR-VHP to grant temporary or disaster privileges to VHPs.

### ***Expanding Scope of Practice***

HCW's legally defined "scope of practice" details the services they may provide with a specific license or certification. Variations in the scope of practice between states can impinge HCWs working or volunteering across state lines in emergencies. Specific guidance may also derive from waiver authority used to recognize out-of-state HCW licensure during a declared emergency, restricting workers' scope of practice as a condition of temporary license recognition. Some emergency laws explicitly address conflicting scope of practice provisions and determinations as to which set of standards controls. EMAC similarly provides for conditions and restrictions on scope of practice as determined by the state requesting assistance.<sup>113</sup>

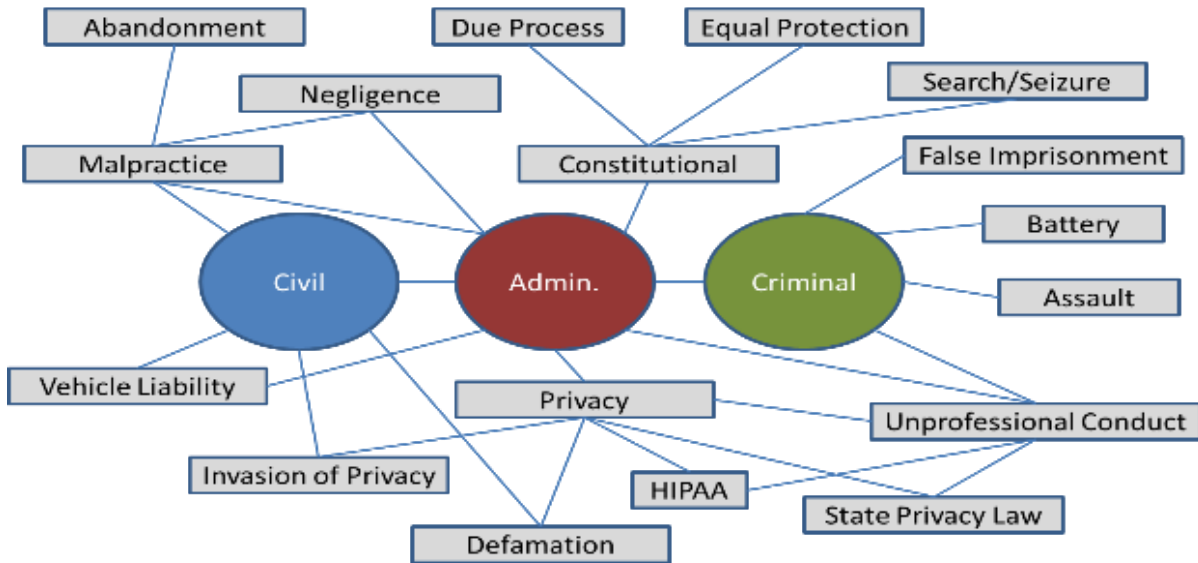
Scope of practice restrictions limit who may provide what services and where services may be delivered. For example, EMS personnel are generally authorized to assess and treat patients at the scene of an emergency, during patient transportation, or, in some jurisdictions, within a health care facility.<sup>114</sup> Non-traditional and expanded EMS functions in declared emergencies may include patient assessment activities, assisting in mass public vaccination campaigns, and other prevention efforts.

Temporary waivers or suspensions of state or local laws can set aside scope of practice restrictions, enabling HCWs to act consistent with their education and training beyond what they are legally authorized to do normally. During the 2009/2010 H1N1 pandemic, Maryland authorized paramedics and Cardiac Rescue Technicians to vaccinate public safety personnel, HCWs, and the public.<sup>115</sup> Other states have used similar authority to address significant public health crises, such as emergency waiver authorization to allow increased Narcan access for Massachusetts' first responders addressing rising rates of opioid overdose.<sup>116</sup>

## IV. CIVIL LIABILITY, IMMUNITY & INDEMNIFICATION

Health care providers (individuals and entities) face varied liability risks in emergencies due to inadequate supplies or facilities, atypical protocols, shifting standards of care, and multiple other factors. As illustrated in **Figure 10** below, civil, criminal, and administrative liability issues comprise a complex web of interconnected risks for HCWs and entities.

**Figure 10: Web of Liability Risks**



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

### **Potential Liability for HCWs & VHPs**

HCWs and VHPs face an array of potential liability risks that include civil claims for medical malpractice or other grounds, criminal charges, administrative sanctions, and constitutional claims (for governmental actors), as briefly explained below.

**Civil liability.** Potential civil liability for HCWs and VHPs is typically grounded in legal claims of negligence, notably malpractice. Negligence claims against HCWs typically require proof of a breach of an affirmative duty to meet the standard of care, or other requirement to perform, that caused patient harms leading to damages. Non-physicians following established protocols or standing orders may be protected from liability in some jurisdictions if they follow instructions from supervising physicians in good faith.<sup>117</sup> However, HCWs are generally not protected if their actions: (1) are intentionally harmful, (2) are completely lacking in care (which may be referred to legally as “recklessness,” “gross negligence,” or “willful and wanton” negligence), or (3) constitute an inexcusable violation of statute or regulation, such as practicing without a license (e.g., often referred to legally as “negligence per se”).<sup>118</sup>

Properly developed treatment protocols and standard operating procedures, especially state-wide level (e.g., guidance from medical boards) or at the institutional level (e.g., hospital system) can significantly reduce the risks of civil liability for HCWs by establishing and reinforcing appropriate standards of care. Deviations from protocols and standard procedures, in contrast, increase liability risks unless adequately justified.<sup>119</sup> Yet prevailing circumstances, and not protocols, generally determine the standard of care. Strict adherence to standing orders and similar tools may incentivize HCWs to ignore potential patient harms to protect against liability claims.<sup>120</sup> Courts recognize that circumstances like medical surge may require deviation from standard procedures, but development and use of comprehensive adaptable protocols coupled with advance and real-time training can mitigate liability risks.

Additional liability claims may surface during emergencies. Patient abandonment occurs if a HCW with a duty to care fails to ensure a patient has necessary care or access to a competent replacement.<sup>121</sup> In emergencies, abandonment claims may stem more so from a lack of personnel and resources. Like other claims, abandonment may be assessed based on medical and legal standards of care dependent on prevailing circumstances.

**Criminal Charges.** Beyond civil claims, HCWs may also be subject to criminal sanctions in limited circumstances. In the aftermath of Hurricane Katrina, Dr. Anna Pou was initially criminally charged by the Louisiana Attorney General following reports of patient euthanasias under her care at Memorial Medical Center in New Orleans. The charges were later dropped.<sup>122</sup> In March 2021, a nurse at an Indiana nursing home was charged with a felony after she removed oxygen therapy from a patient who later died.<sup>123</sup> Criminal charges may also include assault (provoking fear of bodily harm), battery (physical touching without consent), false imprisonment, child endangerment,<sup>124</sup> or abject failures to assist. In 2010, a New York EMT was charged with official misconduct for allegedly failing to assist a woman in distress in a restaurant where she and another EMT were taking a break. The EMTs never attended to the woman despite being informed of her situation. Only after 3 years of legal proceedings were criminal charges eventually dropped.<sup>125</sup>

**Administrative Sanctions.** HCW misconduct may also lead to administrative sanctions through formal complaints with employers or regulatory and oversight agencies.<sup>126</sup> Complaints may stem from failures to maintain patient confidentiality or comply with “Do Not Resuscitate” orders, incompetence, unprofessional conduct, or other misconduct.<sup>127</sup> Employers may conduct their own investigations of misconduct under the guidance of regulatory bodies and pursuant to established disciplinary plans.<sup>128</sup> Resulting sanctions may include employer discipline (e.g., suspension), censure, fines, or license probation or revocation orders.<sup>129</sup> State regulatory agencies may have to report these adverse actions to the National Practitioners Data Bank.<sup>130</sup>

In response to the 2014 Ebola outbreak, for example, Rhode Island’s EMS Chief collaborated on a joint statement regarding professional responsibility and HCW’s refusals to treat. The statement clarified that individual HCWs are “obliged to treat and/or care for Ebola patients” and failure to do so would result in an investigation and potential sanctions.<sup>131</sup> In routine events and declared emergencies, disciplinary actions stemming from criminal convictions, negligence, fraud, substance abuse, or actions outside professional standards may impact individual licensure and livelihoods.<sup>132</sup> In California, nurses were temporarily placed on leave for refusing to treat COVID-19 patients without a N95 mask.<sup>133</sup>

**Constitutional Claims.** Government officials and employees generally are not liable for their official actions unless they deprive a person of constitutional rights while acting “under color” of state law or policy,<sup>134</sup> meaning their actions are or appear to be officially authorized. Resulting

cases are often referred to as “§1983” claims based on the applicable federal statute under which they are brought.<sup>135</sup> Governmental HCWs may be subject to §1983 liability if they violate due process, equal protection, or other constitutional rights. These claims are difficult to prove because they require demonstration of intent to harm the patient or violate his or her rights. In 2005, a Florida federal court held that EMS professionals did not violate a disoriented and resistant patient’s due process rights when they tied and carried him to an ambulance (based on mistaken belief that a stretcher would not fit into his bedroom) because they did not intend to harm him.<sup>136</sup>

Additionally, § 1983 claims generally do not apply to employees of private entities, even when they act on behalf of governmental agencies. A Georgia federal court stated in 1992 that there likely was no “state action” (required for § 1983 claims) when medical workers employed by a private hospital took custody of a woman detained and handcuffed by police and transported her to a hospital at the officers’ request. The court held that even if this constituted state action, the workers did not display a deliberate indifference to serious medical needs in the form of unreasonable refusal, denial, or delay of treatment.<sup>137</sup>

### ***Potential Entity Liability***

Entities employing and supervising HCWs face their own liability risks during emergencies under multiple themes. Health care entities may be liable for their own negligence or that of their employed HCWs and volunteers. Most liability claims against entities for the actions of others tend to require “proof of agency,” or some level of control over the HCW. Proof of agency is relatively easy to establish in cases where a health care entity employs HCWs and fails to properly supervise their efforts, leading to patient harms.

Under legal theories known as “corporate negligence,” health care entities must use reasonable care in maintaining facilities and equipment, ensuring competence among employees, providing required oversight and supervision, and developing and adopting policies to ensure adequate patient care.<sup>138</sup> For example, a Florida regional medical center was held liable for the death of a 5-year-old child in 1990 because it failed to properly supervise, educate, train, and instruct paramedics who acted negligently in providing care.<sup>139</sup> In 2019, the Vermont Supreme Court found that a patient could sue both a hospital and its employee for negligent disclosure of personal information to an outside party.<sup>140</sup> Entity liability may extend directly from noncompliance with provisions of EMTALA, HIPAA Privacy Rule, or multiple other federal or state legal requirements.

Establishing proof of agency is considerably harder where the connections between the entity and its affiliates are less direct or tangential. For example, medical professionals who are members of a nonprofit entity are not typically viewed as agents of the entity,<sup>141</sup> thus negating entity liability for their acts. In 2004, a patient in Georgia brought a negligence claim against multiple health entities including a nonprofit association involved in the billing and collecting of medical service fees. The patient argued that the nonprofit was liable for the physicians’ negligence because it had an employer-employee relationship with the physicians. The court disagreed. To the degree the nonprofit had no control over the medical personnel’s activities it was not responsible for their actions.<sup>142</sup>

Nonprofit entities providing registrants or contributing to the operation of emergency registrations systems may be concerned about liability risks if their submitted registrants cause harm to patients due to their lack of essential skills or improper vetting. Claims may arise against the nonprofit entity on the theory it is partially responsible for the negligent or intentional actions

of the medical registrants. In addition to liability protections (see section below), however, these risks can be minimized through:

- careful crafting of legal documents clarifying the limits of the nonprofit's participation in the registration system;
- proper vetting and training of medical volunteers by the host entity receiving the registrants;
- advising patients of the limited nature of the registrants' involvement and lack of agency with the nonprofit entity; and
- advance confirmation with insurers of medical registrants or nonprofits that they cover specific claims prior to emergencies.

Governmental health entities may also face potential § 1983 liability (noted above) for employees' actions depriving individuals of constitutional rights. Note, however, that municipalities are generally not liable for employees' acts (for § 1983 purposes<sup>143</sup>) unless rights deprivations extend from formal municipal policies, widespread custom or practice, a conscious disregard of unconstitutional applications of policy, or failure to train or supervise employees in a manner that amounts to deliberate indifference to constitutional rights of the public.<sup>144</sup>

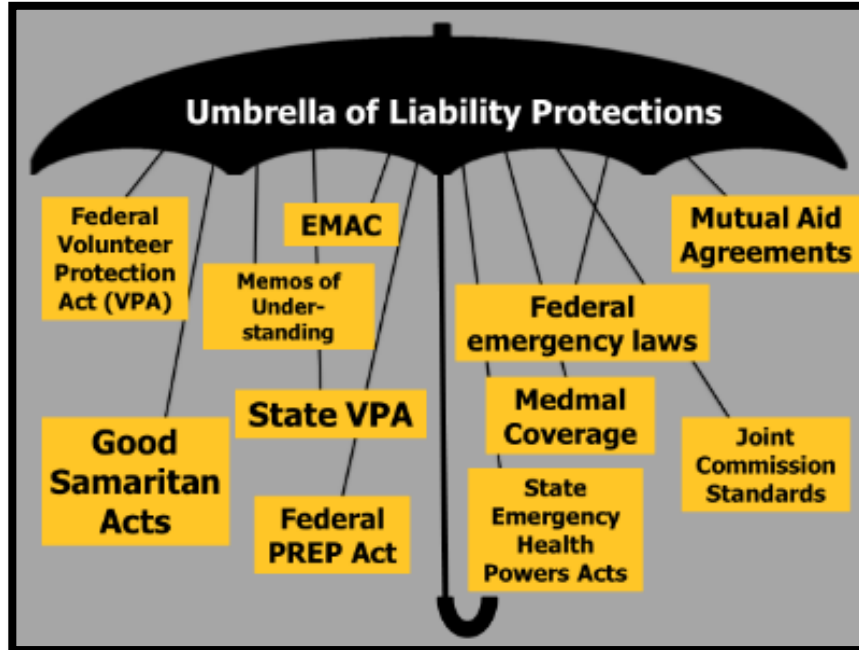
Similarly, the ADA,<sup>145</sup> federal Rehabilitation Act,<sup>146</sup> and corresponding state laws prohibit public entities from discriminating against individuals with physical or mental disabilities through services or programs. ADA violations can occur through laws, policies, or programs leading to direct or indirect discrimination. Individuals with disabilities may require special accommodations in emergencies. Failing to adequately account for the needs of vulnerable populations may result in liability for public entities and municipalities. Municipalities like New York City and Los Angeles County have been sued for failing to properly accommodate persons with disabilities in their emergency preparedness plans (see **Part V. Family Reunification**, below).

Discrimination concerns may also arise if HCWs or entities refuse to treat specific patients with specific conditions. In 1998 the U.S. Supreme Court determined that human immunodeficiency virus (HIV) infection was a disability under the ADA even in early, asymptomatic stages. Refusing to treat an HIV-positive or similar patients may violate the ADA unless the condition poses a significant risk of infection to others under the circumstances, as determined by available medical and other objective evidence.<sup>147</sup> Similar observations arose from initial efforts to successfully treat COVID-19 patients despite lack of efficacy of available interventions.

### ***Liability Protections***

Despite multifarious liability risks for HCWs, VHPs, and health care entities, there are also significant protections from liability during emergencies (illustrated in **Figure 11** and summarized below). These federal and state legal protections include sovereign immunity for government actors, statutory protections for HCWs, emergency laws (e.g., based on MSEHPA and UEVHPA), interstate compacts (e.g., EMAC), and Good Samaritan Acts (GSAs). Together, these laws may immunize or indemnify persons or entities for acts of ordinary negligence (but not for gross negligence or willful, wanton, or criminal acts). In declared emergencies, additional protections are activated, further insulating HCWs and entities from liability. Together these laws provide an "umbrella" of liability protections. Still, there is no universal protection against all possible sources of liability, and no laws can fully prevent the filing of meritless claims.

Figure 11: Liability Protections for Personnel & Entities



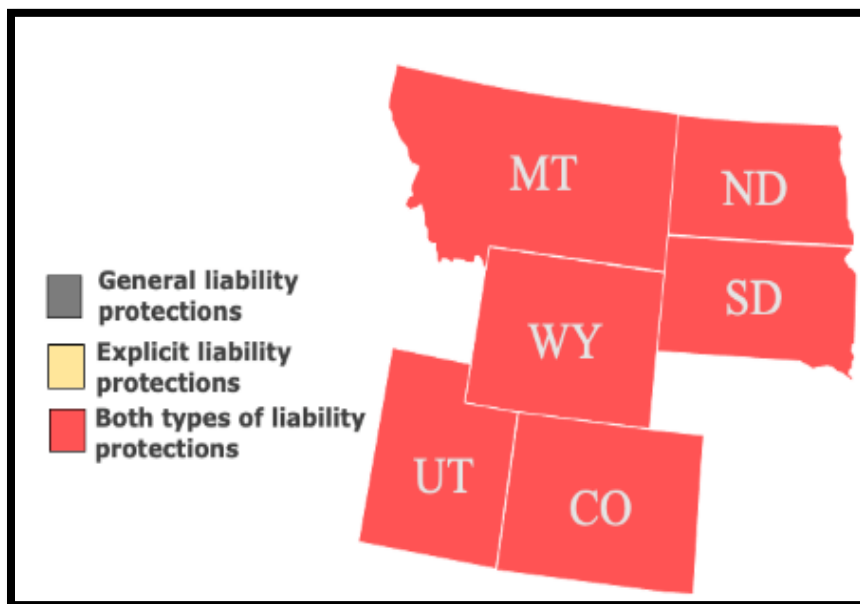
**Sovereign Immunity.** Legal principles of sovereign immunity protect many government entities and their personnel from civil liability related to official functions. In general, sovereign immunity protects a state (the “sovereign”) and its agencies from civil suits unless the state consents (usually via statutory law) to being sued. State “Tort Claims Acts” specify when state and local governments and their employees may be sued. These protections also extend to municipalities and their employees in some states. Employees who are held liable for acts in their official capacity may be indemnified by the state, meaning that the state assumes responsibility for expenses related to claims.<sup>148</sup> Utah’s Governmental Immunity Act broadly provides that all government entities are immune from suit for all “governmental functions.”<sup>149</sup> Governmental function includes “each activity, undertaking, or operation by a department, agency, employee, agent, or officer of a governmental entity.”<sup>150</sup> This may include HCWs deputized during the course of an emergency, although there is no publicized affirmation that Utah state officials sought this option for HCWs during COVID-19. Personal liability of a government employee for negligent acts or omissions within the course and scope of employment is limited to \$10,000 per claim. No employee is liable for any amount over that limit.

Governmental entities may not always be relieved of all liability. In 2009, a New York court held that sovereign immunity did not bar a suit by a home attendant allegedly injured while attempting to prevent her client from falling down a stairwell due to the negligence of 2 municipal EMS workers. The court held that the plaintiff could recover from the municipality if she proved that the workers’ negligence endangered her client and that her injury resulted from an attempt to rescue the client from that danger. When the practitioners undertook transportation of the client, concluded the court, they assumed a duty of reasonable care not only to her, but also to the home attendant.<sup>151</sup>

**Statutory Protections & Limitations.** HCWs are often statutorily protected from civil liability in carrying out their duties at the scene of an emergency or during initial patient transport. State-based volunteer protection acts may also insulate personnel, but often apply only to

volunteers associated with non-profit or governmental entities.<sup>152</sup> Similar protections of the federal Volunteer Protection Act<sup>153</sup> were further reflected in the federal Coronavirus Aid, Relief & Economic Security (CARES) Act concerning VHPs responding to COVID-19.<sup>154</sup> Other state laws may explicitly immunize HCWs from liability during declared emergencies, as per **Figure 12**, below.

**Figure 12. Region States Explicit Liability Protections**



All Mountain Plains states feature general legal authorities to shield HCWs from legal liability during declared emergencies (see Appendix - **Table 4**). For example in Colorado, the state and the members of the Governor Expert Emergency Epidemic Response Committee are not liable for any claim relating to an emergency epidemic, with exceptions for cases of wanton or willful misconduct or willful disregard of protecting public health.<sup>155</sup> Colorado’s legislature introduced a bill that would completely protect entities against liability related to COVID-19.<sup>156</sup> Another Colorado bill would bar liability unless it could be established by “clear and convincing evidence” that damages were caused by “failure to comply with public health guidelines” or gross negligence.<sup>157</sup> Neither bill has been enacted (as of August 15, 2022).

In Montana, individuals or entities acting to respond to a disaster or emergency are not liable for death or injury of individuals or for damage to property, except in cases of willful misconduct, gross negligence, or bad faith.<sup>158</sup> In North Dakota, emergency management functions are declared to be governmental functions and individuals acting in response are not liable for death or injury to persons, or damage to property.<sup>159</sup> All 6 states have additional authority to protect HCWs from liability during declared emergencies. For example, Utah law protects persons from liability related to any act or omission in the course of providing health care for the cause of the PHE performed in good faith.<sup>160</sup>

Governors may also issue specific emergency executive orders or other legal requirements to extend liability protections for HCWs and entities for the duration of the declaration. Attorneys general may also clarify statutory protections through Opinion Letters.<sup>161</sup> In response to COVID-19, for example, Colorado’s Governor issued Executive Order D 2021 135<sup>162</sup>

on October 31, 2021, authorizing the state's Department of Public Health and Environment to order hospitals and freestanding emergency departments to transfer or cease the admission of patients to respond to the current disaster emergency. The EO contained a provision immunizing HCWs:

“Hospitals, physicians, health insurers or managed health care organizations, health care providers, public health workers, or emergency service providers that in good faith comply completely with this Executive Order shall be immune from civil or criminal liability for any action taken to comply with this Executive Order...”

**Good Samaritan Acts.** Many states' GSAs protect persons who provide care at the scene of an emergency.<sup>163</sup> For example, Colorado's GSA states that volunteer HCWs rendering good faith emergency assistance are exempt from liability.<sup>164</sup> Some states' GSAs may only apply to persons responding to *ad hoc* emergencies or without a pre-existing duty to provide aid.<sup>165</sup> In Colorado, only HCWs who are acting *without compensation* are covered under its GSA. Likewise, South Dakota law provides that those providing aid in an emergency are immune from liability for any act or omission resulting in injury or other damage if acting in good faith (with exceptions for gross negligence).<sup>166</sup> Courts may look to the legislative purpose in enacting such protections to determine how broadly to apply them.<sup>167</sup>

**Charitable Immunity Protections.** Select states may also apply “charitable immunity” liability protections to certain nonprofit organizations (including nonprofit healthcare facilities) and its employees.<sup>168</sup> Wyoming, for example, provides liability protections to VHPs working at charitable nonprofit health facilities as long as the act or omission does not constitute willful or wanton misconduct.<sup>169</sup>

**PREP Act.** In addition to a series of state law protections, HCWs and public and private entities may also be protected under the Federal Public Readiness and Emergency Preparedness (PREP) Act.<sup>170</sup> During a federally declared emergency, the PREP Act provides significant liability protections with respect to the use of covered countermeasures defined by HHS' Secretary. Covered countermeasures include pandemic and epidemic products, drugs, products, and devices approved under an EUA. Countermeasures may come initially from federally-owned caches (e.g., SNS) or from other public or private sources.<sup>171</sup>

Protection under the PREP Act applies to all qualified persons (including institutional and governmental entities) who prescribe, administer, or dispense countermeasures and to officials, agents, and employees of these persons or entities.<sup>172</sup> In December 2014, for example, a PREP Act declaration was issued to provide liability protection related to 3 prospective vaccines for Ebola.<sup>173</sup>

PREP Act liability protections were also widely invoked in response to COVID-19.<sup>174</sup> The Biden administration amended PREP Act protections to permit certain qualified professionals such as nurses and retired doctors not licensed under state law to administer COVID-19 vaccines.<sup>175</sup> The Administration additionally encouraged states to allow rapid re-licensure for HCWs and provide temporary vaccination licenses for clinical students and foreign-educated HCWs, including physician assistants, pharmacists, and registered nurses.<sup>176</sup>

### **Workers' Compensation**

Workers' compensation is a government administered system providing limited benefits to victims for work-related injuries or death, regardless of fault.<sup>177</sup> Each state (and the federal



government) has enacted workers' compensation laws, which require work-related injuries to be reported and compensated in accordance with specific guidelines.<sup>178</sup> Every injury or death which occurs at work is subject to administration under workers' compensation for covered employees, often including "occupational diseases" such as infectious diseases for HCWs. Generally, the employer is liable if the employee sustains an injury that arises out of or occurs in the course of employment. Injured employees typically file claims for limited reimbursement for direct costs of medical treatment, lost wages,<sup>179</sup> and resulting disabilities. Most claims are paid via insurance coverage, although some large employers, including state governments, may be self-insured and administer their own claims.<sup>180</sup>

Workers' compensation is often the exclusive remedy for injured employees.<sup>181</sup> Direct lawsuits against employers outside the workers' compensation system are forbidden in most instances.<sup>182</sup> Employers cannot generally settle workers' compensation claims without advance approval of state workers' compensation administrators. Other forms of health insurance may deny claims for medical charges where a workers' compensation carrier is principally liable for these costs.

Generally, workers' compensation laws only cover "employees" and thus exclude unpaid volunteers or gratuitous workers. States may expressly extend explicit coverage to HCWs. North Dakota Governor Doug Burgum, for example, issued an Executive Order on March 25, 2020 allowing all first responders and HCWs exposed to COVID-19 to submit claims for workers' compensation. Those who test positive for the virus may be eligible for wage replacement and other benefits. Absent additional protections for VHPs, these persons may be excluded from such coverage because they may not be defined as "employees" under state law. Some courts have held that an emergency situation may create a presumption of employment through an implied contract for hire, but not typically when a VHP registers his or her willingness to offer services before the emergency situation arises. Interstate agreements like EMAC (see **Part II**) may provide workers' compensation protections for VHPs and emergency management workers.

Even if VHPs are covered through workers' compensation programs, benefits may still be elusive. Absence of workers' compensation benefits is risky for workers who may face hazardous working conditions during emergencies. During the COVID-19 pandemic, coverage depended on provisions related to occupational diseases. State coverage of occupational diseases varies. To receive compensation, states may require: (1) the employment involve peculiar or unusual risks of the disease—beyond that of the general population; and (2) the disease is attributable to a contact that occurred on the job.<sup>183</sup> In a disease outbreak, it may be difficult to prove that a disease was contracted in the course of employment when the spread impacts the general population, especially if the burden of proof falls on the worker.<sup>184</sup>

## V. OTHER LEGAL ISSUES

Consistent with the practice of legal triage in real-time events, every declared emergency features specific, new challenges in law and policy. As described in the sections below, key lessons emanating from the COVID-19 pandemic and prior national or regional emergencies extend from critical issues surrounding telehealth initiatives, CSC (including alternate care sites), EUAs, rights to re-employment, health information privacy, and family reunification efforts. To the extent these issues and their challenges may arise in future emergencies affecting Mountain Plains states, they are explored briefly in this final part.

### ***Telehealth & Telemedicine***

Telehealth and telemedicine are highly efficacious tools to assist patients in routine settings and during PHEs. Though often used interchangeably, these terms have distinct meanings and scope. Telehealth broadly refers to the use of electronic and telecommunications technologies to provide health care and services at-a-distance via clinical and non-clinical services.

Telemedicine (often considered a subset of telehealth) refers to the provision of clinical care by a physician, nurse, or other providers via remote services (video/audio) to a distant patient in real time.<sup>185</sup> In states effectuating routine or emergency licensure reciprocity, the provider and the patient need not be in the same jurisdiction. During PHEs like COVID-19, telemedicine increases the accessibility of health care providers to meet surge capacities, facilitating patient communication with HCWs and VHPs located in other jurisdictions.

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

Federal and state laws may restrict who (e.g., type of provider), where (e.g., interjurisdictional) and how (e.g., video or audio only) telehealth and telemedicine can be practiced. During COVID-19, several laws and regulations were temporarily altered to remove barriers to telehealth. At the federal level, the Coronavirus Preparedness and Response Supplemental Appropriations Act allowed HHS to temporarily waive certain Medicare telehealth restrictions or requirements during the emergency.<sup>186</sup> DEA issued guidance that DEA-registered practitioners may prescribe schedule II-V controlled substances without typical in-person evaluations under certain conditions.<sup>187</sup> HHS' OCR issued guidance that non-compliance with HIPAA Privacy Rule regulatory requirements during "good-faith" telehealth applications would not result in penalties during the COVID-19 PHE.<sup>188</sup> Multiple federal legislative proposals aimed to remove additional telehealth barriers by:

- limiting geographic restrictions;<sup>189</sup>
- improving telehealth for underserved communities;<sup>190</sup>
- establishing certain permanent key waivers;<sup>191</sup>
- conducting studies and report actions taken to expand telehealth access;<sup>192</sup> and
- permitting HHS to waive additional Medicare requirements.<sup>193</sup>

State laws have improved access to telehealth services. Twenty-nine states have enacted “parity” laws, requiring private insurers to reimburse for telehealth services as they would for in-person care.<sup>194</sup> These laws generally do not restrict a patient’s location, unlike Medicaid telehealth laws that have more restrictive “origination site” requirements. In Utah, what constitutes telehealth services expanded via legislation passed on May 12, 2020, broadening the scope of eligible services and requiring health plans to provide coverage parity and reasonable reimbursement.<sup>195</sup> Within Medicaid programs, 26 states<sup>196</sup> explicitly allowed personal homes as valid origination sites for telehealth, but reimbursement may be reserved only for those patients suffering from a chronic condition (e.g., congestive heart failure, diabetes, hypertension).<sup>197</sup> Licensing requirements likewise restrict physicians from administering telehealth services to out-of-state patients. The Interstate Medical Licensing Compact allows physicians to practice across state lines.<sup>198</sup> Furthermore, PSYPACT (see **Part III**) specifically allows for cross-state telepsychology and temporary in-person psychological services between inducted states.

Other telehealth restrictions can be addressed via state-based emergency declarations and gubernatorial executive orders expanding reimbursement and easing usual consent, licensure, and prescription requirements. Governors across the U.S. issued emergency orders or other guidance to facilitate telehealth during COVID-19. Most states expanded their Medicaid programs to cover telehealth services<sup>199</sup> and required private insurance plans to allow in-network providers to provide covered services via telehealth.

Governors in Colorado, North Dakota, and Utah issued orders to suspend telehealth provider licensure, certification, or registration requirements during the pandemic. In Colorado, Governor Polis’ order suspended certain statutes to extend telehealth services for health care providers and veterinarians.<sup>200</sup> Utah Governor Herbert allowed telehealth services to bypass security and privacy standards required by state law.<sup>201</sup>

Federal or state reimbursements for telehealth or telemedicine services present substantial concerns among providers. Prior to COVID-19, CMS could only reimburse clinicians providing telehealth services for Medicare beneficiaries under limited circumstances.<sup>202</sup> For example, a Medicare beneficiary receiving such services had to (1) reside in a designated rural area; and (2) travel to a local medical facility to receive services from a physician in a different location.

On March 16, 2020, however, CMS reimbursement for telehealth services for Medicare beneficiaries was drastically expanded via President Trump’s Stafford Act emergency declaration and Social Security Act §1135 waiver. Under the waiver, Medicare paid for office, hospital, and other health visits (including at one’s residence) conducted via telemedicine across the country. In addition to physicians, other HCWs, including nurse practitioners, clinical psychologists, and licensed clinical social workers, were authorized to offer covered telehealth services to their patients. CMS also allowed telehealth providers to waive patient deductibles and co-payments for the extent of the emergency.

On May 1, 2020, CMS further expanded the: (1) type of telehealth provider eligible for Medicare reimbursement (including physical and occupational therapists and speech pathologists); (2) list of allowable audio-only services (including behavioral health); and (3) type of facility that can bill for telehealth services (including federally qualified health clinics and rural health clinics).<sup>203</sup> Expansion of Medicare coverage for telehealth services lasts only as long as the §1135 waivers remain in place. Under the omnibus legislative package passed by Congress in March 2022,<sup>204</sup> select telehealth flexibilities will continue 151 days beyond the end of the PHE. This includes relaxed site-of-service requirements, extended audio-only services, and expanded

HCW types eligible for Medicare reimbursement. Additional legislative support for expanded telehealth services in H.R. 4040, passed by the U.S. House of Representatives on July 27, 2022, would extend COVID-era Medicare flexibilities through the end of 2024.<sup>205</sup> Professional organizations including the American Hospital Association support these enhanced telehealth services.<sup>206</sup>

Contrasted with Medicare reimbursements, state-based Medicaid programs already feature sufficient flexibility to use telehealth services. Federal approval is not required for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services.<sup>207</sup> States that expanded Medicaid coverage in light of COVID-19 within the realm of their routine authority can do so permanently subject to state discretion.

States can also broaden access to telehealth using Medicaid emergency authorities subject to federal approval. All 50 states and D.C. used §1135 waivers to allow out-of-state providers licensed in another state to provide care to Medicaid beneficiaries during the pandemic.<sup>208</sup> Forty-eight states and DC have used other waiver strategies to amend home and community-based services to expand telehealth access.<sup>209</sup> While these expansions also terminate at the conclusion of declared emergencies, members of Congress, CMS, and other federal actors are considering an array of options to allow greater use of telehealth practices after the COVID-19 pandemic.<sup>210</sup>

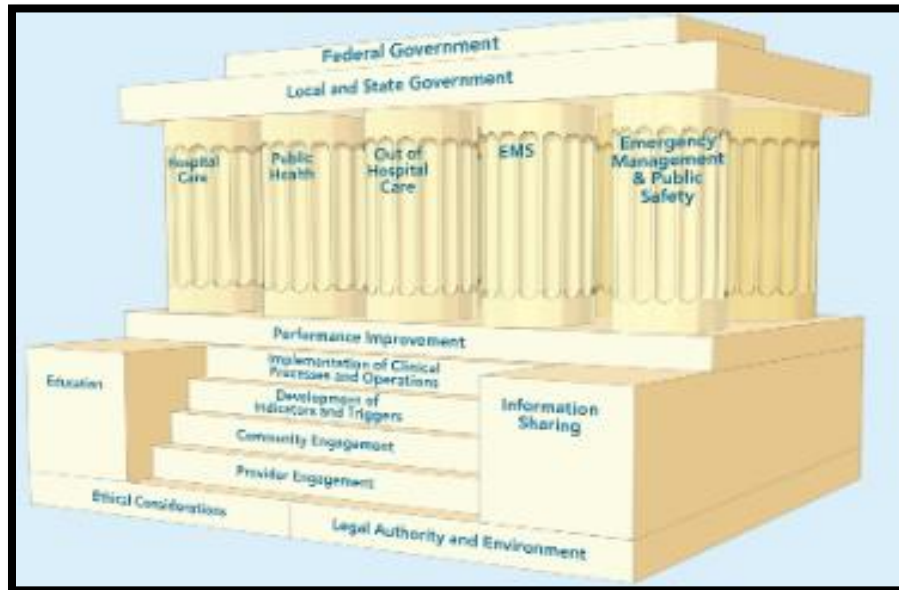
While expansion of telehealth services during COVID-19 has clear health benefits, concerns have arisen over increased risks of fraud and abuse for providers and patients.<sup>211</sup> For example, with increased telehealth reimbursement, providers may be more inclined to encourage health services for patients, yielding an overuse of unnecessary services. Fraud and abuse have arisen in many forms including kickback schemes and false claims from inaccurate billing and coding.<sup>212</sup> If telehealth expansions from COVID-19 are made permanent, updates of federal protections against healthcare fraud, waste, and abuse are anticipated.

### ***Crisis Standards of Care***

CSC refers to the substantial changes in typical healthcare operations and level of care that can occur during pervasive or catastrophic disasters. CSC was originally crafted by NAM in its 2009 original report in the throes of the H1N1 pandemic, updated in 2012, and revisited in a 2019 workshop (just prior to COVID-19). NAM also responded in March 2020 to ASPR's rapid request for guidance on salient issues for consideration related to medical triage decisions involving COVID-19 patients.<sup>213</sup>

Throughout its guidance, NAM describes how the level of patient care in emergencies falls along a continuum from "conventional" to "contingency" to "crisis."<sup>214</sup> Conventional medical standards of care resonate professional norms and expectations. Although they are flexible depending on circumstances, they do not generally address the type of care provided in a PHE when resources are scarce and critical decisions must often be made.<sup>215</sup> As illustrated in **Figure 13**, there are multiple facets, represented by pillars, critical to emergency responses in crises, including health care in hospitals and other settings, public health, EMS, and emergency management.

Figure 13: CSC Systems Framework<sup>216</sup>



Shifting to CSC in declared emergencies requires a change in focus from individual to population needs. Under CSC, persons with the greatest needs tend to receive available care first until everyone requiring services can be assessed and initially treated.<sup>217</sup> Tough decisions outside HCWs' normal practices must be made. For example, during the COVID-19 pandemic, EMS workers were instructed in multiple states to avoid CPR interventions for patients found at home whose heart rates flat lined per electrocardiograms performed on site.<sup>218</sup>

CSC implementation requires coordination of public and private entities and significant advance planning and engagement.<sup>219</sup> Several Mountain Plains states have developed general CSC policies, including Colorado<sup>220</sup> which recast its plan specifically to address COVID-19. Collectively, these plans cover many areas, such as emergency management policies, community and stakeholder outreach, and ethical guidance. Sophisticated plans also entail modifications of public health laws, privacy laws, liability concerns, and other elements consistent with a systems approach framework. Assessing potential liability claims during crises is difficult (as noted in **Part IV** above) when the standards of care change in real-time. CSC decisions may be assessed under changing legal standards resulting in uncertainty over potential liability, necessitating specific liability protections.

No amount of advance planning, however, may predict accurately when specific state jurisdictions may trigger implementation of their plans in crises.<sup>221</sup> Even during COVID-19 most states did not formally shift to CSC through invocation of their plans. In fact, express invocations of state-level CSC plans emerged in only a select number of states (including Alaska, Arizona, Colorado, Idaho, New Hampshire, and New Mexico).<sup>222</sup> Other states did not follow in part because they lacked express CSC plans, were politically reticent,<sup>223</sup> or deferred to health care facility efforts. Utah's CSC plan relied heavily on hospitals to invoke CSC as circumstances warrant. Even in Arizona and New Mexico, which formally triggered their CSC plans, state health authorities still deferred to specific hospitals' assessments as to invocation depending on patient volume and available resources.<sup>224</sup> Consequently, hundreds of hospitals and tens of thousands

of HCWs spontaneously operationalized patient triage efforts during the COVID-19 pandemic without formally invoking CSC.

CSC planning and implementation can help mitigate potential controversial issues. During the COVID-19 outbreak, numerous states' CSC plans were criticized prior to or during implementation related to their potential impacts on persons with disabilities (as chronic conditions are a risk factor for survival) and unequal applications leading to treatment disparities for the elderly or other vulnerable populations.<sup>225</sup> HHS/OCR opined in March 2020 that several states' plans invoked unlawful, discriminatory criteria for making triage decisions.<sup>226</sup> OCR worked with specific states, including Utah (see below), to modify CSC or triage plans that were potentially discriminatory.<sup>227</sup> Several lawsuits also arose related to direct harms to prospective patients extending from anticipated CSC implementation.

Another core legal challenge arose from the creation and operation of ACSs to help alleviate the processing of patients during repeated surges in the throes of the COVID-19 pandemic. As initially discussed in Part I, Colorado Governor Polis issued multiple Executive Orders in 2020-21 addressing ACS locations and operations in his state. Beginning in March 2020, Colorado leased multiple large-scale facilities to serve as ACS locations for medical surge patients transferred from hospitals and other health care facilities.<sup>228</sup> These Orders provided for additional, specific immunity from civil and criminal liability for HCWs and staff.<sup>229</sup> Employees of the Colorado Department of Public Health and Environment were redeployed to staff and manage the facilities. Public health educators were secured to engage in rapid training and offer disaster preparedness expertise. When rates of COVID-19 infections diminished, remote training was shifted to in-person. Colorado-based emergency management consultant groups offered live simulations to organize ACS training efforts into a single toolkit for the state.<sup>230</sup> ACS guidance emphasized accommodations for persons with disabilities or otherwise facing access limitations, including ADA-compliant transportation and adequate signage and communication services.<sup>231</sup>

State-level plans and compacts create additional tools for managing patient movement and transfer. MOUs enable patient transfer between hospitals who are parties to the agreement.<sup>232</sup> When transferring patients, Colorado's Hospital MOU requires hospitals to specify the length of time the patient is to be placed at the assisting hospital and provides specific guidance for reimbursements.<sup>233</sup>

State patient movement plans may apply when EMS systems require assistance to manage patient movement needs. For example, California's Patient Movement Plan<sup>234</sup> is activated whenever local EMS requires emergency assistance in managing patient movement needs, including repatriation. The Plan facilitates patient tracking and repatriation (return of patients to their originating location). For example, it designates HHS Service Access Teams to track and monitor admitted patient status and coordinate needs for discharged patients until transportation to their final destination is completed. Return to the patient's home jurisdiction may depend upon wellness to travel, determined safety of return jurisdiction, and availability of appropriate receiving facilities. Advance planning across California's integrated health systems covering multiple jurisdictions or regions streamlines efforts to repatriate patients post emergency by prioritizing patients to be moved based on multiple factors including capacity transportation availability.

Avoiding the specter of discrimination in CSC implementation is critical. During the COVID-19 pandemic, some states' CSC plans attempted to prioritize patients based on "survivability" using a number of factors including age, disability status, sequential organ failure assessment (SOFA) scores, and other measures. As hospital plans were activated, numerous

complaints were filed with HHS/OCR alleging state plans were impermissibly discriminatory. In Utah, an advocacy entity, Justice in Aging, submitted a complaint alleging that Utah's CSC plan permitted unwarranted resource allocation decision-making on the basis of age. The Disability Law Center separately alleged that Utah's CSC plan "explicitly and implicitly" deprioritized people with disabilities for care.<sup>235</sup> Following review of these and other complaints, OCR worked with Utah to revise its CSC plan to "[r]emove categorical exclusion criteria on the basis of age, disability, and functional impairment, instead requiring an individualized assessment based on the best available objective medical evidence," and other changes.

### ***Emergency Use Authorizations***

PAHPRA significantly enhanced the authority of HHS and FDA to issue EUAs to allow use of otherwise non-approved tests, medications, or treatments. Prior to or during an HHS-declared PHE,<sup>236</sup> HHS' Secretary can authorize FDA to issue EUAs to allow emergency use of tests, drugs, or other products. EUAs were used during the 2009/2010 H1N1 pandemic, for example, to (1) allow unapproved uses of zanamivir (Relenza<sup>®</sup>) and oseltamivir (Tamiflu<sup>®</sup>) for treatment and prophylaxis of young children and hospitalized patients;<sup>237</sup> and (2) use certain lots of antivirals beyond their expiration dates.<sup>238</sup> During COVID-19, EUAs were heavily relied on to authorize use for an array of COVID infection and antibody tests, as well as experimental treatments. On May 1, 2020, FDA issued an EUA for the investigational antiviral drug remdesivir (Veklury<sup>®</sup>) for treating suspected or confirmed COVID-19 cases where symptoms are severe and require hospitalization.<sup>239</sup> FDA also issued several EUAs for medical devices, including for personal respiratory protective equipment.<sup>240</sup> On August 9, 2022, FDA Commissioner Robert Califf utilized an EUA to allow changes to monkeypox vaccination protocols to greater utilize available supplies.<sup>241</sup>

EUAs permit the dispensing of products that are either (a) not yet approved for use or (b) approved but sought for an unapproved use.<sup>242</sup> An EUA can help make available for a temporary period a specific product that might otherwise be off limits in non-emergencies. Prior to issuing an EUA, FDA's Commissioner must conclude that:

1. a disease or other condition specified in the declaration poses a risk of serious or life-threatening disease or condition;
2. it is reasonable to believe that the drug or test may be effective in diagnosing, treating, or preventing the disease or condition;
3. known and potential benefits of use of the product outweigh the risks; and
4. no adequate, approved, and available alternative exists to address the disease or condition.<sup>243</sup>

Once issued, EUAs take effect nationally<sup>244</sup> and may remain in effect for the duration of the emergency (up to 1 year unless revoked or renewed).<sup>245</sup> FDA can also set conditions on activities carried out under an EUA to protect the public's health. These include ensuring that HCWs and patients are informed of risks, benefits, and alternatives, and that adverse events are monitored by manufacturers, HCWs, or public health authorities.<sup>246</sup>

Through its expanded authority pursuant to PAHPRA,<sup>247</sup> FDA can issue advance authorization (prior to any declaration of emergency) if HHS determines that there is significant potential for a PHE involving a biological, chemical, radiological, or nuclear agent that affects (or has significant potential to affect) national security. FDA requirements on the distribution and administration of EUA products, subject to HHS' Secretary approval, cannot be more restrictive than conditions on the approved use of the medical product.<sup>248</sup>

## ***Rights to Reemployment***

In emergencies, various persons including VHPs or members of the National Guard or DMAT teams, called away from their employment to respond to requests by a hospital or other entity elsewhere may seek assurances that their positions are retained when they return. Some states have enacted laws providing reemployment protection to individuals engaged in emergency response services. In addition, the federal government has adopted similar reemployment protections. For example, individuals who are members of federal governmental emergency response teams, such as a DMAT composed of civilian medical personnel, are given job, seniority, and wage protection in accordance with federal law when they are deployed for disaster response.<sup>249</sup>

The Uniformed Services Employment and Reemployment Rights Act (USERRA)<sup>250</sup> provides reemployment protection to non-career members of uniformed services who are called up for duty and provide written notice to their employers. Employees are generally entitled to reemployment upon the termination of the uniformed service, unless doing so would impose an undue hardship on the employer or the employer's circumstances have changed so much as to make reemployment impossible or unreasonable. USERRA also provides for protection from termination upon the return to work after uniformed service, as well as employees' seniority rights and benefits during their period of absence. Essentially, during an employee's period of uniformed service, employers must treat employees as though the employees are on furlough or leave of absence.<sup>251</sup>

Some states also offer limited employment protections for practitioners responding to PHEs via Disaster Service Volunteer Leave Acts.<sup>252</sup> These acts provide state employees who are disaster service volunteers with employment protection, subject to exceptions. In North Dakota, state employees who are certified disaster volunteers at the American Red Cross may be granted up to 5 days of leave per year to provide services, without loss of any other allocated time off.<sup>253</sup> Utah law offers up to 15 days of leave for state employees participating with a disaster relief organization.<sup>254</sup> Colorado law allows paid sick and safe time for employees caring for themselves and family members when ill. These provisions may be extended to afford paid leave to VHPs assisting in emergency response efforts. During COVID-19, Colorado issued orders to temporarily expand their paid time off requirements.<sup>255</sup>

## ***Health Information Sharing & Privacy***

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

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



and local health information privacy requirements should be carefully considered in planning for emergencies to assess how they may address the practical need for uses and disclosures of identifiable information in emergency situations.

Among other laws, the protection of health information privacy in many settings is federally regulated primarily by the HIPAA Privacy Rule.<sup>256</sup> It provides a national floor of privacy protections that treats all identifiable health data as private, and thus entitled to considerable protections and security assurance. Individuals cannot bring direct claims under the Privacy Rule, but violations are investigated by HHS/OCR.

Although the Rule seeks to protect patient privacy, it also allows considerable exchanges of identifiable health information (a.k.a., PHI) without written authorization of patients or their guardians for legitimate public health purposes, especially during emergencies. Distinct laws at the federal, state, and local levels protect the privacy and security of public health data.<sup>257</sup> Some provisions of the HIPAA Privacy Rule may also be effectively waived temporarily during national emergencies like COVID-19.<sup>258</sup> Similar waivers or exceptions may apply to other federal privacy laws. For example, laws related to patient data sharing from federally funded substance use programs allow temporary exchanges of health information without patient consent during declared emergencies that disrupt normal operations at these facilities. Considerable, additional information about the application of the Rule and other federal privacy laws to public health and research uses and disclosures of identifiable health data in routine events and during emergencies is available from CDC and HHS/OCR.<sup>259</sup>

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

These laws, in concert with the HIPAA Privacy Rule and other federal privacy laws, may impact surveillance activities as well even though specific patient data are not collected. For example, during the COVID-19 pandemic, multiple states used emerging technologies to create real-time surveillance dashboards regarding available PPE and other essential resources. Relying on data from specific hospitals and other providers, these information sources provided instant assessments of the availability of key resources as well as potential patient placements, facilitating the implementation of CSC. However, some corporate and other entities in the information chain raised privacy and other concerns about requested data. Proprietary interests, for example, may stymie the reporting of PPE supplies against the backdrop of potential re-allocation CSC strategies. Absent resolution, these issues can limit the flow of accurate syndromic or other non-identifiable data, inhibiting effective CSC responses.

### ***Family Reunification***

Hospitals or other entities in the Mountain Plains states may be asked to serve as temporary reception sites for family reunification during mass disasters. In an emergency, hospitals may assist or directly facilitate reuniting separated families within and across states, including children and persons with specialized health needs. Hospitals must be prepared to verify people's identities and the status of legal guardianship for unaccompanied children during reunification.

Implementing family reunification efforts in the wake of mass disasters or PHEs raises multiple legal and policy considerations affecting varied parties. These include liability risks and protections, accommodations for specific sociocultural and health demographics, and health privacy concerns. Unique legal concerns also arise when children are involved in reunification efforts, including questions of custody and informed consent. These legal issues are resolvable. Emergency declarations lend to specific waivers of existing legal standards and invoke special protections and entitlements for persons at risk of harm, especially minors and persons with disabilities. Proactive efforts to assess and resolve potential legal issues involved in family reunifications can help avoid further legal controversies that may arise during exigencies.

***Liability Risks and Protections.*** Post-disaster treatment facilities, volunteers, and aid organizations involved in family reunification efforts may be exposed to liability for varied claims including civil, criminal, or constitutional violations; medical malpractice; discrimination related to resource allocation decisions; health information privacy breaches; or express violations of specific federal and state laws.<sup>260</sup>

To protect against liability, persons and entities involved in family reunification efforts should strive to meet legal requirements. Facility requirements for reunification centers may vary depending on the nature of the disaster. During a pandemic, hospitals should align with government officials to consider environmental controls and safety measures recommended by CDC, OSHA, EPA, or other federal or state agencies, and ensure the availability of certified PPE.<sup>261</sup>

Despite risks of liability, legal protections are also available, especially concerning VHPs, depending on the type of emergency declared and resulting waivers. As noted in multiple parts above, emergency declarations may (1) trigger suspensions, alterations, or waivers of statutory laws and regulations, (2) invoke state- or hospital-level disaster plans or mutual aid agreements, (3) expand practitioner scopes of practice, and (4) allow real-time allocation and mobilization of essential resources.<sup>262</sup> Each of these shifts in the legal landscape affect liability risks, and potentially offer enhanced protections.

***Disabilities and other Accommodations.*** Emergency responders should also be aware of legal considerations surrounding accommodations for those with specific medical needs or cultural backgrounds. Federal laws like the Stafford Act, Civil Rights Act of 1964, and the Rehabilitation Act of 1973, along with general equal protection concerns, may be implicated.<sup>263</sup> The Stafford Act provides financial assistance to those with “serious needs,” relaxes agency regulatory requirements to benefit those who are disadvantaged, and supports professional counseling services for at-risk workers and victims.<sup>264</sup> The Post-Katrina Emergency Management Reform Act of 2006 mandates that disability coordinators be appointed and involved in disaster preparedness and relief efforts.<sup>265</sup>

While the ADA does not explicitly address emergency preparedness and relief its provisions may still apply to emergency planning.<sup>266</sup> For example, in 2011, a disability advocacy organization and disabled woman alleged that Los Angeles violated the ADA and the federal Rehabilitation Act, in addition to California law, by failing to properly accommodate persons with disabilities in their emergency plans. The City argued that its emergency preparedness plans could adapt *ad hoc* in a disaster and that it was not required under the ADA to formulate a plan until specifically requested by those with disabilities. The Department of Justice asserted that emergency preparedness accommodations for those with disabilities must be made in advance and with input by persons with disabilities. The court ruled against the City, finding that emergency planning falls under the ADA and Rehabilitation Act, and that those with disabilities were excluded

in the City's plans for evacuation and temporary housing.<sup>267</sup> In 2018, Arizona settled a case alleging it had discriminated against persons with hearing impairments under the ADA and Rehabilitation Act when it failed to provide meaningful access to emergency services by forgoing a texting option for 911 resources.<sup>268</sup>

**Privacy.** Family reunification efforts may also involve copious medical and personal information gathered and shared between various stakeholders, heightening concerns over privacy breaches under federal and state data protection laws (as discussed above). Requirements to assure the privacy of personal or medical records depend on the users and purposes of data acquisition and disclosure, as well as characteristics of the data subject (e.g., their age, condition, status). "Routine use" exceptions under the federal Privacy Act may allow sharing of personal information to facilitate family reunification efforts.<sup>269</sup> Similarly, the HIPAA Privacy Rule stipulates that covered entities (including hospitals) may disclose limited health information (e.g., hospital's patient registries) "without patient consent in disaster situations."<sup>270</sup> During COVID-19, additional HIPAA Privacy Rule requirements were temporarily waived by HHS to allow for greater data exchanges in the interests of public health.

**Custody.** Legal questions of child custody may implicate family reunification efforts involving minors. Where a parent has previously lost custody of a child, it may be difficult to track such information in disasters. To avoid inappropriate reunifications, hospitals should check the identity of the alleged guardian and verify his or her legal custody interests of the child. Legal custody may be determined through inquiries and coordinated efforts among several entities, including "child welfare agencies, law enforcement, and the judicial system."<sup>271</sup>

In emergencies, prior custody arrangements for children may not generally be displaced. For example, during the COVID-19 pandemic, the Arizona Administrative Office of the Courts issued custody guidelines stating that guardians should "follow . . . existing parenting plan[s] as closely as possible," though "the Court remains available to hear essential matters, including entering new orders in emergency situations."<sup>272</sup> Likewise, the Judicial Branch of California stated "[g]enerally, child custody and visitation . . . orders must be followed."<sup>273</sup> Mutually agreed upon minor changes to a parenting plan may be made, but any substantive changes to extend beyond exigencies must be approved by a judge. Whenever legal custody pre-disaster is established, generally a child may be released to that individual lawfully entitled to custody.

As per reunification guidance issued by FEMA, if disputes occur between individuals with joint legal custody, the hospital should release the child to the parent with primary physical custody. If issues of joint custody cannot be confirmed by the hospital, law enforcement and child services may become involved.<sup>274</sup> Concerning children located in states where they do not usually reside, their state of primary residence should be contacted to coordinate reunification efforts. Increased concerns of human trafficking, specifically of women and children, during and after emergencies may support additional procedural measures and protections governing the release of minors to alleged guardians through reunification.<sup>275</sup>

**Informed Consent.** When children have been separated from their legal guardians during mass disasters, issues of informed consent to medical procedures like vaccinations, testing, and treatment can be complicated. If there is an immediate threat to a child's life during a disaster necessitating treatment, informed consent of a guardian may be waived. California law states that in emergency situations, such as an unconscious individual in need of life-saving surgery, "consent is implied."<sup>276</sup> However, legal obligations to acquire informed consent are tenuous when injuries are less severe, involve only psychological harms, or when care may be provided in a non-traditional facility.<sup>277</sup>



**Table 1: Emergency Declaration Authorities**

This table provides state statutory/regulatory authorities for emergency declarations as categorized in columns I & II:

- I. **Emergency/Disaster** cites legal authorities for state declarations of “emergency,” “disaster,” or similar terms, as well as specific information on personnel responsible for issuing declarations.<sup>1</sup>
- II. **Public Health Emergency** cites legal authorities for specific declarations of a PHE based in part on the MSEHPA,<sup>2</sup> or other statutory provisions for emergency/disaster declarations premised on public health concerns, as well as specific information on personnel responsible for issuing declarations.

State	I. Emergency/Disaster	II. Public Health Emergency
CO	"A disaster <sup>3</sup> [or] emergency <sup>4</sup> shall be declared by executive order or proclamation of the governor if the governor finds a disaster has occurred or that this occurrence or the threat thereof is imminent. The state of disaster emergency shall continue until the governor finds that the threat of danger has passed or that the disaster has been dealt with to the extent that emergency conditions no longer exist and the governor terminates the state of disaster emergency by executive order or proclamation, but no state of disaster emergency	"The [governor's expert emergency epidemic response] committee shall convene at the call of the governor or the executive director of the department of public health and environment to consider evidence presented by the department's chief medical officer or state epidemiologist that there is an occurrence or imminent threat of an emergency epidemic. <sup>5</sup> If the committee finds that there is an occurrence or imminent threat of an emergency epidemic, the executive director

<sup>1</sup> The terms “emergency,” “disaster,” “emergency declaration,” “disaster declaration,” “catastrophe” and “emergency proclamation” were used to find these and other emergency declarations.

<sup>2</sup> The text of the Model State Emergency Health Powers Act (MSEHPA) is available at: <http://biotech.law.lsu.edu/blaw/bt/MSEHPA2.pdf>. A Summary Matrix of states which have adopted provisions based on the MSEHPA is available at: [https://www.networkforphl.org/\\_asset/80p3y7/MSEHPA-States-Table-022812.pdf](https://www.networkforphl.org/_asset/80p3y7/MSEHPA-States-Table-022812.pdf).

<sup>3</sup> “Disaster” means the occurrence or imminent threat of widespread or severe damage, injury, or loss of life or property resulting from any natural cause or cause of human origin, including but not limited to fire, flood, earthquake, wind, storm, wave action, hazardous substance incident, oil spill or other water contamination requiring emergency action to avert danger or damage, volcanic activity, epidemic, air pollution, blight, drought, infestation, explosion, civil disturbance, hostile military or paramilitary action, or a condition of riot, insurrection, or invasion existing in the state or in any county, city, town, or district in the state.” Colo. Rev. Stat. Ann. § 24-33.5-703(3).

<sup>4</sup> “Emergency” means an unexpected event that places life or property in danger and requires an immediate response through the use of state and community resources and procedures.” Colo. Rev. Stat. Ann. § 24-33.5-703(3.5).

<sup>5</sup> “Emergency epidemic” means cases of an illness or condition, communicable or noncommunicable, caused by bioterrorism, pandemic influenza, or novel and highly fatal infectious agents or biological toxins.” Colo. Rev. Stat. Ann. § 24-33.5-703(4).

State	I. Emergency/Disaster	II. Public Health Emergency
	<p>may continue for longer than thirty days unless renewed by the governor. The general assembly, by joint resolution, may terminate a state of disaster emergency at any time. Thereupon, the governor shall issue an executive order or proclamation ending the state of disaster emergency. All executive orders or proclamations issued under this subsection (4) shall indicate the nature of the disaster, the area threatened, and the conditions that brought it about or that make possible termination of the state of disaster emergency.."</p> <p>(Colo. Rev. Stat. Ann. § 24-33.5-704(4))</p>	<p>of the department of public health and environment shall advise the governor to declare a disaster emergency." (Colo. Rev. Stat. Ann. § 24-33.5-704.5(4)(d))</p>
<p>MT</p>	<p>"A state of emergency<sup>6</sup> may be declared by the governor when the governor determines that an emergency as defined in 10-3-103 exists. A state of disaster<sup>7</sup> may be declared by the governor when the governor determines that a disaster, as defined in 10-3-103, has occurred. The governor may not declare another state of emergency or disaster based on the same or substantially similar facts and circumstances without legislative approval." (Mont. Code Ann. § 10-3-303(1))</p> <p>"[A] state of emergency or disaster may not continue for longer than 45 days unless continuing conditions of the state of emergency or disaster exist, which must be determined through a poll of the legislature as provided in 10-3-122 or by the declaration of the legislature by joint resolution of continuing conditions of the state of emergency or disaster." (Mont. Code Ann. § 10-3-303(3)(a))</p> <p>"[T]he governor has broad authority to proclaim a state of emergency or disaster in the state and to exercise emergency powers during the emergency. The legislature intends to allow the governor to immediately respond during a proclaimed state of emergency or disaster, including through the issuance of executive orders, proclamations, and orders necessary to carry out the purpose of this chapter, and the ability to amend or rescind them.</p>	<p>"If an agency finds that an imminent peril to the public health, safety, or welfare requires adoption of a rule upon fewer than 30 days' notice and states in writing its reasons for that finding, it may proceed upon special notice filed with the committee, without prior notice or hearing or upon any abbreviated notice and hearing that it finds practicable, to adopt an emergency rule. The rule may be effective for a period not longer than 120 days, after which a new emergency rule with the same or substantially the same text may not be adopted, but the adoption of an identical rule under 2-4-302 is not precluded ... An emergency rule may be adopted only in circumstances that truly and clearly constitute an existing imminent peril to the public health, safety, or welfare that cannot be averted or remedied by any other administrative act." (Mont. Code Ann. § 2-4-303(1)(a))</p>

<sup>6</sup> ""Emergency" means the imminent threat of a disaster causing immediate peril to life or property that timely action can avert or minimize." Mont. Code Ann. § 10-3-103(8)

<sup>7</sup> ""Disaster" means the occurrence or imminent threat of widespread or severe damage, injury, or loss of life or property resulting from any natural or artificial cause, including tornadoes, windstorms, snowstorms, wind-driven water, high water, floods, wave action, earthquakes, landslides, mudslides, volcanic action, fires, explosions, air or water contamination requiring emergency action to avert danger or damage, blight, droughts, infestations, riots, sabotage, hostile military or paramilitary action, disruption of state services, accidents involving radiation byproducts or other hazardous materials, outbreak of disease, bioterrorism, or incidents involving weapons of mass destruction." Mont. Code Ann. § 10-3-103(4)

State	I. Emergency/Disaster	II. Public Health Emergency
	These executive orders, proclamations, and regulations have the force of law." (Mont. Code Ann. § 10-3-104(1))	
ND	<p>"A disaster<sup>8</sup> or emergency<sup>9</sup> must be declared by executive order or proclamation of the governor if the governor determines a disaster has occurred or a state of emergency exists." (N.D. Cent. Code Ann. § 37-17.1-05(3))</p> <p>"All executive orders or proclamations issued under this subsection must indicate the nature of the disaster or emergency, the area or areas threatened, the conditions that have brought it about or which make possible termination of the state of disaster or emergency. An executive order or proclamation must be disseminated promptly by means calculated to bring its contents to the attention of the general public, unless the circumstances attendant upon the disaster or emergency prevent or impede such dissemination, and it must be filed promptly with the department of emergency services, the legislative council, the secretary of state, and the county or city auditor of the jurisdictions affected." (N.D. Cent. Code Ann. § 37-17.1-05(3)(a)(d))</p> <p>"[T]he state of disaster or emergency continues until the governor determines the threat of an emergency has passed or the governor determines the disaster has been dealt with to the extent emergency conditions no longer exist, whichever occurs first." (N.D. Cent. Code Ann. § 37-17.1-05(3)(a))</p>	
SD	"In the event of disaster, war, act of terrorism as defined in state law, or emergency that is beyond local government capability, the Governor: (1) May assume direct operational control over all or any	"The secretary of health, with the consent of the Governor, may declare a public health emergency <sup>11</sup> ... In declaring a public health emergency, the secretary shall issue an order

<sup>8</sup> "Disaster" means the occurrence of widespread or severe damage, injury, or loss of life or property resulting from any natural or manmade cause, including fire, flood, earthquake, severe high and low temperatures, tornado storm, wave action, chemical spill, or other water or air contamination, epidemic, blight, drought, infestation, explosion, riot, or hostile military or paramilitary action, or cyber attack which is determined by the governor to require state or state and federal assistance or actions to supplement the recovery efforts of local governments in alleviating the damage, loss, hardship, or suffering caused thereby." N.D. Cent. Code Ann. § 37-17.1-04(1)

<sup>9</sup> "Emergency" means any situation that is determined by the governor to require state or state and federal response or mitigation actions to protect lives and property, to provide for public health and safety, or to avert or lessen the threat of a disaster. Emergencies require an immediate supplement to local governments or aid to critical industry sectors that provide essential lifeline services." N.D. Cent. Code Ann. § 37-17.1-04(4)

<sup>11</sup> "[A PHE] is an occurrence or imminent threat of an illness, health condition, or widespread exposure to an infectious or toxic agent that poses a significant risk of substantial harm to the affected population." (S.D. Codified Laws § 34-22-41)

State	I. Emergency/Disaster	II. Public Health Emergency
	<p>part of the emergency management functions within the state which may affect all or any portion of the state; (2) May declare an emergency or disaster to exist in the stricken area and employ emergency management to assist local authorities to affect relief and restoration ... The powers granted to the Governor under this section shall remain in effect for a period of six months and may be restored for one or more successive six-month periods by declaration of the Governor that the conditions permitting such powers persist." (S.D. Codified Laws § 34-48A-5).<sup>10</sup></p>	<p>that specifies: (1) The nature of the public health emergency; (2) The geographic area subject to the declaration; (3) The conditions that have brought about the public health emergency; and (4) The expected duration of the state of public health emergency, if less than thirty days." (S.D. Codified Laws § 34-22-42)</p>
UT	<p>"A state of emergency<sup>12</sup> may be declared by executive order of the governor if the governor finds a disaster<sup>13</sup> has occurred or the occurrence or threat of a disaster is imminent in any area of the state in which state government assistance is required to supplement the response and recovery efforts of the affected political subdivision or political subdivisions." (Utah Code Ann. § 53-2a-206(1))</p> <p>"[A] state of emergency described in Subsection (1) expires at the earlier of: (i) the day on which the governor finds that the threat or dangers has passed or the disaster reduced to the extent that emergency conditions no longer exist; (ii) 30 days after the date on which the governor declared the state of emergency; or (iii) the day on which the Legislature terminates the state of emergency by joint resolution." (Utah Code Ann. § 53-2a-206(2)(a))</p>	<p>"[I]f the [D]epartment [of Health] determines that a public health emergency exists,<sup>14</sup> [it] may, with the concurrence of the governor and the executive director or in the absence of the executive director, the executive director's designee, declare a public health emergency, issue an order of constraint, and mandate reporting under this section for a limited reasonable period of time, as necessary to respond to the public health emergency." (Utah Code Ann. § 26-23b-104(3)(a))</p> <p>"[A] public health emergency declared by the department as described in Subsection (3) expires at the earliest of: (i) the day on which the department or the governor finds that the threat or danger has passed or the public health emergency reduced to the extent that emergency conditions no longer exist; (ii) 30 days after the date on which the department</p>

<sup>10</sup> Proposed legislation to amend the length that the emergency declaration remains in effect states: "The powers granted to the Governor under § 34-48A-5 may be exercised for a period of thirty days from the date of the Governor's declaration, unless terminated earlier by the Governor." 2022 South Dakota House Bill No. 1259, South Dakota Ninety-Seventh Legislative Assembly, 2022, 2022 South Dakota House Bill No. 1259, South Dakota Ninety-Seventh Legislative Assembly, 2022.

<sup>12</sup> "'State of emergency' means a condition in any part of this state that requires state government emergency assistance to supplement the local efforts of the affected political subdivision to save lives and to protect property, public health, welfare, or safety in the event of a disaster, or to avoid or reduce the threat of a disaster." Utah Code Ann. § 53-2a-102(17)

<sup>13</sup> "'Disaster' means an event that: (a) causes, or threatens to cause, loss of life, human suffering, public or private property damage, or economic or social disruption resulting from attack, internal disturbance, natural phenomena, or technological hazard; and (b) requires resources that are beyond the scope of local agencies in routine responses to emergencies and accidents and may be of a magnitude or involve unusual circumstances that require response by government, not-for-profit, or private entities." Utah Code Ann. § 53-2a-102(5)

<sup>14</sup> "'[PHE]' means an occurrence or imminent credible threat of an illness or health condition, caused by bioterrorism, epidemic or pandemic disease, or novel and highly fatal infectious agent or biological toxin, that poses a substantial risk of a significant number of human fatalities or incidents of permanent or long-term disability. Such illness or health condition includes an illness or health condition resulting from a natural disaster." Utah Code Ann. § 26-23b-102(9)

State	I. Emergency/Disaster	II. Public Health Emergency
		declared the public health emergency; or (iii) the day on which the public health emergency is terminated by a joint resolution of the Legislature." (Utah Code Ann. § 26-23b-104(4)(a))
WY	"The governor has general direction and control of the office of homeland security <sup>15</sup> , and is responsible for the carrying out of the provisions of this act, and in the event of disaster beyond local control, may assume direct operational control over all or any part of the homeland security functions within Wyoming." (Wyo. Stat. Ann. § 19-13-104(a))	"Public health emergency" means an occurrence or imminent threat of an illness or health condition caused by an epidemic or pandemic disease, a novel and highly fatal infectious agent or a biological toxin that poses a substantial risk of a significant number of human fatalities or incidents of permanent or long-term disability. The governor shall declare when a public health emergency exists or has ended." (Wyo. Stat. Ann. § 35-4-115(a)(i))

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<sup>15</sup> "Homeland security" means the preparation for and the carrying out of all emergency functions essential to the recovery and restoration of the economy by supply and resupply of resources to meet urgent survival and military needs, other than functions for which military forces are primarily responsible, necessary to deal with disasters caused by enemy attack, sabotage, terrorism, civil disorder or other hostile action, or by fire, flood, earthquake, other natural causes and other technological, industrial, civil and political events." Wyo. Stat. Ann. § 19-13-102(a)(ii)





## Table 2: Licensure Reciprocity For HCWs in Emergencies

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

- I. **Routine Licensure Reciprocity** cites legal authorities and explanations of potential licensure reciprocity for HCWs outside of formal emergency declarations.
- II. **Emergency Licensure Reciprocity** cites legal authorities and explanations of potential licensure reciprocity for HCWs in declared emergencies.

State	I. Routine Licensure Reciprocity	II. Emergency Licensure Reciprocity
CO	<p>"[T]he [Medical] board may issue a pro bono license to a physician to practice medicine in this state if the physician: (III) Holds an active and unrestricted license to practice medicine in another state or territory of the United States." (Colo. Rev. Stat. Ann. § 12-240-118)</p> <p>Adopted Interstate Medical Licensure Compact (Colo. Rev. Stat. Ann. § 24-60-3602)</p>	<p>"“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 that 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." (Colo. Rev. Stat. Ann. § 25-1.5-602(16))</p> <p>"While an emergency declaration is in effect, a volunteer health practitioner, registered with a registration system that complies with section 25-1.5-605 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 part 6 as if the practitioner were licensed in this state." (Colo. Rev. Stat. Ann. § 25-1.5-606(a))</p>
MT	<p>Montana's laws regarding physician's license reciprocity were <u>repealed in 2015</u>.</p> <p>Adopted Interstate Medical Licensure Compact (Mont. Code Ann. § 37-3-356)</p>	<p>"If a person holding a license, certificate, or other permit issued by a party state evidencing the meeting of qualifications for professional, mechanical, or other skills is requested for assistance by the receiving party state, that person is considered licensed, certified, or permitted by the party state requesting assistance to render aid involving that skill to meet a declared emergency or disaster. However, the person holding the license,</p>

State	I. Routine Licensure Reciprocity	II. Emergency Licensure Reciprocity
		<p>certificate, or permit is subject to limitations and conditions that the governor of the requesting party state may prescribe by executive order or other means." (Mont. Code Ann. § 10-3-1001)</p> <p>"[W]henver a state of emergency or disaster is in effect, a volunteer professional who possesses an active, unrestricted license in another state may practice in Montana to the extent authorized by law as if the person had been licensed in Montana." (Mont. Code Ann. § 10-3-118(1))</p>
ND	<p>"A provisional temporary license for "locum tenens" may be issued for a period not to exceed three months." (N.D. Admin. Code 50-02-01-02)</p> <p>"The board may in its discretion license by endorsement an applicant who has complied with licensure requirements and who has passed an examination given by a recognized certifying agency approved by the licensing agency, provided such examination was, in the opinion of the board, equivalent in every respect to its examination. The board may also, in its discretion, enter into reciprocal agreements with the licensing agencies of other states or territories or the District of Columbia providing for a reciprocal waiver of further examination or any part thereof. In any case the applicant must appear before the board for such examination into the applicant's qualifications as may be required by the board. The board may by regulation make provision for temporary and special licenses to be in effect in the interval between board meetings." (N.D. Cent. Code Ann. § 43-17-21)</p> <p>"The board shall issue a license to an applicant who holds a current valid letter of qualification issued through the interstate medical licensing compact. The issuance of a license does not preclude the board's ability to require additional information from the applicant." (N.D. Admin. Code 50-02-02-01)</p> <p>"Upon prior written application to the appropriate board, a foreign practitioner may provide services in this state which fall within the scope of practice designated by the foreign practitioner's license and by this title without obtaining a license from the board if the services are provided for no more than thirty full or partial days per year. The one-year period commences on the date the written</p>	<p>"Foreign practitioner" means an individual who currently holds and maintains a license in good standing to engage in an occupation or profession in a state or jurisdiction other than this state and who is not the subject of a pending disciplinary action in any state or jurisdiction." (N.D. Cent. Code Ann. § 43-51-01(2))</p> <p>"Upon prior written notice to the appropriate board, a foreign practitioner may provide services in this state which fall within the scope of practice designated by the foreign practitioner's license and by this title without obtaining a license from the board, if the services are provided in response to a disaster or emergency declared by the appropriate authority in this state. The notice provided by a foreign practitioner under this section must include verified documentation from the appropriate licensing authority which identifies the requirements for licensure in that jurisdiction and which confirms that the practitioner is licensed and in good standing in that jurisdiction and any other information requested by the board. A notice provided under this section, if accompanied by sufficient documentation, is deemed to be accepted unless denied by the board." (N.D. Cent. Code Ann. § 43-51-04)</p> <p>"Any requirement for a license to practice any professional, mechanical, or other skill does not apply to any authorized disaster or emergency worker who, in the course of performing the worker's duties, practices the professional, mechanical, or other skill during a disaster or emergency." (N.D. Cent. Code Ann. § 37-17.1-16(2))</p>

State	I. Routine Licensure Reciprocity	II. Emergency Licensure Reciprocity
	<p>application is approved by the board." (N.D. Cent. Code Ann. § 43-51-05)</p> <p>Adopted Interstate Medical Licensure Compact (N.D. Cent. Code Ann. § 43-17.4-01)</p>	
SD	<p>"The Board of Medical and Osteopathic Examiners may, without examination, issue a license to any applicant holding a currently valid license or certificate issued to the applicant by the examining board of the District of Columbia, any state or territory of the United States, the National Board of Medical Examiners, the National Board of Osteopathic Physicians and Surgeons, or any province of Canada, if the legal requirements of the examining board at the time it issued the license or certificate were not less than those of this state at the time the license is presented for registration. However, the board may require the applicant to successfully pass either an oral or written examination and personally appear before the board, a member of the board, or its staff." (S.D. Codified Laws § 36-4-19)</p> <p>"A locum tenens certificate is a certificate allowing the holder thereof to practice medicine in this state for a limited period of time and subject to the requirements and conditions set forth in said certificate." (S.D. Codified Laws § 36-4-20.1)</p> <p>"A certificate for locum tenens practice may be issued by the Board of Examiners to an applicant who is a current holder of a valid license to practice medicine or osteopathy in any state or territory of the United States, the District of Columbia, or province of Canada, or who has graduated and received a diploma from an approved medical or osteopathic college and who has completed at least one year of an approved internship or residency program or its equivalent ... To obtain a locum tenens certificate, a petition shall be presented to the board signed under oath, by a licensed physician practicing in this state and by the applicant requesting a locum tenens certificate which petition shall set forth the reasons why the applicant should be issued a locum tenens certificate.. (S.D. Codified Laws § 36-4-20.2)</p> <p>"Locum tenens certificates shall be issued for a period of not to exceed sixty days, and in the Board of Examiners discretion may set forth requirements</p>	<p>"Whenever any person holds a license, certificate, or other permit issued by any state party to the compact evidencing the meeting of qualifications for professional, mechanical, or other skills, and when such assistance is requested by the receiving party state, such person shall be deemed licensed, certified, or permitted by the state requesting assistance to render aid involving such skill to meet a declared emergency or disaster, subject to such limitations and conditions as the Governor of the requesting state may prescribe by executive order or otherwise." (S.D. Codified Laws § 34-48A-53)</p> <p>"Any requirement for a license to practice any professional, mechanical, or other skill does not apply to any authorized emergency management worker who shall, in the course of performing his duties as such, practice such professional, mechanical, or other skill during a disaster or emergency." (S.D. Codified Laws § 34-48A-50)</p> <p>"If it appears to the State Board of Medical and Osteopathic Examiners by a resolution thereof duly made and adopted, that an urgent need exists in any state-owned and operated medical institution for the services of a practitioner of medicine, surgery, and obstetrics and their branches, as a state employee, which cannot be adequately and effectively served by a regularly licensed practitioner, the board may, in its discretion, grant a temporary permit to an applicant who has satisfactorily passed a special examination and paid a fee not to exceed fifty dollars for the examination, notwithstanding that the applicant has not completed the period of internship or residence training in a hospital approved by the board and has failed or has been unable to satisfactorily show that he is a graduate of an approved medical or osteopathic college. The temporary permit shall be issued and be effective for one year from the date of issuance of such permit. The temporary permit entitles the person to whom issued to engage in the practice of medicine, surgery, and obstetrics and their branches as a state employee under the supervision of a licensed physician in such state-owned and operated medical institution and not elsewhere. . . . Except as may otherwise be provided in this section, applications for such temporary permits shall be processed in the same manner as regular license applications under § 36-4-11,</p>

State	I. Routine Licensure Reciprocity	II. Emergency Licensure Reciprocity
	<p>and conditions governing the practice under it." (S.D. Codified Laws § 36-4-20.4)</p> <p>Adopted Interstate Medical Licensure Compact (S.D. Codified Laws § 36-4-44)</p>	<p>and the holder of any such permit is subject to all restrictions, responsibilities, and privileges inuring to regular licensees under this chapter." (S.D. Codified Laws § 36-4-20)</p>
UT	<p>"An applicant for licensure as a physician and surgeon by endorsement who is currently licensed to practice medicine in any state other than Utah, a district or territory of the United States, or Canada shall: (a) be currently licensed with a full unrestricted license in good standing in any state, district, or territory of the United States, or Canada; (b) have been actively engaged in the legal practice of medicine in any state, district, or territory of the United States, or Canada for not less than 6,000 hours during the five years immediately preceding the date of application for licensure in Utah (plus additional qualifications...)" (Utah Code Ann. § 58-67-302(2))</p> <p>"An individual who is licensed in good standing as a physician in another state with no licensing action pending and no less than 10 years of professional experience may engage in the practice of medicine without being licensed if: the services are rendered as a public service and for a noncommercial purpose, no fee is charged, received, or expected for the services rendered beyond the amount necessary to cover the cost of malpractice insurance, and the individual does not engage in unlawful or unprofessional conduct." (Utah Code Ann. § 58-67-305(7))</p> <p>Adopted Interstate Medical Licensure Compact (Utah Code Ann. § 58-67b-101)</p>	<p>"Upon the declaration of a national, state, or local emergency, a public health emergency as defined in Section 26-23b-102, or a declaration by the president of the United States or other federal official requesting public health-related activities, the Division [of Occupational and Professional Licensing] may in collaboration with the relevant board:</p> <ul style="list-style-type: none"> <li>(a) suspend the requirements for permanent or temporary licensure of individuals who are licensed in another state for the duration of the emergency while engaged in the scope of practice for which they are licensed in the other state;</li> <li>(b) modify . . . the scope of practice restrictions under this title for individuals who are licensed under this title as (a physician, a nurse, a certified nurse midwife, a pharmacist, pharmacy technician, or pharmacy intern, a respiratory therapist, a dentist and dental hygienist or a physician assistant)." (Utah Code Ann. § 58-1-307)</li> </ul> <p>"(1) The following persons may provide emergency medical services to a patient without being licensed under this chapter: (a) out-of-state emergency medical service personnel and providers in time of disaster." (Utah Code Ann. § 26-8a-308)</p>
WY	<p>"Physicians residing in and currently licensed in good standing to practice medicine in another state or country brought into this state for consultation by a physician licensed to practice medicine in this state may practice medicine without first obtaining a Wyoming license for a total of not more than twelve (12) days in any fifty-two (52) week period and, therefore, are exempt from the licensure requirements of these rules and W.S. 33-26-103(a)(iv). Consults of longer duration or greater frequency require written advance approval of a majority of the Board officers. For purposes of this subsection, the term "brought into this state" means establishing a physician-patient relationship, either by the physician's physical presence with the</p>	<p>"Any requirement for a license to practice any professional, mechanical or other skill does not apply to any authorized homeland security worker who, in the course of performing homeland security duties, practices a professional, teaching, training, mechanical or other skill during a homeland security emergency, in training for an emergency or during homeland security exercises." (Wyo. Stat. Ann. § 19-13-113(b))</p> <p>"Physicians and physician assistants residing in and who hold full and unrestricted licenses to practice medicine or to practice as a physician assistant in another state or country who come into this state to provide medical care during an emergency or pandemic declared as such by Order of the Governor of this state and/or pursuant to any</p>

State	I. Routine Licensure Reciprocity	II. Emergency Licensure Reciprocity
	<p>patient or through telemedicine." (Wyo. Admin. Code 052.0001.1 §7(a))</p> <p>"[T]he [Medical] board may grant: (vii) A volunteer license, allowing physicians not otherwise licensed in Wyoming to practice medicine in the state without remuneration, provided the qualifications for and conditions of this license shall be established by rule." (Wyo. Stat. Ann. § 33-26-301)</p> <p>Adopted Interstate Medical Licensure Compact (Wyo. Stat. Ann. § 33-36-202)</p>	<p>State Emergency Plan and who comply with all requirements of the board for verification of licensure and identity, may practice medicine or practice as a physician assistant without first obtaining a Wyoming license for the period during which any such emergency or pandemic Declaration or Order remains in effect." (Wyo. Admin. Code 052.0001.1 §7(d))</p> <p>"A physician's or physician assistant's consultation begins upon the submission of that person's information to the board, and shall terminate on the earlier of forty-five (45) days after the date the governor declares the public emergency has ended, or the state health officer notifies the board that the physician's or physician assistant's consultation has ended." (Wyo. Admin. Code 052.0001.1 §7(d)(i)(B))</p> <p>"The licensing boards for any health care provider holding a permit or license as a health care provider regulated under title 33 of the Wyoming statutes shall provide by rule and regulations for the temporary licensure of health care providers during a public health emergency as declared by the governor pursuant to W.S. 35-4-115(a)(i). If necessary during a declared public health emergency, the state health officer may issue temporary practice licenses to health care providers who are retired, who have an inactive license or who are licensed in another state without a valid Wyoming license pending action on an application for issuance of a temporary license by the appropriate licensing board pursuant to this subsection." (Wyo. Stat. Ann. § 35-4-114(b))</p>



### Table 3: Emergency Waiver Authorities

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

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

State	I. General Waiver Authority	II. Specific Waiver Authority
CO	"[T]he governor may: [s]uspend the provisions of any regulatory statute prescribing the procedures for conduct of state business or the orders, rules, or regulations of any state agency, if strict compliance with the provisions of any statute, order, rule, or regulation would in any way prevent, hinder, or delay necessary action in coping with the emergency."(Colo. Rev. Stat. Ann. § 24-33.5-704(7))	"Under such rules as the governor shall prescribe, to temporarily suspend or modify for not to exceed sixty days any public health, safety, zoning, transportation within or across the state, or other requirement of law or regulation within this state when by proclamation the governor deems such suspension or modification essential to provide temporary housing for disaster victims."(Colo. Rev. Stat. Ann. § 24-33.5-1104(1)(c))  "The governor ... may suspend the standard or control which the governor finds to be inadequate to protect the public safety and by regulation place a new standard or control in effect. The new standard or control shall remain in effect until rejected by joint resolution of both houses of the general assembly or amended by the governor. During the time it is in effect, the standard or control contained in the governor's regulation shall be administered and given full effect by all relevant regulatory agencies of the state and local governments to which it applies." (Colo. Rev. Stat. Ann. § 24-33.5-710(4)).
MT	"[T]he governor may: ... suspend the provisions of a regulatory statute prescribing the procedures for conduct of state business or orders or rules of any state agency if the strict compliance with the provisions of any statute, order, or rule would in any way prevent, hinder, or delay necessary action in coping with the emergency or disaster[.]" (Mont. Code Ann. § 10-3-104(2))	"[T]he governor is authorized: under regulations that the governor prescribes, to temporarily suspend or modify for not to exceed 60 days any state laws or regulations relating to public health, safety, zoning, or transportation, within or across the state, when by proclamation the governor declares the suspension or modification

State	I. General Waiver Authority	II. Specific Waiver Authority
		essential to provide temporary housing for emergency or disaster victims." (Mont. Code Ann. § 10-3-313(1)(c)) <sup>16</sup>
ND	"[The governor may: ...suspend the provisions of any regulatory statute prescribing the procedures for conduct of state business, or the orders, rules, or regulations of any state agency, if strict compliance with the provisions of any statute, order, rule, or regulation would in any way prevent, hinder, or delay necessary action in managing a disaster or emergency." (N.D. Cent. Code Ann. § 37-17.1-05(6))	<p>"[The governor] may issue executive orders related thereto which will: 1. Suspend or modify the enforcement of any statute, ordinance, or regulation relating to the operation of motor vehicles upon the highways and streets of the state where it appears that the enforcement of such statute, ordinance, or regulation would impede or interfere with the national defense ... 4. Suspend the enforcement of any statute, ordinance, or regulation that requires any motor vehicle, bus, or housetrailer, to which a valid and unexpired permit or license has been issued by another state, to obtain a permit or license from this state." (N.D. Cent. Code Ann. § 54-07-01.1)</p> <p>"An order declaring a judicial emergency, whether in civil, criminal, administrative or any other legal proceedings, as determined necessary, may suspend, toll, extend, or otherwise grant relief from deadlines, time schedules, statutes of limitations, statutes of repose, or filing requirements imposed by otherwise applicable rules, or court orders. An order declaring a judicial emergency may not, under authority of this rule, suspend, toll, extend, or otherwise grant relief from deadlines, time schedules, or filing requirements required by the Constitution of the United States or the Constitution of North Dakota." (ND R ADMIN AR 57)</p> <p>"The governor ... may suspend the standard or control which the governor finds to be inadequate to protect the public safety and by regulation place a new standard or control in effect. The new standard or control remains in effect until rejected by concurrent resolution of both houses of the legislative assembly or amended by the governor. During the time it is in effect, the standard or control contained in the governor's regulation must be administered and given full effect by all relevant regulatory agencies of the state and local governments to which it applies." (N.D. Cent. Code Ann. § 37-17.1-11(4)).</p>

<sup>16</sup> Note two key statutory exceptions regarding laws that cannot be suspended or waived: (1) "The governor may not suspend the provisions of any statute prescribing the procedures for an election or otherwise control the ingress and egress to a polling location without the consent of the legislature through the polling process provided in 10-3-121 or through a regular or special legislative session." (Mont. Code Ann. § 10-3-104(4)); and (2) "The governor may not suspend a statute that affects the exercise of an individual's constitutional rights under [federal or state constitutions], including 13-19-104(3), even if the statute is otherwise considered a regulatory statute prescribing the procedures for conduct of state business." (Mont. Code Ann. § 10-3-104(5))

State	I. General Waiver Authority	II. Specific Waiver Authority
SD	<p>"May suspend the provisions of any rules of any state agency, if strict compliance with the provisions of the rule would in any way prevent, hinder, or delay necessary action in managing a disaster, war, act of terrorism, or emergency, including fire, flood, earthquake, severe high and low temperatures, tornado storm, wave action, oil spill, or other water or air contamination, epidemic, blight, drought, infestation, explosion, riot, or hostile military or paramilitary action, which is determined by the Governor to require state or state and federal assistance or actions to supplement the recovery efforts of local governments in alleviating the damage, loss, hardship, or suffering caused thereby[.]" (S.D. Codified Laws § 34-48A-5(4))</p>	<p>"An order declaring a judicial emergency may suspend, toll, extend, or otherwise grant relief from deadlines, time schedules, or filing requirements imposed by otherwise applicable statutes, rules, or court orders, whether in civil cases, criminal cases, administrative matters or any other legal proceedings as determined necessary." (S.D. Codified Laws § 16-3-14)</p>
UT	<p>"The governor may suspend the provisions of any order, rule, or regulation of any state agency, if the strict compliance with the provisions of the order, rule or regulation would substantially prevent, hinder, or delay necessary action in coping with the emergency or disaster." (Utah Code Ann. § 53-2a-209(3))</p>	<p>"[The governor may] temporarily suspend or modify by executive order, during the state of emergency, any public health, safety, zoning, transportation, or other requirement or a statute or administrative rule within this state if such action is essential to provide temporary housing[.]" (Utah Code Ann. § 53-2a-204(1)(j))</p>
WY	<p>"[T]he governor may: (i) Make, amend and rescind the necessary orders, rules and regulations to carry out this act within the limits of the authority conferred upon him herein, with due consideration of the plans of the federal government. The governor may assign to a state agency any activity concerned with the mitigation of the effects of a disaster or national emergency of a nature related to the existing powers and duties of the agency, including interstate activities, and the agency shall undertake and carry out the activity on behalf of the state[.]" (Wyo. Stat. Ann. § 19-13-104(c))</p>	<p>"(a) Upon the request of a health care facility or at the Department's own motion, the Department may waive a requirement established under the rules identified in subsection (b) of this section if the Department determines the waiver is necessary:  (i) To manage and control a communicable disease; or  (ii) To protect the health, safety, and welfare of patients in response to an emergency.  (b) Pursuant to the conditions of subsection (a) of this section, the Department may waive a requirement established under the following rules [see Wyo. Admin. Code 048.0078.1 §3(a)] for complete list]</p>





## Table 4: Emergency Liability Protections

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

- I. **General Liability Protections** cites general legal authorities to protect HCWs or entities from liability in declared emergencies.
- II. **Explicit Liability Protections** cites explicit legal authorities to protect HCWs or entities from liability in declared emergencies.

State	I. General Liability Protections	II. Specific Liability Protections
CO	<p>"Neither the state nor the members of the expert emergency epidemic response committee designated or appointed pursuant to section 24-33.5-704.5 are liable for any claim based upon the committee's advice to the governor or the alleged negligent exercise or performance of, or failure to exercise or perform an act relating to an emergency epidemic. Liability against a member of the committee may be found only for wanton or willful misconduct or willful disregard of the best interests of protecting and maintaining the public health." (Colo. Rev. Stat. Ann. § 24-33.5-711.5(1))</p> <p>"All legal liabilities for damages, not only to property under the constitution of the state of Colorado but also for death or injury to any person, except a civil defense worker regularly enrolled and acting as such, caused by acts done or attempted under the color of the "Colorado Disaster Emergency Act", part 7 of this article, in a bona fide attempt to comply therewith, shall be the obligation of the state of Colorado. Permission is given for suits against the state for recovery of compensation in that behalf, and for the indemnification of any person appointed and regularly enrolled as a civilian defense worker while actually engaged</p>	<p>"The conduct and management of the affairs and property of each hospital, physician, health insurer or managed health-care organization, health-care provider, public health worker, or emergency medical service provider shall be such that they will reasonably assist and not unreasonably detract from the ability of the state and the public to successfully control emergency epidemics that are declared a disaster emergency. Such persons and entities that in good faith comply completely with board of health rules regarding the emergency epidemic and with executive orders regarding the disaster emergency shall be immune from civil or criminal liability for any action taken to comply with the executive order or rule." (Colo. Rev. Stat. Ann. § 24-33.5-711.5(2))</p> <p>"Any person licensed as a physician and surgeon under the laws of the state of Colorado, or any other person, who in good faith renders emergency care or emergency assistance to a person not presently his patient without compensation at the place of an emergency or accident, including a health-care institution as defined in section 13-64-202(3), shall not be liable for any civil damages for acts or omissions made in good faith as a result of the rendering of such emergency care or emergency assistance during the emergency, unless the acts or omissions were grossly negligent or willful and wanton. This section shall not apply to any person who renders such emergency care or emergency assistance to a patient he is otherwise obligated to cover." (Colo. Rev. Stat. Ann. § 13-21-108(1))</p>

State	I. General Liability Protections	II. Specific Liability Protections
	<p>in civil defense duties or as a member of any agency of the state or political subdivision thereof engaged in civilian defense activity, or such person's dependents, as an aspect of damage done to such person's private property, or judgment against such person for acts done in good faith attempts in compliance with this part 9. The foregoing shall not be construed to result in indemnification in any case of willful misconduct, gross negligence, or bad faith on the part of any agent of civilian defense. Should the United States government or any agency thereof, in accordance with any federal statute, rule, or regulation, provide for the payment of damages to property or for death or injury as provided for in this section, then and in that event, there shall be no liability or obligation whatsoever upon the part of the state of Colorado for any such damage, death, or injury for which the United States government assumes liability." (Colo. Rev. Stat. Ann. § 24-33.5-903)</p>	<p>"Any person from another state who is performing a function in this state under an agreement to provide emergency services authorized in this section has the same immunity from liability as a person from the county, municipality, or designated special district of this state performing the same function.... Any person from this state who is performing a function in another state under an agreement to provide emergency services authorized in this section has the same immunity from liability in the other state that he or she would have when performing the same function in this state." (Colo. Rev. Stat. Ann. § 29-1-206.5(3))"</p>
MT	<p>"The state, a political subdivision of the state, or the agents or representatives of the state or a political subdivision of the state are not liable for personal injury or property damage sustained by a person appointed or acting as a volunteer civilian defense or other response and recovery activity worker, a volunteer professional, or a member of an agency engaged in civilian defense or other response and recovery activity during an incident, disaster, or emergency." (Mont. Code Ann. § 10-3-111(1))</p> <p>"The following individuals or entities are not liable for the death or injury of individuals or for damage to property as a result of an act or omission specifically arising out of activities undertaken in response to an incident, disaster, or emergency and while complying with or reasonably attempting to comply with parts 1 through 4 and 12 of this chapter[:]: (a) the state or a political subdivision of the state; (b) except in cases of willful misconduct, gross negligence, or bad faith: (i) the employees, agents, or representatives of the state or a political subdivision of the state; or (ii) a volunteer or auxiliary civilian defense or other response and recovery activity worker, a</p>	<p>"Except as provided in subsection (3), a health care professional licensed to practice in Montana who, in good faith and regardless of compensation, renders or fails to render emergency care, health care services, or first aid during a declared emergency or disaster is not liable for any civil damages or injury unless the damages or injury was caused by gross negligence or willful and wanton misconduct and as a result of: (a) an act or omission arising out of activities undertaken in response to the disaster or emergency; (b) any act or omission related to the rendering of or failure to render services; or (c) evacuation or treatment or the failure to evacuate or provide treatment conducted in accordance with disaster medicine or at the direction of military or government authorities." (Mont. Code Ann. § 10-3-110(1))</p> <p>"Officers or employees of a party state rendering aid in another party state pursuant to [EMAC] are considered agents of the requesting state for tort liability and immunity purposes. A party state or its officers or employees rendering aid in another party state pursuant to this compact are not liable on account of an act taken or omission made in good faith on the part of the forces giving that aid or on account of the maintenance or use of any equipment or supplies in connection with giving that aid. Good faith, as used in this article, does not include willful misconduct, gross negligence, or recklessness." (Mont. Code Ann. § 10-3-1001)</p>

State	I. General Liability Protections	II. Specific Liability Protections
	<p>member of an agency engaged in civilian defense or other response and recovery activity, a volunteer professional, or the owners of facilities used for civil defense or other response and recovery shelters pursuant to a fallout shelter license or privilege agreement or pursuant to an ordinance relating to blackout or other precautionary measures enacted by a political subdivision of the state." (Mont. Code Ann. § 10-3-111(2))</p>	<p>"A physician assistant referred to in subsection (1) who voluntarily, gratuitously, and other than in the ordinary course of employment or practice renders emergency medical care during an emergency or disaster described in subsection (1) is not liable for civil damages for a personal injury resulting from an act or omission in providing that care if the injury is caused by simple or ordinary negligence and if the care is provided somewhere other than in a health care facility as defined in 50-5-101 or a physician's office where those services are normally provided." (Mont. Code Ann. § 37-20-410(3))</p> <p>"A physician who supervises a physician assistant voluntarily and gratuitously providing emergency care at an emergency or disaster described in subsection (1) is not liable for civil damages for a personal injury resulting from an act or omission in supervising the physician assistant if the injury is caused by simple or ordinary negligence on the part of the physician assistant providing the care or on the part of the supervising physician." (Mont. Code Ann. § 37-20-410(4))</p> <p>"A [licensed physician, nurse, or hospital], rendering care or assistance in good faith to a patient of a direct-entry midwife in an emergency situation is liable for civil damages for acts or omissions committed in providing such emergency obstetrical care or assistance only to the extent that those damages are caused by gross negligence or by willful or wanton acts or omissions." (Mont. Code Ann. § 27-1-734)</p>
ND	<p>"All functions hereunder and all other activities relating to emergency management are hereby declared to be governmental functions. The state, a county or city, any disaster or emergency worker, an employee of a federal agency on loan or leave to the state in support of emergency service response whether the emergency is declared or undeclared, or any other person providing goods or services during an emergency if the person is working in coordination with and under the direction of an appropriate governmental emergency or disaster response entity, complying with or reasonably attempting to comply with this chapter, or any executive order or disaster or emergency operational plan pursuant to this chapter, or pursuant to any ordinance relating to any precautionary measures enacted by any county or city of the state, except in case of willful misconduct, gross negligence, or bad faith, is not liable for the death of or injury to persons, or for damage to property except as compensation may be provided in section 37-</p>	<p>"Officers or employees of a party state rendering aid in another state pursuant to [EMAC] shall be considered agents of the requesting state for tort liability and immunity purposes; and no party state or its officers or employees rendering aid in another state pursuant to this compact shall be liable on account of any act or omission in good faith on the part of such forces while so engaged or on account of the maintenance or use of any equipment or supplies in connection therewith. Good faith in this article shall not include willful misconduct, gross negligence, or recklessness." (N.D. Cent. Code Ann. § 37-17.1-14.5)</p> <p>"Any person who is an unpaid volunteer, who in good faith, renders emergency care or services at or near the scene of an accident, disaster, or other emergency, or en route to a treatment facility, is not liable to the recipient of the emergency care or services for any damages resulting from the rendering of that care or services." (N.D. Cent. Code Ann. § 39-08-04.1)</p>

State	I. General Liability Protections	II. Specific Liability Protections
	<p>17.1-12, as a result of any such activity." (N.D. Cent. Code Ann. § 37-17.1-16(1))</p> <p>"Any person owning or controlling real estate or other premises who voluntarily and without compensation grants a license or privilege, or otherwise permits the designation or use of the whole or any part or parts of such real estate or premises for the purpose of emergency management activities during an actual, impending, mock or practice disaster or emergency, is, together with their successors in interest, if any, not civilly liable, except in the case of gross negligence or willful and malicious failure to guard or warn against a dangerous condition, use, structure, or activity, for causing the death of, or injury to, any person on or about such real estate or premises or for loss of, or damage to, the property of such person." (N.D. Cent. Code Ann. § 37-17.1-17)</p>	
SD	<p>"All functions under this chapter and all other activities relating to emergency management are governmental functions. Neither the state nor any political subdivision thereof, nor other agencies, nor, except in cases of willful misconduct, gross negligence, or bad faith, any emergency management worker complying with or reasonably attempting to comply with this chapter, or any order, rule promulgated pursuant to the provisions of this chapter, or pursuant to any ordinance relating to blackout or other precautionary measures enacted by any political subdivision of this state, is liable for the death of or injury to persons, or damage to property, as a result of such activity." (S.D. Codified Laws § 34-48A-49)</p> <p>"Any person owning or controlling real estate or other premises who voluntarily and without compensation grants a license or privilege, or otherwise permits the designation or use of the whole or any part or parts of such real estate or premises for the purpose of sheltering persons during an actual, impending, mock, or practice attack or other disaster or emergency as defined within this chapter shall, together with his successors in interest, if any, not be civilly liable for negligently causing the death of, or injury to,</p>	<p>"Any [health professions] volunteer, as defined in § 34-22-44.1, is immune from civil liability in any action brought in any court in this state on the basis of any act or omission resulting in damage or injury if: (1) The volunteer was acting in good faith and within the scope of the volunteer's official functions; and (2) The damage or injury was not caused by gross negligence or willful and wanton misconduct by the volunteer." (S.D. Codified Laws § 34-22-44.2)</p> <p>"No physician assistant licensed in this state or licensed or authorized to practice in other states of the United States who voluntarily and gratuitously, and other than in the ordinary course of employment or practice, renders emergency medical assistance is liable for civil damages for any personal injuries which result from acts or omissions by those persons in rendering emergency care which constitute ordinary negligence. The immunity granted by this section does not apply to acts or omissions constituting willful, or wanton negligence or if the medical assistance is rendered at any hospital, physician's office, or other health care delivery entity where those services are normally rendered. No physician who supervises a physician assistant voluntarily and gratuitously providing emergency care as described in this section is liable for civil damages for any personal injuries which result from acts or omissions by the physician assistant rendering emergency care." (S.D. Codified Laws § 36-4A-26.3)</p> <p>"Officers or employees of a party state rendering aid in another state pursuant to [EMAC] shall be considered agents of the requesting state for tort liability and immunity purposes; and no</p>

State	I. General Liability Protections	II. Specific Liability Protections
	<p>any person on or about such real estate or premises for loss of, or damage to, the property of such person." (S.D. Codified Laws § 34-48A-51)</p>	<p>party state or its officers or employees rendering aid in another state pursuant to this compact shall be liable on account of any act or omission in good faith on the part of such forces while so engaged or on account of the maintenance or use of any equipment or supplies in connection therewith. Good faith in this article shall not include willful misconduct, gross negligence, or recklessness." (S.D. Codified Laws § 34-48A-53)</p> <p>"No physician, surgeon, osteopath, physician assistant, registered nurse, or licensed practical nurse, licensed under the provisions of chapters 36-4, 36-4A, and 36-9, who in good faith renders, in this state, emergency care at the scene of the emergency, shall be liable for any civil damages as a result of any acts or omissions by such person rendering the emergency care." (S.D. Codified Laws § 20-9-3)</p>
UT	<p>"A person or entity owning a building or other facility and an operator of or an employee in a building or facility is immune from liability with respect to any decisions or actions related to emergency or public health conditions, as described in Subsection 63G-7-201(2)(b)(iii), while acting under the general supervision of or on behalf of any public entity." (Utah Code Ann. § 63G-8-201)</p>	<p>"A health care provider is immune from civil liability for any harm resulting from any act or omission in the course of providing health care during a declared major public health emergency if: (i)(A) the health care is provided in good faith to treat a patient for the illness or condition that resulted in the declared major public health emergency; or (B) the act or omission was the direct result of providing health care to a patient for the illness or condition that resulted in the declared major public health emergency; and (ii) the acts or omissions of the health care provider were not: (A) grossly negligent; or (B) intentional or malicious misconduct." (Utah Code Ann. § 58-13-2.7)</p> <p>"Any emergency responder from another state who enters into this state while responding to an emergency has the same authority to act, including providing care, as does any emergency responder of this state. . . . All privileges and immunities from liability, exemption from law, ordinances, and rules, and any other benefits, which apply to an emergency responder while performing duties in the responder's state of residence or state of employment as a responder, apply when the emergency responder is acting as an emergency responder in Utah." (Utah Code Ann. § 53-2a-506, amended by H.B. 302, 60th Leg., Gen. Sess. (Utah 2013))</p>
WY	<p>"All activities relating to homeland security are governmental functions. The state, any political subdivision, state agencies, and, except in cases of willful misconduct, gross negligence or bad faith, any homeland security worker complying with or reasonably attempting to comply with W.S. 19-13-101 through 19-13-116, any order, rule or regulation promulgated thereunder, or pursuant to any ordinance relating to blackout</p>	<p>"During a public health emergency as defined by W.S. 35-4-115(a)(i) and subject to subsection (d) of this section, any health care provider or other person, including a business entity, who in good faith follows the instructions of a state, city, town or county health officer or who acts in good faith in responding to the public health emergency is immune from any liability arising from complying with those instructions or acting in good faith. This immunity shall apply to health care providers who are retired, who have an inactive license or who are licensed in another state without a valid Wyoming license and while performing as a</p>

State	I. General Liability Protections	II. Specific Liability Protections
	<p>or other precautionary measures enacted by any political subdivision of the state, or in training for such activity, is not liable for the death of or injury to persons or for damage to property as a result of the activity or training. This section shall not affect the right of any person to receive benefits to which he would otherwise be entitled under W.S. 19-13-101 through 19-13-116, under the Wyoming Worker's Compensation Act, or under any pension law, nor affect the right of any person to receive benefits or compensation under any act of congress." (Wyo. Stat. Ann. § 19-13-113(a))</p> <p>"Any person owning or controlling real estate or other premises who voluntarily and without compensation grants a license or privilege or otherwise permits the designation or use of the whole or any part of the real estate or premises for the purposes of sheltering persons during an actual, impending, mock or practice exercise, together with his successors in interest, is not civilly liable for negligently causing the death of or injury to any person on or about the real estate or premises nor for loss of or damage to the property of any person." (Wyo. Stat. Ann. § 19-13-113(d))</p>	<p>volunteer during a declared public health emergency as defined by W.S. 35-4-115(a)(i). This immunity shall not apply to acts or omissions constituting gross negligence or willful or wanton misconduct." (Wyo. Stat. Ann. § 35-4-114(a))</p> <p>"Any health care provider, person or entity shall be immune from liability for damages in an action involving a COVID-19 liability claim unless the person seeking damages proves that the health care provider, person or entity took actions that constitutes gross negligence or willful or wanton misconduct. Nothing in this subsection shall be construed to limit any other immunity available under law, including the immunity provided in subsection (a) of this section. As used in this subsection, "COVID-19 liability claim" means as defined by W.S. 1-1-141(a)(iii)." (Wyo. Stat. Ann. § 35-4-114(d))</p> <p>"Any person licensed as a physician and surgeon under the laws of the state of Wyoming, or any other person, who in good faith renders emergency care or assistance without compensation at the place of an emergency or accident, is not liable for any civil damages for acts or omissions in good faith." (Wyo. Stat. Ann. § 1-1-120(a))</p> <p>"Persons or organizations operating volunteer ambulances or rescue vehicles supported by public or private funds, staffed by unpaid volunteers, and which make no charge, or charge an incidental service or user fee, for services rendered during medical emergencies, and the unpaid volunteers who staff ambulances and rescue vehicles are not liable for any civil damages for acts or omissions in good faith in furnishing emergency medical services. This immunity does not apply to acts or omissions constituting gross negligence or willful or wanton misconduct." (Wyo. Stat. Ann. § 1-1-120(b))</p>



## Table 5 - Aggregate of Emergency Laws

This table marks (✓) specific legal provisions across states' statutory/regulatory codes (see Tables 1-4 for more information re: states' authorities) as categorized in rows I – VIII:

Legal Authority	CO	MT	ND	SD	UT	WY
<b>I. Emergency/Disaster Declaration Authority (Table 1)</b>	✓	✓	✓	✓	✓	✓
<b>II. PHE Declaration Authority (Table 1)</b>	✓	✓		✓	✓	✓
<b>III. Routine Licensure Reciprocity (Table 2)</b>	✓	✓	✓	✓	✓	✓
<b>IV. Emergency Licensure Reciprocity (Table 2)</b>	✓	✓	✓	✓	✓	✓
<b>V. General Waiver Authority (Table 3)</b>	✓	✓	✓	✓	✓	✓
<b>VI. Specific Waiver Authority (Table 3)</b>	✓	✓	✓	✓	✓	✓
<b>VII. General Liability Protections (Table 4)</b>	✓	✓	✓	✓	✓	✓
<b>VIII. Explicit Liability Protections (Table 4)</b>	✓	✓	✓	✓	✓	✓

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- <sup>1</sup> James G. Hodge, Jr., [Regional Disaster Health Response System Legal Resource Guide](#). Massachusetts | Regional Disaster Health Response System. Boston, MA: 2021: 1-64.
- <sup>2</sup> James G. Hodge, Jr., [Legal Resource Guide](#). Western Regional Alliance for Pediatric Emergency Management (WRAP-EM), San Francisco, CA: 2021: 1-115.
- <sup>3</sup> [Colorado/Mountain Plains Regional Disaster Health Response System \(RDHRS\)](#), ASPR (last visited Sept. 29, 2022).
- <sup>4</sup> [Colorado/Mountain Plains Regional Disaster Health Response System \(RDHRS\)](#), ASPR (last visited Sept. 29, 2022).
- <sup>5</sup> [Colorado/Mountain Plains Regional Disaster Health Response System \(RDHRS\)](#), ASPR (last visited Sept. 29, 2022).
- <sup>6</sup> James G. Hodge, Jr. & Lawrence O. Gostin, [How a National Emergency Can Bring the Monkeypox Outbreak Under Control](#), Harvard Petrie Flom Center Bill of Health, (Aug. 8, 2022).
- <sup>7</sup> James G. Hodge, Jr. & Evan D. Anderson, *Principles and Practice of Legal Triage During Public Health Emergencies*, 64 N.Y.U. ANN. SURV. AM. L. 249 (2008).
- <sup>8</sup> AGENCY FOR HEALTHCARE RSCH. & QUALITY, *ALTERED STANDARDS OF CARE IN MASS CASUALTY EVENTS: BIOTERRORISM AND OTHER PUBLIC HEALTH EMERGENCIES* (2005).
- <sup>9</sup> James G. Hodge, Jr. et al., *Emergency Legal Preparedness for Hospitals and Health Care Personnel*, 3(S2) DISASTER MED. & PUB. HEALTH PREPAREDNESS S37 (2009).
- <sup>10</sup> Sara Rosenbaum et al., *State Laws Extending Comprehensive Legal Liability Protections for Professional Health-Care Volunteers During Public Health Emergencies*, 123 PUB. HEALTH REPS. 238 (2008).
- <sup>11</sup> Evan D. Anderson & James G. Hodge, Jr., *Emergency Legal Preparedness Among Select U.S. Local Governments*, 3(S2) DISASTER MED. & PUB. HEALTH PREPAREDNESS S1 (2009).
- <sup>12</sup> Colo. Governor Jared Polis, [Executive Order D 2020 163](#) (Aug. 12, 2020).
- <sup>13</sup> Colo. Governor Jared Polis, [Executive Order D 2020 189](#) (Sept. 10, 2020).
- <sup>14</sup> Colo. Governor Jared Polis, [Executive Order D 2020 189](#) (Sept. 10, 2020).
- <sup>15</sup> 42 U.S.C.A. §§ 5121-205 (West 2008).
- <sup>16</sup> 42 U.S.C.A. § 5122(1) (West 2008).
- <sup>17</sup> [Governor Gordon requests federal disaster declaration for Wyoming](#), Wy. Gov. Mark Gordon (Apr. 9, 2020).
- <sup>18</sup> 50 U.S.C. §§ 1601–51 (2006).
- <sup>19</sup> White House Office of the Press Secretary, *Declaration of a National Emergency with Respect to the 2009 H1N1 Influenza Pandemic* (Oct. 24, 2009).
- <sup>20</sup> [COVID-19 Disaster Declarations](#), FEMA (July 6, 2021).
- <sup>21</sup> Memorandum to Extend Fed. Support to Governors' Use of the Nat'l Guard to Respond to COVID-19 and to Increase Reimbursement & Other Assistance Provided to States from Joseph R. Biden, President, U.S. (Jan. 21, 2021); Notice on the Continuation of the Nat'l Emergency Concerning the Coronavirus Disease 2019 (COVID-19) Pandemic from Joseph R. Biden, President, U.S. (Feb. 24, 2021).
- <sup>22</sup> [Notice on the Continuation of the National Emergency Concerning the Coronavirus Disease 2019 \(COVID-19\) Pandemic](#), White House, (Feb. 18, 2022).
- <sup>23</sup> [Memorandum on Maximizing Assistance to Respond to COVID-19](#), The White House, (Mar. 1, 2022).
- <sup>24</sup> 42 U.S.C. § 201 (2000).
- <sup>25</sup> James G. Hodge, Jr. et al., *Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP): Legal and Regulatory Issues*, HHS (2008).
- <sup>26</sup> James G. Hodge, Jr. & Lawrence O. Gostin, [How a National Emergency Can Bring the Monkeypox Outbreak Under Control](#), Harvard Petrie Flom Center Bill of Health, (Aug. 8, 2022).
- <sup>27</sup> James G. Hodge, Jr., *Global Legal Triage in Response to the 2009 H1N1 Outbreak*, 11 MINN. J.L. SCI. & TECH. 599 (2010).
- <sup>28</sup> Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPRA), Pub. L. No. 113-5, 127 Stat. 161.
- <sup>29</sup> *Pandemic and All-Hazards Preparedness Reauthorization Act*, PHE, (last updated Sept. 17, 2019).
- <sup>30</sup> *The Model State Emergency Health Powers Act: Table of State Laws*, NETWORK FOR PUB. HEALTH L. (Aug. 1, 2011).



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- <sup>31</sup> CTRS. FOR L. & THE PUB.'S HEALTH AT GEORGETOWN & JOHNS HOPKINS UNIV., MODEL STATE EMERGENCY HEALTH POWERS ACT ([MSEHPA](#)) (2008).
- <sup>32</sup> Evan D. Anderson & James G. Hodge, Jr., *Emergency Legal Preparedness Among Select U.S. Local Governments*, 3(S2) DISASTER MED. & PUB. HEALTH PREPAREDNESS S176 (2009).
- <sup>33</sup> Colo. Rev. Stat. Ann. § 24-33.5-709.
- <sup>34</sup> Colo. Eagle County CEO Christopher A. Montera, [Emergency Declaration](#) (Mar. 11, 2020).
- <sup>35</sup> Colo. Eagle River Fire Protection District Community Risk Manager Tracy LeClair, [Disaster Declaration](#) (Mar. 12, 2020).
- <sup>36</sup> [Press Release](#), Gov. Malloy Signs Ord. that will Assist the State's Emergency Response in the Event of a Confirmed Infection or Exposure to Ebola, Gov. Daniel P. Malloy of Conn. (Oct. 7, 2014).
- <sup>37</sup> NETWORK FOR PUB. HEALTH L., [COVID-19 EMERGENCY LEGAL PREPAREDNESS PRIMER](#) (2020).
- <sup>38</sup> Marilyn W. Thompson, Jenny Deam & Mollie Simon, ["The Human Psyche Was Not Built for This": How Republicans in Montana Hijacked Public Health and Brought a Hospital to the Brink](#), PROPUBLICA (Sept. 6, 2021).
- <sup>39</sup> During Hurricane Katrina, Louisiana initially declared a state of emergency on Friday, August 26, 2005, and then declared a state of public health emergency a week later on Friday, September 2, 2005.
- <sup>40</sup> DEL. CODE ANN. tit. 20, § 3102(1) (West 2007); DEL. CODE ANN. tit. 20, § 3102(2) (West 2007); DEL. CODE ANN. tit. 20, § 3132(11) (West 2007).
- <sup>41</sup> Pandemic and All-Hazards Preparedness Act, PL 109-417, §§ 101, 102 (2006).
- <sup>42</sup> AM. COLL. OF SURGEONS, UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT ([UEVHPA](#)) (Feb. 27, 2014).
- <sup>43</sup> AM. COLL. OF SURGEONS, UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT ([UEVHPA](#)) (Feb. 27, 2014).
- <sup>44</sup> Daniel Orenstein, *When Law is Not Law: Setting Aside Legal Provisions During Declared Emergencies*, 41 J.L., MED. & ETHICS (Apr. 1, 2013).
- <sup>45</sup> Colo. Rev. Stat. Ann. § 24-33.5-1104(1)(c).
- <sup>46</sup> N.D. Rev. Admin. Rule 57.
- <sup>47</sup> James G. Hodge, Jr., Jennifer L. Piatt & Leila Barraza, [Legal Interventions to Counter COVID-19 Denialism](#), 49 J.L., MED. & ETHICS (2022).
- <sup>48</sup> H.B. 121, 67th Leg. Reg. Sess. (Mont. 2021).
- <sup>49</sup> H.B. 257, 67th Leg. Reg. Sess. (Mont. 2021).
- <sup>50</sup> H.B. 702, 67th Leg. Reg. Sess. (Mont. 2021).
- <sup>51</sup> H.B. 1323, 74th Leg. Reg. Sess. (N.D. 2021).
- <sup>52</sup> James G. Hodge, Jr. & Evan D. Anderson, *Principles and Practice of Legal Triage During Public Health Emergencies*, 64 N.Y.U. ANN. SURV. AM. L. 249 (2008).
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- <sup>54</sup> Declaration Under the [PREP] Act for Medical Countermeasures Against COVID-19, 85 Fed. Reg. 15198 (Mar. 17, 2020).
- <sup>55</sup> S.B. 277, 67th Leg., Reg. Sess. (Mont. 2021).
- <sup>56</sup> H.B. 1194, 96th. Leg. Sess. (S.D. 2021).
- <sup>57</sup> H.B. 415, 2021 Gen. Sess. (Utah 2021).
- <sup>58</sup> Kevin Breuninger, [Biden Administration Threatens to Claw Back Covid Funds from Arizona over School Anti-Mask Policies](#), CNBC, Jan. 14, 2022.
- <sup>59</sup> James G. Hodge, Jr., Jennifer L. Piatt & Leila Barraza, [Legal Interventions to Counter COVID-19 Denialism](#), 49 J.L., MED. & ETHICS (2022).
- <sup>60</sup> Image adapted from [The EMAC Process](#).
- <sup>61</sup> EMAC, 2005 HURRICANE SEASON RESPONSE: AFTER ACTION REPORT (Sept. 19, 2006), at EX-4.
- <sup>62</sup> [About NEMAC](#), NEMAC (last visited Sept. 29, 2022).
- <sup>63</sup> [State and Province Emergency Management Assistance Memorandum of Agreement](#), NEMAC (last visited Sept. 29, 2022).
- <sup>64</sup> EMAC, [EMAC Legislation](#), PL 104-321, Art. V.
- <sup>65</sup> EMAC, [EMAC Legislation](#), PL 104-321, Art. VI.

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- <sup>66</sup> EMAC, [EMAC Legislation](#), PL 104-321, Art. VIII.
- <sup>67</sup> [An Analysis of EMAC Capabilities for Private Sector and Volunteer Resource Coordination](#), ASFPM (last visited Sept. 29, 2022).
- <sup>68</sup> EMAC, EMAC PREPAREDNESS GUIDE & DEPLOYMENT [TIPS FOR STATE](#), LOCAL & TRIBAL PUBLIC HEALTH & MEDICAL PERSONNEL 3 (last visited Sept. 29, 2022).
- <sup>69</sup> See EMAC, [EMAC Legislation](#), PL 104-321.
- <sup>70</sup> EMAC, [EMAC Reimbursement Process](#).
- <sup>71</sup> EMAC, [EMAC Reimbursement Process](#).
- <sup>72</sup> EMAC, [What is EMAC?](#) (last visited Sept. 29, 2022).
- <sup>73</sup> Jeremy Turley, North Dakota's Rural Hospitals Struggle to Find Relief Valves During COVID-19 Delta Surge, DICKINSON PRESS, (Oct. 11, 2021, 4:00 AM).
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- <sup>76</sup> [Press Release](#), California Shares Lifesaving Ventilators with Hard Hit States through EMAC, EMAC (Apr. 9, 2020).
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- <sup>79</sup> [Reciprocity Packet](#), N.Y. STATE DEP'T OF HEALTH BUREAU OF EMERGENCY MED. SERVS. (Apr. 2013).
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- <sup>81</sup> [Nurse Licensure Compact](#), NAT'L COUNCIL OF STATE BDS. OF NURSING (last visited Sept. 29, 2022).
- <sup>82</sup> PSYPACT, [PSYPACT States Map](#).
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- <sup>84</sup> [Multistate Privilege to Practice for EMS Personnel](#), The EMS Compact (last visited Sept. 29, 2022).
- <sup>85</sup> EMAC, [Intrastate Mutual Aid Legislation](#), Art. V (March 2004).
- <sup>86</sup> MODEL STATE EMERGENCY HEALTH POWERS ACT § 608(b) (2001).
- <sup>87</sup> Colo. Rev. Stat. Ann. § 12-240-118.
- <sup>88</sup> Wyo. Admin. Code 052.0001.1 §7(a).
- <sup>89</sup> N.D. Admin. Code 50-02-02-01.
- <sup>90</sup> Mont. Code Ann. § 10-3-118(1).
- <sup>91</sup> Utah Code Ann. § 58-1-307.
- <sup>92</sup> Colo. Governor Jared Polis, [Executive Order D 2020 038](#) (Apr. 15, 2020).
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- <sup>269</sup> JOEL R. REIDENBERG ET AL., [PRIVACY AND MISSING PERSONS AFTER NATURAL DISASTERS](#) 50 (Policy Series No. 2, 2013).
- <sup>270</sup> JOEL R. REIDENBERG ET AL., [PRIVACY AND MISSING PERSONS AFTER NATURAL DISASTERS](#) 52 (Policy Series No. 2, 2013).
- <sup>271</sup> FEMA ET AL., [POST-DISASTER REUNIFICATION OF CHILDREN: A NATIONWIDE APPROACH](#) 38-39 (2013).
- <sup>272</sup> [Family Court Guidelines for Parenting Time of Children During the COVID-19 Pandemic](#), AZ CTS. (Apr. 8, 2020).
- <sup>273</sup> [Emergency Court Actions and COVID-19 \(Coronavirus\)](#), CAL. CTS. (last visited Sept. 29, 2022).
- <sup>274</sup> FEMA ET AL., [POST-DISASTER REUNIFICATION OF CHILDREN: A NATIONWIDE APPROACH](#) 39 (2013).
- <sup>275</sup> Anna Childs & The Conversation, [Why Child Trafficking Surges After Natural Disasters](#), CNN (Mar. 23 2016, 6:20 AM).
- <sup>276</sup> *Cobbs v. Grant*, 502 P.2d 1, 10 (Cal. 1972).
- <sup>277</sup> Brooke Courtney & James G. Hodge, Jr., *Legal Considerations During Pediatric Emergency Mass Critical Care Events*, 12(S6) PEDIATRIC CRITICAL CARE MED. at S154 (2011).