# Emergency Medical Services & Medical Surge:
# Essential Legal Issues


ORAU

*Further. Together.*

**Acknowledgements**

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## Report Abbreviations

| | | | |
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| ACA | Patient Protection & Affordable Care Act | HCW | Health Care Worker |
| ACO | Accountable Care Organization | HIPAA | Health Insurance Portability & Accountability Act |
| ACS | Alternate Care Site | HPA | Healthcare Preparedness Activity |
| ADA | Americans with Disabilities Act | ICS | Incident Command System |
| AEMT | Advanced Emergency Medical Technician | IND | Investigational New Drug |
| ALS | Advanced Life Support | IOM | Institute of Medicine |
| AMR | American Medical Response | MAA | Mutual Aid Agreement |
| AZMAC | Arizona Mutual Aid Compact | MSEHPA | Model State Emergency Health Powers Act |
| CDC | Centers for Disease Control & Prevention | MOU | Memoranda of Understanding |
| CMS | Centers for Medicare & Medicaid Services | NEMA | National Emergency Management Association |
| CSC | Crisis Standards of Care | NHTSA | National Highway Traffic Safety Administration |
| DHHS | Department of Health & Human Services | ORAU | Oak Ridge Associated Universities |
| ED | Emergency Department | ORISE | Oak Ridge Institute for Science & Education |
| EMAC | Emergency Medical Assistance Compact | PA | Public Assistance |
| EMR | Emergency Medical Responders | PAHPRA | Pandemic & All-Hazards Preparedness Reauthorization Act |
| EMS | Emergency Medical Services | PHEs | Public Health Emergencies |
| EMSA | Emergency Medical Services Authority | PHI | Protected Health Information |
| EMT | Emergency Medical Technician | POD | Point of Dispensing |
| EMTALA | Emergency Medical Treatment & Active Labor Act | PPE | Personal Protective Equipment |
| ESAR-VHP | Emergency System for the Advance Registration of Volunteer Health Professionals | PREP | Public Readiness & Emergency Preparedness |
| EUA | Emergency Use Authorization | REPLICA | Recognition of EMS Personnel Licensure Interstate CompAct |
| ETA | Expanded Treatment Area | REQ-A | Request for Assistance |
| FDA | Food and Drug Administration | SNS | Strategic National Stockpile |
| FEMA | Federal Emergency Management Agency | UEVHPA | Uniform Emergency Volunteer Health Practitioners Act |
| FICEMS | Federal Interagency Committee on Emergency Medical Services | VSA | Volunteer Service Agreement |

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# Executive Summary/Introduction

***Scope***

In 2008, the Centers for Disease Control and Prevention (CDC) Healthcare Preparedness Activity (HPA), in partnership with the Oak Ridge Associated Universities (ORAU)/Oak Ridge Institute for Science and Education (ORISE), initiated a series of workshops and stakeholder meetings to improve community health care responses during public health emergencies (PHEs). A common concern expressed at these events was that large-scale PHEs, such as natural disasters and influenza pandemics, could cause a national or regional surge in demand for medical care and a shortage of available health care resources. In many communities, the emergency medical services (EMS) sector was identified as a critical partner. However, it may also be one of the first health care sectors to be overwhelmed during periods of medical surge in part because of a lack of resources, planning, and coordination with other stakeholders.

A 2009 report from the Federal Interagency Committee on EMS (FICEMS) focused on the pandemic influenza preparedness of state EMS systems validated this concern.[1] FICEMS' report revealed inadequate collaboration and gaps across the prehospital continuum of emergency care, particularly EMS and 9-1-1 systems related to influenza pandemic planning guidelines. FICEMS subsequently outlined the need for federal support of expanded EMS roles in mass vaccination, targeted antiviral prophylaxis, sentinel surveillance, and treatment without transport. Planning for and coordinating expanded roles for EMS during medical surge encompasses several areas:

- Creating a decision-making process for identifying the specific expanded role needed for a given type of disaster
- Authorizing EMS personnel to practice outside of their conventional scopes of practice
- Managing communications and information
- Addressing resource shortages
- Educating and training EMS personnel
- Providing medical oversight
- Coordinating with other public health and health care partners during a response
- Instituting necessary legal requirements and regulations

The Institute of Medicine (IOM) 2012 report, *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response*, complemented FICEMS' findings.[2] IOM's committee highlighted the potential need for EMS agencies to perform tasks outside their conventional scope of practice during medical surge. During PHEs, health care operations can change substantially in transition from conventional scope of practice to crisis standards of care (CSC). In such cases, EMS personnel may have to expand their roles to provide other services, such as assistance to shelters, alternate care sites (ACSs), patient receiving centers, and clinics.

While FICEMS and IOM identify critical, expanded roles for EMS in disaster response, neither provides specific guidance for states and communities on how to plan for or implement these expanded EMS roles. To address this void, CDC-HPA, the Department of Transportation, National Highway Traffic Safety Administration (NHTSA), and ORAU/ORISE commenced a collaborative effort on EMS surge preparedness in November 2012. In August 2013, a stakeholder meeting was convened to better define EMS surge roles and develop guidance for state and community planning entities to coordinate EMS system capacity in PHEs.

***Purpose***

In furtherance of these collaborative efforts, this project advances two primary purposes. First, a series of key inserts were prepared on legal implications for each of the four major topical areas of the CDC/HPA EMS Framework Report, including (1) Tiered Dispatch, (2) Modified Transport and Treatment Strategies, (3) Coordinating Transport to Alternate Destinations, and (4) Support for Rapid Implementation of Patient Interventions.

Second, this project entails research and analysis of legal issues that impact EMS providers during medical surge. The results are described in this report, which is designed to assist communities nationally in their efforts to navigate relevant laws and policies in PHEs. The following core legal issues related to use and deployment of EMS providers are explored.

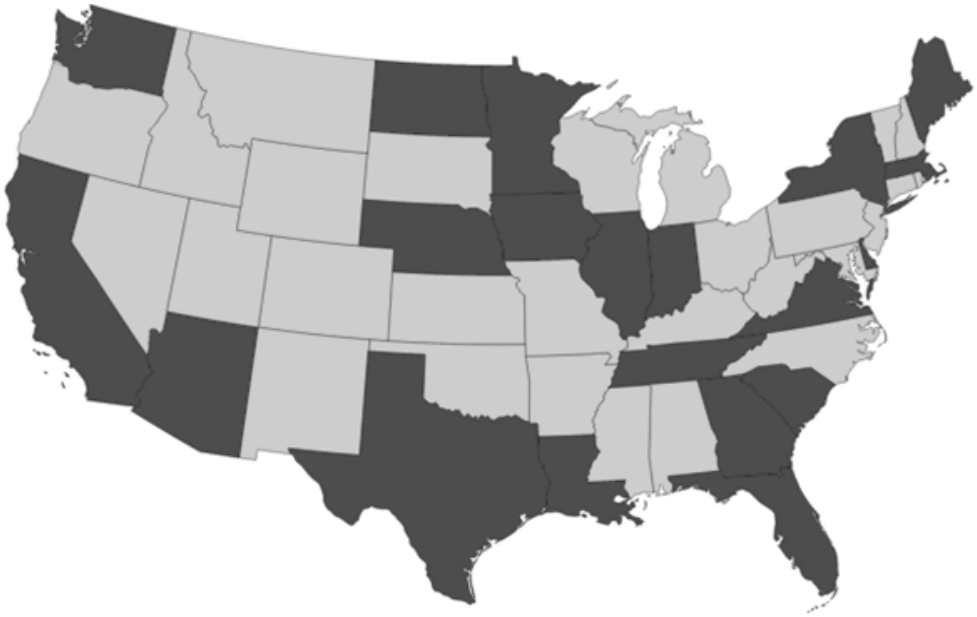
- Emergency, disaster, or PHE authorities
- Licensing reciprocity of EMS providers
- Modification of scopes of practice for emergency medical technicians (EMTs) and paramedics
- Liability of EMS providers and associated companies
- Reimbursement of EMS providers for dispatching or transporting patients to alternate sites
- Use of protocols to authorize specific actions among EMS providers

- State equivalents or extensions of requirements pursuant to the Emergency Medical Treatment and Active Labor Act (EMTALA) related to screening and treatment at nonhospital sites

- Legal accountability for efficacious health outcomes involving EMS providers

While many states' laws are assessed in this report, it focuses on statutes, regulations, and cases in 20 preselected states (Arizona, California, Delaware, Florida, Georgia, Iowa, Illinois, Indiana, Louisiana, Massachusetts, Maine, Minnesota, North Dakota, Nebraska, New York, South Carolina, Tennessee, Texas, Virginia, and Washington) depicted in dark gray in Figure 1.

**Figure 1. Select State Jurisdictions for Legal Assessment**



These states were chosen based on numerous factors:

- Geographical, political, and population diversity

- Array of organizational structures among state and local departments of health and emergency management

- State's prior experience with declared emergencies for a variety of events (e.g., natural disasters, infectious conditions)

- Specific knowledge of existing laws and policies that may provide options/analyses

- Scalability of key findings and lessons to other states and localities

- Existing assessments of relevant laws by the authors (or others) in select states

***Limits***

The report's breadth is extensive, but its scope has some limits.

1. While there are many issues related to the roles of EMS providers during routine, day-to-day care,[3] this report focuses on their services during declared emergencies.

2. To the extent that legal research and analyses for this report are focused on 20 states, the findings present a representative, scalable sampling of laws or policies.

3. Although core research focuses on state-based laws and policies, some territorial or local provisions are discussed in relevant examples.

Notwithstanding these limitations, identifying and addressing core issues of law and policy require examinations of constitutional provisions, statutes, regulations, judicial cases, and policies within and across states. The objective is to unravel and simplify key legal issues and provide solutions for EMS providers and others seeking to meet medical surge during PHEs.

***Organization***

This report is divided into six major parts:

**Part I.** Pre-Surge Planning and Preparedness discusses the steps various jurisdictions and entities take to prepare for PHEs, including interjurisdictional coordination among public and private actors through agreements, memoranda, and protocols.

**Part II.** The Changing Legal Environment in Declared States of Emergency describes how the legal environment transforms during declared states of emergency at the various levels of government to facilitate response efforts by authorizing additional flexible powers and liability protections.

**Part III.** Meeting Surge Capacity examines the legal challenges concerning the availability of adequate EMS personnel to address response needs, as well as the related duties, responsibilities, scope of practice, and location restrictions.

**Part IV.** Liability Risks and Protections for EMS Providers assesses the liability risks for EMS providers during medical surges as well as corresponding liability protections available through emergency declarations and other legal sources.

**Part V.** Allocating Resources focuses on mechanisms to access additional health care supplies and personnel, and the activation and use of ACSs in declared emergencies.

**Part VI.** Reimbursement of EMS Resources and Services explores varied funding and reimbursement mechanisms for EMS providers through state and federal programs and mutual aid compacts. A list of **Select Legal Issues and Potential Solutions Related to EMS in Declared Emergencies** (see table below) highlights key issues and solutions discussed in each part of the report.

## Select Legal Issues & Potential Solutions Related to EMS in Declared Emergencies

| Issues | Solutions |
|---|---|
| ***I. Pre-Surge Planning and Preparedness*** | |
| 1. Jurisdictions and EMS providers may have legal and ethical duties to plan for emergencies. | Federal and state funds may be available for advanced planning; statutory, regulatory, and judicial laws may provide direct guidance regarding content; and existing models may provide templates for solid preparedness planning. |
| 2. Failing to consider the needs of vulnerable populations may violate the Americans with Disabilities Act (ADA) and similar laws. | Policies and protocols should consider and reflect the unique needs of disabled individuals and other vulnerable populations in managing EMS systems and responses. |
| 3. Interjurisdictional coordination among public and private entities is essential to effective management of major emergencies. | Advance contracts, compacts, and MOUs between public and private entities prior to an emergency can address and resolve many needs while providing flexibility in responses. |
| 4. When resources fall short, deploying personnel and resources across state lines is time consuming and legally complex. | EMAC, an interstate mutual aid assistance agreement between all states, allows for efficient, mutual assistance (and assurance of reimbursement and liability protections) between states managing any declared emergency. |
| 5. EMS personnel may be limited legally in their ability to appropriately respond to emergencies and disasters. | Legal arrangements incorporating physician supervision, such as decision support tools and protocols, can enhance EMS response efforts. |

| Issues | Solutions |
|---|---|
| ***II. The Changing Legal Environment in Declared States of Emergency*** | |
| 6. Federal, state, and local laws may hinder EMS response efforts during PHEs. | Declared states of emergency, disaster, or PHE at varying levels of government transform the legal environment, offering flexible powers and waivers of impeding laws. |
| 7. The expansiveness and flexibility of emergency laws are beneficial, but a lack of legal guidance in emergencies may stem from potential constitutional or other legal limits. | Through "*legal triage*," emergency planners, public health practitioners, EMS providers, and their legal counsel can prioritize legal issues and solutions in emergencies to consider and execute legitimate public health responses. |
| ***III. Meeting Surge Capacity – Ensuring and Empowering EMS Personnel*** | |
| 8. In response to shortages during medical surge, EMS personnel may need to provide emergency medical care in states where they are not currently licensed or certified. | License reciprocity provisions, interstate compacts like EMAC, and emergency laws can facilitate expedited sharing of personnel across jurisdictional borders during medical surge. REPLICA is a proposed interstate EMS licensure compact. If enacted, it would enable member states to afford immediate legal recognition to EMS personnel licensed in other member states in nonemergencies. |
| 9. Variations in scope of practice restrictions between states can interfere with out-of-state EMS professionals during medical surge. | EMAC and other emergency laws address conflicting scope of practice provisions and help determine which jurisdiction's restrictions apply to out-of-state EMS professionals. |
| 10. Because of catastrophic conditions and resource shortages, EMS personnel will not be able to meet the standard of care, the legal measure used to evaluate whether a health professional has adequately and appropriately provided care. | During declared emergencies, standards will shift to crisis standards of care (CSC), which requires a change in focus from individual to population needs. The legal standard against which EMS personnel performance is judged changes with this transition as well. |
| 11. During declared emergencies, EMS personnel may need to perform nontraditional functions, act in crises, or transport patients to non-ED destinations. | Flexibility to adapt to prevailing circumstances may be available via surge, treat-and-release, and disaster protocols activated during declared emergencies, as well as waivers and expanded conceptions of "emergency" care based on formal emergency declarations. |

| Issues | Solutions |
|---|---|
| ***IV. Liability Risks and Protections for EMS Providers*** | |
| 12. Catastrophic emergencies exacerbate liability risks for EMS personnel because of difficult circumstances, inadequate supplies or facilities, and application of uncommon protocols. | Existing legal protections for EMS personnel may be enhanced by provisions in emergency laws, changes in legal standards of care (e.g., transition to CSC), and Good Samaritan laws that may apply during declared emergencies. |
| 13. Public and private EMS entities face additional liability risks during emergencies based on entity and employee failures. | Sovereign immunity (which protects a state and its agencies from civil suits unless the state consents to being sued), the PREP Act, statutory limitations, and emergency laws provide numerous liability protections for EMS providers. |
| 14. Health information privacy concerns may be heightened during declared emergencies that generate significant media and public interest. | EMS personnel should be well-trained in existing patient privacy requirements. Certain elements of the HIPAA Privacy Rule may be temporarily suspended by DHHS during a federally declared emergency. |
| ***V. Allocating Resources – Personnel, Supplies, and Space*** | |
| 15. Jurisdictions impacted by PHEs may lack adequate licensed, educated, and trained EMS personnel. | EMAC, FEMA contracted ambulance services, and interstate and intrastate MAAs can facilitate the efficient deployment of additional EMS personnel while clearly identifying each jurisdiction's responsibilities. |
| 16. Medical supplies and vehicles that EMS personnel require to properly respond will be scarce during declared emergencies. | Medical supplies may be legally and efficiently procured through EMAC, MAAs, and additional state laws and compacts. |
| 17. Vaccines, antivirals, and other pharmaceuticals needed to combat a disease outbreak may be in short supply during emergencies. | Pharmaceuticals and medical supplies may be distributed through CDC's SNS, and expired or unapproved pharmaceuticals may be accessed through a number of federal programs including EUAs and SLEP. |
| 18. Legal restrictions may hamper the creation and use of supplemental treatment areas required to assess and treat patients. | States and localities may waive transport and treatment restrictions (e.g., ambulance destination restrictions) or protocols that obstruct the use of supplemental treatment areas like ACSs and ETAs. |

| Issues | Solutions |
|---|---|
| ***VI. Reimbursement of EMS Resources and Services During and After Emergencies*** | |
| 19. EMS providers may incur significant expenses for resources purchased or shared with other jurisdictions and entities during emergencies. | Federal programs and funds administered through FEMA and other organizations and prior contracts may be used to reimburse EMS providers for response-related expenses. |
| 20. CMS' conditions of participation, pre-approval and licensure requirements, and transportation destination restrictions can limit reimbursement during emergencies. | Following a Presidential Major Disaster Declaration and a PHE declaration by DHHS' Secretary, Section 1135 Waivers may modify many of CMS' conditions, allowing reimbursement to entities and providers that otherwise would not be permitted (e.g., patient transport to an ACS approved as an extension of a hospital). |
| 21. Public or private EMS providers may experience a shortage of necessary resources or services during PHEs, and lack sufficient funds to cover costs. | Through EMAC, states can donate resources and services to disaster-affected jurisdictions through "zero dollar missions." Some state laws may also allow entities to make nonreimbursed donations of resources or services. |

[1] FICEMS, STATE EMS SYSTEM PANDEMIC INFLUENZA PREPAREDNESS (2009), *available at* http://www.ems.gov/pdf/State_EMS_System_Pandemic_Influenza_Preparedness.pdf.

[2] IOM, CRISIS STANDARDS OF CARE: A SYSTEMS FRAMEWORK FOR CATASTROPHIC DISASTER RESPONSE (2012), *available at* http://www.iom.edu/Reports/2012/Crisis-Standards-of-Care-A-Systems-Framework-for-Catastrophic-Disaster-Response.aspx.

[3] JAMES G. HODGE, JR. ET AL., EXPANDING MEDICAL SERVICES THROUGH COMMUNITY PARAMEDICINE: A LEGAL ANALYSIS (2014).

## I. Pre-Surge Planning and Preparedness

Legal issues underlying the expanded use of EMS personnel and entities in times of PHEs can be profound, complex, and controversial. Yet, many of them are also easily resolved with proper and sufficient planning and preparedness efforts in advance of declared events. Experience from prior modern emergencies and disasters implicating the public's health lends to greater predictability of the types of issues facing EMS, including liability, licensure, scope of practice, reimbursements, and other concerns. In turn, these analyses help generate advance solutions to these legal issues. As discussed in this part of the report, advance planning and preparedness activities may help mitigate legal issues in real-time events.

### *Legal and Ethical Duties to Plan for Public Health Emergencies*

One of the central tenets of public health legal preparedness is the need to effectively plan, educate, and train for emergencies. Since September 11, 2001, billions of dollars at all levels of government have been spent to support or encourage effective planning, education, and training among emergency managers, health care workers (HCWs), public health personnel, and EMS providers. For example, every state has created a pandemic influenza plan with the help of federal funds. As well, IOM CSC recommendations (noted in the Executive Summary above) are encapsulated in federal spending conditions underlying state and local receipt of grants or other funds.[1]

Setting conditions of the receipt of federal or state funds can stimulate preparedness planning essential to saving lives and preventing disabilities during catastrophic public health events. Such planning may also be legally required in other ways. Federal or state emergency laws may directly outline and require preparedness planning among various actors or entities. Corresponding state-based regulations may require local governments to participate in statewide or regional emergency preparedness planning, education, and training exercises.

Private entities may also have to engage in preparedness planning. Nearly every U.S. hospital generates emergency plans through federal funding[2] or in response to the need to meet certain federal[3] or state/local benchmarks.[4] These include grants made pursuant to DHHS' Hospital Preparedness Program and CDC's Public Health Emergency Preparedness (PHEP) Cooperative Agreements. The Joint Commission also requires hospitals to demonstrate levels of emergency preparedness through its accreditation processes.[5]

Appropriate planning may also be conducted to deter potential liability for failures to plan. In the aftermath of Hurricane Katrina in New Orleans, Louisiana, in 2005, a major health provider—Tenet Health Systems—settled a series of claims for a reported $25 million on March 23, 2011.[6] Victims and their families alleged that Tenet's emergency responses at its Memorial Medical Center in New Orleans were not only insufficient, but that Tenet's failure to prepare for a foreseeable hurricane emergency caused the deaths of multiple patients and other survivors' harms.[7] Staff shortages, losses of power, high temperatures, delayed evacuations, inadequate

supplies, and even involuntary euthanasia (via the alleged excess administration of palliative medications without explicit patient consent) all likely contributed to patient injuries and deaths.

Although a health care entity may be responsible for faulty designs or dangerous conditions on its premises, it is not usually liable for disaster-related "acts of God," like flooding, or governmental breaches, like faulty construction of levees that cause patients' harms. In the Tenet case, however, claimants alleged that the provider created unreasonable and preventable risks of harm to patients by failing to have a viable patient evacuation plan, an adequate backup power system, or sufficient arrangements to care for patients if power was lost for extended periods. Health care entities, including EMS providers, may not be prepared for every contingency in a catastrophe, but it may be liable for failures to plan depending on the (1) foreseeability and magnitude of patient risks; (2) relative costs of adequate planning; and (3) causal connections between planning/preparedness lapses and specific patient harms or deaths.

Some preparedness plans may be legally suspect because they fail to address the needs of a specific group of persons. In other cases, planning failures may impact entire classes of vulnerable persons, such as persons with disabilities. In *Communities Actively Living Independent and Free v. City of Los Angeles*,[8] a federal district court in 2011 reviewed a challenge that the 'emergency preparedness plan for the City of Los Angeles (LA) failed to accommodate persons with disabilities under the federal Americans with Disabilities Act (ADA)[9] and other state-based claims. "Communities" alleged that LA's emergency operations plan did not address how it would meet the unique needs of hundreds of thousands of individuals with disabilities in the event of an emergency. Its claims were based on 2008 findings of LA's Department on Disability that the City lacked compliance with the ADA.

The district court found that individuals with disabilities were disproportionately burdened by the City's failure to consider their unique needs in the administration of its emergency preparedness plans, including provisions on how to notify, evacuate, transport or shelter individuals with disabilities. The court disagreed with the City's counter-arguments that (1) it had not engaged in any affirmatively discriminatory actions, and (2) there was no evidence that anyone with a disability had requested or was refused reasonable accommodations. Although the City's actions did not directly discriminate against persons with disabilities, the emergency plan unlawfully discriminated against disabled individuals by failing to address their needs, requiring a retooling of LA's emergency plans.

On the opposite side of the country, a similar result played out in New York City (NYC) in 2013. NYC's emergency planning and preparedness activities were tested during Hurricane Sandy in October 2012. Thousands of persons lacked shelter because of flooding, wind, and fire damage. Hundreds were at risk because of power outages in hospitals and other settings. The public health threats from this massive storm were profound, especially among thousands of New Yorkers with physical or mental disabilities. In *Brooklyn Center for Independence v. Bloomberg*,[10] a class

of disabled persons sued NYC for its alleged failure to accommodate the disabled into its emergency planning. Class members testified that they were trapped and suffered in their residences for hours or days during and after Hurricane Sandy.

As in LA, the court found NYC liable for its inadequate planning to meet disabled persons' needs, including failures to address (1) adequate transportation; (2) evacuations (particularly from multistory buildings); (3) physical shelters and related communications; (4) power outages; (5) recovery operations to check on those who had not been evacuated; and (6) communications to alert the disabled about what to do in emergencies. These court decisions in NYC and LA together support the need for affirmative measures to provide for persons with physical and mental disabilities in all phases of PHE planning and response. This includes accommodations for EMS personnel who are directly and negatively impacted psychologically through response efforts.[11]

## II. Pre-Surge Interjurisdictional Coordination among Public and Private Actors

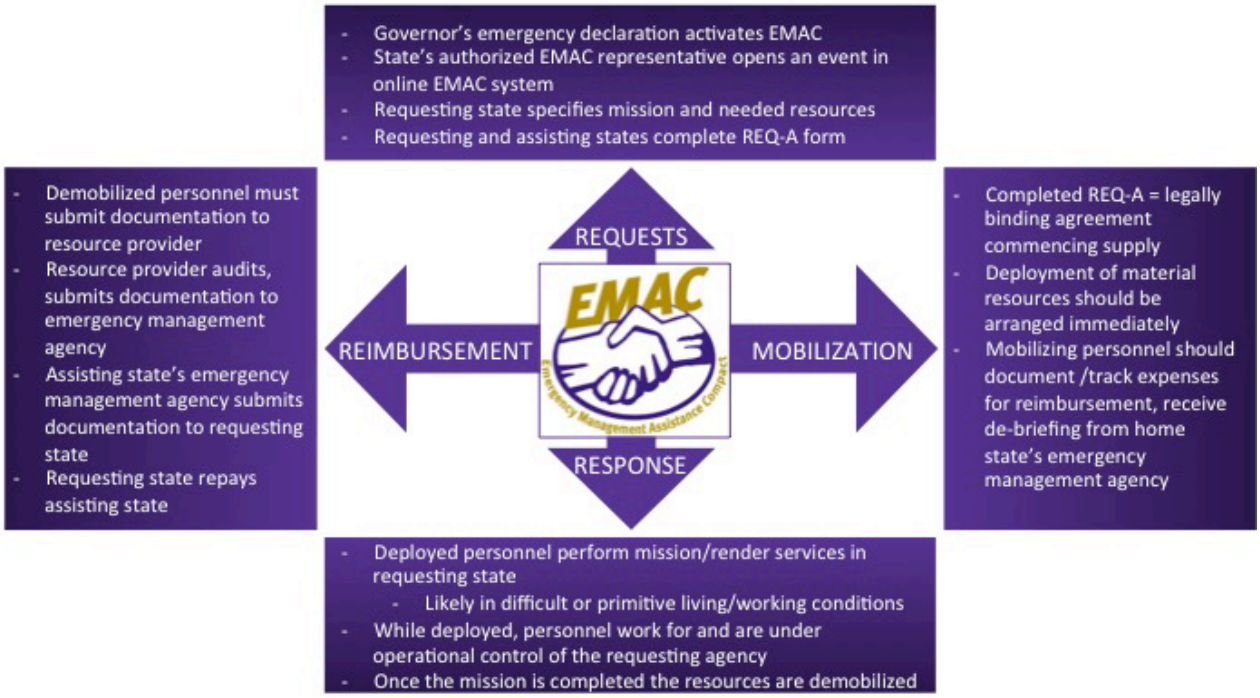
Lessons learned from the 2014 Ebola outbreak, 2009/2010 H1N1 pandemic, and prior emergency events include the need for strong, interjurisdictional coordination among varied actors to craft and effectuate organized responses to emergencies. Multiple, potential logistical and other obstacles challenge the seamless sharing of personnel, supplies, information, and other resources across boundaries and between public and private sectors. As discussed below, however, numerous legal tools can support effective sharing, collaboration, and coordination among and between EMS providers and their partners before, during, and after declared emergencies.

## III. Agreements/Memoranda of Understanding to Negotiate Coordination

Advance arrangements can help delineate terms of collaboration, understanding, and expectations concerning the roles and purposes of EMS providers before or after an emergency. Some agreements may embrace a legal contractual approach, obligating parties to adhere to specific terms. Others, such as memoranda of understanding (MOUs) or compacts, may be crafted so as to avoid the binding qualities of formal contracts. These documents can provide considerable flexibility for participants needing to adapt to unforeseen circumstances.

A premier, existing example of these types of agreements is the Emergency Management Assistance Compact (EMAC). EMAC is an interstate mutual aid assistance agreement between all states (as well as D.C. and several territories) administered by the National Emergency Management Association (NEMA). When activated, EMAC allows for mutual assistance between states managing any declared emergency or disaster (Figure 2). If resources fall short, personnel or resources can be deployed across state lines to facilitate efficient and effective responses.

**Figure 2. EMAC Organization**[12]




In an array of emergency scenarios, EMAC invokes the participation of individuals from numerous health- and non–health-related professions, including EMS providers. Jurisdictions assist each other by providing requested goods (e.g., generators, temporary shelters, equipment) and services (e.g., security, medical personnel). For example, within 36 hours of Hurricane Katrina's landfall in September 2005, more than 6,000 health care personnel were deployed to the affected regions through EMAC.[13]

As discussed in Part III, out-of-state HCWs normally cannot practice legally in a state in which they are not licensed. 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 during a declared emergency or disaster, 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.[14] These personnel must adhere to a requesting state's scope of practice requirements and other limitations. Individuals who provide aid through EMAC are considered agents of the requesting state and are not liable for any acts or omissions conducted in good faith.[15] Furthermore, all jurisdictions must provide workers' compensation benefits for the volunteers they deploy.[16]

Though highly useful in emergencies, EMAC has limitations. In most jurisdictions, only public sector professionals can be deployed. Following Hurricane Katrina, a few states deputized private sector individuals as state agents, or issued executive orders to allow private sector

volunteers to be deployed through EMAC. Some volunteers enter into volunteer services agreements (VSAs) or MOUs with their state emergency management agency prior to deployment. In Ohio, for example, state officials have executed MOUs with county governments that authorize the use of local personnel for EMAC response efforts.[17]

Other legal tools in addition to EMAC may be executed in advance of emergencies to facilitate EMS roles. These include agreements between EMS and various other parties:

1. ***Federal/state/local public health agencies***. Agreements between EMS providers and CDC, other federal agencies, or state and local health departments may set terms for roles before, during, and after an emergency, including (a) triggers for EMS expansion of roles; (b) staffing and operating responsibilities; (c) development and use of uniform decision support tools such as protocols; and (d) chain of command and oversight structures.

2. ***Other health providers***. Agreements between EMS providers and health providers or receiving facilities, most notably through collaborative practice agreements (CPAs) or MOUs, may address issues such as (a) adherence to clinical guidelines to ensure consistent patient handling; (b) allowable modifications to decision support tools to accommodate providers' electronic records systems;[18] (c) reimbursement (see Part VI); and (d) numbers and types of EMS personnel available during routine and peak activity periods.

3. ***Suppliers***. EMS providers may also execute agreements directly with suppliers to help make sure adequate medical or other supplies are ready in cases of emergencies. Such agreements may address price, quantities, delivery, and types of supplies.

## IV. Potential legal requirements may apply to these agreements or documents depending in part on whether EMS providers are public or private entities.

## V. Liability Insurance Requirements

Federal regulations, as well as some state or local laws, may legally require private entities to carry liability insurance as part of their contracts with government.[19] For example, Minnesota requires entities or individuals contracting with the state for professional or technical services to carry state-approved minimum insurance coverage.[20] King County, Washington,[21] and Tampa, Florida,[22] require contractors to carry general commercial liability insurance. Additional laws typically require private contractors to provide workers' compensation coverage for their employees.[23]

## VI. Limiting Advance Payments

Some jurisdictions may limit the flexibility of state contracts by legally preventing prepayment for goods or services through government contracts. Minnesota requires that goods or services provided under contract with the state or its agencies be provided before payment is approved.[24] South Carolina does not explicitly prohibit prepayment, but presumes that payment will not be approved until after the state accepts goods or services.[25] Conversely, states like New Jersey and Alaska expressly allow prepayments in state contracts.[26]

## VII. Additional Fiscal Requirements.

Additional constraints related to distributing funds also exist. Many states require state contracts to be submitted for competitive public bidding[27] or be approved by specific agencies or officials[28] before funds can be released for purchases or services. While contracts or agreements that do not comply with these and other legal restrictions may be void, many jurisdictions' emergency declaration laws authorize waiver of some fiscal requirements to obviate potential statutory or regulatory contractual burdens or delays (see Part II).[29]

## VIII. Application and Use of Evidence-Based Guidelines and Protocols

Legal routes to expanding the roles and responsibilities of EMTs during PHEs vary among jurisdictions according to type of licensure or certification (discussed in Part III). Treatment and transportation protocols incorporating EMT collaboration and supervision can enhance their ability to deliver quality patient care. Clinical protocols help to ensure that state EMS systems standardize their approaches to patient care.[30] Essential to the implementation of clinical protocols is the development of evidence-based guidelines to facilitate and assess the provision of patient care based on the best available scientific knowledge of prehospital care practices.[31]

***Protocols Related to Pandemics***. States like Minnesota[32] and Georgia[33] specifically authorize doctors to direct other licensed practitioners, including nurses and EMTs, via protocols. During the H1N1 pandemic, Minnesota's FluLine used clinical algorithms through vendor-operated nurse triage lines and associated lines operated by various health care systems. Nurses were authorized to prescribe limited medications through a protocol issued by the state epidemiologist (who was a state-licensed physician) based in part on CDC guidance.[34] Similar protocols extending the scope of practice or authorized activities of EMS personnel in declared emergencies are possible.

***Protocols Related to Predictable, Additional Conditions***. Decision support tools for handling conditions may include procedures for referring callers to 9-1-1 emergency services when they present with particularly serious symptoms (e.g., chest pain, seizures) and recommending evaluation by a health care provider for complicating conditions (e.g., pregnancy, immunodeficiency). Several decision support tools provide guidance for EMTs, including

American Medical Response (AMR) Federal Disaster Protocols, Sort-Assess-Lifesaving Interventions/Treatment-Transport (S.A.L.T.), and Austere EMS Guidelines.

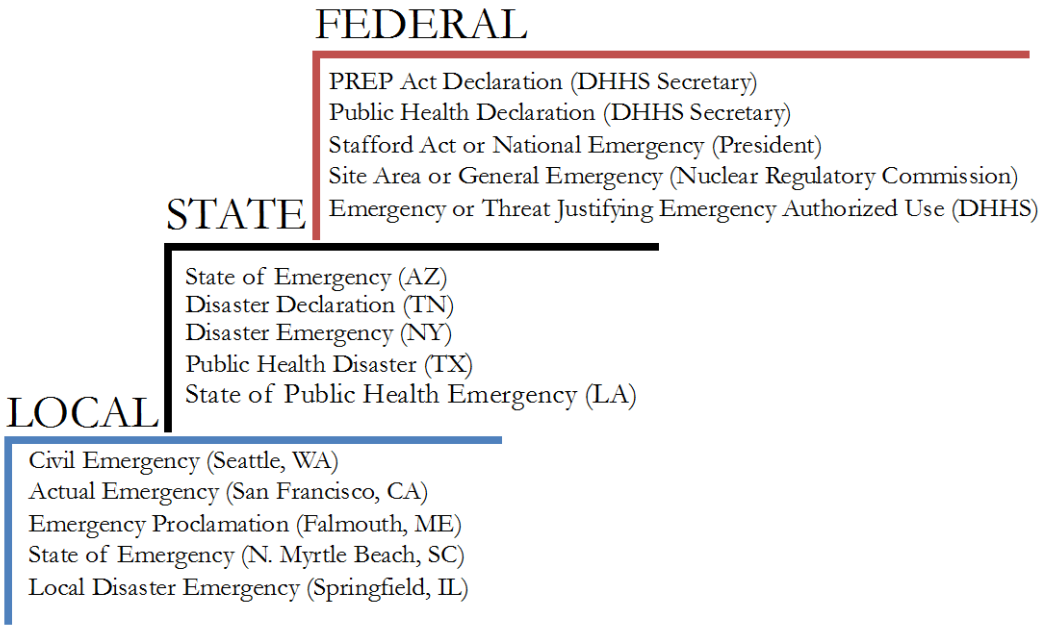
## IX. The Changing Legal Environment in Declared States of Emergency

Advance planning and preparedness efforts through MOUs, collaborative practice agreements, or other agreements or protocols are essential to firming up approaches and preserving options for EMS providers responding during public health crises. Understanding the essential legal dynamics of declared emergencies is equally important. During pandemics or other major events that impact the public's health, the legal environment can be transformed through declared states of emergency, disaster, or PHE. These declarations, whether made at the federal, state, or local level, trigger an array of powers to facilitate EMS public- and private-sector response efforts.[35] Emergency laws may

1. Offer flexible powers to respond rapidly
2. Waive legislative or regulatory provisions that impede effective responses
3. Smooth shifts from conventional to CSC[36]
4. Allow for out-of-state EMS licensure reciprocity
5. Alter professional scopes of practice for EMS personnel[37]
6. Initiate special liability protections for EMS providers[38]

Each of these authorities may depend in part on the level and type of emergency declared. As depicted in Figure 3, various levels of government may declare an array of differing types of emergencies.[39] As per **Table 1. Select Levels of Emergency Declarations** (see Appendix), the range of emergency declarations and corresponding powers is extensive.

**Figure 3. Types and Levels of Emergency Declarations**




As summarized below, the federal government, every state, many territories, and local governments may declare either general states of "emergency" or "disaster" in response to crises that affect the public's health. DHHS, many states, and select local governments may also declare states of PHE. Each of these declarations can change the legal landscape instantly and significantly in response to public health crises in ways that may benefit EMS providers in carrying out new and emerging roles and responsibilities.

***Federal Emergency Declarations***

The U.S. president can declare a state of emergency or disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act ("Stafford Act")[40] upon 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."[41] The president can also declare a state of emergency pursuant to the National Emergencies Act[42] for incidents requiring a national response.[43] These emergency declarations typically authorize emergency management agencies, like the Federal Emergency Management Agency (FEMA) and partners, to coordinate emergency responses, mobilize funding, and activate specific programs.

Pursuant to the Public Health Service Act,[44] DHHS may declare a state of "public health emergency"[45] to enable resources (e.g., Strategic National Stockpile [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.

Some of DHHS' PHE powers are authorized only when coupled with a declaration of a national emergency. During the 2009/2010 H1N1 pandemic, DHHS immediately declared a state of PHE on April 26, 2009, just days after initial cases were confirmed in the United States. It was months later on October 23, 2009, before President Obama declared a national state of emergency. Coupled with DHHS' PHE declaration, the 'president's subsequent declaration allowed for broader waivers of federal regulatory requirements (e.g., specific provisions of the State Children's Health Insurance Program and EMTALA).[46] In 2013, Congress passed the Pandemic and All-Hazards Preparedness Reauthorization Act[47] (PAHPRA) to expand DHHS' PHE powers, in part, without the need for an additional national emergency declaration.

### *Emergency Use Authorizations*

PAHPRA significantly enhanced the authority of DHHS and FDA to issue emergency use authorizations (EUAs) to allow use of otherwise nonapproved tests, medications, or treatments. Prior to or during a DHHS-declared PHE,[48] FDA can issue an EUA to allow emergency use of tests or drug products. EUAs were used during the 2009/2010 H1N1 pandemic, for example, to allow unapproved uses of zanamivir (Relenza®) and oseltamivir (Tamiflu®) for treatment and prophylaxis of young children and hospitalized patients.[49] As well, FDA issued an EUA during the 2014 Ebola outbreak to allow greater use of an assay test for Ebola developed in part by the Department of Defense.[50]

EUAs permit the dispensing of products that are either (a) not yet approved for use or (b) approved but sought for an unapproved use.[51] The latter type of EUA approval is more likely in the context of antivirals used during influenza pandemics because of the potential for unapproved drugs to require lengthier investigational new drug (IND) application processes.[52] An EUA can help make available for a temporary period of time a specific product that might otherwise be off limits in nonemergencies. Prior to issuing an EUA, FDA's commissioner must conclude that

1. A disease or other condition specified in the declaration poses a serious or life-threatening health risk

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

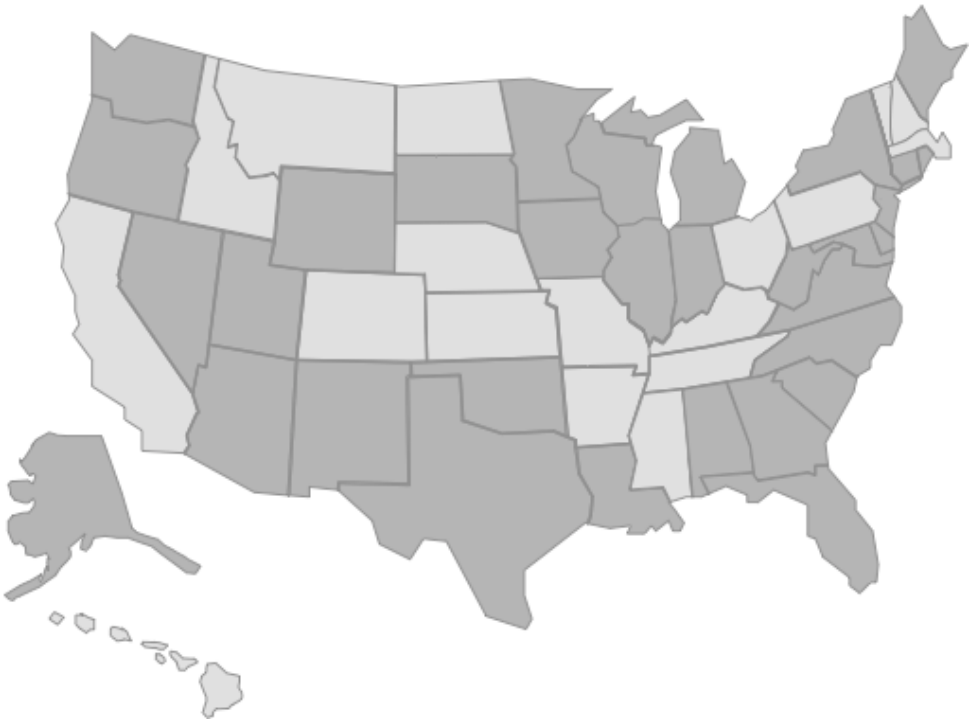
4. No adequate, approved, and available alternative exists to address the disease or condition[53]

Once issued, EUAs take effect nationally[54] and may remain in effect for the duration of the emergency (up to 1 year unless revoked or renewed).[55] 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.[56]

### *State, Territorial, and Local Declarations*

As categorized in **Table 2. State Emergency Declarations** (see Appendix), all states and territories (and some localities) are legally authorized to declare states of emergency or disaster in response to multifarious events, including crises that impact the public's health (e.g., pandemics, bioterrorism events, widespread foodborne illnesses). In addition, 33 states and D.C. (Figure 4; shaded in darker gray) also authorize declarations of "public health emergencies," or like terms, as part of their laws.[57] Many of these states' approaches are based on the Model State Emergency Health Powers Act (MSEHPA) developed by the *Centers for Law and the Public's Health* in response to the anthrax exposures in late 2001.[58]

**Figure 4. States Defining "Public Health Emergency"**

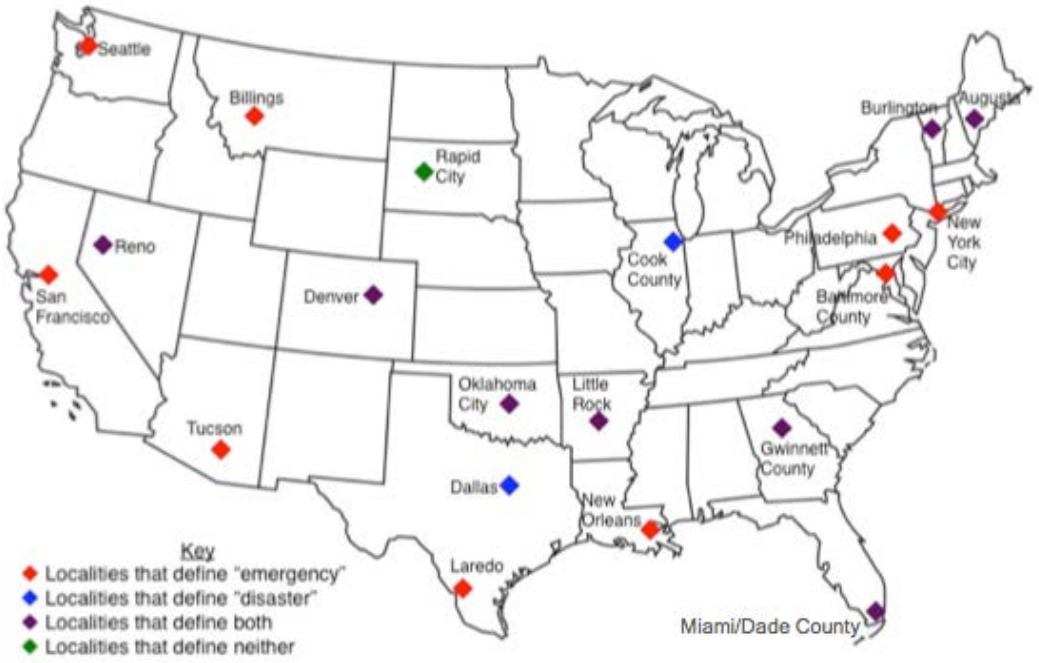


PPHE declarations typically empower state public health officials (in collaboration with emergency management agencies) to focus on the public health aspects of emergencies, including the roles of EMS providers. Though designed originally for application in bioterrorism events or widespread emerging infectious diseases, states and localities have increasingly declared PHEs for a variety of purposes, some of which may seem only tangentially related to threats to communal health. As documented in **Table 3. Public Health Emergency Declarations** (see Appendix), over the past decade, PHE declarations have been made to address numerous situations:

- Suspension of out-of-state medical personnel licensure regulations
- Contamination of public water supplies
- Localized measles outbreaks
- Release and threatened release of amphibole asbestos
- Drinking water contamination
- Dramatic increase in reports of domestic violence
- Shortage of affordable, safe medical cannabis
- Abuse of prescription medication and illegal drugs
- Illness due to use of "bath salts"
- Severe storms and tornadoes
- Food insecurity
- West Nile Virus outbreaks
- Opioid addictions

Some larger cities and counties may also declare states of emergency depending on the degree of "home rule." Home rule refers generally to the amount of power allotted by states to local governments to address largely local matters. One 2010 study[59] reviewed emergency legal authorities of 20 select local jurisdictions of various population sizes across the United States. Researchers found that 19 (95%) of the localities authorized local officials to declare either an emergency or disaster (Figure 5).

**Figure 5. Select Localities that Define "Emergency" or "Disaster"**




## X. Timing of Emergency Declarations

One of the key lessons from prior public health crises is that the timing and duration of emergency declarations across states can be hard to predict. While all states initiated their pandemic influenza 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 of 2014, only Connecticut declared a PHE.[60] Clearly not all (or even most) states and territories may decide to declare states of emergency or PHE in future events even if they are legally authorized to do so.

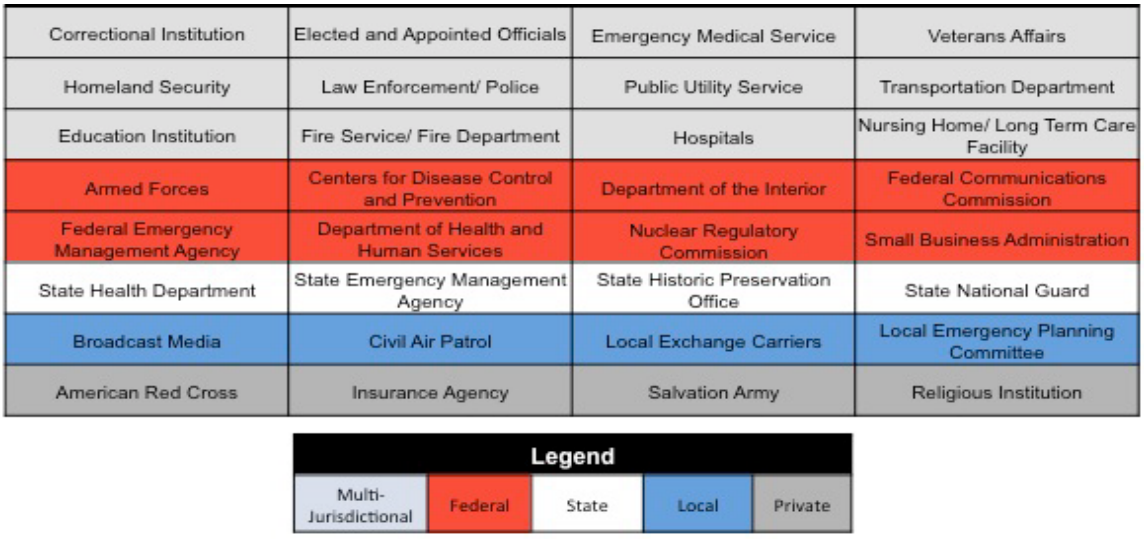
Among those states or localities that do declare some type of emergency, their declarations may be staggered over months as officials assess the severity of the threat and other concerns. As a result, advance planning concerning the roles and responsibilities of EMS personnel cannot rely on potential legal changes precipitated on declarations of emergencies when the issuance of these declarations is uncertain. In jurisdictions that do not formally declare states of emergency, other legal techniques and maneuvers (outside of those authorized during declared events) embedded within agreements, MOUs, contracts, or existing public health laws may have to be relied on to facilitate effective EMS responses.

## XI. Simultaneous Emergency Declarations

A different dilemma arises when state or local governments declare (1) states of "emergency" or "disaster" along with (2) a PHE. Issuance of two or more declarations in a single jurisdiction is possible because the different types of declarations share similar statutory definitions and constructs.[61] In Delaware, for example, an influenza pandemic could simultaneously trigger statutory declarations of emergency, disaster, and PHE.[62] The potential for overlapping declarations within and across jurisdictions can confuse response efforts.

Divergent public and private actors are mobilized or authorized to act under different declarations that invoke distinct powers and chains of command (Figure 6). When multiple declarations are issued, these actors can respond in duplicative, overlapping, and potentially inconsistent ways as experienced during Hurricane Katrina in 2005.

**Figure 6. Select Actors in Declared Emergencies**




## XII. Practicing Legal Triage

Since the timing, duration, and variance of emergency declarations can be difficult to predict, as noted above, emergency laws may not always be relied on in public health crises. Furthermore, these laws do not always ensure best practices, in part because of their lack of specificity and potential limitations stemming from constitutional requirements or contractual limitations (noted in Part I).

Framed in broad language, shaped by political realities, and subject to fluctuations on the frontlines of response efforts, emergency laws offer more so a menu of legal powers and options instead of definitive guidance. Without affirmative direction, EMS providers may act unknowingly outside of legal boundaries. Alternatively, they may fail to act at all because of

erroneous legal advice, liability fears, or other actual or perceived legal consequences. Neither of these outcomes is acceptable.

Emergency planners, public health practitioners, EMS providers, and their legal counsel must be prepared to triage legal issues and solutions in emergencies to effectuate legitimate public health responses. Responders must make critical legal decisions that balance communal and individual interests in emergencies where facts may be unclear, resources are scarce, and communal well-being is imperiled. This entails real-time identification and solutions to vexing legal issues.[63]

As noted above, emergency declarations may allow for waivers of state-based laws or policies that otherwise hinder emergency response. In a declared disaster, Texas's governor may suspend provisions of state regulations that would impede response.[64] Colorado's governor may suspend any state agency order, rule, or regulation once an emergency is declared.[65] **Table 4. Select Examples of Emergency Waivers of Statues, Rules or Regulations** (see Appendix) provides other examples of waiver authorities pursuant to emergency declarations and how they have been used to facilitate response efforts. Each of these examples involves key "legal triage" decisions. Advance planning and artful, well-communicated interpretations in real time can alleviate specific legal impediments that may hinder EMS providers in carrying out their roles and responsibilities.

## XIII. Meeting Surge Capacity – Ensuring and Empowering EMS Personnel

Ensuring the availability of adequate EMS personnel to address emergency response needs is a big challenge. Personnel must be adequately educated and trained, appropriately vetted, and legally authorized to perform functions. EMS professionals may have to provide services outside their typical scope of practice. As a result, a series of legal issues, including state licensing requirements and scope of practice restrictions, must be addressed to facilitate response efforts. In routine events, licensing and scope of practice requirements are designed to promote the public's health by helping to ensure EMS and other health personnel are qualified to provide essential services. In emergencies or public health crises, however, sometime these and other legal requirements can impede rapid, effective responses. Consequently, as described in this part of the report, varied pathways exist to resolve potential legal obstacles that may hamper the delivery of patient care.

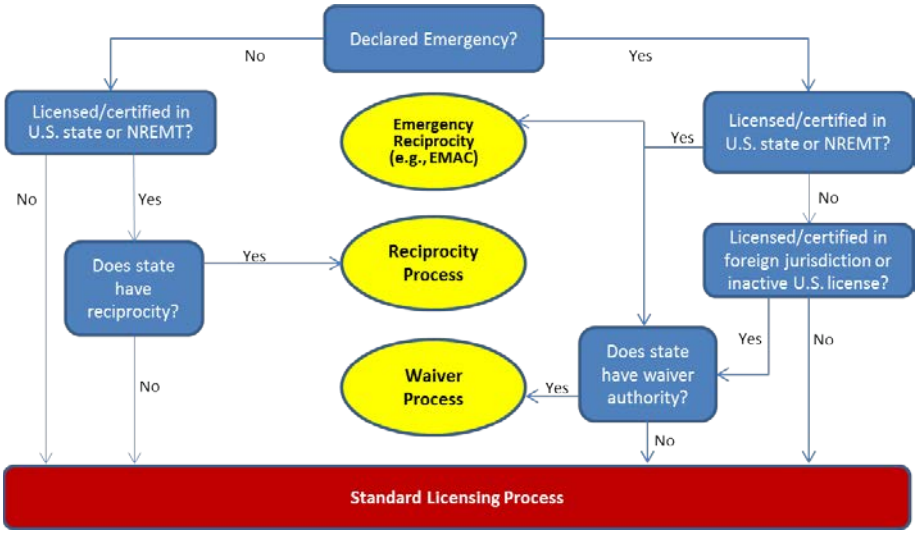
### *Licensure and Reciprocity*

EMS professionals must generally be licensed or certified in the states where they practice routinely. Each state has established licensing systems for such personnel, involving examinations, background checks, and other requirements. As discussed below (see Expanding Scope of Practice), the legally defined "scope of practice" for the various designations of EMS personnel (EMRs, EMTs, advanced emergency medical technicians (AEMTs), or paramedics) details the services they may provide within their license or certification. During times of

medical surge, however, increased needs for EMS personnel may outstrip locally available resources and require the temporary relocation or sharing of out-of-state EMS providers. This presents an immediate legal conundrum related to the potential use of out-of-state licensed EMS personnel in jurisdictions affected by emergencies.

This problem is easily solved. As explained in sections below, several pathways to licensure in nonemergency and declared emergency environments may facilitate rapid deployment and use of EMS personnel from other jurisdictions. Figure 7, Pathways to Licensure Reciprocity, illustrates a variety of routes to authorize out-of-state EMS personnel to practice in the state. When an emergency has been declared, emergency personnel licensed or certified in a U.S. state or through NREMT may be able to obtain licensure reciprocity through existing processes (e.g., EMAC) or via waivers of licensing requirements from the state requesting assistance. If no emergency declaration has been declared, licensed or certified emergency personnel may be able to obtain licensure reciprocity through expedited or routine reciprocity processes.

**Figure 7. Pathways to Licensure Reciprocity**




In nonemergencies, licensure reciprocity for EMS personnel is available in some states for those who are licensed in good standing in other states.[66] Examinations and other requirements are generally waived for reciprocity applicants, although application forms and fees may be required.[67] Additional fees may also be charged by the applicant's home state for certification of status.[68] Most jurisdictions (e.g., New York) similarly offer "fast-track" licensure for military veterans and those with current National Registry of EMT certification.[69] While this type of reciprocity reduces the time required to obtain EMS licensure, it does not provide instantaneous out-of-state licensure recognition, and thus may be of limited utility during a catastrophic emergency.

Other licensure reciprocity structures may also help EMS personnel work across state borders. Twenty-four states have adopted the Nurse Licensure Compact;[70] other states are considering it also.[71] To the extent that some EMS workers may additionally be licensed as nurses, the Compact allows them to practice in any of the compact states in that capacity. Similar agreements may be adopted to extend similar reciprocity to licensed EMS personnel. Still, creating EMS licensure reciprocity may be tenuous for several reasons. EMS licensing varies extensively between states as to classifications, scope of practice, and other elements. For example, Iowa has five EMS licensure classifications, while Florida has only two. NHTSA's National EMS Scope of Practice Model[72] may help reconcile differing state licensure structures for reciprocity purposes.

Most states are presently updating their classifications to more closely match NHTSA's model. According to the National Association of State EMS Officials (NASEMSO), 76% of states have implemented or plan to implement the model for emergency medical responders (EMRs), 88% for AEMTs, and 100% for EMTs and paramedics. Transition of existing, alternative classifications (e.g., EMT-Basic, I-99, I-85) is ongoing in most states, but at least 17 states plan to retain existing classifications that diverge from the model for currently licensed EMS professionals (e.g., Arizona, Georgia, New York, Virginia).[73]

In September 2014, NASEMSO and industry partners proposed the Recognition of EMS Personnel Licensure Interstate CompAct (REPLICA)—model legislation intended to facilitate the deployment of EMS personnel.[74] REPLICA proposes EMS licensure reciprocity within all states that enact it into law, and establishes a national commission of which those enacting states are members. The Act also ensures that member states have appropriate liability mechanisms in place for receiving and investigating individual complaints. REPLICA is innovative in that it allows immediate legal recognition of EMS licensure across state lines with or without a formal emergency declaration. Though it has yet to be enacted by any state, REPLICA may provide a future route to licensure reciprocity in times of emergency by enabling member states to afford immediate legal recognition to EMS personnel licensed in other member states.

***Emergency Laws***. As discussed in Part II, official declarations of emergency, disaster, or PHE may activate various compacts and agreements that can facilitate out-of-state licensure recognition for EMS professionals and other HCWs. Pursuant to EMAC, persons licensed or certified in any other compact jurisdiction are automatically "deemed licensed" by the requesting state (subject to any limitations or conditions imposed by the state's governor).[75] EMS personnel 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 jurisdictions as part of coordinated response efforts.

Many states' laws provide significant flexibility in recognizing out-of-state licensure during an emergency. The aforementioned MSEHPA provides for recognition of out-of-state licenses among HCWs, including EMS personnel, during a declared PHE.[76] Arizona allows "any person holding any license, certificate or other permit issued by any state . . . for professional, mechanical or other skills" to render aid during a declared emergency "as fully as if . . . [it] had been issued in [Arizona]" if the state issues a "substantially similar" professional license, certificate, or permit.[77] Similar provisions can pave recognition of out-of-state licenses where titles and other elements vary between states.

***Volunteer Licensure Reciprocity***. Among the 15 states adopting the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) [78], EMS volunteers can be granted temporary out-of-state license recognition for the duration of an emergency.[79] However, they must be listed within volunteer registration systems, such as the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) or the Medical Reserve Corps, and serve through coordinated efforts.

Some EMS personnel may be willing to volunteer but may not be registered with a volunteer database or associated with official governmental volunteer deployments. These "spontaneous volunteers"[80] may not legally be entitled to licensure reciprocity. Because of liability concerns, public and private entities may be reluctant to fully utilize spontaneous volunteers who cannot be thoroughly vetted in advance, as discussed below. However, spontaneous volunteers may still carry out other roles, like coordination and communication activities, that do not require licensure.

***Emergency Waivers***. As noted in Part II, federal, state, and some local governments may suspend or waive legal provisions, including licensure laws, during a declared emergency. Louisiana suspended state laws to facilitate use of out-of-state volunteer EMS and other health professionals in several instances, including Hurricane Katrina in 2005, the Deep Water Horizon oil spill in 2010, and Hurricane Isaac in 2012.[81] 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 professionals from other states (as well as other countries) and those with expired or inactive licenses, to assist response efforts depending on state law and the content of the waiver.

Sometimes the type of emergency declared may determine the waiver process. For example, Arizona's governor has very broad waiver authority during a state of war emergency[82], but less so during other types of declared emergencies. However, during any declared emergency involving substantial public health risks, Arizona's state health department can coordinate with state licensing boards to waive licensure requirements to respond to the threat.[83]

***Distinguishing Licensing and Credentialing***. Unlike other medical professionals who provide care in health care facilities, out-of-state EMS professionals do not generally have to meet

credentialing or privileging requirements imposed by health care facilities or similar entities. These credentialing requirements are often derived from entity accreditation requirements[84] typically found in organization bylaws. Reciprocity agreements, waivers, and similar legal strategies may legally authorize EMS professionals to provide services, but may not authorize work in a specific facility that imposes additional requirements. However, their application to EMS personnel is minimal since (1) these personnel typically provide services outside medical facilities and (2) many facilities do not apply requirements to them. Other types of credentialing such as for EMS vehicles[85] or individual EMS professionals may, however, apply.[86]

***EMS Providers***. In addition to licensure requirements for EMS personnel, licenses may also be required for EMS businesses and service vehicles. Local fire departments and public service agencies provide a significant portion of ambulance response and transport in the United States, often in collaboration with private EMS companies.[87] Where private EMS providers are used, some localities require contracts, MOUs, and prior approval between the entity and the municipality served.[88] States may also provide licenses or permits for ambulance services and their vehicles.[89] Local governments may require business licenses for ambulance companies,[90] leading some applicants to obtain certificates of public convenience and necessity (although these certificates' requirements have decreased nationally over the past few years).[91] Cities or counties may also enter exclusive, single-source agreements with private ambulance companies.[92] For example, in California, ambulance service areas can designate an exclusive provider, but each must follow a strict bidding system for selection to avoid legal antitrust issues.[93]

During medical surge, EMS transport needs may outstrip available ambulance services. Real-time reallocation of vehicles and personnel may be complicated by existing contracts and restrictions. MAAs can help circumvent some of these legal obstacles by allowing EMS providers to support needs in affected areas.[94] Failure to utilize resources available through such agreements may even result in claims of patient abandonment against the responsible entity, though no specific cases have been identified to date[95] (as discussed further in Part IV).

EMS personnel may also use nonambulance vehicles in many circumstances, such as through mobile integrated health (MIH) systems.[96] Nonambulance vehicles may have alternative equipment requirements,[97] with further exceptions afforded in emergencies under various state laws. For example, Maine requires air ambulance services to be licensed, but allows use of unlicensed aircraft if transport is medically indicated and in the patient's best interests.[98] New York allows a waiver to be granted if the service can demonstrate how the emergency ambulance service vehicle can appropriately respond with the reduced supply/equipment requirements.[99]Massachusetts provides waivers from statutory requirements "for special projects which demonstrate innovative delivery of emergency medical care services."[100] As noted above and in **Table 4. Select Examples of Emergency Waivers of Statutes, Rules or Regulations**

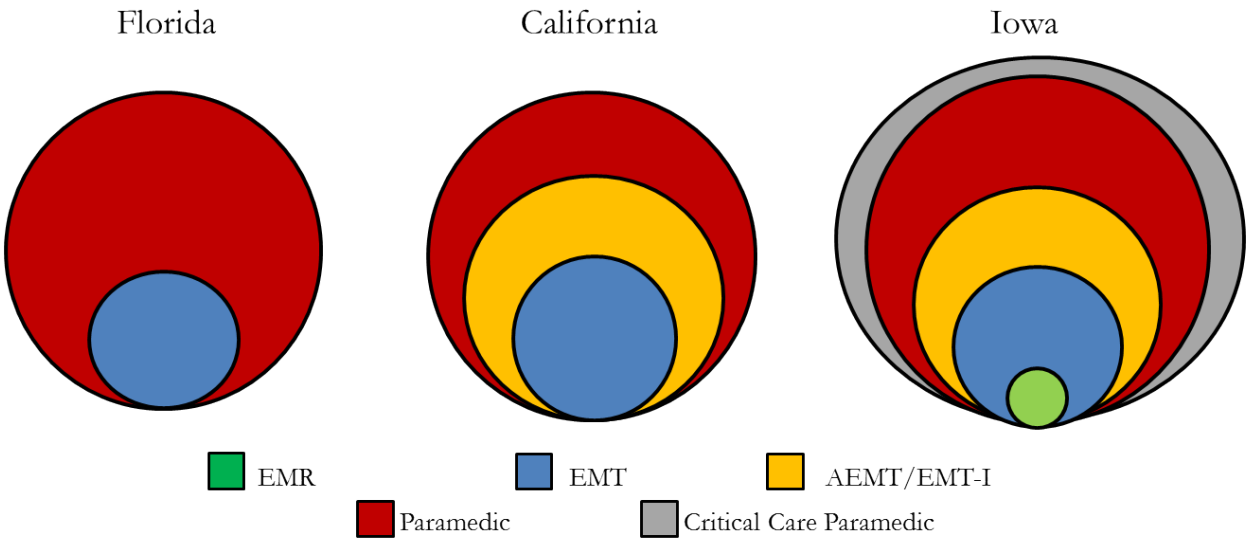
(see Appendix), if state licensing laws impede emergency response efforts, these provisions may also be temporarily suspended or waived during a declared emergency.

### *Expanding Scope of Practice*

***Scope of Practice Variation***. EMS personnel include a diverse range of professionals with specific training and education. EMS functions may be performed by individuals licensed or certified as EMRs, EMTs, AEMTs, or paramedics, among other designations.[101] Their legally defined "scope of practice" details the services they may provide with a specific license or certification. States like Iowa[102] are highly specific in designating which services may be provided. Other states (e.g., Georgia, California)[103] allow for some flexibility with medical director approval via "local optional scopes of practice" and similar mechanisms.

States also vary in the structures used to differentiate between levels of EMS professionals (Figure 8). Such variations may complicate rapid license reciprocity efforts absent advance consideration of equivalency between different classifications. For example, scope of practice for an Iowa AEMT volunteering in Florida may be problematic as Florida does not offer this specific license.

**Figure 8. Select State Scope of Practice Classifications**




Variations in the scope of practice between states can interfere with EMS professionals who volunteer across state lines in times of medical surge. Specific guidance may also derive from waiver authority used to recognize out-of-state EMS licensure during a declared emergency, restricting EMS scope of practice as a condition of temporary license recognition. Some emergency laws, such as those incorporating UEVHPA, explicitly address conflicting scope of practice provisions and determinations as to which set of standards control. EMAC similarly

provides for conditions and restrictions on scope of practice as determined by the state requesting assistance.[104] Such restrictions may arise when a state requests additional personnel, but has a more limited scope of practice for EMS personnel and does not necessarily need to expand allowable functions to address the emergency. For example, a requesting state may not authorize EMS professionals to provide immunizations, but may receive volunteers from a state that does (e.g., North Dakota).[105] Additionally, if the volunteer's home state features a more restrictive scope of practice than the requesting state, the volunteer generally must continue to abide by these restrictions.

Scope of practice considerations differ for federal EMS deployments. AMR is contracted to provide EMS response in federally declared disasters as approved by FEMA with a scope of practice defined by NHTSA's National EMS Scope of Practice Model.[106] Unlike some state scope of practice models that set upper limits on allowable functions, the national model sets minimum competencies. States that allow EMS personnel to perform additional functions must provide necessary education and certification to use federally deployed personnel for these activities. However, AMR notes that changes to scope of practice may be necessitated during declared emergencies.[107] Federal VHPs remain bound by scope of practice restrictions in their state of licensure and may not act beyond their formal education, training, and certification.[108]

***Location Restrictions and Nontraditional Functions***. Scope of practice restrictions dictate not only who may provide what services, but also where services may be delivered. 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.[109] California EMTs can perform various functions only "during training, while at the scene of an emergency, during transport of the sick or injured, or during interfacility transfer."[110] Other laws allow EMS in any location, focusing on the patient's condition. Georgia authorizes EMS personnel in any location to evaluate persons who present themselves with an "emergency condition,"[111] defined as "any medical condition of a recent onset and severity" such that immediate medical care is necessary to protect against serious jeopardy to health, impairment of bodily functions, or serious dysfunction.[112] Virginia defines "emergency medical services" as those in response "to an individual's perceived needs for immediate medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury."[113]

Nontraditional and expanded EMS functions in declared emergencies may not come under traditional conceptions of "emergency" care. While day-to-day patient assessment activities are fully authorized under these definitions, some activities during declared emergencies may not readily fall into these categories, such as assisting in mass public vaccination campaigns and other efforts focused on prevention, rather than treatment. For example, while Illinois authorizes EMS personnel to provide nonemergency services, it limits the definition of nonemergency services to care or monitoring "before or during transportation . . . to or from health care facilities."[114] Providing nonemergency care to patients who are not being transported to or from a

health care facility may be outside the realm of authorized EMS scope of practice in jurisdictions with similar definitions. Other states explicitly allow EMS personnel to provide care in nonemergency and non–transportation-related circumstances to encourage their utilization in community health care. Florida permits trained and supervised paramedics and EMTs to perform health promotion and wellness activities and provide immunizations pursuant to a county health department agreement.[115]

In emergencies, EMS personnel may have to serve outside of typical environments, such as at "shelters, ACSs, patient receiving centers, clinics, and tented free-standing medical units."[116] These activities may appear to lie outside acceptable scope of practice because they are not conducted at a traditional "scene of an emergency." However, formal declarations of emergency may arguably convert the affected jurisdiction into an "emergency scene" for purposes of EMS scope of practice and liability protections, as discussed below.

***Waivers***. Temporary waivers or suspensions of state or local laws can also set aside scope of practice restrictions, enabling EMS personnel to act consistent with their education and training even if they are not legally authorized to engage under normal circumstances. During the 2009/2010 H1N1 pandemic, Maryland authorized paramedics and cardiac rescue technicians to vaccinate public safety personnel, health care providers, and the public.[117] Other states have used similar authority to address significant public health crises, such as emergency waiver authorization to allow increased Narcan access for Massachusetts's first responders to address rising rates of opioid overdose.[118]

***Distinguishing Standards of Care***. Scopes of practice differ from legally required standards of care.[119] Scope of practice derives from statutes and regulations and provides limitations on EMS professionals' activities and services based on their level of licensure, certification, and training. Standard of care, in contrast, refers to the legal measure used to evaluate whether a health professional has adequately and appropriately performed these duties, as discussed below in Part IV. Scope of practice impacts standard of care, however, because the legal standard of care for EMS personnel, like other health professionals, is generally that of a professional of the same classification operating in similar circumstances. For example, a California court in 1990 upheld a jury verdict against a paramedic who failed to perform an adequate examination because his conduct was "an extreme departure from the standard of care for a paramedic in such a situation."[120] The paramedic performed only a visual examination of a man who had been in a fight and was detained by police. The man later died of complications that would have been uncovered and corrected if appropriate tests were performed consistent with the efforts and practices reasonably expected for paramedics. The standard of care expected for EMS personnel depends in part on the education, training, and authority associated with their specific scope of practice. An EMT is not held to the same standard of care as a paramedic, for instance, because a paramedic is authorized and expected to perform services the EMT is not, but both must act competently to avoid liability.

***Treatment Protocol Development and Approval***. EMS personnel rely extensively on treatment protocols that provide guidance and satisfy supervision requirements under state laws.[121] Treatment protocols may also be developed for expanded functions,[122] as well as broader disease evaluation and response[123] and specific populations.[124] Emergency protocols can address additional EMS functions and changes extending from resource scarcity. When shifting to CSC (discussed below), EMS personnel may deviate from existing protocols to decline transport for patients without significant injury or illness, employ batch transports, use nonambulance transportation, or alter required ambulance staffing levels.[125] However, changes to protocols may require approval by an entity's medical director as well as local or state officials.[126] Protocols for federal volunteers may be set by national models if not defined at the local or state levels or if inaccessible due to emergency conditions.[127]

### *Other Protocols*

In declared emergencies, EMS personnel need flexibility in assessing, treating, and transporting patients. Adaptable surge, treat-and-release, and disaster protocols allow EMS practitioners to assess and treat patients on scene without transporting or referring them to a health care facility. Yet some state laws, administrative rules, or mandatory protocols may restrict or prevent the use of critical treat-and-release procedures during emergencies. Generally, states base transport requirements on the patient's condition and situation rather than broadly requiring EMS personnel to transport all patients to a health care facility. These requirements generally may be waived or altered during a declared emergency.

***Statutory and Regulatory Requirements to Transport***. The 2012 FICEMS report, *State EMS System Pandemic Influenza Preparedness*,[128] reported on data on pandemic influenza preparedness collected by HHS in 2008 from states, incorporated territories, and D.C. Its authors determined that jurisdictions frequently did not address EMS providers' roles in treating and releasing patients without transporting them to a health care facility.

Very few states' laws require EMS personnel to transport all patients to a health care facility or hospital following dispatch to the scene of an emergency.[129] Forty states allow EMS agencies to respond to 9-1-1 dispatch calls without subsequent patient transport.[130] Some local protocols ultimately leave transport decisions up to the patient or guardian.[131] Further, it has been estimated that more than 70% of EMS agencies allow providers to respond without transport, and 35% allow EMS providers to refuse transport of prospective patients,[132] depending in part on issues related to patient consent and reimbursement.

Massachusetts is an exception. Once activated through 9-1-1 or other emergency triggers, EMS providers in Massachusetts must dispatch an ambulance and assess, treat, and transport the patient to a health care facility.[133] Massachusetts's Office of EMS issued an advisory reiterating this requirement to transport patients to a health care facility in all circumstances, absent

documented patient refusal. To the extent this policy bars treat-and-release protocols, it may frustrate EMS efforts in declared emergencies.[134]

More commonly, EMS providers are required to transport emergency patients to a health care facility only under specific circumstances. For instance, Florida regulations provide that EMS practitioners must transport every trauma alert patient to the nearest trauma center.[135] If the patient does not fall into the designated categories, state and local protocols or policies govern care and transportation.

A state's EMS structure may allow medical directors to establish protocols directing patient care and transport as needed for the population, locality, and circumstance. Arizona permits its state EMS council, in consultation with an EMS medical director, to establish transport and care procedures.[136] These protocols may require patients meeting certain criteria, such as specific physical conditions, to be transported to appropriate facilities.[137] Local EMS agencies may also establish policies. In Santa Clara County, California, the EMS director may issue orders regarding medical control or patient care when immediate changes are necessary to protect the public's health.[138] Through these directives, an EMS director may initiate treat-and-release protocols that otherwise would not be permitted.

Waiver of conflicting state or local provisions during declared emergencies presents another possibility. For example, the Ulster County, New York, Emergency Management Plan dictates that the county emergency manager and county attorney may waive local laws, ordinances, and regulations, including any requirements to transport during local emergencies.[139] Still, suspension or waiver of local laws may create conflicts with existing state laws, which would nonetheless govern.

***Surge and Austere Care Protocols***. Prior to or during an emergency declaration, surge, austere, disaster, and treat-and-release protocols may be activated.[140] Generally, surge protocols relate to response needs for patients in PHEs. In California, a "surge event" is defined as an event or circumstance that results in "excess demand over capacity and/or capability in hospitals, community care clinics, public health departments, other primary and secondary care providers, resources, and/or EMS."[141] Surge protocol activation does not require an emergency declaration. If surge protocols are activated prior to a declaration, all statutory, regulatory, and local requirements still apply (absent other waivers).

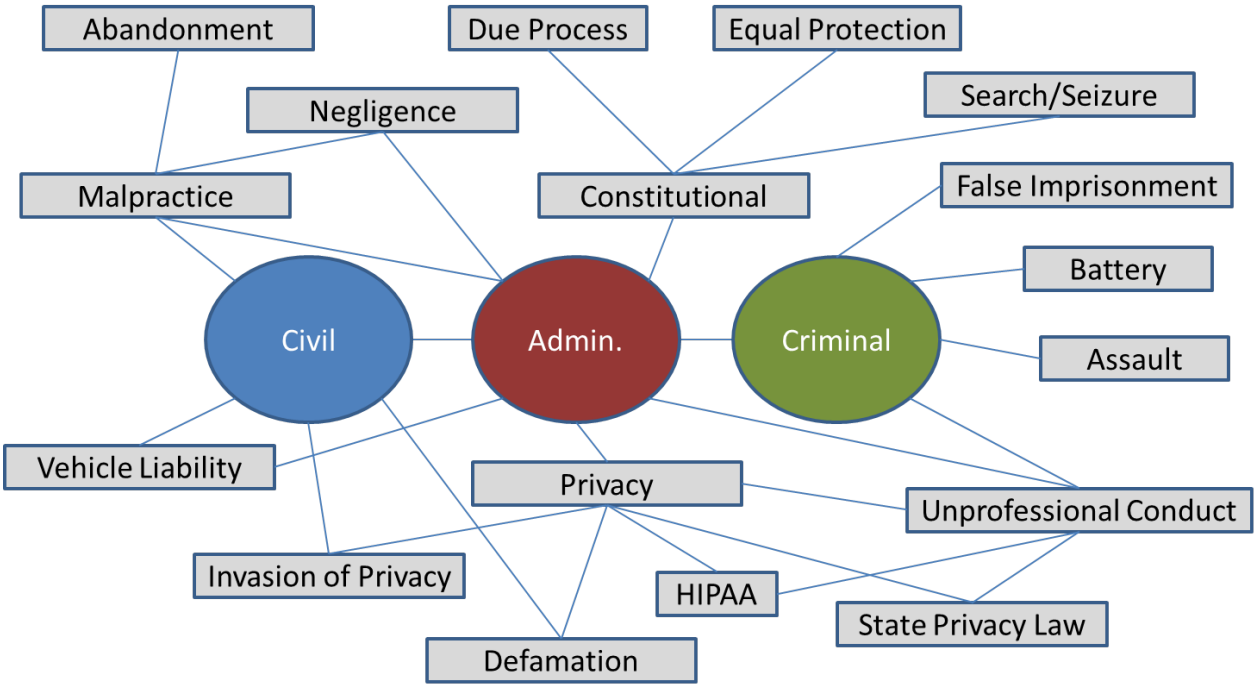
Austere protocols may apply when there is a severe shortage of personnel and resources because of emergency circumstances. When austere conditions exist, EMS providers are expected to perform their usual duties with fewer resources, in dangerous or hostile conditions, and possibly with limited communication.[142] Austere protocols help ensure that EMS can adapt to provide care consistent with best known practices. San Francisco's "Austere Care Protocols" apply only when activated by the county health officer and must be communicated through the ICS, generally once ACSs are activated. Triage guidelines under austere protocols dictate if patients

should be referred to a public health information line, and, if transport is required, where patients should be taken.[143] Specific steps to declare and authorize such protocols are essential to their legal compliance. In addition to surge and austere protocols, disease-specific protocols may apply during contagious disease outbreaks such as H1N1 in 2009/2010[144] and Ebola in 2014.[145]

## XIV. Liability Risks and Protections for EMS Providers

EMS providers may face varied liability risks during times of medical surge. In some ways, these liability risks may mimic the same ones faced in routine practice. However, catastrophic emergencies tend to exacerbate these risks because of uncertainty, inadequate supplies or facilities, and application of uncommon protocols, among other factors. As illustrated in Figure 9, civil, criminal, and administrative liability issues form a complex web of interconnected risks for EMS providers.

**Figure 9. "Web" of EMS Liability Risks**

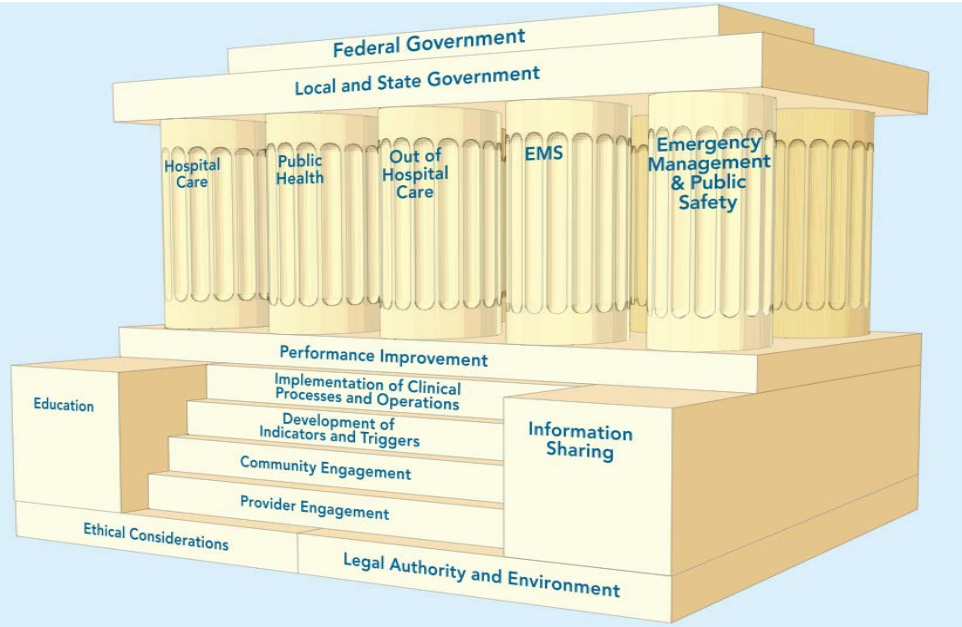



Despite heightened risks of liability, a series of legal protections extend to EMS personnel and entities from nonemergency laws as well as enhanced protections triggered by emergency declarations (discussed in Part II). Changes in the legal standards of care during crises also may help insulate EMS providers from claims for injuries or deaths related to the provision of care in times of medical surge.

### *Crisis Standards of Care*

As expressed by IOM's CSC committee illustration in Figure 10, EMS represents one of five "pillars" critical to disaster response in crises. IOM's report describes how the level of patient care in emergencies falls along a continuum from "conventional" to "contingency" to "crisis."[146] Conventional medical standards of care resonate in 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.[147]

**Figure 10. CSC Systems Framework for Catastrophic Disaster Response[148]**




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.[149] CSC implementation requires coordination of public and private entities, as well as significant advance planning and engagement. Several states are currently in the process of developing CSC policies,[150] addressing many areas, such as emergency management policies, community and stakeholder outreach, and ethical guidance. It may also entail modifications of public health laws, privacy laws, and other elements consistent with the systems framework approach. Assessing potential liability claims during crises is difficult when the standards of care change in real time.[151] CSC decisions may be assessed under changing legal standards rather than those deployed within CSC, resulting in uncertainty over potential liability.[152] Potential claims and protections from liability are assessed in the sections below.

### *Potential Liability for EMS Workers and Volunteers*

***Emergency Medical Treatment and Active Labor Act***. During crises, contingency or CSC-related protocols may be activated, allowing for patient transportation (or nontransportation) as necessary and with appropriate medical guidance. EMTALA normally requires Medicare-participating hospitals with emergency departments (EDs) to receive any patient who comes to the hospital in an emergency condition and requests treatment. Hospitals are obligated to screen for an emergency condition and, if identified, to stabilize the patient or transfer him or her to another facility willing and able to provide care. In some circumstances, transfer to specially equipped, designated facilities may be necessary, such as in response to Ebola in 2014.[153] EMTALA may also apply beyond EDs in some instances, including urgent care clinics, labor and delivery departments, and psychiatric departments.[154] To facilitate these efforts DHHS and CMS may waive some provisions of EMTALA[155] in a federally declared emergency. To the extent EMTALA provisions remain in effect, advance preparation and planning are necessary to ensure that patients are appropriately screened and potentially diverted consistent with available resources.

***Personal Liability***. Potential civil liability for EMS personnel is typically grounded in legal claims of negligence, particularly malpractice. Negligence claims require proof of (1) a duty, (2) breach of that duty, (3) causation, and (4) damages. A duty is generally established through the existence of some form of professional-patient relationship. A breach may occur if the practitioner's conduct does not meet applicable professional standards of care. Causation and damages are established by proving that the failure to meet the standard of care caused or exacerbated a patient's injury. For example, two Florida paramedics were found liable in a 1990 case for the death of a young child from congestive heart failure after they failed to transport her to a medical center following an inadequate examination and history without a physician consultation.[156] The paramedics had a duty to provide care and failed to do so consistent with expected standards, which contributed to the child's death.

EMS personnel following an established protocol or standing order may be protected from liability in some jurisdictions, as discussed below,[157] if they follow instructions from supervising physicians in good faith.[158] These protections may apply even if EMS personnel act negligently in carrying out orders or following instructions. However, EMS personnel are generally not protected if their actions (1) are intentionally harmful, (2) completely lacking in care (which may be referred to legally as "recklessness,"[159] "gross negligence,"[160] or "willful and wanton" negligence[161]), or (3) constitute an inexcusable violation of statute or regulation, such as practicing without a license (often referred to in legal terms as "negligence per se").[162] Properly developed treatment protocols and standard operating procedures can significantly reduce the risk of civil liability for EMS personnel to the extent they help establish and reinforce the appropriate standard of care. Deviation from protocols and standard procedures, in contrast, increases liability risks unless adequately justified under the circumstances.[163]

Still, prevailing circumstances, and not protocols, generally determine the standard of care. A federal appellate court explained that requiring strict adherence to standing orders and similar tools without exception would create a "perverse incentive" for EMS professionals to ignore potential negative consequences for patients to protect themselves from liability.[164] 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 claims that may arise during emergencies include acts of patient abandonment. Legal abandonment occurs if a health care practitioner who has entered a relationship with a patient ends the relationship without ensuring the patient has necessary care, adequate notice, or access to a competent replacement. Abandonment claims against individual EMS personnel may arise, for example, if they transport a patient to an ED or alternative destination without giving a report or transferring care to a responsible party.[165] During medical surge, abandonment claims may stem more so from a lack of personnel and resources. Like other claims, abandonment may be assessed on the basis of medical and legal standards of care dependent on prevailing circumstances.

***Vehicle Liability***. EMS providers may also face potential liability for negligent operation of emergency vehicles. Many states' laws exempt emergency vehicles from common traffic laws, but do not fully insulate operators from liability when accidents lead to patient injuries.[166] New York allows emergency vehicles to exceed speed limits and proceed through red lights while responding to emergencies, but does not relieve drivers from the duty to "drive with due regard for the safety of all persons nor . . . from the consequences of . . . reckless disregard for the safety of others."[167] California similarly exempts EMS personnel from standard traffic laws, but only while responding to emergencies calls and situations.[168] Louisiana requires a standard of "due care" unless a set of specific factors are met. If an emergency vehicle, including an ambulance, is responding to an emergency call and using warning lights or sirens, nonadherence to ordinary traffic rules may result in liability only if the driver acts in "reckless disregard" for the safety of others.[169] Vehicle liability provisions would most likely remain active even during declared emergencies. Additionally, some liability protections for volunteers, such as the federal Volunteer Protection Act, explicitly exclude vehicle liability from their scope.[170]

***Criminal Sanctions***. Beyond civil claims, EMS personnel may also be subject to criminal sanctions in limited circumstances. For example, if EMS personnel completely ignore the risks or consequences of their actions, they may be charged with criminal negligence. On few occasions criminal charges may include assault (provoking fear of bodily harm), battery (physical touching without consent), or false imprisonment. Patient abandonment may also give rise to criminal charges, such as child endangerment.[171] Failure to assist patients can also result in criminal charges. 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 saw the woman, but were informed of her situation. They responded by contacting emergency dispatch. After 3 years of legal proceedings, criminal charges were eventually dropped, although administrative investigations continued afterward.[172]

***Administrative Sanctions***. EMS misconduct may also lead to administrative sanctions through formal complaints with employers or regulatory and oversight agencies.[173] Complaints may stem from failures to maintain patient confidentiality or comply with "Do Not Resuscitate" orders, incompetence, unprofessional conduct, or other misconduct.[174] Employers may conduct their own investigations under the guidance of regulatory bodies and pursuant to established disciplinary plans.[175] Resulting sanctions may include employer discipline (e.g., suspension), censure, fines, or license probation or revocation orders.[176] State regulatory agencies report these adverse actions to the National Practitioners Data Bank.[177]

In response to the 2014 Ebola outbreak, for example, Rhode Island's EMS chief collaborated on a joint statement regarding professional responsibility and HCWs' 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.[178] 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.[179]

***Constitutional Infringement***. 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,[180] meaning their actions are, or appear to be, officially authorized. Resulting cases are often referred to as "section (§) 1983" claims based on the applicable federal statute in which they are brought. Governmental EMS personnel may be subject to §1983 liability if they violate due process, equal protection, or other constitutional rights. However, these suits are usually unsuccessful because they require proof of intent to harm the patient or violate his or her rights. In *Davidson v. City of Jacksonville*, a Florida federal court held that EMS professionals did not violate a disoriented and resistant patient's due process right to be free from unreasonable seizure when they "hogtied" 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.[181] However, the court noted that, had the patient lucidly refused treatment or restraint, the actions might have violated his constitutional rights.[182]

Additionally, §1983 claims generally do not apply to employees of private EMS entities, even when they act on behalf of governmental agencies. In *Williams v. Richmond County,* a Georgia federal court stated that there likely was no "state action" (required for §1983 claims) when EMTs 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, EMS workers did not display a deliberate indifference to serious medical needs in the form of unreasonable refusal, denial, or delay of treatment.[183]

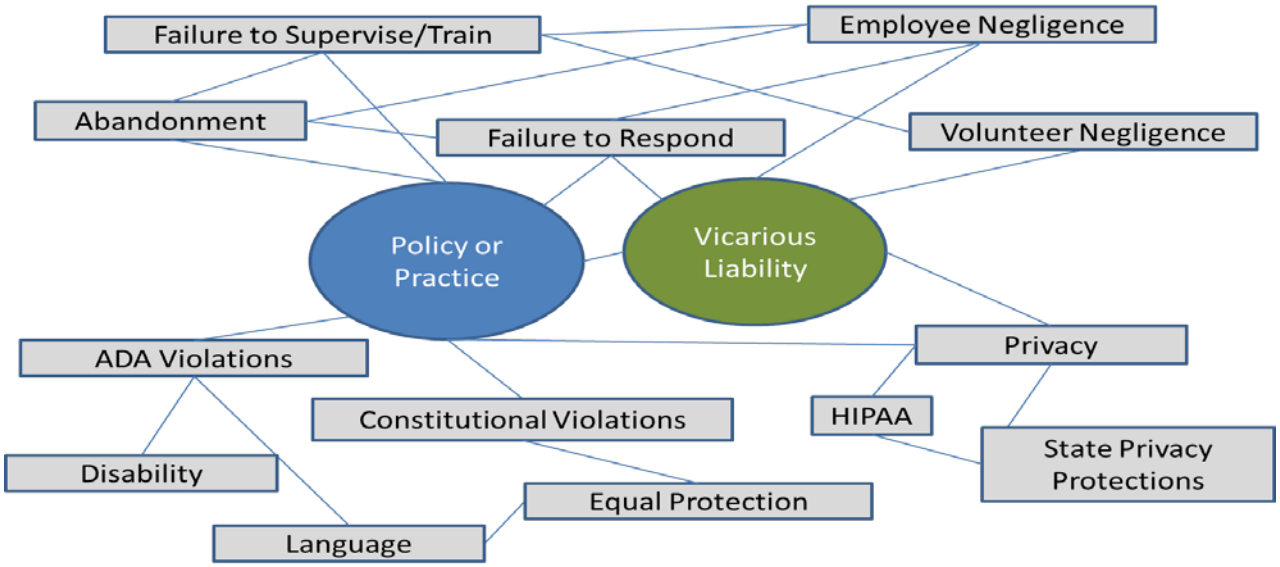
***Health Information Privacy***. Health information privacy concerns may be heightened especially during emergencies that generate significant media and public interest, such as Ebola in 2014.[184] Federal law (e.g., HIPAA Privacy Rule[185]) and various state laws protect the privacy of identifiable health information and prohibit disclosure outside of specific circumstances. Individuals cannot bring suit directly for violation of the Privacy Rule. Instead, violations are prosecuted by the DHHS Office of Civil Rights.[186] HIPAA violations can lead to civil penalties and criminal sanctions (reserved for blatant violations).[187] Some state laws authorize individuals to sue for privacy violations related to PHI and other types of sensitive health data. [188] In *R.K. v. St. Mary's Medical Center, Inc.*, a hospital was sued for negligence after employees violated the Privacy Rule by inappropriately accessing a patient's file and disclosing PHI regarding a psychiatric condition and hospitalization. The court held that the Rule did not preempt the patient's civil claims against the hospital under state law.[189] In *Pachowitz v. Ledoux*, a patient sued after an EMT disclosed PHI to the patient's co-workers.[190]

While EMS personnel are privy to significant amounts of personal health information, they have an excellent record of respecting patients' privacy based on their training on patient privacy requirements. Some privacy infringements during emergencies may be obviated through temporary waivers of elements of the Privacy Rule. Still, medical surge planning for EMS providers should include information on alterations in typical privacy practices related to the use of electronic records, public health disclosure considerations, and use of nonstandard facilities and transportation.

### *Potential Liability for Public and Private Entities*

Entities that employ and supervise EMS personnel face their own liability risks during PHEs when making critical resource allocation decisions that may adversely affect vulnerable populations if improperly designed (Figure 11).

**Figure 11. "Web" of Liability Risks for Public and Private Entities**




***Corporate Negligence***. EMS entities may face potential liability for their own negligence or that of their employees and volunteers. 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.[191] Entities are similarly liable for failure to comply with provisions of EMTALA or the HIPAA Privacy Rule, as well as for violations by employees, as referenced above.[192]

Entities may also be responsible for negligence by employees or volunteers acting within their scope of employment. 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.[193] Concerning volunteers, some states' laws specify the responsibility of entities related to the volunteer's performance.[194]

***Failure to Respond***. Private EMS entities that fail to respond to requests for assistance may face claims for patient abandonment if they do not adequately respond to a call using available resources, or if the unit is delayed by another accident scene enroute to the original call.[195] Conversely, public EMS entities, such as local fire departments, may not equally be held liable.[196] Government entities are typically immune from such suits because of the lack of a special duty to provide care for individual members of the public.

***Discrimination and Vulnerable Populations***. Public entities employing EMS professionals may face potential §1983 liability concerning employees' actions that deprive individuals of constitutional rights. Note, however, that municipalities are generally not liable for employees' acts (for §1983 purposes) unless deprivations of constitutional rights extend from formal municipal policies, widespread custom or practice, conscious disregard of unconstitutional application of policy, or failure to train or supervise employees in a manner that amounts to deliberate indifference to constitutional rights of the public.[197]

A court in *Green v. City of New York* held that NYC was not liable under §1983 to the estate of a patient who was transported against his will by EMS, unless it had a widespread custom or practice of failing to properly evaluate refusals of treatment. The patient was unable to communicate verbally. City EMS personnel failed to consider the patient's communications via blinking and computer assistance, which violated local policy and ADA provisions. Though the patient claimed that lack of knowledge of official policy and failure to train personnel were widespread, the court found insufficient evidence to suggest the City was deliberately indifferent to the deprivation of rights to allow liability under §1983.[198]

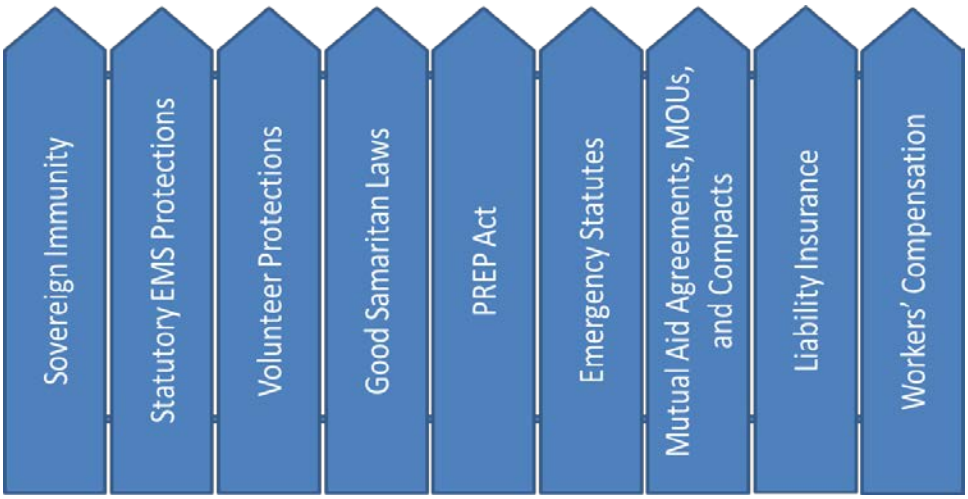
Similarly, the ADA,[199] the federal Rehabilitation Act,[200] and state laws like the California Disabled Persons Act,[201] prohibit public entities from discriminating against individuals with physical or mental disabilities through services or programs. As discussed in Part I, ADA violations can occur through laws, policies, or programs in which discrimination is direct or indirect. Individuals with disabilities may require special accommodations during calls to ensure they can follow guidance, receive assistance from a health care surrogate when needed, or access services or transportation. Failing to adequately account for the needs of vulnerable populations may result in liability for public entities and municipalities.

Discrimination concerns may also arise if EMS professionals or entities refuse to treat specific patients. Refusing to transport or treat a patient based on a medical condition (e.g., infectious disease) may violate ADA provisions if the condition qualifies as a disability. For example, in 1998 in *Bragdon v. Abbott*, 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 patient (in this case, in a dentist's office) violates 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.[202] Similarly, refusal by EMS to transport a patient with an infectious condition that may qualify as a disability (e.g., Ebola) may violate the ADA if transmission risks can be adequately mitigated through use of universal precautions and appropriate PPE. State laws may also prohibit EMS professionals and entities from discriminating against patients based on medical conditions or other factors. For example, Virginia law provides that "EMS personnel and agencies may not discriminate in the provision of EMS based on race, gender, religion, age, national origin, medical condition or any other reason."[203]

### *Liability Protections*

Despite multifarious risks of liability for EMS personnel and entities, there are significant protections from liability as well (Figure 12). These federal and state legal protections include sovereign immunity for government actors, statutory protections for EMS personnel, emergency laws (e.g., based on MSEHPA[204] and UEVHPA[205]), interstate compacts (e.g., EMAC[206]), and Good Samaritan laws. 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). During a declared emergency, additional protections can be activated, further insulating EMS personnel from liability for acts in good faith.

**Figure 12. Protections for EMS Personnel and Entities**




However, no universal protection exists to defend against all possible sources of liability, and no laws can fully prevent the filing of meritless claims. The range of responsibilities is extremely broad. For example, liability may extend to health care professionals, direct care providers, and medical directors during interfacility transport.[207] As a result, many EMS providers carry professional liability insurance.[208]

***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. These protections also extend to municipalities in some states. In some places, employees who are held liable for acts in their official capacity are indemnified by the state, meaning that the state assumes responsibility for expenses related to the claim.[209]

Some states have entirely abolished sovereign immunity (e.g., Arizona, Washington).[210] Others allow suits against state and local governments, but limit the monetary amount of potential liability (e.g., Florida, Minnesota).[211] State "Tort Claims Acts" specify when state and local

governments and their employees may be sued (e.g., California, Maine).[212] Immunity can also extend to health care professionals employed by government entities (e.g., municipal EMS). Stronger protections are often available through other laws applying to EMS professionals discussed below.

Even in states where sovereign immunity doctrine applies, governmental entities are not always relieved of liability. A New York court in *Velazquez v. New York City Health and Hospital Corporation* 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 two 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. According to the court, when the EMS practitioners undertook transportation of the client, they assumed a duty of reasonable care not only to her, but also to the home attendant.[213] Similarly, the California Supreme Court has held that the state's Government Claims Act (a sovereign immunity provision) requires showing that a public entity negligently or wrongly created a dangerous condition or had sufficient notice to protect against danger. A public entity may be liable, however, for negligent or wrongful acts or omissions by employees acting within the scope of employment that create a dangerous condition.[214]

Municipalities in some jurisdictions may be held to have a special duty to provide EMS once they undertake the obligation to assist 9-1-1 callers.[215] Additionally, some jurisdictions have waived sovereign immunity to varying degrees, as noted above. For example, a Georgia court held that a county that had waived sovereign immunity to the extent of its insurance coverage was liable up to that amount for the negligence of its employees in performing official functions, even if the employee was immune.[216] Some states (e.g., Texas)[217] have also waived sovereign immunity for particular situations in which a private entity would otherwise be liable, such as for injuries caused by negligence related to the condition or use of property.

***Statutory Protections and Limitations***. EMS personnel are often statutorily protected from civil liability in carrying out their duties at the scene of an emergency or during patient transport. Illinois protects EMS personnel acting in the normal course of their duties unless their actions constitute willful and wanton misconduct (e.g., intentional harm or reckless disregard for safety).[218] Idaho protects EMS professionals from liability so long as they do not behave recklessly or in a grossly negligent manner.[219] Georgia provides broad civil liability protection to persons licensed to provide ambulance service when rendering emergency care in good faith.[220] California protects EMS personnel, police officers, and other professionals who act in good faith and are not grossly negligent.[221] Some states' statutory protections (e.g., Georgia) apply only to those who provide services without payment (not including fees to defray the costs of providing services);[222] other states make no such distinction (e.g., Texas).[223] State volunteer protection acts may also insulate EMS personnel, but often these apply only to volunteers associated with

nonprofit or governmental entities,[224] much like the protections of the federal Volunteer Protection Act.[225]

Because many of these statutory protections refer specifically to conduct "at the scene of an emergency" or when a patient is in "imminent peril" (or similar terms), questions may arise during medical surge as to how broadly to apply such protections. As discussed in Part III, some statutes may be interpreted to protect entire areas encompassed by an emergency declaration on the premise that an entire jurisdiction is now an emergency scene. Such an interpretation would provide broad protection to EMS personnel responding as employees or volunteers during medical surge.

Other legal protections may immunize EMS professionals from liability during emergencies. Statutory protections for EMS providers may apply to failures to treat or diagnose a patient's condition, in addition to negligence in treatment or diagnosis. For example, the Illinois Supreme Court found in *Abruzzo v. City of Park Ridge* that the state's EMS immunity provision applied to paramedics who responded to a 9-1-1 call and allegedly failed to make an adequate attempt to enter.[226] The court reasoned that statutory immunity applied broadly to component acts of EMS, including initially locating and contacting a patient. Courts in other states may take a different approach. In *Crewey v. American Medical Response of Georgia, Inc.*, the court found that failing to provide timely care did not constitute rendering "emergency care" for purposes of the state's statutory protection.[227]

Many states extend immunity to medical professionals who advise EMS personnel. Georgia, for example, physicians acting as medical advisers to ambulance services (unless their conduct constitutes willful and wanton negligence).[228] Washington similarly protects supervising physicians, medical program directors, and others as part of its statutory protections for EMS professionals.[229] Nebraska's EMS professional liability protection[230] provides immunity for good faith efforts by emergency care providers and others. If an employee or agent is released from liability, the employer or principal is protected to the same degree under Nebraska law.[231] However, some states may not extend personal liability protections for EMS personnel to their employers (e.g., Massachusetts,[232] Kansas[233]).

Some states explicitly protect EMS employers. California and Louisiana protect public entities to the same extent as the individual EMS professionals they employ.[234] Other states protect all employers, public or private through EMS protection statutes (e.g., Washington)[235] or as part of the state's Good Samaritan law (e.g., North Dakota).[236] Other states explicitly hold entities accountable for negligence by those acting on their behalf, including volunteers (e.g., Arizona).[237]

***PREP Act***. In addition to state law protections, EMS personnel and public and private entities may also be protected under the Federal Public Readiness and Emergency Preparedness (PREP) Act.[238] During a federally declared emergency, the PREP Act provides significant liability protections with respect to the use of covered countermeasures, as defined by DHHS' secretary. Covered countermeasures include pandemic and epidemic products, security countermeasures, and 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.[239] 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.[240] In December 2014, for example, a PREP Act declaration was issued to provide liability protection related to three prospective vaccines for Ebola.[241] EMS providers who help administer or dispense covered countermeasures may be protected from civil liability via the PREP Act when acting in good faith.[242]

***Good Samaritan Acts***. Many states' Good Samaritan laws protect persons who provide care at the scene of an emergency. Florida explicitly includes medical professionals under their Good Samaritan laws, protecting "*any person*, including [a physician], who gratuitously and in good faith renders emergency care or treatment" at the scene of an emergency or during a declared state of emergency.[243] Courts in other states may interpret ambiguous Good Samaritan protections to apply to EMS professionals. Texas protects "persons not licensed or certified in the healing arts who in good faith administer emergency medical care as EMS personnel . . . unless the act is willfully or wantonly negligent."[244] Texas courts have interpreted this protection to apply to EMS personnel despite their professional licensure, on the basis that EMS was not among the professions included among "the healing arts" under state law.[245]

Some courts may question whether Good Samaritan statutes apply to those with a pre-existing duty to provide aid, such as EMS personnel.[246] A Wisconsin court found in 2006 that Good Samaritan protections applied only to care provided before transfer to a hospital or other location was possible, and not to nonemergency care provided hours after an initial assessment and evaluation.[247] While this case involved laypersons, this legal interpretation of a Good Samaritan statute could also apply to care provided by EMS personnel. Courts may look to the legislative purpose in enacting Good Samaritan protections to determine how broadly to apply such provisions,[248] depending in part on how broadly the scope of the "scene of emergency" is defined in a large-scale crisis.

Good Samaritan protections might also protect spontaneous volunteers who may otherwise lack liability protections. Arizona's volunteer protection statute applies only to volunteers acting "within the scope of . . . official functions and duties for a nonprofit corporation or nonprofit organization, hospital or governmental entity."[249] In contrast, Arizona's Good Samaritan statute extends to any "person who renders emergency care at a public gathering or at the scene of an emergency occurrence gratuitously and in good faith."[250]

***Workers' Compensation***. In addition to protections against others' lawsuits, EMS personnel may also be protected against their own losses through workers' compensation benefits. Workers' compensation benefits apply generally to all employees. They cover expenses or provide benefits related to injuries or deaths suffered while acting within the scope of employment regardless of fault. Application of workers compensation to EMS volunteers as well is subject to state-specific provisions. Some states' laws may not recognize volunteers as "employees." Coextensively, EMS volunteers serving outside their home state may lack workers compensation protections from their day-to-day employer because they are deemed as acting outside the scope of employment while volunteering. State laws may fill this gap by defining the "host" hospital, institution, municipality, or state receiving assistance as the volunteer's employer for purposes of workers' compensation liability, but approaches vary significantly.[251]

## XV. Allocating Resources – Personnel, Supplies, and Space

Areas affected by emergencies need access to additional resources to assess, treat, and care for patients, as well as to prevent additional injuries and deaths. These resources may include EMS personnel or supplies such as ambulances and medical equipment. During declared emergencies, jurisdictions can legally deploy and lend various resources to areas in need through a number of federal, state, and local programs, including EMAC, Mutual Aid Agreements (MAAs), EUAs, and SNS. FEMA contracts with a national ambulance service to provide additional EMS personnel and ambulances in federally declared emergencies.[252] States may legislatively allow execution of MAAs with other states, municipalities, or private entities for additional assistance. As explained in the sections below, these programs allow resources to deploy quickly and provide additional protections (e.g., liability, reimbursement requirements) to jurisdictions seeking and providing assistance. Emergency declarations may also permit the use of supplemental treatment locations such as ACSs or expanded treatment areas (ETAs).

### *Personnel*

***EMAC***. As initially described in Part I, EMAC provides a pathway for states' mutual assistance during declared emergencies[253] by facilitating the exchange of supplies, equipment, personnel, and services provided to requesting states pursuant to the compact.[254] Many different resources may be deployed through EMAC, including EMS supplies and personnel, which are generally grouped into packages depending on the jurisdiction's needs and available personnel. For example, basic life support transport strike teams include 10 EMTs and a team leader. Advanced life support (ALS) strike teams include a varying number of paramedics, EMTs, and team leaders. The language of the compact ensures that licenses and certifications for EMS personnel allow them to legally perform their duties in the requesting state.[255] Requesting states are generally responsible for lodging and food for assisting personnel, although deployed practitioners are encouraged to be as self-sufficient as possible given the lack of general resources available during many disasters. EMAC Requests for Assistance (REQ-A) must also

identify potential safety and health concerns EMS personnel may face, including suggested vaccinations and necessary PPE.[256]

***FEMA***. FEMA established a comprehensive EMS response program through private ambulance contractors following Hurricane Katrina in 2005. FEMA contracted with AMR, the nation's largest private ambulance provider, to supply ground ambulances, air ambulances, and para-transit services during federal emergency declarations.[257] The contract covers the 48 contiguous states and all 4 FEMA zones.[258] AMR may deploy up to 300 ground ambulances and 25 air ambulances per zone. During Hurricane Gustav in 2008, FEMA contracted with AMR for EMS response in Mississippi, Louisiana, and Texas. AMR deployed over 600 ambulances from 41 states over 16 days following the hurricane. AMR's EMS Disaster Response Team (DRT), which runs the ambulances, includes personnel from public, private, and volunteer EMS agencies. To avoid conflicts regarding the supplies and personnel, AMR avoids using resources that are previously contracted through EMAC.[259]

***Mutual Aid Agreements***. In addition to EMAC, most states allow for additional sharing of resources and personnel through MAAs. In Illinois, prior to a state or local emergency declaration, local governments can enter into MAAs with other local governments across state lines. MAAs allow emergency responders from other states to provide services within Illinois so long as the responder acts within the scope of his or her license or certification, within the scope of the equivalent license level in Illinois, and pursuant to a request for aid.[260]

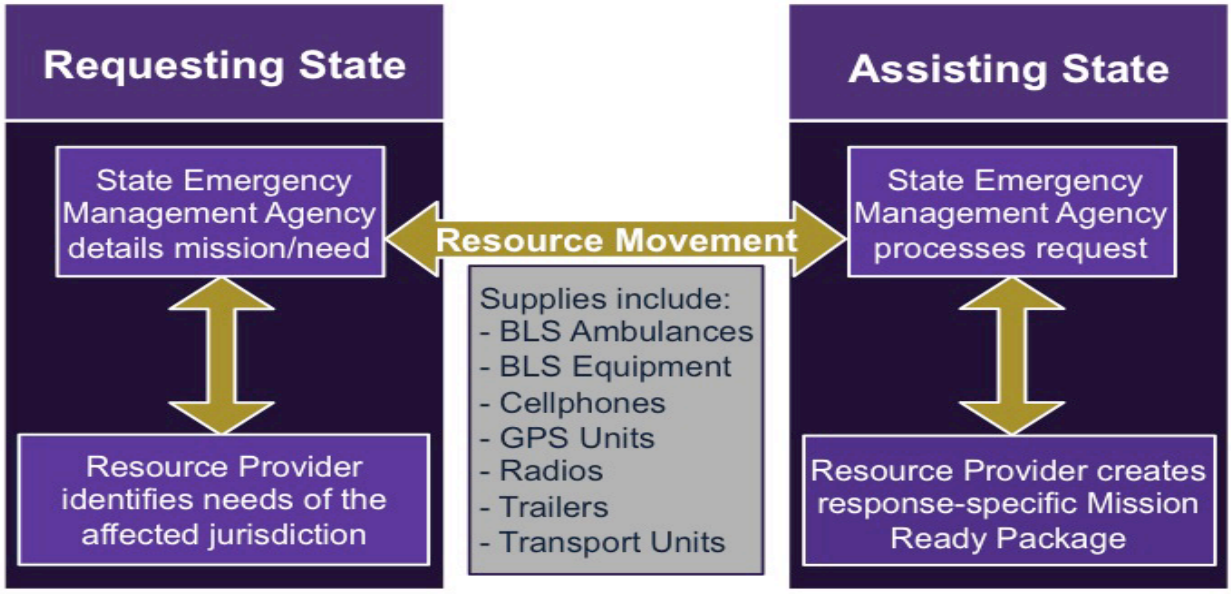
In addition, states may permit localities to enter into MAAs with other public and private agencies to provide assistance in emergencies. Indiana requires such agreements to be consistent with the state emergency management program and operations plan.[261] Louisiana established an Intrastate Mutual Aid Compact system allowing parishes to enter into agreements for mutual assistance to train for, prevent, assist, or recover from emergencies.[262] EMS personnel that respond to a requesting parish come under the direction and control of incident management system officials of the receiving parish, and are subject to recall by their home jurisdiction at any time.[263]

### *Supplies*

EMS supplies are often scarce during declared emergencies. Accordingly, a number of legal paths are available for jurisdictions to access additional resources. States may request and share supplies, like ambulances, through EMAC. The federal government may make drugs and other medical products available for additional uses or extend expiration dates of these products through EUAs and the Shelf Life Extension Program. CDC can provide local EMS agencies with needed emergency medication through the SNS. States may also share supplies via MAAs and contracts.

***EMAC***. During declared emergencies, affected states may seek additional resources held by other states through EMAC[264] (Figure 13). Assisting states can package resources, including available personnel, as well as equipment such as ambulances and other vehicles, basic life support equipment, GPS units, cell phones, and trailers with additional supplies.[265] EMAC contracts also list the resources the requesting state must supply. These resource requirements often include fuel for ambulances, area maps, medical supplies, and lodging and meals for assisting personnel.[266]

**Figure 13. Role of EMAC and Allocations**




***Emergency Use Authorizations***. As described in Part II above, FDA implements EUAs to allow the use of unapproved medical products or the use of approved products in an unapproved manner.[267] Through its expanded authority pursuant to PAHPRA,[268] FDA can issue advance approval (prior to any declaration of emergency) if DHHS 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 or the health and security of U.S. citizens abroad.[269]According to FDA, CDC is the most appropriate requester for an EUA.[270] Consequently, state and local jurisdictions may work through CDC to streamline requests. FDA requirements on the distribution and administration of EUA-approved products cannot be more restrictive than conditions on the approved use of the medical product.[271]

***Expired Supplies***. EUAs may also impact the expiration date and product labeling of covered drugs. A manufacturer may be permitted to change the label on a product under an EUA to extend the product's expiration date. During the 2009/2010 H1N1 outbreak, FDA authorized the use of certain lots of antivirals beyond their expiration dates through a series of EUAs.[272]

The Shelf-Life Extension Program also allows expiration dates of qualified drugs in federal stockpiles to be extended. The Program was created to defer the high cost of replacing date-sensitive drugs in federal stockpiles by extending their useful life.[273] The Department of Defense in conjunction with FDA operates this fee-for-service program where participating agencies pay each time for the periodic testing of eligible drugs.[274] To participate, agencies with federally maintained stockpiles pay FDA to test and analyze eligible drugs, which are granted extended expiration dates and continue to be monitored if they pass initial testing. Only certain stockpile products are eligible for the program (generally products with historically high success rates). If an extension is approved, FDA documents the extension length and any additional labeling requirements.[275]

***Strategic National Stockpile***. CDC's SNS is a national reserve of vaccines, drugs, and medical supplies allocated for the public's health security in emergencies.[276] SNS is designed to supplement and resupply state and local resources when emergency response efforts exhaust resources.[277] SNS medicines, funded through the federal Special Reserve Fund, are distributed free to the public.[278] As needs for certain supplies arise, CDC may decide to increase SNS stocks. For example, during the 2014 Ebola outbreak, CDC ordered $2.7 million of PPE for SNS supplies, with each kit capable of providing all the PPE needed to manage the care of an Ebola patient for 5 days.[279]

A state or federal emergency declaration is not necessary for SNS deployments. Generally, a direct request and justification from a state to CDC or DHHS triggers SNS asset deployment.[280] Requests for SNS deployment vary by jurisdiction. For example, in San Benito County, California, an unexplainable increase in EMS requests may trigger a request for SNS supplies.[281] After receipt of a request for which SNS resources may be deployed, assets may arrive within 12 hours.[282] Once deployments arrive at the designated receiving point, authority to distribute and dispense SNS assets transfers to state officials[283] to ensure efficient SNS management.[284]

State SNS protocols generally include instruction on transferring and distributing supplies to points of dispensing (PODs), but leave administration and designation of exact locations up to individual localities.[285] San Benito County[286] designated one of its city hall offices as a traditional POD site, while Lake County, Illinois, designated its polling sites as PODs in times of emergency.[287] Some political subdivisions, such as Orlando, Florida, have turned to alternate modes of dispensing supplies.[288] Orlando designed a drive-through POD model to more quickly distribute SNS material to greater numbers of people while reducing the number of staff needed.[289] Efficient disbursement of supplies within a jurisdiction is factored in when determining if a local plan will employ the traditional POD system or choose alternative dispensing methods. Beyond distribution of SNS resources, vaccinations and antivirals may be administered to the public or select groups at PODs.[290] During the 2009/2010 H1N1 outbreak, Ohio EMTs and paramedics (with appropriate education and training) administered immunizations at PODs statewide pursuant to an emergency declaration.[291]

***Mutual Aid Agreements***. In addition to providing access to more personnel, MAAs can help in distribution of scarce supplies. Louisiana statutorily encourages its parishes to provide aid to each other through MAAs prior to, during, and after emergencies when additional resources are required.[292] Louisiana statute provides that supplies borrowed through intrastate MAAs are under the control and direction of incident management officials of the parish receiving assistance.[293] While the jurisdiction receiving aid controls how the supplies are used during deployment, loaned assets and equipment are subject to the responding jurisdiction's recall at any time.

***State Procurement Authority***. State law may permit health departments or EMS providers to control, restrict, procure, and distribute vaccines and other pharmaceutical agents within the state during disasters. Iowa permits its state public health department during a public health disaster to take immediate possession of these supplies as is reasonably necessary to respond.[294] The state must pay the owner of the commandeered products up to the amount the owner paid to procure the supplies (see Part VI for further discussions of takings and compensation).[295] The department may also restrict or regulate any such products within the state through rations, prohibitions on shipments, allocations, sale, or use to protect the public's health.[296]

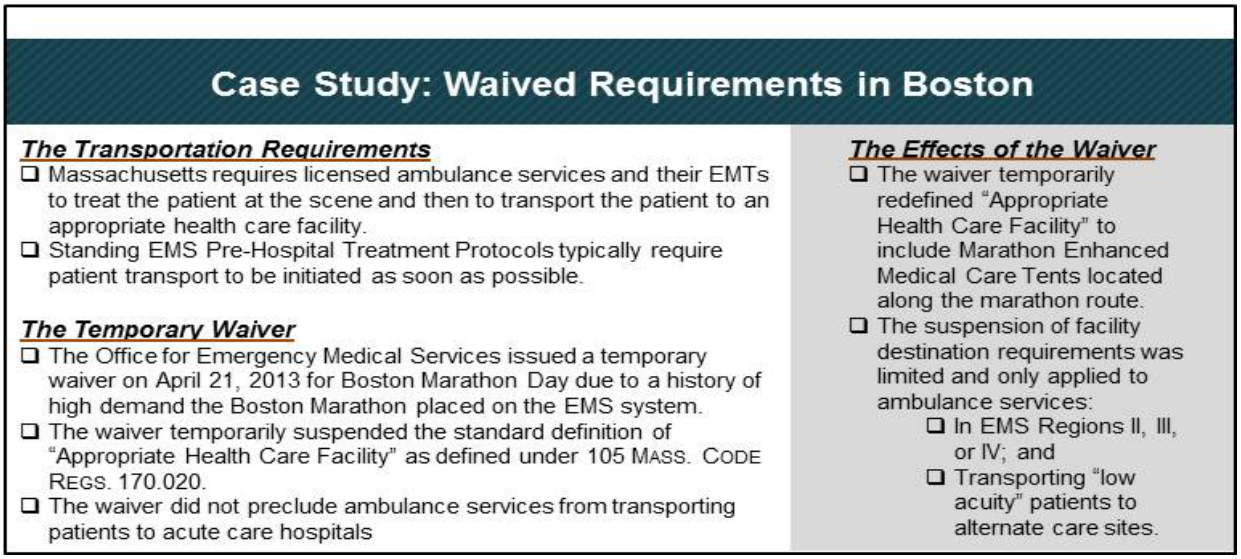
### *Alternative Locations*

ACSs and ETAs include facilities that presently do not provide health services, but can be converted to provide services temporarily during emergencies. In general, interfacility transfer involves complicated planning and coordination among stakeholders, and entails significant operational and financial considerations.[297] ACSs provide a framework allowing EMS personnel to respond to and care for emergency patients during medical surges and mass casualty events efficiently and effectively. Often state emergency plans provide for the conditions under which ACSs should be established, while hospital and health care systems may dictate the use of ETAs. Recent legislation in Maryland expands the definition of ACSs to include ETAs. Maryland statutorily defines an ACS as an area that is (1) not located on a health care facility's premises or located in an area on the premises not usually used to provide health care services and (2) used by an accredited health care facility to provide medical care services during a declared state of emergency.[298]

To expedite emergency response, ACS and ETA facilities should be predesignated. They may include nonmedical buildings near medical facilities, mobile medical centers (such as mobile surge units or converted tractor trailers), or portable facilities (container systems). Possible preselected sites could include convention centers, schools, churches, community centers, closed hospitals, warehouses, hotels, and military bases.[299] In response to specific needs, such as Ebola in 2014, jurisdictions may predesignate ACSs that meet the needs of certain conditions (e.g., ample water supply and sanitary procedures).[300] In addition to ACSs and ETAs, if federal assistance is required, DHHS may request a "federal medical station" to provide surge capacity support, such as shelter, nonacute treatment, or quarantine.[301]

***Statutory and Regulatory Restrictions***. State laws may hamper the use of ACSs through statutes and protocols that require transport of patients to specific health facilities. As discussed in Part III, some states permit EMS practitioners to provide prehospital care only in specified settings including the scene of the accident, the ambulance, and in a hospital, restricting the use of ACSs. For example, regulatory restraints in Massachusetts require EMS personnel to transport emergency patients to emergency facilities only.[302] Massachusetts's rule defines EMS as prehospital assessment and treatment during transport to appropriate health care facilities.[303] While seemingly broad, the state's department of public health limits "appropriate health care facility" to an ED that is located within an acute care hospital or an approved satellite emergency facility.[304] Absent a waiver of these requirements, the department would likely have to amend this regulatory definition to allow transport to other health care facilities, including ACSs. As noted in Figure 14, during the 2013 Boston Marathon, the Massachusetts Office for EMS temporarily suspended the definition of appropriate health care facility to permit EMS personnel to transport patients to medical care tents along the marathon route, instead of acute care facilities.[305]

**Figure 14. Case Study: Waived Transport Requirements in Boston**




Similarly, California's EMS Authority interprets California law to require EMS personnel to transport patients to hospitals with at least a basic ED[306] based on requirements to make available "advanced life support." [307] California has waived these requirements on numerous occasions for nonemergency purposes. Through its Health Workforce Pilot Projects program, California approved 13 community paramedicine pilot projects, 4 of which allow for patients' destinations to be altered to other locations, presumably including ACSs.[308] Establishment of a Health Workforce Pilot Projects through the Office of Statewide Planning and Development allows for the temporary waiver[309] of state laws that (1) limit destinations to which paramedics

may transport patients or (2) restrict paramedics to providing services in limited emergency settings.[310] During declared emergencies, similar waivers may also permit the use of ACSs.

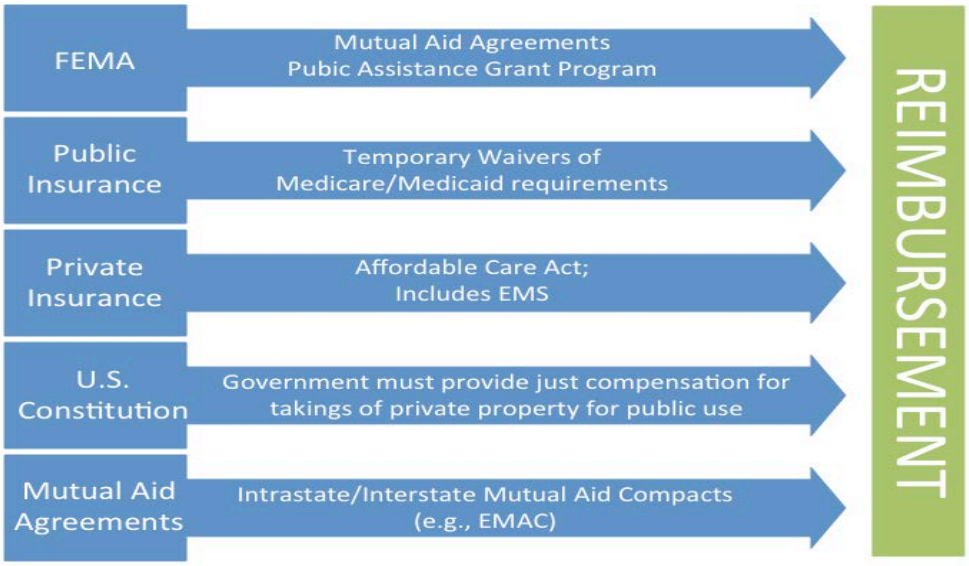
Beyond specific destination restrictions, ambulance services may be limited to set geographic boundaries by Certificates of Necessity (sometimes referred to as certificates of public need or convenience) issued by the state or locality in some jurisdictions (e.g., Arizona, Florida).[311] During outbreaks in which specified facilities are designated (or better suited) to handle certain conditions, ambulance providers may need a Certificates of Necessity waiver in these jurisdictions, to transport a patient to the specified facility, if the facility (or patient) lies outside their boundaries.[312] During the 2014 Ebola outbreak, Arizona determined that the state health department director could waive Certificates of Necessity requirements temporarily to allow the necessary transport to designated facilities if a case arose in the state.[313]

***Local Protocols***. In many states, EMS offices delegate some authority to create and establish additional protocols directing patient care to local medical boards or medical directors.[314] These protocols may cover specific situations and conditions beyond the statutory requirements to transport a patient to a trauma center. For example, Arizona's health department can establish protocols in conjunction with local EMS medical directors allowing EMS personnel to transport patients without life-threatening conditions to the most appropriate health care institution considering patient choice and provider.[315] Local protocols generally dictate assessment, treatment, and transport requirements on the basis of the patient's condition at the scene.[316] Santa Clara County, California, requires all adult patients meeting the major trauma victim criteria to be expeditiously transported to the nearest trauma center.[317] These protocols may hinder the use of ACSs and ETAs, but can also be waived in emergencies, as noted in Part III.

## XVI. Reimbursement of EMS Resources and Services During and After Emergencies

Meeting the needs of a community during and after declared emergencies requires additional resources and advance outlays of expenses through all partners, including EMS providers. Availability of these resources, including personnel, equipment, supplies, and technologies, entails assurances of reimbursement. A variety of mechanisms exist through which public and private sector entities may be reimbursed for their emergency response efforts (Figure 15). Some of these reimbursement mechanisms require advance planning (e.g., MAAs), while others result from real-time decisions during declared emergencies (e.g., temporary waivers of Medicare and Medicaid requirements). Most reimbursements for EMS services during nationally declared emergencies stem from the federal government; however, some state or local jurisdictions may allow for reimbursement through aid agreements.

**Figure 15. Pathways to Emergency Reimbursement Funds**




### *Compensation for Takings*

As noted in Part V, government is authorized to commandeer private property or supplies for public use in some circumstances, including during an emergency, if rationally related to a public purpose. This power is known constitutionally as a "taking." However, the U.S. Constitution requires federal, state, and local governments to compensate owners for resources taken for public use.[318]

In an emergency, government may take privately held property to allow for additional patient care sites, ambulance equipment, or EMS supplies. For example, a state could temporarily take a large arena to use for patient care sites for the duration of an emergency. The takings clause protects private entities against losses by ensuring the provision of fair compensation for equipment, supplies, or temporary use of property, subject to specific procedures to obtain compensation consistent with due process.

### *Federal Funds and Programs*

***Stafford Act***. Pursuant to the 'president's approval during major disasters under the federal Stafford Act, the federal government can reimburse a state, tribal, or local government for basic pay salaries (1) for governmental employees who do not normally engage in emergency protective measures or (2) for overtime or hazardous duty compensation for permanent employees engaged in emergency protective measures.[319] The president is also authorized to dispense up to 75% of the cost of hazard-mitigation measures to reduce the risk for further damage, hardship, loss, or suffering in an area affected by a major disaster.[320] Additional funds through FEMA may be used to reimburse EMS providers through the Public Assistance (PA) Grant Program[321] or via MAAs.

***Public Assistance Grant Program***. FEMA's PA Grant Program provides state, tribal, and local governments, and certain private nonprofit organizations, assistance for their responses to declared disasters or emergencies.[322] FEMA provides supplemental federal disaster relief for the repair, replacement, and restoration of a public facility or certain private, nonprofit facilities damaged or destroyed by a major disaster.[323] FEMA also provides PA grant assistance for debris removal and emergency protective measures. The federal government provides a minimum of 75% of the eligible cost for emergency measures and permanent restoration.[324] Subgrantees can include state agencies, local governments, tribes, private nonprofit organizations, or other legal entities for which PA grant funds have been awarded.[325] EMS providers may receive monies, for example, to rent necessary equipment to remove debris following a hurricane or for search and rescue measures.

***Reimbursement for Ebola Response***. The 2014 Ebola outbreak created costly response and care for U.S. patients, including EMS-related expenses for preparedness, treatment, and transportation expenses. In November 2014, Senator Schumer of New York called for reimbursement from the federal government for NYC's efforts in caring for an Ebola patient.[326] Whether this request is meant to reimburse EMS services as well is not clear. President Obama also requested Congress to appropriate $6 billion for Ebola response efforts, some of which would fund state and local preparedness activities.[327] In December 2014, Congress included $5.4 billion for domestic and international Ebola response in its omnibus spending measure.[328]

***Mutual Aid Agreements***. FEMA reimburses for activities conducted pursuant to various forms of MAAs, including EMAC and other statewide MAAs. To be eligible, mutual aid must

1. Have been requested by an entity needing assistance
2. Be directly related to a presidential declaration of a major disaster or emergency
3. Be used in the performance of eligible work
4. Represent reasonable costs associated with the aid

FEMA also reimburses for postevent agreements, provided they are documented in writing, administered by authorized officials from each entity, and shared with FEMA. Reimbursement provisions in the aid agreement cannot be contingent on the federal government declaring a major disaster, emergency, or fire for FEMA to provide reimbursement. Therefore, reimbursement sections of MAAs should apply to reimbursement any time aid has occurred between one or more organizations or agencies, be it during a federally declared emergency or an emergency situation that does not rise to the level of a federal declaration.[329]

Emergency and grant management work are eligible for reimbursement. Emergency work is mutual aid work that is necessary to meet immediate threats to life, public safety, and property, including temporary emergency medical care, transport of equipment or personnel to the incident site, or operation of an ICS. Grant management work applies only to costs under the PA Program incurred via MAAs, including work associated with the performance of a grantee's responsibilities. Reimbursement for any entities providing assistance is done through the entity that is requesting aid. The entity providing assistance would submit any claims for reimbursement through the requesting entity. States may be considered eligible applicants, if a statewide MAA or compact allows the state to execute mutual aid in local jurisdictions.[330]

***Medicare and Medicaid***

***Section 1135 Waiver***. Pursuant to §1135 of the Social Security Act, DHHS' Secretary may waive or modify certain requirements for Medicare, Medicaid, Children's Health Insurance Program, and HIPAA.[331] Section 1135 waivers were authorized, for example, in 2009 and 2010 for the H1N1 influenza pandemic, in 2010 and 2011 for floods in North Dakota, in 2011 for severe storms and tornadoes in Missouri, and in 2012 for Hurricane Sandy.[332] Two conditions must occur in either order before the secretary may invoke DHHS' waiver authority: [333]

1. The president must make a major disaster declaration under the Stafford Act or an emergency declaration under the National Emergencies Act

2. DHHS' secretary must declare a PHE[334]

Pursuant to a formal §1135 waiver, the secretary may modify (1) certain conditions of participation or other certification requirements for health care providers; (2) requirements that health care providers hold a license in the state in which they provide health care services for purposes of reimbursement; and (3) limitations on payments for health care items and services provided to Medicare Advantage enrollees to allow use of out-of-network providers.[335] Health care facilities may receive specific waivers or modifications. Even if such facilities do not comply with Medicare, Medicaid, or other requirements while the waiver is in effect, facilities can continue to be reimbursed for covered services.[336] Implementation of these waivers or modifications is usually delegated to CMS.

During a declared emergency, §1135 waivers may impact payments for ambulance services by permitting transportation to an ACS. In general, origin and destination requirements, along with Medicare coverage requirements, must be met for Medicare to reimburse for ambulance transportation services.[337] The origin and destination requirements permit the transfer of a patient to a hospital, critical access hospital, skilled nursing facility, a beneficiary's home, or a dialysis facility. While a §1135 waiver does not eliminate approved destination requirements, reimbursement from Medicare for ambulance transport to an ACS may be available if CMS approves the site as an extension of an approved destination (i.e., hospital, critical access

hospital, skilled nursing facility).[338] In 2009, in response to the H1N1 influenza pandemic, DHHS used §1135 to waive certain provisions of EMTALA,[339] permitting hospitals to transfer patients (normally restricted by EMTALA) if necessary due to the declared PHE. Additionally, hospitals were allowed to direct patients arriving at the ED to alternative off-campus sites for a medical screening pursuant to state emergency or pandemic preparedness plans.[340]

***Interstate and Intrastate Mutual Aid Compacts***

As mentioned in Part V, MAAs not only foster resource sharing during an emergency, but can also address issues related to reimbursement for such resources as summarized below.

***Interstate Mutual Aid Compacts***. Pursuant to EMAC, any state providing assistance to another state must be reimbursed by the receiving state for any cost incurred in connection with providing the assistance or for expenses due to loss or damage incurred in the operation of equipment.[341]An EMAC REQ-A[342] details expenses that are eligible for reimbursement. The requesting state may be responsible for travel expenses; costs incurred by deployed personnel; damaged equipment; and deployed personnel's time and wages. In general, personal-use items, workers' compensation, and items for which no receipt or other form of proof is provided are ineligible expenses.[343] Additionally, a state providing aid may "donate" resources and services to the requesting state. Referred to as a "zero-dollar mission," this allows states to provide resources at no charge to the emergency-impacted state. REQ-As between states must reflect a "zero" cost estimate to show the state is donating the resource or service.[344]

***Intrastate Mutual Aid Compacts***. Some states also devise formal MAAs between organizations and agencies within the state to foster resource sharing during emergencies. These intrastate MAAs can take various forms. Arizona's Division of Emergency Management developed the Arizona Mutual Aid Compact, for use between participating jurisdictions within Arizona and between political subdivisions and the Arizona Department of Emergency and Military Affairs. Under these agreements, the party requesting aid must reimburse the party providing aid if requested in advance.[345]

The Iowa Department of Public Health provides a template MAA to help county EMS agencies develop mutual aid plans. It suggests that neither the party providing aid nor the party receiving aid should seek reimbursement for services, except for those services that are normally billed when providing ambulance transport.[346] Minnesota's model MAA indicates that the party providing aid should not bill the requesting party for any costs associated with assistance rendered unless the period of assistance is longer than 8 hours.[347]

Some local jurisdictions also enter into MAAs. For example, an MAA between Wilson County and the City of Mt. Juliet in Tennessee prescribes that the Wilson County Emergency Management Agency should provide emergency medical supplies and services to the city at no cost.[348] An MAA between the City of Clarkston and the Garfield County Rural Fire Protection

District in Washington State authorizes the parties to provide mutual assistance for fire prevention, fire control, emergency services, hazardous materials control, and other emergency support. Both parties agree not to seek compensation for services rendered pursuant to the agreement, except for fire suppression chemicals.[349]

### *Potential Impacts on Reimbursement via the Affordable Care Act*

The Patient Protection and Affordable Care Act (ACA) increased access to health insurance by requiring most individuals to obtain coverage. In addition, the ACA expanded the population eligible for Medicaid coverage in many states and provided tax subsidies for the purchase of health insurance through a state or federal insurance exchange.[350] Greater numbers of insured individuals increases the opportunities for EMS reimbursement through private and public insurance. The ACA also requires that health insurance plans provide coverage for enrollees for ten essential health benefits, including emergency services.[351] As a result, EMS is more likely to be reimbursed than prior to ACA implementation.

ACA-authorized accountable care organizations (ACOs) bring health care providers, hospitals, and related businesses (e.g., pharmacies) together into one entity to provide coordinated care.[352] In emergencies, ACOs may provide an additional source of reimbursement due to their coordinated nature. For example, a patient may be transferred between hospitals or between a health care provider's office and a hospital facility, all of which are part of the ACO facilitating reimbursement for EMS services.

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## Conclusion

During declared PHEs when the demand for medical care surges, public health and health care responses entail strong collaborations with EMS personnel and entities. Effective responses in turn are precipitated on a favorable legal environment that facilitates coordinated efforts among EMS entities and their many partners. EMS practitioners may have to expand their scopes of practice, administer vaccinations, provide services across state borders, work with ACSs, and activate disaster protocols. These expanded roles implicate a host of potential legal issues and pitfalls absent sufficient advance and real-time solutions.

The dynamic, changing legal environment during declared emergencies allows EMS personnel and entities to respond in ways that might otherwise be impermissible. Emergency declarations may lead to temporary waivers of conflicting laws, authorize licensure reciprocity, alter scopes of practice, activate CSC, initiate specific liability protections, and launch additional powers to further responses. In addition, advanced planning and adept use of existing emergency agreements like EMAC and state and local MAAs permit efficient sharing of supplies and personnel across jurisdictions. Potential claims of liability for EMS professionals and entities can be obviated through adherence to protocols and expanded liability protections. A number of reimbursement mechanisms may be activated to help ensure EMS agencies and personnel are appropriately paid for their essential efforts. Presurge planning and preparedness efforts coupled with a jurisdiction-specific understanding of the changing legal environment during declared emergencies work in concert to avoid and overcome an array of legal obstacles lending to the essential contributions of EMS personnel and entities to protecting the population's health.

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**Table 1. Select Levels of Emergency Declarations**

This table lists legal authorization for select emergency/disaster declarations at the federal, state, and local levels. **Columns I** names the specific title of the declarations; **II** indicates the entity or locality to which the authorization pertains; **III** indicates the specific statute or regulation authorizing the declaration; and **IV**, **V**, and **VI** indicate the official authorized to make the declaration, the conditions allowing for determination and declaration of an emergency or disaster, and the key aspects of the particular declaration process.

| I. Title | II. Entity | III. Legal Authorization | IV. Declared by | V. Declared When | VI. Process |
|---|---|---|---|---|---|
| **Federal** | | | | | |
| CERCLA Public Health or Environmental Emergency | President | 42 U.S.C. § 9604(a)(4) (2012) | President | Declaration may be made to respond to a release or threatened release of a substance[1] if no other person with the authority and capacity to respond to the emergency will do so in a timely manner. | Determination of the release or threat of release constitutes a public health or environmental emergency is made at the discretion of the president. |
| Emergency or Threat Justifying Emergency Authorized Use | DHHS | 21 U.S.C. § 360bbb-3 (2012). | DHHS Secretary | Declaration may be made when circumstances exist to justify the authorization of emergency use of a product if one of four determinations[2] has been made. | The declaration must be promptly published in the Federal Register. |
| Emergency Situation | DOD | 10 U.S.C. § 382 (2012). | Secretary of Defense & AG | Determination may be made when there is an emergency situation involving weapons of mass destruction.[3] | Proclamation must be immediately submitted to Congress and published in the Federal Register. |
| National Emergency | President | 50 U.S.C §§ 1621, 1631 (2011). | President | Declaration may be made under any circumstances authorized by Acts of Congress. | Proclamation must be immediately submitted to Congress and published in the Federal Register. |

| I. Title | II. Entity | III. Legal Authorization | IV. Declared by | V. Declared When | VI. Process |
|---|---|---|---|---|---|
| Physical Disaster Declaration | SBA | 13 C.F.R. § 123.3 (2011). | SBA | Declaration may be made when a minimum amount of damage to buildings, machinery, equipment, inventory, homes and other property occurs. | The damage must meet one of the two requirements[4] and the Governor of the affected state must submit a written request for a physical disaster declaration to SBA. |
| PREP Act Declaration | DHHS | 42 U.S.C. §§ 247d-6d, 247d-6e (2012). | DHHS Secretary | Declaration may be made when it is determined a disease, other health condition, or other threat to health constitutes a PHE, or that there is a credible risk the condition may cause an emergency in the future. | Declaration may be made by publication in the Federal Register. Declaration should include specifics for each specified countermeasure. |
| Public Health Emergency | DHHS | 42 U.S.C. § 247d (2010) | DHHS Secretary | Determination may be made when a disease or disorder presents a PHE; or a there is a PHE, including infectious disease or bioterrorist attacks. | Secretary may consult with public health officials as necessary to make a determination and must submit written notification of the determination to Congress. |
| Site Area or General Emergency | NRC | 10 C.F.R. § 50 app. E (2014). | Authorized NRC Licenses | Site Area Emergency may be declared when conditions exist where there is clear potential for significant release of nuclear material, or such releases are likely or are occurring, but such a situation does not involve indications of a core melt at the time the declaration is made.<br><br>General Emergency may be declared when conditions exist that involve actual or imminent substantial core degradation or melting with the potential or actual loss of containment integrity. | NRC Operations Center must be notified of the declaration via the Emergency Notification System. |

| I. Title | II. Entity | III. Legal Authorization | IV. Declared by | V. Declared When | VI. Process |
|---|---|---|---|---|---|
| Stafford Act Emergency or Major Disaster | President | 42 U.S.C. §§ 1521-5205 (2012). | President | Declaration may be made when the Governor of the affected state makes a request for a declaration after effective response the disaster is beyond the capabilities of the State and the affected local governments and necessitates Federal assistance. | The Governor of the affected state must provide information and certification[5] as part of the declaration request. |
| **State** | | | | | |
| Air Pollution Emergency | IN | Ind. Code §13-17-4 (2013). | Governor | Declaration may be made when air pollution poses a serious risk to the health and safety of the population such that emergency powers are needed to prevent or minimize disasters of unforeseen proportions. | Declaration issued by executive order if the Air Pollution Control Comm'r, in consultation with the Comm'r for the State Dep't of Health, determines pollution poses an emergency risk. |
| Disaster Declaration | TN | Tenn. Code § 58-2-107 (2010). | Governor or Governor's Designee | Declaration may be declared when the Governor finds an emergency has occurred or may be imminent. | Declaration is issued by executive order or proclamation, or by activation of the Tennessee Emergency Management Plan. |
| Disaster Emergency | NY | N.Y. Exec. Law § 28 (2012). | Governor[6] | Declaration may be made when a disaster occurs or is imminent and local governments are unable to adequately respond. | Declaration is issued by executive order including description of the disaster and area(s) affected.[7] |
| Electric Energy Emergency | VA | Va. Code Ann. § 56-586.1 (2013). | Governor | Declaration may be made only when one of seven conditions[8] endangers life and property and the situation cannot be adequately handled by local government resources. | Upon declaration, the majority and minority leaders of the senate and the speaker and majority and minority leaders of the house of representatives must be immediately notified. |

| I. Title | II. Entity | III. Legal Authorization | IV. Declared by | V. Declared When | VI. Process |
|---|---|---|---|---|---|
| Peacetime Emergency | MN | Minn. Stat. § 12.31 (2013). | Governor | Declaration may be made only when one of seven conditions[9] endangers life and property and the situation cannot be adequately handled by local government resources. | Upon declaration, the majority and minority leaders of the senate and the speaker and majority and minority leaders of the house of representatives must be immediately notified. |
| Public Health Disaster | TX | Tex. Health & Safety Code § 81.003 (2013). | Governor in conjunction with the Comm'r | Declaration may be made when Governor determines a state of disaster exists and when the Commissioner determines that there is an immediate threat from a communicable disease posing a high risk of death or serious long-term disability to a large number of people, or a substantial risk of public exposure to a disease with a high level of contagion. | A public health disaster may not last longer than 30 days and may be renewed once by the Comm'r for an additional 30 days. The Governor may terminate the declaration at any time. |
| State of Emergency | AZ | Ariz. Rev. Stat. § 26-303 (2013). | Governor | Declaration may be made when conditions of disaster or extreme peril caused when one of nine qualifying events[10] threaten the safety of people or property within the state. | Declaration takes immediate effect in affected areas or areas likely to be affected. |
| State of Public Disorder Emergency | IA | Iowa Code § 29C.3 (2012). | Governor | Declaration may be made when conditions qualifying as a public disorder[11] exist. | The governor must make the proclamation in writing and file it with the Secretary of State[12]. |
| State of Public Health Emergency | LA | La. Rev. Stat. § 29:766(A) (2013). | Governor | Declaration may be made when conditions qualifying as a PHE[13] exist. | The emergency must be declared by executive order or proclamation, immediately circulated to the general public, and filed with state offices.[14] |

| I. Title | II. Entity | III. Legal Authorization | IV. Declared by | V. Declared When | VI. Process |
|---|---|---|---|---|---|
| State of War Emergency | CA | Cal. Gov. Code § 8558 (2012). | Governor | Declaration may be made whenever the state or nation is attacked by an enemy of the United States, or when the federal government issues a warning indicating an enemy attack is probable or imminent. | A State of War Emergency may be declared with or without proclamation, existence of immediate conditions is sufficient. |
| **Local** | | | | | |
| Actual Emergency | San Francisco (CA) | S.F., Cal., Code § 6.60(C) (2013). | Bd. of Supervisors | Declaration may be made when a sudden, unforeseeable, and unexpected occurrence creating clear and imminent danger, or the discovery of conditions creating clear and imminent danger to public health or safety, requires immediate action to prevent or mitigate loss of or damage to life, health, property, or essential public services.[15] | Declaration by the Board, necessitates any work required by the declaration be expedited by the department head responsible for such work. |
| Civil Emergency | Seattle (WA) | Seattle, Wash, Code § 10.02.010(A) (2003). | Mayor | Declaration may be made upon the occurrence or imminent threat of one of eleven conditions[16] that results in or threatens to result in death or injury of persons, destruction of property, or disruption of local gov't, and requires extraordinary measures to prevent death or injury of persons and to protect the public peace, safety and welfare, and alleviate damage, loss, hardship or suffering. | The Mayor must proclaim in writing a civil emergency exists and the proclamation must be filed immediately with the Clerk for ratification by City Council. |
| Emergency Proclamation | Fal-mouth (ME) | Falmouth, Me., Code § 2-507 (2013) | Town Council Chairperson[17] | Proclamation may be made whenever a disaster or civil emergency exists or appears imminent. | A copy of the proclamation must be filed in the Office of the Town Clerk within 24 hours. |

| I. Title | II. Entity | III. Legal Authorization | IV. Declared by | V. Declared When | VI. Process |
|---|---|---|---|---|---|
| Local Disaster Emergency | Spring-field (IL) | Springfield, Ill., Code § 33.110 (2013). | Mayor[18] or City Council | Declaration may be made when it is necessary to activate the response and recovery aspects of any and all applicable disaster emergency plans and to authorize aid and assistance under such plans. | Any proclamation of this kind must be promptly filed with the City Clerk and given general publicity. |
| State of Emergency | N. Myrtle Beach (SC) | N. Myrtle Beach, S.C., Code §§ 8-1, 8-2 (2013). | City Council | Declaration may be made during times of great public crisis, disaster, rioting, catastrophe or similar public emergency and city public safety authorities are unable to maintain public order or protect persons or property. | All proclamations, ordinances, resolutions and directives shall be executed by the City Manager and his appointees. |

[1] A substance for the purpose of this declaration provision includes: a naturally occurring substance in its natural form, or altered only by natural processes from its originating location; products which are part of the structure of, and cause exposure within, residential buildings or business or community structures; or anything released into public or private drinking water supplies due to deterioration of the system through ordinary use.

[2] The four qualifying determinations are as follows: (1) the Secretary of Homeland Security determines there is, or is significant potential for, a domestic emergency; (2) the Secretary of Defense determines there is, or is significant potential for, a military emergency; (3) DHHS' Secretary determines that there is, or is significant potential for, a public health emergency; or (4) a material threat under 42 U.S.C. 247d-6b has been identified and is sufficient to affect national security or the health and security of United States citizens living abroad.

[3] An emergency situation involving a weapon of mass destruction involves a weapon of mass destruction that poses a serious threat to U.S. interests; and civilian expertise and capabilities are not readily available to counter the threat, requiring special capabilities and expertise of the DOD are critical to counter the threat and enforce 18 U.S.C. §§ 175, 229, or 2332a.

[4] The 2 tests the damage must conform to are as follows: (1) In any county or other smaller political subdivision of a State, at least 25 homes, 25 businesses or other institutions, or a combination thereof, must each sustain uninsured losses of 40 percent or more of the estimated fair replacement value or pre-disaster fair market value of the damaged property, whichever is lower; or (2) In any such political subdivision, 25 percent or more of the work force in the community would be unemployed for at least 90 days as a result physical damage causing of uninsured losses of at least three businesses, each 40 percent or more of the estimated fair replacement value or pre-disaster fair market value of the damaged property, whichever is lower.

[5] The information provided by the Governor should indicate the nature and amount of State and local resources committed to alleviating the results of the disaster, and certify that State and local resources committed to alleviating the results of the disaster will comply with all applicable cost-sharing requirements of the Stafford Act for the current disaster.

[6] Governor may make the declaration by his own initiative or upon request from one or more chief executives.

[7] If the disaster declaration is due to a radiological accident, one or more chief executives and emergency services must notify the public that an emergency exists and take appropriate protective actions as outlined in the approved radiological preparedness plan.

[8] The conditions allowing for declaration of a peacetime emergency include: an act of nature, a technological failure or malfunction, a terrorist incident, an industrial accident, a hazardous materials accident, or a civil disturbance.

[9] The conditions allowing for declaration of a peacetime emergency include: an act of nature, a technological failure or malfunction, a terrorist incident, an industrial accident, a hazardous materials accident, or a civil disturbance.

[10] The qualifying events causing disaster or extreme peril include: air pollution, fire, flood or floodwater, storm, epidemic, riot, earthquake, or other cause.

[11] Under Iowa Code § 29C.2 (2012), conditions of public disorder may exist in times of insurrection, rioting, looting, and persistent violent civil disobedience that substantially interfere with the public peace and cause a significant threat to the health and safety of the people or property.

[12] The Secretary of State shall give notice of the proclamation by publication in a general circulation newspaper, broadcast by radio and television, and posting signs in conspicuous locations in the affected area(s).

[13] Under La. Rev. Stat. § 29:762(12) (2013), a public health emergency exists upon imminent threat or occurrence of an illness or health condition that is believed to be caused by bioterrorism, the appearance of a novel or previously controlled biological agent or toxin, a disaster; and poses a high probability of a large number of deaths, serious or long-term disabilities, or people at risk of substantial future harm.

[14] The executive order or proclamation must be filed with the Governor's Office of Homeland Security and Emergency Preparedness, the Department of Health and Hospitals, Office of Public Health, and the Secretary of State.

[15] Examples of an actual emergency include: weather conditions, fire, flood, earthquake or other unforeseen occurrences of unusual character; or the breakdown or imminent breakdown of any plant, equipment, structure, street or public work necessitating immediate emergency repair or reconditioning to protect the citizens or public property; or unusual and unforeseen circumstances resulting in insufficient or lack of hospital beds or required hospital or medical services.

[16] Conditions include: riot, unlawful assembly, insurrection, other disturbance, fire, flood, storm, earthquake or other catastrophe or disaster.

[17] Town Council Chairperson has the authority to issue a proclamation if done in consultation with the town manager. If the Chairperson is unavailable, then the Vice-Chairperson of the Town Council may issue the proclamation.

[18] A proclamation made by the Mayor must be ratified by City Council if it is to last longer than 7 days.

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**Table 2. State Emergency Declarations**

This table provides state statutory and regulatory authorities for emergency declarations in all 50 U.S. States and the District of Columbia. It includes emergency declarations, PHE declarations, and other types of declarations that may relate to the public's health. **Columns I** provides citations and hyperlinks to legal authorities in all jurisdictions for state declarations of "emergency," "disaster," and similar terms (as noted);[1] **II** lists the legal authorities in 33 jurisdictions for specific declarations of a "public health emergency," which may be based on the Model State Emergency Health Powers Act (MSEHPA),[2] or other statutory bases for emergency/disaster declarations premised on public health concerns; **III** catalogs additional types of declarations that may relate to public health in 43 jurisdictions;[3] and **IV** links existing online archives of active or expired declarations. These websites are illustrative and may not be current or comprehensive.

| State | I. Emergency/Disaster | II. Public Health Emergency | III. Other Declarations | IV. Posted Declarations |
|---|---|---|---|---|
| AL | Emergency: ALA. CODE § 31-9-8 | ALA. CODE § 31-9-8(a) | Air Pollution Emergencies (ALA. CODE § 22-28-21)<br>Drought Emergency Conditions (ALA. CODE § 9-13-140) | http://www.ema.alabama.gov<br>http://governor.alabama.gov/newsroom/category/executive-orders/ |
| AK | "Disaster Emergency": ALASKA STAT. § 26.23.020 | ALASKA STAT. §18.15.390[4] | Terrorist Attack and or National Security Emergency Declaration (ALASKA STAT. § 26.20.040) | http://gov.state.ak.us/admin-orders/index.php |
| AZ | Emergency: ARIZ. REV. STAT. ANN. §§ 35-192, 26-303(D) | ARIZ. REV. STAT. ANN. § 36-787(A)[5] | Local Emergency (ARIZ. REV. STAT. ANN. § 26-311) | http://www.azgovernor.gov/newsroom/Gov_DE.asp |

| State | I. Emergency/Disaster | II. Public Health Emergency | III. Other Declarations | IV. Posted Declarations |
|---|---|---|---|---|
| AR | "Disaster Emergency": ARK. CODE ANN. § 12-75-107 | | Local Disaster Emergency (ARK. CODE ANN. § 12-75-108) | http://governor.arkansas.gov/newsroom/index.php?do:newsList=1&category_id=10 |
| CA | Emergency: CAL. GOV'T CODE §§ 8625,[6] 14970, 14120[7] | | Local Emergency (CAL. GOV'T CODE § 8630)<br><br>State of War Emergency (CAL. GOV'T CODE §§ 8558, 8620) | http://gov.ca.gov/s_executiveorders.php<br><br>http://www.calema.ca. gov/ChiefofStaff/Pages/Emergency-Proclamations.aspx |
| CO | Emergency: COLO. REV. STAT. § 24-33.5-704 | | Local Disaster Emergency (COLO. REV. STAT. §24-33.5-709) | http://www.colorado.gov/cs/Satellite/GovHickenlooper/CBON/1249674959203<br><br>http://www.coemergency.com |
| CT | Emergency: CONN. GEN. STAT. §§ 28-9,[8] 13b-4d[9] | CONN. GEN. STAT. § 19a-131a | Air Pollution Emergency (CONN. AGENCIES REGS. § 22a-174-6)<br><br>Public Drinking Water Supply Emergency (CONN. GEN. STAT. § 25-32b)<br><br>Water Supply Emergency (CONN. GEN. STAT. § 22a-378) | http://www.governor.ct.gov/malloy/cwp/view.asp?a=11&Q=470854 |

| State | I. Emergency/Disaster | II. Public Health Emergency | III. Other Declarations | IV. Posted Declarations |
|---|---|---|---|---|
| DE | Emergency: DEL. CODE ANN. tit. 20, § 3115 | DEL. CODE ANN. tit. 20, § 3132 | | http://dema.delaware.gov/news.shtml<br><br>http://governor.delaware.gov/orders/index.shtml |
| DC | Emergency: D.C. CODE § 7-2304; D.C. MUN. REGS. tit. 24, § 2200 | D.C. CODE §§ 7-2304, 7-2304.01 | | http://mayor.dc.gov/newsroom |
| FL | Emergency: FLA. STAT. §§ 252.35, 252.36 | FLA. STAT. § 381.00315 | Water Shortage Emergency (FLA. STAT. § 373.246; FLA. ADMIN. CODE ANN. r. 40E-21.331) | http://www.flgov.com/all-executive-orders/ |
| GA | Emergency or Disaster: GA. CODE ANN. § 38-3-51 | GA. CODE ANN. § 38-3-51(a) | Air Pollution Emergency (GA. COMP. R. & REGS. 391-3-1-.04) | http://gov.georgia.gov/executive-orders |
| HI | Emergency: HAW. REV. STAT. § 128-5[10] | | Tourism Emergency (HAW. REV. STAT. § 201B-9)<br><br>Water Supply Emergency (HAW. CODE R. § 13-171-50) | http://governor.hawaii.gov/newsroom/disasteremergency-proclamations/ |
| ID | "Disaster Emergency": IDAHO CODE ANN. § 46-1008 | | Drought Emergency (IDAHO CODE ANN. § 42-222A)<br><br>Local Disaster Emergencies (IDAHO CODE ANN. § 46-1011) | http://gov.idaho.gov/mediacenter/execorders/index.html |

| State | I. Emergency/Disaster | II. Public Health Emergency | III. Other Declarations | IV. Posted Declarations |
|---|---|---|---|---|
| IL | Disaster: 20 ILL. COMP. STAT. 3305/7 | 20 ILL. COMP. STAT. 3305/4[11] | Environmental Emergency (415 ILL. COMP. STAT. 5/34, ILL. ADMIN. CODE tit. 35, § 244.165)<br>Local Disaster Declaration (20 ILL. COMP. STAT. 3305/11) | http://www.illinois.gov/Government/ExecOrders/Pages/default.aspx |
| IN | "Disaster Emergency": IND. CODE § 10-14-3-12 | IND. CODE ANN. § 10-14-3-1(b)(23)[12] | Air Pollution Emergency (326 IND. ADMIN. CODE 1-5-4)<br>Blood Shortage Emergency (IND. CODE § 16-41-12-18)<br>Drought Emergency (312 IND. ADMIN. CODE 6.3-5-2)<br>Energy Emergency (IND. CODE § 10-14-3-13)<br>Freshwater Lake Emergency (IND. CODE § 14-25-5-7)<br>Ground Water Emergency (IND. CODE § 14-25-4-9)<br>Local Disaster Emergency (IND. CODE § 10-14-3-29) | http://www.in.gov/gov/2384.htm |
| IA | "Disaster Emergency": IOWA CODE § 29C.6 | IOWA CODE § 29C.6[13] | State of Public Disorder Emergency (IOWA CODE § 29C.3) | http://www.iowahomelandsecurity.org/quick_links/current_disaster.html<br>https://governor.iowa.gov/news/executive-orders/ |
| KS | "Disaster Emergency": KAN. STAT. ANN. § 48-924 | | Local Disaster Emergency (KAN. STAT. ANN. § 48-932) | http://www.kansastag.gov/kdem.asp?PageID=434<br>https://governor.ks.gov/media-room/executive-orders |

| State | I. Emergency/Disaster | II. Public Health Emergency | III. Other Declarations | IV. Posted Declarations |
|---|---|---|---|---|
| KY | Emergency: KY. REV. STAT. ANN. § 39A.100 | | | http://kyem.ky.gov/currentdisasters/Pages/default.aspx<br><br>http://migration.kentucky.gov/Newsroom/governor/ |
| LA | Emergency or Disaster: LA. REV. STAT. ANN. § 29:724 | LA. REV. STAT. ANN. § 29:766(A) | Local Disaster Emergency (LA. REV. STAT. ANN. § 29:727)[14]<br><br>Pesticide Emergency (LA. ADMIN. CODE tit. 7, § 2905) | http://www.gov.state.la.us/index.cfm?md=newsroom&tmp=home&catID=9<br><br>http://www.deq.louisiana.gov/portal/Default.aspx?tabid=2570 |
| ME | Emergency: ME. REV. STAT. tit. 37-B, § 742(1) | ME. REV. STAT. tit. 22, §§ 802(2),[15] 802(2-A)[16] | Energy Emergency (ME. REV. STAT. tit. 37-B, § 742(2))<br><br>Marine Resources Emergency (ME. REV. STAT. tit. 12, § 6171-A)<br><br>Oil Spill Emergency (ME. REV. STAT. tit. 37-B, § 742(3))<br><br>Uncontrolled Hazardous Substance Emergency (ME. REV. STAT. tit. 38, § 1368) | http://www.maine.gov/governor/lepage/official_documents/index.shtml |
| MD | Emergency: MD. CODE ANN., PUB. SAFETY § 14-107 | MD. CODE ANN., PUB. SAFETY § 14-3A-02[17] | Air Pollution Episode Criteria (MD. CODE REGS. 26.11.05.03)<br><br>Local State of Emergency (MD. CODE ANN., PUB. SAFETY § 14-111)[18]<br><br>Snow Emergency (MD. CODE ANN., TRANSP. § 21-1119) | http://news.maryland.gov/mema/category/emergency-news/<br><br>http://www.governor.maryland.gov/newsletters.html - eo |

| State | I. Emergency/Disaster | II. Public Health Emergency | III. Other Declarations | IV. Posted Declarations |
|---|---|---|---|---|
| MA | Emergency: 1950 Mass. Acts ch. 639, § 5 | | Air Pollution Emergency (MASS. GEN. LAWS ch. 111, § 2B)<br>Energy Emergency (MASS. GEN. LAWS ch. 25A, § 8)<br>Water Emergency (MASS. GEN. LAWS ch. 21G, § 15) | http://www.mass.gov/alert/alertlanding.html<br>http://www.mass.gov/governor/legislationeexecorder/executiveorder/ |
| MI | Emergency or Disaster: MICH. COMP. LAWS § 30.403 | MICH. COMP. LAWS §§ 10.122; 10.125[19] | Animal Emergency (MICH. COMP. LAWS § 287.710)<br>Energy Emergency (MICH. COMP. LAWS § 10.83)<br>Hazardous Waste Emergency (MICH. ADMIN. CODE r. 299.9902)<br>Heightened State of Terror Alert (MICH. COMP. LAWS § 30.421)[20]<br>Local Emergency (MICH. COMP. LAWS § 30.410)[21] | http://www.michigan.gov/snyder/0,4668,7-277-57632---,00.html |
| MN | Emergency: MINN. STAT. § 12.31[22] | MINN. R. 4735.0100[23] | Air Pollution Emergency (MINN. R. 7009.1030)<br>Energy Supply Emergency (MINN. R. 7620.0210)<br>Local Emergency (MINN. STAT. § 12.29)[24] | http://mn.gov/governor/resources/executive-orders/ |
| MS | Emergency: MISS. CODE ANN. § 33-15-11(b)(17),(18)[25] | | Air Pollution Emergency (11-3 MISS. CODE R. §3)<br>State of War Emergency (MISS. CODE ANN. § 33-15-13) | http://www.governorbryant.com/executive-orders/<br>http://www.msema.org |
| MO | Emergency: MO. REV. STAT. § 44.100 | | Air Contaminant Emergency (MO. REV. STAT. § 643.090) | http://governor.mo.gov/orders/<br>http://mda.mo.gov/disaster/ |

| State | I. Emergency/Disaster | II. Public Health Emergency | III. Other Declarations | IV. Posted Declarations |
|---|---|---|---|---|
| MT | Emergency: MONT. CODE ANN. §§ 10-3-302, Disaster: 10-3-303 | | Energy Emergency (MONT. CODE ANN. § 90-4-310, MONT. ADMIN. R. 14.8.211)[26]<br>Local Disaster (MONT. CODE ANN. § 10-3-403)<br>Local Emergency MONT. CODE ANN. § 10-3-402)<br>School Closure Emergency (MONT. CODE ANN. § 20-9-806) | http://governor.mt.gov/Home/Newsroom.aspx |
| NE | Emergency: NEB. REV. STAT. § 81-829.40(3)[27] | | Local Emergency (NEB. REV. STAT. § 81-829.50)[28]<br>Vital Resource Emergency (NEB. REV. STAT. § 84-164) | http://www.governor.nebraska.gov/news/index.html |
| NV | Emergency or Disaster: NEV. REV. STAT. § 414.070 | NEV. REV. STAT. § 439.970(2) | Local Emergency (NEV. REV. STAT. § 414.090)[29]<br>Water or Energy Emergency (NEV. REV. STAT. § 416.090) | http://gov.nv.gov/News-and-Media/Executive-Orders/ |
| NH | Emergency: N.H. REV. STAT. ANN. § 4:45 | | Oil Discharge Emergency (N.H. REV. STAT. ANN. § 146-A:12)<br>Public Water Supply Emergency (N.H. REV. STAT. ANN. § 485:23) | http://www.governor.nh.gov/media/orders/index.htm |
| NJ | Emergency: N.J. STAT. ANN. § 9-34[30] | N.J. STAT. ANN. § 26:13-3 | Air Pollution Emergency (N.J. REV. STAT. §26:2C-30)<br>Local Disaster Emergency (N.J. REV. STAT. § App. A:9-40.5)[31]<br>State of Water Emergency (N.J. REV. STAT. § 58:1A-4) | http://nj.gov/infobank/circular/eoindex.htm |

| State | I. Emergency/Disaster | II. Public Health Emergency | III. Other Declarations | IV. Posted Declarations |
|---|---|---|---|---|
| NM | Emergency: N.M. STAT. ANN. § 12-10-4[32] | N.M. STAT. ANN. § 12-10A-5 | Energy Supply Emergency (N.M. STAT. ANN. § 12-12-3) | http://www.governor.state.nm.us/Press_Releases.aspx |
| NY | "Disaster Emergency": N.Y. EXEC. LAW § 28 | N.Y. PUB. HEALTH LAW § 1388[33] | | http://www.dhses.ny.gov/oem/recovery/<br><br>http://www.governor.ny.gov/sl2/ExecutiveOrderindex |
| NC | Emergency: N.C. GEN. STAT. §§ 166A-19.20<br><br>Disaster: 166A-19.21[34] | 25 N.C. ADMIN. CODE § 1N.0401 | Energy Crisis (N.C. GEN. STAT. § 113B-20)<br><br>Municipal or County Emergency (N.C. GEN. STAT. § 166A-19.22)[35]<br><br>Offshore Oil and Gas Emergency (N.C. GEN. STAT. § 143-215.94II)<br><br>PHE (Shellfish) (15A N.C. ADMIN. CODE 18A.0913)<br><br>Rabies Emergency (N.C. GEN. STAT. § 130A-201)<br><br>Water Shortage Emergency (N.C. GEN. STAT. § 143-355.3) | http://www.governor.state.nc.us/newsroom/orders-and-proclamations |

| State | I. Emergency/Disaster | II. Public Health Emergency | III. Other Declarations | IV. Posted Declarations |
|---|---|---|---|---|
| ND | Emergency or Disaster: N.D. CENT. CODE § 37-17.1-05 | | Animal Health Emergency (N.D. CENT. CODE § 20.1-08-04.11)<br>Drought Emergency (N.D. ADMIN. CODE 7-08-01-10, N.D. ADMIN. CODE 89-11-01-02)<br>Local Disaster or Emergency (N.D. CENT. CODE § 37-17.1-10) | http://governor.nd.gov/media-center/executive-orders<br>http://www.nd.gov/des/news/ |
| OH | Emergency: OHIO REV. CODE ANN. §§ 5502.22, 5502.28[36] | | Air Pollution Emergency (OHIO REV. CODE ANN. § 3704.032)<br>Asbestos PHE (OHIO REV. CODE ANN. § 3710.13(B))[37]<br>Energy Emergency (OHIO REV. CODE ANN. § 4935.03)<br>Public Health State of Emergency (OHIO REV. CODE ANN. § 3715.74)[38] | http://www.governor.ohio.gov/MediaRoom/PressReleases.aspx<br>http://ema.ohio.gov/PAO_PressReleases.aspx |
| OK | Emergency: OKLA. STAT. tit. 63, § 683.9 | OKLA. STAT. tit. 63, § 6401[39] | Animal Disease Emergency (OKLA. STAT. tit. 2, § 6-401)<br>Drought Emergency (OKLA. STAT. tit. 27A, § 2251)<br>Local Emergency (OKLA. STAT. tit. 63, § 683.11) | http://www.ok.gov/OEM/Emergencies_&_Disasters/index.html |
| OR | Emergency: OR. REV. STAT. § 401.165; Disaster: OR. CONST. art. X-A, § 1[40] | OR. REV. STAT. § 433.441(1); OR. ADMIN. R. 333-003-0020 | Local Emergency (OR. REV. STAT. § 401.309) | http://www.oregon.gov/gov/Pages/exec_orders.aspx |

| State | I. Emergency/Disaster | II. Public Health Emergency | III. Other Declarations | IV. Posted Declarations |
|---|---|---|---|---|
| PA | "Disaster Emergency": 35 PA. CONS. STAT. § 7301 | | Local Emergency (35 PA. CONS. STAT. § 7501)<br>Petroleum Product Shortage Emergency (71 PA. CONS. STAT. ANN. § 720.2) | http://www.portal.state.pa.us/portal/server.pt?open=514&objID=1072223&parentname=ObjMgr&parentid=396&mode=2 |
| RI | Emergency: R.I. GEN. LAWS § 30-15-9 | R.I. GEN. LAWS § 30-15-2[41] | Local Disaster Emergency (R.I. GEN. LAWS § 30-15-13) | http://www.ri.gov/press/<br>http://www.governor.ri.gov/newsroom/executiveorders/ |
| SC | Emergency: S.C. CODE ANN. § 25-1-440(a)(2) | S.C. CODE ANN. § 25-1-440(d)(2); S.C. CODE REGS. 61-112 | Drought Emergency (S.C. CODE ANN. § 49-23-80) | http://governor.sc.gov/ExecutiveOffice/Pages/ExecutiveOrders.aspx |
| SD | Emergency or Disaster: S.D. CODIFIED LAWS § 34-48A-5[42] | S.D. CODIFIED LAWS § 34-22-4243 | | http://dps.sd.gov/emergency_services/emergency_management/disaster_info.aspx<br>http://sd.gov/governor/PressReleases.aspx |
| TN | Emergency or Disaster: TENN. CODE ANN. § 58-2-107(b)[44] | | Local Emergency (TENN. CODE ANN. § 58-8-104) | http://www.tnema.org |

| State | I. Emergency/Disaster | II. Public Health Emergency | III. Other Declarations | IV. Posted Declarations |
|---|---|---|---|---|
| TX | Disaster: TEX. GOV'T CODE ANN. § 418.014 | TEX. HEALTH & SAFETY CODE ANN. §§ 81.003(7)(a), 81.082(d); 22 TEX. ADMIN. CODE § 166.1(f)(5)[45] | | http://governor.state.tx.us/news/proclamation/ |
| UT | Emergency: UTAH CODE ANN. § 53-2a-206 | UTAH ADMIN. CODE r. 386-702-10 | Local Emergency (UTAH CODE ANN. § 53-2a-208) | http://www.utahemergencyinfo.com/go/doctype/2515/42223/<br><br>http://www.utah.gov/governor/news_media/index.html |
| VT | Emergency: VT. STAT. ANN. tit 20, § 9 | | | http://governor.vermont.gov/executive_orders |
| VA | Emergency: VA. CODE ANN. § 44-146.17 | VA. CODE ANN. § 44-146.17[46] | Electrical Energy Emergency (VA. CODE ANN. § 56-586.1)<br>Local Emergency (VA. CODE ANN. § 44-146.21) | http://www.governor.virginia.gov/PolicyOffice/ExecutiveOrders/<br><br>http://www.vaemergency.gov/news |
| WA | Emergency: WASH. REV. CODE §§ 38.52, §43.06.010[47] | WASH. REV. CODE § 70.119A.040[48] | Air Pollution Emergency (WASH. REV. CODE § 70.94.720)<br>Energy Supply Emergency (WASH. REV. CODE § 43.21G.040) | http://www.wadisasternews.com/go/site/1105/<br><br>http://www.governor.wa.gov/office/proclamations/default.aspx |

| State | I. Emergency/Disaster | II. Public Health Emergency | III. Other Declarations | IV. Posted Declarations |
|---|---|---|---|---|
| WV | Emergency: W. VA. CODE § 15-5-6 | W. VA. CODE R. § 65-7-2(2.9)[49] | | http://www.governor.wv.gov/media/pressreleases/Pages/default.aspx |
| WI | Emergency: WIS. STAT. § 323.10[50] | WIS. STAT. § 323.10 | Local Emergency (WIS. STAT. § 323.11) | http://walker.wi.gov/newsroom/executive-orders |
| WY | Emergency or Disaster: WYO. STAT. ANN. §§ 19-13-102; 19-13-104[51] | WYO. STAT. ANN. § 35-4-115(a)(1) | Air, Water or Other Pollution Emergency (WYO. STAT. ANN. § 35-11-115) | http://www-wsl.state.wy.us/sis/wydocs/execorders.html<br><br>http://governor.wy.gov/media/pressReleases/Pages/PressReleases.aspx |

[1] The search terms "emergency," "disaster," "emergency declaration," "disaster declaration," "catastrophe," and "emergency proclamation" were used to find these provisions and other emergency declarations potentially affecting the public's health.

[2] The text of the Model State Emergency Health Powers Act (MSEHPA) is available at: http://www.publichealthlaw.net/ModelLaws/MSEHPA.php. A Summary Matrix of states which have adopted provisions based on the MSEHPA is available at: https://www.networkforphl.org/_asset/80p3y7/Western-Region---MSEHPA-States-Table-8-10-12.pdf. Additionally, cited provisions have been compared to those identified in a recent statutory analysis by other researchers in this area. Lainie Rutkow, et al. *The Public Health Workforce and Willingness to Respond to Emergencies: A 50-State Analysis of Potentially Influential Laws*, 42(1) J. L. MED. & ETHICS 64, 69 (2014).

[3] Note that additional types of emergency declarations are not included if they may not relate to public health. Examples include Alabama's "Banking Emergency," authorizing the Superintendent of Banks to declare an emergency bank holiday when an emergency exists and South Dakota's "Major Grasshopper Infestation Emergency," authorizing the governor to declare an agricultural emergency pursuant to a threat of grasshopper population surge.

[4] Alaska provides for expanded public health authorities during a public health disaster, defined as a disaster emergency due to an outbreak or credible threat of an imminent outbreak of disease (ALASKA STAT. §18.15.390). However, there is no separate declaration beyond that in ALASKA STAT. § 26.23.020.

[5] Public health threats may support declaration of an emergency or disaster, and Arizona provides significant public health authority under ARIZ. REV. STAT. ANN. § 36-787(A), among other statutes, but state law does not separately authorize declaration of a specific public health emergency.

[6] California has three types of emergency: "state of war emergency," "state of emergency" and "local emergency". All are defined in CAL. GOV'T CODE § 8558.

[7] California also authorizes the director of the Department of Transportation to declare an emergency.

[8] Connecticut refers to emergencies as "Civil Preparedness Emergencies".

[9] Connecticut also authorizes the director of the Department of Transportation to declare an emergency.

[10] Hawaii refers to emergencies as "Civil Defense Emergencies".

[11] Illinois defines "public health emergencies" in 20 ILL. COMP. STAT. 3305/4 as among the circumstances supporting a declaration of "disaster". While Illinois also separately includes a statutory definition of "public health emergency" that tracks the MSEHPA in the same section, there is no provision for a separate and distinct type of declaration.

[12] Indiana lists a public health emergency as a condition supporting declaration of a disaster (IND. CODE ANN. § 10-14-3-1(b)(23)), and separately grants authority under IND. CODE ANN. § 10-14-3-19(a) for the governor or executive director to establish mobile support units to respond to a public health emergency, but does not provide for a separate declaration of "public health emergency."

[13] Iowa authorizes declaration of a public health emergency through the same authority as a "state of disaster emergency".

[14] Louisiana only authorizes parish presidents to declare local disasters or emergencies.

[15] Maine authorizes the Department of Public Health to declare a "health emergency" in the event of an actual or threatened epidemic event.

[16] Maine gives the governor separate authority to declare an "extreme public health emergency" using the disaster declaration procedure found in ME. REV. STAT. ANN. tit. 37-B, § 742(1).

[17] Maryland refers to public health emergencies as "catastrophic health emergencies".

[18] Maryland authorizes the principle executive officers of political subdivisions to declare an emergency for that area.

[19] Michigan authorizes the governor to declare a public health emergency when there is a reasonable basis to believe that a consumer product presents a threat to the public's health. The governor may order the removal and segregation of the product as well as any other limitations deemed necessary to protect the public.

[20] Michigan authorizes the governor to declare a "heightened state of alert," if there is a threat of terrorism or terrorist activity in the state. The governor may exercise all of the powers available in the event of a declared emergency.

[21] Michigan authorizes appointed emergency management coordinators of municipalities and counties to declare a local state of emergency. Additionally, if another official perceives that an emergency exists, he or she can request a declaration from the designated coordinator or governor under MICH. COMP. LAWS § 30.414.

[22] Minnesota has two types of emergency declaration: "national security emergency" and "peacetime emergency". The governor may declare a national security emergency when information from the federal government indicates a national security threat to the state. The governor may declare a peacetime emergency when there is a threat of "act of nature, a technological failure or malfunction, a terrorist incident, an industrial accident, a hazardous materials accident, or a civil disturbance [that] endangers life and property".

[23] Minnesota defines public health emergency and public health hazard (MINN. R. 4735.0100). Minnesota also grants power to the state commissioner of health "in the event of a public health emergency" to suspend terms of agreements with local boards of health regarding shared responsibility for data collection (MINN. R. 4735.0110). However, there are no specifically denoted procedures for declaring a public health emergency.

[24] Minnesota authorizes municipal officials to declare emergencies for up to 3 days before the governing body must be consulted.

[25] Mississippi defines multiple types of emergency and disaster in its statutes including "man-made emergency," "natural emergency," "catastrophic disaster," 'major disaster," "minor disaster," and "technological emergency".

[26] Montana authorizes the governor to declare an "energy emergency" when a situation exists that threatens to disrupt energy supply in a way that endangers public health and safety.

[27] Nebraska separately defines "emergency," "disaster" and "civil defense emergency," however all are declared as an "emergency" by the governor.

[28] Nebraska authorizes the executive official of a local government to declare an emergency.

[29] While the statute does not explicitly authorize municipalities to declare an emergency, the Nevada Supreme Court decided in Nylund v. Carson City (117 Nev. 913, 34 P.3d 578 (2001)) that NEV. REV. STAT. §§ 414.090 and 414.0345 should be construed to grant municipalities that authority, absent the governor's declaration of an emergency if their city code provides for such a declaration.

[30] New Jersey separately defines emergency, "war emergency" and "disaster".

[31] New Jersey authorizes the emergency management coordinators within a municipality to declare a local disaster emergency.

[32] New Mexico's governor has general authority over homeland security and emergency management, including implied authority to declare an emergency.

[33] New York authorizes declaration of the existence of an emergency in "case of great and imminent peril to the health of the general public from . . . exposure to toxic substances emanating from landfills" and authorizes the commissioner of the state health department to take measures deemed "reasonably necessary and proper for the preservation and protection of the public health" (N.Y. PUB. HEALTH LAW § 1388).

[34] North Carolina defines emergency and disaster separately and authorizes the governor only to declare a disaster after a damage assessment has been made following an emergency declaration either by the governor, legislature, local municipality, or federal government. An "emergency" is defined as "an occurrence or imminent threat of widespread or severe damage, injury, or loss of life or property resulting from any natural or man-made accidental, military, paramilitary, weather-related, or riot-related cause." Disasters are divided into three types, which are defined in N.C. GEN. STAT. § 166A-19.21.

[35] North Carolina authorizes the executive officials of counties or municipalities to declare local emergencies.

[36] While there are no specific provisions that authorize the governor explicitly, the authority is derived generally from the emergency management provisions authorizing the governor to mobilize resources.

[37] Ohio authorizes the Department of Health and Safety to declare an asbestos public health emergency in the event that a building is contaminated with asbestos and presents a threat to the public's health.

[38] Ohio authorizes the governor to declare a public health state of emergency in the event that a consumer product is or possibly is contaminated and presents a threat to the public's health.

[39] Oklahoma refers to public health emergencies as "catastrophic health emergencies".

[40] Oregon authorizes the governor or the legislature to declare an emergency, but the governor also has constitutional authority to declare a "catastrophic disaster" based on an act of terrorism, earthquake, flood, public health emergency, tsunami, volcanic eruption, or war.

[41] Bases for declaring a general emergency include "public health emergency" (R.I. GEN. LAWS § 30-15-2).

[42] South Dakota separately defines "emergency" and "disaster"; however, both can be declared by S.D. CODIFIED LAWS § 34-48A-5.

[43] South Dakota authorizes the Secretary of Health and Safety to declare a public health emergency.

[44] Tennessee separately defines emergency, "disaster," "energy emergency," "manmade emergency," "natural emergency," and "technological emergency."

[45] Texas states that the governor declares a "public health emergency" in its provision explaining physician registration.

[46] VA. CODE ANN. § 44-146.17 indicates that the governor may declare a state of emergency in response to a State Health Commissioner's issuance of quarantine orders regarding a "communicable disease of public health threat."

[47] While Washington does not explicitly authorize the governor to declare an emergency, the authority to do so is derived from the statutes regarding emergency management and the general executive authority of the governor.

[48] This authority relates primarily to public water systems.

[49] West Virginia recognizes "Emergency Circumstances That Pose a Threat to Public Health" as a basis upon which a declaration of emergency may be declared under W. VA. CODE § 15-5-6 (W. VA. CODE R. § 65-7-2(2.9)).

[50] Wisconsin uses the same provision to give the governor authority to declare an "emergency" or a 'public health emergency." Wisconsin also defines "disaster" in its emergency management section; however, there is no provision for declaring a "disaster" specifically.

[51] Wyoming does not have a specific provision that gives the governor explicit authority to declare an emergency; however, the powers provided to the governor in WYO. STAT. ANN. § 19-13-102 and WYO. STAT. ANN. § 19-13-104 are construed to give the governor such authority.

**Table 3. Public Health Emergency Declarations**

This table provides select examples of differing types of PHE declarations since 9/11/01. **Columns I** lists the date of the declaration; **II** and **III** indicate the jurisdiction covered by the declaration and issuing official; **IV** indicates the general event that necessitated the declaration; **V** indicates the amount of time elapsed between the first occurrence of the event and the issuance of the declaration; **VI** indicates the amount of time the declaration was in effect; **VII** denotes the number of individuals affected by the event necessitating the declaration; **VIII** estimates of the number of individuals affected by the declaration based on those residing in the covered jurisdiction(s) around the time of the declaration; and **IX** provides the specific title and brief description of the declaration with relevant link for more information.

| I. Date | II. Jurisdiction | III. Declared by | IV. Purpose/Reason | V. Time Between First Event and Declaration | VI. Original Duration | VII. Number Persons Affected | VIII. Number Persons Covered | IX. Declaration Description and Links |
|---|---|---|---|---|---|---|---|---|
| 9/2/05 | LA | Gov. Kathleen B. Blanco | Suspend out-of-state medical personnel licensure regulations | 5 days | 23 days | | 4,523,628 | Declaration of PHE to Suspend Out-of-State Licensure for Medical Professionals and Personnel. Due to statewide shortage of medical professionals and personnel after Hurricane Katrina, licensure regulations were suspended. La. Exec. Order No. KBB 2005-26 (Sept. 2, 2005). |
| 3/21/08 | Alamosa Cnty. (CO) | Gov. Bill Ritter | Contamination of public water supply | 7 days | 30 days | 138 cases of salmonella | 15,000 | Declaring a Disaster Emergency Due to the Contamination of the Public Water Supply in Alamosa County. PHE declared after water contamination identified as source of community-wide salmonella infection. Colo. Exec. Order No. D 006 08 (Mar. 21, 2008). |
| 5/6/08 | Pima Cnty. (AZ) | Cnty. Bd. of Supervisors | Measles outbreak | 84 days | 80 days | 4,000 exposed, 17 confirmed cases | 1,042,703 | Proclamation of the Existence of a PHE. County resolution ratified the local proclamation made on May 1, 2008. Pima Cnty. Bd. of Supervisors Res. No. 2008-107 (May 6, 2008). |

| I. Date | II. Jurisdiction | III. Declared by | IV. Purpose/Reason | V. Time Between First Event and Declaration | VI. Original Duration | VII. Number Persons Affected | VIII. Number Persons Covered | IX. Declaration Description and Links |
|---|---|---|---|---|---|---|---|---|
| 5/6/08 | Pima Cnty. (AZ) | Cnty. Bd. of Supervisors | Measles outbreak | 84 days | 80 days | 4,000 exposed, 17 confirmed cases | 1,042,703 | Proclamation of the Existence of a PHE. County resolution ratified the local proclamation made on May 1, 2008. Pima Cnty. Bd. of Supervisors Res. No. 2008-107 (May 6, 2008). |
| 8/31/08 | AL, LA, MS, & TX | DHHS Sec'y Mike Leavitt | Hurricane Gustav | Preemptive | 90 days | | 35,744,220 | PHE Declaration as a Consequence of Hurricane Gustav. Effective retroactively to 8/28/08. Declared via Public Health Service Act section 319, 42 U.S.C. § 247d. DHHS Order (Aug. 31, 2008). |
| 1/16/09 | U.S. | DHHS Sec'y Mike Leavitt | 56th Presidential Inauguration | Preemptive | 4 days | | 1,800,000 (inaugurat-ion attendance) | PHE Declaration for the 56th Presidential Inauguration. Effective January 17-21, 2009 in support of emergency actions for the Presidential Inauguration. DHHS Order No. 8 (Jan. 16, 2009). |
| 4/26/09 | U.S. | Acting DHHS Sec'y Charles E. Johnson | H1N1Outbreak | 27 days from first confirmed H1N1 case | Originally 90 days, renewed four times | | 307,006,550 | 2009 H1N1 Flu Outbreak: Determination That a PHE Exists. Declared via section 319 of the Public Health Service Act, 42 U.S.C. § 247d. DHHS Order (Apr. 26, 2009). |
| 6/17/09 | Towns of Libby and Troy (MT) | U.S. EPA Admin. Lisa P. Jackson | Release and threatened release of amphibole asbestos | 10+ years | To be determined at EPA discretion | Undetermina ble due to multiplicity of exposure routes and cumulative exposures | 3,843 | Determination and Findings of PHE for the Libby Asbestos Site in Lincoln County, MT. Declaration made under § 104(a)(4) of the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA). EPA Region 8, PHE Determination & Findings (June 17, 2009). |

| I. Date | II. Jurisdiction | III. Declared by | IV. Purpose/Reason | V. Time Between First Event and Declaration | VI. Original Duration | VII. Number Persons Affected | VIII. Number Persons Covered | IX. Declaration Description and Links |
|---|---|---|---|---|---|---|---|---|
| 1/15/10 | Black Falls and Grand Falls (Navajo Nation) | Navajo Nation Comm'n on Emergency Mgmt. | Ensure access to safe drinking water due to drinking water contamination | 5+ years | | | | Public Health State of Emergency. Declaration to ensure safe drinking water for the Navajo reservation residents after uranium contamination. Linda Robyn, *State-Corporate Crime on the Navajo Nation: State-Corporate Crime on the Navajo Nation: A Legacy of Uranium Mining Professor*, 22 INDIGENOUS POL'Y. J. 2, 13 (2011). |
| 8/11/10 | Nassau Cnty., Long Island (NY) | Cnty. Exec. Edward P. Mangano | Dramatic increase in reports of domestic violence | Approx. 6 months after the task force was commissioned | | Increase in domestic violence arrests (58%), reports (25%); child physical abuse claims (16%) | 1,341,245 | Family Violence PHE. Declaration made to help victims of domestic abuse. Press Release, Mangano Declares 'Family Violence PHE' in Nassau County (Aug. 10, 2010) (on file with Nassau Cnty. Press Office). |
| 10/5/10 | City of Oakland (CA) | Oakland City Council | Shortage of affordable, safe medical cannabis | 34 months after dispensary received a DEA alert | 2 months, most recently renewed 3/18/2014 | 2,200 medical cannabis users | 391,680 | Resolution Renewing City Council's Declaration of a Local PHE with Respect to Safe, Affordable Medical Cannabis Access in Oakland. Declaration followed DEA letter to dispensary indicating it violated federal law, exacerbating the already limited supply of safe, affordable medical cannabis. Oakland City Council. Res. No. 82994 (Oct. 5, 2010). |

| I. Date | II. Jurisdiction | III. Declared by | IV. Purpose/Reason | V. Time Between First Event and Declaration | VI. Original Duration | VII. Number Persons Affected | VIII. Number Persons Covered | IX. Declaration Description and Links |
|---|---|---|---|---|---|---|---|---|
| 1/31/11 | White Earth Reservation (White Earth Band of Ojibwe) | The White Earth Reservation Tribal Council | Abuse of prescription medication and illegal drugs | | | | 9,562 | Declaration of a PHE with Respect to Prescription Medication and Illegal Drug Abuse. Declaration made to develop solutions to problems caused by drug use and solicit assistance from state and federal agencies to combat them. The White Earth Reservation Tribal Council Proclamation (Jan. 31, 2011). |
| 2/4/11 | Marquette County (MI) | Cnty. Health Dep't | Illness due to use of designer drugs sold as "bath salts" | Approximately 5 months | Until imminent danger to health/lives deemed no longer a threat | 12 individuals admitted to the hospital over 4 weeks | 67,694 | Emergency Order to Prevent Imminent Danger to Health or Lives concerning "bath salts" sale. Declaration made to prevent specific people from selling, trading, or serving "bath salts" to remove imminent danger posed by the substance. Marquette Cnty. Health Dep't. Order (Feb. 4, 2011); *see also* CDC, *Emergency Department Visits After Use of a Drug Sold as "Bath Salts"*, 60 MMWR Rep. 19, 624 (2011). |
| 4/8/11 | ND | DHHS Sec'y Kathleen Sebelius | In anticipation of Red River flooding | Preemptive | 90 days | | 683,932 | Flooding in North Dakota: Determination That a PHE Exists. Declared via section 319 of the Public Health Service Act to ensure Medicare, Medicaid, CHIP beneficiaries still received benefits during emergency. DHHS Order (Apr. 8, 2011). |
| 5/23/11 | MO | DHHS Sec'y Kathleen Sebelius | Severe storms and tornadoes | 1 day | 90 days, renewed 3 times | | 6,010,688 | Missouri Tornadoes: Determination That a PHE Exists. Declared via section 319 of the Public Health Service Act to ensure Medicare, Medicaid, CHIP beneficiaries still received benefits during emergency. DHHS Order (May 23, 2011). |

| I. Date | II. Jurisdiction | III. Declared by | IV. Purpose/Reason | V. Time Between First Event and Declaration | VI. Original Duration | VII. Number Persons Affected | VIII. Number Persons Covered | IX. Declaration Description and Links |
|---|---|---|---|---|---|---|---|---|
| 7/1/11 | FL | Dep't of Health, directed by Fla. Legislature | Prescription drug abuse related deaths | | 60 days | 7 prescription drug abuse deaths per day | 19,057,542 | Declaration of PHE. The order was executed by the state surgeon general. The order enforced proper disposal of controlled substance inventory and required some practitioners to make their premises available for inspection. Fla. Dep't. of Health Order (July 1, 2011). |
| 3/9/12 | County of Hawai'i (HI) | Cnty. Council | Food insecurity | | 60 days | 16% of residents and 26.6% of children <18 residing there | 189.191 | An Emergency Ordinance That Finds and Declares That a PHE Exists and Makes an Emergency Appropriation of $200,000 to Alleviate Hunger in the County of Hawai'i. Declaration based upon 16% of residents lacking food security. Cnty. of Haw. B. No. 199. |
| 8/9/12 | Dallas Counnty (TX) | Judge Clay Jenkins | West Nile Virus Outbreak | 50 days from first confirmed case of West Nile Virus | | 9 fatalities, more than 100 hospitalized | 2,453,843 | PHE declared to help control mosquito populations, address the crisis. Declaration enabled access to state and federal mosquito control funds. *West Nile Crisis: Public Health Emergency*, Mosquito Cont. Mag., Summer 2013, at 8. |
| 1/7/13 | Admin. Bldg. Two (Navajo Nation) | Navajo Nation Comm'n. on Emergency Mgmt. | Significant mold levels found within the bldg. | 11 days from ordered bldg. closure | 6 mo. | Approx. 200 workers at risk from continued exposure | 200 | Public Health State of Emergency for Navajo Nation Tribal Administration Building Number Two. Declaration went into effect to protect the health of Navajo citizens and Navajo Nation employees regarding Administration Building Two. Press Release, The Navajo Nation, Navajo President Signs Resolution Creating Health Emergency for Administration Building Two (Jan. 7, 2013) (on file with author). |

| I. Date | II. Jurisdiction | III. Declared by | IV. Purpose/Reason | V. Time Between First Event and Declaration | VI. Original Duration | VII. Number Persons Affected | VIII. Number Persons Covered | IX. Declaration Description and Links |
|---|---|---|---|---|---|---|---|---|
| 8/15/13 | Pondera County (MT) | Cnty. Disaster/ Emerg. Serv. | Water contamination | Declared same day septic contamination was discovered | | 200 residents | 6,211 | PHE declared to address immediate sanitation and drinking water needs of residents in the City of Brady. Declaration made after high concentrations of biological contaminants detected in the Brady water supply to provide for the sanitation and drinking water needs of affected residents. Water Pol'y Interim Comm. Ex. 11 (Sept. 9, 2013). |
| 3/27/14 | MA | Gov. Deval Patrick | Opioid addiction epidemic | | 60 days | At least 140 deaths over the preceding several months | 6,692,824 | PHE Declaration. Declaration made to combat overdose, prevent its escalation, and aid in addict recovery. Press Release, Deval Patrick, Governor Patrick Declares PHE, Announces Actions to Address Opioid Addiction Epidemic (Mar. 27, 2014) (on file with Mass. Press Office). |

**Table 4. Select Examples of Emergency Waivers of Statutes, Rules or Regulations**

This table provides examples of waivers of legal authorities during declared emergencies. **Columns I** lists the state in which the emergency was declared; **II** lists the date of the emergency declaration; **III** denotes the duration of the declaration; **IV** specifies which statute, rule, or regulation was waived during the emergency; and **V** describes the nature and reasoning concerning the waiver.

| State | Date | Duration | Legal Authority | Description |
|---|---|---|---|---|
| **LA** | 6/4/10 | 30 days | LA. REV. STAT. ANN. § 29:766(D)(1) (2006). | Governor suspended state licensure laws to allow out-of-state EMTs to provide services in LA after Deepwater Horizon oil spill. |
| **MD** | 11/6/09 | 90 days | MD. CODE ANN., PUB SAFETY § 14-107(d)(1)(i) (West 2014). | Governor eased scope of practice, allowing EMTs to provide public vaccinations during H1N1 pandemic to increase public access to vaccinations. |
| **MA** | 3/27/14 | Ongoing | MASS. GEN. LAWS ANN. ch. 17, § 2A (West 1965). | Governor eased scope of practice, allowing first responders to carry and administer naloxone to counteract opiate overdoses. |
| **MN** | 2/7/14 | 29 days | MINN. STAT. ANN. § 12.21 subd. 3(1) (West 2003). | Governor suspended hours of service regulations to allow fuel drivers and carriers to bring fuel to areas affected by a shortage during a cold spell. |
| **NY** | 10/26/12 | 60 days | N.Y. EXEC. LAW § 29-a(1) (McKinney 2012). | Governor eased scope of practice, allowing pharmacists to dispense controlled substances 7 days prior to when the supply was expected to run out if their former supply was destroyed by Hurricane Sandy. |
| **NY** | 10/26/12 | 90 days | N.Y. EXEC. LAW § 29-a(1) (McKinney 2012). | Due to Hurricane Sandy, Governor eased scope of practice so federal security officers could have the same powers as federal officers and carry guns if permitted to do so in another state. |
| **ND** | 5/31/11 | 30 days | N.D. CENT. CODE ANN. § 37-17.1-05(6)(a) (West 2013). | Governor suspended state licensure laws to allow out of state health care providers and ambulance services to provide treatment and transportation in response to flooding. |

| State | Date | Duration | Legal Authority | Description |
|---|---|---|---|---|
| **TN** | 2/14/08 | 46 days | TENN. CODE ANN. § 58-2-107(e)(1) (West 2013). | Governor allowed vehicles carrying emergency equipment, services, or supplies in response to severe storms and tornadoes to carry amounts in excess of legal restrictions. |
| **TN** | 8/31/08 | 30 days | TENN. CODE ANN. § 58-2-107(e)(1) (West 2013). | After Hurricane Gustav, Governor allowed: (1) out-of-state health care providers to practice within Tennessee; (2) pharmacists to dispense a 30-day prescription without authorization; and (3) individuals authorized to practice medicine to provide prescriptions without charge. |
| **TX** | 5/16/14 | 30 days | TEX. GOV'T CODE ANN. § 418.016(a) (West 2013). | Governor generally suspended any laws, rules, or regulations that may inhibit or prevent prompt response to wildfires. |
| **FED** | 10/23/09 | 241 days | 42 U.S.C.A. § 1320b-5 (West 2006). | DHHS Secretary delegated authority to CMS administrator to determine waivers for specific providers, a group of providers, or a geographic area on a case-by-case basis during the H1N1 outbreak. |

## Table 5. State Liability Protections

This table lists select examples of state laws providing immunity from civil liability that may apply to EMS professionals during a declared emergency. **Columns I** includes laws that specifically protect EMS professionals in the course of their normal duties; **II** lists Good Samaritan provisions that protect persons providing care at the scene of an emergency and may apply to EMS professionals in some jurisdictions; and **III** provides state laws that immunize volunteers, often limited to those who are part of coordinated response efforts.

| State | I. EMS Protection Laws | II. Good Samaritan Laws | III. Volunteer Protection Laws |
|---|---|---|---|
| **AZ** | ARIZ. REV. STAT. ANN. § 26-314(A)-(C). | ARIZ. REV. STAT. ANN. § 32-1471. | ARIZ. REV. STAT. ANN. § 12-982. |
| **CA** | CAL. HEALTH & SAFETY CODE § 1799.108; § 1799.106; § 1799.104(b). | CAL. BUS. & PROF. CODE § 2395-96. | CAL. GOV'T CODE § 50086; CAL. CIV. CODE § 1714.2. |
| **DE** | DEL. CODE ANN. tit. 16, § 9813. | DEL. CODE ANN. tit. 16, § 6801. | DEL. CODE ANN. tit. 10, § 8133, 8135. |
| **FL** | FLA. STAT. ANN. § 408.45; FLA. STAT. ANN. § 768.13(2)(b). | FLA. STAT. ANN. § 768.13. | FLA. STAT. ANN. § 768.1355. |
| **GA** | GA. CODE ANN. § 31-11-8. | GA. CODE ANN. § 51-1-29; § 51-1-29.1. | GA. CODE ANN. § 51-1-29.1 |
| **IA** | IOWA CODE ANN. § 147A.10. | IOWA CODE ANN. § 613.17. | IOWA CODE ANN. § 669.24. |
| **IL** | 210 ILL. COMP. STAT. ANN. 50/3.150. | 745 ILL. COMP. STAT. ANN. 49/70. | 745 ILL. COMP. STAT. ANN. 49/68; 49/67. |
| **IN** | IND. CODE ANN. § 16-31-6-1; § 16-31-6-3. | IND. CODE ANN. § 34-30-12-1. | IND. CODE ANN. § 34-30-13-1; § 34-30-13.5-1. |
| **LA** | LA. REV. STAT. ANN. § 40:1233. | LA. REV. STAT. ANN. § 37:1731. | LA. REV. STAT. ANN. § 29:791. |
| **MA** | MASS. GEN. LAWS ANN. ch. 111C, § 20-21. | MASS. GEN. LAWS ANN. ch. 112, § 12V. | MASS. GEN. LAWS ANN. ch. 112, § 12V. |
| **ME** | ME. REV. STAT. ANN. tit. 32, § 93. | ME. REV. STAT. ANN. tit. 24, § 2904; ME. REV. STAT. ANN. tit. 14, § 164. | ME. REV. STAT. ANN. tit. 14, § 158-A. |
| **MN** | MINN. STAT. ANN. § 145C.11. | MINN. STAT. ANN. § 604A.01. | MINN. STAT. ANN. § 317A.257. |

| State | I. EMS Protection Laws | II. Good Samaritan Laws | III. Volunteer Protection Laws |
|---|---|---|---|
| **ND** | N.D. CENT. CODE ANN. § 23-27-04.1. | N.D. CENT. CODE ANN. § 32-03.1-02; § 23-27-04.1. | N.D. CENT. CODE ANN. § 32-03-45; § 10-33-48. |
| **NE** | NEB. REV. STAT. ANN. § 38-1232. | NEB. REV. STAT. ANN. § 25-21,186. | NEB. REV. STAT. ANN. § 35-107. |
| **NY** | Common Law Doctrine of Governmental Immunity. | N.Y. PUB. HEALTH LAW § 3000-a, 3013. | N.Y. PUB. HEALTH LAW § 3013; N.Y. UNCONSOL. LAW § 9193. |
| **SC** | S.C. CODE ANN. § 15-78-120; § 15-78-60(6). | S.C. CODE ANN. § 15-1-310. | S.C. CODE ANN. § 8-25-40(2). |
| **TN** | TENN. CODE ANN. § 68-140-312. | TENN. CODE ANN. § 63-6-218. | TENN. CODE ANN. § 63-6-708. |
| **TX** | TEX. HEALTH & SAFETY CODE ANN. § 773.009. | TEX. CIV. PRAC. & REM. CODE ANN. § 74.151. | TEX. CIV. PRAC. & REM. CODE ANN. § 74.151. |
| **VA** | VA. CODE ANN. § 8.01-195.3; § 8.01-225.01; § 8.01-225.02. | VA. CODE ANN. § 8.01-225. | VA. CODE ANN. § 2.2-3605. |
| **WA** | WASH. REV. CODE ANN. § 18.71.210. | WASH. REV. CODE ANN. § 4.24.300. | WASH. REV. CODE ANN. § 38.52.180. |