UNRESOLVED ISSUES IN DISASTER PLANNING FOR HOSPITAL CLIENTS

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According to an old proverb, "He who fails to plan, plans to fail." When it comes to disaster planning, the health care industry cannot afford to fail. The events of September 11, 2001 and, more recently, the aftermath of Hurricane Katrina have made hospitals and others keenly aware of the importance of planning for unexpected disaster situations.

While businesses of all types are embracing the concept of "disaster planning" to avoid disruption of business activities, hospitals have the added burden of being expected to participate in community planning on a local, state, or national level. Because they work in one of the most heavily regulated industries in the country, hospitals must also comply with many stringent regulations governing the industry. When the uncertainty regarding liability in a disaster response situation, as well as the uncertainty of reimbursement for services provided in an unconventional manner or environment is added, disaster planning becomes an even more daunting task. Lawyers play an important role in assisting their health care clients with navigating regulatory issues, avoiding increased liability, and negotiating reimbursement for services provided during a potential disaster.

Participation in community response plans is a requirement for hospitals accredited by The Joint Commission[1] and is also a condition for receiving certain funds from the federal government. Each year the Health Resources and Services Administration ("HRSA") sets aside money for state grants to fund state-wide disaster preparedness efforts.[2] A condition of the state receiving these funds is based on the development of Memoranda of Understanding ("MOU"s) among health care entities to define relationships and organize a response for an emergency.[3] Although these MOUs are "voluntarily", hospitals may be pressured by the state to sign on as a condition for receiving equipment and/or training provided through the HRSA funds.

These MOUs generally contemplate activation of the Modular Emergency Medical System ("MEMS"),[4] a concept developed by the Department of Defense to handle biological warfare incidents. A key component of the MEMS is the development of Acute Care Centers ("ACC"), which are facilities or buildings (for example, a school gymnasium or community hockey rink) temporarily used to collect, treat, and triage casualties during an epidemic or other prolonged emergency situation with mass casualties. In documents related to the MEMS, the Department of Defense contemplates that an ACC will serve as an extension of an existing hospital.[5] Requiring one hospital to take the "lead" in operating an ACC is logical. However, as more fully explained below, certain legal and financial risks have caused hospitals to express concerns about the responsibility of treating the ACC as an "extension" of its facility.

Although many hospitals are eager to be team players and to receive the equipment or training offered by the state, hospitals should consult with their attorneys when negotiating terms of MOU agreements and carefully consider the legal ramifications associated with providing care in the type of environment contemplated by the MEMS.

OSHA Issues

In many instances, an MOU may require hospitals to share employees with another hospital or send employees to an ACC. In these situations, employers will want to take precautions to ensure that they are not being asked to send their employees into a situation with conditions that present workforce hazards in violation of Occupational Safety and Health Administration ("OSHA") standards.

To plan for OSHA compliance, hospitals should address OSHA standards when entering into MOUs with other facilities. Hospitals that are expected to send employees to other hospitals and/or ACCs will want assurances that the facilities to which their employees are being deployed will be operated in accordance with the "OSHA Best Practices for the Protection of Hospital-Based First Receivers of Victims from Mass Casualty Incidents Involving the Release of Hazardous Substances." The OSHA "Best Practices" address the appropriate assessment of the hazard, the use of appropriate personal protective equipment ("PPE"), proper procedures for decontamination of victims, and appropriate training of personnel who will be first receivers.[6] For hospitals that may be responsible for operating the ACC and ensuring such compliance, however, this is a troublesome issue. Specifically, hospital leaders have valid concerns regarding the extent to which stockpiles of PPE will be adequate to appropriately supply the ACC workers for the duration of the emergency, especially in light of the shortages of appropriate masks that were seen in Canada during the SARS epidemic.[7]

HIPAA Privacy Issues

In the wake of a disaster, health care providers, first responders, and public health officials must communicate with each other regarding the identification of potential victims, as well as the triage and transfer of patients to hospitals or off-site triage and treatment centers. Some hospitals have voiced concern that

the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule would create barriers to sharing patient information as necessary to implement disaster response plans. It is important for attorneys to counsel their clients regarding the various exceptions to the HIPAA Privacy Rule that would allow for disclosures of protected health information in a disaster situation.

The HIPAA Privacy Rule generally allows disclosures of protected health information without a patient's authorization for the purposes of treatment, payment, or health care operations. Because the disclosures of patient information for those patients transferred to an ACC would be considered disclosures for "treatment" purposes, they would clearly be permissible. The HIPAA Privacy Rule also allows disclosures to government agencies and disaster relief organizations for the purpose of notifying family members of an individual's location.[8]

In addition, the HIPAA Privacy Rule contains several useful exceptions for a bioterrorism or other infectious outbreak emergency. Specifically, disclosures of protected health information are permissible if made to a "public health authority" authorized by law to collect or receive such information for "preventing or controlling disease" or "to avert an imminent threat to health or safety."[9]

Credentialing Issues

Hospitals may also have concerns regarding the use of physicians and other providers who have not been properly credentialed through the hospital's formal credentialing process. To address this concern, the Joint Commission has implemented two new standards to address emergency credentialing of "disaster privileges" for volunteer practitioners. HR 1.25 addresses the assignment of disaster job responsibilities to volunteer practitioners, while HR 4.35 addresses the assignment of disaster privileges to such volunteer practitioners. Specifically, HR 4.35 requires hospital leaders to 1) assign an individual who will be responsible for granting disaster privileges; 2) document this individual's responsibilities; and 3) document the mechanism for overseeing such volunteers. Privileges may be granted upon presentment of a valid picture ID and any of the following:

- A current picture hospital or health care organization ID card;
- A current license to practice;
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team ("DMAT"), Medical Reserve Corps ("MRC") Emergency System for Advance Registration of Volunteer Health Professionals ("ESAR-VHP") or other recognized state or federal organizations or groups;
- Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity);
- Presentation by current organization staff member(s) with personal knowledge regarding the practitioner's identity.

The hospital's leaders must initiate primary source verification of licensure and competence as soon as the immediate situation is under control. This verification is not to exceed 72 hours unless communication capabilities are disrupted so as to make verification impossible.[10]

The establishment of the ESAR-VHP is a tool that can facilitate emergency verification of credentials. The ESAR-VHP is a system of state data bases that will include verifiable, up-to-date information regarding the identity, licensing, credentialing, accreditation and privileges of volunteer health care workers.[11] The ESAR-VHP was created in 2004 as another mandate of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002. Like the implementation of MOUs, the development of an ESAR-VHP system is a requirement for a state to receive National Bioterrorism Hospital Preparedness Program ("NBHPP") grants (see footnote 2).

While the ESAR-VHP is useful for credentialing those individuals who volunteer and register before a disaster, there may be situations where a hospital is obligated through MOUs to send individuals to assist at other hospitals or ACCs as employees, rather than volunteers. In these situations, hospitals that are parties to the MOU should include provisions for verifying credentials of such employees.

Vaccination/Worker's Compensation Issues

Also of concern for health care employers are issues related to smallpox vaccination. It is expected that individuals who volunteer or are recruited to be part of an emergency bioterrorism response team will be vaccinated for illnesses such as smallpox.

The Smallpox Emergency Personnel Protection Act of 2003[12] authorized the Secretary of Health and Human Services to establish the Smallpox Vaccine Injury Compensation Program to compensate emergency responders, including health care workers, for injury or death related to the smallpox vaccination.[13] However, this legislation fails to address many other vaccination concerns of health care institutions. One such concern is the possibility that vaccine recipients might infect immuno-compromised patients during the time period after the vaccination. One possible solution is to quarantine health care workers for a time following the administration of the smallpox vaccination. However, this raises obvious concerns of staffing shortages and compensation of the employee during the quarantine period.

EMTALA Issues

The diversion of patients to other hospitals or off-site facilities also raises concerns regarding compliance with the Emergency Medical Treatment and

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Labor Act ("EMTALA"),[14] which requires all hospitals with emergency departments to provide a medical screening examination and prohibits such hospitals from refusing to examine or treat individuals with an emergency medical condition.

The Centers for Medicare and Medicaid Services ("CMS") addresses this issue in its State Operations Manual for Participating Hospitals. Specifically, the manual provides that " . . . in the event of a national emergency or crisis (e.g. bioterrorism), State or local governments may develop community response plans that designate specific entities (hospitals, public health facilities, etc.) with the responsibility of handling certain categories of patients during these catastrophic events."[15] The manual notes that hospitals remain responsible for providing a medical screening examination upon request of the patient; however, transfer or diversion of the patient in accordance with the plan would not result in EMTALA sanctions against the transferring hospital.

Liability Issues

Unfortunately, hospitals must also consider liability implications associated with participating in disaster response plans. Many states have statutes that protect disaster workers if certain conditions are met. However, some statutes only protect volunteers; others are limited to governmental workers. This can leave hospitals and other private employers vulnerable to malpractice lawsuits, especially where they are bound by MOUs to oversee the operation of ACCs or to send their employees into less than optimal conditions to provide patient care. Health care employers should check with their liability insurance carriers to determine whether employees would be covered in an ACC setting or whether employees "borrowed" from other institutions would be covered.

If hospitals do not believe that their state's statutes provide for adequate immunity, they should consider organizing and lobbying for legislative amendments that will better protect health care workers and their employers from liability when responding to a disaster situation.

Reimbursement Issues

One of the most difficult issues to resolve during the disaster planning process is the issue of reimbursement, especially with regard to services provided in an ACC as contemplated by the MEMS plan. An ACC, standing alone, does not have a provider number to bill Medicare, nor is it recognized as a participating facility by other third party payors. If a hospital takes the lead in operating an ACC, it is possible that the hospital may be able to treat the ACC as a temporary off-site facility, billing services under the hospital's provider number. In addition, ambulances might be more likely to be reimbursed since they would be transporting patients from the disaster to the extension of a hospital. However, there is no clear guidance on this subject from CMS or other third party payors.

The Federal Emergency Management Agency ("FEMA") is a funding option, but is a payor of last resort. If no other funding sources are available, FEMA will theoretically compensate health care entities for "extraordinary costs" related to a disaster, such as the need for additional employees to assist with evacuation efforts.[16] However, with regard to ACCs, it is unclear which entity would be responsible for requesting FEMA funds. While it may make sense for one hospital to take the lead in operating an ACC, many hospitals are reluctant to accept this responsibility if funding has not been worked out. MOUs should set forth the process by which funding will be secured and allocate losses among the participating providers if such funding cannot be obtained.

Conclusion

Attorneys should advise their health care clients to have all MOUs reviewed by legal counsel prior to signature. They should also be involved with negotiating third party payor reimbursement issues and approaching the legislature as appropriate to remove barriers to disaster response. Although there are no easy answers with regard to some of the legal issues presented, MOUs should be structured to protect providers from liability to the greatest extent possible and provide the greatest opportunities for reimbursement for services provided during a disaster.

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Endnotes

1 The Joint Commission, Comprehensive Accreditation Manual for Hospitals, Standard E.C. 4.10.

2 These grants are the result of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 which was enacted by Congress in response to threats of bioterrorism and public health emergencies. The National Bioterrorism Hospital Preparedness Program ("NBHPP") provides funding in the form of grants to state health departments with the intention that the funds will be used to prepare hospitals and supporting health care systems to deliver coordinated and effective care to victims of terrorism or other public health emergencies. *See* www.hrsa.gov/bioterrorism/.

3 *See e.g.*, HRSA National Bioterrorism Hospital Preparedness Program ("NBHPP") Guidance, CFDA 93.889 available in archives at https://grants.hrsa.gov/webexternal/fundingOpp.asp

4 "Modular Emergency Medical System, Expanding Local HealthCare Structure in a Mass Casualty Terrorism Incident", Prepared by the Department of Defense, June 1, 2002.

5 *Id.* at p. 9.

6 The "Best Practices" can be found on the OSHA website, at *http://www.osha.gov/SLTC/emergencypreparedness/responder.html.*

7 "Ontario Tightens Hospital Rules to Fight SARS", CBC News, March 30, 2003, *http://www.cbc.ca/canada/story/2003/03/29/sars_ontario030329.html.*

8 45 CFR §164.510.

9 45 CFR §164.512.

10 Joint Commission for the Accreditation of Healthcare Organizations, Comprehensive Accreditation Manual.

11 Emergency System for Advance Registration of Volunteer Health Professionals, Legal and Regulatory Issues, available on the HRSA website at: *ftp://ftp.hrsa.gov/bioterror/May_06_Legal_Report.pdf.*

12 P.L. 108-20 (2003).

13 42 U.S.C. §239 *et. seq.*

14 42 USC 1395dd

15 CMS State Operations Manual for Participating Hospitals, Appendix V, available at http://cms.hhs.gov/manuals/Downloads/som107ap_v_emerg.pdf.

16 *See* FEMA Policy No. 9525, available at *http://www.fema.gov/government/grant/pa/9525_4.shtm.*

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***The Health Lawyer* invites comments from its readers. Reader comments will be published from time to time, especially where comments provide additional insights into topics previously addressed in *The Health Lawyer*. To help assure editorial notice, please submit your comments to Marla Durben Hirsch, Esq., Editor, at MDHirsch@Comcast.net.**

Our April 2007 issue (Vol. 19, no 5, p.42) included an article by James Kim, entitled "Governor Schwarzenegger's Proposal for Universal Health Care: A Policy-Based and Legal Analysis." *The Health Lawyer* wishes to clarify that footnote 20 is missing the word "neither" and should read instead as follows:

> U.S.C. § 1144(b)(2)(B) (2000) (stating that "neither an employee benefit plan described in section 1003(a)... shall be deemed to be an insurance company...for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies").

The Health Lawyer thanks Alan Rachlin, Principal Attorney, New York State Insurance Department, for pointing out this error.