

Emergency Volunteer Management

Planning Considerations and Resources

Integrating Emergency Volunteers for Medical Surge



June 2018



Mission to Care. Vision to Lead.

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Acknowledgements

This document identifies key planning and operational considerations for managing emergency volunteers. It includes a planning checklist, templates, guidance, and resources for integrating emergency volunteers during a medical surge event.

The Florida Hospital Association (FHA) expresses deep appreciation to the Iroquois Health Care Association, the Health Care Association of New York State and the Central New York Health Emergency Preparedness Coalition for their sharing of this information.

This information is based on a 2012 document titled “Integrating Emergency Volunteers During Medical Surge: Hospital Checklist” which was developed by Iroquois Health Care Association and the Health Care Association of New York State.

Specific sources are listed at the end of this document.

Assess Resource Needs

- **Identify situations that would necessitate the health care facility's need for emergency volunteers.**
 - **Identify the health professional roles and numbers of volunteers needed in identified situations.**
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Determine Volunteer Roles

- **Consider how volunteers may be used to augment basic clinical care, allowing health care facility clinical staff to provide advanced care.**
 - **Assess how existing health care facility volunteers may augment non-clinical staff.**
 - **Determine the tasks that clinical volunteers will perform** (i.e. take vitals, but not detailed primary assessments). Volunteers will need to be provided a written job description, on-the-job training, assignment, and supervision accordingly.
 - Develop job descriptions for clinical emergency volunteers and non-clinical emergency volunteers.
 - Develop job action sheets for emergency volunteers. Attach job action sheets to position descriptions.
 - **Determine whether the health care facility will accept unaffiliated volunteers in during an emergency.** Unaffiliated volunteers may present to offer aid. If unaffiliated volunteers will be accepted, determine how they will be screened, assigned, and supervised, and reference them accordingly.
-

Consult with Volunteer Deployment Organizations

- **Review volunteer management functions with deploying organizations prior to an event** (see 2017-2022 HPP - PHEP Cooperative Agreement and 2017-2022 Health Care Preparedness and Response Capabilities sections).

- **Conduct appropriate assessment and planning with deployment organizations** to ensure the health system's ability to:
 - Coordinate volunteers;
 - Notify volunteers;
 - Organize, assemble, and dispatch volunteers; and,
 - Demobilize volunteers.
-

Review Standards, Regulations, Legal and Liability Issues

- **Review and ensure compliance with related standards, regulations and guidance** (see Standards and Requirements Relating to Volunteer Management section for references, document links and detailed information):
 - CMS Conditions of Participation
 - 2017-2022 HPP – PHEP Cooperative Agreement
 - 2017-2022 Health Care Preparedness and Response Capabilities
 - NFPA 99 Health care Facilities Code
 - NFPA 1600 Standard on Disaster/Emergency Management and Business Continuity
 - Legal Authorities
- **Ensure compliance with employment requirements (e.g., immunization requirements) and training on standard employment practices (e.g., HIPAA training).**
- **Determine what, if any, legal or regulatory issues could interfere with use of volunteers.**
- **Assess malpractice and other insurance coverage for volunteers within the health care facility.**
- **Consider federal legal protections which may apply to volunteers**, including applicable declarations under:
 - Public Readiness and Emergency Preparedness Act¹;

¹ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response. (May 10, 2017), Public Readiness and Emergency Preparedness Act. Available at: <https://www.phe.gov/Preparedness/legal/prepact/Pages/default.aspx>

- Volunteer Protection Act²; and,
- State legal protections (e.g., Florida Statute Title X Public Officers, Employees and Records, Chapter 110 – State Employment, Part IV – Volunteers, §110.501-110.504)³.

Develop Plans and Policies

- **Position Descriptions and Job Action Sheets** - Develop a written position description and job action sheets for clinical emergency volunteers and non-clinical emergency volunteers. Attach job action sheets to position descriptions.
- **Emergency Volunteer Policies and Procedures Handbook** - Review and update (or create) an Emergency Volunteer Policies and Procedures Handbook based on the facility's emergency management plans, emergency volunteer management policies and procedures and all applicable health care facility employee policies and procedures.
- **Emergency Volunteer Coordinator** - Assign the person(s) who will serve as Volunteer Coordinator per HICS. This position may be assigned the following responsibilities:
 - Develop a written position description for clinical emergency volunteers and non-clinical emergency volunteers.
 - Develop job action sheets for jobs likely to be activated, and for emergency volunteers to assume. Attach job action sheets to position descriptions.
 - Assist with development of volunteer training.
 - Maintain staff and planned volunteer contact list.
- **Emergency Volunteer Management Center** - Develop plans for establishing an Emergency Volunteer Management Center during an event in which emergency volunteers are requested or present spontaneously. The Center should be set-up in a safe location based on incident conditions, away from patient treatment areas, and be sufficient to provide for the following:
 - **Registration** – Volunteers should be directed to report to the Volunteer Staging Area. Each Volunteer should complete and sign an application to serve as an emergency volunteer (see Emergency Volunteer Privileges Application Template section).

² 105th Congress. (June 18, 1997). Volunteer Protection Act of 1997, PL 105-19, 42 USC § 14501. Available at: <https://www.gpo.gov/fdsys/pkg/PLAW-105publ19/pdf/PLAW-105publ19.pdf>

³ Online Sunshine. 2018 Florida Statutes, Florida Statute Title X Public Officers, Employees and Records, Chapter 110 – State Employment, Part IV – Volunteers, §110.501-110.504. Available from Online Sunshine at: http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0100-0199/0110/0110ContentsIndex.html&StatuteYear=2018&Title=%2D%3E2018%2D%3EChapter%20110

- **Identification** - Each Volunteer must provide a government-issued ID (such as a driver's license or passport) and at least one of the following identification items:
 - Current employer or health care facility picture identification card that clearly identifies professional designation;
 - A current license, certification or registration at the level at which privileges are requested;
 - Primary source verification of licensure, certification or registration;
 - Identification as a member of a Disaster Medical Assistance Team (DMAT) or Medical Reserve Corps (MRC), or Public Health Service Commissioned Corps;
 - Identification demonstrating registration with an Emergency System for the Advance Registration of Volunteer Health care Professionals (ESAR-VHP) or with other recognized disaster assistance state or federal organizations or groups;
 - Other identification, demonstrating that the Volunteer has been granted authority to render patient care, treatment and services in disaster circumstances, including licensure designation; and,
 - Identification by a health care facility employee or medical staff member who possesses personal knowledge regarding the Volunteer's competence and qualifications.

The Volunteer Staging Area Leader or designee should provide the medical staff office a copy of all the identification materials, provided by the Volunteer.

The medical staff office should:

- Document that it has received and reviewed all identification materials provided by the volunteer; and,
 - Advise the health care facility's Administrator or the designee regarding the information provided and obtain from the Administrator approval or disapproval of the privileges requested.
- **Orientation** - Develop and implement an orientation plan for emergency volunteers (see Orientation Template).
 - **Training** - Develop training material for emergency volunteers (see training section).
 - **Assignment** - The Volunteer Staging Area Leader should coordinate all assignments with the health care facility Incident Commander or designee.

- **Credentialing and Privileging** - Review and update the health care facility's credentialing and privileging policies and process for verifying volunteer licenses, registrations, or certificates (see Credentialing and Privileges Guidelines section and Emergency Volunteer Privileges Application template). Key components of the Disaster Privileging Process include:
 - Maintaining the integrity of the usual process for determining qualifications and competence. The primary components of which include:
 - Verification of licensure;
 - Certification or registration required to practice a profession; and,
 - Oversight of care, treatment, and services provided.
 - Primary source verification of licensure, certification, or registration should begin immediately or as soon as the situation permits. The medical staff office should complete a primary source verification of the individual's license, certification, or registration, verification of current competency and primary source verification within 72 hours from the time the volunteer presents to the health care facility.
 - Volunteer Physicians and Allied Health care Practitioners that are granted disaster privileges shall be subject to oversight, assessment, and verification of their professional competence through the Medical Staff and according to health care facility policy. Oversight, assessment, and verification should include direct supervision, observation or monitoring, retrospective review, or other appropriate means.
 - After completion of the preceding steps and/or a review of documents obtained through Primary Source Verification and the completion of the Criminal Background Check, the medical staff office shall indicate on the Application that the Volunteer has been approved or disapproved for service at the health care facility.
- **Establish Expedited Disaster Privileges Procedures** - In exceptional circumstances, expedited disaster privileges may be granted immediately - prior to completing other steps of the process - to members of a Disaster Medical Assistance Team (DMAT), National Disaster Medical Service (NDMS), Medical Reserve Corps (MRC), Public Health Service Commissioned Corps personnel (PHS), or Stafford Act Temporary Disaster Employees (see Credentialing and Privileging Guidelines, Section B. Expedited Disaster Privileging Procedures).

Training

- **Develop and implement internal awareness-training programs for health care facility staff** regarding the use of emergency volunteers and planned volunteers during emergency events.

- **Develop and implement an orientation plan for emergency volunteers.** (See Orientation Template).
- **Develop training material for emergency volunteers.** Training material may include:
 - Incident objectives, volunteer role to which they are assigned, and the chain of command;
 - Job specific training for volunteers to perform required tasks, including job description and job action sheet;
 - Logistical, medical and mental health support services available to volunteers including applicable liabilities related to the incident and the volunteer's role; and,
 - Use of the computer systems, electronic prescribing, and electronic medical record capabilities, and, as appropriate, user identification name, and password for electronic systems.

Assignment and Supervision

- **List of Approved Volunteers** - A list of approved volunteers, including those who have been granted disaster privileges, should be maintained by the medical staff office and be sent to the appropriate departments. The Volunteer Staging Area Leader or designee may accept the volunteer assistance as needed.
- **Identification** - The health care facility shall issue each volunteer a photo identification card identifying the individual as a volunteer and indicating the volunteer's level of licensure. If the health care facility is unable to issue photo identification cards, it should adopt an alternate means of identifying approved volunteers and issue such identification to each volunteer.

Volunteers should be required to prominently display proper volunteer identification at all times.

- **Assignment** - Each volunteer shall be assigned to a specific role to provide services as needed and appropriate based on the approved competency and qualification of the volunteer. The Volunteer Staging Area Leader or designee should indicate the assignment of the volunteer and the name and title of the individual to whom the volunteer is to report (see Part E and Part F of the Emergency Volunteer Privileges Application template).
- **Supervision** - The assigned supervisor's responsibilities for supervising the volunteer include:
 - Providing any further orientation and training required for the position that the volunteer will be filling and, after the assignment of responsibilities, signing an application indicating approval of scope of practice;

- Monitoring the competencies and scope of practice of the volunteer through observation, mentoring, chart review, and debriefings. Any adjustments and/or limitations on scope of practice with respect to the core competencies, consistent with the volunteer's licensure level, should be noted on the Application; and,
- Monitoring the physical and emotional well-being of the volunteer and confirming that the volunteer has received any health screenings and immunizations required by health care facility policy within 72 hours of deployment unless this requirement has been waived by the health care facility Incident Command, upon consultation with Infection Control or Employee Health.

Incident Management

- **Review HICS volunteer management assignments under Operations, Planning, and Logistics Sections.** Tasks for key positions include:
 - **Labor Pool & Credentialing Unit Leader**
 - Implement the facility's emergency credentialing standard operating procedure when volunteers present;
 - Establish a credentialing desk in the Labor Pool area;
 - Initiate intake and processing procedures for affiliated and, if accepted, unaffiliated volunteers presenting to the facility;
 - Record information on the Volunteer Staff Registration form (HICS Form 253);
 - Obtain assistance from the Security Branch Director in the screening and identification of volunteer staff; and,
 - Monitor and evaluate the effectiveness of the emergency credentialing standard operating procedure.
 - **Staff Health & Well-Being Unit Leader**
 - Assess current capability to provide medical care and mental health support to staff members including emergency volunteers;
 - Project immediate and prolonged capacities to provide services based on current information and situation;
 - Ensure staff are using recommended Personal Protective Equipment (PPE) and following other safety recommendations;

- Implement staff prophylaxis plan if indicated;
 - Prepare for the possibility that a staff member or their family member may be a victim and anticipate a need for psychological support;
 - Assign mental health personnel to evaluate staff needs; and,
 - Ensure that staff and volunteer health and safety issues are being addressed.
- **Volunteer Coordinator**
 - Assess the need for volunteers at the facility site and at any off-site care center or shelters operated by the facility;
 - Set up a volunteer reporting station at facility or alternative site;
 - Check credentials of non-staff volunteers who are health professionals and persons authorized by ServFL to respond to disaster when reporting for duty;
 - Assign to appropriate site/activity based on each volunteer's credentials;
 - Orient volunteers to assigned duties;
 - Assign tasks to convergent volunteers as appropriate;
 - Keep volunteer roster and track assignments;
 - Pursuant to a Memorandum of Understanding between the facility and ServFL authorizing such activity, impress volunteers into services as disaster service workers according to ServFL procedure; and,
 - Assure appropriate supervision of volunteers.

Demobilization

- **The Labor Pool & Credentialing Unit Leader should conduct demobilization procedures and complete:**
 - Demobilization Checklist GP Form 221 (Attachment); and,
 - Volunteer Staff Registration HICS Form 253.
- **Provide volunteer incident de-briefing.**
- **Upon conclusion of deployment, volunteers should be evaluated by their supervisor(s) using a modified version of ICS Form 225, Individual Personal Rating. Review evaluation with volunteer.**

- **Ensure the assigned tasks are completed and/or replacement volunteers are informed of the task status.**
- **Ensure equipment is returned by volunteers.**
- **Confirm volunteers' follow-up contact information.**
- **Identify and document injuries and illnesses, and mental/behavioral health needs** due to participation in the response when requested or indicated, referral of volunteers to medical and mental/behavioral health services.
- **Provide volunteers with a written demobilization plan** to include "pertinent information" – i.e. phone numbers to call if issues come up when leaving the facility. The volunteer is the health care facility's responsibility until the volunteer reaches the point of departure.
- **Disaster privileges should be terminated** immediately when the volunteer's services are no longer needed or when the health care facility's Emergency Management Plan is inactivated.

Orientation Template

By checking the following “boxes”, I certify that I understand my obligation under each of these categories and commit to abiding by these policies along with all the policies provided to me by my supervisor or any other authorized person at this organization:

- **Mission and Values:** *(Include here a brief description of its Mission and Values).*
- **Confidentiality:** The state and federal privacy laws require all employees and volunteers to maintain a high level of confidentiality with respect to all information of medical or business nature concerning patients, residents, clinicians, or employees. Access to documents, materials, and information containing medical, personal, and/or financial information regarding patients, employees, and volunteer or health care facility matters is restricted to those who need the information to carry out their specific work assignments.

Protected Health Information (confidential information about patients) can be used for treatment, payment, or operations. Other uses of Protected Health Information must be cleared through a supervisor. Keep in mind when determining whether you should have access to patient information; use the “need to know” phrase.

Unauthorized access to documents or materials and inappropriate use of, discussion of, or dissemination of such information will be considered a breach of confidence, and as such may involve me in legal proceedings and result in immediate termination of my volunteer assistance in the disaster operation. *(Include or provide standard facility HIPAA information or forms).*

- **Infection Control:** (Hand Hygiene): Hand hygiene is the most effective way to prevent the spread of infection. Hand-washing products and stations, hand sanitizers, or similar materials are provided. If your hands are visibly soiled, wash with soap and water. If your hands are not visibly soiled, using an alcohol-based hand hygiene product such as foam or gel is acceptable.

When washing hands, wet hands, keep water running and apply soap to palm of hands. Rub hands together vigorously covering all surfaces including fingernails, rinse and dry with a paper towel. Use the paper towel to turn off the faucet and to exit the door.

When using alcohol-based hand hygiene procedure apply foam or gel to the palm of one hand, rub together vigorously, covering all surfaces including the fingernails for approximately 15 seconds. When hands are dry, they are considered clean.

Alcohol based hygiene products are the preferred method when hands are not visibly soiled. Hand hygiene should be performed when you have direct contact with patients, before eating, after using the bathroom, if in contact with body fluids or broken skin, and after touching equipment or furniture near the patient.

- **Infection Control (Additional):** I will not enter any room designated as “isolation” or any sterile area, unless approved by my supervisor.

If I will be exposed to blood or other bodily fluids or to airborne contaminants that require the use of protective equipment, I understand that I must wear personal protective equipment (PPE). I understand that I will consult with my supervisor for any instructions about PPE or patient contact.

On-Site Hazards: Disaster locations are particularly hazardous locations. I will comply with all safety directions given to me by my supervisor. I understand that the Safety Officer has authority with respect to safety in the disaster zone. I will follow directions given to me by the Safety Officer. I will wear safety-related clothing and equipment as directed.

Hazardous Materials: Potentially hazardous materials and chemicals are used in certain areas as part of the daily operations of the health care facility. Special precautions should be taken when working with certain products. Material Safety Data Sheets (MSDS), which describe the physical, health, and fire hazards of the materials, appropriate first aid measures, and handling instructions for all chemical products, are available on file and readily available to employees and Volunteers in (*location*). I understand that I should consult with my supervisor for further information.

General Safety: I understand that:

In the case of any Emergency, I will dial Incident Command Center at Extension _____.

I will report to my supervisor or nearest staff person any unsafe condition and/or injury that I sustain while serving as a volunteer.

In the event of a called Code or a called Emergency, I will report to my supervisor or the nearest staff person. A description of Codes used in the health care facility are provided: (*Include health care facility code description*).

“Code RED” (*insert appropriate code if different*) indicates that there is a fire and that I am to report to my work area. My supervisor will provide me with the information needed to report a fire and to where I need to report.

When a fire alarm sounds, every staff member should take action by noting the location of the fire. To respond rapidly and effectively, memorize an easy to remember word like R.A.C.E., Rescue, Alarm, Confine and Evacuate; this tells you how to proceed and in what order.

When using a fire extinguisher, use the word P.A.S.S., to help you remember the steps to extinguish a fire: Pull the pin out of the extinguisher; Aim the nozzle at the fire; Squeeze the extinguisher handle; Sweep the solution at the base of the fire. Apply extinguishing agent even after the flames are extinguished never leave an extinguished fire unattended. Stay until the fire department arrives.

Check which extinguishers are available in your area and be sure you can properly operate them.

Facility Map/Floor Plan: I have reviewed the facility map and floor plan.

Tobacco Use: I understand that there is no use of tobacco in the health care facility or on its grounds.

- ❑ **Health Requirements:** I understand that within 72 hours of being approved to serve as a volunteer, I must complete the required health screenings as so directed by Employee Health.
- ❑ **Identification:** I understand that I must wear my I.D. Badge at all times while serving as a volunteer.
- ❑ **Patient Rights:** I understand that patients deserve care, treatment, and services that safeguard their personal dignity, that respect their cultural, psychosocial, and spiritual values, and that these values often influence the patient’s perception and needs.
- ❑ **Weapons:** I understand that the policy of the health care facility restricts me from bringing any weapons of any kind into the health care facility.

Code of Conduct: I will abide by the following standards of conduct:

- ❑ I will treat all individuals served by this health care facility with care and compassion and without discrimination.
- ❑ I am serving without expectation of compensation. I will not seek payment for care I render.
- ❑ I will not discuss personal topics, such as religious beliefs or political views, with staff or patients unless initiated by the patient. Nor will I offer medical advice outside my role. I will speak professionally about the health care facility, its staff, its volunteers, and its facilities.
- ❑ I will not report for service while under the influence of an intoxicant or illegal controlled substance, nor will I consume any such illegal controlled substance during my service hours.
- ❑ I shall present myself in a professional manner.
- ❑ I understand that I am responsible for my valuables and personal items.
- ❑ I understand that it is against the policy of this health care facility and is illegal under state and federal law for any volunteer, male or female, to harass a patient, staff member, or volunteer.
- ❑ I understand that I must sign in, sign out for each shift, and accurately record my time served as a volunteer.

I hereby acknowledge the above conditions of Volunteering at:

Facility Name

Name of Volunteer

Signature

Date

Emergency Volunteer Privileges Application Template

PART A: Volunteer Information

I am a volunteer, who is making application to assist with an emergency or disaster situation. As a volunteer, I affirm that I am not employed by this organization, and I am willing to provide services to this organization without the expectation of compensation. I authorize the release of any information as may be necessary to enable the health care institution to authorize me to provide services. I understand the health care institution may utilize the ServFL system or obtain information from any health care facility, ambulatory surgery center, physician office, or other entity with which I have privileges or at which I work to verify my credentials, which will include, but not be limited to, licensure, criminal background check, etc.

Name:
Home Address:
Mailing Address (<i>if different than Street Address</i>):
Social Security Number:
Please indicate by which telephone it is best to contact you and at what time(s) Phone No: _____ Times: _____ AM PM to _____ AM PM Cell No: _____ Times: _____ AM PM to _____ AM PM
E-mail Address:
Date of Birth:
Specialty/Area of Expertise:
Current Employer: Phone No: Address:
Name of Primary Health Care Facility Affiliation (<i>if applicable</i>):

Fluent in These Languages:		
Licensed? <input type="checkbox"/> Yes <input type="checkbox"/> No	License Number:	State:
Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	Certification Number:	State:
Registered? <input type="checkbox"/> Yes <input type="checkbox"/> No	Registration Number:	State:
Please list other states in which you hold a License, Certification, or Registration:		
Emergency Contact Person:		
Emergency Contact Telephone:		

Please answer the following questions:

Do you have any special needs or accommodations that need to be addressed?

- No
- Yes (If "Yes," please specify): _____

Are any challenges pending against your license, certification or registration; or has your license, certification or registration ever been refused, revoked, suspended, terminated, relinquished, reprimanded, probated, monitored, limited, investigated, or challenged in any way or otherwise encumbered either voluntarily or involuntarily or while under or in lieu of investigation?

- No
- Not Applicable
- Yes (If "Yes," please specify): _____

Have you ever been convicted of a crime, felony, or gross misdemeanor, or have any pending charges?

- No

- Yes (If "Yes," please specify): _____

Have you ever been excluded or received sanctions from any state or federal health care program?

- No
- Yes (If "Yes," please specify): _____

Are you free of communicable or contagious diseases?

- No (If "No," please explain): _____

- Yes

Are you presently experiencing any symptoms or health conditions that may negatively affect your ability to serve as a volunteer?

- No
- Yes (If "Yes," please specify): _____

FOR PHYSICIANS and ALLIED HEALTH PRACTITIONERS ONLY:

Are there currently pending challenges against your appointment and/or membership or request for any privileges or scope of practice in any health care facility or medical facility, medical organization, society, insurance company, or managed care plan, or has your appointment or membership or request for privileges or scope of practice ever been refused, revoked, suspended, reduced, withdrawn, probated, reprimanded, investigated, challenged, or not renewed either voluntarily or involuntarily or while under or in lieu of an investigation?

- No

- Not Applicable
- Yes (If "Yes," please specify _____

Are there currently pending challenges against your federal or state narcotics license (DEA registration), or has your license ever been refused, revoked, suspended, terminated, relinquished, reprimanded, probated, monitored, limited, investigated, or challenged in any way or otherwise encumbered either voluntarily or involuntarily or while under or in lieu of investigation?

- No
- Not Applicable
- Yes (If "Yes," please specify _____

PART B: Identification

I have provided a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following for identification purposes:

- A current picture employer I.D. card that clearly identifies professional/job designation.
- A current license, certification, or registration to practice.
- Primary source verification of the license.
- Identification indicating membership on a Disaster Medical Assistance Team (DMAT), Medical.
- Reserve Corps (MRC), Emergency System for the Advance Registration of Volunteer Health.
- Professionals (ESAR-VHP) or other recognized state or federal organization or groups.
- Identification indicating that I have 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).

- Identification by current health care facility or medical staff member(s) who possesses personal knowledge regarding my ability to act as a volunteer during a disaster.
- Other forms of acceptable identification (please specify): _____

PART C: Attestation

I attest that all the above statements in Parts A and B are true and accurate.

Name of Applicant (Printed)

Signature of Applicant

Date/Time

FOR PHYSICIANS ONLY

- I attest that all information provided is true and accurate;
- I attest that I have been provided access to and agree to be bound by, as appropriate, health care facility policies and procedures, medical staff bylaws, and directions of the Administrator or designee, Incident Commander, supervising/monitoring physicians, and other administrative and medical staff leaders while acting as a Volunteer and/or providing care during the disaster; and,
- I agree to accurately and legibly complete medical records and other documents associated with providing care, as much as is reasonably possible given the exigencies of the situation, and to cooperate with health care facility as necessary regarding such care.

Name of Applicant (Printed)

Signature of Applicant *Date/Time*

STOP HERE: *The organization will complete the following sections.*

PART D: Primary Source Verification and Membership on Medical Staff

A “checkmark” indicates which of the following sources have been queried and that documentation resulting from these queries is attached:

- | | | |
|---|--|---|
| <input type="checkbox"/> Licensure | <input type="checkbox"/> Certification | <input type="checkbox"/> Registration |
| <input type="checkbox"/> Office of the Inspector General | <input type="checkbox"/> Drug Enforcement Agency | <input type="checkbox"/> NPDB |
| <input type="checkbox"/> Criminal Background Check | <input type="checkbox"/> Employer Verification® | <input type="checkbox"/> SSN Background Check |
| <input type="checkbox"/> National Practitioner Identifier | | |

Primary Source Verification could not be completed due to: _____

<i>Name of Verifier (Printed)</i>	<i>Signature of Verifier</i>	<i>Date/Time</i>
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Membership on Medical Staff: The following sources have been queried to document that the physician or allied health practitioner has privileges and is in good standing at a health care facility:

- Florida Department of Health, Division of Medical Quality Assurance
- Telephone verification
- Other (*attached*)

Date: _____ *Time:* _____ *Person Verifying* _____

PART E: Approval / Disapproval

- Approval:** This Applicant has been approved to provide volunteer services as a _____ in the specialty/area of expertise of _____ effective _____.
- Disapproval:** This Applicant has been denied to serve as a volunteer.

Signature of Volunteer Staging Area Leader or Designee

Date/Time

PART F: Assignment and Supervision

This volunteer has been assigned to the following supervisor: _____

Signature of Volunteer Staging Area Leader or Designee

Date/Time

PART G: Dismissal

This volunteer was dismissed on _____ because services were no longer needed.

Signature of Volunteer Staging Area Leader or Designee

Date/Time

Purpose

Licensed independent practitioners who are not members of the Medical Staff of the health care facility and who do not already possess clinical privileges to practice at the health care facility may be granted temporary disaster privileges if the health care facility experiences a disaster that causes activation of the health care facility's Emergency Management Plan and overwhelms the health care facility's ability to handle immediate patient needs.

These Guidelines describe the procedures for the granting of disaster privileges to Volunteer Physicians and Allied Health care Practitioners (licensed independent practitioners) that are competent to provide safe and adequate care, treatment, and services. Even in a disaster, the integrity of the primary components of the usual process for determining qualifications and competence must be maintained: verification of licensure, certification or registration, required to practice a profession and oversight of care, treatment and services provided.

Definitions

Administrator means, for the purpose of these guidelines, the health care facility Chief Executive Officer or Administrator or President of the Medical Staff or their designee, who has authority to grant disaster privileges.

Allied Health care Practitioners means health care practitioners, who are not physicians but are authorized under state law to practice and are eligible to apply for and, if approved, be granted individual clinical privileges to provide services within the health care facility. Examples of Allied Health care Practitioners may include optometrists, nurse anesthetists, nurse midwives, nurse practitioners, advanced practice nurses and physician assistants.

Criminal Background Check means any action taken to evaluate whether a possible volunteer has a criminal record, which indicates to a reasonable person that the volunteer might pose a threat to the health or safety of patients or staff.

Disaster means a situation or event, which overwhelms local capacity to respond to the immediate needs of the community and requires immediate response. A Disaster may result in a declaration of a disaster, emergency, or public health emergency by an authorized governmental official, and require regional, state, federal, or international assistance, or may be limited to an event, which overwhelms the ability of the health care facility to care for patients in the ordinary course of business. A Disaster can be of short duration or may be a sustained incident.

Emergency means an incident that calls for an immediate response and “stresses” the staff and resources of the health care facility; an emergency is usually of short duration.

Exceptional Circumstances means any situation in which any delay in the deployment of Volunteer Physicians or Allied Health Practitioners may cause the exacerbation of illness or injury and/or death of patients at the health care facility.

Expedited Disaster Privileges Process means the process, which permits rapid deployment of health care providers during exceptional circumstances upon demonstration of licensure and identity.

Licensed Independent Practitioner means “any individual permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the individual’s license and consistent with individually granted privileges.”

Physician means an individual who, at the time of the disaster, is duly licensed as a medical doctor or doctor of osteopathy by any state in the United States.

State ESAR-VHP Program means an Emergency System for Advance Registration of Volunteer Health Professionals program created by or in a manner authorized by the U.S. Department of Health and Human Services, Office of the Assistant Secretary of Preparedness and Response (ASPR) to provide advance registration and credentialing of health care professionals able to provide services during a disaster or an emergency.

Volunteers are defined, for the purpose of these guidelines, as Physicians and Allied Health care Practitioners, who are not employed by the health care facility or any parent or sister organization that offer to provide services to the health care facility without the expectation of compensation from the health care facility.

General Principles

1. These guidelines shall at all times be interpreted and implemented in a manner that best meets the needs of the health care facility and its patients.
2. The Administrator may grant disaster privileges to Volunteer Physicians and Allied Health care Practitioners. In the event that the Administrator is not available or unable to act in accordance with the policy of the health care facility, the authority to grant disaster privileges shall be deemed to have been delegated in accordance with the delegation of other authorities under the Continuity of Operations Plan of the health care facility.
3. The Administrator and/or their designees may declare the health care facility to be in exceptional circumstances, in which case the Expedited disaster privileges process may be used.
4. The decision to grant disaster privileges will be on a case-by-case basis and at the discretion of the Administrator or designee.
5. Volunteer Physicians and Allied Health care Practitioners that are granted disaster privileges shall be subject to oversight of their professional competence as directed by the Administrator. Oversight may include direct supervision, observation or monitoring, retrospective review, or

any other appropriate means. Oversight of the Volunteer Physician or Allied Health care Practitioner shall be provided through the Medical Staff.

6. Disaster privileges are effective only so long as the disaster continues. The granting or denial of disaster privileges does not afford the individual seeking such privileges any rights under the Medical Staff Bylaws.
7. Disaster privileges will terminate:
 - a. Immediately upon notice to the Volunteer in the event the Administrator/ designee determines that such termination is in the best interest of safe, effective and efficient care; in the event the Volunteer's competency or qualifications are in doubt; or if the health care facility is unable to obtain adequate primary source verification of the Volunteer's qualifications;
 - b. Upon notice to the Volunteer, when the Volunteer's services are no longer needed; or,
 - c. Immediately when the health care facility's Emergency Management Plan is deactivated.

Expedited Disaster Privileging Procedures

1. In exceptional circumstances, expedited disaster privileges may be granted immediately, prior to completing the other steps of the Disaster Privileging Process, to members of a Disaster Medical Assistance Team (DMAT) or other National Disaster Medical Service (NDMS) volunteers, Medical Reserve Corps (MRC), Public Health Service Commissioned Corps personnel (PHS), or Stafford Act Temporary Disaster Employees, upon the following:
 - a. Submission of official designation as defined above by the applicable issuing agency; or,
 - b. Submission of other identifying information indicating licensure, such as a current health care facility identification badge with licensure noted or a copy of a state license.
2. In exceptional circumstances, Volunteers who are not members of DMAT, NDMS, MRC, PHS or Stafford Act Temporary Disaster volunteers may be approved to provide immediate, life-saving care upon display of a government-issued photo identification card and proof of current licensure prior to completing the process described under *Recommended Disaster Privileging Process*. This is limited to exceptional circumstances, and all care rendered will be subject to supervision by Medical Staff members. As soon as the situation has stabilized, such Volunteers shall complete the *Recommended Disaster Privileging Process*.
3. Once the health care facility has sufficient personnel to provide necessary services, the Recommended Disaster Privileging Process will be followed, and serving Volunteer Physicians and Allied Health care Practitioners, who were granted Expedited disaster

privileges will be processed under the Recommended Disaster Privileging Process, if assistance is still required.

Recommended Disaster Privileging Process

1. All individuals seeking to be approved as Volunteer Physicians and/or Allied Health care Practitioners will be asked to report to the Volunteer Staging Area and present themselves to the Volunteer Staging Area Leader or designee.
2. The Volunteer Staging Area Leader shall coordinate all assignments with the health care facility Incident Commander or designee. As appropriate, the health care facility Incident Commander shall coordinate deployment of Volunteers through the local, regional, or state Incident Command or Emergency Operations Center, as the case may be.
3. Each Volunteer must complete and sign an application (See Emergency Volunteer Privileges Application template). The signature of the Volunteer on the Application:
 - a. Serves as an attestation that all information provided is true and accurate;
 - b. Serves as an agreement by the Volunteer to be bound by health care facility policies and procedures, Medical Staff Bylaws, and directions of the Administrator or designee; supervising/monitoring physicians, and other administrative and medical staff leaders while acting as a Volunteer and/or providing care during the disaster; or,
 - c. Serves as an agreement to accurately complete medical records and other documents associated with providing care, as much as is reasonably possible given the exigencies of the situation, and to cooperate with health care facility as necessary regarding such care.
4. Each Volunteer must provide a government-issued ID (such as a driver's license or passport) and at least one of the following identification items:
 - a. Current employer or health care facility picture identification card that clearly identifies professional designation;
 - b. A current license, certification or registration at the level which privileges are requested;
 - c. Primary source verification of licensure, certification or registration;
 - d. Identification as a member of a Disaster Medical Assistance Team (DMAT) or Medical Reserve Corps (MRC), or Public Health Service Commissioned Corps;
 - e. Identification demonstrating registration with an Emergency System for the Advance Registration of Volunteer Health care Professionals (ESAR-VHP) or with other recognized disaster assistance state or federal organizations or groups;

- f. Other identification, demonstrating that the Volunteer has been granted authority to render patient care, treatment and services in disaster circumstances, including licensure designation; or,
 - g. Identification by a health care facility employee or medical staff member, who possesses personal knowledge regarding the Volunteer's competence and qualifications.
5. An individual(s) may also be approved to serve as a disaster volunteer, if, due to the Disaster, there has been declared a State of Emergency, a Public Health Emergency, or other declaration authorized by law, and one or more of the following has occurred:
 - a. Authorized waiver of licensure, certification or registration;
 - b. Recognition of licensure, certification or registration from other states or nations;
 - c. Modifications of requirements ordinarily imposed on a profession with respect to:
 - i. certain health care-related services;
 - ii. evidence of licensure, certification or registration in another state or country; or
 - iii. relevant education, training, and experience.
 - d. The decision to accept or not accept such licensure, certification or registration, or such evidence of relevant education, training or experience, shall be in the sole discretion of the Administrator/designee, based on the best interests of the patients to be served.
6. The Volunteer Staging Area Leader or designee shall provide to the medical staff office a copy of all the identification materials, provided by the Volunteer.
 - a. The medical staff office shall document that it has reviewed and received all identification materials provided by the Volunteer. Documentation from a state ESARVHP system, even Level 1 credentialing, or other documentation provided by a third party cannot be a substitute for credentialing and privileging the Physician or Allied Health care Practitioners at the health care facility, unless the documentation is received from a delegated Credentials Verification Organization that the health care facility has a formal agreement.
 - b. The medical staff office shall advise the health care facility 's Administrator or the designee regarding the information provided and obtain from the Administrator approval or disapproval of the privileges requested.
 - c. Primary source verification of licensure, certification, or registration will begin immediately or as soon as the situation is under control and will be completed within 72 hours from the time the Volunteer presents. The medical staff office will complete a primary source verification of the individual's license, certification, or registration, verification of current competency, and primary source verification/query of:

- i. Drug Enforcement Agency Registration;
 - ii. Office of the Inspector General Excluded Individuals List;
 - iii. Board Certification through the American Board of Medical Specialties and/or American Osteopathic Association Specialty Boards, if applicable;
 - iv. National Practitioner Data Bank; and,
 - v. Criminal Background Check.
7. When an unusual situation prohibits primary source verification of licensure from occurring within 72 hours of the Volunteer presenting to the health care facility, the medical staff office will document:
 - a. The reason that the primary source verification could not be completed within the 72hour timeframe;
 - b. The means used by the health care facility to evaluate the competency and qualifications of the Volunteer, and,
 - c. The efforts made by medical staff office to obtain primary source verification as soon as possible.

In all cases, the Volunteer must submit some evidence of licensure, even though primary source verification of this licensure cannot be completed within 72 hours of the volunteer presenting to the health care facility.

Note: Primary source verification of licensure, certification or registration is not required if the Volunteer Physician and/or Allied Health care Practitioner does not or has not provided care, treatment or services at the health care facility.

8. The current competency of the Volunteer will be assessed and be verified according to health care facility policy.
 - a. If a Volunteer is listed on the ServFL database, the Provider Affiliation Report for the Volunteer can be used to document the current competency of the Volunteer. (*The health care facility should have a corresponding policy to support this.*) This listing on the "Provide Affiliation" database may serve as verification of the current competency of the Volunteer as long as the "Provider Affiliation" report used to determine competency was updated and issued within 90 days preceding the date on which competency of the Volunteer is being evaluated.
 - b. If a Volunteer is not listed on the ServFL ESAR-VHP database, the health care facility shall verify current competency by contacting the health care facility at which the Volunteer has privileges. If the health care facility at which the Volunteer has privileges cannot be contacted or if the Volunteer does not maintain active privileges at a health

care facility, the health care facility shall document the means by which competency was determined.

9. After completion of the preceding steps and/or a review of documents, obtained through Primary Source Verification and the completion of the Criminal Background Check, the medical staff office shall indicate on the Application that the Volunteer has been approved or disapproved for service at the health care facility.
10. Upon receipt of this approval from the Medical Staff Office, the Volunteer Staging Area Leader or designee may accept the Volunteer's assistance, as needed, but not beyond the duration of the disaster.
11. A list of Volunteers who have been granted disaster privileges shall be sent to the following departments (*as examples*), and shall be maintained in the Medical Staff Office:
 - a. Health care facility Incident Command Center
 - b. Emergency Department
 - c. Radiology
 - d. Laboratory
 - e. Pharmacy
 - f. Medical Records
 - g. Admitting
 - h. Health care facility administration
 - i. Medical Staff – Chief of Applicable Service
 - j. Surgery
 - k. Information Technology
12. If possible, the health care facility shall issue to each Volunteer a photo identification card identifying the individual as a Volunteer and indicating the Volunteer's level of licensure. If the health care facility is unable to issue photo identification cards, the health care facility shall adopt an alternate means of identifying approved Volunteers and shall issue to each volunteer such identification. Volunteers are required to prominently display, at all times when providing services, proper Volunteer identification.
13. As appropriate, Information Technology shall provide to the Volunteer a user identification name and password. Volunteers shall be briefed on proper use of the computer systems, electronic prescribing, and electronic medical record capabilities of health care facility.

14. Each Volunteer shall be assigned to a specific role to provide services where most needed or most appropriate given the competency and qualifications of the Volunteer.
15. The Volunteer Staging Area Leader or designee shall complete the following on the Application:
 - a. The assignment of the Volunteer; and,
 - b. The name and title of the individual to whom the Volunteer is to report.
16. The assigned supervisor at the deployment site is responsible for supervising the Volunteer.

This responsibility includes:

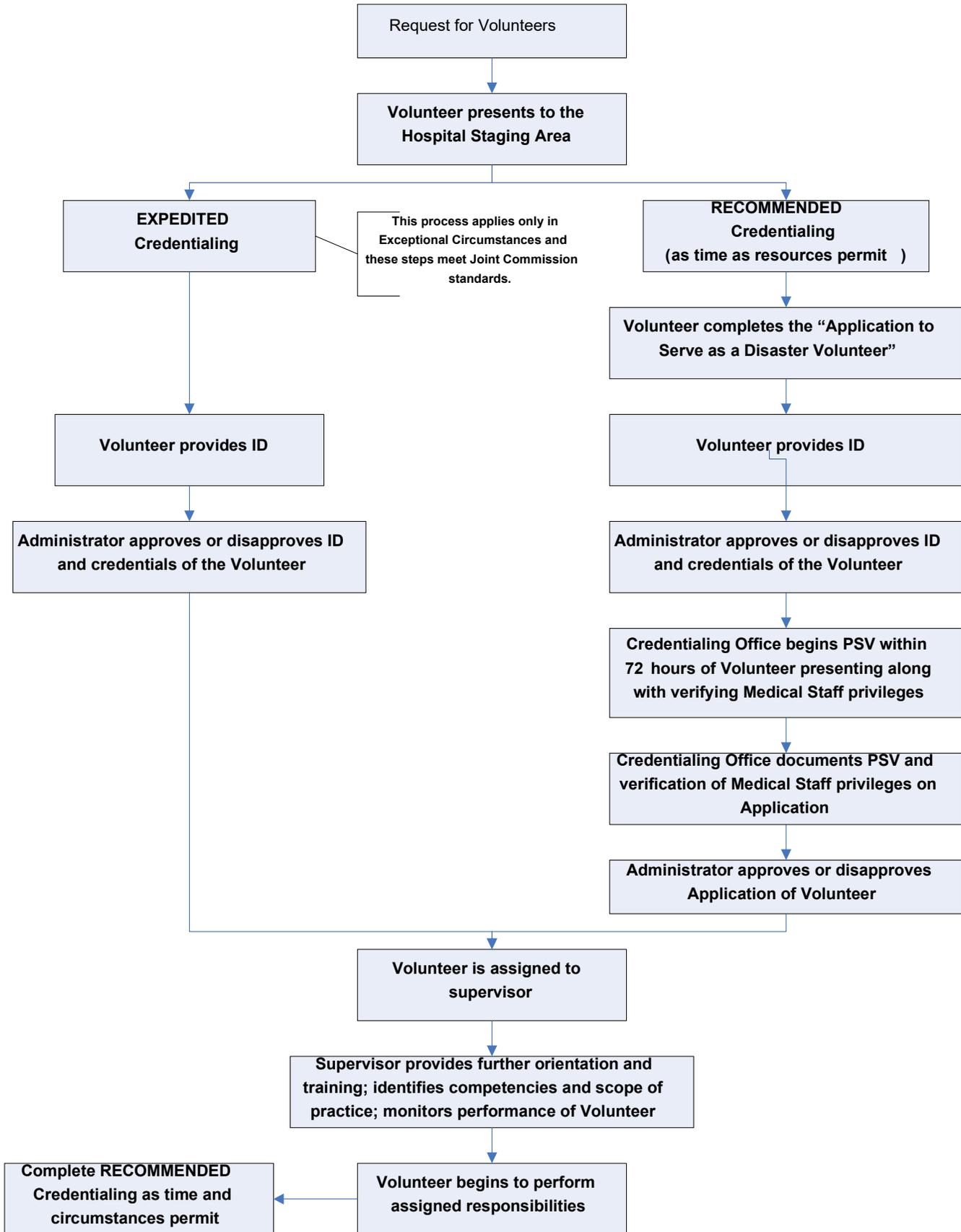
- a. Providing any further orientation and training, required for the position that the Volunteer will be filling and, after the assignment of responsibilities, signing the Application indicating approval of scope of practice;
 - b. Monitoring the competencies and scope of practice of the Volunteer through observation, mentoring, chart review, and discussion with the Volunteer. Any adjustments and/or limitations on scope of practice with respect to the core competencies, consistent with the Volunteer's licensure level, shall be noted on the Application. The assigned supervisor may use any reasonable means to evaluate competencies including, but not limited to:
 - i. Direct observation of performance of work responsibilities;
 - ii. Mentoring;
 - iii. Clinical record review; and,
 - iv. Periodic debriefings with the Volunteer.
 - c. Confirming that the Volunteer has received any health screenings and immunizations required by the health care facility policy within 72 hours of deployment of the Volunteer or refusal of same, unless this requirement has been waived by the health care facility Incident Command, upon consultation with Infection Control or Employee Health.
 - d. Monitoring the physical and emotional well-being of the Volunteer Physicians and Allied Health care Providers.
17. Upon completion of the service of the Volunteer, the supervisor shall;
 - a. Hold an exit interview with the Volunteer and document the following:
 - i. Status of physical and mental health;

- ii. Follow-up resources offered;
- iii. Collection of the Identification Badge; and,
- iv. Date and time of termination of service.

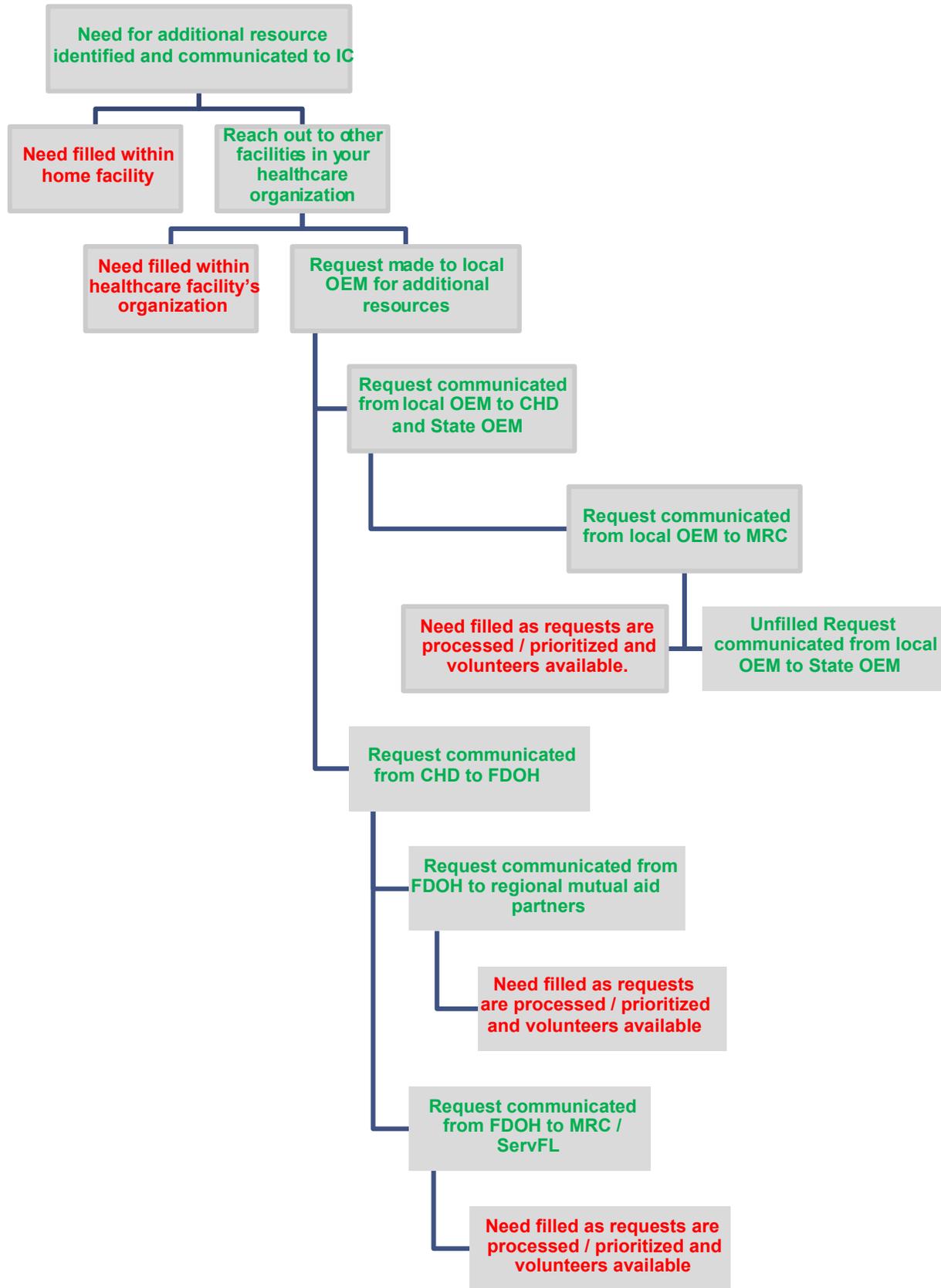
b. Forward all documentation regarding the Volunteer to the Medical Staff Office.

18. The health care facility will send a "Thank You" letter to the Volunteer within a reasonable period after termination of service.

Physician and AHP (LIP) Credentialing



Emergency Volunteer Request Algorithm



Mission Statement

The mission of the Florida Medical Reserve Corps Network Program is to augment local community health and medical services staff with pre-identified, trained and credentialed MRC volunteers.

Purpose

The Florida Medical Reserve Corps Network was established to effectively facilitate the use of private volunteers in emergency response.

The Medical Reserve Corps (MRC) is a national network of local groups of volunteers committed to improving the health, safety and resiliency of their communities. MRC volunteers include medical and public health professionals, as well as others interested in strengthening the public health infrastructure and improving the preparedness and response capabilities of their local jurisdiction. MRC units identify, screen, train and organize the volunteers, and utilize them to support routine public health activities and augment preparedness and response efforts.

The Florida Medical Reserve Corps Network comprises 33 Florida MRC units covering all 67 Florida counties.

Florida Medical Reserve Corps units are community-based and function to locally organize and utilize health professionals and other volunteers who want to donate their time and expertise to promote community health and respond to emergencies.

The following occupations represent some of Florida's MRC Volunteer specialties.

- Advanced Registered Nurse Practitioner
- Clinical Social Worker
- Counselor, Mental Health
- EMT-Basic
- Licensed Practical Nurse
- Marriage & Family Therapist
- Medical Records and Health Information Technologist
- Medical and Clinical Lab Technician
- Medical and Clinical Lab Technologist
- Paramedic
- Pharmacist
- Physician
- Physician Assistant
- Psychologist
- Radiologic Technologist / Technician
- Registered Nurse
- Respiratory Therapist

- Social Worker

The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VAP)

[ESAR-VHP](#) is a federal program created to support states and territories in establishing standardized volunteer registration programs for disasters and public health and medical emergencies.

The program, administered on the state level, verifies health professionals' identification and credentials so that they can respond more quickly when disaster strikes. By registering through ESAR-VHP, volunteers' identities, licenses, credentials, accreditations, and health care facility privileges are all verified in advance, saving valuable time in emergency situations.

SERVFL

The State Emergency Responders and Volunteers of Florida (SERVFL) is the State of Florida's online ESAR-VHP system for managing public health and medical disaster responders (volunteers and staff teams). [SERVFL](#) registry supports a variety of personnel who may be utilized during disasters, all-hazard response efforts, and public health activities. Volunteer Today!!!

Members must help FL MRC Network maintain accurate and up-to-date contact information, including mailing addresses, phone numbers and e-mail addresses.

Additional material includes:

- Florida MRC [Fact Sheet](#)
- [Local map](#) of Florida MRC Units

Incident Command System Forms

- [HICS Incident Management Team Structure](#)
- [HICS Form 204](#) – Branch Assignment List to document staff/volunteer assignments.
- [HICS Form 207](#) – Organizational Chart to document HICS positions assigned.
- [HICS Form 213](#) – Incident Message Form to provide a standardized method for recording messages.
- [HICS Form 214](#) – Operational Log to document incident issues encountered, decisions made and notifications conveyed.

- [ICS Form 221](#) – Demobilization Checklist to document demobilization or resource type (personnel) and equipment (radios, phones, pagers) and forms (time sheets, identification badges, etc.) and those they are returned.
- [HICS Form 253](#) – Volunteer Staff Registration to document volunteer sign-in for operational period.

Standards and Requirements Relating to Volunteer Management

CMS Conditions of Participation

The Centers for Medicare & Medicaid Services (CMS) published a final rule on September 16, 2016 titled [Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers](#). The rule applies to 17 provider types, with degrees of variation. Health care facilities and other affected providers must meet all applicable requirements of the rule upon the implementation date of November 15, 2017.

The final rule contains summaries of public comments on the proposed rule along with CMS responses, cited references and resources, and cost projections for providers to implement these provisions. [Interpretive guidelines and survey procedures](#) were published in June, 2017.

Policies and Procedures for Volunteers

Except for hospices, transplant centers and organ procurement organizations, all other provider and supplier types must have policies and procedures for volunteers. Regulatory text states,

“Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:

Policies and procedures: The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

For religious non-medical health care institutions, Policies and procedures: The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.”

CMS interpretive guidance provides the following explanation of the regulatory text:

“During an emergency, a facility may need to accept volunteer support from individuals with varying levels of skills and training. The facility must have policies and procedures in place to facilitate this support. In order for volunteering health care professionals to be able to perform services within their

scope of practice and training, facilities must include any necessary privileging and credentialing processes in its emergency preparedness plan policies and procedures. Non-medical volunteers would perform non-medical tasks. Facilities have flexibility in determining how best to utilize volunteers during an emergency as long as such utilization is in accordance with State law, State scope of practice rules, and facility policy. These may also include federally designated health care professionals, such as Public Health Service (PHS) staff, National Disaster Medical System (NDMS) medical teams, Department of Defense (DOD) Nurse Corps, Medical Reserve Corps (MRC), or personnel such as those identified in federally designated Health Professional Shortage Areas (HPSAs) to include licensed primary care medical, dental, and mental/behavioral health professionals. Facilities are also encouraged to integrate State-established volunteer registries, and where possible, State-based Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP).

Facilities are expected to include in its emergency plan a method for contacting off-duty staff during an emergency and procedures to address other contingencies in the event staff are not able to report to duty which may include, but are not limited to, utilizing staff from other facilities and state or federally-designated health professionals.”

Communications Plan Inclusive of Volunteers

All provider and supplier types except hospices and transplant centers must:

“... develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:

(1) Names and contact information for the following:

- (i) Staff.*
- (ii) Entities providing services under arrangement.*
- (iii) Patients’ physicians*
- (iv) Other [facilities].*
- (v) Volunteers.*

For religious non-medical health care institutions, the communication plan must include all of the following:

(1) Names and contact information for the following:

- (i) Staff.*
- (ii) Entities providing services under arrangement.*
- (iii) Next of kin, guardian, or custodian.*

(iv) Other RNHCIs.

(v) Volunteers.

For ambulatory surgical centers, the communication plan must include all of the following:

(1) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Patients' physicians.

(iv) Volunteers.

For organ procurement organizations, the communication plan must include all of the following:

(1) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Volunteers.

(iv) Other OPOs.

(v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA)."

Interpretive language suggests

"A facility must have the contact information for those individuals and entities outlined within the standard. The requirement to have contact information for "other facilities" requires a provider or supplier to have the contact information for another provider or supplier of the same type as itself. For instance, hospitals should have contact information for other hospitals and CORFs should have contact information for other CORFs, etc. While not required, facilities may also find it prudent to have contact information for other facilities not of the same type. For instance, a hospital may find it appropriate to have the contact information of LTC facilities within a reasonable geographic area, which could assist in facilitating patient transfers. Facilities have discretion in the formatting of this information, however it should be readily available and accessible to leadership and staff during an emergency event. Facilities which utilize electronic data storage should be able to provide evidence of data back-up with hard copies or demonstrate capability to reproduce contact lists or access this data during emergencies. All contact information must be reviewed and updated as necessary at least annually. Contact information contained in the communication plan must be accurate and current. Facilities must update contact information for incoming new staff and departing staff throughout the year and any other changes to information for those individuals and entities on the contact list.

Transplant Centers should be included in the development of the hospitals communication plans. In the case of a Medicare-approved transplant center, a communication plan needs to be developed and disseminated between the hospitals, OPO, and transplant patients. For example, if the transplant program is planning to transfer patients to another transplant center due to an emergency, the communication plan between the hospitals, the OPO, and the patient should include the responsibilities of each of the facility types to ensure continuity of care. During an emergency, should an organ offer become available at the time the patient is at the “transferred hospital,” the OPO’s emergency preparedness communication plan should address how this information will be communicated to both the OPO and the patient of where their care will be continued.

Procedures for Sheltering in Place

Except for home health agencies, transplant centers and organ procurement organizations, providers and supplier types must develop and implement emergency preparedness policies and procedures that, at a minimum address the following:

“(4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility].

For inpatient hospices -

(i) A means to shelter in place for patients, hospice employees who remain in the hospice.”

CMS interpretation of the regulatory text states:

“Emergency plans must include a means for sheltering all patients, staff, and volunteers who remain in the facility in the event that an evacuation cannot be executed. In certain disaster situations (such as tornadoes), sheltering in place may be more appropriate as opposed to evacuation and would require a facility to have a means to shelter in place for such emergencies. Therefore, facilities are required to have policies and procedures for sheltering in place which align with the facility’s risk assessment.

Facilities are expected to include in their policies and procedures the criteria for determining which patients and staff that would be sheltered in place. When developing policies and procedures for sheltering in place, facilities should consider the ability of their building(s) to survive a disaster and what proactive steps they could take prior to an emergency to facilitate sheltering in place or transferring of patients to alternate settings if their facilities were affected by the emergency. For example, if it is dangerous to evacuate or the emergency affects available sites for transfer or discharge, then the patients would remain in the facility until it was safe to effectuate transfers or discharges. The plan should take into account the appropriate facilities in the community to which patients could be transferred in the event of an emergency. Facilities must determine their policies based on the type of emergency and the types of patients, staff, volunteers and visitors that may be present during an emergency. Based on its emergency plan, a facility could decide to have various approaches to sheltering some or all of its patients and staff.”

Emergency Preparedness Training Program Inclusive of Volunteers

All provider and supplier types except transplant centers and hospice must provide training programs inclusive of volunteers. Specific regulatory language states:

“(1) Training program. The facility, except critical access hospitals, ambulatory surgery centers, Programs of All-inclusive Care for the Elderly organizations, psychiatric rehabilitation treatment facilities, hospices, and dialysis facilities] must do all of the following:

- (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.*
- (ii) Provide emergency preparedness training at least annually.*
- (iii) Maintain documentation of the training.*
- (iv) Demonstrate staff knowledge of emergency procedures.*

The ambulatory surgery center must do all of the following:

- (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles.*
- (ii) Provide emergency preparedness training at least annually.*
- (iii) Maintain documentation of the training.*
- (iv) Demonstrate staff knowledge of emergency procedures.*

The psychiatric rehabilitation treatment facility must do all of the following:

- (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.*
- (ii) After initial training, provide emergency preparedness training at least annually.*
- (iii) Demonstrate staff knowledge of emergency procedures.*
- (iv) Maintain documentation of all emergency preparedness training.*

The Programs of All-inclusive Care for the Elderly organization must do all of the following:

- (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.*
- (ii) Provide emergency preparedness training at least annually.*

(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.

(iv) Maintain documentation of all training.

The comprehensive outpatient rehabilitation facility must do all of the following:

(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

The critical access hospital must do all of the following:

(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures.

The community mental health center must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually."

CMS regulatory text interpretation says:

Facilities are required to provide initial training in emergency preparedness policies and procedures that are consistent with their roles in an emergency to all new and existing staff, individuals providing services under arrangement, and volunteers. This includes individuals who provide services on a per

diem basis such as agency nursing staff and any other individuals who provide services on an intermittent basis and would be expected to assist during an emergency.

PACE organizations and CAHs have additional requirements. PACE organizations must also provide initial training to contractors and PACE participants. CAHs must also include initial training on the following: prompt reporting and extinguishing of fires; protection; and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities.

Facilities should provide initial emergency training during orientation (or shortly thereafter) to ensure initial training is not delayed. With the exception of CORFs which must complete initial training within the first two weeks of employment, we recommend initial training be completed by the time the staff has completed the facility's new hire orientation program. Additionally, in the case of facilities with multiple locations, such as multi-campus hospitals, staff, individuals providing services under arrangement, or volunteers should be provided initial training at their specific location and when they are assigned to a new location.

Facilities have the flexibility to determine the focus of their annual training, as long as it aligns with the emergency plan and risk assessment. Ideally, annual training should be modified each year, incorporating any lessons learned from the most recent exercises, real-life emergencies that occurred in the last year and during the annual review of the facility's emergency program. For example, annual training could include training staff on new evacuation procedures that were identified as a best practice and documented in the facility "After Action Report" (AAR) during the last emergency drill and were incorporated into the emergency plan during the program's annual review.

While facilities are required to provide annual training to all staff, it is up to the facility to decide what level of training each staff member will be required to complete each year based on an individual's involvement or expected role during an emergency. There may be core topics that apply to all staff, while certain clinical staff may require additional topics. For example, dietary staff who prepare meals may not need to complete annual training that is focused on patient evacuation procedures. Instead, the facility may provide training that focuses on the proper preparation and storage of food in an emergency. In addition, depending on specific staff duties during an emergency, a facility may determine that documented external training is sufficient to meet some or all of the facility's annual training requirements. For example, staff who work with radiopharmaceuticals may attend external training that teach staff how to handle radiopharmaceutical emergencies. It is up to the facility to decide if the external training meets the facility's requirements.

Facilities must maintain documentation of the annual training for all staff. The documentation must include the specific training completed as well as the methods used for demonstrating knowledge of the training program. Facilities have flexibility in ways to demonstrate staff knowledge of emergency procedures. The method chosen is likely based on the training delivery method. For example: computer-based or printed self-learning packets may contain a test to demonstrate knowledge. If facilities choose instructor-led training, a question and answer session could follow the training.

Regardless of the method, facilities must maintain documentation that training was completed and that staff are knowledgeable of emergency procedures.”

2017-2022 HPP – PHEP Cooperative Agreement

Below is a summary of requirements related to volunteer management contained in the 2017-2022 HPP – PHEP Cooperative Agreement.⁴ The primary requirements relate to coordination of volunteers as part of managing a public health surge event.

Domain 5. Strengthen Surge Management – Management of Public Health Surge

Activity 3. Coordinate Volunteers

HPP and PHEP awardees must coordinate the identification, recruitment, registration, training, and engagement of volunteers to support the jurisdiction’s response to incidents. Awardees should ensure volunteers are included in training, drills, and exercises.

HPP awardees, including HCCs and their members, should work to manage volunteers in the health care facility or other health care setting. This includes:

- Identifying situations that would require volunteers in health care facilities. Leverage existing health care facility volunteer services and staffing resource mechanisms;
- Identifying processes to assist with volunteer coordination, including protocols to handle walk up volunteers and others who cannot participate due to state regulations;
- Estimating the anticipated number of volunteers and health professional roles based on identified situations and resource needs of the facility;
- Identifying and addressing volunteer liability, licensure, workers compensation, scope of practice, and third-party reimbursement issues that may deter volunteer use;
- Leveraging existing government and nongovernmental volunteer registration programs, such as ESAR-VHP and MRC; and,
- Developing rapid credential verification processes to facilitate emergency response.

PHEP awardees must implement plans that support ESAR-VHP including coordinate identification, recruitment, registration, training and engagement of volunteers to support the jurisdictional public health agency’s response. Awardees must ensure volunteers are included

⁴ CDC-RFA-TP17-1701 Hospital Preparedness Program - Public Health Emergency Preparedness Cooperative Agreement, 2017. Available at: <https://www.grants.gov/web/grants/view-opportunity.html?oppId=290860>

in training, drills, and exercises to develop competency at implementing plans as described in the ESAR-VHP compliance requirements.

Domain 5. Strengthen Surge Management – Management of Public Health Surge

Activity 2. Address E.D. and Inpatient Surge

As part of HPP requirements, HCCs and their members should focus their health care facility medical surge capability and Immediate Bed Availability activities in areas which include health care volunteer management.

Additional PHEP Awardee Requirements

Awardees must have operational plans or annexes that address volunteer management (*Domain 2: Strengthen Incident Management; Activity 1. Coordinate Emergency Operations*).

Awardees must describe emergency legal authorities applicable to the Public Health Emergency Law Competency Model, including protection of volunteers against tort liability and licensure penalties, and Workers' Compensation claims. Awardees should distinguish between in-state and out-of-state volunteers and indicate whether EMAC may be used to send or receive volunteers. (*Domain 2: Strengthen Incident Management; Activity 1. Coordinate Emergency Operations; Activity 5. Expedited Fiscal Procedures Are in Place for Ensuring Funding Reaches Impacted Public Health Departments, HCCs, and their Members during an Emergency Response; Emergency Legal Authority*).

Awardees should train and exercise on capabilities-based plans with all needed personnel including volunteers and non-public health staff as necessary to increase their response ability. (*2017-2022 HPP-PHEP Cooperative Agreement's supplemental document on HPP-PHEP Exercise Requirements*).

Awardees must meet ESAR-VHP compliance, coordinate with volunteer health professional entities, and are encouraged to collaborate to facilitate integration of MRC units with state and regional infrastructure to help ensure an efficient response. (*Federal Requirements*)

PHEP awardees must submit outcome performance measures for timely coordination and support of response activities with health care and other partners which include:

- Program Measure 7: Percent of awardees that have plans, processes, and procedures in place to manage volunteers supporting an emergency or incident.
- PHEP Performance Measure: Plans, processes, and procedures are in place to manage volunteers who support an emergency or health incident.
- Joint Program Measure 2 (PM J.2): Percent of awardees able to request, activate, and deploy volunteers appropriately within requested time (HPP-PHEP 15.1). (Awardees

and HCCs will not report data on these PMs to HPP. EMSC and PHEP will collect this information. Further details relating to PM J.2: Volunteer Management are outlined in:

- [2017-2022 HPP Performance Measures Implementation Guidance](#) pages 57 - 61
- PHEP Performance Measure: Percentage of volunteers deployed in appropriate time to support an incident or exercise (formerly HPP-PHEP 15.1). Target time for volunteers to activate and deploy: TBD.

2017-2022 Health Care Preparedness and Response Capabilities⁵

Capability 1. Foundation for Health Care & Medical Readiness

Objective 2. Identify Risk and Needs

Activity 5. Assess and Identify Regulatory Compliance Requirements

The HCC should understand the process and information required to request necessary waivers and suspension of regulations, including: Legal resources related to health care facility legal preparedness, such as the deployment and use of volunteer health practitioners Capability 1. Foundation for Health Care & Medical Readiness.

Objective 4: Train and Prepare the Health care and Medical Workforce

Activity 3. Plan and Conduct Coordinated Exercises

When appropriate, the HCC should include federal, state, and local response resources such as ESAR-VHP and MRC in exercises.

Capability 4. Medical Surge

Objective 2. Respond to a Medical Surge

Activity 1. Implement ED & Inpatient Medical Surge Response

Areas to Develop Emergency Department and Inpatient Medical Surge Capacity and Capability: Health Care Volunteer Management

- Identify situations that would necessitate the need for volunteers in health care facilities.
- Identify processes to assist with volunteer coordination.
- Estimate the anticipated number of volunteers and health professional roles based on identified situations and resource needs of the facility.
- Identify and address volunteer liability issues, scope of practice issues, and third-party reimbursement issues that may deter volunteer use.
- Leverage existing government and non-governmental volunteer registration programs

⁵ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, (November 2016). *2017-2022 Health Care Preparedness and Response Capabilities*. Available at: <https://www.phe.gov/Preparedness/planning/hpp/reports/Documents/2017-2022-healthcare-pr-capabilities.pdf>

(e.g., Emergency System for Advance Registration of Volunteer Health Professional [ESAR-VHP] and Medical Reserve Corps [MRC]).

- Develop rapid credential verification processes to facilitate emergency response.

Capability 4. Medical Surge

Objective 2. Respond to a Medical Surge

Activity 3. Develop an Alternate Care System

Key Considerations to Develop an Alternate Care System:

Identify the process to assist with multiagency volunteer coordination to organize, assemble, dispatch, and properly out-process volunteers (e.g., Volunteer Reception Center).

NFPA 99 Health Care Facilities Code

Category 1: Facility systems in which failure of such equipment or system is likely to cause major injury or death of patients or caregivers.

Category 2: Facility systems in which failure of such equipment is likely to cause minor injury to patients or caregivers.

Chapter 12 Emergency Management 12.5.3.4.5

The organization shall make provisions for emergency credentialing of volunteer clinical staff.

Chapter 12 Emergency Management 12.5.3.4.5.1

At a minimum, a peer evaluation of skill shall be conducted to validate proficiency for volunteer clinical staff. 12.5.3.4.5.2.

Prior to beginning work, the identity of other volunteers offering to assist during response activities shall be verified.

Note: During emergency conditions, a health care facility may see an influx of volunteers offering to help. While this can certainly benefit the facility, it is important that the identity of these volunteers be verified and that they be given any special access. In previous editions of the code, the language in this paragraph made it possible to interpret the requirement to mean only that the facility should try to identify volunteers. It has been revised in for the 2015 edition to clarify that this is a mandatory

provision of the code. The facility needs to provide these volunteers whose identities have been verified with a means of identification that is able to be worn and kept visible at all times.⁶

NFPA 1600 Standard on Disaster / Emergency Management and Business Continuity

The main text of NFPA 1600 does not include reference to volunteers, however volunteers are referenced within Annex A: Explanatory Material which is not a part of the requirements of the NFPA document but is included for informational purposes only. The annex contains explanatory material, numbered to correspond with the applicable text paragraphs in parenthesis.

A.5.4.2(1)

The resource needs assessment might include “credentialing,” which addresses the need for individuals licensed (e.g., doctors, engineers) in one jurisdiction (state or country) performing their professional duties (as volunteers or under mutual aid compacts) during an incident in a jurisdiction where they are not licensed or do not hold the proper credentials. Credentialing provides minimum professional qualifications, certifications, training, and education requirements that define the standards required for specific emergency response functional assignments.

(5.4.2 The resource needs assessment shall include the following: (1) *Human resources, equipment, training, facilities, funding, expert knowledge, materials, technology, information, intelligence, and the time frames within which they will be needed).

A.5.4.3

All program equipment should be checked and tested on a regularly scheduled basis to ensure it will function properly when required. This might include vehicles, personal protective equipment (PPE), radio, information technology equipment, and warning and alerting devices and equipment, including sirens, special emergency response equipment, and so forth. Resources can be prepositioned to expedite deployment. These resources can include the following:

(10) Specialized human resources (medical, faith-based, and volunteer organizations; emergency management staff; utility workers; morticians; and private contractors).

(5.4.3 The entity shall establish procedures to locate, acquire, store, distribute, maintain, test, and account for services, human resources, equipment, and materials procured or donated to support the program).

A.6.9.3

⁶ National Fire Protection Association. (2015). NFPA 99: Health Care Facilities Code. Available online at: <https://www.nfpa.org/codes-and-standards/all-codes-and-standards/list-of-codes-and-standards/detail?code=99>

Recovery planning for the public and private sectors should provide for continuity of operations to return the entity, infrastructure, and individuals back to an acceptable level. This includes implementation of mitigation measures to facilitate short-term and long-term recovery.

Long-term goals and objectives should be based on the entity's strategic plan and include the following:

(3) Management of volunteers (both affiliated and spontaneous), contractual, and entity resources.

(6.9.3 The recovery plan shall provide for restoration of functions, services, resources, facilities, programs, and infrastructure).⁷

Legal Authorities

Public Health Security and Bioterrorism Preparedness and Response Act of 2002

The Act amends the Public Health Service Act to “improve the ability of the United States to prevent, prepare for, and respond to bioterrorism and other public health emergencies.” The Act requires the Secretary of HHS to “develop and implement” a coordinated strategy in the form of a national preparedness plan. The Act also establishes the position of Assistant Secretary for Public Health Emergency Preparedness (renamed the Assistant Secretary for Preparedness and Response, see Pandemic and All-Hazards Preparedness Act below), who is responsible for coordinating the operations of the National Disaster Medical System and other emergency response activities within HHS. The Act also provides the Secretary of HHS with the authority to regulate select agents and toxins and to temporarily exempt individuals or entities from the requirements of these regulations if necessary to provide for a timely response to a public health emergency. Additionally, several provisions for protection of the food and drug supply are included. Further, the Act directs the Secretary to establish and maintain the Emergency System for Advance Registration of Health Professions Volunteers (ESAR-VHP).⁸

Pandemic and All-Hazards Preparedness Act of 2006 (PAHPA)

The Act identifies the Secretary of HHS as the lead federal official for public health emergency preparedness and response and establishes the Assistant Secretary for Preparedness and Response

⁷ National Fire Protection Association. (2015). NFPA 1600: Standard on Disaster/Emergency Management and Business Continuity/Continuity of Operations Programs. Available online at: <https://www.nfpa.org/codes-and-standards/all-codes-and-standards/list-of-codes-and-standards/detail?code=1600>

⁸ 107th Congress. (June 12, 2002). Public Health Security and Bioterrorism Preparedness and Response Act of 2002, PL 107-188, 42 USC § 201. Available at: <https://www.gpo.gov/fdsys/pkg/PLAW-107publ188/pdf/PLAW-107publ188.pdf>

(formerly named the Assistant Secretary for Public Health Emergency Preparedness, see Public Health Security and Bioterrorism Preparedness and Response Act of 2002 above). The Act also provides new authorities for developing countermeasures, establishes mechanisms and grants to continue strengthening state and local public health security infrastructure, and addresses surge capacity by placing the National Disaster Medical System and the Emergency System for Advance Registration of Health Professions Volunteers (ESAR-VHP) under the purview of HHS.⁹

The Medical reserve Corps, founded in 2002, was codified by PAHPA. PAHPA also added certain requirements and protections for MRC members, and provides the Secretary with authority to hire certain MRC members to assist with federal response efforts. During a public health emergency (whether or not declared to be a public health emergency pursuant to section 319 of the PHS Act), the Secretary is authorized to activate and deploy willing members of the Corps to areas of need, with the concurrence of state, local, or tribal officials from the area where the members reside. 42 U.S.C. §300hh-15(e). The Secretary may appoint selected MRC members to serve as intermittent personnel pursuant to section 2813(h) of the PHS Act. 42 U.S.C. § 300hh-15(h). Certain protections that apply to NDMS personnel will apply in the same manner to MRC members who are hired as intermittent personnel including FTCA coverage when working within the scope of such appointment, worker's compensation (i.e., FECA coverage), and certain employment and re-employment rights. State, local, and tribal officials may not designate MRC members as federal intermittent disaster-response personnel but may request the services of such members.

MRC members who are not hired as federal intermittent personnel are allowed travel or transportation expenses, including a per diem, while engaged in performing duties pursuant to an assignment by the Secretary. 42 U.S.C. § 300hh-15(f). Such non-federal personnel are subject to the laws of the state in which their activities are undertaken (e.g., state licensing laws would apply to non-federal personnel). MRC members who are not intermittent personnel and who are not assigned federal duties by the Secretary generally will not qualify for FTCA or FECA coverage. However, like other non-federal volunteer health care professionals (VHPs), such MRC members may qualify for various state tort liability protections. Non-federal MRC members may also need to obtain a license when providing health care across state lines.

Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA) of 2013

PAHPRA reauthorized funding for provisions of the Pandemic and All-Hazards Preparedness Act of 2006, as well as amended several provisions of the Public Health Service Act and the Food Drug and Cosmetic Act. PAHPRA requires Pandemic and All-Hazards Preparedness Act fund recipients to

⁹ 109th Congress. (December 119, 2006). Pandemic and All Hazards Preparedness Act of 2006, PL 109-417, 42 USC § 201. Available at: <https://www.gpo.gov/fdsys/pkg/PLAW-109publ417/pdf/PLAW-109publ417.pdf>

account for children and “at-risk individuals” in their All-Hazards Public Health Emergency Preparedness and Response Plan, as well as coordinate with local Metropolitan Medical Response Systems, local Medical Reserve Corps, and the local Cities Readiness Initiative.¹⁰

Volunteer Protection Act of 1997

The federal Volunteer Protection Act (VPA) of 1997 was enacted to limit liability of volunteers serving public and private not-for-profit organizations and government agencies. The VPA provides a minimum level of liability protection for volunteers who meet the Act’s requirements.

The Volunteer Protection Act supports and promotes the activities of organizations that rely on volunteers by providing the volunteers some protections from liability for economic damages for activities relating to the work of the organizations. Under the Act, to be found not liable for the injury caused by a negligent act or omission of the volunteer, the volunteer must have been acting within the scope of his or her responsibilities in the nonprofit or government agency. The volunteer must have appropriate licensure or certification if required for the volunteer’s duties; he or she must not have acted with gross negligence, reckless disregard, willful or criminal misconduct, or flagrant indifference; and the injury cannot have occurred while the volunteer was intoxicated. Further, the injury cannot have occurred while the volunteer was operating an automobile or other vehicle for which the state requires an operator’s license and insurance. This Act does not limit the liability of the nonprofit or government agency. The Act does not limit an injured party’s ability to sue for non-economic damages, provide immunity to the nonprofit organization or government entity supervising the volunteer, nor limit a nonprofit or government entity’s ability to bring a civil action against the volunteer. States may opt out of the Volunteer Protection Act.¹¹

Under the Federal Volunteer Protection Act, volunteers:

- Have immunity from (no liability for) negligence if you volunteer for a nonprofit organization or governmental entity. No need for federal funding.
- Must act within the scope of your responsibilities in the organization.
- Must be properly licensed, certified, or authorized to act. Protection is not limited to emergencies.
- Are not protected if the harm occurred through your operation of a motorized vehicle.

¹⁰ 113th Congress. (March 13, 2013). Pandemic and All Hazards Preparedness Reauthorization Act of 2013, PL 113-5, 42 USC § 201. Available at: <https://www.gpo.gov/fdsys/pkg/PLAW-113publ5/pdf/PLAW-113publ5.pdf>

¹¹ 105th Congress. (June 18, 1997). Volunteer Protection Act of 1997, PL 105-19, 42 USC § 14501. Available at: <https://www.gpo.gov/fdsys/pkg/PLAW-105publ19/pdf/PLAW-105publ19.pdf>

- Are not protected for reckless misconduct or gross negligence.

Emergency Management Assistance Compact (EMAC) of 1996

EMAC facilitates resource sharing among member states during an emergency. The National Emergency Management Association (NEMA) administers EMAC, which has been enacted by every state. A governor's declaration of emergency and request for assistance triggers EMAC for the requesting state. An assisting state then responds to the request by providing the needed resources, including personnel. EMAC stipulates that a provider who is licensed or certified in one state will be considered licensed or certified in the receiving state subject to limitations described in the requesting state's governor's order. EMAC provides for protection of officers or employees of the assisting state from tort liability for negligent acts or omissions unless the officer or employee acted with gross negligence, recklessness, or willful misconduct. EMAC also requires that each state provide for worker's compensation in instances of injury or death for their own employees.¹²

Section 319I of the Public Health Service (PHS) Act (42 U.S.C. 247d-7b), as added by Section 107 of the Public Health Security and Bioterrorism Preparedness and Response Act authorized the Secretary of HHS to establish and maintain a system for advance registration of health professionals to verify credentials, licenses, accreditations, and health care facility privileges when such professionals volunteer to provide services during public health emergencies.

Section 319I was amended in December 2006 by section 303(b) of the Pandemic and All-Hazards Preparedness Act (PAHPA). Section 319I(a) directs the Secretary to link existing state verification systems to maintain a single national interoperable network of systems. Section 319I(h) clarifies that inclusion of a VHP in the verification network does not constitute appointment of such individual as a federal employee for any purpose.

Federal Tort Claims Act (FTCA)

Allows individuals to seek compensation when they are injured by federal employees and volunteers acting within the scope of their employment or volunteer service. The act immunizes federal government volunteers from tort liability (except in certain instances); the federal government assumes a volunteer's role as defendant in a lawsuit against the volunteer.¹³

¹² 104th Congress. (October 19, 1996). Emergency Management Assistance Compact of 1996, PL 104-321. Available at: <https://www.congress.gov/104/plaws/publ321/PLAW-104publ321.pdf>

¹³ U.S. Department of Health and Human Services, Health Resources & Service Administration. (n.d.). *About the Federal Tort Claims Act*. Available online at: <https://bphc.hrsa.gov/ftca/about/index.html>

Volunteer Protection Act (VPA)

VPA provides immunity from ordinary negligence to volunteers of nonprofit organizations or governmental entities. It does not cover gross negligence, willful misconduct, recklessness, or acts committed by the volunteer while intoxicated or operating a motor vehicle. It does not cover organizational entities of any type or persons volunteering at private businesses. VPA does not require a declared emergency for its protections to apply.

VPA provides protection to nonprofit organizations' and governmental entities' volunteers for harm caused by their acts or omissions on behalf of the organization or entity. The act does not require that an emergency declaration be in place for its protections to apply.

VPA applies to an uncompensated volunteer for acts of ordinary negligence committed within the scope of the volunteer's responsibilities. If the volunteer's responsibilities are covered by licensure laws, the volunteer must be properly licensed, certified, or authorized by the appropriate authorities as required by the law in the state in which the harm occurred.

Protection under VPA does not apply if the volunteer engages in willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individual(s) harmed by the volunteer. VPA also does not apply if the volunteer causes harm by operating a motor vehicle, vessel, aircraft, or other vehicle for which the state requires its operator to possess an operator's license or maintain insurance.

Volunteers of businesses (including for-profit health care facilities) and the organizational entities that use the volunteers (including nonprofit or governmental organizations) are not protected by VPA. For example, a health professional who volunteers at a for-profit private health care facility or receives compensation for volunteering at a nonprofit health care facility is not protected from liability by VPA. There may, however, be other laws that provide this volunteer with immunity.

VPA does not affect any legal actions taken by the volunteer's organization against the volunteer.

VPA applies to:

- Uncompensated volunteers.
- Volunteers properly licensed, certified, or authorized by state law.
- Volunteers of nonprofit organizations or governmental entities.
- Acts within a volunteer's scope of responsibility.
- Acts of ordinary negligence.

VPA does not apply to:

- Willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individual(s) harmed by the volunteer.
- Harm caused by operating a motor vehicle, vessel, aircraft, or other vehicle for which the state requires its operator to possess an operator’s license or maintain insurance.
- Volunteers for businesses.
- The organization or entity utilizing the volunteer.¹⁴

National Response Framework Volunteer and Donations Management Support Annex

The Volunteer and Donations Management Support Annex describes the coordination processes used to support the State in ensuring the most efficient and effective use of unaffiliated volunteers, unaffiliated organizations, and unsolicited donated goods to support all Emergency Support Functions (ESFs) for incidents requiring a Federal response, including offers of unaffiliated volunteer services and unsolicited donations to the Federal Government.¹⁵

Emergency Support Function #8 – Public Health and Medical Services Annex

ESF8 lists as a response action for Medical Surge: “Coordinates with states to integrate Federal assets with civilian volunteers deployed from local, state, and other authorities, including those deployed through the ESAR-VHP and MRCs.¹⁶

¹⁴ 105th Congress. (June 18, 1997). Volunteer Protection Act of 1997, PL 105-19, 42 USC § 14501. Available at: <https://www.gpo.gov/fdsys/pkg/PLAW-105publ19/pdf/PLAW-105publ19.pdf>

¹⁵ U.S. Department of Homeland Security, Federal Emergency Management Agency. (May 2013). *Volunteer and Donations Management Support Annex*. Available online at: https://www.fema.gov/media-library-data/20130726-1914-25045-5208/nrf_support_annex_volunteer_20130505.pdf

¹⁶ U.S. Department of Homeland Security, Federal Emergency Management Agency. (January 2008). *Emergency Support Function #8 – Health and Medical Services Annex*. Available online at: https://www.fema.gov/media-library-data/20130726-1825-25045-8027/emergency_support_function_8_public_health_medical_services_annex_2008.pdf

Resources

- *Integrating Emergency Volunteers During Medical Surge: Hospital Checklist*, 2012; Iroquois Health care Association, Health care Association of New York State
- [*Health care Preparedness Capabilities: National Guidance for Health care System Preparedness*](#), 2012; U.S. Department of Health & Human Services
- [*Disaster Credentialing Toolkit*](#), 2009; Wisconsin Hospital Association
- [*Emergency System for Advanced Registration of Volunteer Emergency Professionals \(ESAR VHP\)*](#); U.S. Department of Health & Human Services
- [*Blueprint for the Use of Volunteers in Hospitals and Rural Medical Centers*](#), 2011; Mesa County Advanced Practice Center
- *Disaster Staffing Plan*; University of Rochester Medical Center