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Medical Volunteers During Pandemics, Disasters, and Other Emergencies: Management Best Practices

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I. INTRODUCTION

Disaster preparedness is a fundamental obligation of every hospital.¹ Major emergencies can result in vastly increased demand² for clinical and non-clinical staff. Managing volunteer-related legal issues during a disaster may be difficult or even impossible. Careful preparation is essential for the successful integration of volunteers during a surge in patients.³ Efficiently onboarding skilled and unskilled volunteers allows current providers and first responders to remain focused on triage, critical care, and specialized patient needs. In some instances, volunteers may be the only personnel available to fill essential functions when organic resources cannot fully respond to peak demand. Volunteers can also fill gaps if current staff are unable to report for duty because of mandated quarantine periods or restricted travel conditions. Regular employees may even refuse to

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¹ See generally U.S. DEP'T TRANS., EVACUATING POPULATIONS WITH SPECIAL NEEDS: ROUTES TO EFFECTIVE EVACUATION PLANNING PRIMER SERIES 30 (2009); see also DAVID A. MCENTIRE, DISCIPLINES, DISASTERS AND EMERGENCY MANAGEMENT: THE CONVERGENCE AND DIVERGENCE OF CONCEPTS, ISSUES AND TRENDS IN THE RESEARCH LITERATURE (2007).

² J. L. Hick et al., *Health care facility and community strategies for patient care surge capacity*, 44 ANNALS EMERGENCY MED. 253 (2004).

³ See generally Sharon Einav et al., *Surge Capacity Logistics: Care of the Critically Ill and Injured During Pandemics and Disasters: CHEST Consensus Statement*, 146 CHEST e17S-e43S (2014).

report out of fear of contracting an infectious disease, dangerous travel conditions, or other concerns.⁴ Treating or evacuating large numbers of elderly, medically-frail, or chronically-sick patients⁵ may not be possible at all without volunteers. A viable Emergency Operations Plan (EOP),⁶ consistent with the National Disaster Medical System (NDMS) should contemplate the potential necessity of volunteer medical and public health professionals such as physicians, nurses, pharmacists, dentists, veterinarians, and epidemiologists, as well as key support positions that include but are not limited to interpreters, chaplains, office workers, legal advisors and others.⁷ Volunteer partners may include non-credentialed but otherwise qualified clinicians as well as non-clinicians from the surrounding area. Supplemental staff may be sourced from community clinics, health departments, EMT-fire departments, or law enforcement agencies. Volunteers may also be provided by local non-profits such as American Red Cross, Salvation Army, food kitchens, churches, or others.⁸

Recent experience indicates healthcare facilities that fail to plan and respond adequately to emergency conditions may be held liable for resulting patient or staff harm.⁹ The continuous threat posed by natural disasters, communicable diseases, or bio-terrorism has revolutionized hospital planning. Following Hurricane Katrina, there was no coordinated system for recruiting, deploying, and managing volunteers to help deal with the crisis.¹⁰ Thousands of healthcare professionals and other volunteers from New York City and surrounding communities responded in the hours and days following the 9/11 attack.¹¹ Preparation for worst-case scenarios involves consideration of all reasonable measures to mitigate the

⁴ The refusal of healthcare workers to report for duty during public health emergencies is well documented. See Kerri S. Reisdorff & Ruthie L. Goodboe, *Triaging Employee Refusals to Work Due to COVID-19: A Legal Update for Healthcare Employers*, NAT'L L. REV. (May 19, 2020), <https://www.natlawreview.com/article/triaging-employee-refusals-to-work-due-to-COVID-19-legal-update-healthcare-employers> [<https://perma.cc/2TLV-D4WN>].

⁵ See generally Tara Heagele & Dula Pacquiao, *Disaster Vulnerability of Elderly and Medically Frail Populations*, HEALTH EMERGENCY & DISASTER NURSING (2018).

⁶ Federal regulation requires hospitals to maintain an "all hazards" comprehensive emergency preparedness plan that is reviewed and updated every two years. 42 C.F.R. § 482.15 (2019).

⁷ U.S. Dep't of Health & Hum. Services, *The Emergency System for Advance Registration of Volunteer Health Professionals*, <https://www.phe.gov/esarvhp/Pages/more-volunteer-opportunities.aspx> [<https://perma.cc/4WJP-9CGM>]. The NDMS assists state and local authorities in dealing with the medical impacts of major peacetime disasters and is administered by the U.S. Department of Health and Human Services. *Id.*

⁸ See generally CTRS. DISEASE CONTROL & PREVENTION, PUBLIC HEALTH EMERGENCY PREPAREDNESS AND RESPONSE, NATIONAL STANDARDS FOR STATE, LOCAL, TRIBAL, AND TERRITORIAL PUBLIC HEALTH (Rev. 2019).

⁹ See J.G. Hodge & E.F. Brown, *Assessing Liability for Healthcare Entities that Insufficiently Prepare for Catastrophic Emergencies*, 306 J. AM. MED. ASS'N 308 (2011).

¹⁰ See generally Crystal Franco et al., *Systemic Collapse: Medical Care in the Aftermath of Hurricane Katrina*, 4 BIOSECURITY & BIOTERRORISM 135 (2006).

¹¹ See generally Allan Rosenfeld et al., *September 11: The Response and Role of Public Health*, 92 AM. J. PUB. HEALTH 10 (2002).

risk that responding volunteers may harm others¹² or injure themselves. Injured volunteers might also seek to file lawsuits themselves against host facilities. A well-conceived plan for incorporating volunteers within an EOP could significantly enhance liability protection for facilities, providers, and others who act in good faith conformity with the plan.¹³

II. DEPLOYMENT AND CREDENTIALING

Emergency compliance standards are developed by the Joint Commission (JCAHO),¹⁴ United States Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS),¹⁵ as well as state and local regulatory agencies. Surge preparation typically envisions increased patient volume during disasters, pandemics,¹⁶ bioterrorism incidents,¹⁷ or large-scale HAZMAT exposures. The American College of Emergency Physicians defines “surge” as the capacity of the healthcare facility or system “to manage a sudden and rapidly progressive influx of patients within the currently available resources at a given point in time.”¹⁸ 42 C.F.R. § 482.15 declares the two most important aspects of emergency compliance for hospitals are: (1) continuity of care and (2) cooperation with state, federal, and local emergency preparedness officials.¹⁹ 42 C.F.R. § 483.73b(6) requires facilities preparing EOPs to consider the possibility that these facilities will need volunteers to address surge

¹² SEE GENERALLY INST. OF MED., *LEGAL ISSUES IN EMERGENCIES, LIABILITY RISKS AND PROTECTIONS FOR HEALTH CARE PRACTITIONERS* (MAR. 21, 2012),

<https://www.ncbi.nlm.nih.gov/books/NBK201075/> [<https://perma.cc/W6XP-BRT2>].

¹³ Brooke Courtney et al., *Legal Preparedness: Care of the Critically Ill and Injured During Pandemics and Disasters: CHEST Consensus Statement*, 146 CHEST e134S-e144S (2014).

¹⁴ Joint Commission (JCAHO) guidance requires continuing, effective patient care during emergencies. Facility competencies are evaluated across six critical areas: communications, supply, security, staff, utilities, and clinical care. THE JOINT COMMISSION, *EMERGENCY MANAGEMENT STANDARDS SUPPORTING COLLABORATIVE PLANNING 2* (2016).

¹⁵ Emergency Preparedness Final Rule Interpretive Guidelines and Survey Procedures, 81 Fed. Reg. 180, Appendix Z (Nov. 15, 2016).

¹⁶ See generally Eric Toner et al., *Hospital Preparedness for Pandemic Influenza*, 4 BIOSECURITY & BIOTERRORISM STRATEGY: BIODEFENSE STRATEGY, PRAC., & SCI. 207 (2006). According to a 2004 GAO report, no state has proposed any benchmarks for infectious diseases response for an epidemic involving 500 or more patients. U.S. GOV'T ACCOUNTABILITY OFF., *GAO-04-360R, HHS Bioterrorism Preparedness Programs: States Reported Progress but Fell Short of Program Goals for 2002*, (2004).

¹⁷ The U.S. Department of Health and Human Services obligates grant awardees to develop systems allowing for the “advance registration and credentialing of clinicians needed to augment a hospital or other medical facility” to meet surge capacity needs. U.S. DEP'T OF HEALTH AND HUM. SERV., *ANNOUNCEMENT NO. 5-U3R-05-001, THE NAT'L BIOTERRORISM HOSP. PREPAREDNESS PLAN* (2005).

¹⁸ *Health Care System Surge Capacity Recognition, Preparedness, and Response*, AM. COLL. OF EMERGENCY PHYSICIANS (Oct. 2017), <https://www.acep.org/patient-care/policy-statements/health-care-system-surge-capacity-recognition-preparedness-and-response/> [<https://perma.cc/PTY9-ZRCB>].

¹⁹ *Id.*

capacity issues.²⁰ Emergency management, especially after 9/11, Katrina,²¹ and now COVID-19, envisions a broad-spectrum of strategies “reflecting the full life cycle of disaster, i.e., preparedness, response, recovery, and mitigation.”²²

Although routine compliance activities such as HIPAA,²³ False Claims,²⁴ and the Stark Act²⁵ should remain in place when possible, compliance during emergencies involves significantly altered priorities. JCAHO standards²⁶ require hospitals to develop emergency management plans and conduct drills.²⁷ JCAHO reports that while the use of volunteers is not mandated, the standard provides a means for hospitals to use volunteers in emergencies.²⁸ JCAHO guidance provides that healthcare organizations that receive Medicare or Medicaid must follow Emergency Preparedness regulations in order to participate. (These are also known as Conditions of Participation (CoP).)²⁹ Under the JCAHO standards, during disaster circumstances in which the emergency management plan has been activated, the Chief Executive Officer (CEO) or medical staff president or their designee may grant emergency privileges.³⁰

To fully address all these competencies during an emergency, credentialing may involve federal or state employee volunteers, members of non-government agencies, or spontaneous “Samaritans.” JCAHO standard MS.5.14.4.1 addresses emergency credentialing and privileging of volunteer physicians during emergencies. Emergency privileging is activated by the facility CEO or designee following a determination the organization is, or will be, unable to adequately meet immediate patient needs. The EOP identifies those persons responsible for granting emergency privileges

²⁰ 42 C.F.R. § 483.73b(6) (2019).

²¹ See James Hodge, *Legal Issues Concerning Volunteer Health Professionals and The Hurricane-Related Emergencies in The Gulf Coast Region*, 121 PUB. HEALTH REP. 205, 205–207 (2006).

²² FED. EMERGENCY MGMT. AGENCY, DEVELOPING AND MAINTAINING EMERGENCY OPERATIONS PLANS, COMPREHENSIVE PREPAREDNESS GUIDE (CPG) 101, VERSION 2.0 3-10 (Nov. 2010).

²³ 45 C.F.R. § 160.103 (2013).

²⁴ 31 U.S.C. § 3729 (2009).

²⁵ 42 U.S.C. § 1395nn (2018).

²⁶ JOINT COMM’N, REVISIONS TO EMERGENCY MANAGEMENT OVERSIGHT REQUIREMENTS (2012).

²⁷ JOINT COMM’N ON ACCREDITATION OF HEALTHCARE ORG., COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: MEDICAL STAFF SECTION MS.5.14.4.1: DISASTER PRIVILEGING STANDARD (2003) [hereinafter JCAHO].

²⁸ The JCAHO defines “community partners” as including “vendors, community organizations, public safety and public works officials, representatives of local municipalities, and other government agencies.” JOINT COMM’N, EMERGENCY MANAGEMENT STANDARDS SUPPORTING COLLABORATION PLANNING, EM.01.01.01, EP3 4 (2016).

²⁹ *Emergency Management*, JOINT COMM’N, <https://www.jointcommission.org/resources/patient-safety-topics/emergency-management/> [https://perma.cc/ZKV3-45BS] (citing Centers for Medicare & Medicaid Services Emergency Preparedness Rule (SOM Appendix Z), 81 Fed. Reg. 63,860 (Sept. 16, 2016); see also JOINT COMM’N, EMERGENCY MANAGEMENT STANDARDS SUPPORTING COLLABORATION PLANNING 2 (2016); see also JOINT COMM’N ON ACCREDITATION OF HEALTHCARE ORG., HEALTH CARE AT THE CROSSROADS: STRATEGIES FOR CREATING AND SUSTAINING COMMUNITY-WIDE EMERGENCY PREPAREDNESS SYSTEMS (2003).

³⁰ JCAHO, *supra* note 27, at MS.5.14.4.1.

following review of a “key identification document.”³¹ Key identification documents include hospital photo-ID, medical license, valid photo-ID from federal or state emergency management authority, or verbal assurances from a current staff member with personal knowledge of the licensed provider’s identity and qualifications. Under JCAHO, emergency privileging is normally limited to seventy-two hours with extensions of not more than one additional seventy-two-hour period if necessary.³²

The Emergency Management Assistance Compact of 1996 (EMAC)³³ is an interstate mutual aid compact ratified by all states and U.S. Territories that facilitates sharing and cooperation during natural or man-made disasters.³⁴ EMAC empowers sending states, which provide support to requesting states, to deploy employees, equipment, and supplies to other states upon receiving the emergency declaration and request for assistance from the requesting state’s governor.³⁵ EMAC licensed or certificated medical clinicians providing the same type of care in a sending state are considered as licensed (or certified) in the requesting state subject to limitations or conditions specified in an emergency proclamation.³⁶ EMAC addresses liability, compensation, reimbursement, and credentialing for deployed personnel by supplementing the federal National Incident Management System (NIMS).³⁷ NIMS is a national coordination and standardizations doctrine developed by the Federal Emergency Management Agency (FEMA) to ensure best practices and cross-jurisdictional interoperability.³⁸ The current version of NIMS, dated October 17, 2017, provides a common, nationwide approach enabling whole communities to work together to manage all types of threats and hazards. NIMS applies to all incidents, “regardless of cause, size, location, or complexity.”³⁹ Under NIMS, the sending state’s workers compensation provisions as well as tort liability statutes generally cover deployed personnel.⁴⁰ The major shortcoming of EMAC and NIMS is the lack of provisions for utilization of private sector volunteers.⁴¹ From 2006 through 2013, the overwhelming

³¹ *Id.*

³² JOINT COMM’N, EMERGENCY MANAGEMENT STANDARDS SUPPORTING COLLABORATION PLANNING, EM.02.02.13 2 (2016).

³³ 6 U.S.C. § 761 (2018).

³⁴ Emergency Management Assistance Compact (EMAC), 110 Stat. 3877 (1996) (codified as 6 U.S.C. § 761) (a joint resolution granting the consent of the United States Congress to the EMAC).

³⁵ *Id.* at Art. 1.

³⁶ *Id.*

³⁷ FED. EMERGENCY MGMT. AGENCY, NATIONAL INCIDENT MANAGEMENT SYSTEM (3rd. ed. Oct. 2017).

³⁸ *Id.* at 6.

³⁹ *Id.*

⁴⁰ *Id.* at 7.

⁴¹ See NAT’L EMERGENCY MGMT. ASS’N, *An Analysis of EMAC Capabilities for Private Sector and Volunteer Resource Coordination* (2014).

majority of EMAC status deployed personnel were public employees of sending states or members of the sending state's National Guard units.⁴²

The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)⁴³ aids in establishing private-sector volunteer registration programs for medical emergencies. 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."⁴⁴ Formerly promulgated by the Health Resources and Services Administration (HRSA), ESAR-VHP is currently administered by the U.S. Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR). Clinical providers within the ESAR-VHP system include physicians, physician assistants (PA), nurses, behavioral health professionals, emergency medical technicians and paramedics, laboratory technicians, pharmacists, and even veterinarians.⁴⁵ ESAR-VHP has developed a uniform process for classifying and assigning volunteers into one of four credential levels, based on the credentials provided and verified.⁴⁶ Personal information provided by potential volunteers is accessible only to authorized personnel.⁴⁷ Various state-affiliated ESAR-VHP systems vary by name (e.g. "Washington State Emergency Registry of Volunteers," the "Kentucky Health Emergency Listing of Professionals for Surge," etc.) as do registration protocols. Some states use online electronic registration, while others still require registration via mailed-in paper applications.⁴⁸ Even with an ESAR-VHP database in place, the ability to communicate immediate facility needs to multiple sending agencies may be difficult or compromised during a crisis. Redundancies and back-up planning for crisis credentialing are needed to meet critical needs during the most exigent circumstances.

III. TORT CONSIDERATIONS

State tort protections for volunteers depend upon the nature of services provided, type of facility, and (regular) employment status⁴⁹ of the provider (or organization). Although general charitable immunity was

⁴² *Id.*

⁴³ 42 U.S.C. § 201(1993). §107 of the Act directs the HHS Secretary to develop an Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP).

⁴⁴ *About ESAR-VHP*, U.S. DEP'T OF HEALTH & HUM. SERV., <https://www.phe.gov/esarvhp/pages/about.aspx> [<https://perma.cc/TQ2X-XP24>] [hereinafter ESAR-VHP].

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ The common law doctrine of charitable immunity exists to any significant extent in only nine states: Alabama, Arkansas, Georgia, Maine, Maryland, New Jersey, Utah, Virginia, and Wyoming. See NONPROFIT RISK MGMT. CTR., STATE LIABILITY LAWS FOR CHARITABLE ORGANIZATIONS AND VOLUNTEERS (Dec. 2009).

broadly recognized at common law,⁵⁰ “charitable immunity has been abolished in the majority of the states [while only] vestiges of this common law doctrine remain in various jurisdictions.”⁵¹ Many states provide charitable immunity for healthcare providers and volunteers only during “declared emergencies.”⁵² Several states narrowly define those emergencies during which protections and immunities are available.⁵³ Other state tort protections include so-called “Good Samaritan” laws or the ability to invoke “sovereign immunity” if volunteers are designated as agents or employees of a (host) state.⁵⁴ In addition to sovereign immunity and Good-Samaritan laws, states may have tort-limiting or immunity statutes for non-profit organizations.⁵⁵ Unfortunately, there remains much confusion and uncertainty regarding the scope and efficacy of these laws. Many statutes make liability limitations inapplicable to officers, employees, or other agents of state governments.⁵⁶ Some provisions are ineffective until a formal emergency declaration is promulgated.⁵⁷ Volunteers and spontaneous Samaritans rendering assistance generally have no ‘guarantee’ of liability protection, and no state provides anything resembling a full or complete solution to volunteer liability protection.

Under federal law, the Volunteer Protection Act (VPA) of 1997 preempts state laws unless the state statute provides greater liability protections. VPA affords volunteers working for 501(c)(3) organizations or local and state agencies with personal immunity for acts of simple

⁵⁰ *McDonald v. Mass. Gen. Hosp.*, 120 Mass. 432 (1876).

⁵¹ See P.T. O’Neill, *Charitable Immunity: The Time to End Laissez-Faire Health Care in Massachusetts Has Come*, 82 MASS. L. REV. 223, 230 (1997).

⁵² DEP’T OF HEALTH & HUM. SERV., HEALTH RESOURCES AND SERVICES ADMINISTRATION HEALTHCARE SYSTEMS (HRSA), EMERGENCY SYSTEM FOR ADVANCE REGISTRATION OF VOLUNTEER HEALTH PROFESSIONALS (ESAR-VHP) — LEGAL AND REGULATORY ISSUES, DRAFT (May 2006).

⁵³ *Immunity Issues in Emergencies*, ASS’N OF STATE AND TERRITORIAL HEALTH OFF., <https://www.astho.org/Programs/Preparedness/Public-Health-Emergency-Law/Emergency-Authority-and-Immunity-Toolkit/Immunity-Issues-in-Emergencies-Fact-Sheet/> [<https://perma.cc/BE2P-GB4J>].

⁵⁴ *Id.*

⁵⁵ In Virginia, nonprofits are immune from suits by beneficiaries alleging negligence absent a finding of corporate negligence or failure to exercise ordinary care in the selection of employees or volunteers. VA. CODE ANN. § 8.01-38 (1990); see also *Davidson v. Colonial Williamsburg Found.*, 817 F.Supp 611 (1993); see generally Michelle R. Rack, *The Doctrine of Charitable Immunity: Alive and Well in Virginia*, 24 U. RICH. L. REV. 541 (1990). Wyoming limits charitable immunity only if a nonprofit provides services without charge. WYO. STAT. ANN. § 1-1-125 (2017). Colorado limits judgments against non-profits to the extent of existing insurance coverage. COLO. REV. STAT. ANN. § 7-123-105 (West 2013). Massachusetts has a tort cap of \$20,000 for torts committed while engaged in acts to directly accomplish the charitable purposes of the organization. MASS. GEN. LAWS ANN. ch. 231, § 85K (West 2012). South Carolina limits awards to \$250,000 in actions for injury or death caused by the tort of an agent, servant, employee, or officer of the charitable organization. S.C. CODE ANN. § 33-56-180 (2000). Texas operational tort liability is 500,000 per person and 1,000,000 per event but does not extend to hospitals. TEX. CIV. PRAC. & REM. CODE ANN. § 84.006 (1987).

⁵⁶ See generally MATTHISEN, WICKERT, & LEHER, S.C., STATE SOVEREIGN IMMUNITY AND TORT LIABILITY IN ALL 50 STATES (Jan. 2021).

⁵⁷ *Id.*

negligence.⁵⁸ In the absence of compacts that grant reciprocity on licensure, like the Nurse Licensure Compact (NLC), state statutes supplement the VPA by mandating volunteers undergo training or require sponsoring facilities to provide liability or workers compensation insurance coverage.⁵⁹ For the VPA to apply, volunteers must be acting within the scope of assigned volunteer duties and be unpaid except for reasonable expenses not exceeding \$500.00 per year.⁶⁰ VPA does not provide immunity for acts of “willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference”⁶¹ to the rights or safety of harmed individuals. The VPA also exempts criminal violence, terrorism, hate-crimes, sexual offenses, and harms committed while a volunteer is intoxicated.⁶² The VPA does not protect unlicensed or uncertified persons from liability if licensing or certification is normally required in that area.

Although there is no specific requirement for an emergency declaration under VPA, an “opt-out” provision allows state legislatures to limit or eliminate protections in cases where parties are citizens of the state.⁶³ The “pre-emption” aspect of the VPA does not actually preempt state liability protections beyond what is provided in the VPA.⁶⁴ If the state fails to enact laws meeting or exceeding the protections afforded under the VPA, the federal statute supersedes the state law.⁶⁵ The VPA also limits punitive damages against volunteers “unless the claimant establishes by clear and convincing evidence that the harm was proximately caused by an action of such volunteer that constitutes willful or criminal misconduct, or a conscious, flagrant indifference to the rights or safety of the individual harmed.”⁶⁶ The VPA does not protect volunteers from civil cases brought under federal law⁶⁷ and does not prevent a nonprofit organization from suing its own volunteers. The major shortcoming of the VPA is that the statute affords no liability protection for sponsoring host facilities or for regular (paid) employees. As a result, host facilities may remain liable for the negligent selection or supervision of volunteers.

⁵⁸ 42 U.S.C. § 14503 et. seq., (2018).

⁵⁹ See *Key Federal and State Laws Regarding Emergency Volunteers*, ASS'N OF STATE & TERRITORIAL HEALTH OFF., <https://www.astho.org/Programs/Preparedness/Public-Health-Emergency-Law/Emergency-Volunteer-Toolkit/Key-Federal-and-State-Laws-Regarding-Emergency-Volunteers/> [<https://perma.cc/4ZK4-NZDU>] (citing *Nurse Licensure Compact (NLC)*, NAT'L COUNCIL OF STATE BDS. OF NURSING, <https://www.ncsbn.org/nlc.htm> [<https://perma.cc/3QQA-GUD6>]).

⁶⁰ 42 U.S.C. § 14503(a)(1) (2018); 42 U.S.C. § 14505(6) (1997).

⁶¹ 42 U.S.C. § 14503(a)(3) (2018).

⁶² 42 U.S.C. § 14503(g) (2018).

⁶³ 42 U.S.C. § 14502(b) (1997).

⁶⁴ U.S. CONST. art. VI, § 2.

⁶⁵ 42 U.S.C. § 14502 (1997).

⁶⁶ 42 U.S.C. § 14503(f) (2018).

⁶⁷ See *Am. Produce v. Harvest Sharing*, No. 11-cv-00241 (D. Colo. Mar. 20, 2013). See also *Ar-mendarez v. Glendale Youth Ctr.*, 265 F. Supp. 2d 1136, 1140-41 (D. Ariz. 2003).

Considering the COVID-19 pandemic, the Public Readiness and Emergency Preparedness Act (PREP)⁶⁸ may be of benefit in volunteer planning. PREP authorizes the Secretary of HHS to decide when a communicable disease or other threat constitutes a public health emergency. In January 2020, then-HHS Secretary, Alex Azar issued the first formal PREP Act Declaration invoking third-party liability protections available under the law (effective February 4, 2020) for battling COVID-19.⁶⁹ The declaration immunizes covered persons from legal liability for COVID-19 activities and countermeasures.⁷⁰ What constitutes “appropriate activities and products” is not, however, clarified in the Act. On April 14, 2020, HHS issued a follow-up advisory opinion⁷¹ providing additional guidance on how the PREP Act and the PREP Declaration would be applied during the COVID-19 emergency. Although non-binding as law, the PREP Declaration guidance provides important answers on who might be eligible for PREP Act protections, which products (e.g. vaccines or therapeutics) are covered, and what specific clinical activities are immunized. The opinion emphasizes that PREP Act immunity is broad and provides a “reasonable belief” safe harbor for persons and businesses manufacturing, distributing, and providing COVID-19 products.⁷² This “safe harbor” protects those engaged in COVID-19 countermeasures even if they are not expressly covered under PREP, if these persons acted with a reasonable belief that they were entitled to such coverage at the time of the action or omission.⁷³

IV. WORKERS’ COMPENSATION

Workers’ compensation programs are administered almost exclusively under state⁷⁴ laws and regulations. Coverage varies significantly from state to state. Generally, workers’ compensation programs limit benefits to those workers injured while acting within the “course and scope of employment.”⁷⁵ Given the intrinsically hazardous nature of emergency care, determining if these benefits will be available for volunteers injured while providing uncompensated labor requires careful analysis of state law, the affiliations (if any) of the volunteer, and the scope of assigned responsibilities. Some employees not covered by workers’ compensation

⁶⁸ 42 U.S.C. § 247d-6d (2020).

⁶⁹ Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19, 85 Fed. Reg. 15198-01 (Mar. 17, 2020).

⁷⁰ *Id.*

⁷¹ DEP’T OF HEALTH & HUM. SERV., *Advisory Opinion on the Public Readiness and Emergency Preparedness Act and the March 10, 2020 Declaration under the Act* (rev. ed. May 19, 2020).

⁷² *Id.*

⁷³ *Id.*

⁷⁴ However, the Federal Employees Compensation Act (FECA) provides workers compensation benefits to federal employees injured or killed when appointed as intermittent disaster-response personnel. 42 U.S.C. § 300hh-15; 42 U.S.C. § 300hh-11.

⁷⁵ See generally *Marazas v. Workers’ Comp. Appeal Bd.*, 97 A.3d 854, 861-64 (2014).

may retain coverage for workplace accidents under disability insurance or collective bargaining agreements.⁷⁶ For that matter, unless authorities can verify an individual's claims, they may be reluctant to accept the individual's professional services, particularly where VHPs arrive "spontaneously."⁷⁷

Complicating matters, some volunteers may continue to receive salaries from their current employers. In other instances, sending or lending employers may remain legally responsible under state or federal law for workers' compensation benefits.⁷⁸ Some state laws expressly exclude workers' compensation coverage for volunteers because during emergencies volunteers may not be considered as regular employees.⁷⁹ Other states authorize workers' compensation protection for volunteer health professionals but allow employers to "opt out" of coverage for "unregistered" volunteers.⁸⁰ In some states, volunteer firefighters and reserve police are covered by workers' compensation. In others, volunteers coming to the assistance of police and firefighters in emergencies are covered by state workers' compensation.⁸¹ At best, if workers' compensation is available at all, it will normally be limited to volunteer duties. In other words, was an injured volunteer performing triage or assisting a patient? Was the volunteer injured during training? Did the volunteer slip-and-fall while moving a patient or while "off-duty" in a rest area?⁸²

The Uniform Emergency Volunteer Health Practitioners Act (UEVHPA)⁸³ is a post-9-11 model statute adopted and proposed by the National Conference of Commissioners on Uniform State Laws to address the complexity of workers' compensation for cross-border volunteer

⁷⁶ For example, many airline employees (including pilots and flight attendants) as well as some commercial drivers (including FedEx and UPS) have long term disability insurance through their collective bargaining agreements. *See, e.g.*, Flight Attendant Agreement 2016-2021 United Airlines, ASS'N OF FLIGHT ATTENDANTS - CWA, 241-43. <https://unitedafa.org/docs/contract/jcba-final.pdf> [<https://perma.cc/VM4B-UUTF>].

⁷⁷ CONG. RSCH. SERV., R40176, EMERGENCY RESPONSE: CIVIL LIABILITY OF VOLUNTEER HEALTH PROFESSIONALS 10 (Jan. 19, 2011).

⁷⁸ CONG. RSCH. SERV., R44580, WORKERS' COMPENSATION: OVERVIEW AND ISSUES 6, (Feb. 18, 2020). "After passing one of the first workers' compensation laws in the United States in 1882, the federal government has largely ceded jurisdiction over workers' compensation policy to the states. Today, the federal government administers two comprehensive workers' compensation programs and two programs that provide limited benefits to workers in selected industries with selected medical conditions." *Id.*

⁷⁹ *See id.*

⁸⁰ *See* WIS. HOSP. ASS'N, 2010 HOSPITALS GUIDE FOR MASS CASUALTY EVENTS (2010); *see also* U.S. CHAMBER OF COM., ANALYSIS OF WORKERS' COMPENSATION LAWS Chart 1, 15-26 (2019).

⁸¹ *Workers' Compensation Laws By State*, FINDLAW (Sept. 30, 2019), <https://www.findlaw.com/injury/workers-compensation/workers-compensation-laws-by-state.html> [<https://perma.cc/E7CW-SRQZ>].

⁸² *See generally* Wilfredo Lopez et al., *Volunteers: Liability and Workers' Compensation*, 11 BIOSECURITY & BIOTERRORISM: BIODEFENSE STRATEGY, PRAC., & SCI. 217 (2013).

⁸³ U.S. DEP'T HEALTH & HUM. SERV., *Uniform Emergency Volunteer Health Practitioners Act* (Sept. 10, 2008), <https://asprtracie.hhs.gov/technical-resources/resource/1766/uniform-emcnny-volunteer-health-practitioners-act-uevhpa> [<https://perma.cc/FZP3-XWHD>].

healthcare practitioners. As of this writing, only eighteen states and the District of Columbia have adopted UEVHPA.⁸⁴ In these jurisdictions, upon registration,⁸⁵ healthcare providers may elect workers' compensation coverage under the host state's compensation system. UEVHPA also provides civil liability protections for physicians and other licensed healthcare practitioners by cloaking these volunteers as employees or agents of the receiving state's government under sovereign immunity.⁸⁶ For UEVHPA to apply, the volunteer's actions must be within the course and scope of employment (i.e. clinical volunteer duties) and not arise from gross negligence, recklessness, or intentional misconduct, or while operating a motor vehicle.

ESAR-VHP establishes a four-level credentialing verification system based upon the provider's submitted documentation. The four-levels range from Level 1 active and privileged providers to Level 4 volunteers with "healthcare experience" such as nursing students or retired clinicians.⁸⁷ UEVHPA applies only to clinicians, and, in some states, volunteer compensation limits remain in place. For injuries occurring while volunteers are resting, cooking, training, or attending a meeting, commercial accident or disability insurance may be the best, if not the only viable solution. Volunteers might also be requested to assume the risks of accident or injury upon themselves via hold-harmless agreements, which absolve one or both parties to a contract of legal liability for any injuries or damage suffered by the parties signing the contract. Liability releases (or "Waivers") by volunteers may insulate host facilities for injuries or accidents from civil liability for negligent acts or omissions resulting in injuries to the volunteer.⁸⁸ Be advised however, that consideration for the use of volunteer liability releases would require a detailed analysis of the host state's statutory and case law. Generally, liability releases must be clearly

⁸⁴ *Id.*

⁸⁵ ESAR-VHP registration may be completed before or after a declared emergency. Each state sets registration requirements. Most specify the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or Medical Reserve Corps.

⁸⁶ Am. Coll. Surgeons, *Statement of the Uniform Emergency Volunteer Health Practitioners Act*, BULLETIN AM. COLL. SURGEONS (Jan. 6, 2018), <https://bulletin.facs.org/2018/01/statement-on-the-uniform-emergency-volunteer-health-practitioners-act/> [<https://perma.cc/U5XG-UBPJ>]; see generally James G. Hodge, Jr. et al., *The Legal Framework for Meeting Surge Capacity Through the Use of Volunteer Health Professionals During Public Health Emergencies and Other Disasters*, 22 J. CONTEMP. HEALTH L. & POL'Y 5 (2006).

⁸⁷ *Interim Technical and Policy Guidelines, Standards, and Definitions: System Development Tools*, U.S. DEP'T OF HEALTH & HUM. SERV., <https://www.phe.gov/esarvhp/Pages/registration.aspx> [<https://perma.cc/2PNX-7YRP>].

⁸⁸ See generally Danielle J. Marlow & Lauren Bernstein, *Enforceability of Liability Waivers in the Age of COVID*, N.Y.L.J. (Oct. 19, 2020), <https://www.law.com/newyorklawjournal/2020/10/19/enforceability-of-liability-waivers-in-the-age-of-covid/> [<https://perma.cc/JT7Y-ZNDQ>].

intelligible and unambiguously waive only specified risks.⁸⁹ Overbroad “all harms” waivers seeking to limit host liability for any and every type of accident or illness is not recommended and would likely prove ineffective.⁹⁰

V. CRISIS LEADERSHIP

A considerable amount of current disaster planning focuses upon meeting unrealistic “minimum”⁹¹ standards as determined by state regulators or accreditors. Minimum crisis standards incorporate “reasonable diligence, skill, competence, and prudence.”⁹² Yet, meeting even these crisis “minimums” requires adequate “facilities, services, equipment, and options”⁹³ to be on-hand and be reasonably available. Failures of leadership to develop and test realistic EOPs could result in compromised care and expanded liability for any shortcomings in care for unanticipated “major events.” The overriding clinical expectation is the competency to transition from “individualized” care to “population-centric health services to save as many lives as possible and prevent injuries among patients, practitioners, and responders.”⁹⁴ In crisis mode, leaders seeking to move from optimizing individual care to meeting “population-centric” outcomes⁹⁵ will face major challenges whether or not volunteers are needed. Toward these ends, leaders must carefully plan how and when volunteers will best fit within their facilities’ specific crisis infrastructure. To facilitate the transition, leaders should always seek constructive input from stakeholders who might be impacted by supplementing volunteers. EOPs should always assume volunteers will remain fully accountable for meeting basic standards of care from the front desk to the operating room. Volunteer taskings should include measurable goals, timelines, and objectives. Leaders should exercise careful oversight of volunteer screening, training, and deployment as they keep volunteers apprised of any potential risks to their health or safety.⁹⁶

⁸⁹ See generally Moritt Hock & Hamroff LLP, *Absolution Denied, The Enforceability of Liability Waivers in the Age of COVID-19*, JD SUPRA (July 28, 2020), <https://www.jdsupra.com/legal-news/absolution-denied-the-enforceability-of-59841/> [<https://perma.cc/9HM5-DLBN>].

⁹⁰ *Mettler v. Nellis*, 659 N.W.2d 861 (Wis. Ct. App. 2005).

⁹¹ See generally Christopher T. Born et al., *Disasters and Mass Casualties: I. General Principles of Response and Management*, 15 J. AM. ACAD. ORTHOP. SURG. 388 (2007).

⁹² *Hall v. Hilbun*, 466 So.2d 856, 873 (Miss. 1985).

⁹³ *Id.*

⁹⁴ See generally INSTITUTE OF MEDICINE, *CRISIS STANDARDS OF CARE: A SYSTEMS FRAMEWORK FOR CATASTROPHIC DISASTER RESPONSE* (Dan Hanfling et al. eds., Nat’l Academic Press 2012).

⁹⁵ Kristi L. Koenig et al., *Crisis Standard of Care Goals During Catastrophic Disasters and Emergencies*, 3 J. EXPERIMENTAL & CLIN. MED. 159 (2011); see also Eleanor D. Kinney et al., *Altered Standards of Care for Health Care Providers in the Pandemic Influenza*, 6 IND. HEALTH L. REV. 2, 16 (2009).

⁹⁶ See FED. EMERGENCY MGMT. AGENCY, *DEVELOPING AND MANAGING VOLUNTEERS: INDEPENDENT STUDY 122-124* (Feb. 2006).

Even with the most careful planning, to paraphrase Von Moltke, “no battle plan lasts beyond first contact with the enemy.”⁹⁷ In other words, no EOP will remain unchanged past the first hour of a crisis. Volunteer functions will probably remain a moving target that requires active and continuous attention. The more hazardous the duties, the greater need for oversight. Lack of volunteer training or a laissez-faire supervisory atmosphere will invite harm or liability. On the other hand, volunteers should be confident that their leaders will use the inevitable mistakes of volunteers as opportunities to learn rather than for criticism and scapegoating. Effective “in-extremis” leadership is based upon a willingness to share risks and remain open to constructive criticism.⁹⁸ Building mixed teams of permanent employees and volunteers will require every “new” member to feel needed. Volunteers raising legitimate safety or operational concerns should be considered an asset. When training is needed, encourage volunteers to take “ownership” whenever practical.⁹⁹ Building organizational values within volunteer cadres produces greater accountability and may even yield unexpected innovation or improvements.¹⁰⁰ When mistakes or shortcomings are revealed, strong leaders will ask questions first and never scold. In emergencies, leaders share a vision of trust, transparency, and inclusion¹⁰¹ to all team members, but especially to their volunteers. Trust, in turn, fosters a culture in which all work together for a common goal. Volunteers may not completely understand why they are being requested to perform a specific task but will have confidence what is asked of them is in the best interests of all. The incorporation of volunteer staff may not be the one and only solution to crisis planning, but leaders who can successfully integrate volunteers may best be able to fill their most critical gaps in service, safety, and resiliency during a crisis.

VI. SUGGESTED MANAGEMENT BEST PRACTICES¹⁰²

1. Identify what events trigger a call for emergency volunteers. Volunteers should not normally be activated without an emergency

⁹⁷ HELMUTH VON MOLTKE, MOLTKE ON THE ART OF WAR: SELECTED WRITINGS 92 (Daniel Hughes trans., Presidio Press 1995) (1871).

⁹⁸ THOMAS A. KOLDITZ, IN EXTREMIS LEADERSHIP: LEADING AS IF YOUR LIFE DEPENDED ON IT (Jossey-Bass 2007).

⁹⁹ J. Anitha, *Determinants of Employee Engagement and their Impact on Employee Performance*, 63 INT’L J. PRODUCTIVITY & PERFORMANCE MGMT. 308 (2014).

¹⁰⁰ David E. Bowen, *The Changing Role of Employees in Service Theory and Practice: An Interdisciplinary View*, 26 HUM. RES. MGMT. REV. 4 (2016).

¹⁰¹ J. Seth Chatfield, *Ten CEO Imperatives for Healthcare Transformation: Lessons from Top-Performing Academic Medical Centers*, 62 J. HEALTHCARE MGMT. 371 (2017).

¹⁰² See U.S. DEP’T OF HEALTH & HUM. SERV., CTRS. FOR DISEASE CONTROL & PREVENTION, PUBLIC HEALTH PREPAREDNESS CAPABILITIES: NATIONAL STANDARDS FOR STATE AND LOCAL PLANNING 133-139 (Mar. 2011); *COVID-19 volunteer guide for health care professionals*, AM.

declaration. However, the lack of declaration should not prevent medical staff management from issuing “warning notices” to volunteers of an impending or potential call-up.

2. Prepare and publish an Emergency Volunteer Handbook.¹⁰³ The handbook should include standards of conduct, HIPAA requirements, unlawful discrimination and harassment policies, workplace-bullying policies, and alcohol and other substance abuse policies. The handbook should set forth whether (or which) volunteers will be covered by workers’ compensation or commercial insurance.¹⁰⁴
3. Be aware of and sensitive to any type of compensation (or gifts) to volunteers. Some gifts may count as compensation, which could create an employer-employee relationship under some state laws. If volunteers are reimbursed for any expenses, ensure records are carefully kept to avoid triggering wage-and-hour laws and to prevent voiding any available tort protections.
4. Ensure that volunteer call-up planning anticipates reasonable travel times. When the volunteers arrive, a Volunteer Management Center (VMC) should assist them in contacting family members or their (full-time) employers. The VMCs should update the family members and others via email or social media. The VMCs can also assist volunteers with food and housing. The VMCs should always be sited in a safe, convenient, and secure location.
5. Provide volunteers with a place to spend off-duty time. Find locations that are convenient for the current employees. The volunteers should have comfortable, welcoming spaces, which will help reflect a

MED. ASS’N (Feb. 2, 2021), <https://www.ama-assn.org/delivering-care/public-health/covid-19-volunteer-guide-health-care-professionals> [<https://perma.cc/K5RX-F38N>].

¹⁰³ Some hospitals have developed their own curriculum or training guides for staff volunteers. The Hudson Valley Veterans Administration Hospital, Volunteer Training Handbook is one such example. VA HUDSON VALLEY HEALTHCARE SYSTEM, VOLUNTEER TRAINING HANDBOOK (2006). The Corporation for National & Community Service provides a training outline for utilization of spontaneous volunteers in disasters. CORP. FOR NAT’L & CMTY. SERV., MANAGING SPONTANEOUS VOLUNTEERS IN TIMES OF DISASTER 65. The California Hospital Association’s own plan is yet another example. CAL. HOSP. ASS’N, GET READY, STAY READY: DISASTER PLANNING FOR CALIFORNIA HOSPITALS (2014).

¹⁰⁴ See Daniel L. Kurtz, *Protecting Your Volunteer: The Efficacy of Volunteer Protection Statutes and Other Liability Limiting Devices, Not-for-Profit Organizations: The Challenge of Governance in an Era of Retrenchment*, California Continuing Education of the Bar, C726 ALI-ABA 263 (1992); see also David W. Barrett, *A Call for More Lenient Director Liability Standards for Small, Charitable Nonprofit Corporations*, 71 IND. L. J. 967 (1996).

commitment toward them. Beds, hot showers, and minimal privacy are important features of these spaces.

6. In the event of an infectious disease outbreak, the volunteers must be adequately trained in hygiene measures and the wearing of personal protective equipment (PPE) in accordance with local, state, and federal guidelines. If volunteers will be involved in screening, triage, or other patient contact, they must strictly adhere to infection control measures.
7. Check with Human Resources (HR) and Information Technology to ensure that current Human Resources Information Systems are able to accommodate the volunteers. HR should be able to track every volunteer's work schedule, duty limitations, contact information, etc.
8. Consider employing advance volunteer registration systems, such as ESAR-VHP, EMAC, or Medical Reserve Corps (MRC), to prequalify clinical providers. Determine if your state has licensure waivers or reciprocity for physicians, nurses, and other providers during declared emergencies.
9. Absent the most exigent circumstances, volunteers should be carefully background-screened.¹⁰⁵ Due diligence includes checking criminal records, conducting drug tests, and reviewing sexual offender databases. Furthermore, no volunteer should perform duties until HR contacts at least one trusted reference provided by the volunteer at the time of application.
10. Do not discount workplace violence during emergencies. Workplace violence is four times more common in hospitals than private industry.¹⁰⁶ Volunteers may cause increased tensions or conflicts among employees during an emergency. Report to law enforcement real-time information in the event of workplace violence. Consider hiring or increasing private security if law enforcement resources may be delayed or temporarily unavailable.

¹⁰⁵ See generally John I. Winn & Kevin H. Govern, *Due Diligence Employment Screening in Healthcare Organizations*, 87 U. CINCINNATI L. REV. 1 (2018).

¹⁰⁶ OCCUPATIONAL SAFETY & HEALTH ADMIN., *Caring for Caregivers, Facts about Hospital Safety*, U.S. DEP'T LABOR, <https://www.osha.gov/hospitals> [<https://perma.cc/KEC3-5UL9>]; see also U.S. DEP'T LABOR, OCCUPATIONAL SAFETY & HEALTH ADMIN., *GUIDELINES FOR PREVENTING WORKPLACE VIOLENCE FOR HEALTHCARE AND SOCIAL SERVICE WORKERS* (2016).

11. Volunteer positions should have at least a basic job description. This description includes work location(s), general and specific duties, supervisory chain-of-command, and work-time limits. An informal written “contract” between the host facility and volunteers may include agreed upon work hours, documentation and credentialing requirements, and minimum training criteria.
12. Volunteer identification badges should be prepared in advance. The badges should conspicuously include the word “VOLUNTEER” and have access codes as needed.
13. If utilized, volunteer liability releases (waivers) should be in plain-language as prepared by competent legal advisors.¹⁰⁷ Waivers must be tailored to the applicable state law.¹⁰⁸ In most jurisdictions, liability releases must include contractual “consideration” clauses and expressly waive liability for “negligence”¹⁰⁹ on the part of host institutions or others. Volunteers should not perform duties or be issued badges until registration forms (and/or liability releases) are signed and verified.
14. Volunteer registration forms should include family contact information for accidents or illness, health limitations (if any), drivers-license data (photocopied), vaccination records, blood-group data, private healthcare insurance provider, and clinical qualifications or special skills (e.g. language fluencies). Contact information for current employment (or volunteer sending agencies) is also important. A “tickler” system within HR can ensure documents are updated annually or semi-annually.¹¹⁰
15. If volunteers will be requested to use personal vehicles for hospital business, consider purchasing a “hired, borrowed, and non-owned vehicle” commercial liability insurance rider to cover risk of automobile

¹⁰⁷ See MATTHIESEN, WICKERT & LEHRER, S.C., EXCULPATORY AGREEMENTS AND LIABILITY WAIVERS IN ALL 50 STATES (2021).

¹⁰⁸ See *Atkins v. Swimwest Fam. Fitness Ctr.*, 691 S.W.2d 334 (Wis. 2005).

¹⁰⁹ See *Hanks v. Powder Ridge Rest. Corp.*, 885 A.2d 734 (Conn. 2005). On the other hand, Virginia public policy forbids enforcement of any waiver of personal injury arising from future acts of negligence per *Johnson’s Admin. v. Richmond & Danville R.R. Co.*, 11 S.E. 829 (Va. 1890).

¹¹⁰ Authors’ Note: For reference, a tickler file does not need to be date orientated. Instead, it might be “situation” orientated: “schedule annual training,” “report due to agency,” then perhaps a reminder to follow up, and so on.

accidents. Hired vehicle policies may not cover volunteers commuting or running their personal errands.

16. Hire pre-credential clinical volunteers whenever possible. Develop Memoranda of Agreement (MOA) or Understandings (MOU) for volunteers with local clinical providers, agencies, and non-profits. The MOA/MOU should indicate whether a sending organization's workers' compensation, disability, or other insurance will cover the volunteers.
17. Make sure any volunteer mobilization plan includes a demobilization plan. Once crisis conditions have abated, management must ensure an immediate termination of temporary privileges and the return of keys, badges, and other equipment in the custody of the volunteer.
18. Contact state bar associations to explore emergency 'pro-bono' legal aid services¹¹¹ for assisting volunteers. These services include assistance with financial issues, car-rentals, disaster assistance (FEMA), auto-accidents, etc.

¹¹¹ See Katherine Asaro, *Hurricane Florence, A Chance for Attorney Volunteerism*, 18 N.C. State Bar J. 15 (2019).